Education & Training Curriculum on Multiple Chronic Conditions (MCC)

Strategies & tools to support health professionals caring for people living with MCC.

Module 5

Coordinated Care Delivery

Full citations for this presentation appear in the notes section of the slides.

Slide 1 Speaker Notes

This is the fifth module of the HHS Education & Training Curriculum on Multiple Chronic Conditions (MCC)—a six-module curriculum designed for academic faculty, educators and trainers to inform healthcare professionals caring for persons living with multiple chronic conditions. Based on the MCC Education and Training Framework *(http://www.hhs.gov/ash/initiatives/mcc/education-and-training/index.html),* these modules provide knowledge and tools health professionals can use as they improve quality of care of persons living with MCC.

Terminology used throughout this presentation:

- Multiple chronic conditions (MCC) is defined many ways in the literature and in practice. For the purposes of this presentation, MCC is defined as a person with two or more concurrent chronic conditions. Other similar terms used are complex patient, multimorbidity and comorbidity for this population.
- "Persons living with multiple chronic conditions" (PLWMCC) is used instead of "patient" to place greater emphasis on the individual being at the center of care.

Each module has a PowerPoint® slide presentation that can be saved, modified, and used in your presentations with health professionals at any stage of education (undergraduate, graduate or continuing education). The notes in the presentation will help guide your talking points during the presentations.

Visit http://www.hhs.gov/ash/initiatives/mcc/education-and-training/index.html to download this and other modules—and to access helpful tools and resources.

Suggested citation:

U.S. Department of Health and Human Services. Multiple Chronic Conditions Initiative. Education and Training Curriculum on Multiple Chronic Conditions. Washington, DC. June 2015.

Learning Objectives for this module

After completing this module, you will be able to:

- Apply Coordinated Care Delivery (COORD) strategies for persons living with multiple chronic conditions (PLWMCC)
- Communicate the benefits of COORD for PLWMCC

Slide 2 Speaker Notes

This module, “Coordinated Care Delivery” of the MCC curriculum provides:

1. An overview of coordinated care delivery as an effective mechanism for healthcare professionals to help people manage their multiple chronic conditions, and;
2. Practical strategies and resources for integrating coordinated care delivery into practice.

Overview of contents in this module

- Fundamentals of coordinated care delivery for persons living with multiple chronic conditions (PLWMCC)
- Effective coordinated care delivery
- Integrating coordinated care strategies into practice

Slide 3 Speaker Notes

This module is divided into three sections: How Coordinated Care Delivery helps PLWMCC, components of coordinated care delivery and putting coordinated care strategies into practice. These modules address coordinated care delivery components, strategies and tools to better help you care for persons living with multiple chronic conditions.

The purpose of this module is to introduce Coordinated Care Delivery as an effective mechanism for healthcare professionals to help PLWMCC manage their multiple chronic conditions.

Section 1

Fundamentals of Coordinated Care Delivery for Persons Living with Multiple Chronic Conditions (PLWMCC)

Slide 4 Speaker Notes

This section will define Coordinated Care Delivery (COORD), identify key competencies to COORD for PLWMCC and the benefits of COORD with PLWMCC.

Coordinated Care Delivery

Definition:

The facilitation of timely, appropriate delivery of healthcare services by organizing PLWMCC's care activities and sharing information among all members of the interprofessional care team involved in their care

Slide 5 Speaker Notes

Coordinated Care Delivery is the facilitation of timely, appropriate delivery of healthcare services by organizing PLWMCC's care activities and sharing information among all members of the interprofessional care team involved in their care[1].

Care is coordinated and/or integrated across all elements of the complex healthcare system and PLWMCC community. Care is facilitated by registries, information technology, health information exchange, and other means to assure that PLWMCC get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner[2].

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[1] McDonald, K. M., Sundaram, V., Bravata, D. M., Lewis, R., Lin, N., Kraft, S. A., McKinnon, M., Paguntalan, H., & Owens, D. K. (2007). Closing the quality gap: a critical analysis of quality improvement strategies (Vol. 7: Care Coordination).

[2] Singer, S. J., Burgers, J., Friedberg, M., Rosenthal, M. B., Leape, L., & Schneider, E. (2011). Defining and measuring integrated patient care: promoting the next frontier in health care delivery. Med Care Res Rev, 68(1), 112-127.

COORD Competencies

1. Coordinate the management of care, including pharmacological and behavioral interventions, and community resources for PLWMCC's across settings and providers.

2. Ensure communication and patient safety across transitions of care.

3. Integrate the acute needs into the plan of care for PLWMCC.

Slide 6 Speaker Notes

The following six competencies for Coordinated Care are needed to appropriately provide care for PLWMCC. The underpinning concepts that support these competencies will be discussed in greater detail in this presentation.

The competencies are

COORD 1. Coordinate the management of care, including pharmacological and behavioral interventions, and community resources for PLWMCCs across settings and providers.

COORD 2. Ensure communication and patient safety across transitions of care.

COORD 3. Integrate the acute needs into the plan of care for PLWMCC[1].

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[1] Workforce Competencies of Patient-Centered Health Care Delivery Through Health IT: A Framework for Practice Transformation. Retrieved from http://www.healthit.gov/sites/default/files/hie_role-based_competencies.pdf.

COORD Competencies (Continued)

4 Include preventive care and health promotion in the plan of care for PLWMCC.

5 Promote mental health services as essential components of the plans of care for PLWMCC.

6 Facilitate effective healthcare delivery, with the consent of PLWMCC, by communicating information to all team members about the health of PLWCMCC.

Slide 7 Speaker Notes

COORD 4.Include preventive care and health promotion in the plan of care for PLWMCC.

COORD 5. Promote mental health services as essential components of the plans of care for PLWMCC.

COORD 6. Facilitate effective healthcare delivery, with the consent of PLWMCC, by communicating information to all team members about the health of PLWMCC.

Goals of COORD

Care coordination

- Facilitates effective care and transitions between settings of care
- Ensures PLWMCC understand their care plan
- Certifies quality referrals and transitions to optimize care
- Improves the effectiveness, safety, and efficiency of the healthcare system

Slide 8 Speaker Notes

Goals of care coordination:

- Facilitate effective care and transitions between settings of care for PLWMCC and family;
- Ensure PLWMCC and their families and caregivers understand the care plan;

For PLWMCC who are children or have cognitive impairments (i.e., dementia or Alzheimer's), their designated family member or POA (Power of Attorney) should be highly involved in their care plan. Not all PLWMCC in this group will have the ability to review, understand, provide input and agree to a care plan because of their conditions affecting their cognitive abilities.

- Ensure high-quality referrals and transitions to optimize care[1];
- Improve the effectiveness, safety, and efficiency of the healthcare system and;
- Respond to the needs to multiple stakeholders[2][3].

Not only should PLWMCC and their families and caregivers understand the care plan, the care plan should be jointly developed and maintained by the PLWMCC by the PLWMCC (and their families and caregivers). Clinicians/the interprofessional team are responsible for the overall coordination of care.

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[1] Institute of Medicine (US). Committee on Quality of Health Care in America. (2001). Crossing the quality chasm: A new health system for the 21st century. National Academy Press.

[2] Agency for Healthcare Research and Quality-Care Coordination. Retrieved from http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/.

[3] Corrigan, J. M., & Adams, K. (Eds.). (2003). *Priority Areas for National Action:: Transforming Health Care Quality.*: National Academies Press.

The Benefits of COORD

A higher continuity of care results in better care outcomes:

- Improved preventive care
- Better control of chronic diseases
- Higher PLWMCC satisfaction

- Reduces ER visits
- Reduces hospitalizations

Slide 9 Speaker Notes

Research has demonstrated that a higher continuity of care results in better care outcomes[1], such as reducing the frequency of emergency department visits and hospitalization, while offering better preventive care [23,], better control of chronic diseases[4], and higher PLWMCC satisfaction[5]. Concordance between clinicians and PLWMCC leads to greater motivation, persistence and adherence and improves practitioners' perspectives on prescribing, which helps prevent adverse reactions with problematic medications[6].

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[1] van Walraven, C., Oake, N., Jennings, A., & Forster, A. J. (2010). The association between continuity of care and outcomes: a systematic and critical review. *J Eval Clin Pract, 16*(5), 947-956.

[2] Lin, W., Huang, I. C., Wang, S. L., Yang, M. C., & Yaung, C. L. (2010). Continuity of diabetes care is associated with avoidable hospitalizations: evidence from Taiwan's National Health Insurance scheme. *Int J Qual Health Care, 22*(1), 3-8.

[3] Cheng, S. H., Chen, C. C., & Hou, Y. F. (2010). A longitudinal examination of continuity of care and avoidable hospitalization: evidence from a universal coverage health care system. Arch Intern Med, 170(18), 1671-1677.

[4] Hong, J. S., Kang, H. C., & Kim, J. (2010). Continuity of care for elderly patients with diabetes mellitus, hypertension, asthma, and chronic obstructive pulmonary disease in Korea. *J Korean Med Sci, 25*(9), 1259-1271.

[5] Adler, R., Vasiliadis, A., & Bickell, N. (2010). The relationship between continuity and patient satisfaction: a systematic review. *Fam Pract, 27*(2), 171-178.

[6] Patient-centered care for older adults with multiple chronic conditions: a stepwise approach from the American Geriatrics Society: American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity. (2012). *J Am Geriatr Soc, 60*(10), 1957-1968.

Section 2

Effective coordinated care delivery

Slide 10 Speaker Notes

This section, “Effective coordinated care delivery” describes key principles and challenges of COORD.

Successful Care Coordination

Key Factors

- Defined Interprofessional team from clinic and community
- Established PLWMCC person-centered & self-management goals in care plan
- Ensured information transfer during transitions between care settings
- Developed communication processes
- Sustained relationships between clinical and community settings

Slide 11 Speaker Notes

Key factors that ensure successful care coordination include:

- Providing a supportive and well-defined interprofessional team of healthcare and community-based professionals;
- Establishing person-centered goals that are acknowledged by the entire care team and reassessed as needed;
- Supporting PLWMCC self-management care goals;
- Optimizing information transfer during transitions between care settings;
- Developing clearly managed communication processes between members of the care team in each setting;
- Developing and sustaining strong relationships between clinical and community settings to maximize PLWMCC's access to appropriate resources[1][2][3][4].
- Tracking and monitoring PLWMCC via the use of patient registries can support care coordination activities and functions and improve patient safety.

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[1] Bayliss, E. A., Balasubramianian, B. A., Gill, J. M., & Stange, K. C. (2014). Perspectives in primary care: implementing patient-centered care coordination for individuals with multiple chronic medical conditions. *Ann Fam Med, 12*(6), 500-503.

[2] Agency for Healthcare Research and Quality-Care Coordination. Retrieved from http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/.

[3] Interprofessional Care Coordination: Looking To The Future. (2013) *The New York Academy of Medicine* (Vol. Issue Brief 1).

[4] Boyd, C. M., & Lucas, G. M. (2014). Patient-centered care for people living with multimorbidity. *Curr Opin HIV AIDS, 9*(4), 419-427.

COORD to PLWMCC

PLWMCC who receive coordinated care should feel:

- A part of a trusted care team
- Well informed about their health
- Confident that they can ask questions about their health and care plan

Slide 12 Speaker Notes

The healthcare system can feel like a maze to anyone and more so for PLWMCC. PLWMCC and their caregivers need a clear path to feel that they are supported in making healthcare decisions.

Care coordination delivery (COORD) to PLWMCC

PLWMCC who are receiving coordinated care should feel[1]:

Part of a trusted team of professionals;

Well informed ;

Confident that they can ask questions about their health and care plan.

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[1] The New York Academy of Medicine Center for Evaluation. Perspectives on Care Coordination: Voices of Older New Yorkers. (2010).Retrieved from http://www.nyam.org/social-work-leadership-institute/docs/publications/Older-Adult-s-Perspectives-of-Care-Coordination.pdf.

Barriers & Challenges to Coordinated Care

Barriers

- Limited/Lack of reimbursement
- Poor communication among health professionals within and across settings and health systems

Challenges

- Fragmented healthcare system:
  - Varying processes among and between primary care and specialty care sites

Slide 13 Speaker Notes

Many barriers and challenges exist when coordinating the care for people living with multiple chronic conditions (PLWMCC) that results in fragmented care. To care for PLWMCC, their healthcare teams address the myriad disease-specific recommendations from multiple care providers, while supporting self-management strategies that can improve functionality and quality of life. The unique needs of this population can present a significant challenge to primary care providers who, in reality, have limited interaction time per PLWMCC per visit[1]. Referrals and care coordination issues are not only true for primary care providers and specialists, but also apply across other disciplines (i.e. physicians to physical therapists; nurses to social work, etc.).

Referral staff members that deal with many different processes and lost information, which means that care is less efficient.

Barriers and challenges to coordinated care include:

- Ineffective reimbursement for care coordination;
- A fragmented healthcare system[1] that produces:
- processes that vary among and between primary care sites and specialty sites;
- primary care referrals that do not often provide enough information to specialists about reasons for referral, previous information and testing and; specialty care that doesn't always communicate back to primary care on treatment recommendations and next steps.

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[1] Sampalli, T., Fox, R. A., Dickson, R., & Fox, J. (2012). Proposed model of integrated care to improve health outcomes for individuals with multimorbidities. *Patient Prefer Adherence, 6*, 757-764.

COORD Models of Care

Care Transitions Intervention Program

- Trains PLWMCC and their caregivers on how to manage their care using transition coaches.

Transitional Care Model

- Prepares PWLMCC to more effectively manage changes in their health
- Addresses the negative effects associated with common breakdowns in care.

Slide 14 Speaker Notes

The following four models stress the importance of several key elements of care coordination such as assessment and understanding of goals, the use of an interprofessional team, active engagement of PLWMCC and their caregivers, and ongoing effective communication processes across all team members and settings[1].

Care Transitions Intervention Program utilizes transition coaches to train PLWMCC and their family caregivers on how to manage their own care[2]. These designated transition coaches include nurse practitioners, nurses and social workers.

For more information on the care transitions intervention program, visit http://www.caretransitions.org/.

Transitional Care Model also prepares patients and family caregivers to more effectively manage changes in health associated with multiple chronic illness. This model addresses the negative effects associated with common breakdowns in care when older adults with complex needs transition from an acute care setting to their home or other care setting[3].

For more information on the transitional care model, visit http://www.transitionalcare.info/.

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[1] Reducing Care Fragmentation: A Toolkit for Coordinating Care. Retrieved From http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf.

[2] Academy Health. Research Insights: What works in care coordination? Activities to reduce spending in Medicare Fee-for-service. Retrieved from http://www.academyhealth.org/files/RICareCoordination.pdf

[3] Naylor, M. D., Bowles, K. H., McCauley, K. M., Maccoy, M. C., Maislin, G., Pauly, M. V., & Krakauer, R. (2013). High-value transitional care: translation of research into practice. *J Eval Clin Pract, 19*(5), 727-733.

COORD Models of Care (Continued)

Patient Centered Medical Home Model

- Using an interprofessional team coordinated care is delivered across all settings including specialty care, hospitals, home healthcare, and community services and supports

Grand Aides Program

- Peer-level personnel provide home care to PLWMCC under nurse/physician supervision.

Slide 15 Speaker Notes

The Patient Centered Medical Home[1] model encompasses five functions:

- comprehensive care using interprofessional teams (include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators);
- patient-centered care that is relationship-based with emphasis on the whole person;
- coordinated care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports;
- accessible services for PLWMCC; and,
- quality & safety - demonstrates a commitment to quality and quality improvement

To learn more about PCMHM, visit the Agency for Healthcare Research and Quality (AHRQ)'s Patient Centered Home Resource Center at http://www.pcmh.ahrq.gov/. You can also visit National Committee for Quality Assurance (NCQA)'s Patient Centered Home Website at http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx.

The Grand-Aids program[2] is an effective and less expensive model to help coordinate care for PLWMCC. This model trains peer-level personnel to provide home care under nurse supervision.

To learn more about the Grand Aides Program, visit http://www.grand-aides.com/.

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[1] Patient Centered Medical Home. Retrieved from http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx.

[2] Grand-Aides Program. Retrieved from http://www.grand-aides.com/

Section 3

Integrating Coordinated Care Strategies into Practice

Slide 16 Speaker Notes

This section “integrating coordinated care strategies into practice” provides effective mechanism for healthcare professionals to help people manage their multiple chronic conditions.

Integrating COORD into Practice

Interprofessional teams

Effective communication

Community resources

Care transitions

Medication management

Cultural differences

Slide 17 Speaker Notes

These key areas will be further examined for integration into your practice:

1. Interprofessional teams
2. Effective communication
3. Community resources
4. Care transitions
5. Medication management
6. Cultural differences

Interprofessional Teams

Interprofessional teams help:

- ✓ Improve communication
- ✓ Alleviate care fragmentation
- ✓ Connect PLWMCC to community resources
- ✓ Increase trust in interactions with other health professionals

Slide 18 Speaker Notes

PLWMCC are integral to the Interprofessional Team as they know best their own chronic conditions in the context of their lives.

Interprofessional teams strive to provide culturally and linguistically appropriate care by integrating team members who can help achieve this goal.

Interprofessional teams may include:

- Physicians in conjunction with a care coordinator, pharmacists, behavioral health specialist, physical therapists and other professionals (e.g., care support nurse, home care manager, pharmacist) to alleviate care fragmentation.

Interprofessional teams help:

- Improve communication;
- Connect PLWMCC to community resources and;
- Increase trust in interactions with other health professionals[1].

Since care for PLWMCC is so complex, PLWMCC and their families and caregivers benefit from an interprofessional team's training and expertise.

Communities can also cross organizational boundaries to include professionals outside of primary care practice. [2]

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[1] Mann, K., Sargeant, J., & Hill, T. (2009). Knowledge translation in interprofessional education: what difference does interprofessional education make to practice? *Learning in Health and Social Care, 8*(3), 154-164.

[2] Soubhi, H., Bayliss, E. A., Fortin, M., Hudon, C., van den Akker, M.,… & Fleiszer, D. (2010). Learning and caring in communities of practice: using relationships and collective learning to improve primary care for patients with multimorbidity. *Ann Fam Med, 8*(2), 170-177.

Effective Communication Practices

Effective communication is the cornerstone to coordinated care delivery.

- Electronic health records (EHR)
- Traditional email systems
- Telephone calls
- Faxes
- Paper-based charting
- In-person meetings
- Telemedicine/telehealth
- Interprofessional team meetings/huddles
- Patient/family portals

Slide 19 Speaker Notes

Different individuals, clinics, networks, and systems will have different means and preferences for how to communicate. Methods of communication may to change depending on which settings are sharing information.

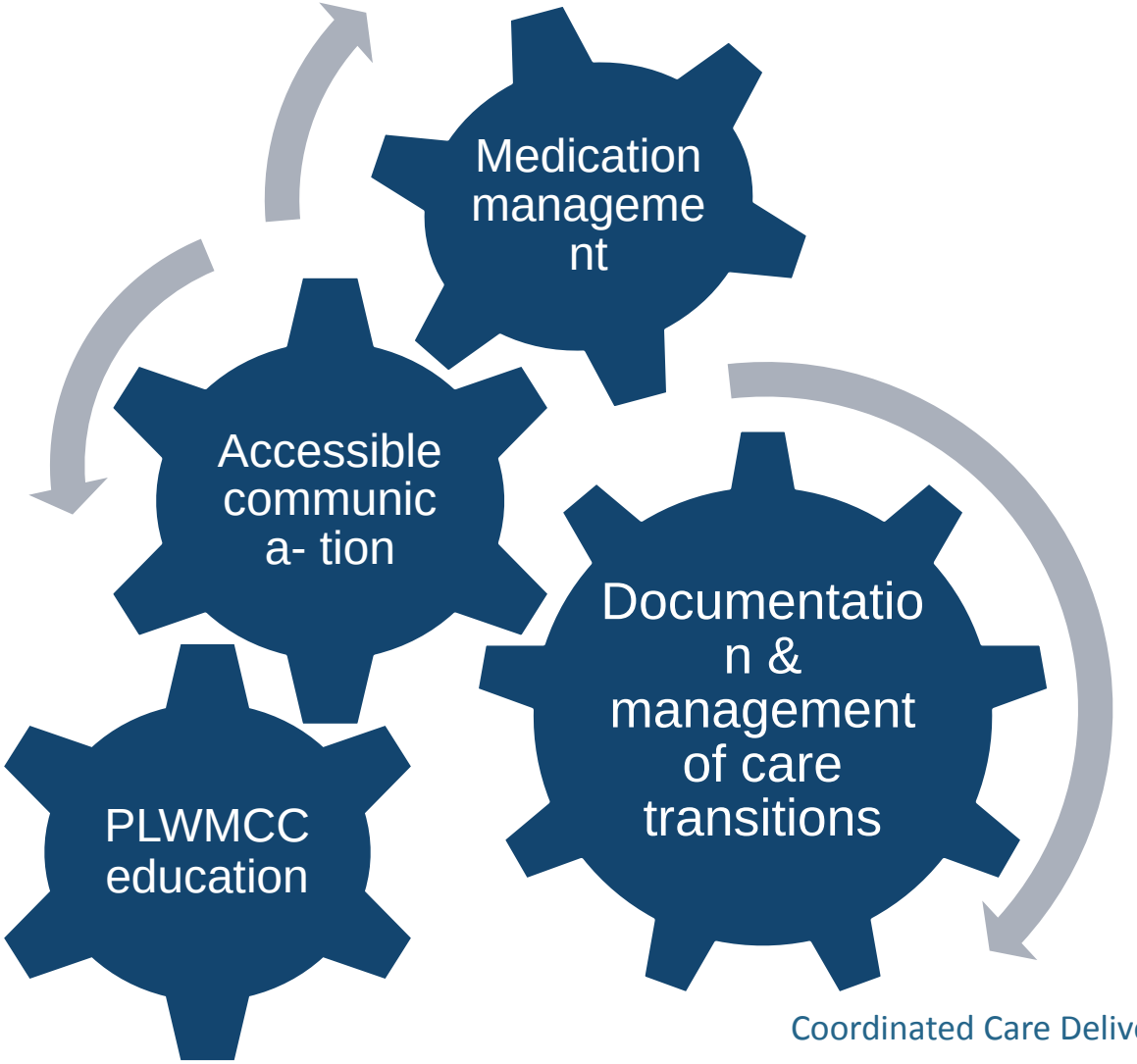
Common communication tools:

- Electronic health records (EHR)
- Traditional email systems
- Telephone calls
- Faxes
- Paper-based charting
- In-person meetings
- Telemedicine/telehealth

Within the healthcare and community settings, interprofessional team meetings/huddles are a helpful communication practice.

The use of patient or family portals is another way healthcare teams can communicate with PLWMCC.

Effective Communication Practices



Slide 20 Speaker Notes

Effective Communication Practices:

Open and accessible communication between all members;

Successful documentation and management of care transitions, medication management, and PLWMCC education[1].

[1] Brown, R., Reikes, D., and Peterson, G. (2009). Features of Successful Care Coordination Programs: Webinar on Care Management of Patients with Complex Health Care Needs. Robert Wood Johnson Foundation: Mathematica Policy Research.

Effective Communication Techniques

- ✓ Applying Motivational Interviewing
- ✓ Implementing the “Teach-back” method
- ✓ Encouraging PLWMCC to ask questions
- ✓ Using plain language & providing materials that are appropriate for PLWMCC’s literacy level

Slide 21 Speaker Notes

Techniques that help improve communication include:

- Motivational Interviewing;
- "Teach-back" method (clinician asks PLWMCC to repeat back instructions)[1];
- Encouraging PLWMCC to ask questions;
- Using plain language and providing materials that are appropriate for PLWMCC's literacy level. As much as possible, have materials available in the PLWMCC/family's primary language.

Five general principles of Motivational Interviewing[2]:

- Express empathy through reflective listening.
- Develop discrepancy between PLWMCC's goals or values and their current behavior.
- Avoid argument and direct confrontation.
- Adjust to PLWMCC resistance rather than opposing it directly.
- Support self-efficacy and optimism.

Research on the "teach-back" method consistently shows that it improves recall and participation in the care plan. Communication should be bi-directional and each team member should have a voice.

For materials that help identify PLWMCC's literacy level, refer to easy-to-use, consumer friendly websites such as www.healthfinder.org.

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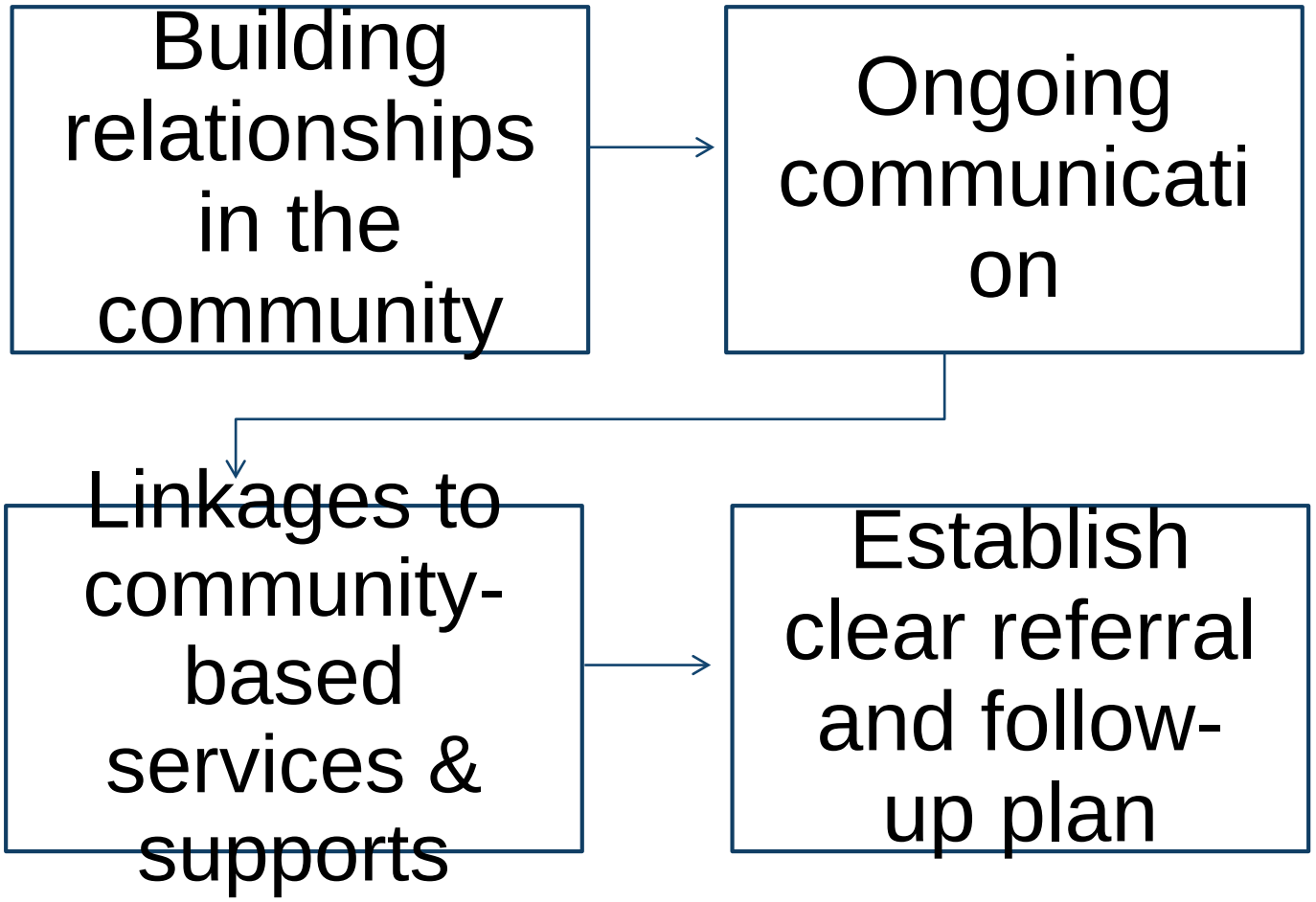
[1] Indian Health Service. Patient-Provider Communication Toolkit. Healthcare Communications. Retrieved from http://www.ihs.gov/healthcommunications/index.cfm?module=dsp_hc_toolkit.

[2] Center for Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment. *(Treatment Improvement Protocol (TIP) Series, No. 35.) Chapter 3—Motivational Interviewing as a Counseling Style*. (1999). Rockville, (MD): Retrieved from Available from http://www.ncbi.nlm.nih.gov/books/NBK64964/.

Community Resources



Slide 22 Speaker Notes

It is important that PLWMCC also be connected to resources in their community in order to receive services that the clinical healthcare setting may not have the time or expertise to provide[1].

Community Resources

Team members' are responsible for maintaining ongoing communication and providing PLWMCC linkages to community-based resources.

A clear referral and follow-up plan should be established between PLWMCC and the clinical and community setting[2].

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[1] Woolf, S. H., Dekker, M. M., Byrne, F. R., & Miller, W. D. (2011). Citizen-centered health promotion: building collaborations to facilitate healthy living. *Am J Prev Med, 40*(1 Suppl 1), S38-47.

[2] Agency for Healthcare Research and Quality Clinical-Community Linkages. Retrieved from http://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/.

Care Transitions, Referrals & Follow-up

- Care Transitions involve multiple primary care clinicians, specialists, and professionals in the community.
- Patient navigation can be useful for PLWMCC.

Slide 23 Speaker Notes

Care Transitions, Referrals, and Follow-up

Care Transitions involve multiple primary care clinicians, specialists, and professionals in the community. Patient navigation can be useful for PLWMCC[1].

The Guided Care program is a care model that trains nurses to serve as care coordinators ; that help PLWMCC develop and implement a care plan in collaboration with their interprofessional care team.

Resources for mental health services:

Wellness Recovery Action Planning http://www.mentalhealthrecovery.com/ and recovery in general http://www.ncmhr.org/index.htm

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[1] Ferrante, J. M., Cohen, D. J., & Crosson, J. C. (2010). Translating the patient navigator approach to meet the needs of primary care. *J Am Board Fam Med, 23*(6), 736-744.

Medication Management

- Polypharmacy can be dangerous. As the number of medications increases, PLWMCC have an increased risk of adverse drug events, independent of the chronic conditions.
- Multiple medications and clinicians can lead to medication-related problems and gaps in care coordination.
- One solution: Include pharmacists on interprofessional teams, whenever possible. Pharmacists can alleviate many polypharmacy issues.

Slide 24 Speaker Notes

Polypharmacy (the use of four or more medications by an individual) can be dangerous in that it generally accompanies multimorbidity. As the number of medications increases PLWMCC have an increased risk of adverse drug events, independent of the chronic conditions[1]. Multiple medications and providers can lead to medication-related problems and gaps in care coordination[2][3] . It should be noted that the use of multiple medications may directly affect the cognition of PLWMCC. Interprofessional teams should include a pharmacist to alleviate any polypharmacy issues, whenever possible. Sometimes medications will have side effects that may exacerbate MCC, so having that knowledge as part of the team is critical.

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[1] Fried, T. R., Tinetti, M. E., & Iannone, L. (2011). Primary care clinicians' experiences with treatment decision making for older persons with multiple conditions. *Arch Intern Med, 171*(1), 75-80.

[2] Academy Health. Research Insights: What works in care coordination? Activities to reduce spending in Medicare Fee-for-service.

[3] Institute of Medicine. Informing the future: critical issues in health. Pharmaceuticals: the good and the bad. (2007). Washington. Retrieved from http://www.nap.edu/catalog.php?record_id=12014.

Cultural Considerations

- ✓ All forms of communication should be provided in cultural-, linguistic-, and literacy-level appropriate formats. i.e. PLWMCC's medications should be in their primary language and translation services should be offered.
- ✓ Knowledge of cultural customs can help avoid misunderstandings and enable clinicians to provide better care.

Slide 25 Speaker Notes

Cultural differences play an important role in the communication and how the plan is "received" and implemented by PLWMCC and their families/caregivers. Using interpreters, family, caregivers, community health workers and/or staff who are proficient in the language primarily used by the PLWMCC can assist in making sure the plan is understood. All forms of communication (verbal & written) need to be provided in cultural, linguistic, and literacy level appropriate formats[1]. For example, PLWMCC's medications should be in their primary language and translation services should be offered[2].

Cultural sensitivity can be defined in the broadest sense to be an awareness and utilization of knowledge related to ethnicity, culture, gender, or sexual orientation in explaining and understanding situations and responses of individuals in their environment[3].
It is critical to assess PLWMCC individually and not make cultural assumptions about PLWMCC's beliefs or health practices.

Asking PLWMCC and their families/caregivers to define what they perceive as the cause of illness and what health practices PLWMCC follows will allow for development of an individualized culturally sensitive care plan[4]. Knowledge of cultural customs can help avoid misunderstandings and enable practitioners to provide better care[5].

Cultural Differences

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[1] U.S. Department of Health and Human Services. Healthfinder.gov. Retrieved from www.healthfidner.gov.
[2] Hernandez, L., Anderson, K., & Chao, S. (2009). *Toward Health Equity and Patient-Centeredness:: Integrating Health Literacy, Disparities Reduction, and Quality Improvement: Workshop Summary*. National Academies Press.
[3] Broome, B. (2006). Culture 101. *Urol Nurs, 26*(6), 486-489.
[4] Chang, M., & Kelly, A. E. (2007). Patient education: addressing cultural diversity and health literacy issues. *Urol Nurs, 27*(5), 411-417.
[5] Galanti, G. A. (2000). An introduction to cultural differences. *West J Med, 172*(5), 335-336.

COORD Resources

- Alliance for Geriatric Education in Specialties

  http://www.pogoe.org/productid/21198

- Teaching Principles of Managing Chronic Illness Using a Longitudinal Standardized Patient Case

  www.mededportal.org/publication/7833

- The Care Coordination Atlas
  http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/

- HHS MCC Education and Training Repository
  http://www.hhs.gov/ash/initiatives/mcc/educationalresources

Slide 26 Speaker Notes

The following resources may further support or reinforce coordinated care delivery concepts discussed in this presentation.

The Alliance for Geriatric Education in Specialties (AGES) training program is aimed at specialties/subspecialties that commonly care for large numbers of older adults, but none of which currently require geriatrics' proficiency.

Teaching Principles of Managing Chronic Illness Using a Longitudinal Standardized Patient Case is a standardized patient vignette to expose first- and second-year medical students to caring for a patient with several chronic illnesses and a complex psychosocial situation. Other health professions might find it a useful tool for group discussions as well.

The Care Coordination Atlas, developed by the Agency for Healthcare Research and Quality, provides a list of measures proposed as a means of achieving coordinated care. http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/

To find more MCC related education and training resources for health professionals, visit the HHS MCC Education and Training Repository at http://www.hhs.gov/ash/initiatives/mcc/educationalresources.