

CARE COORDINATION FUNDAMENTALS

STUDENT EXERCISE BOOK



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



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For more information about the Care Coordination Fundamentals Course visit www.1199seiubenefits.org or www.pcdc.org.

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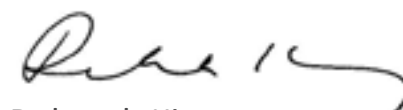
FORWARD BY DEBORAH KING, EXECUTIVE DIRECTOR, 1199 SEIU TRAINING & EMPLOYMENT FUNDS

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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MODULE 1 **ORIENTATION: CARE COORDINATION BASIC SKILLS — PART 1**

Orientation: Care Coordination Basic Skills — Part 1

AGENDA

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

GROUP CASE STUDY EXERCISE: MR. A.B.

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

Referred by his family physician to the diabetes specialty clinic, A.B. presents with recent weight gain, uncontrolled diabetes, and foot pain. Today he has a visit with the diabetes nurse practitioner (N.P.). Sylvia, the patient navigator, is assigned to A.B. to help him arrange any appointments he might need and answer any questions he might have. After seeing the nurse practitioner, A.B. meets with Sylvia.

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

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

During the past year, A.B. has gained 22 lbs. He has never seen a dietitian, and has not been instructed in self-monitoring of blood glucose (SMBG.) The N.P. has given him a prescription for a blood glucose meter and test strips, a referral to the diabetes educator who will show him how to use the blood glucose meter, and a referral to the registered dietitian. She has asked him to make a follow up visit with her in one month.

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

EXERCISE:

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

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

GROUP EXERCISE

- Divide into small groups of 4-5 students
- Below, make a list of all of the things that could make someone frustrated when accessing healthcare
- As a group brainstorm solutions to each of these frustrations

INDIVIDUAL EXERCISE: CARE COORDINATION QUIZ

Let's start with a quiz to see how much you already know about your role as a staff member who would provide care coordination services. Answer the questions below and be prepared to discuss your answers with the group.

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

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

Adapted From Colonoscopy Patient Navigator Program Orientation Manual, page 9, NYCDOHMH

HOMEWORK FOR NEXT CLASS

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

Some examples of this might be addressing a time when::

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

Include how you think the situation could have been improved.

Be ready to share your story with the group.

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

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

HOMEWORK QUESTIONS FOR DISCUSSION

While reading the article, think about the questions below and be prepared to discuss next class.

- What do you think Dr. Brenner means when he says, "Emergency room visits and hospital admissions should be considered failures of the health-care system until proven otherwise,"
- Dr. Brenner's calculations revealed that just 1% of the 100,000 people who made use of Camden's medical facilities accounted for 30% of its costs. Why might this be?
- What is Dr. Brenner's basic approach to helping patients who are the sickest and are in and out of the hospital multiple times? Does it involve a lot of technology and testing? What does it require?
- The article mentions a patient with developmental disabilities, high blood pressure, and diabetes who said he was taking his medications, but really wasn't. What intervention did Dr. Brenner's team see as crucial to helping the patient get better?

- “High-utilizer work is about building relationships with people who are in crisis,” Brenner said. “The ones you build a relationship with, you can change behavior. Half we can build a relationship with. Half we can’t.” What do you think this means? How would this be applicable to patient navigator work?
- The Special Care Center in Atlantic City employs eight health coaches. What do these health coaches do with patients? What does Fernandopulle say are the most important attributes for a health coach to have?
- At Fernandopulle’s clinic, some patients were still calling 911 for problems the clinic could handle better. What intervention did his team use to inform patients about calling the clinic instead of 911?
- When Dr. Brenner proposes setting up a clinic in the housing project, residents are worried about people they don’t know yet - like social workers - being involved in their lives. How can this help us think about introducing patient navigator services to patients? What reactions might we expect from patients?

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NOTES:



MODULE 2

ORIENTATION: CARE COORDINATION BASIC SKILLS — PART 2

Orientation: Care Coordination Basic Skills — Part 2

AGENDA

- 1 WELCOME, FEEDBACK FROM FIRST CLASS
- 2 HOMEWORK DISCUSSION:
ATUL GAWANDE ARTICLE
- 3 STORIES ABOUT HAVING TROUBLE
NAVIGATING THE HEALTHCARE
SYSTEM
- 4 POWERPOINT WITH DISCUSSION:
THE STATE OF HEALTHCARE TODAY:
CHRONIC DISEASE, NEW MODELS OF
HEALTHCARE
- 5 VIDEOS:
WITHOUT A MEDICAL HOME;
WITH A MEDICAL HOME
- 6 BREAK
- 7 VIDEO DISCUSSION
- 8 POWERPOINT WITH DISCUSSION:
WHAT DOES IT MEAN TO WORK AS PART
OF A MEDICAL TEAM?
- 9 GROUP EXERCISE:
CARE COORDINATION DUTIES QUIZ
- 10 GROUP EXERCISE/DISCUSSION:
PATIENT'S BILL OF RIGHTS/
EMPOWERING THE PATIENT
- 11 POWERPOINT WITH DISCUSSION:
ETHICAL RESPONSIBILITIES
- 12 REVIEW HOMEWORK FOR NEXT CLASS,
WRAP UP

GROUP EXERCISE: CARE COORDINATION DUTIES QUIZ

True or False: Read the following statements as a staff member providing care coordination services, and decide whether it would be within your job description to do the following. Mark as true or false.

1. A 50-year-old woman with asthma and cardiovascular disease has an appointment with a cardiologist and a pulmonologist. You make sure that she understands when her appointments are, and where they are located. You confirm that she will be able to take time away from her job to go them. You make sure that her Medicaid managed care plan will cover these visits, and you talk with her about how she will get to these visits. You arrange transportation for her if she needs assistance.
___ True ___ False
2. A 60-year-old man with depression tells you that he's really been feeling down lately. You agree to meet with him at the coffee shop down the street so that you can hear about his problems.
___ True ___ False
3. A young woman with obesity and schizophrenia was just referred to a new therapist since her old one has changed jobs. She's upset about having to see this new therapist and tells you that she's not sure if she can make it to the appointment since she's "been so busy lately." You get her home phone number and cell phone number and ask if it would be OK if you called her to see how she is doing. She says that would be fine. You call her twice over the next week to check on her, and also to remind her that she has an appointment with her therapist coming up and that it's really important that she keep this appointment.
___ True ___ False
4. A 17-year-old pregnant patient has been to the ER three times during the first three months of her pregnancy with severe asthma attacks where she had significant trouble breathing. When you speak to her she tells you that she has not been taking the asthma medication prescribed to her by the nurse-midwife who she sees for prenatal care. Her friend, who is also pregnant, told her the asthma medication would harm her baby. You meet with the patient and recommend that she explain her concerns about the asthma medication to the midwife, and in a prenatal team meeting you explain to the midwife that the patient is not taking her asthma medication because she believes it will harm her baby.
___ True ___ False

5. A 45-year-old man with chronic obstructive pulmonary disease repeatedly misses his appointments with his primary care provider. He was also seen in the ER recently after feeling short of breath and dizzy. You call him at home and speak with him. When you ask the patient why he has been missing his appointments with his doctor, he states that the doctors have his diagnosis wrong and that he is just tired and needs a rest. You meet with his primary care doctor and tell the doctor that he must have the diagnosis wrong for the patient and then make a referral to a specialist.
___ True ___ False
6. A 50-year-old woman recently diagnosed with HIV tells you that she "thinks her life is over" and she is not going to take her medications because "what's the point?" You make sure that she sees the social worker today in the office before she goes home, letting the social worker know that it is "urgent." You also let the patient know that there is a free HIV support group that meets once a week at the church down the street.
___ True ___ False

SAMPLE

HEALTH CENTER PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

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

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

EVERY PATIENT HAS A RIGHT TO:

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

10. Receive information regarding the availability of support services, including translation, transportation and education services.
11. Receive sufficient information to participate fully in decisions related to his or her health care and to provide informed consent prior to any diagnostic or therapeutic procedure (except in emergencies). If a patient is unable to participate fully, he or she has the right to be represented by parents, guardians, family members, or other designated surrogates.
12. Ask questions (at any time before, during or after receiving services) regarding any diagnosis, treatment, prognosis and/or planned course of treatment, alternatives and risks, and receive understandable and clear answers to such questions.
13. Refuse any treatment (except as prohibited by law), be informed of the alternatives and/or consequences of refusing treatment, which may include the CHC having to inform the appropriate authorities of this decision, and express preferences regarding any future treatments.
14. Obtain another medical opinion prior to any procedure.
15. Be informed if any treatment is for purposes of research or is experimental in nature, and be given the opportunity to provide his or her informed consent before such research or experiment will begin (unless such consent is otherwise waived).
16. Develop advance directives and be assured that all health care providers will comply with those directives in accordance with law.
17. Designate a surrogate to make health care decision if he or she is or becomes incapacitated.
18. Ask for and receive information regarding his or her financial responsibility for the services.
19. Receive an itemized copy of the bill for his or her services, an explanation of charges, and description of the services that will be charged to his/her insurance.
20. Request any additional assistance necessary to understand and/or comply with the CHC's administrative procedures and rules, access health care and related services, participate in treatments, or satisfy payment obligations by contacting [INSERT POSITION AND NAME OF RESPONSIBLE PERSON(S)]
21. File a grievance or complaint about the CHC or its staff without fear of discrimination or retaliation and have it resolved in a fair, efficient and timely manner. [INSERT COMPLAINT PROCEDURES AND RESPONSIBLE PERSON(S)]

EVERY PATIENT IS RESPONSIBLE FOR:

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

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

<http://nachc.com/client/documents/health-center-information/health-center-growth/SampleCHCPatientsBilloRights.pdf>

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

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

Coverage

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

Costs

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

Care

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

From <http://www.hhs.gov/healthcare/rights/index.html>

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NOTES:

Lined writing area for student notes.



MODULE 3
COMMON CHRONIC DISEASES — PART 1
DIABETES

Common Chronic Diseases — Part 1

Diabetes

AGENDA

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

QUIZ: DIABETES, HYPERTENSION AND CARDIOVASCULAR DISEASE

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

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

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

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

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

Before the visit:

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

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

What should patients bring with them to a healthcare visit?

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

During the visit:

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

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

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

After the visit:

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

What problems should patients discuss with the provider and not wait until their next visit?

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

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

Before the visit:

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

What to do during the visit:

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

After the visit:

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

HOMEWORK FOR NEXT CLASS:

Read the following handouts on hypertension, high cholesterol, and asthma:

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

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

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

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

CDC: Asthma: http://www.cdc.gov/asthma/impacts_nation/AsthmaFactSheet.pdf pages 1-4

Asthma action plan: http://www.nhlbi.nih.gov/health/public/lung/asthma/asthma_actplan.pdf

REFERENCES

American Diabetes Association

www.diabetes.org

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

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

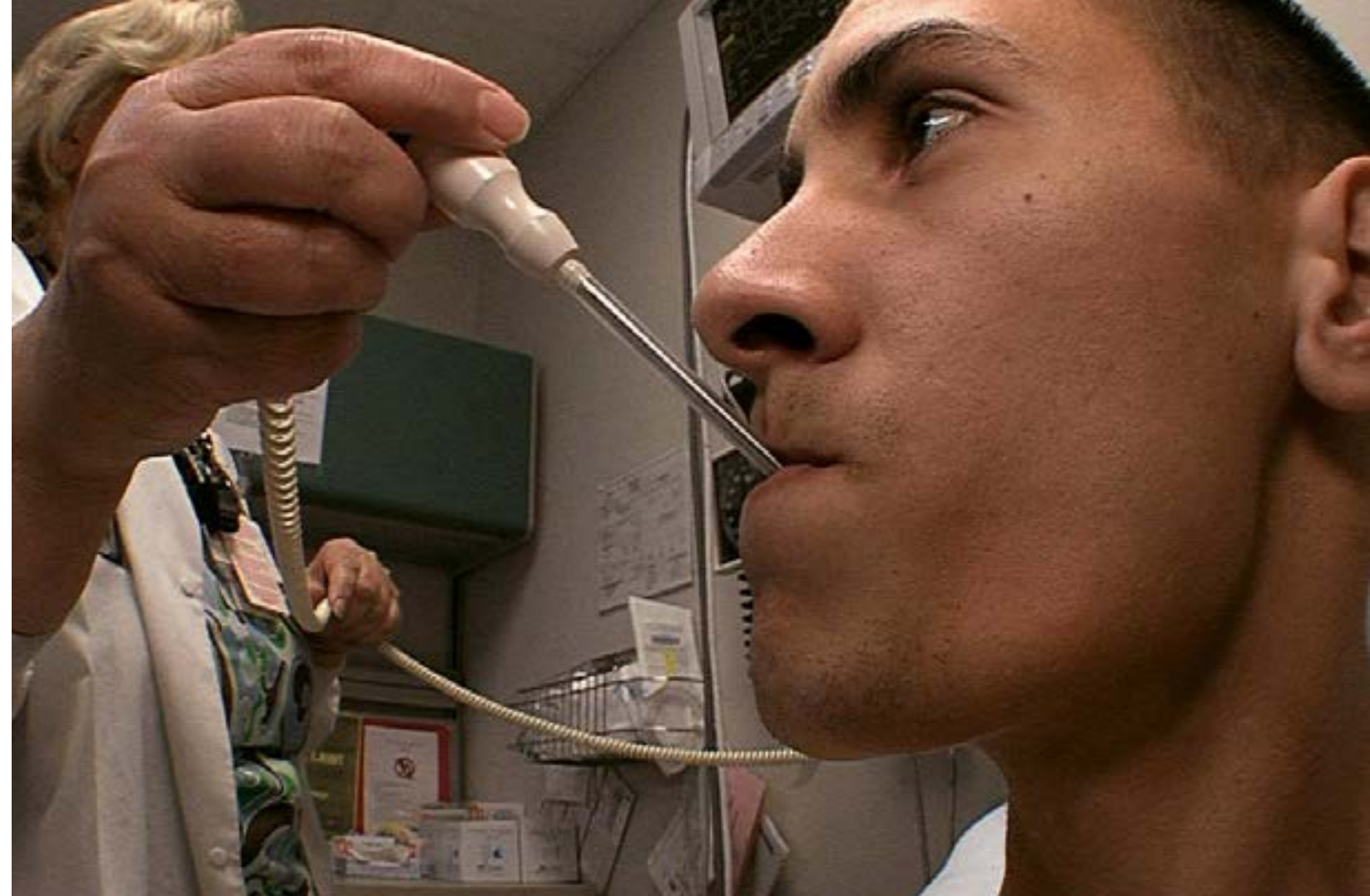
Diabetes Resources

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

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

<http://www.nhlbi.nih.gov/>

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MODULE 4

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

Common Chronic Diseases — Part 2

Hypertension/High Cholesterol/Asthma

AGENDA

- 1 HOMEWORK REVIEW/FEEDBACK ON LAST CLASS
- 2 POWERPOINT WITH DISCUSSION: BASICS OF HYPERTENSION
- 3 VIDEO: MANAGING HYPERTENSION WITH LIFESTYLE CHANGES
- 4 POWERPOINT WITH DISCUSSION: BASICS OF HIGH CHOLESTEROL
- 5 GROUP EXERCISE: SATURATED FAT IN FOODS
- 6 GROUP EXERCISE: ROSA’S DILEMMA
- 7 BREAK
- 8 POWER POINT WITH DISCUSSION: ASTHMA
- 9 VIDEO: LIVING WITH AND MANAGING ASTHMA
- 10 VIDEO DISCUSSION
- 11 VIDEO: NDEP | GETTING READY FOR YOUR DIABETES CARE VISIT
- 12 SMALL GROUP EXERCISE: HEALTHY BEHAVIORS: DIET/ EXERCISE/SMOKING QUIZ
- 13 WRAP-UP, QUESTIONS, HOMEWORK ASSIGNMENT

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

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

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

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

What can Rosa do?

Write down some ideas for Rosa to try:

From: Your Heart, Your Life a Lay Educator’s Manual

http://www.nhlbi.nih.gov/health/prof/heart/latino/eng_mnl.pdf

Possible answers/suggestions for Rosa:

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

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

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

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

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

11. There are two types of fat — saturated and unsaturated fat. Which of the following are true of these types of fats:
- Both types of fat are equally bad for you
 - Unsaturated fat is the worst for you
 - Too much saturated fat will raise your cholesterol and risk of heart disease
 - Saturated fat is found mainly in animal products such as meat, whole milk, cheese, butter, lard, ice cream and pastries
12. Some oils are also very high in saturated fat including:
- Olive oil
 - Palm oil
 - Coconut oil
 - Canola oil
13. Foods that are lower in saturated fat include:
- Fish, chicken without skin
 - Rice and Beans
 - Fruits and vegetables
 - Cheese
14. Ways to improve your diet include:
- Cooking more at home
 - Using fewer pre-prepared foods
 - Bringing your lunch from home
 - Eating at fast food restaurants
15. People who smoke:
- Can always quit when they want to
 - Are negatively affecting the health of those around them
 - usually need a game plan for managing stress if they are planning to quit cigarettes
 - can be helped by joining a smoking cessation program if they want to quit
16. Tobacco companies:
- Target young people in their ads because they know they are likely to be lifelong smokers
 - Go to community events and festivals to promote their products by giving away free merchandise and cigarettes
 - Target particular racial groups who they believe are more likely to take up smoking
 - Are unaware of the thousands of people who die each day from disease related to cigarette smoking
17. When people smoke, they are at higher risk for developing:
- Cancer
 - Emphysema
 - Stroke
 - Wrinkles
18. A diagnosis of high blood pressure is given for people with two *separate* blood pressure readings that are:
- Greater than 110/60
 - Greater than 70/50
 - Greater than 140/90
 - Greater than 135/88
19. A diagnosis of diabetes is given when a fasting blood glucose test result is:
- > 126
 - < 126
 - > 200
 - Between 100 and 126
20. A reason that patients need to check their blood sugar when they have diabetes is:
- To avoid complication such as long-term complications such as nerve damage, kidney damage, and eye damage
 - To toughen up their fingers
 - So they can assess if their diabetes is under control or not
 - So they can adjust their diet and/or medications if their blood glucose is too high or too low
21. In general, asthma treatment involves two types of medicine:
- Medicine to control and prevent asthma, and quick-acting relief medicine
 - Medicine to clean out the lungs, and quick acting relief medicine
 - Medicine that is taken daily for control and prevention, and medicine that is used to calm and suppress an asthma attack
 - Medicine that is in pill form and medicine that is in inhaler form
22. Carbohydrate intake should be limited for someone who has diabetes. The following are high in carbohydrates:
- Cheese and nuts
 - Bread and pasta
 - Cakes, doughnuts, and pastries
 - Fish

HOMEWORK REVIEW FOR NEXT CLASS: RELATED TO HEART DISEASE AND STROKE

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

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

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

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

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>

Common Chronic Diseases — Part 3

Heart Disease/Stroke



MODULE 5

COMMON CHRONIC DISEASES — PART 3

HEART DISEASE/STROKE

AGENDA

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

GROUP ACTIVITY CULTURE AND CARDIOVASCULAR DISEASE

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

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

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

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

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

HOW CAN STAFF PROVIDING CARE COORDINATION SERVICES HELP PATIENTS TAKE THEIR MEDICINES?

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

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

Be prepared to report back to the group.

ACTIVITY: JOB DESCRIPTIONS MATCHING GAME

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

1. Primary Care Physician _____
2. Specialist _____
3. Nurse Practitioner, Nurse Midwife, Physician Assistant _____
4. Nurse _____
5. Medical Assistant _____
6. Social Work _____
7. Radiologist _____
8. Endocrinologist _____
9. Cardiologist _____
10. Pulmonologist _____
11. Surgeon _____
12. Oncologist _____
13. Administrator _____
14. Certified Diabetes Educator _____
15. Podiatrist _____

16. Registered Dietitian	_____	A. Physician who specializes in the diagnosis and treatment of disorders of the heart and heart disease
17. Rehabilitation Specialist	_____	B. Doctors who oversee patients' general health and their treatment. They order tests, make diagnoses, make referrals to specialists, and follow patients through the process of treatment.
18. Pharmacist	_____	C. Assist patients with activities of daily living (such as eating, bathing, walking) in their home
19. Dentists	_____	D. Diagnoses and treats patients who have specific conditions or diseases. May focus on one particular body system or type of disease.
20. Physical Therapist	_____	E. Take vital signs, sometimes obtain patient history, obtain testing results, set up rooms, and send out reminder letters to patients.
21. Vascular Surgeon	_____	F. Have master's degrees and are trained to provide counseling and individual and group therapy for patients and their families. Can be a useful resource for finding support groups and community resources.
22. Pathologist	_____	G. Doctor who specializes in the reading and interpretation of X-rays and other medical images.
23. Home Health-aid	_____	H. Doctor who specializes in the diagnosis and treatment of respiratory disorders
24. Psychiatrist	_____	I. Doctors who specialize in performing surgery, sometimes needed to perform amputations for patients with diabetes
25. Staff member providing care coordination	_____	J. Doctor who specializes in treating patients who have cancer
		K. Oversees patients' general health and treatment. They order tests, make diagnoses, make referrals to specialists, and follow through the process of treatment. They do similar work to doctors but with a more limited scope. They usually work with a collaborating physician.
		L. Clinic coordinators, schedulers, medical records, medical billing, center directors, office managers
		M. Provide education on diabetes, help patients learn how to self-manage their diabetes and prevent it from getting worse
		N. Treat problems of the feet, prescribe corrective devices, medication, or recommend physical therapy. Some perform foot surgery.
		O. Diagnose diseases by examining body tissues
		P. Provide information to patients about nutrition and diet
		Q. A healthcare professional who helps people recover from an illness or injury, such as a stroke or cancer, and return to daily life. Examples of rehabilitation specialists are physical therapists and occupational therapists.

- R. Usually in charge of carrying out the plan the doctor has put in place for the patient. Administer medications, monitor side effects, provide education, obtain testing results, monitor patient symptoms, triage
- S. Fill prescriptions and help patients understand medication-related side effects
- T. Work with patients to “navigate” the healthcare system and help them overcome barriers to receiving timely care
- U. Support oral health and treat problems of the mouth and teeth
- V. Help patients recover from a stroke or serious injury. They help patients restore the functioning of their body by providing hands on treatment such as stretching and strengthening exercises
- W. Physician whose specialty is surgical solutions to diseases of the body’s blood vessels, including the heart and lymph systems. Treat patients for lymphatic diseases, stroke, aneurysms, varicose veins and other conditions
- X. Doctor who specializes in the health of the endocrine system. They diagnose and treat hormone imbalances including diabetes, thyroid disease, menopause, infertility, bone disease, weight issues, pituitary gland disorders, growth disorders, lipid disorders, cancers of the endocrine glands, metabolic disorders, and hypertension
- Y. A physician who specializes in mental, emotional, or behavioral disorders, licensed to prescribe medication and provide verbal-based psychotherapy

HOMWORK REVIEW FOR NEXT CLASS: HEPATITIS AND HIV

Read the following handouts on Hepatitis and HIV:

The ABCs of Hepatitis:

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

Hepatitis A:

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

Hepatitis B:

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

Hepatitis B and sexual health:

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

Hepatitis C:

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

Living with Chronic Hepatitis C:

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

Basic HIV facts:

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

HIV trends:

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

HIV challenges:

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

Condoms and STDs:

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

Common Chronic Diseases — Part 4

Hepatitis/HIV

AGENDA

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

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

Imagine that you are HIV positive:

1. What do you think would be the three biggest challenges for you about being HIV positive?
2. What barriers do you think you might face trying to get care for your HIV?
3. What do you think would be the hardest thing about taking care of yourself?

HOMEWORK: FAMILY RELATIONSHIP TO HEALTHCARE

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

- a) When you were young, what did your family do if you had a fever? What, if anything, would they do to try to bring your temperature down?
- b) When did you/your family members see a doctor? Did you go for regular appointments or only when you were sick?
- c) How did you/your family feel about your regular doctor, if you had one? How did you/your family feel about hospitals?

REFERENCES:

CDC:

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

CDC: HIV:

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

Mayo Clinic: HIV/AIDS

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

PubMed: Hepatitis:

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

Web MD: A man with HIV infection:

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

Web MD: A woman with HIV:

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

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

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

Bias, Culture, and Values

AGENDA

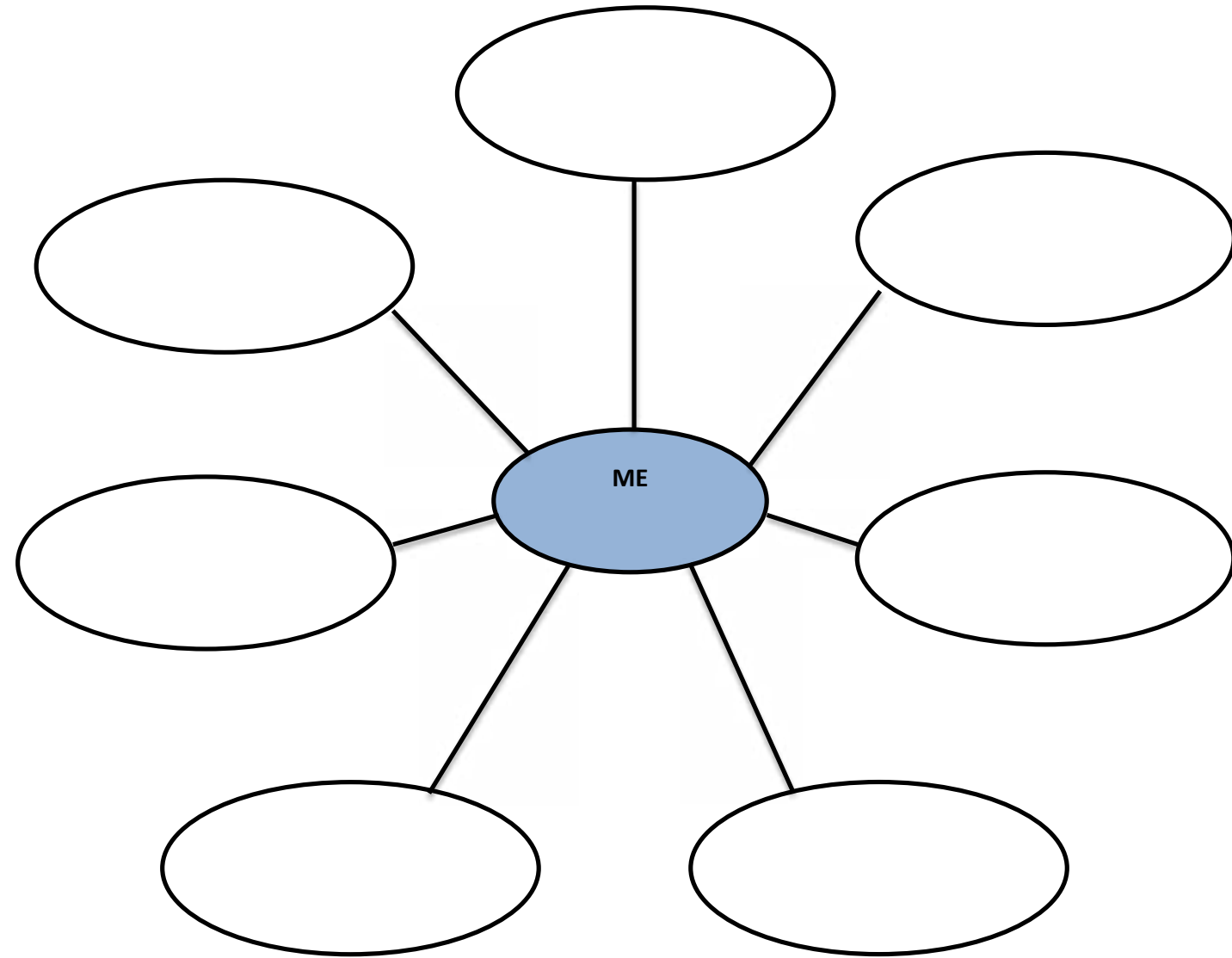
- 1 HOMEWORK REVIEW
- 2 POWERPOINT: CULTURAL COMPETENCE DEFINITIONS
- 3 VALUES CLARIFICATION EXERCISE
- 4 POWERPOINT WITH DISCUSSION: CULTURAL IDENTITY
- 5 ACTIVITY: FROM MY PERSPECTIVE
- 6 BREAK
- 7 VIDEO: INCOMPETENT VS. COMPETENT CULTURAL CARE
- 8 VIDEO DISCUSSION
- 9 POWERPOINT: CULTURALLY COMPETENT INTERVIEW TECHNIQUES
- 10 ACTIVITY: CULTURAL COMPETENCY ROLE PLAY
- 11 WRAP UP, HOMEWORK FOR NEXT CLASS



MODULE 7 BIAS, CULTURE, AND VALUES

ACTIVITY: FROM MY PERSPECTIVE

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



ROLE PLAY: CROSS-CULTURAL STRATEGIES IN PRACTICE

CARE COORDINATORS

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

Remember: Respect - Curiosity - Empathy.

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

ROLE PLAY: CROSS-CULTURAL STRATEGIES IN PRACTICE

PATIENT

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

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

HOMEWORK FOR NEXT CLASS

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

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

REFERENCES

Missouri People to People Training Manual, 2008

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).

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<http://www.lgbthealtheducation.org/training/learning-modules/>

VIDEO

Incompetent vs. Competent Cultural Care

<http://www.youtube.com/watch?v=Dx4Ia-jatNQ>

Health Disparities

AGENDA

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

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

GROUP #1: PREVENTION & EARLY DETECTION

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

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

GROUP #2: HEALTHCARE ACCESS & COORDINATION

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

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

GROUP #3: INSURANCE COVERAGE AND CONTINUITY

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

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

GROUP #4: DIVERSITY AND CULTURAL COMPETENCY

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

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Basic Communication Skills



MODULE 9

BASIC COMMUNICATION SKILLS

AGENDA

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

ACTIVITY: CREATING AN ELEVATOR SPEECH ABOUT CARE COORDINATION

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

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

In the space below:

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

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

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

HOMEWORK FOR NEXT CLASS

Instructions: Read “What Can Mississippi Learn from Iran?”

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

HOMEWORK QUESTIONS FOR DISCUSSION

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

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

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

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

Patient Safety and Quality: An Evidence-Based Handbook for Nurses, Chapter 33. Professional Communication and Team Collaboration

http://www.ahrq.gov/professionals/cliniciansproviders/resources/nursing/resources/nursesfdbk/ODanielM_TWC.pdf

Addressing Chronic Disease through Community Health Workers

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

Community Health Workers: A Front Line for Primary Care?

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

Continuous and team based healing relationships-Safety Net Initiative

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

Conflict Resolution: What Nurses Need to Know, Pam Marshall

May 2006 <http://www.mediatecalm.ca/pdfs/what%20nurses%20need%20to%20know.pdf>

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

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

Hope for customer service in health care?

http://www.cbsnews.com/8301-505143_162-57464332/hope-for-customer-service-in-health-care/

Accessing Patient Resources

AGENDA

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

CARE COORDINATION INTAKE FORM AND TRACKING TOOL

Adapted and copied here with permission from Kansas Cancer Partnership,
www.cancerkansas.org

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

Are you the: Patient Loved One Caregiver

Name:

Address:

Telephone number(s):

Email:

Can messages from this office be left at this phone number? Yes No

Can texts from this office be sent to this number? Yes No

Can emails be sent from this office to your email? Yes No

Emergency contact person:

Telephone number:

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

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

Physician

Name:

Hospital

Name:

Clinic

Name of clinic:

Screening center

Name of center:

Nurse

Name and department:

Social worker

Name:

Other

Please explain on next page:

3. What concerns might keep you from getting to all of your appointments?
(for example: child care or transportation needs, job responsibilities, or finances)

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

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

5. Do you have health insurance? Yes No

If yes, is it: Private/Commercial Medicare Medicaid Other:

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

(for example: Medicaid, COBRA, etc.)? Yes No

Please explain: _____

6. Are you a citizen of the United States? Yes No

If no, please provide information about your residency:

LEARNING PREFERENCES

7a. What is your native language? _____

b. What other languages do you speak? _____

What other languages do you write? _____

What other languages do you read? _____

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

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

(When they are in your preferred language)

(Check all that apply.)

Reading Watching a video

Listening (person-person) Personal demonstration

SUPPORT SYSTEM

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

10. Who is available to help you at home?

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

(For Care Coordinator Use Only)

POTENTIAL PROBLEMS/BARRIERS TO CARE

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

Health Insurance/Financial Concerns

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

Transportation To and From Treatment

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

Physical Needs

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

Communication/Cultural Needs

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

Disease Management

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

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

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

Supportive Services for Referrals

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

TRACKING TOOL

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

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

Patient name and identification: _____

Date: _____

Reason for visit: _____

Barrier/concern identified: _____

Action to be taken: _____

Desired result: _____

Resolution and date: _____

Additional comments: _____

Patient name and identification: _____

Date: _____

Reason for visit: _____

Barrier/concern identified: _____

Action to be taken: _____

Desired result: _____

Resolution and date: _____

Additional comments: _____

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CANCER CARE COORDINATION PROGRAM TOOLKIT, Kansas Cancer Partnership, September 2009, www.cancerkansas.org under Health Care Professionals

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

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

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

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Basics of Mental Illness and Crisis Management — Part 1

AGENDA

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

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

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

Column Totals _____ + _____ + _____

Add Totals Together _____

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

ROLE PLAY: THE PHQ-9

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

Health Professional

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

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

Today you are visiting M in her home for the first time. Even though it’s 4:00 PM, you notice that she is still in her bathrobe, her hair hasn’t been brushed and it doesn’t look like the apartment has been cleaned for weeks. You begin by asking her about the glucose checks.

ROLE PLAY: THE PHQ-9

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

Patient “M”

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

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

HOMEWORK FOR NEXT CLASS

The following handouts are used by community health workers to educate their patients about depression and identify symptoms. Please review these handouts, think about the following questions and be prepared to discuss in class:

- **“Signs of Depression”** *The Community Health Worker’s Sourcebook, A Training Manual for Preventing Heart Disease and Stroke, Centers for Disease Control and Prevention; 6-13*
- **“Four Steps to Understand and Get Help for Depression”** *The Community Health Worker’s Sourcebook, A Training Manual for Preventing Heart Disease and Stroke, Centers for Disease Control and Prevention; 6-14*
- When do you think would be an appropriate time to give your patients this information?
- Do you think this information is clear, or do you think you would need to provide additional explanations?
- How would you explain this information to your patient? What would you say in your own words as to why addressing depression is important?
- How would you feel explaining this information to patients? (for example, comfortable, anxious, unprepared)
- Is there any other information you would want your patient to have about how to understand and get help for depression?

REFERENCES

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

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

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

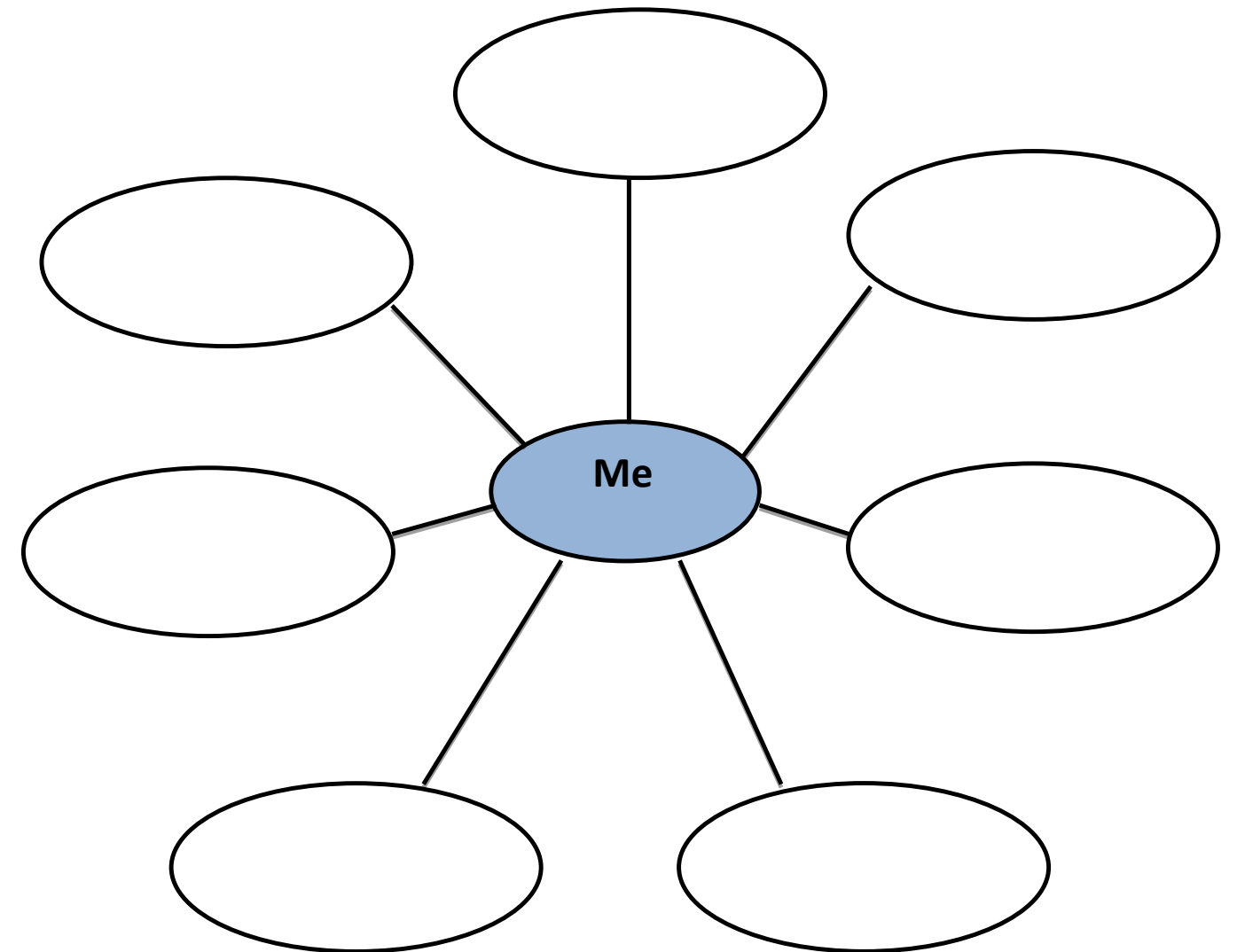
Basics of Mental Illness and Crisis Management — Part 2

AGENDA

- 1 HOMEWORK REVIEW
- 2 VIDEO: ASHLEY'S STORY
- 3 VIDEO DISCUSSION
- 4 POWERPOINT WITH DISCUSSION: SCHIZOPHRENIA
- 5 VIDEO: CHOICES IN RECOVERY – PHYSICIAN'S PERSPECTIVES
- 6 VIDEO DISCUSSION
- 7 POWERPOINT WITH DISCUSSION: SOCIAL SUPPORT
- 8 **ACTIVITY: IDENTIFY YOUR SOCIAL SUPPORT NETWORK**
- 9 POWERPOINT WITH DISCUSSION: ASSESSING A PATIENT'S SOCIAL SUPPORT SYSTEM
- 10 POWERPOINT WITH DISCUSSION: IMPROVING A PATIENT'S SOCIAL SUPPORT SYSTEM
- 11 SOCIAL SUPPORT FOR THOSE WITH CHRONIC DISEASES
- 12 VIDEO: CLAUDIA AND SOCIAL SUPPORT
- 13 VIDEO DISCUSSION
- 14 SUMMARY & WRAP UP

ACTIVITY: IDENTIFY YOUR SOCIAL SUPPORT NETWORK

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



Social Support

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

Please circle one number on each line

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

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

- | | |
|---------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Community Health Worker |
| <input type="checkbox"/> Other family members | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Friends | <input type="checkbox"/> No one |
| <input type="checkbox"/> Paid helper | <input type="checkbox"/> Doctor |
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Case manager |
| <input type="checkbox"/> Other health care professional | |

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

SOCIAL SUPPORT QUESTIONNAIRE

PLEASE READ ALL DIRECTIONS ON THIS PAGE BEFORE STARTING

Please list each significant person in your life on the right. Consider all the persons who provide personal support for you or who are important to you.

Use only first names or initials, and then indicate the relationship, as in the following example:

Example:

First Name or Initials	Relationship
1. <u>Mary T</u>	<u>friend</u>
2. <u>Rob</u>	<u>brother</u>
3. <u>MT</u>	<u>mother</u>
4. <u>Sam</u>	<u>friend</u>
5. <u>Mrs. R</u>	<u>neighbor</u>
etc.	

Use the following list to help you think of the people important to you, and list as many people as apply in your case.

- spouse or partner
- family members or relatives
- friends
- work or school associates
- neighbors
- health care providers
- counselor or therapist
- minister/priest/rabbi
- other

You do not have to use all 24 spaces. Use as many spaces as you have important persons in your life.

WHEN YOU HAVE FINISHED YOUR LIST, PLEASE TURN TO PAGE 2.

© 1988 by Jane S. Norbeck, DNSc
University of California, San Francisco
Revised 1982, 1995

Page 1

For each person you listed, please answer the following questions by writing in the number that applies.

- D = not at all
- 1 = a little
- 2 = moderately
- 3 = quite a bit
- 4 = a great deal

- D = not at all
- 1 = a little
- 2 = moderately
- 3 = quite a bit
- 4 = a great deal

Question 1:

How much does this person make you feel liked or loved?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____
- 11. _____
- 12. _____
- 13. _____
- 14. _____
- 15. _____
- 16. _____
- 17. _____
- 18. _____
- 19. _____
- 20. _____
- 21. _____
- 22. _____
- 23. _____
- 24. _____

[EMD1]

Page 2

Question 2:

How much does this person make you feel respected or admired?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____
- 11. _____
- 12. _____
- 13. _____
- 14. _____
- 15. _____
- 16. _____
- 17. _____
- 18. _____
- 19. _____
- 20. _____
- 21. _____
- 22. _____
- 23. _____
- 24. _____

[EMD2]

GO ON TO NEXT PAGE

Question 3:

How much can you confide in this person?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____
- 11. _____
- 12. _____
- 13. _____
- 14. _____
- 15. _____
- 16. _____
- 17. _____
- 18. _____
- 19. _____
- 20. _____
- 21. _____
- 22. _____
- 23. _____
- 24. _____

[EMD3]

Page 3

Question 4:

How much does this person agree with or support your actions or thoughts?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____
- 11. _____
- 12. _____
- 13. _____
- 14. _____
- 15. _____
- 16. _____
- 17. _____
- 18. _____
- 19. _____
- 20. _____
- 21. _____
- 22. _____
- 23. _____
- 24. _____

[EMD4]

GO ON TO NEXT PAGE

- D = not at all
- 1 = a little
- 2 = moderately
- 3 = quite a bit
- 4 = a great deal

Question 5:

If you needed to borrow \$10, a ride to the doctor, or some other immediate help, how much could this person usually help?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

[END]

Page 4

Question 6:

If you were confined to bed for several weeks, how much could this person help you?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

[END]

GO ON TO NEXT PAGE

Question 7:

How long have you known this person?

- 1 = less than 6 months
- 2 = 6 to 12 months
- 3 = 1 to 2 years
- 4 = 2 to 5 years
- 5 = more than 5 years

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

[DURATION]

PLEASE BE SURE YOU HAVE RATED EACH PERSON ON EVERY QUESTION. GO ON TO THE LAST PAGE.

Question 8:

How frequently do you usually have contact with this person? (Phone calls, visits, or letters)

- 5 = daily
- 4 = weekly
- 3 = monthly
- 2 = a few times a year
- 1 = once a year or less

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

[FREQUENCY]

Number _____
 Date _____

9. During the past year, have you lost any important relationships due to moving, a job change, divorce or separation, death, or some other reason?
 _____ 0. No
 _____ 1. Yes

PERSONAL NETWORK

First Name or Initials	Relationship	
1. _____	_____	①C0111
2. _____	_____	①C0112
3. _____	_____	①C0113
4. _____	_____	①C0114
5. _____	_____	①C0115
6. _____	_____	①C0116
7. _____	_____	①C0117
8. _____	_____	①C0118
9. _____	_____	①C0119
10. _____	_____	①C01110
11. _____	_____	①C01111
12. _____	_____	①C01112
13. _____	_____	①C01113
14. _____	_____	①C01114
15. _____	_____	①C01115
16. _____	_____	①C01116
17. _____	_____	①C01117
18. _____	_____	①C01118
19. _____	_____	①C01119
20. _____	_____	①C01120
21. _____	_____	①C01121
22. _____	_____	①C01122
23. _____	_____	①C01123
24. _____	_____	①C01124

IF YOU LOST IMPORTANT RELATIONSHIPS DURING THIS PAST YEAR:

- 9a. Please indicate the number of persons from each category who are *no longer available* to you.
- _____ spouse or partner ①C0201
 - _____ family members or relatives ①C0202
 - _____ friends ①C0203
 - _____ work or school associates ①C0204
 - _____ neighbors ①C0205
 - _____ health care providers ①C0206
 - _____ counselor or therapist ①C0207
 - _____ minister/priest/rabbi ①C0208
 - _____ other (specify) _____ ①C0209
- 9b. Overall, how much of your support was provided by these people who are no longer available to you? ①C0210
- _____ 0. none at all
 - _____ 1. a little
 - _____ 2. a moderate amount
 - _____ 3. quite a bit
 - _____ 4. a great deal



MODULE 13

**BASICS OF MENTAL ILLNESS AND
CRISIS MANAGEMENT — PART 3****Basics of Mental Illness and
Crisis Management —Part 3****AGENDA**

- 1 POWERPOINT WITH DISCUSSION:
OVERVIEW OF CRISIS MANAGEMENT
- 2 POWERPOINT WITH DISCUSSION:
COPING STRATEGIES
- 3 ACTIVITY: COPING STRATEGIES
BRAINSTORM
- 4 ACTIVITY DISCUSSION
- 5 GROUP ACTIVITY: CRISIS
MANAGEMENT: CHRONIC DISEASE
DIAGNOSIS
- 6 BREAK
- 7 POWERPOINT WITH DISCUSSION:
CRISIS MANAGEMENT: SUBSTANCE
ABUSE
- 8 POWERPOINT WITH DISCUSSION:
CRISIS MANAGEMENT: DV/IPV
- 9 SUMMARY & WRAP-UP

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

COPING STRATEGIES BRAINSTORM

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

Positive Techniques (Adaptive or Constructive Coping):

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

Negative Techniques (Maladaptive Coping or Non-Coping):

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



MODULE 14
HOME VISITS

Home Visits

AGENDA

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

OPEN FORUM: SHARED EXPERIENCES

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

- Pretend for a moment that you are a patient about to receive a home visit from a care coordinator for help in managing your chronic disease. What would you hope to gain from this visit?
What would you fear?
- What is the purpose of a home visit when working with patients with chronic illness?
- As a health professional providing care coordination services, how would you facilitate a positive home visit?
- Do home visits differ whether they are for diabetic care, prenatal care or mental health (behavioral health) care? If so, what are some of the differences?
- What are some key areas one should always keep in mind when providing a home visit?

HOME VISIT CASE STUDY – MR. DIAZ

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

Mr. Diaz is expecting his first home visit from his new care coordinator, Eddie. Mr. Diaz is very anxious and nervous to meet Eddie and hopes this visit goes better than his last visit with his last worker. In preparation for the visit, Mr. Diaz makes an elaborate early dinner for his 5:00 pm scheduled home visit. Mr. Diaz sets the dining table for two - for him and Eddie.

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

Eddie rings the bell to the apartment and receives no response. He waits about 2-5 minutes and rings it again; no answer. Eddie decides to call Mr. Diaz and on the first rings, Mr. Diaz says “You are really early; I can’t allow you in the apartment until 5:00 pm” and then hangs up.

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

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

HOME VISITING CASE STUDY – MS. JONES

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

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

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

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

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

REFERENCES

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

Resources:

Making the Most of Home Visits

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

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

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

Home Visitor's Handbook

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

VIDEOS

Video: Nurse Home Visiting at Commonwealth Care Alliance

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

Transitions of Care

AGENDA

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

GROUP EXERCISE: TRANSITIONS OF CARE CASE STUDY

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

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

At home, Gladys was confused. Was she supposed to now take two medications for her high blood pressure? Or was she supposed to just take the new medication that the hospital had given her? Gladys decided to take only the new medication since she was feeling better and she didn't like the idea of taking two. That seemed like a lot of medication.

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

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

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

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

GROUP EXERCISE: HOW CAN SOMEONE PROVIDING CARE COORDINATION HELPS PATIENTS HAVE BETTER TRANSITIONS OF CARE?

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

What tasks will you need to carry out?

What problems might you anticipate?

What resources will these patients possibly need?

A middle-aged patient referred to a specialist

An adolescent discharged from the hospital

An elderly patient moving from the hospital to a nursing home

A young homeless woman discharged from a psychiatric facility

REFERENCES

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

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

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

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

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

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

VIDEOS

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

U of U Health Care- Transitions Program <http://www.youtube.com/watch?v=HCizQLCBrz4&list=PLqF>

Northern Piedmont Community Care <http://www.youtube.com/watch?v=Gxfo3ejP8c&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)

NOTES:

Electronic Health Records

AGENDA

- 1 POWERPOINT WITH DISCUSSION:
ELECTRONIC HEALTH RECORDS SYSTEMS
- 2 POP QUIZ:
PATIENT-CENTERED MEDICAL HOME
- VIDEOS:
- 3 EMR TECHNOLOGY IS LIFE CHANGING
EMR: HELPING DELIVER BETTER PATIENT
CARE
- 4 VIDEO DISCUSSION
- 5 POWERPOINT WITH DISCUSSION:
EHR AND QUALITY IMPROVEMENT
- 6 POWERPOINT WITH DISCUSSION:
HEALTH INFORMATION EXCHANGE
- VIDEO:
- 7 HEALTH INFORMATION EXCHANGE:
MAKING A DIFFERENCE
- 8 VIDEO DISCUSSION
- 9 POWERPOINT WITH DISCUSSION:
PATIENT PORTALS
- VIDEO:
- 10 VETERANS ADMINISTRATION ON THE
"BLUE BUTTON"
- 11 VIDEO DISCUSSION
- 12 EXERCISE: RECAP ACTIVITY
- 13 POWERPOINT WITH DISCUSSION:
PRIVACY AND SECURITY
- VIDEO:
- 14 ELECTRONIC HEALTH RECORDS: PRIVACY
AND SECURITY
- 15 VIDEO DISCUSSION
- 16 SUMMARY AND WRAP-UP

MODULE 16

ELECTRONIC HEALTH RECORDS

POP QUIZ! PCMH MATCHING GAME

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

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

- A. A series of recommendations on clinical care, supported by the best available evidence in the clinical literature.
- B. The smallest, most patient-centric model that pairs a clinician with a medical assistant (MA), community health worker or health coach. It works to provide a variety of services for a panel of patients and to help patients and their families manage their own chronic conditions within the context of their daily lives.
- C. A set of patient-centered, goal-oriented, culturally relevant and logical steps to assure that the patient receives needed services in a supportive, effective, efficient, timely and cost-effective manner.
- D. Systematic, data-guided activities designed to bring about immediate improvement in health care delivery in particular settings.
- E. Sharing clinical information with others who are involved in delivering care to a given patient – the hospital, other physicians, and home health agencies in order to improve patient care and patient health outcomes.
- F. A technology framework that allows providers to write and send prescriptions to a participating pharmacy electronically instead of using handwritten or faxed notes or calling in prescriptions.
- G. Care of patients by a multidisciplinary team usually organized under the leadership of a physician; each member of the team has specific responsibilities and the whole team contributes to the care of the patient.



MODULE 17

NAVIGATING THE INSURANCE SYSTEM & HELPING THE UNINSURED

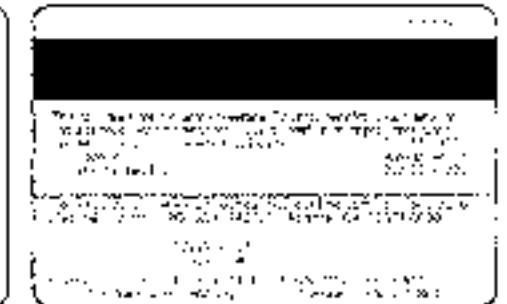
Navigating the Insurance System & Helping the Uninsured

AGENDA

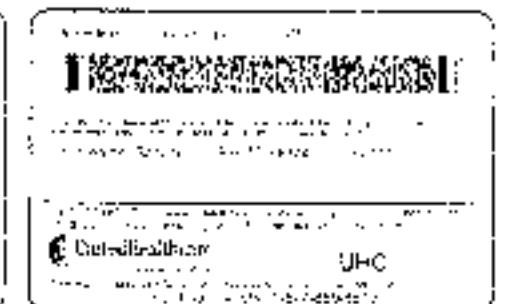
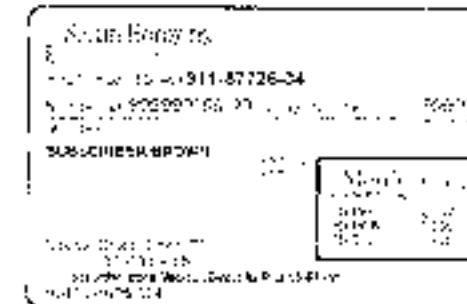
- 1 INTRODUCTION: THE CHANGING WORLD OF HEALTH INSURANCE
- 2 VIDEO: GETTING READY FOR OBAMACARE
- 3 VIDEO DISCUSSION
- 4 POWERPOINT WITH DISCUSSION: HEALTH INSURANCE OPTIONS IN NYS
- 5 POWERPOINT WITH DISCUSSION: NAVIGATING THE INSURANCE SYSTEM
- 6 VIDEO: REFERRAL VS. AUTHORIZATION
- 7 VIDEO DISCUSSION
- 8 EXERCISE: INSURANCE CARD BASICS
- 9 POP QUIZ: HEALTH CARE REFORM
- 10 POWERPOINT WITH DISCUSSION: HELPING UNINSURED PATIENTS NAVIGATE THE HEALTH SYSTEM
- 11 RESOURCE REVIEW: NEW YORK
- 12 TEAM EXERCISE: HEALTH INSURANCE GLOSSARY MATCHING GAME

Samples of Commercial, Medicare and Medicaid Health Care ID cards

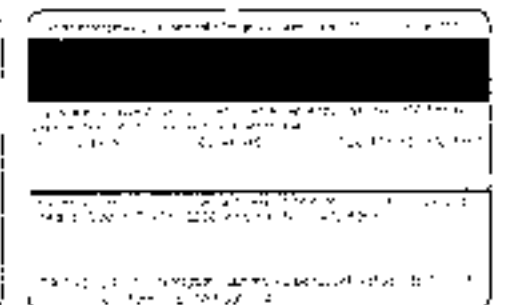
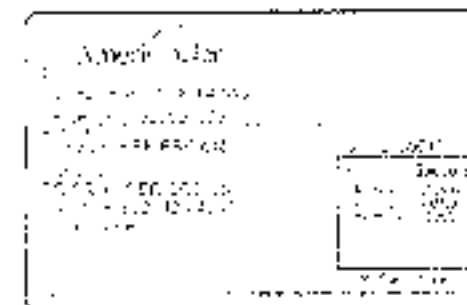
Commercial Plans – Sample Cards



Medicare Plans – Sample Cards



Medicaid Plans – Sample Cards



www.unitedhealthcareonline.com

Pop Quiz! Healthcare Reform

1. Will the health reform law require nearly all Americans to have health insurance starting in 2014 or else pay a fine?
 - A. No, the law will not do this
 - B. Yes, the law will do this
 - C. Don't know
2. Will the health reform law allow a government panel to make decisions about end-of-life care for people on Medicare?
 - A. No, the law will not do this.
 - B. Yes, the law will do this.
 - C. Don't know
3. Will the health reform law cut benefits that were previously provided to all people on Medicare?
 - A. No, the law will not do this.
 - B. Yes, the law will do this.
 - C. Don't know
4. The health reform law expand the existing Medicaid program to cover low-income, uninsured adults regardless of whether they have children?
 - A. No, the law will not do this.
 - B. Yes, the law will do this.
 - C. Don't know
5. Will the health reform law provide financial help to low and moderate income Americans who don't get insurance through their jobs to help them purchase coverage?
 - A. No, the law will not do this.
 - B. Yes, the law will do this.
 - C. Don't know
6. Will the health reform law prohibit insurance companies from denying coverage because of a person's medical history or health condition?
 - A. No, the law will not do this.
 - B. Yes, the law will do this.
 - C. Don't know
7. Will the health reform law require all businesses, even the smallest ones, to provide health insurance for their employees?
 - A. No, the law will not do this.
 - B. Yes, the law will do this.
 - C. Don't know
8. Will the health reform law provide tax credits to small businesses that offer coverage to their employees?
 - A. No, the law will not do this.
 - B. Yes, the law will do this.
 - C. Don't know
9. Will the health reform law create a new government run insurance plan to be offered along with private plans?
 - A. No, the law will not do this.
 - B. Yes, the law will do this.
 - C. Don't know
10. Will the health reform law allow undocumented immigrants to receive financial help from the government to buy health insurance?
 - A. No, the law will not do this.
 - B. Yes, the law will do this.
 - C. Don't know

Used with permission of the Healthcare Center Advancement Program (H-CAP).

HEALTH INSURANCE GLOSSARY MATCHING GAME

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

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

- A A tool used by Community Health Centers, Family Planning Centers, and other nonprofit organizations to provide services to the community based on their ability to pay for those services. In some cases, it may be necessary for a patient to prove their income to obtain services using this tool.
- B From the patient’s perspective, an important feature of all of these types of plans is that they in some way restrict or limit coverage for the providers and hospitals that a plan participant can use. Plan types include Health Maintenance Organizations, Preferred Provider Organizations, and Independent Practice Associations.
- C Managed care plans and some Fee for Service plans limit their insured patients’ access to provider by providing financial incentive to use a specific group of providers and hospitals.
- D In New York State, most Medicaid patients are enrolled in this kind of plan (if they don’t select one, it will be assigned). The plans each have different panels of participating providers and hospitals. Patients enrolled in a plan will be required to use providers participating in that plan (with the exception of Emergency Rooms and Family Planning Services.)
- E This is the patient/members point of contact with the Managed Care Plan. The phone number of the Members Services Department appears on the patients plan ID card and can provide assistance with finding providers, navigating the system, arranging transportation, selecting a Primary Care Provider or obtaining a replacement ID Card.
- F Plans are generally less restrictive health insurance plans (than Managed Care Plans) that allow patients to select providers and services. Patients can chose which providers they want to use (without respect to their insurance) and providers are compensated for service they provide. In some cases, these plans restrict the level of coverage or the group of providers a patient can see.
- G In addition to a Referral from a Primary Care Provider, some procedures or services require the permission of a patient’s health insurance or managed care plan. This permission is usually required in advance of the patient receiving the services.
- H Insurance plans offered through employers or paid for by individuals on their own. This includes plans that are offered through professional associations, alumni groups, and COBRA.
- I The medical professional assigned or selected by the patient to be their primary point of contact within a Managed Care Plan. This professional is both a provider of services and a point of contact for specialty services.
- J Primary Care Providers send patients to see specialists or receive tests.

REFERENCES

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

RESOURCES

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

www.hitesite.org

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

www.coverageforall.org/finder/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>

Motivational Interviewing — Part 1

AGENDA

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

MODULE 18

MOTIVATIONAL INTERVIEWING — PART 1

GROUP ACTIVITY: REFLECTIVE LISTENING – BREAST CANCER SCREENING

Table I. Types of reflections

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

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



OARS Coding Sheet

Open Questions 	
Affirmations 	
Reflections 	
Summaries 	

Motivational Interviewing — Part 2

AGENDA

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

MODULE 19

MOTIVATIONAL INTERVIEWING — PART 2



OARS Coding Sheet

Open Questions



Affirmations



Reflections



Summaries



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MOTIVATIONAL INTERVIEWING PRACTICE SESSION -OBSERVER

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

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

Open-ended Questions

Affirmative Statements

Reflective Listening

Summary Statements

MOTIVATIONAL INTERVIEWING PRACTICE SESSION - PATIENT “K”

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

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

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

MOTIVATIONAL INTERVIEWING PRACTICE SESSION HEALTH COACH

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

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

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

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

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



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

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

1. Day in the life

- Ask for permission to talk about drinking.
- How does drinking fit into your life?
- What does drinking mean for you?



2. Pros and cons

- What are the good things about drinking?
 - What are some more good things about drinking?
- What are the not so good things about drinking?
 - What are some more not so good things about drinking?
- Summarize in the patient's own words
- So where does that leave us?



3. Sharing information and discussion

- Ask permission to share some information about safe drinking
- Share information
- What do you think about this information?



4. Assess readiness to change

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

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



5. Set a goal

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

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Health Coaching and Patient Care Follow-Up — Part 1

AGENDA

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

EXERCISE: SETTING AGENDAS WITH PATIENTS

Dialogue 1

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

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

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

Patient: Oh.

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

Patient: My headache...

Caregiver: We'll deal with that next time

Dialogue 2

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

Patient: I have a bad headache.

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

Patient: I don't think so.

Caregiver: There is one other thing I'd like to talk about, which is your cholesterol. Would that be OK after we deal with the headache?

Patient: OK.

EXERCISE: SETTING AGENDAS WITH PATIENTS

Dialogue 3

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

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

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

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

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

Dialogue 4

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

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

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

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

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

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

Patient: OK.

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

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

HOMework FOR NEXT CLASS

For next class read:

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

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

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

- When does the health coach Victoria Ngo meet or interact with the patient?
- What des Dr. Hammer and Victoria do to improve communication and anticipate how to best address patients' concerns?
- What might the health coach do between visits with patients?
- What operational challenges did Dr. Hammer and Victoria Ngo experience?
- In the stories presented, what are some of the strategies used by the coaches to foster trust with patients?

Health Coaching & Patient Care Follow-up — Part 2

AGENDA

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

Dialogue 1

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

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

Caregiver: What is it you like about eating candy?

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

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

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

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

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

Caregiver: Do you want to give that a try?

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

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

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

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

Patient: We'll see.

Caregiver: Do you want to start this week?

Patient: That might work

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

Patient: OK.

Dialogue 2

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

Do you know what your goal is for cholesterol?

Patient: I don't remember

Caregiver: Since you had a heart attack 3 years ago, your LDL cholesterol goal is to be below 100. Now you are 145. Do you know why it has gone up again? I'll bet you haven't been taking your pills.

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

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

OK?

Patient: I guess so.

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

Dialogue 3

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

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

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

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

Caregiver: That's what over 30 means.

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

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

Dialogue 4

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

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

Caregiver: do you want to do something about that?

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

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

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

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

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

Caregiver: This isn't Russia.

Dialogue 5

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

Patient: Good

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

Patient: OK

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

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

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

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

Dialogue 6

Caregiver: Hello. How are you?

Patient: I'm fine.

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

Patient: I really feel good.

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

Patient: I really feel fine.

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

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

Dialogue 7

Caregiver: Hello. How are you?

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

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

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

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

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

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

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

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

Action plan follow-up/problem-solving dialogue

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

Patient: OK

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

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

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

Patient: Yes, I need to do that.

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

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

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

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

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

Discussion

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

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Transforming the Role of Medical Assistants: A Key to an Effective Patient- Centered Medical Home.

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VIDEOS

Health Coaching: (Medication Reconciliation) Techniques to Deliver Patient Centered Care

http://www.youtube.com/watch?v=3UpzKL_aYU

Quality Improvement and Outcomes

AGENDA

POWERPOINT WITH DISCUSSION:
1 WHY IS IT IMPORTANT TO MEASURE OUTCOMES?

POWERPOINT WITH DISCUSSION:
2 WHAT ARE PERFORMANCE INDICATORS?

3 EXERCISE: HOW DO YOU KNOW YOU ARE DOING A GOOD JOB?

4 BREAK

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

6 VIDEO DISCUSSION

7 BRAINSTORM:
QI AT THE STAFF MEETING

8 POWERPOINT WITH DISCUSSION:
QUALITY IMPROVEMENT STRATEGIES

GROUP ACTIVITY:
9 QUALITY IMPROVEMENT FOR THE POSTPARTUM VISIT

MODULE 22

QUALITY IMPROVEMENT AND OUTCOMES

EXERCISE: HOW DO YOU KNOW YOU ARE DOING A GOOD JOB?

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

EXERCISE: QUALITY IMPROVEMENT FOR THE POSTPARTUM VISIT

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

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

– Done: The current 6-week postpartum visit rate is 25%.

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

For this one, since you can't do any background research, come up with a reason on your own:

3. Assess what can be done to achieve improvement

4. Put improvement in place

5. Check to see if it's working

Lined writing area for student exercises.



MODULE 23
PROFESSIONAL BOUNDARIES — PART 1

Professional Boundaries — Part 1

AGENDA

- 1 EXERCISE: A TIME WHEN YOU EXPERIENCED TROUBLE MAINTAINING BOUNDARIES
- 2 POWERPOINT WITH DISCUSSION: PERSONAL BOUNDARIES
- 3 VIDEO: DON'T BE AFRAID TO SET BOUNDARIES
- 4 VIDEO DISCUSSION
- 5 BREAK
- 6 EXERCISE: VALUES CLARIFICATION
- 7 POWERPOINT WITH DISCUSSION: PROFESSIONAL BOUNDARIES

EXERCISE: A TIME WHEN YOU EXPERIENCED TROUBLE MAINTAINING BOUNDARIES

Think about a time when you had trouble maintaining boundaries in your professional or personal life. (For example, saying “no” to someone, sticking to a set time to meet with a patient or to end a meeting with a patient, feeling stressed out by a co-worker or by a patient who was demanding.)

How did you know that you were having trouble?

Who was involved?

Why do you think it was hard?

How might you handle it differently next time?

EXERCISE: VALUES CLARIFICATION

- Mark asks Jane if he can trade patient assignments so he can care for a patient with whom he likes working.
- Julie likes to grab a cup of coffee with one of her patients after work since she knows her from the neighborhood.
- Hugging a patient is sometimes ok.
- Accepting a cash gift from a patient is sometimes ok.
- Flirting with a patient at work is all right if you are not obvious about it.
- The other day in the waiting room, John the patient got into an argument with another patient, Jack. Susie, the care coordinator, took John's side and let everyone know that she did. This is acceptable because Jack is difficult and provocative.
- It's fine to sometimes move your favorite patients in front of other scheduled patients to see the doctor so they don't have to wait as long as everyone else.
- Peter, the community health worker, sometimes places his hand on a female patient's shoulder when he's talking to them.
- If a patient threatens to hurt me or other staff, it would be wrong to get help or call security. The patient probably doesn't really mean it and is just upset.
- If a patient wants to keep talking longer than the allotted time for the visit, you should let them because they probably really need to talk.
- It's usually better not to care for a friend and ask that they be assigned to another staff member.

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MODULE 24

PROFESSIONAL BOUNDARIES — PART 2 & WRAP-UP

Professional Boundaries — Part 2 & Wrap-Up

AGENDA

- 1 POWER POINT WITH DISCUSSION:
THE RELATIONSHIP BETWEEN
BOUNDARIES AND BURN-OUT
- 2 POWER POINT WITH DISCUSSION:
CHALLENGES OF BOUNDARIES WHILE
PROVIDING CARE COORDINATION
- 3 EXERCISE: YOUR TRIGGERS AT WORK:
PEOPLE, SITUATIONS-PART I
- 4 POWER POINT WITH DISCUSSION:
STRESS MANAGEMENT
- 5 EXERCISE: YOUR TRIGGERS AT WORK:
PEOPLE, SITUATIONS – HOW CAN YOU BE
PREPARED? - PART II
- 6 BREAK
- 7 POWER POINT WITH DISCUSSION:
HEALTH & WELLNESS
- 8 VIDEO: HUMOR IN THE WORKPLACE
- 9 EXERCISE: SIMPLE WELLNESS
PRACTICES
- 10 WRAP-UP DISCUSSION
- 11 EVALUATION COMPLETION
- 12 FINAL CELEBRATION/CERTIFICATE
DISTRIBUTION

Simple Wellness Practices

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

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NOTES:

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.

Video Title	Module Name	Organization
UIC Science Bytes: Patient Navigators	Basic Skills 1	This is UIC, University of Illinois at Chicago
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	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
Diabetes Made Simple	Basic Common Chronic Diseases 1	Stuff Made Simple
Making Sense of Diabetes-Tudiabetes	Basic Common Chronic Diseases 1	Diabetes Hands Foundation
NDEP: Getting Ready for your Diabetes Care Visit	Basic Common Chronic Diseases 1	National Diabetes Education Program
Managing Hypertension with Lifestyle Changes	Basic Common Chronic Diseases 2	National Heart, Lung, and Blood Institute; National Institutes of Health; U.S. Department of Health and Human Services
Living with and Managing Asthma	Basic Common Chronic Diseases 2	National Heart, Lung, and Blood Institute; National Institutes of Health; U.S. Department of Health and Human Services
Living With and Managing Coronary Artery Disease	Basic Common Chronic Diseases 3	National Heart, Lung, and Blood Institute; National Institutes of Health; U.S. Department of Health and Human Services

Stroke Heroes Act Fast	Basic Common Chronic Diseases 3	You Tube video with no organization indicated
Hepatitis C Made Simple: Know Your Status	Basic Common Chronic Diseases 4	Vertex Pharmaceuticals, Inc.
George's Story: Hepatitis C	Basic Common Chronic Diseases 4	Vertex Pharmaceuticals, Inc.
Su Wang: Faces of Hepatitis	Basic Common Chronic Diseases 4	Viral Hepatitis Action Coalition www.viralhepatitisaction.org and www.cdc.gov/hepatitis
Living with HIV	Basic Common Chronic Diseases 4	HRSA
Faces of HIV: Kamaria's Story	Basic Common Chronic Diseases 4	We Make the Change
Incompetent vs. Competent Cultural Care	Bias, Culture and Values	You Tube video with no organization indicated
Unnatural Causes: Is Inequality Making us Sick?	Health Disparities	California Newsreel
Unnatural Causes: Living in Disadvantaged Neighborhoods is Bad for your Health	Health Disparities	California Newsreel
Kristin Baird: Service Excellence	Basic Communication Skills	Kristin Baird
Poor Communication	Basic Communication Skills	Context of care
More than a Place to Live: The Corporation for Supportive Housing	Accessing Patient Resources	Robert Wood Johnson Foundation
Health Angels: Help for Society's Most Vulnerable People	Accessing Patient Resources	Robert Wood Johnson Foundation
What is Depression?	Mental Health 1	Health Guru
Stories of Hope and Recovery: The Jordan Burnham Story	Mental Health	National Suicide Prevention Lifeline
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Living with Schizophrenia – Ashley's Story	Mental Health 2	J&J Health
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Nurse Home Visiting at Commonwealth Alliance	Home Visits	Commonwealth Care Alliance ©2008 Commonwealth Care Alliance, Inc
Circle of Care: Returning Home from the Hospital	Care Transitions	Mills - Peninsula
University of Utah - Transitions Program	Care Transitions	U of U Healthcare, Barb Smith
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Electronic Medical Records helping deliver better patient care in Markham	Electronic Health Records	eHealth Ontario
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Health Insurance Basics: Part 1	Navigating the Insurance System	HealthiNation
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How NOT to Do Motivational Interviewing: A Conversation with Sal	Motivational Interviewing 1	The TEACH project
Motivational Interviewing: A Conversation with Sal	Motivational Interviewing 1	The TEACH project
The Effective Physician	Motivational Interviewing 2	Merlolab Produced by University of Florida Department of Psychiatry. Funded by Flight Attendant Medical Research Institute Grant #63504 (Co-PIs: Gold & Merlo).
Anti-SBIRT (Doctor A)	Motivational Interviewing 2	BNI Art Institute
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Don't Be Afraid To Set Boundaries: Julie Hanks LCW on KSL TV's Studio 5	Professional Boundaries 1	Julie Hanks
Humor in the Workplace	Professional Boundaries 2	Michael Kerr - Humor at Work

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