Core Care Coordinator Training
Day 3

Primary Care Development Corporation

Day 3

Core Care Coordinator Training Objectives

By the end of the day, you will be able to:

1. Describe best practices in transitions of care
2. Discuss how your colleagues can assist in finding solutions to challenging situations
3. Discuss how looking through a poverty lens is helpful in care management work
4. List and discuss some of the hidden rules for the different classes
5. Discuss professional boundaries and appropriate actions/responses in different situations
6. Reflect on the three days of training with PCDC

Connecting with Others Activity

Transitions of Care

Care Transition

- Movements of patients from one care setting to another
- Can be an extremely vulnerable time for patients and their caregivers
- Unique vulnerabilities for patients with multiple chronic conditions, mental illness or substance use disorders

Transitions of Care: Statistics

- Poor care coordination increases the chance that a patient will suffer from a medication error or other health care mistake by 140 percent.

- Communication failures between providers contribute to nearly 70 percent of medical errors and adverse events in health care.

- Uninsured patients or those with Medicare or Medicaid are 60 percent more likely than those with private insurance to go to the ED for follow-up care instead of a PCP or outpatient clinic.

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

Transitions of Care: Statistics

- 17% of adults hospitalized in previous two years reported that information about their care had not been communicated to them

- 27% said the hospital made no arrangements for follow-up visit in primary care

- 67% who were given a new prescription were not told whether to take their other medications

- 48% reported receiving no information on medication side effects

- "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

Transitions of Care: Statistics

Centers for Medicare and Medicaid Services (CMS) Data states:

- 19% of patients had identifiable adverse events in the first 3 weeks home.
- 73% of older patients misused at least one medication.

AHRQ: Data on Adult Care Transitions: 2010

Transitions of Care Exercise

Best Practices around Care Transitions: Five key Areas to Focus on:

- Patient/Family Engagement and Activation
- Medication Management
- Comprehensive Transition Planning
- Care Transition Support
- Transition Communication

Patient/Caregiver Engagement and Activation: Typical Failures

- Self-care:
  - Unrealistic optimism of patient and family to manage at home
  - Patient lack of adherence to self care
  - Mutliple drugs exceed patient’s ability to manage
- Care planning
  - Failure to include patient and care givers
  - Lack of understanding of patient’s physical and cognitive functional health status
  - Mutliple providers; patient believes someone is in charge
- Health Literacy:
  - Patient/caregivers fail to ask clarifying questions on plan of care

Patient/Family Engagement and Activation: Best Practices

- Self-care:
  - Assessment is conducted of patient/caregiver's ability to provide self-care after discharge
  - Post discharge telephone care management
- Care planning
  - Work with patient/caregivers to prepare for post discharge visit (goals, questions, concerns)
- Health Literacy:
  - Embed health literacy principles into all patient education and materials
  - Employ Teach Back method
  - Provide culturally and linguistically appropriate care

Medication Management: Typical Failures

- Oversight of Medication List:
    - Medication list is incorrect
    - Interaction of medication from multi-prescribers not assessed
    - No care provider assigned accountability of the patient’s medications
- Communication:
    - Lack of communication with providers across the continuum of care
- Patient/Caregiver engagement:
    - Understanding of patient’s ability to take medication not assessed
    - Patient does not have resources to obtain medication after discharge

Medication Management: Best Practices

- Assess knowledge
  - Assess patient's knowledge of medications, include Teach Back and include this information in care plan
- Communication:
  - On transition the patient's most current reconciled medication list is provided to the next care provider
- Medication List:
  - A written list of medications is provided to the patient and family including name, dose, route, purpose, side effects and special considerations
- Bring in pharmacists:
  - For patients with complicated medication regimes, pharmacy may perform patient education, medication review, follow up phone calls, in home visits

Comprehensive Discharge Planning: Typical Failures

- Discharge Planning Process:
  - Failure to actively include the patient and caregivers in identifying needs and resources
- Discharge Plan Content:
  - Written discharge instructions confusing, contradictory, hard to understand
  - Lack of an emergency plan, who the patient should call first, lack of understanding of red flags
- Care Coordination:
  - Lack of coordination and information sharing between facility and community care providers including primary care
  - Mutliple care providers; patient believes someone is in charge
  - Patient returns home without essential equipment (scale, supplemental oxygen)

Comprehensive Discharge Planning: Best Practices

- Discharge Planning Process:
  - Work with patient and family/caregivers to prepare for post discharge visit planning
- Written discharge plan includes (in plain language):
  - Reason for hospitalization
  - Medications to be taken post discharge
  - Self-care activities such as diet and activity
  - Supplies needed and where to obtain them
  - Symptom recognition and management-who to contact and how to contact them if needed
  - Coordination and planning for follow up appointments
  - Community resources patient will utilize such as Meals on Wheels, home health care, physical therapy, etc.

Transition Care Support: Typical Failures

- No follow up appointment scheduled
- Follow up with provider too long after hospitalization
- Follow up is seen as sole responsibility of patient
- Patient unable to keep follow up appointments because of transportation issues
- Multiple care providers; patient believes someone is in charge

Transition Care Support: Best Practices:

- Assess the patient's understanding of the discharge plan by asking them to explain the details of the plan in their own words
- Assign accountability for patient issues between hospitalization and next provider visit, and inform the patient who is in charge of their care and how to contact them
- Provide telephone reinforcement of the plan 2-3 days after discharge
- Provide a coach for a pre-discharge hospital visit, home visit and follow up telephone calls

Transition Communications: Typical Failures

- Poor documentation of hospital care
- Medication discrepancies
- Discharge plan not communicated in a timely fashion
- Poor communication of plan to the nursing home team, home health care team, primary care team or family/caregivers
- Discharge instructions missing, inadequate, incomplete, or illegible

Transition Communications: Best Practices:

- At every point during the care transition, patients and their families know who is responsible for care and how to contact them
- As the hub of care, coordinating clinicians/care managers provide timely communication to other care providers
- A section on the transfer record is devoted to communicating a patient's preferences, priorities, goals and values (i.e. the patient does not want to be intubated)

Lunch

The Poverty Lens

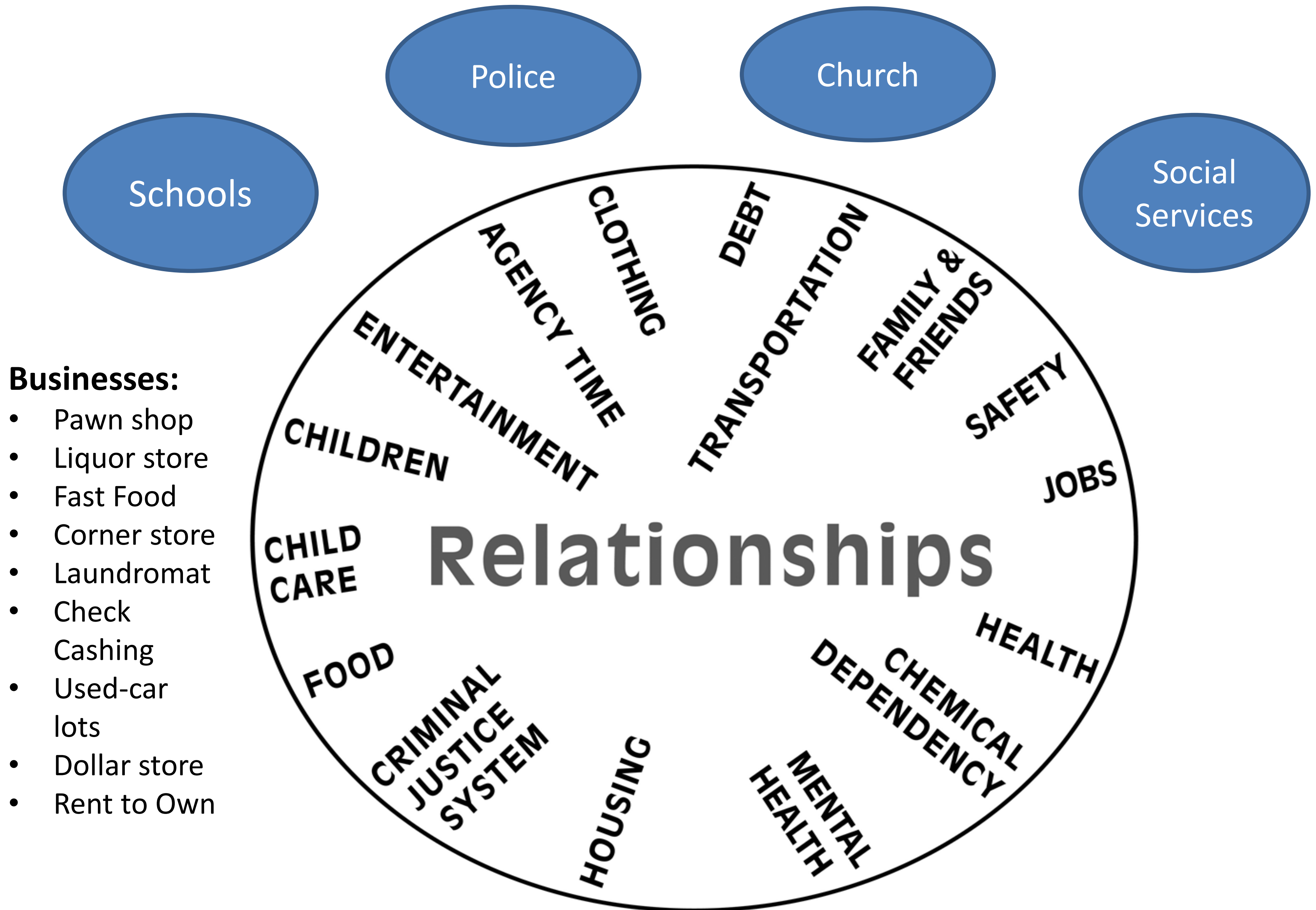
Living in Poverty and Middle Class Activity

Poverty is about doing without these resources…

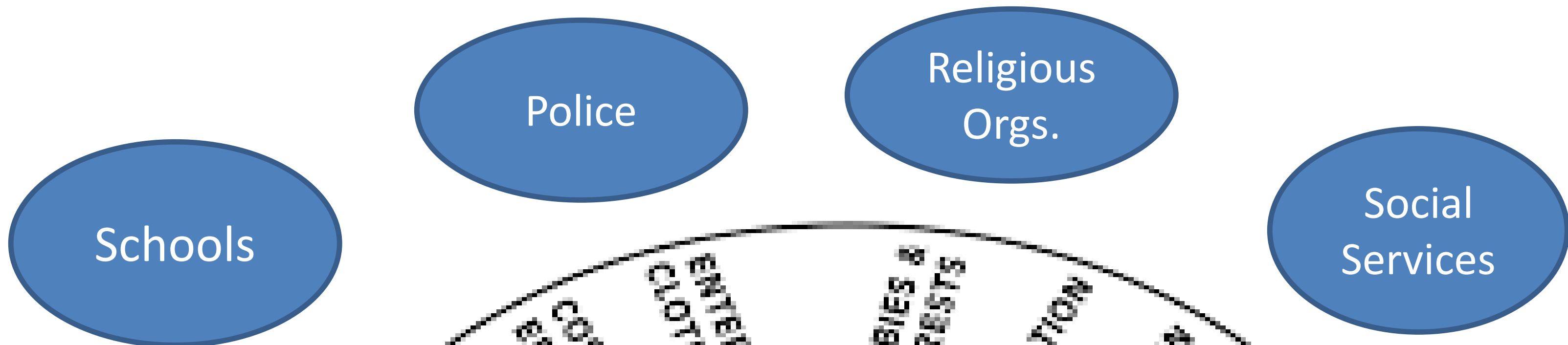
- Financial
- Emotional
- Mental
- Support Systems
- Physical
- Spiritual
- Relationships and Role Models
- Knowledge of Hidden Rules
- Formal Register

Source: Bridges to Health and Healthcare by Ruby K. Payne, PhD, Terie Dreussi-Smith, MAEd, Lucy Y. Shaw, MBA, and Jan Young, DNSc. 2014

Mental Model for Poverty



Model for Middle Class



Businesses:

- Shopping malls
- Bookstores
- Banks
- Fitness Centers
- Vet Clinics
- Office Complexes
- Coffee Shops
- Restaurants
- Bars
- Golf Courses

Achievement

COST OF CHILD CARE
CHILDREN
COST OF EDUCATION
ENTERTAINMENT/ CLOTHING
HOBBIES & INTERESTS
TRANSPORTATION
EDUCATION
FAMILY & FRIENDS
CLUBS & CIVIC GROUPS
CRIME
CAREERS
VACATIONS
WORKING LONGER & HARDER
PREVENTION
MORTGATE PAYMENTS
GROWING FINANCIAL INSTABILITY
HOUSING & ASSETS
RETIREMENT
CREDIT CARD DEBT

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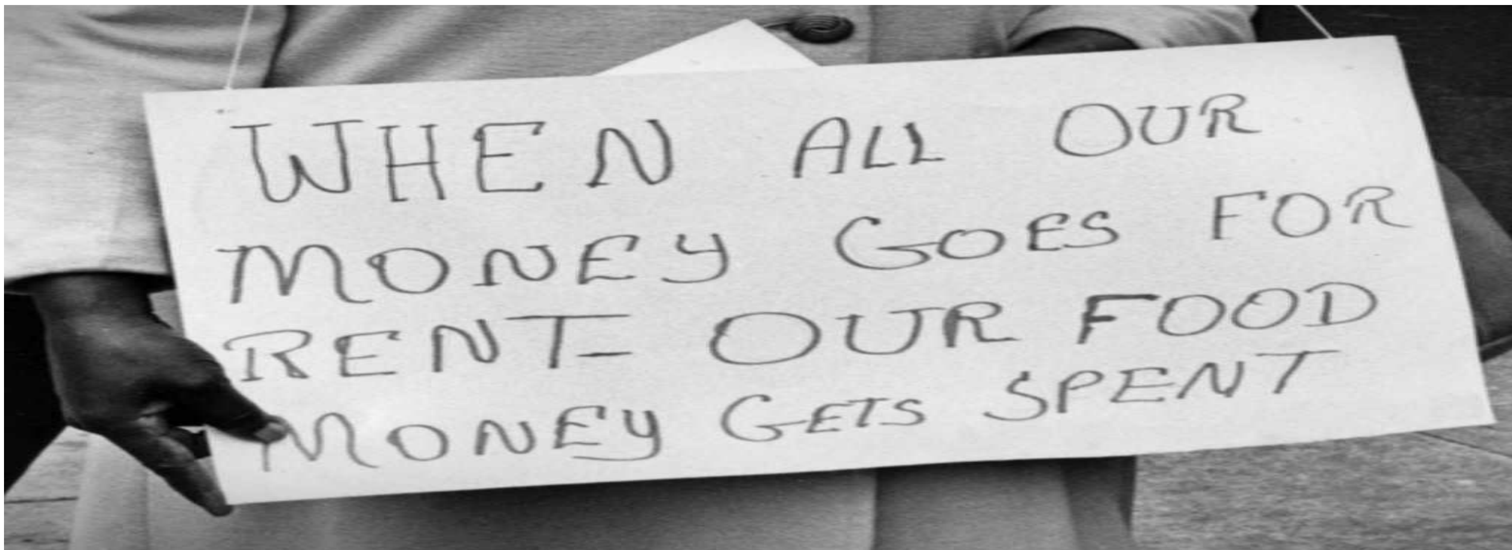
Financial Resources

- Having enough money to buy things
- Stable shelter and food
- Hunger and malnutrition impacts thinking and health



Source: Bridges to Health and Healthcare by Ruby K. Payne, PhD, Terie Dreussi-Smith, MAEd, Lucy Y. Shaw, MBA, and Jan Young, DNSc. 2014

Emotional Resources

- Emotional resources get drained.
- Lack of control/lack of power in of many situations.
- Can’t control things like unpredictable work hours, can’t afford to leave abusive boss, etc.

Source: Bridges to Health and Healthcare by Ruby K. Payne, PhD, Terie Dreussi-Smith, MAEd, Lucy Y. Shaw, MBA, and Jan Young, DNSc. 2014

Mental Resources

- Fundamental Literacy
- Health Literacy
- Using these to get through daily life (both with health and non-health related situations)
- Can you follow the directions to take your prescription medicine correctly?
- Can you understand and follow the directions for preparation for a procedure?

Source: Bridges to Health and Healthcare by Ruby K. Payne, PhD, Terie Dreussi-Smith, MAEd, Lucy Y. Shaw, MBA, and Jan Young, DNSc. 2014

Support Systems

- Having friends, family, and backup resources available in times of need.
- Key resource
- External
- Do you have transportation to get to doctor?
- Do you have someone to care for children if you are sick or overwhelmed or just need a break?
- Do you have people who can offer sound advice?

Source: Bridges to Health and Healthcare by Ruby K. Payne, PhD, Terie Dreussi-Smith, MAEd, Lucy Y. Shaw, MBA, and Jan Young, DNSc. 2014

Physical Resources

- Having physical health and mobility
- Taking care of yourself (dressing, feeding, getting to bathroom, etc.)
- If you need a caretaker, there is one less person in the home earning money

Source: Bridges to Health and Healthcare by Ruby K. Payne, PhD, Terie Dreussi-Smith, MAEd, Lucy Y. Shaw, MBA, and Jan Young, DNSc. 2014

Spiritual Resources

- Having hope for the future and a story for yourself for the future (seeing yourself positively in the future)
- Does not necessarily mean you are religious
- Without a future story, little point to staying healthy, and changing health behavior

Source: Bridges to Health and Healthcare by Ruby K. Payne, PhD, Terie Dreussi-Smith, MAEd, Lucy Y. Shaw, MBA, and Jan Young, DNSc. 2014

Relationships and Role Models

- Having strong relationships with people you care about and who care about you
- Having frequent contact with adults who are nurturing, and help you problem solve, grow, and learn
- Bonding relationships are people who are like you
- Bridging relationships are people who are different than you and can help you move in a more healthy direction

Source: Bridges to Health and Healthcare by Ruby K. Payne, PhD, Terie Dreussi-Smith, MAEd, Lucy Y. Shaw, MBA, and Jan Young, DNSc. 2014

Formal Register/Fundamental & Health Literacy

- Language used in business, and institutions
- Critical

Source: Bridges to Health and Healthcare by Ruby K. Payne, PhD, Terie Dreussi-Smith, MAEd, Lucy Y. Shaw, MBA, and Jan Young, DNSc. 2014

Time Resources

- "The trouble with being poor is that it takes up all your time." (Willem de Kooning)
- Resources are so low that TODAY must be the focus
- Robs people of their future story
- Make decisions based on NOW and TODAY, not the future
- Relationships and survival are most important (helping a neighbor get their car started is more important than being on time to your medical appointment)

Knowledge of Hidden Rules

- Knowing the unspoken cues and habits of a group
- Always know the rules of the group you were raised in, but don't always know the rules of the group you are moving into
- Knowing the rules of another socio-economic class is an important resource

Source: Bridges to Health and Healthcare by Ruby K. Payne, PhD, Terie Dreussi-Smith, MAEd, Lucy Y. Shaw, MBA, and Jan Young, DNSc. 2014

Shared Decision Making

What is Shared Decision Making?

- Shared decision making is a process where healthcare providers and patients work TOGETHER to make important health decisions, often about complicated treatments
- The best decision takes into account evidence-based information about available options, the provider's knowledge and experience, and the patient's values and preferences

Source: The SHARE Approach. Essential Steps of Shared Decision Making: Quick Reference Guide, AHRQ, http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html

1st Step – Involve Patient

- Get the patient involved
- Choices exist and there are options
- Include family and friends as appropriate
- Summarize health problem
- Use health literacy principles

Source: The SHARE Approach. Essential Steps of Shared Decision Making: Quick Reference Guide, AHRQ, http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html

2nd Step – Help Patient Explore and Compare Treatment Options

- Discuss benefits and harms of each treatment option
- Use health literacy principles to be sure they fully understand – plain language, diagrams, videos, etc.
- Assess what they already know
- Clearly describe risks and benefits
- Use teach-back

Source: The SHARE Approach. Essential Steps of Shared Decision Making: Quick Reference Guide, AHRQ, http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html

3rd Step – Assess Patient Values and Preferences

- Take into account what matters most to the patient and their family
- Encourage patient to talk about what matters most to them (recovery time, cost, being pain free, having a specific level of functionality, etc.)
- Ask open-ended questions
- Actively listen
- Reflect

Source: The SHARE Approach. Essential Steps of Shared Decision Making: Quick Reference Guide, AHRQ, http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html

4th Step – Reach a Decision with Patient

- Guide patient to make the best decision for them by asking if he/she is ready to make a decision
- Ask if they need additional resources (information, decision aids)
- See if he/she needs more time to make a decision
- Ask patient about any possible barriers and try to trouble-shoot beforehand
- Confirm decision by using teach back
- Schedule the treatment or follow up appointment

Source: The SHARE Approach. Essential Steps of Shared Decision Making: Quick Reference Guide, AHRQ, http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html

5th Step –Evaluate the Decision

- Track progress on the decision to see how it is working
- Assist him/her with any barriers or challenges as they come up
- Revisit the decision to see how it is going, if it needs to be changed, or if other decisions need to be made after some time

Source: The SHARE Approach. Essential Steps of Shared Decision Making: Quick Reference Guide, AHRQ, http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html

Professional Boundaries

Personal Boundaries

- Rules or limits that a person creates to identify what are reasonable, safe and permissible ways for other people to behave with them
- Guidelines that a person creates that will dictate how a person will respond when someone steps outside of those limits
- Built out of a mix of beliefs, opinions, attitudes, past experiences and social learning

Why are Personal Boundaries Important?

- Establish you as an individual with your own needs
- Key to ensuring relationships are mutually repectful, supportive, and caring
- Allow you to take care of yourself by maintaining control of what you need to feel safe, secure and appreciated

What happens when someone has no boundaries?

- Exhaustion
- No respect
- Resentment
- Exploding Anger

Why would someone have trouble with boundaries?

- Most people who have trouble with boundaries have good intentions
- They don't want to hurt or disappoint others
- They like to please others and make them happy
- They worry that if they set boundaries they will lose friends or negatively alter relationships

There is a "happy medium" in which people can be considerate of others and considerate of themselves.

Professional Boundaries

- Mutually understood, unspoken, physical and emotional limits of the relationship between the patient/client and staff (care manager) (Farber et al. 1997)
- Can be messy & tricky

Professional Boundaries

- Effectively establishing and maintaining professional boundaries is essential when providing healthcare
- Provide limits that enable care managers/others to interact with others in a professional setting
- Ensure a secure and therapeutic environment where the care manager and patient are mutually respected

Boundaries help protect the patient

- You as the healthcare provider have power
- Boundaries help keep that power in check
- Boundaries create standard ground rules so everyone knows what is expected and how to behave

Boundaries help protect you

- Keep you clear about your role
- Help prevent you from "burning-out"
- Allow you to take care of yourself so you can continue to care for others

How are Professional Boundaries Established?

- By law
- Set by licensing and/or certifying bodies
- Facility sets policies
- Individually

What is the Connection between Personal Boundaries and Professional Boundaries?

- Everyone has their own personal boundaries
- It's important to be aware of your boundaries and others, such as your patients and co-workers in order to maintain positive relationships

Boundaries are proactive, not reactive.

Boundaries are proactive, not reactive

- A good boundary is set ahead of time, and is transparent
  - i.e. “We have fifteen minutes for the visit. I am not able to do that today but will connect you with someone who can.”
  - It is not a patient’s fault if they call you at 2 am to ask you ask a question if you never told them during what hours they can and can’t use the contact number you gave them

It is our job to take care of ourselves, just as it is ultimately the patient or client's job to take care of themselves.

Professional Boundaries Activity

Professional Boundaries Video and Discussion

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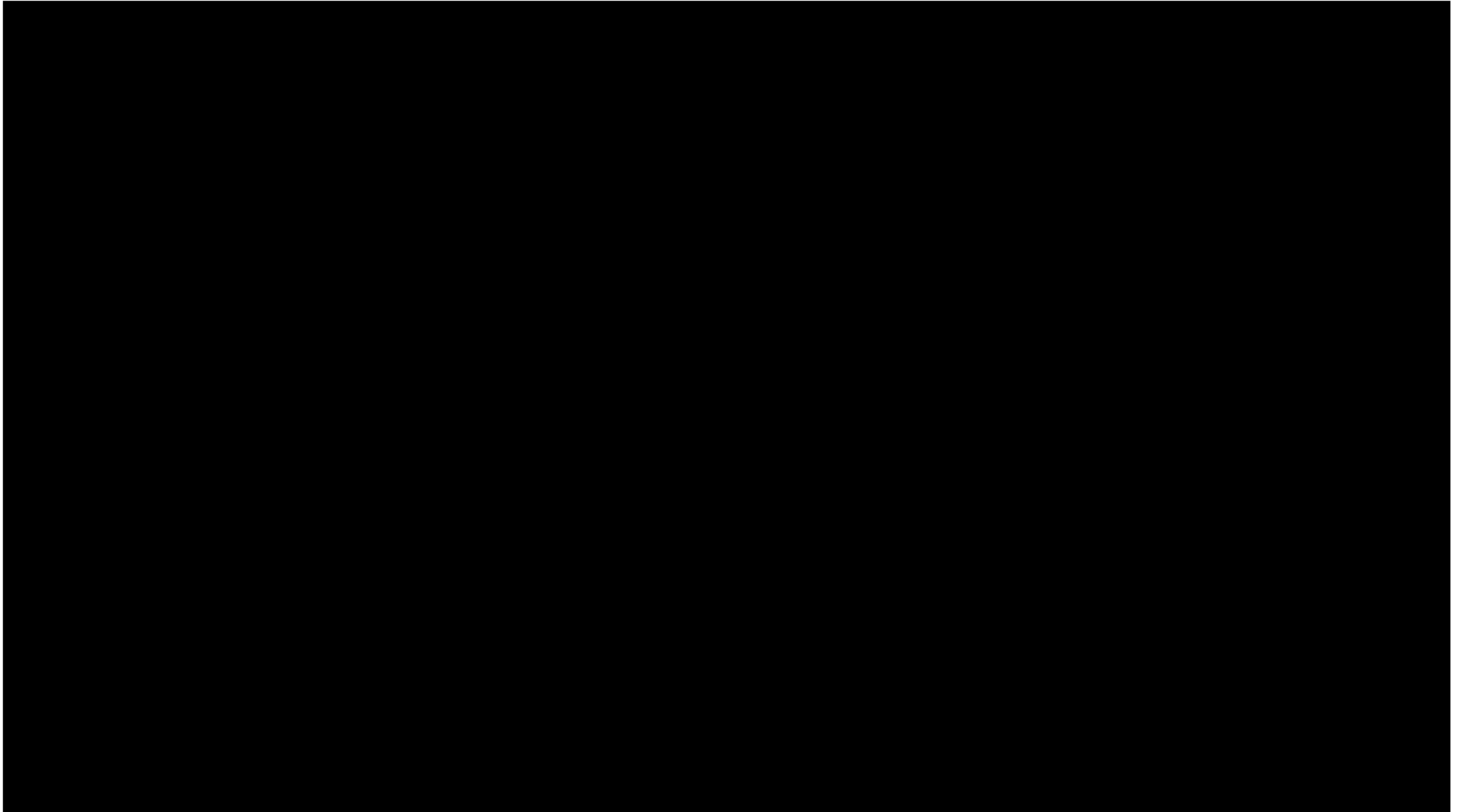
Professional Boundaries Video



https://www.youtube.com/watch?v=74kKWrhTKbI

Care Coordination work can make it challenging to maintain boundaries

- Work closely with patients
- Develop trust and learn a lot about their personal lives
- Line between personal and preofessional can become blurred

Some people think that working on in healthcare means going "above and beyond the call of duty"

- Involvement beyond your professional role opens you up to personla liability
- Involvement beyond your professional role establishes unrealistic expectations that can quickly get out of control

"Keep it Professional"

- **Know your role**: Explain to patients/clients what you can and cannot do for them

- **Keep it simple**: Patients are easily overwhlemed by too much information. Do not share other pateint's stories or experiences. Do not share or compare your personal health storeos with theirs.

- **Ultimately patients are responsible for their own health**: Be patient. Accept that some patients will not use the information or resources that you provide, or may delay or refuse care.

- **Recognize that some situations and patients may be particularly stressful and challenging for you and be prepared.**

Reflection Activity

Care Coordination Training Topics

- Care Coordination and Care Management
- Patient Engagement and Health Literacy
- Helping Patient Cope with Chronic Disease
- Care Coordination and Team-Based Care
- Values and Bias
- Person-Centered Assessment and Care Planning
- SMART Goals
- Stages of Change Theory
- Motivational Interviewing
- Health Coaching
- Best Practices in Transitions of Care
- The Poverty Lens
- Professional Boundaries

We do not learn from experience… we learn from reflecting on experience.

- John Dewey

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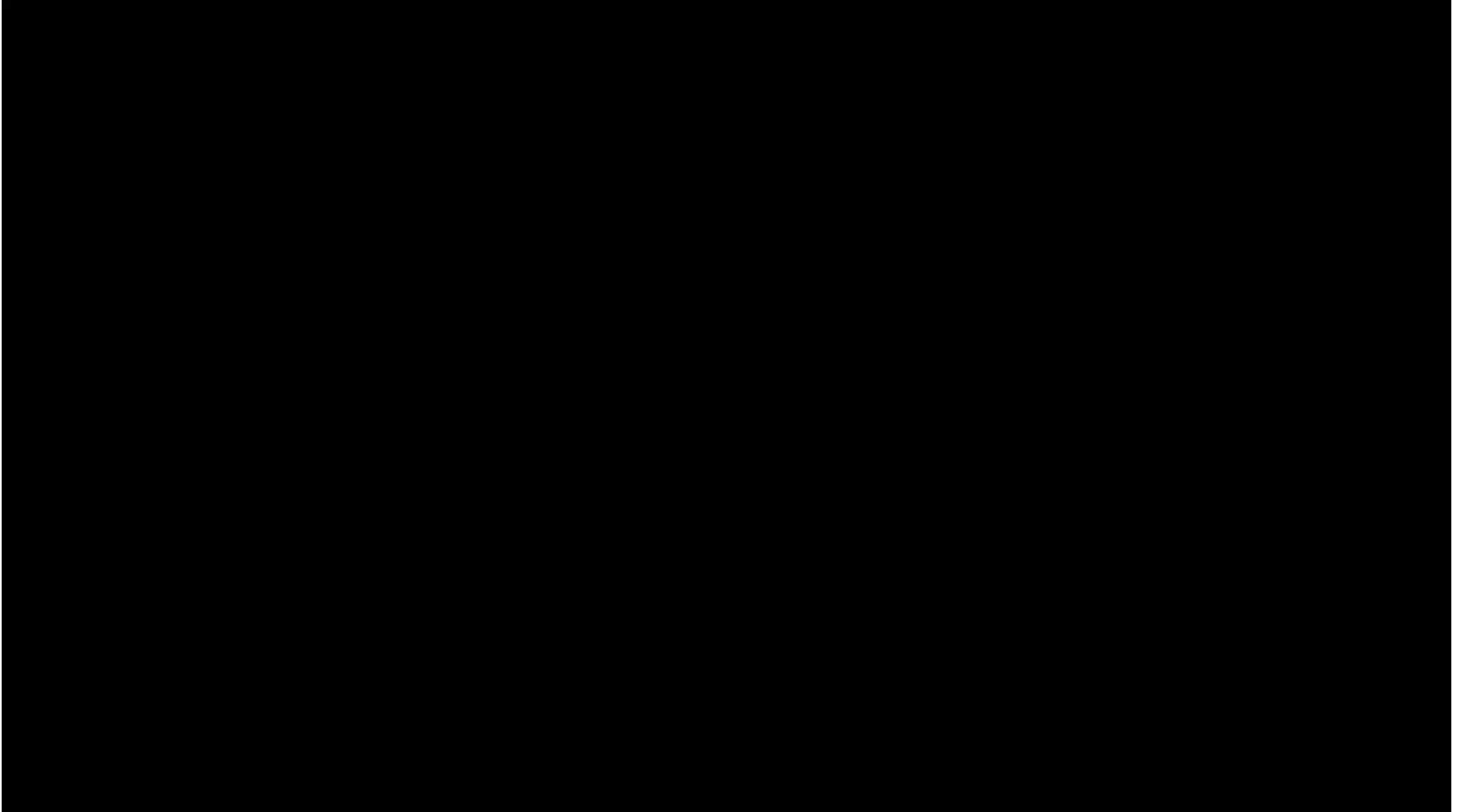
Video - Northern Piedmont Community Care



https://www.youtube.com/watch?v=Gxfxo3ejP8c

Wrap Up/Evaluations