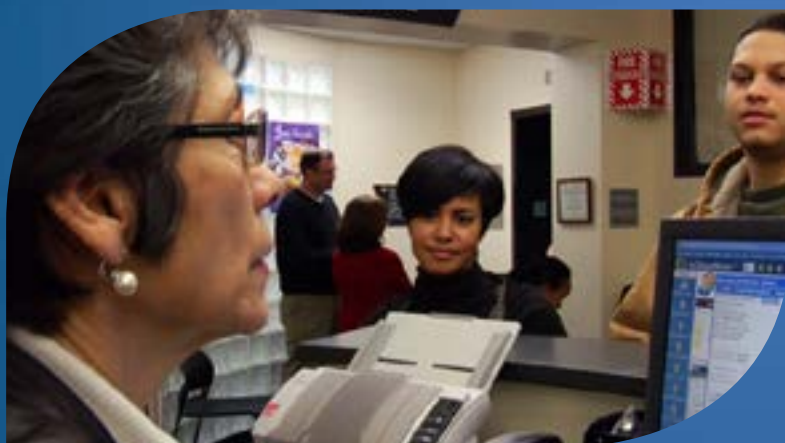


CARE COORDINATION FUNDAMENTALS

STUDENT TEXTBOOK



“This training is essential for any individual who comes into contact with patients, whether it be via telephone or in person. The training promotes patient centered care with a focus on high quality.”

*- Laila Haruna
Customer Service Liaison
CMO Montefiore Care Management*

COURSE CREATED BY
PRIMARY CARE DEVELOPMENT CORPORATION AND
1199 SEIU TRAINING AND EMPLOYMENT FUNDS



“The class was interesting, educational and will be very useful in working with my patients. Gave you a way to think outside the box.”
- **Noreen Martine**, Social Worker
North Shore LIJ Dialysis Facility, Queens Village

“This training is great to know what you do with a patient so they know we are here to help them and not to judge. It puts us in a patient’s shoe for a minute. It also shows us how important team work and communication is.”
- **Jarayha Wolf**, Customer Service Liaison
CMO Montefiore Care Management

“A patient called us this week and seemed incoherent, and because of what you’d taught us about stroke last week, we contacted her family to be sure she was alright. They were very grateful. So you see, we’re learning!”
- **Diana Nichols**, Unit Receptionist
North Shore LIJ Dialysis Facility, Queens Village

“Great training material and information. A must for all new hires and staff in the health care system. Should be hospital initial training 101 -Introduction to Health Care System. Awesome!”
- **Sharon Thompson**, Customer Service Liaison
CMO Montefiore Care Management

“This class is a resource for me as a customer service liaison. It combined practice with policy; (trainer) listened to concerns and identified challenges and also reinforced policy. Excellent in every area.”
- **Belinda Copeland**, Customer Service Liaison
CMO Montefiore Care Management

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

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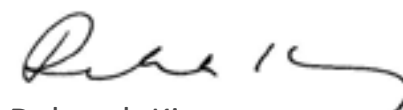
FORWARD BY DEBORAH KING, EXECUTIVE DIRECTOR, 1199 SEIU TRAINING & EMPLOYMENT FUNDS

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

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

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

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



Deborah King
Executive Director
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 are being asked to serve as a bridge between patients and providers. To accomplish this, frontline staff members require more advanced skills and training than they have received in the past. Specifically, they will need patient navigation and care coordination skills.

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

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

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

ICONS USED IN THIS COURSE



KEY TERMS

Throughout each course, students will learn new medical terms to help them better understand their roles as Care Coordinators.



WANT TO LEARN MORE?

Use these online resources to extend your learning outside of the classroom. These websites are also located in the “Resources” section at the end of each module.



QUICK TIPS

Use these helpful tips to successfully interact with patients and staff in the real world. Apply these real world tips to help you in your practice.



MODULE 1

ORIENTATION: CARE COORDINATION BASIC SKILLS — PART 1

KEY TERMS:

- >> Care Coordination
- >> Patient Navigation
- >> Health Disparities

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



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
- disempowering
- 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 the patient to avoid or delay healthcare.
- When this happens, and the illness is serious, chances of survival drop, and treatment becomes difficult and problematic.

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

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

Care coordination.

Care Coordination

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

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

Goal of Care Coordination

- reduce fragmentation of care
- help patients to access timely, appropriate care
- help patients to fully engage in their care

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

Patients and their families

- to help them access care and overcome barriers to quality care

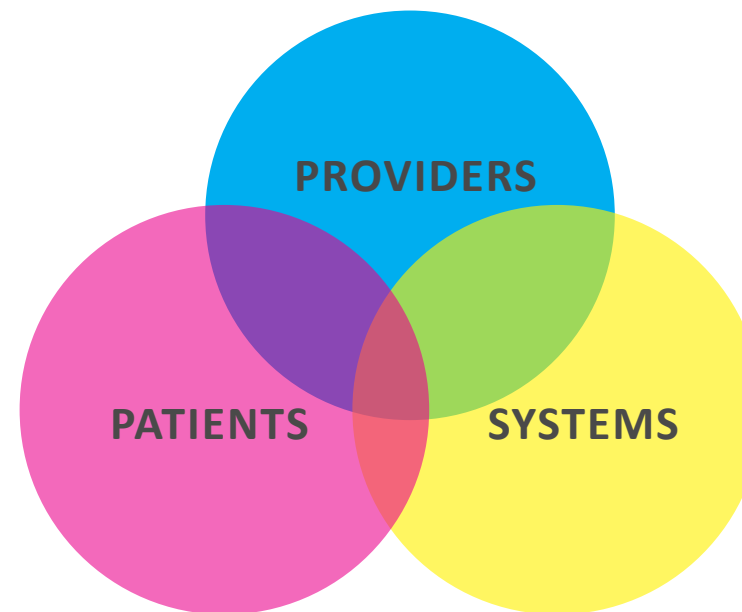
Providers

- coordinate interactions between providers that 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 patient care

SUCCESSFUL CARE COORDINATION NEEDS TO INVOLVE



This Care Coordination fundamentals course focuses on patients and their families, and interactions between providers and system. It places emphasis on understanding patient needs and the barriers patients 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

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

What is Patient Navigation?

Patient Navigation

is defined as "assistance offered to patients in 'navigating' through the complex healthcare system to overcome barriers in accessing quality care and treatment"

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

A staff member providing navigation and coordination services:

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

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

Patient navigation and care coordination can be provided by:

- medical assistants
- 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?

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.”

CDC: Social Determinants of Health: <http://www.cdc.gov/socialdeterminants/Definitions.html>

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.

CDC: Social Determinants of Health: <http://www.cdc.gov/socialdeterminants/Definitions.html>

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?

- Guide patients through the healthcare system
- Help patients arrive at scheduled appointments on time and prepared
- Identify barriers to care
- Ensure follow up for abnormal screenings
- Link patients, caregivers, and their families with necessary follow up services
- Increase access to culturally appropriate, supportive care
- Offer patient education materials in several languages
- Assist patients in filling out forms
- Identify financial aid options
- Help arrange patient transportation
- Maintain regular contact with patients during their care
- Coordinate services within the healthcare organization, with outside healthcare facilities, and within the community

Adapted from A Patient Navigator Manual for Latino Audiences <http://www.redesenaccion.org/sites/www.redesenaccion.org/files/PNmanualfinal.pdf>

Patient Navigation is Similar to Care Coordination

Where did the idea for patient navigation come from?

- 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

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



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 sooner than those who did not

Care Coordination staff should know how the healthcare system works, basic medical information, warning/danger signs for when to get help with a patient, and which resources are available in the community.

SKILLS AND QUALITIES STAFF PROVIDING CARE COORDINATION SHOULD HAVE:

RESPONSIBLE & TRUSTWORTHY

Staff should be responsible and trustworthy

CARING & FRIENDLY

Staff should be caring and friendly

POSITIVE ATTITUDE & CREATIVE

Staff should have a good attitude and the ability to brainstorm and think creatively

GOOD COMMUNICATORS

Staff should have clear communication skills with patients and be good listeners

ORGANIZED

Staff should be organized and resourceful



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Colonoscopy Patient Navigator Program Orientation Manual, NYC Health DOHMH

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Colorado Patient Navigator Training Program, www.patientnavigatortraining.org

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McDonald KM, Sundaram V, Bravata DM, et al. Closing the Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7-Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, US Department of Health and Human Services, June 2007

NIH fact sheets-health disparities:

<http://report.nih.gov/nihfactsheets/viewfactsheet.aspx?csid=124>

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

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

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

VIDEOS

UIC Science Bytes: Patient Navigators

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

Eye to Eye: Dr. Harold Freeman

<http://www.youtube.com/watch?v=DQhUlliZ0N4&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>



MODULE 2
**ORIENTATION: CARE COORDINATION
 BASIC SKILLS — PART 2**

KEY TERMS:

- >> Chronic Disease
- >> Patient Centered Care
- >> Health Home

**Orientation: Care Coordination
 Basic Skills — Part 2**

OBJECTIVES

DEFINE A CHRONIC DISEASE 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, ACCOUNTABLE CARE ORGANIZATIONS 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 THE PATIENT’S BILL OF RIGHTS

The State of Healthcare Today: Chronic Disease, New Models of Delivering Healthcare

- 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 Chronic Disease? 

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

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



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

- Diabetes
- Hypertension
- Cardiovascular disease
- Asthma
- Depression/schizophrenia
- HIV
- Hepatitis

What are some challenges that patients with chronic diseases face?

- Numerous appointments with multiple doctors, nurses, educators, nutritionists, and therapists
- Learning how to self-manage their illness
- 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 by access to care earlier
- Receive better care in a health center with a medical team that 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 of the doctors, nurses, and therapists that provide care for a patient communicate with each other
- Test results are shared between providers, so that the same tests are not repeated at different doctors' offices

- The healthcare team ensures that patients have transportation to referral appointments and follow up on screening results

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 to make informed decisions and fully participate in their own care

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?

Emergency room care:

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

What is a health home?

Health Home

- **Network of organizations** that work together to provide and **coordinate all health and social service needs** for patients with multiple chronic conditions
- 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 access patient 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 cost, and improving patient experience
- Unlike a Health Home, does not focus only on chronically ill patients

WANT TO LEARN MORE

patientnavigatortraining.org

TOPIC: Patient Navigation



Understand your **Role** and Responsibilities

How do you find out what your role is and what your responsibilities are?

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 PATIENTS?

- You may be the only person on the team who understands the challenges that a patient may be facing
- Your role is to communicate the challenges your patients face to the rest of the team

HOW DO YOU BUILD STRONG RELATIONSHIPS WITH PATIENTS?

- Build trust by
 - Keeping your word (i.e. if you say you will call at a certain time, call at that time)
- Be empathetic and compassionate
- Make efforts to understand their background, and respect their culture and community - your ability to help depends on it!
- Try to “stand in their shoes”

Build relationships with others to provide care coordination:

Care Coordination Relationships:



Why should you build a strong relationship with the healthcare team?

Because the Healthcare Team...

- Takes primary responsibility for the patient
- Provides, facilitates, and coordinates all patient care
- The 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 roles

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

Examples of Community resources

- Housing and transportation assistance
- Support groups
- Substance abuse providers
- Food pantries
- Domestic violence support services

Remember: some patients may not be able to focus on their health if they have more basic needs related to food, shelter, and safety

BEING A STAFF MEMBER WHO PROVIDES CARE COORDINATION

You spend a lot of time working on maintaining professional relationships!



Key Competencies

- Understand your role and responsibilities
- Be a “team player”
- Advocate for your patients
- Build relationships

Why do you need to build strong relationships with specialists and hospitals?

Specialists and Hospitals provide. . .

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

Why is it important for you to understand patient insurance and financial resources?

Insurance/Financial Resources:

- 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

The Patient's Bill of Rights

What is a Patient's Bill of Rights?

Have you ever been given a patient's bill of rights in a health care center? Did you read it? Did you understand it? 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 should be aware of the patient's bill of rights in case you need to advocate for your patient.

Look in your exercise book for a sample Patient's Bill of Rights.

Ethical Responsibilities

It's important to recognize that even if you feel inexperienced, patients will view you as an authority with most of the answers. You need to be careful about this responsibility and use your power in a way that empowers the patient. Always remember to take the patient's needs into account first, and attempt to do what is best for your patient.

Remember, you should NOT:

- Burden clients with your problems
- Assume that patients will meet your needs
- Insist patients follow your solutions
- Exploit dependency

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!

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MODULE 3

COMMON CHRONIC DISEASES — PART 1 DIABETES

KEY TERMS:

- >> Glucose
- >> Diabetes
- >> Insulin

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

DIFFERENT WAYS THAT PATIENTS COPE WITH HAVING A CHRONIC DISEASE

HELPING PATIENTS TALK TO THEIR DOCTORS AND PREPARING THEM FOR PRODUCTIVE MEDICAL VISITS



Common Chronic Diseases and Health Homes

Recap: What is a Patient Centered Medical Home?

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 is a Health Home?

HEALTH HOME

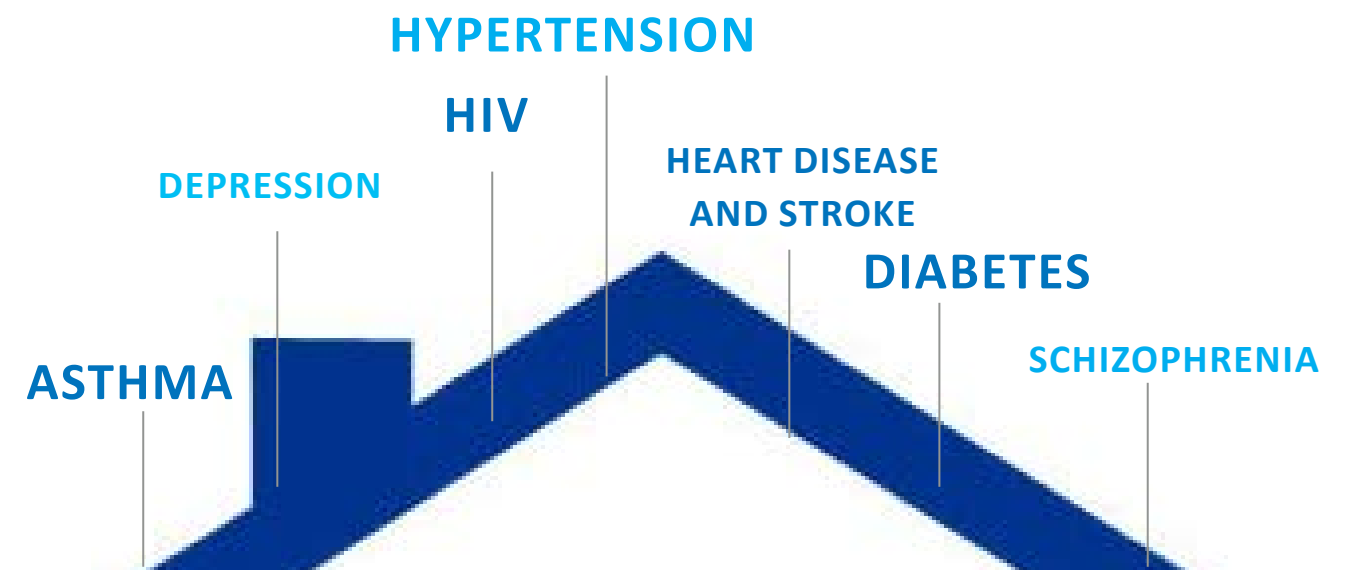
A health home is for Medicaid patients with multiple chronic conditions. It is a network of organizations that work together to provide and coordinate care that uses a care management service model. It is done by a “care manager” who oversees and coordinates access to services. A health home measures success by lowering rates of emergency room visits and hospital admission rates for its patients.

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

Patients with multiple chronic illnesses:

- highest costs
- frequently in the Emergency Room
- admitted to the hospital more than other patients
- extensive care coordination needs
- difficulty with self-management of their illnesses

HEALTH HOMES’ CHRONIC DISEASE FOCUS



What is the “clinical” role of staff providing coordination 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

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

Basics of Diabetes: What is it?

Diabetes is too much glucose, or sugar, in the blood.
Glucose can’t get into a person’s cells and builds up in their 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 is a hormone made by the pancreas to help glucose get into our body cells
- The pancreas is an organ near your stomach

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 common — 9 out of 10 people with diabetes have this type
- 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 has diabetes become more common in recent years in people in their 30's and 40's?

Type 2 diabetes on the rise

- More people who are less active
 - Use cars, instead of walking
 - Watch more television and play video games
- More people eat more high calorie foods and processed fast foods
 - Higher obesity rates

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

Diagnosing diabetes, tests, specialists, danger signs and symptoms

How is diabetes diagnosed?

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

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 their 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
- If left untreated, both conditions can be dangerous and 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, and then patient will need dialysis
- Podiatrist, infectious disease, neurologist:
 - For problems with nerve damage
 - High blood sugar can damage nerves leading to loss of sensation in feet and hands leading to infections, main cause of amputations in diabetics
- Dentist:
 - For problems with teeth and gums
 - Problems with blood flow can cause gum infections and disease

Routine care for diabetes patients:

Twice a year

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

Once a year

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

WANT TO LEARN MORE?

diabetes.org

TOPIC: Diabetes



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
- Other patients with diabetes, hypertension and cardiovascular disease may not think of themselves as having a chronic disease since these conditions are so common
- 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.

SUPPORT YOU CAN OFFER YOUR PATIENTS

- ✓ 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 / ALCOHOL ABUSE COUNSELORS OR GROUPS
- ✓ EDUCATION AND NUTRITION SPECIALIST

Talk to your doctor

How comfortable do you feel talking to your doctor?

How comfortable do your family members feel?

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

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
- Patients may have more than one doctor and other health care staff, such as nurses, as part of their medical team

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



MAIN QUESTIONS A PATIENT SHOULD ASK THE MEDICAL PROVIDER:

1

What is my main health problem?

2

What do I need to do about it?

3

Why is it important for me to do these things?

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Diabetes Resources

[1 800 DIABETES](http://1800diabetes.org)

National Heart, Lung and Blood Institute, National Institutes of Health; Department of Health and Human
Services

www.nhbli.nih.gov

VIDEOS

Diabetes Made Simple

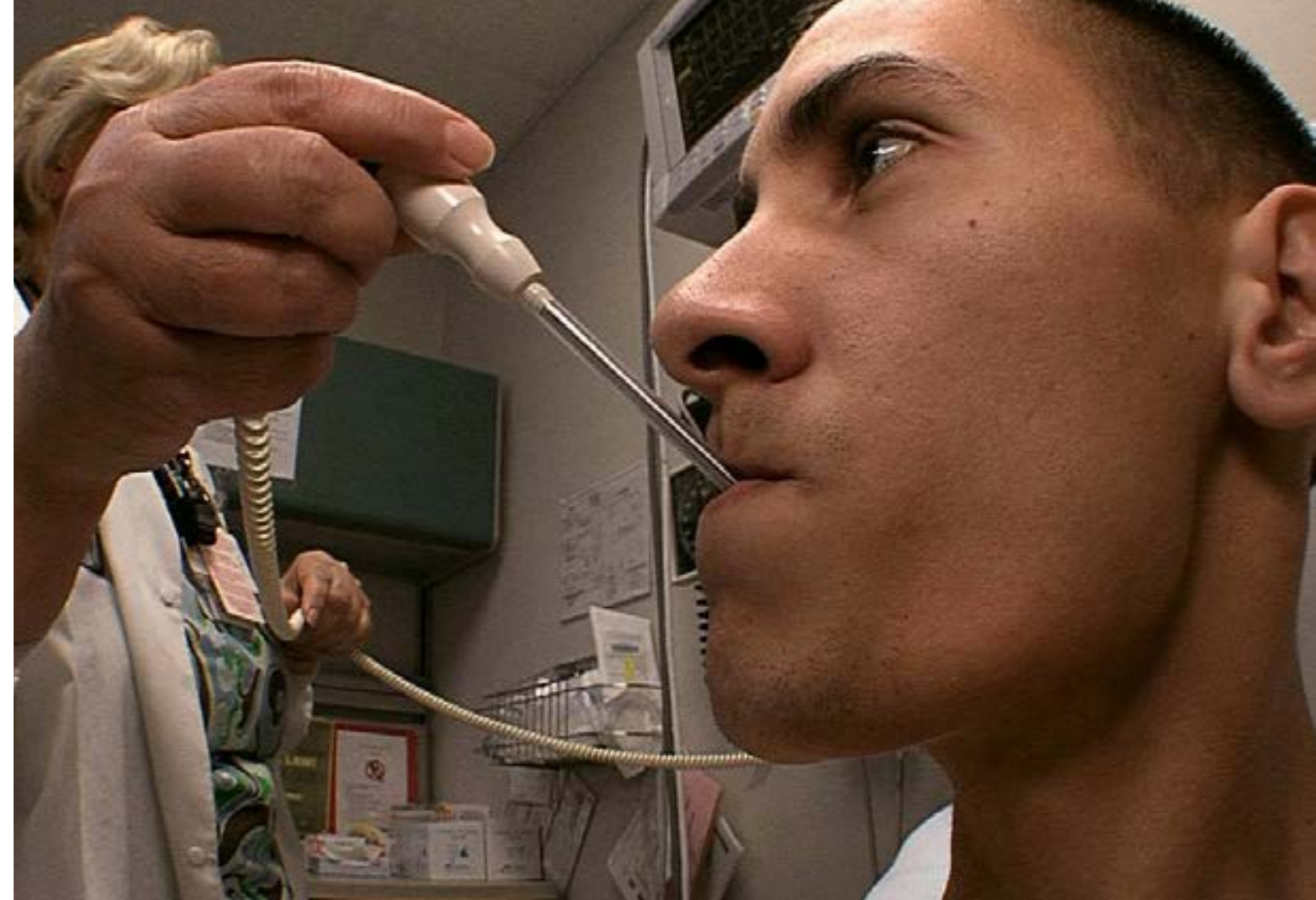
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MODULE 4

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

KEY TERMS:

- >> Hypertension
- >> Cholesterol
- >> Asthma

Common Chronic Diseases — Part 2

Hypertension/High Cholesterol/Asthma

OBJECTIVES

UNDERSTAND THE BASICS OF HYPERTENSION

UNDERSTAND THE BASICS OF HIGH CHOLESTEROL

UNDERSTAND THE BASICS OF ASTHMA

DESCRIBE HEALTHY BEHAVIORS AND RISK FACTORS RELATED TO DIET, EXERCISE AND SMOKING



Basics of Hypertension

What is Blood Pressure?

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.

HIGH BLOOD PRESSURE/HYPERTENSION

Hypertension is a common condition in which the force of the blood against artery walls is high enough to eventually cause health problems, such as heart disease.

- 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 and stroke

What Causes High Blood Pressure?

Causes of 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 and increases a person’s risk of heart attacks, strokes, kidney damage, eye damage, heart failure and atherosclerosis (*hardening of the arteries*)

How can high blood pressure be 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 medications as prescribed

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

Signs of high blood pressure

Fatigue, confusion, nausea, vision problems, nosebleeds, headache, dizziness, anxiety, and impotence

It is also possible to have high blood pressure without experiencing any symptoms at all.



Did you know...

A person can be calm and relaxed and still have high blood pressure?

HIGH BLOOD CHOLESTEROL

High blood cholesterol: too much cholesterol in the blood contributes to the build-up of plaque along walls of blood vessels

CAUSES OF HIGH BLOOD CHOLESTEROL

- INACTIVITY
- OBESITY
- DIET HIGH IN SATURATED FAT, TRANS FAT AND CHOLESTEROL
- AGE
- FAMILY HISTORY

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

HDL is “good” cholesterol

LDL: is “bad” cholesterol

You want the highs to be high (HDL) and the lows to be low (LDL)

NORMAL LEVELS

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

Triglycerides

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

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

Diagnosing with blood tests

- Finger stick
- Lipid profile test (fasting test)

High blood cholesterol treatment

- Dietary changes - reduce saturated fat, trans fat, and cholesterol
- Quit smoking
- Increase activity and exercise
- Lose weight
- Medications

ASTHMA

Chronic lung disease that inflames and narrows the airways.

In the United States, more than 22 million people have asthma.

Nearly 6 million of these people are children.

Asthma

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

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

Causes and risk factors

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

Two 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

Treatment helps control the disease and prevent asthma attacks.

The goal is to reduce need for quick relief medications and help maintain good lung function. Patients should be able to maintain normal activities such as sleeping through the night and exercising. Treatment can prevent attacks that result in emergency room visits or hospital admissions.



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 is an asthma action plan?

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

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

- Hand held device 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
- Use of a peak-flow meter allows patients to obtain much earlier indication of oncoming attacks
- Allows a patient to gauge how under control their asthma is

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**

REFERENCES

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

CDC: Asthma:

<http://www.cdc.gov/asthma/>

CDC: Heart Disease and Stroke prevention:

<http://www.cdc.gov/heartdisease/>

Nutrition and Physical Activity:

<http://www.cdc.gov/nutrition/>

Tobacco:

<http://www.cdc.gov/tobacco/>

American Heart Association:

www.americanheart.org

Your Heart, Your Life: A Community Worker's Manual for the Hispanic Community

<http://www.nhlbi.nih.gov/health/prof/heart/latino/english/overview.htm>

VIDEOS

Managing Hypertension with lifestyle changes

<http://www.youtube.com/watch?v=DT2DmGVa2SY>

Living With and Managing Asthma

<http://www.youtube.com/watch?v=ImYZd6KxO8c>

WANT TO LEARN MORE?

medterms.com

TOPIC: Asthma



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

Overview: Heart Disease and Stroke

What is Heart Disease?

Heart disease is any disease or condition that affects or damages the heart or blood vessels. It is also called cardiovascular disease.

What is a 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



MODULE 5

COMMON CHRONIC DISEASES — PART 3

HEART DISEASE/STROKE

KEY TERMS:

- >> Heart Disease
- >> Stroke
- >> Heart Attack



WANT TO LEARN MORE?

americanheart.org

TOPIC: Heart Disease



COMMON CHRONIC DISEASES

STROKE

When a blood vessel in the brain becomes blocked or bursts open and blood can no longer reach the brain



HEART ATTACK

When blood supply to the heart is blocked.

HEART DISEASE AND STROKE CAUSE MORE

THAN **1/2** OF ALL DEATHS IN AMERICA

Chances of surviving a heart attack/limiting damage to heart are best if person receives treatment within first hour after a heart attack



REDUCING RISK FOR HEART DISEASE AND STROKE

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

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
- Suddenly breaking out in a cold sweat, feeling nauseated or feeling light headed

CAN EQUAL PERMANENT DISABILITY

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

Heart Attack

Educate your patients about the warning signs of heart attack

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

YES!

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 of survival!

Warning signs of a heart attack

- Sometimes no warning signs at all
- Symptoms may come and go
- Women often have less common warning signs
 - 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 and 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 attacked occurred within last three hours
- Coronary artery bypass surgery
 - Cut and sew veins or arteries to a place past the blockage
- Coronary angioplasty
 - A thin tube is passed through an artery to the blocked artery in the heart
 - A balloon is inflated to open the blocked artery or a small wire mesh tube called a stent is put in place to hold the 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: may feel they have too many things to remember or too many changes to make in their lives
 - 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
- Helps patient change their lifestyle habits
- Usually patient sees a team of healthcare professionals such as: doctors, nurses, physical therapists, nutritionists, social workers
- Exercise therapy, strength training
- Stress management techniques
- Help quitting smoking

EDUCATE YOUR PATIENTS ABOUT THE WARNING SIGNS OF STROKE

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

YES!

Timing is important

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

What are the warning signs of a stroke?

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

TEACH YOUR PATIENTS

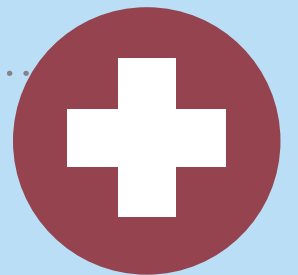
- It is important to recognize the signs of a stroke
- If you think you or someone else is having a or has had a stroke, call 911 immediately
- There are medicines and treatments that can greatly improve recovery but only if they are started soon after the stroke has occurred

How is a stroke diagnosed?

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

EMOTIONAL SUPPORT THERAPY “TALK THERAPY” AND MEDICINES FOR DEPRESSION, LEARNING STRESS MANAGEMENT

PHYSICAL THERAPY RELEARNING HOW TO WALK,MOVE, MAINTAIN BALANCE



HOW IS A STROKE TREATED?

4 METHODS OF STROKE REHABILITATION

To recover from disabilities caused by stroke a person always needs rehab or therapy

SPEECH THERAPY RELEARNING HOW TO SPEAK



OCCUPATIONAL THERAPY RELEARNING BASIC ACTIVITIES OF DAILY LIVING SUCH AS BATHING AND DRESSING

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

THE RESULTS OF A STROKE

Damage from a stroke:

- Depends on location and amount of damage to the brain
- Patients may recover completely or only partially from a stroke
- A person who suffered a stroke is likely to face emotional as well as physical problems
- 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 others
- Change in behavior, such as asking question after question, repeatedly
- Depression

Helping patients to take their medicine

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

Reasons patients don't take their medicines as prescribed:

- Don't understand what the medicine is supposed to do
- Not sure how to take medicines
- Cannot afford their medicines so they don't fill prescriptions
- Try to save money by cutting pills in half or taking them every other day
- Taking so many medications already that they don't want to take any new ones
- 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 Don't feel well and think the medicine isn't helping
- Feel that the medicine is giving them side effects that they don't like
- Don't have anyone to help or remind them to take medications

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

Taking medicine as prescribed:

- Medicines work best when taken exactly as prescribed
- Skipping doses can be harmful and lead to worsening patient health
- 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

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VIDEOS

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Living With and Managing Asthma

<http://www.youtube.com/watch?v=ImYZd6KxO8c>



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

Basics of Hepatitis A, B, and C

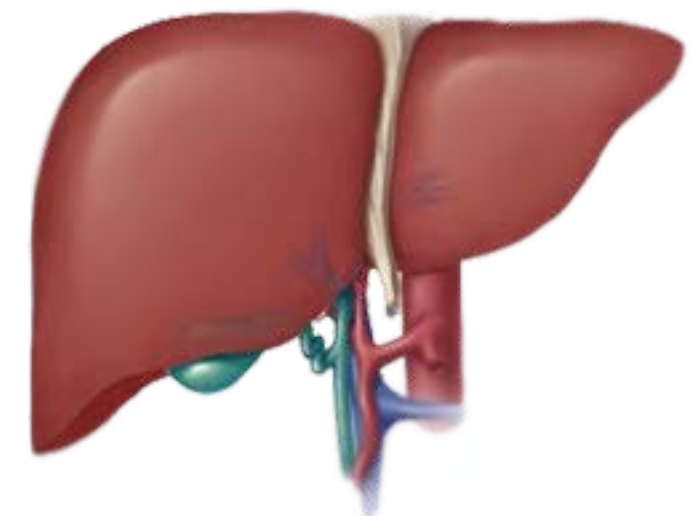
HEPA TITIS

Hepa=liver

Titis=inflammation

Hepatitis is Inflammation of the liver

The liver is a vital organ that processes nutrients, filters the blood, removes toxins and fights infection



MODULE 6 COMMON CHRONIC DISEASES — PART 4 HEPATITIS/HIV

KEY TERMS:

- >> Hepatitis
- >> HIV
- >> AIDS



INFLAMMATION OF THE LIVER MAKES IT WORK LESS EFFECTIVELY AND DAMAGES AND SCARS IT

How does a person find out if they have Hepatitis?

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

HEPATITIS A

Spread by objects, food or water contaminated with virus // Fecal-oral route// hand washing lowers risk of infection

Vaccine available

What causes Hepatitis?

- Usually caused by a virus
- Heavy alcohol use, some medications, toxins and some medical conditions
- Some types are spread through sexual activity

HEPATITIS C

Spread mainly through blood and less so through sexual activity // Sharing or using unsterilized needles to inject drugs// Reused needles, i.e. for tattoos

No Vaccine

HEPATITIS D AND E (LESS COMMON)

HEPATITIS B

Spread through blood, body fluids // Sexual activity // Contaminated needles // Contact with blood // From an infected mother to her baby at birth

Vaccine available

HOW CAN CARE COORDINATION HELP PATIENTS WITH HEPATITIS?

Provide education and support. **Encourage patients 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.**



STATISTICS ON HEPATITIS B

5 - 25% of people with chronic Hepatitis B develop serious liver disease, liver damage, or liver failure.

3,000 people die every year in the US from Hepatitis B related liver disease.

TREATING HEPATITIS B

REGULAR MONITORING

MEDICATION

GOOD NUTRITION

ALCOHOL/DRUG AVOIDANCE



STATISTICS ON HEPATITIS C

An estimated **3.2 million** in the U.S. have chronic Hepatitis C.

Most people with Hepatitis C are not aware they have it.

Hepatitis C now kills more Americans than HIV.

75 - 85% of those infected develop chronic infection.

TREATING HEPATITIS C



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 MAY REDUCE LENGTH OF TREATMENT

FOR MANY PEOPLE MEDICATION CAN RESULT IN VIRUS BECOMING UNDETECTABLE

INTERNET CONNECT

cdc.gov

LEARN ABOUT HEPATITIS



HIV / AIDS



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

PEOPLE GET HIV THROUGH :

sexual contact, sharing needles or syringes, contact with infected blood, being born to an infected mother.

RISK OF GETTING HIV INCREASES:

with multiple sex partners, untreated sexually transmitted infection (STI) or a partner with an untreated STI. Risky sex also increases the risk.

RISKY 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

You can't tell if someone has HIV or AIDS without an HIV test



Early symptoms of HIV

Many people don't feel anything

Some experience fever, headache, sore throat, rash

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 non-sterile 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 tell without a test

How do HIV tests work?

- Detect 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

How does the HIV test detect antibodies in a person's blood?

- In the case of HIV, 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 is not 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 test to be positive after an encounter with HIV?

- Up to three months

What are early symptoms of HIV?

Early symptoms of HIV:

- many people don't experience any symptoms when they contract HIV
- some people experience: fever, headache, sore throat, or rash

What are later symptoms of HIV?

- Years later, some still feel fine
- Other people may feel sick:
 - have 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?

- There is no cure for HIV
- Variety of drugs can be used to control the virus
- Treatment should begin if CD4 count is < 500, the patient is pregnant, or has 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, and weakened bones

Co-diseases and Co-treatments

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

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

- 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 is not "cured," but is under control
- Body becomes stronger and healthier

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

- HIV can get worse and become AIDS
- Body develops resistance to the medications
- May 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

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CDC: HIV:

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

Mayo Clinic: HIV/AIDS

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

PubMed: Hepatitis:

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

Web MD: A man with HIV infection:

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

Web MD: A woman with HIV:

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

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

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

VIDEOS:

Hepatitis C Made Simple: Know Your Status

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

George's Story: Hepatitis C

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

Video: Su Wang: Faces of Hepatitis

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

FACES of HIV: Kamaria's Story

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

Living with HIV

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



MODULE 7 BIAS, CULTURE, AND VALUES

KEY TERMS:

- >> Cultural Competence
- >> Cultural Sensitivity
- >> Sexual Orientation
- >> Gender Identity

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.



Cultural Competence Definitions

WHAT IS CULTURE?

>> Thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

WHAT IS CULTURAL COMPETENCE?

>> Having the capacity to work effectively and interact with people from cultures different than our own.

WHAT IS CULTURAL AWARENESS AND WHAT IS CULTURAL SENSITIVITY?

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

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

Definitions in this section from Missouri People to People Training Manual, 2008, http://peer.hdwg.org/sites/default/files/6%20CultureAndCulturalCompetence-CommunicationSkills-Peer_Training.pdf

Cultural Identity

Culture and language have a significant impact on health care.

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

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

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

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.

WANT TO LEARN MORE?

redesenaccion.org

TOPIC: Patient Navigation for Latino Patients



CROSS CULTURAL INTERVIEW STRATEGIES

Respect – Curiosity – Empathy

When caring for patients of any background different from your own, it is vitally important to maintain curiosity, respect, and empathy.

- Be curious about the patient’s beliefs, practices, fears, and customs. Patients are usually 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.

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., ask about 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 the expected response.
- Take communication cues from the patient regarding touch, eye contact, and so on.

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



“ WHAT ARE SOME QUESTIONS CARE COORDINATION STAFF CAN ASK TO HELP PROVIDE GOOD CROSS CULTURAL CARE? ”

1. What is your full name and your primary language?
2. Tell me about yourself.
3. Who lives in the home with you?
4. Are you involved in a relationship?
5. What kind of work do you do?
6. What race do you identify yourself as?
7. Can you describe what your current illness or surgery means to you?
8. Can you tell me about any special things or processes that you use as a form of relaxation or medication?
9. Who in (or outside) your family helps you make decisions about your illness or surgery?
10. Can you share your spiritual beliefs including their influence (if any) on your current illness?

TRY TO UNDERSTAND THE FOLLOWING ABOUT YOUR PATIENTS

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



Cross Cultural Focus: Sexual Orientation

“Sexual orientation” is the preferred term used when referring to an individual’s physical and/or emotional attraction to the same and/or opposite gender.

“Heterosexual,” “bisexual” and “homosexual” are all sexual orientations. A person’s sexual orientation is distinct from a person’s gender identity and expression.

From Human Rights Campaign, <http://www.hrc.org/resources/entry/sexual-orientation-and-gender-identity-terminology-and-definitions>

Cross cultural questions to ask:

- 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 “gay” if he has sex with men. The patient may consider himself 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

The term “gender identity,” distinct from the term “sexual orientation,” refers to a person’s innate, deeply felt psychological identification as male or female, which may or may not correspond to the person’s body or designated sex at birth (meaning what sex was originally listed on a person’s birth certificate).

From Human Rights Campaign, <http://www.hrc.org/resources/entry/sexual-orientation-and-gender-identity-terminology-and-definitions>

Cross cultural questions to ask:

- 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 personal pronoun?” For example, do you prefer “she” or “he?”

REFERENCES

Missouri People to People Training Manual, 2008

<http://peer.hdwg.org/sites/default/files/Level%201%20Instructor%20Manual.pdf>

The Center for Linguistic and Cultural Competence in Health Care: Glossary of Terms. Office of Minority Health Home Page, U.S. Department of Health and Human Services, October 19, 2005.

<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=11> (last accessed June 11, 2012)

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=Dx4Ia-jatNQ>



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



Health Disparities

OBJECTIVES

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

Health disparities and the social determinants of health

What are health disparities?

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

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

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

...Increases with decreasing socioeconomic circumstances



MODULE 8 HEALTH DISPARITIES

KEY TERMS:

>> Health Disparities

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 [...].

-The World Health Organization

People's socioeconomic circumstances strongly influence their health.

Income/poverty, being uninsured

Where a person lives, safety of the neighborhood

Where they work

Not having a primary care provider or receiving preventive services

Educational attainment, literacy level

Health disparities exhibit themselves by the presence of a constellation of risk factors and behaviors that may cluster together for some groups of people more than others such as:



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

Racial/ethnic differences in mortality and morbidity rates may reflect, in part, differences in socio-demographic and behavioral risk.

**CDC Health Disparities and Inequalities Report — United States, 2011

WHAT HEALTH DISPARITIES CAN BE DECREASED WITH CARE COORDINATION?



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

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 of 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 that sicker individuals will no longer be excluded from coverage or charged higher premiums.

Care coordination staff can help facilitate selection of plans and applications

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.

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.

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 serve diverse patient populations will be expanded and strengthened by the Affordable Care Act (ACA):

- ACA will expand initiatives to increase racial and ethnic diversity in the health care professions
- ACA will strengthen cultural competency training for all health care providers
- ACA will require health plans to use language services and community outreach in underserved communities

Health Care Access and Coordination

Staff that provide care coordination can play a critical role in coordinating access to a comprehensive continuum of services by:

- Tailoring 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.

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

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

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>



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

What are “excellent” communication skills and why do staff who provide care coordination need them?

Staff who provide care coordination need excellent communication skills

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

Lack of communication

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

MODULE 9 BASIC COMMUNICATION SKILLS

KEY TERMS:

- >> Communication
- >> Interdisciplinary Team
- >> Customer Service



Communication:

The exchange of thoughts, messages, or information, as by speech, signals, writing, or behavior

Communication & Relationships



Understand the needs of your patients and barriers to care that they face
Build strong relationships with other care team members, specialists, mental health providers, and community resources

What is good communication with a patient?

Active Listening



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

Speaking



- 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

✓ **Use the patient's name**

x **Don't interrupt the patient**

x **Don't give the patient unsought or unrelated advice**

x **Don't talk about yourself**

x **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

- Assume a position 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 that you understand and empathize.

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 non-verbal communications

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

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

Communicating as Part of an Interdisciplinary Team

Patient Safety and Quality: An Evidence-Based Handbook for Nurses, Chapter 33. Professional Communication and Team Collaboration, pp 1-3
http://www.ahrq.gov/qual/nursesdbk/docs/O'DanielM_TWC.pdf

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

Interdisciplinary team:

a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient

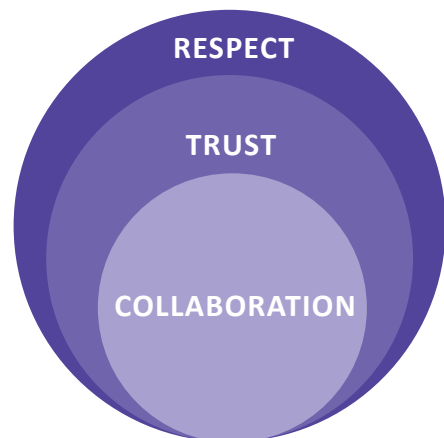
In the healthcare environment what do we mean by collaboration?

Collaboration in healthcare means that professionals:

- 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:



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?

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

Tips for communication by phone

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

Communication that is not face-to-face carries risks

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

Telephone Etiquette

- Remember that you represent the organization
- A phone call may make a first impression 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?

Patients may have strong emotions

- Emotions may be directed at you, but they are not necessarily because of you
- Patients can experience enormous frustration trying to navigate the healthcare system
- Patients may legitimately have a right to be upset- do not 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?

- 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 is policy for patients to give authorization for any information to be released.

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
- Instructions, directions, etc. can be sent 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

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
- ***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***

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

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

- Be positive toward others
- If someone is difficult to deal with, assume they are dealing with difficulty in their life
- Remember that the conversation is about ***them***, not ***you***
- Practice forgiveness
- Give the benefit of the doubt

Know when to seek help or get assistance

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

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

- Easier
- Better
- Less scary
- Less overwhelming

Find colleagues, friends, or a therapist to talk through difficult work situations and hard to handle emotions that are coming up

Manage your own emotions

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

- 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.



Care Coordination = Customer Service

What are things that care coordinators do that are a form of customer service?

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

What can we do to help prevent and manage conflict?

- Improve your communication skills
- Practice kindness (it is good customer service and a business strategy)
- Be empathetic
- Manage your own emotions
- Be professional
- Know when to seek help or get assistance

Kindness is good customer service and a business strategy

- The patient is your customer
- Your attitude counts
- Practice forgiveness and giving someone the benefit of the doubt
- If patients are cared for, they will come back if treated with kindly and respectfully

Use Empathy

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

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MODULE 10
ACCESSING PATIENT RESOURCES

KEY TERMS:

- >> Patient Resources
- >> Resource Directory

Accessing Patient Resources

OBJECTIVES

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

Helping Patients Access Resources

Patient Resources: 

Services that are needed by the patient but are not directly provided by the provider.

They may be clinical and require a referral from the provider:
Specialists, social workers, physical therapists, procedures, lab work, etc.

They may be non-clinical, and do not require a referral from the provider:
Community organizations, housing services, transportation services, etc.



WHAT IS THE ROLE OF STAFF WHO PROVIDE CARE COORDINATION TO HELP PATIENTS TO ACCESS RESOURCES?

Identify and effectively LINK patients to the people, services, and organizations that can provide them with support or needed care

For resources that need a referral from the primary care doctor, ensure that the patient:

| | | | |
|--|-------------------|---|----------------------|
| HAS AN APPOINTMENT | KNOWS WHERE TO GO | HAS THE CORRECT PAPERWORK FOR THE APPOINTMENT | MADE IT TO THE VISIT |
| ENSURE THAT ANY REPORTS, NOTES, OR TEST RESULTS FROM THE VISIT ARE SENT TO THE PRIMARY CARE PROVIDER AND ARE ADDED INTO THE PATIENT'S CHART. | | | |

For resources that do not need a referral from the primary care doctor:

| | | | |
|--|---|-----------------------------------|---|
| IDENTIFY NON-CLINICAL NEEDS OF PATIENT | MAKE PATIENT AWARE OF WHICH SERVICES MAY BE AVAILABLE TO THEM | MAKE APPOINTMENTS FOR THE PATIENT | HELP PATIENT FILL OUT FORMS OR APPLY FOR PROGRAMS OR ASSISTANCE THEY NEED TO ACCESS |
|--|---|-----------------------------------|---|

Since helping patients to access resources is a responsibility of staff who provide care coordination, what can help you do this?

- Resource directory
- Relationships with the people and organizations in that directory

WHAT IS A RESOURCE DIRECTORY?



A list of resources available for patients

- > Clinical, requiring a referral
- > Non-clinical, not requiring a referral

Finding Resources

When you begin your job as a staff member providing care coordination you will need to learn about what resources are available in your community.

Find out if your health center has its own internal resource directory

Many health centers have their own resource directory that is used by all internal clinicians and health center staff. This is a good place to start! Ask your supervisor or manager if he or she is aware of an internal resource directory.

Find out if there is a local resource directory

Local resource directories may be organized by individual towns, counties, or states. If you are not aware of any that exist, begin by contacting the local town hall in your town or city to see if there are any available.

Ask your supervisor or manager.



Find state and national resource directories

Depending on whether or not your patients live in the surrounding area or in towns outside of the medical practice, you may want to find state and national resource directories.

State and national resource directories are likely found most easily by searching the internet or contacting your local town hall.

Make your own Community Resource Directory

1. Think about and talk to others at your organization about the needs of the patients
2. Gather information for the directory
 - Search the internet
 - Contact local community collective organizations (such as The United Way or the American Cancer Society) and review their resources and relevant information
3. Organize information into logical groupings that suit your patients' needs
4. Contact each organization to confirm services and placement within directory groups
5. If possible, develop a partnership agreement with certain community resources to strengthen collaborations

Make your own Community Resource Directory

- It is possible that there are no resource directories available in your community. It is also possible that you live in the community where you work and are aware of multiple organizations and agencies that might be beneficial to your patients.
- Either way, it may be a good idea to compile your own directory so you have a single file to consult and are familiar with all available resources.

Make your own Community Resource Directory

- For each listing include:
 - Names of organizations
 - Contact persons
 - Addresses
 - Telephone numbers
 - Websites
 - Brief description of the services offered by each organization
 - Include other helpful information

Working With Community Agencies

What do you want to establish with all of the resources for patients that you have on your list?

A relationship.

Working with 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 these resources to better assist your patients. In fact, it would be most beneficial to form contacts within organizations so you can build relationships over time.

How can staff providing care coordination establish a relationship with the community agencies they are recommending?

Make a connection

- Introduce yourself as a staff member who provides care coordination
- Briefly explain what you do
- Try to establish a contact at the organization that you can reach out to in the future
- Offer your help as a contact at your organization that they can reach out to if in need of assistance

More tips for making a connection

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.

- Ask the person at the front desk or over the phone if there is anyone available with whom you could learn more about the available services
- Introduce yourself and hand out your business card
- Ask about what services are available or learn more about the program
- Ask for the person's card in order to obtain his or her contact information
- Thank the contact for talking to you and ask if it would be okay to contact him or her in the future
- Send a thank you email

What information would staff providing care coordination want to find out about an organization they are directing patients to when they visit it?

- 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?

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MODULE 11

BASICS OF MENTAL ILLNESS AND CRISIS MANAGEMENT — PART 1

KEY TERMS:

- >> Mental Health
- >> Depression
- >> Suicidal Ideation

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



Chronic Diseases 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

MENTAL HEALTH

Mental health is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”

World Health Organization. Strengthening Mental Health Promotion. Geneva, World Health Organization (Fact sheet no. 220), 2001.

CHRONIC DISEASE AND MENTAL HEALTH

Knowledge of mental health conditions can help us understand why a patient might be acting in frustrating or self-destructive ways



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

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

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

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

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 to help your patient manage their chronic disease.

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

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

What could be some reasons for this connection?

- Some common ways that people cope with stress are bad for the heart, such as overeating, heavy drinking, and smoking.
- 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.

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 may improve and your risk for heart attack goes down.

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

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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. They don’t exercise as much and may not watch their diet, check their blood sugar, and take medications properly.
- 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, which are all risk factors for diabetes risk
- 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

DEPRESSION

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

What causes depression?

- Gender?
 - Depression is twice as common in women as in men
 - It is not clear why this is the case
 - Changes in women’s hormonal levels may play a part
 - 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 or 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 (When did symptoms start? How long do they last? How severe? Previous treatment? Family history?)
 - Assessment for substance abuse, suicidal tendencies

How Is depression treated?

There are two common types of treatment for depression:

- Medicine
- “Talk” therapy:
 - Cognitive behavioral therapy
 - Psychotherapy
 - Psychoanalysis

Other types of mental health treatment

- Holistic
 - Yoga, journaling, art-making, music, dance, physical exercise
- Spiritual
 - Ceremony, church, prayer

Suicidal Ideation

Suicidal Ideation:

Thinking about, considering, or planning for suicide

www.cdc.gov/violenceprevention/suicide/definitions.html

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 via cell phone.
 - Patient should not be left alone

If no, you can say:

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

Other Things to Keep in Mind

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

Role of Care Coordination

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

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

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

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MODULE 12
**BASICS OF MENTAL ILLNESS AND
 CRISIS MANAGEMENT — PART 2**

KEY TERMS:

- >> Schizophrenia
- >> Stigma

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



Schizophrenia

Have you ever worked with a patient who has schizophrenia?

Or perhaps known someone who has it?

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



Schizophrenia



Definition: a psychotic disorder characterized by loss of contact with the environment, noticeable deterioration in the level of functioning in everyday life, and disintegration of personality expressed as disorder of feeling, thought (as delusions), perception (as hallucinations), and behavior

<http://www.merriam-webster.com/dictionary/schizophrenia>

It has been called “the modern-day equivalent of leprosy” - E. Fuller Torrey, M.D.,

Surviving Schizophrenia: A Manual for Families, Patients, and Providers.

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.

Stigma

A mark of shame or discredit, an identifying mark or characteristic

www.merriam-webster.com/dictionary/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 (above) 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 characterized?

Schizophrenia is a mental disorder that is characterized by at least 2 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)

How is schizophrenia diagnosed?

- 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

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” (Fairbrother, 2004).

Who needs social support?

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.

ASSESS A PATIENT'S SUPPORT SYSTEM

When you meet your client...

There are tools that can help you assess a patient's level of social support when you meet your client. These tools can be as simple as having a patient write down numbers of those in their social support network to something a bit more in depth as having a patient fill out a questionnaire to assess their level of social support. Whichever type of tool you decide to use, it is very important to use a tool to assess a patient's level of social support, especially for patients who have a chronic disease.

Often, as a staff member providing care coordination, you will find that you are part of that patient's support system. But there needs to be a sustainability plan for when you are not there as a staff member to support them. This raises the importance of using a tool to assess a patient's level of social support when you are first meeting with them.

Below are a few examples –

- Norbeck Social Support Questionnaire:
<http://nurseweb.ucsf.edu/www/ffnorb.htm>
- Social Support Assessment Tool for those with a Specific Chronic Disease (i.e. Diabetes):
http://www.diabetesinitiative.org/resources/topics/documents/8-LAC-SocialSupportToolEnglish_web.pdf

After meeting with your client and assessing their level of **SOCIAL SUPPORT**, you may find that the patient's social support network is not strong. Therefore, how can the patient improve their social support network?

.....

YOU CAN CREATE THE CONDITIONS TO EMPOWER PATIENTS TO...

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



IN ORDER TO IMPROVE THEIR SOCIAL SUPPORT NETWORK.

.....

When might a patient want to change their 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 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).

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MODULE 13

BASICS OF MENTAL ILLNESS AND CRISIS MANAGEMENT — PART 3

KEY TERMS:

- >> Crisis
- >> Coping Strategies
- >> Substance Abuse
- >> Domestic Violence

Basics of Mental Illness and Crisis Management — Part 3

CRISIS MANAGEMENT

WHAT IS A 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 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.

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.

COPING STRATEGIES

WHAT ARE COPING STRATEGIES? 📄

Coping strategies are techniques that reduce stress. They 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 mechanisms for coping with stress (and their disease), but their strategy may not always be the most beneficial.

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



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

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"

Medical

(i.e., a newly diagnosed medical condition or an exacerbation of a current medical problem): Multiple sclerosis, HIV, infertility, heart attack, 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

As someone providing care coordination, what are the most common kinds of crisis might you 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. **YES**

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.

Crisis Management : Substance Abuse

Some of your patients or clients may be using **substances** as a coping mechanism to make themselves feel better. Using “harm reduction” strategies may be helpful with these clients. For example, working with them to develop goals to reduce smoking, drinking or drug use but not quit, as they are not ready to quit completely.

 **Substance abuse** is a pattern of harmful use of any substance for mood-altering purposes.

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.

Red Flags



PHYSICAL SIGNS

- Bloodshot eyes, pupils larger or smaller than usual.
- Changes in appetite or sleep patterns. Sudden weight loss or weight gain.
- Deterioration of physical appearance, personal grooming habits.
- Unusual smells on breath, body, or clothing.
- Tremors, slurred speech, or impaired coordination.



BEHAVIORAL SIGNS

- Missed appointments or a 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.

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 **9 categories**:

| | | |
|-----------|----------------|---------------|
| Marijuana | Hallucinogens | Tranquilizers |
| Cocaine | Inhalants | Stimulants |
| Heroin | Pain Relievers | Sedatives |

However, cigarettes and alcohol are also “substances.”

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, such as Alcoholics Anonymous (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.

Domestic Violence: Intimate Partner Violence

Some of your patients or clients might be in difficult or abusive family relationships.

In particular, 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

- Seems afraid or anxious to please their partner
- Goes along with everything their partner says and does
- Checks in often with their partner to report where they are and what they’re doing
- Receives frequent, harassing phone calls from their partner
- Talks about their partner’s temper, jealousy, or possessiveness
- Is restricted from seeing family and friends
- Rarely goes out in public without their partner
- Has limited access to money, credit cards, or the car
- Frequently misses appointments, work, school, or social occasions, without explanation

Physical Signs

- Has frequent injuries, with the excuse of “accidents”
- Dresses in clothing designed to hide bruises or scars (e.g. wearing long sleeves in the summer or sunglasses indoors)

Psychological Signs

- Has very low self-esteem, even if they used to be confident
- Shows major personality changes (e.g. an outgoing person becomes withdrawn)
- Is 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

- 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 feel validated

WANT TO LEARN MORE?

nnedv.org

LEARN ABOUT DOMESTIC VIOLENCE



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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

KEY TERMS:

- >> Family Dynamics
- >> Cultural Dynamics
- >> Professional Boundaries

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



PRINCIPLES OF HOME VISITING: PURPOSE OF HOME VISITS

1 IDENTIFIES AND REDUCES BARRIERS TO PATIENT CARE

2 HELPS HEALTH PROFESSIONALS UNDERSTAND THE “WHOLE STORY” OF WHAT MIGHT BE PREVENTING THE PATIENT FROM BEING HEALTHY

3 BUILDS TRUST AND CONNECTION

4 HELPS ENGAGE OTHER CAREGIVERS IN THE HOME

How to Plan, Conduct, and Debrief 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.

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.

Detective work

- **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

The patterns of relating, or interactions, between family members. Each family system and its dynamics are unique, although there are some common patterns. All families have some helpful and some unhelpful dynamics

<http://www.strongbonds.jss.org.au/workers/families/dynamics.html>

- 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; while 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.

Cultural dynamics

Dynamics that result from cultural differences

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2719963/>

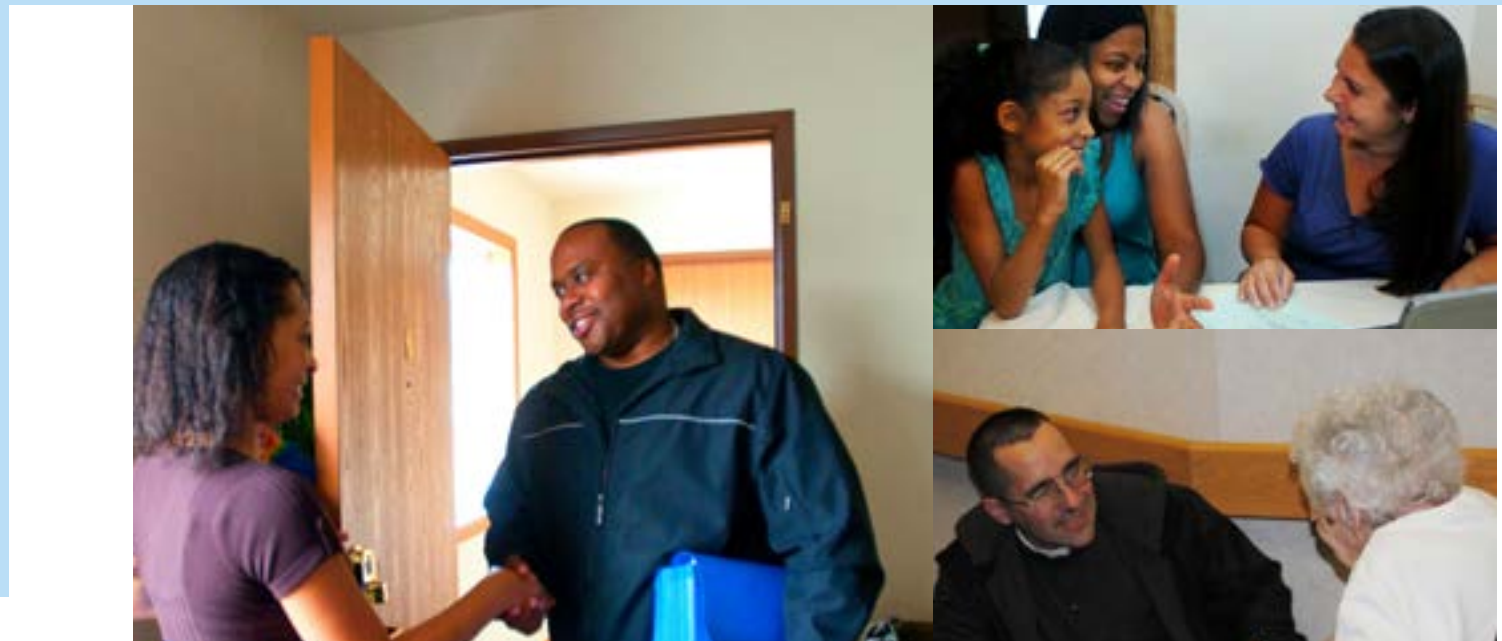
- Knowing and understanding your patient's cultural background can help prepare you for certain expectations, beliefs, or behaviors
- Some patients or family members will prefer you to address them formally, even if you are in their home. One approach is to address your patient formally and allow them 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

Professional boundaries define effective and appropriate interaction between professionals and the public they serve. Boundaries exist to protect both the professional and the client.

<https://professionalboundaries.com/faq.php>

- 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 be harder to maintain boundaries than in a clinic or a hospital.
- Particularly if patients are homebound or sick, they 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.



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, permanence, 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 is crucial to good documentation.
- Once you are back in the office, document your findings in the appropriate database or EMR as soon as possible.
- Debrief the home visit to your supervisor 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.

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 okay to discuss cases with supervisors as needed, do not share specifics or identifying information with your 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 a 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.

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Resources:

Making the Most of Home Visits

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

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

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

Home Visitor’s Handbook

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

VIDEOS

Video: Nurse Home Visiting at Commonwealth Care Alliance

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



Transitions of Care

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

WHAT IS A CARE TRANSITION?

The movement of patients from one healthcare provider or setting to another. It can be an extremely high-risk time for patients.

MODULE 15 TRANSITIONS OF CARE

- KEY TERMS:**
- >> Care Transition
 - >> Tracking System



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?

- IF PATIENT'S DIFFERENT PROVIDERS DON'T WORK TOGETHER, THEN CARE WILL BE UNCOORDINATED AND CONFUSING FOR PATIENT.
- PATIENT MAY BE TOO SICK TO ADEQUATELY CARE FOR THEMSELVES, MAKE APPOINTMENTS, OR READ INSTRUCTIONS AND MEDICATION LABELS.
- LANGUAGE BARRIERS AND LOW LITERACY LEVELS CAN ADD TO THE RISK.
- SOME PATIENTS HAVE LITTLE OR NO FAMILY SUPPORT OR FAMILY/FRIENDS WHO ARE WORKING AND UNABLE TO CARE FOR THEM.

TRANSITIONS OF CARE: STATISTICS



- POOR CARE COORDINATION INCREASES THE CHANCE THAT A PATIENT WILL SUFFER FROM A MEDICATION ERROR OR OTHER HEALTH CARE MISTAKE BY **140%**
- COMMUNICATION FAILURES BETWEEN PROVIDERS CONTRIBUTE TO NEARLY **70%** OF MEDICAL ERRORS AND ADVERSE EVENTS IN HEALTH CARE.
- **68%** OF SPECIALISTS RECEIVE NO INFORMATION FROM THE REFERRING 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%** MORE LIKELY THAN THOSE WITH PRIVATE INSURANCE TO GO TO THE EMERGENCY ROOM 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

http://statehieresources.org/wp-content/uploads/2013/01/Bright-Spots-Synthesis_Care-Coordination-Part-I_Final_010913.pdf

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DATA STATES:

- **19%** OF PATIENTS HAD IDENTIFIABLE ADVERSE EVENTS IN THE FIRST 3 WEEKS AT HOME.
- **73%** OF OLDER PATIENTS MISUSED AT LEAST ONE MEDICATION.
- **>1%** MEDICAL ERROR PER DISCHARGE SUMMARY.

AHRQ: Data on Adult Care Transitions: 2010

How can care coordination help to improve transitions of care for patients?

What can go wrong when a patient is discharged from the hospital?

When a patient is discharged from hospital

- Patient may be confused about:
 - New diagnoses
 - New treatment plan
 - New medications
 - Old medications
- Follow-up call or visit to patient is 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



Tracking System: system that follows a patient and their changing medical status.

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

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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=HCizQLCBRz4&list=PLqF>

Northern Piedmont Community Care

<http://www.youtube.com/watch?v=Gxfxo3ejP8c&list=PLqF-bKPCi6Cqr2PoNBURCNggW4RYX8qpX>

Coaching for Safer Healthcare Transitions

[http://www.qualishealthmedicare.org/about-us/results/stepping-stones-\(care-transitions-project-of-whatcom-county\)/project-videos](http://www.qualishealthmedicare.org/about-us/results/stepping-stones-(care-transitions-project-of-whatcom-county)/project-videos)

WANT TO LEARN MORE?

improvingchronicillnesscare.org

LEARN ABOUT TRANSITIONS



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

ELECTRONIC HEALTH RECORD (EHR)

A computerized system for documenting patient's health information

- Synonym: "Electronic Medical Record"
- EHR replaces paper charts, but can also do so much more
- Can connect to labs, pharmacies, hospitals
- All clinical staff can use it, not just providers
- 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 (referrals and lab orders)
- Track an entire population of patients
 - Answer questions like "How are my diabetic patients doing?"



MODULE 16

ELECTRONIC HEALTH RECORDS

KEY TERMS:

- >> EHR
- >> Structured Data
- >> Free Text

EHR and Care Coordination

>> An EHR helps to share important information with care team

>> Facilitates information flow for a team (messages and “tasking”)



EHR CAN HELP YOU WITH PATIENT CARE

- Assess and document barriers
- Coordinate care, track referrals
- Document phone calls, conversations, etc.
- Easy access to patient education materials

EHR & THE PATIENT CENTERED MEDICAL HOME

Nearly all aspects of Patient Centered Medical Home can be supported by EHR

- Care management
- Care coordination
- Evidence-based guidelines
- Care teams and “teamlets”
- ePrescribing
- Quality Improvement and reporting

EHR AND 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 “QUALITY IMPROVEMENT”?
“DOING THE RIGHT THING, AT THE RIGHT TIME,
IN THE RIGHT WAY, FOR THE RIGHT PERSON
– AND HAVING THE BEST POSSIBLE RESULTS.” –
AHRQ

How do you use your EHR now?

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.

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.”

WHAT ELSE CAN AN EHR DO THAT PAPER CAN’T DO?

TRENDING/TRACKING

Track results for a patient over time
EHR can also be used to motivate patients

PERFORMANCE REPORTING

Track performance by provider or care team across an organization
See patient data averages across all patients; sort by provider/care team

CREATE REGISTRIES

Allows health care staff to see a list of patients with specific conditions and risk levels – can provide a “snapshot”

WANT TO LEARN MORE?

healthit.gov

LEARN ABOUT HEALTH
INFORMATION TECHNOLOGY



Registries and Population Management

Population management is identifying the specific health status and needs of a target group of patients 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.
- Enables sharing patient data among different healthcare organizations
 - Hospitals, primary care providers, specialists, etc.
 - Health homes, accountable care organizations
- Data may include:
 - Alerts when patient is admitted to hospital
 - Medication list, problem list, surgical history
 - X-Rays, labs, transcribed reports
- You can better help the patient when you have better information

HIE and Patient Consent

- Patients must give consent to allow their data to move through the HIE
- Moving forward, patients will either need to “opt-in” or “opt-out” of the HIE

Can you think of some patient scenarios in which an HIE would help get them better care?

- Patient needs to go from their primary care provider to a specialist and back again
- Patient needs to be admitted to a hospital (expected or emergency)
- Patient is traveling or moving

Patient’s Portals

What is a patient portal?

- An EHR feature that enables patients to view their records and interact via the web
- Helps engage patients in their care

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)
- HIPAA: Mandates industry-wide standards for health care information on electronic billing and other processes and requires the protection and confidential handling of protected health information.

How can you protect the privacy and security of your patient’s health information?

Privacy and Security Best Practices

- 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=fmrgAjJXHUU>

Video: Veterans Administration on the “Blue Button”

<http://www.youtube.com/watch?v=IGGnda44Yik>

Video: Electronic Health Records: Privacy and Security

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



MODULE 17

NAVIGATING THE INSURANCE SYSTEM & HELPING THE UNINSURED

KEY TERMS:

- >> ACA
- >> Medicaid
- >> Managed Care Plan

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

UNDERSTAND HOW TO REDUCE BARRIERS TO CARE FOR UNINSURED AND INSURED PATIENTS

THE CHANGING WORLD OF HEALTH INSURANCE AFFORDABLE CARE ACT (ACA)

With the Affordable Care Act (ACA), much of what we now know about health insurance is changing.

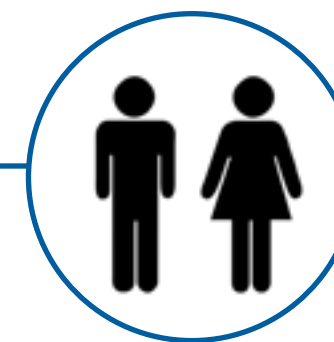
Understanding the health insurance system and how you can get your clients covered may be one of the most important things you can do as a care coordinator.

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.

See more at: <http://www.healthinsurance.org/glossary/affordable-care-act-aca/#sthash.L1ixHjYv.dpuf>

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

Many people are not eligible for private insurance because of previous medical conditions or are not able to afford it (pre-ACA).

Many people are not eligible for public insurance because of age, citizenship, etc.

Public health clinics and hospitals offer services to uninsured patients on a “sliding scale.”

MEDICAID/MEDICARE:

Insurance funded by the federal and state governments.

WANT TO LEARN MORE?

healthcare.gov

LEARN ABOUT HEALTH INSURANCE



Health Insurance Options in New York State

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

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

MEDICARE



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 much medical costs go up, their monthly payments stay 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
 - Copayments or coinsurance
 - Costs in the coverage gap (i.e., 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 use a pharmacy in their plan's network
 - Whether the drugs consumers use are on their plan's formulary

Navigating the Insurance System

How can Care Coordination help patients with insurance use their insurance?

- Can provide “translation services”
 - Insured patients may not understand how to use their cards
 - Insured patients may not understand their benefits and which services are covered
- Can help patients be “educated consumers”
 - Insured patients may not know how to request referrals or obtain prior authorizations
 - Insured patients may not know how to switch plans or apply for additional benefits
 - Insured patients may not know how to prepare for visits with new providers
- Can help patients advocate for themselves
 - Insured patients may not know their rights and responsibilities
 - Insured patients may not know how to appeal insurance denials
- Can help patients prepare for visits

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

- Every health facility is different, so 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

Helping Uninsured Patients Navigate the Health System

How can health professionals help uninsured patients’ access essential health services?

- Know what populations of patients may be eligible for insurance (review of health insurance options)
- Understand why a patient may be uninsured
- Can help determine whether the uninsured patient might actually be eligible for insurance
- Know who at their health center is an expert on coverage for the uninsured
- Know how to talk about obtaining insurance with patients (or refer them to someone who does)
- Know which resources exist for patients who cannot qualify for insurance (e.g., undocumented patients).

What resources exist for uninsured (besides the Emergency Room)?

- Community Health Centers
 - Sliding fee scale
- Family Planning Centers
 - Sliding fee scale
- Assistance available for special populations including:
 - Pregnant women - PCAP
 - AIDS/HIV
- Prescription Medication coverage
- Public Hospitals (New York Health and Hospitals Corporation) and Charity Care at private hospitals
 - Sliding fee scale
 - Online tool for identifying resources

http://www.nyc.gov/html/hhc/html/access/hhc_options.shtml

- City/State Agencies
 - In New York City: Office of Citywide Health Insurance Access (OCHIA)

<http://www.nyc.gov/html/hia/html/resources/hhc.shtml>

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)

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

For more information on insurance options and terminology:

www.healthcare.gov/using-insurance/index.html

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/everyoucomepage.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

KEY TERMS:

- >> Motivational Interviewing
- >> OARS

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

WHAT IS MOTIVATIONAL INTERVIEWING (MI)?

A clinical method for helping people to resolve ambivalence about change by evoking internal motivation and commitment. It is a skillful, clinical style for eliciting patients' motivations for making behavioral changes to improve their own health.

THE STORY OF MOTIVATIONAL INTERVIEWING



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

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
 However, when clients were confronted, their natural instinct was to defend themselves
 - thereby removing any desire to behave any differently

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. 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.)

And 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
- MI is 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 cessation
- Co-occurring mental health & substance abuse disorders

MI has also been found to be useful in primary care because it's:

Relatively [brief](#)

[Verifiable](#) (there are ways to know it's being delivered properly)

[Generalizable](#) across problem areas

[Complementary](#) to other treatment methods

[Learnable](#) by a broad range of providers

MI also supports the philosophy of Patient Centered Medical Homes (PCMH)

- In the world of Patient-Centered Medical Homes (PCMH) a patient centered counseling approach is required
- Looking ahead, MI will not only be the right thing to do, but the thing you should do and get paid to do

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

Besides the more than 200 randomized clinical trials...

- Over 1000 publications
- Dozens of books and videotapes
- 10 Multi-site clinical trials

How does someone learn how to do MI?

- Currently there is not official certification for MI
- A complete training on MI usually lasts 1 to 2 days
- Many online resources and trainings exist
- However, in-person supervision or peer support group supervision is highly recommended to achieve solid MI skills
- Practice is necessary

A complete training on MI includes learning eight stages:

- 1) The Spirit of MI
- 2) Open-Ended, Affirming, Reflective Summary (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

This module will focus on:

- 1) The Spirit of MI
- 2) Open Ended, Affirming, Reflective Summary (OARS)

The Spirit of MI – Collaborative

- 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 valid 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, and even warn the patient, but ultimately it is the patient who decides what to do.
- Honoring this can help facilitate change.

WANT TO LEARN MORE?

motivationalinterview.org

LEARN ABOUT MOTIVATIONAL
INTERVIEWING



MI Techniques



One of the main strategies used in MI is OARS.

OARS uses four basic communication techniques to move the client along the path to change.

- Open-ended questions
- Affirmations
- Reflective listening
- Summary statements

Example

Closed Question

“Did you take your medicine last night?”

Open Question

“Tell me what it’s like for you fitting medicine into your day.”

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.

OARS: Closed questions

- Often damage rapport
- Decrease empathic connections
- Paradoxically end up taking more time

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

Interpret what the patient means and reflect 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.

Besides ensuring the patient feels heard, reflective listening can also highlight certain ideas or emotions the patient 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 provides a 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?”

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?”

REFERENCES

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

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

WEB RESOURCES

<http://www.motivationalinterview.org/>

http://motivationalinterviewing.org/about_mint

VIDEOS

Video: Dr. William Miller, “Motivational Interviewing” www.psychotherapy.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_IO

Video: Motivational Interviewing: A Conversation with Sal about managing his asthma

<http://www.youtube.com/watch?v=-RXy8Li3ZaE>



MODULE 19

MOTIVATIONAL INTERVIEWING — PART 2

KEY TERMS:

- >> Ambivalence
- >> DARN
- >> Change Talk

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

SPIRIT OF MI, OARS, AND CHANGE TALK

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

Do you remember what OARS is?

Open-Ended Questions

Affirmative Statements

Reflective Listening

Summary Statements

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.
- While ambivalence can be difficult, MI recognizes that ambivalence is a natural part of the change process.
- 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" (Miller and Rollnick, 1991)
- 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”

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.

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. Such as: *“I will not smoke more than 2 cigarettes a day.”*

Brief Negotiated Interviewing

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)

Did you know 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.

WANT TO LEARN MORE?

[motivationalinterview.org](https://www.motivationalinterview.org)

LEARN ABOUT MOTIVATIONAL
INTERVIEWING



REFERENCES

Bodenheimer, T. Training Curriculum for Health Coaches, May 2008 <http://familymedicine.medschool.ucsf.edu/cepc/pdf/HealthCoachTrainingCurriculumMay08.pdf>

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

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

Boston University, BNI-ART Institute

<http://www.bu.edu/bniart/sbirt-in-health-care/>

VIDEOS

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

<http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-videos/>

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

<http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-videos/>

The Effective Physician: Motivational Interviewing Demonstration

<http://www.youtube.com/watch?v=URiKA7CKtfc>

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).



MODULE 20

HEALTH COACHING AND PATIENT CARE FOLLOW-UP — PART 1

KEY TERMS:

- >> Health Coaching
- >> Care Plan

Health Coaching and Patient Care Follow-Up — Part 1

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'S 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



Health coaching can improve patient understanding and engagement.

HEALTH COACHING AND CARE PLANS

What is Health Coaching? 

Helping patients gain knowledge, skills, tools, and confidence to become active participants in their care so they can reach self-identified health goals.

From Health Coaching for Patients With Chronic Illness, Bennett H. MD, et al. <http://www.aafp.org/fpm/2010/0900/p24.html#fpm20100900p24-ut1>

2007 JAMA article states:

- **50% of patients leave without understanding advice given to them**
- **In only 10% of visits is the patient involved in the decisions made**

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

SPECIFIC COACHING TASKS

- 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 dislike being told what they already know
- Find out who they are
- Find out how much they are willing and able to do

Care Plans: What are they?

INTERDISCIPLINARY COMPREHENSIVE ASSESSMENT

Medical:

- History and physical, including mental health, substance abuse, and risk behavior needs.
- Conducted by Primary Care Provider and/or 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

CREATING A CARE PLAN

- 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 a manager to follow up on designated tasks
- Work with the patient to negotiate action plans for goals (health coaching)

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

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

Purpose of action plans

- Understand the specific steps involved in moving toward their goals
- Leave visit feeling confident about steps they can take now
- Lead to small successes
- Success increases patient’s confidence to continue making 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

The Specific Tasks of a Health Coach

What does it mean to help patients set the agenda for their visit with the clinician?

- Patients’ concerns may be different from a clinician’s but are equally important
- Find out about all their concerns, then negotiate which concerns, and when they will be addressed
- Phone call before the visit, or an in-person pre-visit when the patient is being triaged
- Let clinician know about patient’s concerns by noting in chart or during 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,” which means asking patients to tell you whether they understand what the clinician said
- Ask patients to repeat back what they understood “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 correctly, they need to agree with what they are being asked
- Coach can ensure that they understand, agree with, and are willing and able to participate in the management of their chronic conditions

WANT TO LEARN MORE?

www.pcmhri.org/files/uploads/Campanile_BP_Sharing_4.15.11.ppt

LEARN ABOUT MEDICAL ASSISTANTS PROVIDING HEALTH COACHING



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 own 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 correctly

How common is 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?

- Patient has to pay for it and can't afford it
- Medication was not on their insurance formulary so pharmacy didn't give it to them
- Medication causes side effects
- Patient is worried that 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?

- Continue to ask the patient questions
- Make sure patient understands and agrees with medications
- Ask about barriers
- Follow-up phone call

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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

Coaching patients for successful self-management

<http://youtube/DmNBOVykeoM>



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
- MEDICATION RECONCILIATION

GAINING TRUST WHEN YOU WORK AS A HEALTH COACH

An effective health coach needs to gain the trust of patients and clinicians

Why does a health coach need to gain the trust of patients?

Patients may not understand the role of the health coach. At first, they may not trust that the health coach or staff member providing coordination is reliable, accessible, and will listen to their concerns.



MODULE 21

HEALTH COACHING & PATIENT CARE FOLLOW-UP — PART 2

KEY TERMS:

- >> Medication Reconciliation

HOW DO YOU GAIN THE TRUST OF PATIENTS?



CLEARLY EXPLAIN YOUR ROLE

ASK THE CLINICIAN TO INTRODUCE YOU TO NEW PATIENTS

BE RELIABLE, FOLLOW THROUGH ON WHAT YOU SAY YOU WILL DO

WHY WOULD A STAFF MEMBER PROVIDING COACHING NEED TO GAIN THE TRUST OF CLINICIANS?

- 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)

HOW DO YOU GAIN THE TRUST OF CLINICIANS?

Have your role and responsibilities clearly defined

Maintain clear, open channels of communication

Be accountable and dependable

Ask questions when you don't know something or need help

Coordinating Care as a Coach

What are some of the coordination responsibilities of staff who provide care coordination?

- Help patients make and get to appointments
- Ensure a productive appointment
- Follow up on patients who missed appointments
- Follow up on patients lost to care
- Coordinate social services and benefits

How can staff who provide care coordination services help ensure that patients get to their appointments?

- Make sure that every patient knows where, when, and how to access all health and related services including primary care, mental health, and substance abuse services
- Provide patients with reminders of upcoming appointments or plans
- Ask whether the patient requires assistance with transportation
- Assist the patient in scheduling and rescheduling appointments
- Provide appropriate childcare resources

How can staff who provide care coordination help to ensure a productive appointment?

- Make sure the patient has all necessary information for appointments and services
- Confirm that the patient has the needed resources for appointments and services
- Ensure translation services are available
- Follow up with the service provider the same day
- Ensure that specialty reports and test results get back to the primary care provider

How can staff who provide coordination services follow up on patients who have missed appointments?

- Monitor patient schedule
- Note missed appointment on the same day
- Notify supervisor of missed appointment or follow agency protocols
- Perform phone outreach
- Visit patient's home or follow agency protocols
- Send certified letter if outreach attempts fail
- Document process on outreach log

How can staff who provide coordination services follow up on patients lost to care?

- Create a list of patients and prioritize with the most recently lost first
- Filter list based on primary care provider records or other team members
- Do internet search to verify contact information and home visit
- Follow the missed appointment outreach procedure
- Assist patient back to care or close case
- Repeat every three months.

How can staff who provide coordination services help to coordinate social services and benefits?

- Under the supervision of a care manager:
 - Obtain and coordinate services including social support, peer groups, and access to food/nutrition services
 - Evaluate for eligibility and assist with applications to ensure housing
 - Evaluate for eligibility and develop a plan for submitting applications for health insurance and other benefits, including child care, employment, training, financial assistance and food/nutrition services
 - Maintain formal relationships with community service agencies to ensure patient access to support from their community peers

Adapted from NYC DOHMH BUREAU OF HIV/AIDS PREVENTION AND CONTROL, Care Coordination Program Fact Sheet, HIVCTHP@health.nyc.gov September 2009

Quick Review

What is the purpose of health coaching?

- There is not enough time in a 15-minute visit to handle all the problems that patients bring
- Current focus on evidence-based guidelines means that many of clinicians tell patients what to do rather than:
 - Asking them about their preferences
 - Finding out which evidence based advice patients are willing and able to follow, given their life situations

Health coaching gives you time to address these issues

Problem Solving as a Coach

Problem solving requires considerable ingenuity on the coach's part, trying to find 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 and 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 solved at this time

Medication Training

What is medication reconciliation?

- Medication reconciliation is comparing the list of medicines the doctor has prescribed with the list of medicines the patient is actually taking
- Done 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 patients are taking
- So the providers don't prescribe more medication 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 is not usually available
- Many organizations experimenting with using medical assistants, nurses, health coaches, and community health workers to do it

What are the two main tasks of medication reconciliation?

1. Finding out what the patient is actually taking (detective work) which can be done by coach
2. Deciding what the patient should be taking, which is done by a clinician

How do you do medication reconciliation? (med-rec)

- 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
- If the patient brought pill bottles, leave them out for the provider to see

What is the coach's only real job when doing medication reconciliation?

- Get information from the patient
- Do not advise patient

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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

KEY TERMS:

- >> Quality Improvement
- >> Performance Indicators
- >> Data
- >> HRSA

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



WHY IS IT IMPORTANT TO MEASURE OUTCOMES?

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



Quality improvement (QI):

Systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

<http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>



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 assurance to patients, regulators, and researchers that care is being delivered safely with the intended results.



Data:

Factual information, especially information organized for analysis or used to reason or make decisions.

WHO SETS THE STANDARDS IN HEALTHCARE? 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/AFFORDABLE CARE ACT**
- **MEANINGFUL USE**
- **MEDICARE**

ROLE OF STATES

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

ROLE OF LOCAL MUNICIPALITIES

- Local municipalities also make considerations on healthcare regulations
 - For example, only the NYCDOH considers a completed colonoscopy as a screening for colorectal cancer. This regulation is not consistent across New York State.

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

WHAT IS UDS DATA? 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)

 HRSA is the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable.

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. Collect Data – to identify a problem

- weight screening

2. Drill down on the data/define root cause of issues

- certain staff didn't know they were responsible for weighing patients

3. Assess what can be done to achieve improvement

- staff training

4. Put improvement in place

- train all staff that are responsible for weighing patients

5. Check to see if improvement is working

- look at weight screening report one month after training

If the improvement is working... continue!

If it is not working... ask if the same activity should be continued?

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 and may be using data as part of quality improvement initiatives.

As care coordination staff, you are key to gathering good data.

By fully documenting your work, you directly affect the quality of the data that your organization gathers 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_It_Works.pdf

VIDEOS

Comparing Health Care and Quality: A Road Map to Better Care

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

WANT TO LEARN MORE?

hrsa.gov

LEARN ABOUT HRSA: HEALTH RESOURCES
AND SERVICES ADMINISTRATION





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

UNDERSTAND WHICH PROFESSIONAL BOUNDARIES ARE NEEDED WHEN PROVIDING CARE COORDINATION

UNDERSTAND WHEN TO ASK FOR HELP FROM CARE MANAGEMENT TEAM

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.
- Personal boundaries define you as an individual, outlining likes and dislikes, and setting distances others are allowed to approach

MODULE 23
PROFESSIONAL BOUNDARIES — PART 1

KEY TERMS:

- >> Personal Boundaries
- >> Professional Boundaries



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 they do not get 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 a person can be considerate of others but also 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 are often 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 acceptable, but over time this can become a lack of respect.

10. RESPECT FOR PHYSICAL TOUCH

While it is fine to be affectionate, you need to be aware of how it is being received. If it's not being received positively, then it's not acceptable.

Professional Boundaries

WHAT ARE PROFESSIONAL BOUNDARIES?

- Rules that define the limits of professional behavior
- Mutually understood, unspoken physical and emotional limits of the relationship between the patient and the [staff member].” (Farber et al., 1997)
- Professional boundaries separate therapeutic behavior from any behavior that - 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 entities
- Policies set by individual facilities
- Set by individuals

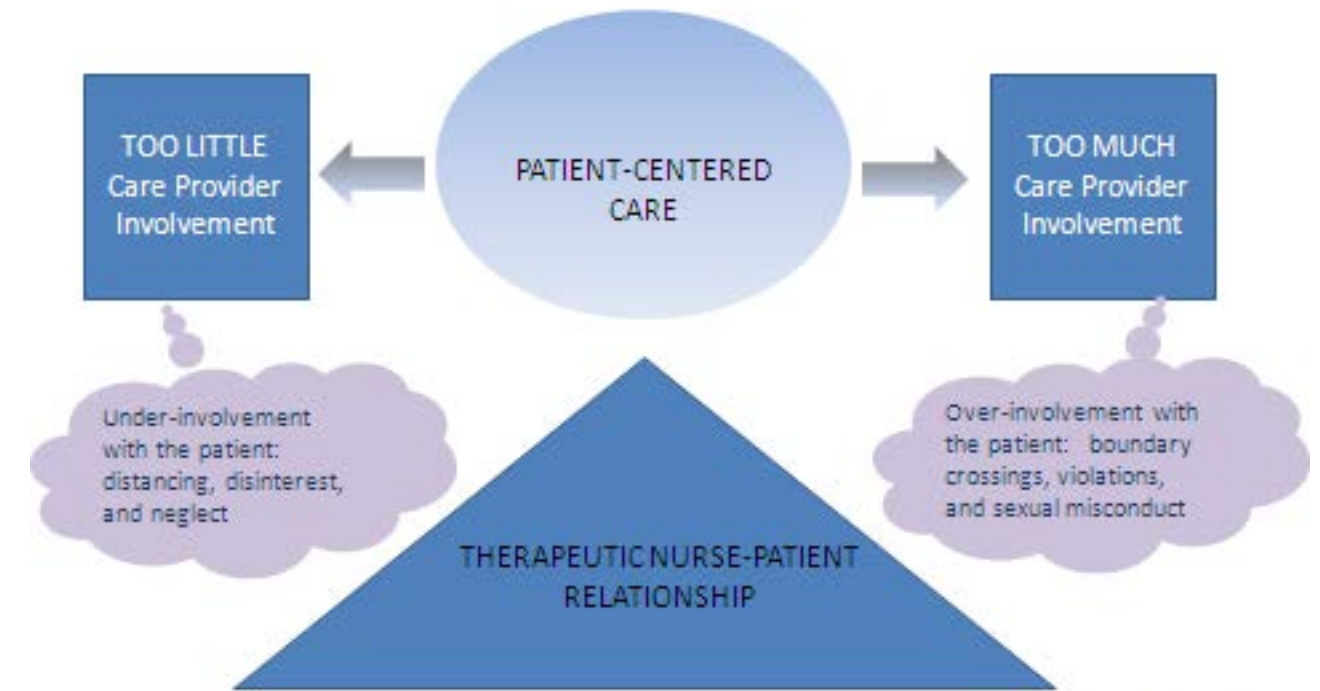
What is the connection between personal and professional boundaries?

- 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, 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?

- Situations when a professional acts in a way that could be considered “unprofessional” once or many times over a period of time.
- Repeatedly crossing boundaries sets 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

A CONTINUUM OF PROFESSIONAL BEHAVIOR



(Adapted from NCSSN, 1997)

- Boundary crossings may also be thought of as a health professional being too involved or not involved enough 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.”

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

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

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

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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

KEY TERMS:

- >> Burnout
- >> Stress Management
- >> Wellness

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

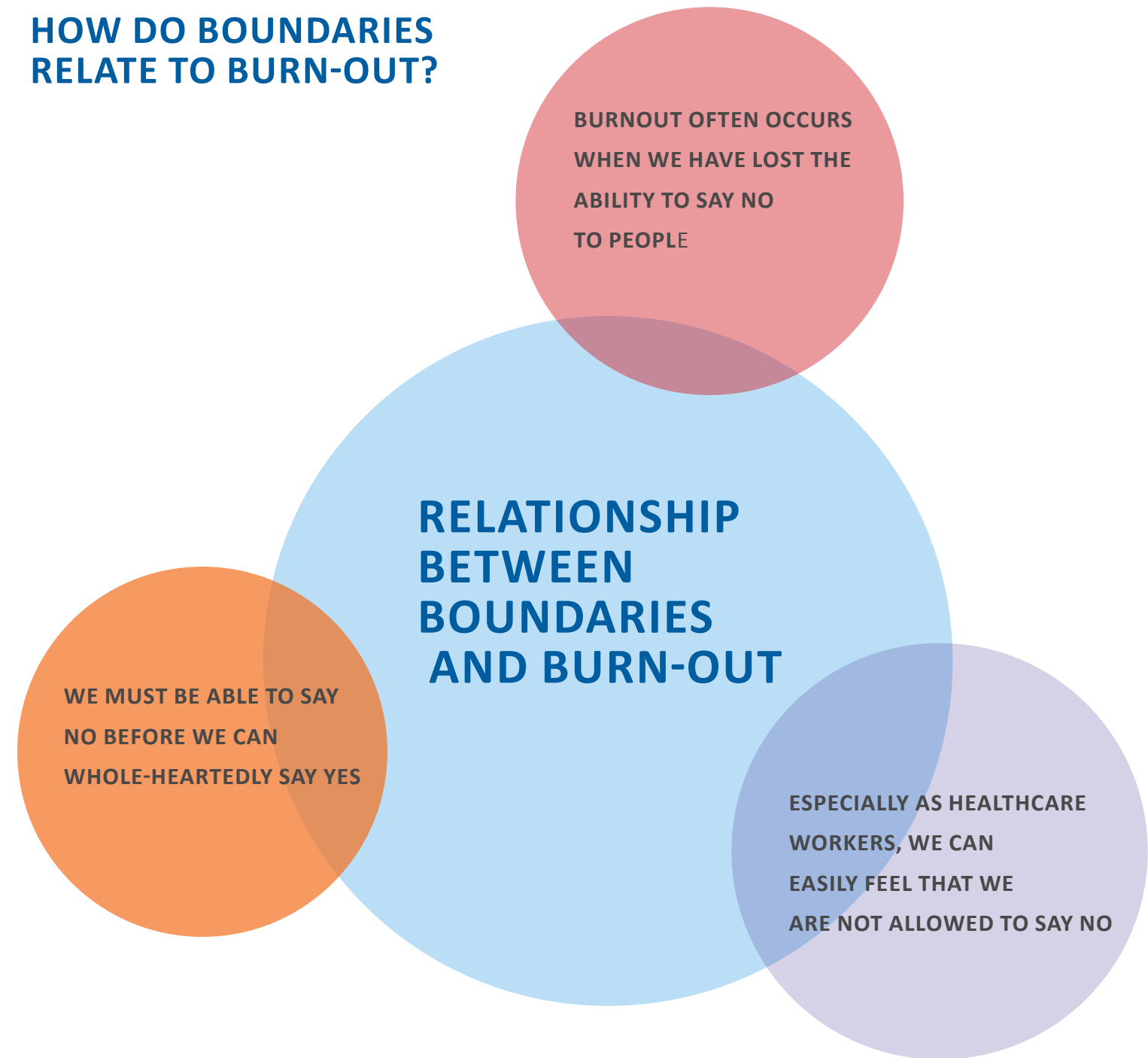


The Relationship between Boundaries and Burnout

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?



Boundaries are proactive, not reactive

- A good boundary is set ahead of time and is transparent
 - “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 2:00 am to ask a question if you never specified which hours they can contact you

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.

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?

- Working closely with patients
- Developing trust and learning a great deal about patients’ personal lives
- The 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 will reduce your stress and patients’ stress because they know what to expect from you

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 PATIENTS ARE RESPONSIBLE FOR THEIR OWN HEALTH

- Handle patients with patience
- Realize that 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.

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 by identifying the source of your stress.
- 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 perhaps 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?

Unhealthy Coping Strategies

- Smoking
- Drinking too much
- Eating too much or too little
- 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)

The 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?

“Adapting” 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 cannot 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 things you can't control, focus on the things you CAN control, such as the way you 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.

Beyond managing how you deal with stress in the moment, you can also reduce stress in your life by [nurturing yourself](#).

As caregivers, it's especially 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.

- **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.

- 1. Get moving:** some exercise or fresh air daily (take a walk, swim, dance, go to gym, yoga class.) Regular exercise helps us manage mood, weight, & energy level. Even a 15-minute stroll at lunchtime can help us feel less stressed & more grounded.
- 2. Spend quiet time in nature:** go to the park, beach, woods or if you can't get there, go to a quiet place in nature during meditation. Put some pictures of places you love in your work space so you can remember them when you're feeling stressed.
- 3. Plan a weekly "fun" activity:** go with a friend, colleague, or family member. Find free fun things to around town or have folks over for dinner or a game night.
- 4. Practice gratitude:** think of 3 things that you feel grateful for everyday upon waking or before bed. Notice how you feel when you appreciate the good things you already have.
- 5. Body care:** try acupuncture, massage, or hot tub soak for relaxation. We hold our stress in our bodies! Many places have affordable services if you work with a student or trainee.
- 6. Pray:** when you feel tempted to worry about a person/situation in your life, prayer may be helpful. This does not need to be "religious" but instead a way of releasing the fear to a "Higher Power" and developing trust that things will work out ok. Focus on wishing well to the person/problem rather than building up stressful feelings or sit in quiet reflection.
- 7. Help someone else:** volunteer, help a friend, clean the office kitchen. Often the simple act of recognizing we have much to offer or that another person is struggling with something we are not helps us feel better and appreciative of what we have.
- 8. Ask for help & graciously receive it:** this takes courage! As caregivers, we often have a hard time taking help (or recognizing that we need it). Give someone the gift of being able to help you. It usually feels good to the other person and gives us a big boost, as well as brings us closer in the connection.
- 9. Do something you love that brings you joy every day:** It could be something different and simple every day: a bubble bath, talk with a good friend, cook a meal you enjoy, buy a fancy coffee, work in the garden, listen to favorite music in the car, good sex, take a nap.
- 10. Honor yourself:** we all have limitations and amazing strengths. Notice what you're good at & what you like about yourself & focus on it a few minutes daily. Smile at yourself in the mirror!
- 11. Express yourself:** write in a journal, draw/paint/sing, or do something creative as a way to express your feelings & get yucky stuff out of your system.
- 12. Build community:** consider participating in a group that's meaningful to you (AA, church, sports team). Spending time with people you enjoy & with whom you share values/interests helps us feel more connected & supported as we face life stressors.

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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

20 HEALTH COACHING AND PATIENT CARE FOLLOW-UP — PART 1

- 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

21 HEALTH COACHING AND PATIENT CARE FOLLOW-UP — PART 2

- 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

22 QUALITY IMPROVEMENT AND OUTCOMES

- 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

23 PROFESSIONAL BOUNDARIES — PART 1

- 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

24 PROFESSIONAL BOUNDARIES — PART 2 & WRAP UP

- 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

VIDEO CREDITS

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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| Eye to Eye: Dr. Harold Freeman | Basic Skills 1 | CBS |
| Patient Navigators - Center for Advanced Digestive Care | Basic Skills 1 | New York Presbyterian |
| Kings County Patient Navigators: Healthbeat Brooklyn | Basic Skills 1 | Brooklyn Independent Television, a community media program of BRIC Arts Media Brooklyn |
| Without Medical Home (“Bad”) | Basic Skills 2 | Willis Group |
| With Medical Home (“Better”) | Basic Skills 2 | Willis Group |
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