MODULE 2: SERVICE COORDINATION

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OUTLINE FOR THIS MODULE

- Background on the Health Care System
- Care Management
- Chronic Disease Management
- Review and Assessment

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REVIEW OF "SELF-AWARENESS" MODULE

What did we learn during our last session?

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BACKGROUND ON THE U.S. HEALTH CARE SYSTEM

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Explain how health care services are financed or paid for in the United States.
- Describe who provides health care services in the United States.
- Identify health care programs, insurance coverage and other resources that serve low-income clients.
- Describe the remaining gaps in the coverage and care delivery systems and who is left out.

WORDS TO KNOW

- Advance premium tax credits
- Affordable Care Act
- Children's Health Insurance Program
- Copayments
- Deductible
- Federal poverty level
- Health insurance marketplaces

- Individual mandate
- Medicaid
- Medicare
- Premiums
- Safety net
- Small Business Health Options Program

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HOW DO WE PAY FOR HEALTH CARE?

- Half of all health care dollars come from local, state and federal taxes.
  - Support programs such as Medicare, Medicaid and the State Children's Health Insurance Program (CHIP).
- The other half comes from private sectors, mostly employers.

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HEALTH INSURANCE PROGRAMS

Private health insurance
- The goal is to spread the financial risk for an unexpected event.
- Consumers pay a monthly premium for coverage.
- Important to determine access and quality to health care services.

Employer-based health insurance
- 60% of insured people have this type of health insurance.
- Majority of people who are uninsured are employed but do not receive benefits from their employer.

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MEDICARE

Federally funded and administered program that provides medical care to people over age 65.

- Part A — covers health care, nursing facilities, hospice care and home health care.
- Part B — covers cost of physicians' services, outpatient care and other medical services that Part A does not.
- Part C — known as Medicare+ Choice or Medicare Advantage.
- Part D — the newest part of the Medicare program, and now covers prescription drugs.

Does not cover long term care, dental or vision services.

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MEDICAID

Helps some, but not all, low-income individuals and families.
- Federally and state-funded — administered by each state.
- Individuals and families who are eligible for Medicaid:
  - Pregnant women and families with income below 133% of federal poverty level.
  - Recipients of Supplemental Security Income (SSI) and recipients of adoption or foster care assistance.
  - U.S. citizens or permanent residents.

Services are hospital stays, nursing home care, preventive care, family planning, labs and x-rays.

Majority of funds pay services for the elderly who are low income.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Funded by federal and state funds and administered by each state.

Services provided by each state are well baby and well child care, immunizations and emergency services.

Most states provide a comprehensive benefits package and some states include vision and dental services.

HEALTH INSURANCE MARKETPLACE

Federally managed website to buy health insurance.
- Affordable Care Act.
- Individual mandate.
- Small Business Health Options Program (SHOP).
- Advance premium tax credits.

FEDERAL POVERTY LEVEL (FPL)

- Used to determine eligibility for federal and state programs.
- Updated annually.
- Does not account for:
  - Childcare costs.
  - Regional variations in cost of living.

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WHO PROVIDES HEALTH CARE SERVICES?

Hospitals
- Wide range of care from primary care to specialty care.
- Outpatient clinics and inpatient services.
- A hospital stay costs $2,157 a day, plus the cost of services.

Physicians
- Physicians do not work for hospitals — admitting privileges.
- People with insurance see a primary care doctor most often.

Community health centers
- More then 9,000 community health centers in the U.S.
- Affordable and accessible source of healthcare.
- Non-profit outpatient care intended to serve the neediest.

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GROUP ACTIVITY

CARE MANAGEMENT

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define care management.
- Explain their scope of practice as a care manager.
- Understand the differences and similarities between working with an individual versus working with families as their client.
- Analyze and examine concepts of gender identity and working with transgender and gender nonconforming communities.
- Work with clients from a strength-based perspective to identify both strengths and needs.
- Support clients to develop a detailed care management plan designed to promote their health and well-being.
- Identify and provide meaningful referrals to community resources.
- Organize their work and manage their files.
- Clearly document the care management services they provide.

WORDS TO KNOW

- Care management
- Homeostasis

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CARE MANAGEMENT

- A care manager develops knowledge of local health, educational and social service programs and links clients to these resources.
- Care management is defined as "a client-centered, goal-oriented process for assessing the need of an individual for particular services and obtaining those services."
- A client-centered care management plan documents the strengths, needs, goals and actions taken to promote the client's health and well-being.

CHW RESPONSIBILITIES IN CARE MANAGEMENT

- Initial assessment.
- Orient individuals or families to the program.
- Obtain informed consent.
- Work with clients to:
  - Assess strengths, health risks and services.
  - Develop a case management plan.
  - Maintain proper documentation and confidentiality.
  - Provide clients with referrals.
  - Advocate.
  - Participate in case conferences.

CLIENT RESPONSIBILITIES

- Decide to participate.
- Provide informed consent.
- Provide accurate information in a confidential setting.
- Identify strengths and needs.
- Identify goals.
- Communicate regularly / attend appointments / follow regimen.
- Decide on confidentiality agreements.
- Ask questions and raise concerns.
- Strive to learn and actively participate.

STRENGTH-BASED APPROACH

- Client-centered practice emphasizes assessing, valuing and building on a client's strengths.
- Use both open-ended and close-ended questions to assess strengths and needs. An example of an open-ended question:
  - "What do you most want to change about your life?"

ASSESSMENTS

Used to understand a client's concerns, strengths and needs.

Involves gathering:

1. Basic demographic information.
2. Strengths (or internal and external resources).
3. Current risks and needs (including needs for additional resources).

GOALS AND PRIORITIES

- Your priorities and the client's may be different.
  - Their priorities might not align with the goals of your employer.
- Address one issue at a time.
- Acknowledge progress.

ACTION PLAN

- Identify who is responsible for each action.
- Assign each action a timeline.
  - Include short- and long-term items.
  - Start with small, achievable steps.

ENDING SERVICES

- Also known as "discharge" or "termination."
- What to discuss to prepare for ending services:
  - What has been learned and accomplished.
  - The client's internal and external resources.
  - Relapse prevention.
  - What the client can do when faced with challenges or crises.

OTHER SUGGESTIONS

Keeping in touch.
- Can maintain contact within professional boundaries.

Key times to offer clients guidance:
- When they establish unrealistic goals for themselves.
- When they have unrealistic expectations of you or others.
- When they are harming themselves or another.

CLIENT ADVOCACY

When is it appropriate to advocate for services on behalf of a client?

Tips:
- Always encourage autonomy and self-advocacy.
- Use resources only when the client is hitting dead-ends.
- Get permission from client first and maintain full transparency.

POTENTIAL CHALLENGES

- Difficult moments with clients:
  - Fear, anger, mistrust, dishonesty.
    - Avoid taking the behavior personally.
- Setting boundaries:
  - Be honest and clear up-front about your professional limits.
- Prioritize self care.

FAMILIES AS CLIENTS

Individual
- One person, the client.
- Individual health concerns / goals / priorities.
- Focuses on supporting the individual to take action and change.
- Individual balance.

Family
- Two or more people, family is the client.
- Family / group health concerns / goals / priorities.
- Focuses on supporting the family system to take action and change the family's health as a whole.
- Strive for family balance.

COMMUNITY RESOURCES AND REFERRALS

- Local resources that clients need include housing, legal assistance, employment training, education, child care, health care, mental care, drug treatment resources and more.
- These guides to local resources may be available online — become familiar with them.
- Organize your resource guide in a three-ring binder, categorize different types and update regularly.
- Network and establish professional relationships.
- Referrals: Clearly explain the referral to the client, check eligibility requirements, contact the agency, and follow up with clients and agency.

DOCUMENTING YOUR WORK

Some CHWs use **SOAP** notes to document their notes:

- **S**ubjective: what clients report to you.
- **O**bjective: what you directly observe and hear.
- **A**ssessment: document your own thoughts, interpretations and analysis.
- **P**lan: what you and the client plan to do in the future.

CASE CONFERENCES

Meeting with a team to discuss a particular case or cases to:
- Improve the quality of services.
- Improve coordination between providers and teams.
- Enhance profession skills of providers.

GROUP ACTIVITIES

CHRONIC DISEASE MANAGEMENT

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Identify some of the most common chronic diseases in the United States and discuss health inequalities in rates of chronic disease among populations.
- Apply the ecological model to analyze the causes and consequences of chronic conditions.
- Analyze and discuss the limitations of traditional medical models for the treatment of chronic conditions, and ways to integrate medical and public health approaches.
- Discuss team-based approaches to the delivery of primary health care, and the role and scope of practice of CHWs within these teams.
- Analyze and explain the concept of patient empowerment and the self-management of chronic conditions.
- Discuss the application of client-centered concepts and skills to supporting patients in learning how to effectively manage their own chronic conditions.

WORDS TO KNOW

- Adherence
- Chronic condition
- Concordance
- Discordance
- Medication management
- Panel management

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DEFINING CHRONIC CONDITIONS

Illness or health condition that lasts for **at least 3 months** and is slow to progress.

- Cardiovascular and coronary heart disease.
- Diabetes.
- Respiratory disease (Asthma and COPD).
- Cancers.
- Depression, PTSD, PTS, schizophrenia, and other mental health conditions.
- Substance abuse.
- Arthritis.
- HIV, Hepatitis C, TB and other communicable chronic diseases.
- Chronic kidney disease.
- Alzheimer's, MS, muscular dystrophy, other progressive disabling conditions.

CHRONIC CONDITIONS AND INEQUALITIES

- Asthma: eight out of every 100 people in the U.S.
  - 7.1 million children.
  - 17.5 million adults.
- Deaths: 70% of all U.S. deaths are from chronic disease.
- Hospitalization: chronic conditions are the leading cause of hospitalization, and 75% of all health care costs.

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CAUSES AND CONTRIBUTIONS

Individual
- Level of physical activity.
- Diet and nutrition.
- Tobacco use.
- Alcohol consumption.
- Family history.

Family / Friends
- Influence.
- Social support.

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CAUSES AND CONTRIBUTIONS

Neighborhood and Community
- Access to health resources.
- Environmental conditions.
- Violence.
- Parks, schools, etc.

Societal Factors
- Food / water.
- Safe housing.
- Working conditions.
- Civil rights.

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CONSEQUENCES FOR INDIVIDUALS

- Fatigue or extreme tiredness.
- Chronic pain.
- Daily living challenges.
- Nausea, bowel, bladder problems.
- Loss of mobility, eyesight, hearing.

- Nerve damage.
- Increased levels of stress.
- Stigma.
- Shame and isolation.
- Symptoms worsen.
- Invisible illness.

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CONSEQUENCES FOR SOCIETY

Families
- Stress.
- Economic.
- Educational.
- Medical costs.
- Transportation.
- Housing.
- Food.

Communities
- High rates of disease.
- Higher rates of disabilities.
- Higher medical costs.
- Economic.
- Social.
- Loss of culture.

TREATMENT

- Medications.
- Increased activity.
- Diet.
- Therapy.
- Mental health.
- Medical equipment.
- Assistance.
- Holistic and integrative medicine.
- Access to treatments.

INTEGRATING CHWS, MEDICINE AND PUBLIC HEALTH

CHWs contribute to chronic disease management by:
- Sharing knowledge and raising awareness about health issues.
- Identifying community health priorities.
- Identifying community health risks.
- Assisting the community to identify local resources.
- Upstream medicine.
- Coordinating care though team-based care and panel management.
- Promoting empowerment and patient self-management.
- Assisting in the development of health goals.

PANEL MANAGEMENT

- Panel manager identifies highest risk patients using data.
  - Team proactively contacts patient to schedule care.

- Panel management is:
  - Organized and coordinated.
  - Population based.
  - Data driven.
  - Evidence based.
  - Focused on patient outcomes.
  - Committed to prevention.

SELF MANAGEMENT

- Rapidly becoming new standard of care.
- Recognizes that patients are in charge of day-to-day care.
- Focuses on supporting patients to successfully control their condition.
  - Develops skills.
  - Builds confidence.
  - Increases motivation.

SELF MANAGEMENT

Strategies typically include:
- Developing goals and action plan.
- Talking with family, friends and caregivers.
- Evaluating available treatment options.
- Managing symptoms.
- Changing patterns of behavior.
- Monitoring progress.
- Making decisions.

CHW SCOPE IN CHRONIC DISEASE MANAGEMENT

- Outreach to local agencies.
- Outreach to patients.
- Home visits.
- Panel management.
- Health education.
- Behavior change support.
- Developing action plans.
- Case management.
- Attending appointments.
- Medication management.
- Health exams / status checks.
- Facilitation support groups.
- Referrals to social services.
- Health system navigation

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CLIENT-CENTERED CONCEPTS AND SKILLS

- Cultural humility.
- Ecological model.
- Big eyes, big ears, and a small mouth.
- Harm reduction.
- Motivational interviewing (MI).
- Honoring self-determination.

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ACTION PLANNING

Establishing Health Goals:

- Reduce symptoms or indicators.
- Slow progression of disease.
- Sustainable self-management.
- Increased ability to engage in activities.
- Enhanced autonomy.
- Improved economic and social circumstances.
- Stress reduction.
- Mental / spiritual health.
- Medication management.
- Family acceptance / support.
- Belonging.
- Social change / social justice.

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MEDICATION MANAGEMENT

- Medication reconciliation.
  - Comparing the list of medications prescribed and those actually taken.
- Medication concordance.
  - *Understanding* of how to take medication as directed.
    - Concordance — patient and clinician have the same understanding of how a medication should be taken.
    - Discordance — patient and clinician have a different understanding of how the medication should be taken.
- Medication adherence.
  - Actually *taking* all of the medications correctly, as prescribed.

RESPONDING TO AMBIVALENCE, RESISTANCE AND RELAPSE

- Listen without judgement.
- Demonstrate unconditional positive regard.
- Use client-centered skills.
- Roll with it — don't argue or lecture.
- Reflect on your own reaction.

FOLLOW-UP SERVICES

- Reminding clients of appointments.
- New medications.
- New social service need.
- No longer using health services.
- Client visited an ER or urgent care.
- Client is discharged from a hospital or inpatient center.
- Reestablishing care.

ENDING SERVICES

- Client moves.
- Client changes clinics or providers.
- Client is no longer eligible for services.
- Client is incarcerated.
- Client no longer wishes to continue with you or your clinic.
- Clinic discharges client.
- Need for specialized care.
- Death.

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GROUP ACTIVITY

REVIEW – WHAT HAVE WE LEARNED TODAY?

SERVICE LEARNING