Enhanced Care Management Process
Catholic Medical Partners - January 2016

CMP provides HCC patient list annually

Practice reviews HCC patients

Practice informs CMP of termed, deceased patients

Practice assigns enhanced care management to all eligible patients, follow EMR specific process

Practice assesses if patient is currently stable

- Complete assessment (care coordination template)
- Identify problems and determine interventions to resolve
- Complete care plan

Patient remains stable

- Evaluate plan to identify and address problems
- Use clinical judgment to determine if patient outreach is needed (secure portal, office visit, phone call)
- Care plan updates as indicated

Patient admitted to hospital

Follow Transitional Care process upon discharge including:

- Provide office appointment when contacted by Catholic Health
- A phone call within 2 days using Transitional Care triage note
- Follow up office visit within 5-7 days of discharge for high complexity
- Medication reconciliation performed
- Care plan updates as indicated
- Use clinical judgment to determine frequency of patient outreach

Y

N

N

Y

N
PROCESS FLOW FOR CMP SOCIAL WORK REFERRAL

**IMMEDIATE REQUIRES PATIENT CONTACT**
- Office calls CMP social worker - Leave a voice message if no answer
- Social worker calls patient and loops back to office with what has occurred via a written document. Intervention to be made within 2 business days (dependent on ability to reach patient)

**NOT IMMEDIATE REQUIRES PATIENT CONTACT (majority)**
- Office completes forms, leaves for social worker to pick up or work on at the Office will need to call social worker to let know of referrals waiting.
- Social worker will follow up with documentation on the form for the office to the system. Interventions to be made within 7 business days (dependent on ability to reach patients).

**CONSULT FOR ADVICE OR LINKAGE**
- Office calls CMP social worker for advice/ linkage.
- Social worker will document on a CMP housed log regarding assistance to off issue and advice only to trend patient needs in community (no pt info neede

**Care Coordinator follow up**
- Care Coordinator to follow up with any and all referrals and document in the record.
- **NOTE TO ALL - this is a work in progress and this process may be revised as needed.**
Social Work Referral

Practice Making Referral: _____________________________ Contact Name: _______________
Office Phone: ___________________________ Office Fax: _____________________________

Patient Name: ________________________________________ DOB: ____________________
Address: ______________________________________________________________________
Phone Number: __________________________ Insurance: _____________________________

Person to contact: (If other than patient, is person authorized to discuss patient care?)
Name: _______________________________________ Phone: _________________________

Reason for referral:

_____ Abuse  _____ Mental health
_____ Higher level of care  _____ Housing
_____ Transportation  _____ Insurance
_____ Home safety  _____ Lack of support
_____ Financial issues  _____ Substance abuse
_____ Domestic violence  _____ Frequent ER and hospital visits

Other________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please Fax Completed Referrals to 716-882-0478

Feel free to call us at 716-862-2125 or 716-862-2193 if you have any questions.
# Care Management Contact List

Catholic Medical Partners, IPA  
www.catholicmedicalpartners.org

Catholic Health System  
www.chsbuffalo.org

<table>
<thead>
<tr>
<th>Care Management Fax: (716) 882-0704</th>
<th>Clinical Transformation Fax: (716) 961-1942</th>
</tr>
</thead>
</table>
| Peggy Smering  
*Director Care Management*  
Ph: 862-2833 / C: 262-7394  
psmering@chsbuffalo.org | Sarah Fleming Cotter  
*VP Clinical Transformation & Operations*  
862-2150  
scotter@chsbuffalo.org |
| Patty Kersten  
*Administrative Assistant*  
862-2163  
pkersten@chsbuffalo.org | Paula Conti  
*Director Clinical Transformation*  
862-2188  
pconti@chsbuffalo.org |
| Desiree Corrao  
*Manager Care Management*  
862-2358  
dcorrao@chsbuffalo.org | Linde Freeland  
*Administrative Assistant*  
Phone: 862-2192  
lfreeland@chsbuffalo.org |
| Breanne Bosy  
*Care Management Advisor*  
862-2476  
bbosy@chsbuffalo.org | Kristin Cortese  
*Coordinator Clinical Transformation*  
862-2452  
k cortese@chsbuffalo.org |
| Amanda Cody  
*Care Management Advisor*  
862-2466  
acody@chsbuffalo.org | Sheree Arnold  
*ACO Clinical Transformation Specialist II*  
862-2453  
sarnold@chsbuffalo.org |
| Sheila Gould  
*Care Management Advisor*  
862-2187  
sgould@chsbuffalo.org | Kendra Hennessey  
*Clinical Transformation Specialist I*  
862-2455  
khennessey@chsbuffalo.org |
| Susan Morrissey  
*Care Management Advisor*  
862-2460  
smorrissey@chsbuffalo.org | Kimberlee Hoyt-Folaron  
*Clinical Transformation Specialist I*  
862-2171  
khoytfolaron@chsbuffalo.org |

(cont’d on next page)
<table>
<thead>
<tr>
<th>Care Management (cont’d)</th>
<th>Clinical Transformation (cont’d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amy Zwirecki</td>
<td>Jamie Perry</td>
</tr>
<tr>
<td>Renal Care Manager</td>
<td>Clinical Transformation Specialist I</td>
</tr>
<tr>
<td>862-2859</td>
<td>862-2459</td>
</tr>
<tr>
<td><a href="mailto:azwirecki@chsbuffalo.org">azwirecki@chsbuffalo.org</a></td>
<td><a href="mailto:jperry@chsbuffalo.org">jperry@chsbuffalo.org</a></td>
</tr>
<tr>
<td></td>
<td>Kristen Radzwill</td>
</tr>
<tr>
<td></td>
<td>Clinical Transformation Specialist I</td>
</tr>
<tr>
<td></td>
<td>862-2345</td>
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<td></td>
<td><a href="mailto:kradzwill@chsbuffalo.org">kradzwill@chsbuffalo.org</a></td>
</tr>
<tr>
<td></td>
<td>Michelle Ruggiero</td>
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<td></td>
<td>Clinical Transformation Specialist I</td>
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<tr>
<td></td>
<td>862-2191</td>
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<tr>
<td></td>
<td><a href="mailto:mruggiero@chsbuffalo.org">mruggiero@chsbuffalo.org</a></td>
</tr>
<tr>
<td></td>
<td>Lindsay Gillon, RD, CDN, CDE</td>
</tr>
<tr>
<td></td>
<td>Nutrition Team Lead</td>
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<tr>
<td></td>
<td><a href="mailto:lgillon@chsbuffalo.org">lgillon@chsbuffalo.org</a></td>
</tr>
<tr>
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<tr>
<td></td>
<td>Social Work</td>
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<td></td>
<td>Fax: (716) 882-0478</td>
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<tr>
<td></td>
<td>David Nannen</td>
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<tr>
<td></td>
<td>Social Worker</td>
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<td></td>
<td>862-2193</td>
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<td></td>
<td><a href="mailto:dnannnen@chsbuffalo.org">dnannnen@chsbuffalo.org</a></td>
</tr>
<tr>
<td></td>
<td>Robin Popken</td>
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<td></td>
<td>Social Worker</td>
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<td></td>
<td>862-2193</td>
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<td></td>
<td><a href="mailto:rpopken@chsbuffalo.org">rpopken@chsbuffalo.org</a></td>
</tr>
<tr>
<td></td>
<td>Susan Watts-Garguiolo</td>
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<tr>
<td></td>
<td>Social Worker</td>
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<tr>
<td></td>
<td>862-2125</td>
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<td></td>
<td><a href="mailto:sgarguio@chsbuffalo.org">sgarguio@chsbuffalo.org</a></td>
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<tr>
<td></td>
<td>Rick Kraft, Pharm.D., BCPS</td>
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<tr>
<td></td>
<td>Director, Clinical Pharmacy Services</td>
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<tr>
<td></td>
<td>862-2165</td>
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<td></td>
<td>r <a href="mailto:Kraft@chsbuffalo.org">Kraft@chsbuffalo.org</a></td>
</tr>
<tr>
<td></td>
<td>Christina Manciocchi, Pharm.D., BCACP, CDE</td>
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<tr>
<td></td>
<td>Clinical Pharmacy Consultant</td>
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<tr>
<td></td>
<td>862-2340</td>
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<tr>
<td></td>
<td><a href="mailto:cmanciocchi@chsbuffalo.org">cmanciocchi@chsbuffalo.org</a></td>
</tr>
<tr>
<td></td>
<td>Timothy Vink, Pharm.D., BCPS</td>
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<tr>
<td></td>
<td>Clinical Pharmacy Consultant</td>
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<tr>
<td></td>
<td>828-2117</td>
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<td></td>
<td><a href="mailto:tvink@chsbuffalo.org">tvink@chsbuffalo.org</a></td>
</tr>
<tr>
<td></td>
<td>Catholic Health Resources</td>
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<tr>
<td></td>
<td>Health Plans Case Management</td>
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<tr>
<td></td>
<td>CHS Care Transitions .................. 716-685-4870</td>
</tr>
<tr>
<td></td>
<td>HealthNow (BCBS) Case Mgmt. ........ 877-878-8785</td>
</tr>
<tr>
<td></td>
<td>Independent Health Case Mgmt. ...... 716-635-3523</td>
</tr>
<tr>
<td></td>
<td>Univera Healthcare Case Mgmt. ...... 716-857-6254</td>
</tr>
</tbody>
</table>
**CARE MANAGEMENT**

**COMMUNITY SERVICE LIST**

**HEALTH CONNECTION** 447-6205  A service of the Catholic Health System offering health related information including physician referral, community education programs, and other Catholic Health System services

2-1-1 ([www.211wny.org](http://www.211wny.org)) or 851-5555  24 hour information line for health and human service providers in WNY

**CERTIFIED HOME HEALTH AGENCIES:**  Short term intermittent skilled services to homebound persons under a physician’s order

<table>
<thead>
<tr>
<th>Agency</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAULEY SETON</td>
<td>685-4870</td>
<td>685-3868 (Catholic Health System Agency), Erie, Niagara</td>
</tr>
<tr>
<td>Alleghany County Health Dept.</td>
<td>585-268-9250</td>
<td>585-268-9264</td>
</tr>
<tr>
<td>Amedisys</td>
<td>632-6420</td>
<td>626-7618 Erie, Niagara, Chautauqua counties</td>
</tr>
<tr>
<td>Cattaraugus County Health Dept</td>
<td>800-251-2584</td>
<td>375-5994</td>
</tr>
<tr>
<td>Genesee County Health Dept</td>
<td>585-344-2692</td>
<td>585-344-2117</td>
</tr>
<tr>
<td>Genesee County VNA</td>
<td>585-344-2894</td>
<td>585-344-2692</td>
</tr>
<tr>
<td>HCR (Home Care of Roch)</td>
<td>585-281-2246</td>
<td>585-672-2520 Genesee, Orleans counties</td>
</tr>
<tr>
<td>HCR: Orleans Contact</td>
<td>585-261-5482</td>
<td></td>
</tr>
<tr>
<td>Jamestown VNA</td>
<td>483-1940</td>
<td>488-0701</td>
</tr>
<tr>
<td>Livingston County Health Dept.</td>
<td>585-243-7290</td>
<td>585-243-7287</td>
</tr>
<tr>
<td>McKean County VNA &amp; Hospice</td>
<td>814-362-7466</td>
<td>814-362-4306</td>
</tr>
<tr>
<td>Medina Home Care</td>
<td>585-798-5054</td>
<td>585-798-1687</td>
</tr>
<tr>
<td>Monroe County VNA</td>
<td>585-787-2233</td>
<td>585-787-9723</td>
</tr>
<tr>
<td>Orleans County VNA</td>
<td>261-5482</td>
<td></td>
</tr>
<tr>
<td>People Inc.</td>
<td>874-5600</td>
<td>874-0388</td>
</tr>
<tr>
<td>Rosa Coplon Home Care</td>
<td>639-3311 ext. 2417</td>
<td>689-0013</td>
</tr>
<tr>
<td>Visiting Nurses Assoc.</td>
<td>630-8000</td>
<td>630-8700 Erie, Allegheny, Genesee, Chautauqua, Cattaraugus, Wyoming counties</td>
</tr>
<tr>
<td>Willcare</td>
<td>961-4320</td>
<td>961-4355 Erie, Chautauqua Counties</td>
</tr>
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**MEDICAID HOMECARE PROGRAMS (Erie County)**

<table>
<thead>
<tr>
<th>Program</th>
<th>Phone</th>
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</thead>
<tbody>
<tr>
<td>Medina LTHHCP</td>
<td>585-798-5054</td>
</tr>
<tr>
<td>Rosa Coplon LTHHCP</td>
<td>639-3311</td>
</tr>
<tr>
<td>Schofield LTHHCP</td>
<td>874-2600</td>
</tr>
<tr>
<td>TLC Lakeshore LTHHCP</td>
<td>951-7167</td>
</tr>
<tr>
<td>VNA LTHHCP</td>
<td>630-8000 630-8700</td>
</tr>
<tr>
<td>CASA</td>
<td>858-2323 858-1931</td>
</tr>
</tbody>
</table>

**Catholic Health Life Program** 819-5433  Total Aging in Place (Weinberg) 250-3101

**Catholic Health Home Response:** 447-6309  Direct link to emergency help 24 hours a day, 7 days a week with just a push of a button and a response time of less than 45 seconds

**LICENSED HOME CARE AGENCIES**  (fee for service home care)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>MERCY HOMECARE 668-3511</td>
<td>894-7777</td>
</tr>
<tr>
<td>Gentiva</td>
<td>800-280-8202</td>
</tr>
<tr>
<td>Interim Home Care</td>
<td>852-5900</td>
</tr>
<tr>
<td>Maxim</td>
<td>881-2800</td>
</tr>
<tr>
<td>Menorah Home Care</td>
<td>639-3311</td>
</tr>
<tr>
<td>Schofield Home Care</td>
<td>873-7800</td>
</tr>
<tr>
<td>Willcare</td>
<td>856-7900</td>
</tr>
<tr>
<td>Givers</td>
<td>838-6060</td>
</tr>
<tr>
<td>Independent Nursing Care</td>
<td>655-8776</td>
</tr>
</tbody>
</table>

**NON MEDICAL HOME CARE**  (fee for service companions, light housekeeping, chaperone to appts.)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisting Angels</td>
<td>741-1330</td>
</tr>
<tr>
<td>Comfort Keepers</td>
<td>674-0061</td>
</tr>
<tr>
<td>Preferred Care at Home</td>
<td>406-2662</td>
</tr>
<tr>
<td>Christian Home Companion</td>
<td>625-8100</td>
</tr>
<tr>
<td>Home Instead</td>
<td>630-0657</td>
</tr>
</tbody>
</table>

Revised: 7/2/14
HOMECARE FOR PERSONS WITH LIMITED FINANCES

EISEP Erie County 858-8526 Niagara County 278-8620

SENIOR COMPANION PROGRAMS

Erie County 768-2381 Niagara County (HANCI) 285-8224 x 217

DURABLE MEDICAL EQUIPMENT & SUPPLIES (DME), OXYGEN (O2), HOME INFUSION (I)

Catholic Health Home Respiratory 681-2242 McAuley Seton 685-4870
American Homecare Supply, DME O2 656-0195 First Community Care, DME O2 691-9300
Atlantic Medical Equipment, DME O2 910-791-6442 Health System Services, DME O2 283-2339
Lincare, DME O2 662-7444 Home Respiratory Care, DME O2 771-0648
American Home Patient, DME O2 I 681-2242 PRO2, DME O2 667-9600
Apnea Care, O2 923-2727 Respiratory Service WNY, DME O2 683-6699
Apria, DME O2 800-277-4288 Sheridan Surgical, DME 836-8780
Associated Healthcare/PPS, DME O2 564-4500 Upstate Homecare, DME O2 I 565-2110
Buffalo Wheelchair, DME 675-6577 Upstate Pharmacy, I 675-3784
Complete Homecare, DME O2 694-2253 VNA Pharmacy, I 630-8200
Coram Homecare, I 691-3000 VNA Respiratory Supplies 630-8340

ADULT SOCIAL DAY CARE

Amherst Adult Day 689-1403 St. Catherine Adult Day 862-2513
Aurora Adult Day 652-4269 (Catholic Health System Program)
Catholic Charities Sr. Day 896-6388 Schofield Adult Day 849-8720
DeGraff Adult Day 694-7662 Guild Care (for the visually impaired) 885-8041
Garden Club at Weinberg 639-3311
Hamburg Adult Day 646-0255
Lord of Life 668-8000
Niagara Adult Day 285-8224
Seniors Unlimited Adult Day (People, Inc.) 853-4500

TRANSPORTATION

Ambulance
Rural Metro 882-8400
Twin City 692-2100

Wheel Chair Van (costs vary and are typically not covered by health insurance)
Aries 362-9701 Elderwood Transportation 250-0062
Buffalo Transportation 877-5600 Good Care 833-3445
Caring Hart’ s 457-3051 We Care 898-7900
Carrier Coach 632-8756 We Care (weekends) 836-3500

Erie County Sr. Svc. Van Transportation 858-7433 for most towns (small contribution)
Amherst 636-3075 Town of Tonawanda 875-1029

Niagara County Medical Van Program 438-4040

Niagara County Medicaid Transportation 304-3335

American Cancer Society 1-800-227-2345 central intake for any county/state; volunteers who provide
car transportation for persons receiving treatment
NFTA PAL Program 855-7268 (curb to curb service for qualified disabled persons with application and
approval; there is a fee)
MEDICATION ASSISTANCE PROGRAMS

EPIC  800-332-3742  (assists with medication costs; income requirements; 65 yrs and older)
St. Vincent DePaul Society  882-3360  (assists qualified people with completing forms for free medication
Programs offered by many pharmaceutical companies)
Catholic Charities (under 60)  856-4494  (assists with medication costs on a one time basis; must go in person,
and bring prescriptions, identification, and proof of income; must also
be Medicaid denied)
(Cover 60)  896-6388

ERIE COUNTY CONNECTS  858-8526  For information about long term care options and resources
NY CONNECTS NIAGARA COUNTY- 438-3030 For information about long term care options and resources

FINANCIAL/BENEFIT ASSISTANCE

Social Security/SSI  800-772-1213
Medicare  800-633-4227
Erie County Veteran’s Services  858-6363

Erie County Dept. of Social Services
Public Assistance  858-8000
Medicaid (general)  858-8000
Medicaid (nursing home)  858-8000  858-1901
Medicaid (in home care)  858-8000
HEAP (assists w/heat bills)  858-8000

Niagara County Dept. of Social Services
Public Assistance  278-8400
Medicaid  278-8400
HEAP  278-8400, 278-8645

MEALS ON WHEELS

Meals on Wheels of Western NY  822-2002  If outside service area, will provide number of appropriate program

Albion (Orleans County)  585-589-5424
Alden  937-7105
Amherst  636-3065
Buffalo  822-2002
East Aurora  655-4566
Grand Island  773-9682

FOOD STAMPS

Erie County  858-8347; 858-7239
Niagara County (Lockport)  439-7749
(Niagara Falls)  278-8600

GROCERY DELIVERY SERVICE: (check with your local market for delivery service)

Super Saver Grocery Delivery Service (all of WNY)  894-7990
Charge is 15% of order; $8.00 minimum
(accepts food stamps, cash, credit, checks)

LEGAL SERVICES

Neighborhood Legal Services:  Erie County  847-0650
Niagara County  284-8831
Orleans,Genesee,Wyoming Counties  585-343-5450

Legal Services for the Elderly & Disabled  Erie County  853-3087
Office of Aging Legal Assistance  Niagara County  438-4020
LODGING FOR PERSONS RECEIVING TREATMENT OR WITH FAMILY RECEIVING TREATMENT IN AREA

HOSPITALS (daily charge)

<table>
<thead>
<tr>
<th>Lodge/Center</th>
<th>Address</th>
<th>Phone Number</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hope Lodge</td>
<td>197 Summer St. Buffalo</td>
<td>882-9244</td>
<td>(for persons receiving cancer treatment)</td>
</tr>
<tr>
<td>Kevin Guest House</td>
<td>782 Ellicott St. Buffalo</td>
<td>882-1818</td>
<td></td>
</tr>
<tr>
<td>Ronald McDonald House</td>
<td>780 West Ferry Buffalo</td>
<td>883-1177</td>
<td>(for families of children in treatment)</td>
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</table>

EMERGENCY HOTLINES

<table>
<thead>
<tr>
<th>Hotline</th>
<th>Phone Number</th>
<th>Website</th>
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<tbody>
<tr>
<td>Adult Protection (Erie) weekdays</td>
<td>858-6877</td>
<td></td>
</tr>
<tr>
<td>Adult Protection (Niag) weekdays</td>
<td>278-8621</td>
<td></td>
</tr>
<tr>
<td>Child Abuse Reporting Hotline</td>
<td>800-342-3720</td>
<td></td>
</tr>
<tr>
<td>Hotline for Professionals</td>
<td>800-635-1522</td>
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<tr>
<td>Child Protection (Erie)</td>
<td>858-6487</td>
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<tr>
<td></td>
<td>(Niagara)</td>
<td>278-8667</td>
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<tr>
<td>Crisis Services (Erie)</td>
<td>834-3131</td>
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<tr>
<td></td>
<td>(Niagara)</td>
<td>285-3515</td>
</tr>
<tr>
<td>Domestic Violence Hotline</td>
<td>800-942-6906</td>
<td></td>
</tr>
<tr>
<td>Domestic Violence Haven House</td>
<td>884-6000</td>
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SPECIALIZED SERVICE AGENCIES

<table>
<thead>
<tr>
<th>Agency</th>
<th>Phone Number</th>
<th>Website</th>
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<tbody>
<tr>
<td>American Cancer Society</td>
<td>800-227-2345</td>
<td><a href="http://www.cancer.org">www.cancer.org</a></td>
</tr>
<tr>
<td>American Cancer Society of WNY</td>
<td>689-6981</td>
<td></td>
</tr>
<tr>
<td>American Heart Association</td>
<td>800-242-8721</td>
<td><a href="http://www.heart.org">www.heart.org</a></td>
</tr>
<tr>
<td>Alzheimers Association</td>
<td>626-0600</td>
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<tr>
<td>Cancer Wellness Center</td>
<td>873-0905</td>
<td></td>
</tr>
<tr>
<td>Center for Hospice (Erie)</td>
<td>686-8000</td>
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</tr>
<tr>
<td>Center for Hospice (Niagara)</td>
<td>439-4417</td>
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</table>

SPECIALIZED SERVICES

<table>
<thead>
<tr>
<th>Agency</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Catholic Charities Older Adults</td>
<td>896-6388</td>
</tr>
<tr>
<td>Erie County Dept of Senior Svcs</td>
<td>858-8526</td>
</tr>
<tr>
<td>Niagara County Office of Aging</td>
<td>438-4020</td>
</tr>
<tr>
<td>Erie County Children’s Svcs</td>
<td>858-1655</td>
</tr>
<tr>
<td>Niagara County Children’s Svcs</td>
<td>278-8667</td>
</tr>
</tbody>
</table>

CATHOLIC HEALTH SYSTEM PRIMARY CARE CENTERS

<table>
<thead>
<tr>
<th>Center/Center Name</th>
<th>Address</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenmore Specialty Center (Pulmonary Medicine)</td>
<td>2950 Elmwood Ave. Kenmore</td>
<td>876-8760</td>
</tr>
<tr>
<td>KenTon Family Care/Sheridan Health Center</td>
<td>300 Two Mile Creek Rd. Tonawanda</td>
<td>447-6450</td>
</tr>
<tr>
<td>LoveJoy/St. Vincent Health Center</td>
<td>1500 Broadway., Buffalo</td>
<td>893-8550</td>
</tr>
<tr>
<td>M. Steven Piver, M.D. Center for Women’s Health &amp; Wellness</td>
<td>2121 Main St. Suite, Buffalo</td>
<td>862-1965</td>
</tr>
<tr>
<td>Mercy Comprehensive Care Center</td>
<td>397 Louisiana St., Buffalo</td>
<td>847-6610</td>
</tr>
<tr>
<td>Mercy OBGYN Center</td>
<td>515 Abbott Rd. Suite 302, Buffalo</td>
<td>828-3520</td>
</tr>
<tr>
<td>OLV Family Care Center</td>
<td>227 Ridge Rd., Lackawanna</td>
<td>822-5944</td>
</tr>
<tr>
<td>Sisters OBGYN Center</td>
<td>2157 Main St., Buffalo</td>
<td>862-1984</td>
</tr>
<tr>
<td>Springville Primary Care Center</td>
<td>27 Franklin St., Springville</td>
<td>592-7400</td>
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There are many services in Western New York. This list, although comprehensive, is not all inclusive. For additional resources specific to your need, please consult the Care Coordinator or Social Worker with whom you are working, or refer to your telephone directory.
CATHOLIC MEDICAL PARTNERS, IPA

- Catholic Medical Partners, IPA is a partnership between the Catholic Health System (CHS) and a network of associated physicians. Through a comprehensive clinical integration program, Catholic Medical Partners and the Catholic Preferred Provider Organization are building a quality driven health care network.

- Catholic Medical Partners and the Catholic Preferred Provider Organization promote and support a clinical integration program that engages physicians and the Catholic Health System in programs that improve the effectiveness, efficiency and safety of healthcare.

- Catholic Medical Partners initiatives promote Evidence Based Medicine, adoption of Electronic Health Records and best practices in physician incentive programs.

- The cornerstones of the Catholic Medical Partners programs are physician-hospital leadership and clinical liability.

What is Clinical Integration?

- Simply stated Clinical Integration is a process that evaluates that practice patterns of the network’s participants and creates a high degree of cooperation among the physicians and hospitals.

- Our program focuses on improving the effectiveness, safety and the coordination of medical care and jointly developed by CHS and Primary, Specialty, and Hospital-based physicians.
CARE MANAGEMENT
PROGRAM GOAL:

To train clinical office staff in care management, in order to improve the care and treatment of patients with chronic health conditions.
CARE MANAGEMENT
PROGRAM OBJECTIVES:

The Care Management program will develop the skills, knowledge and ability to:

1. Identify patients with Chronic Health Conditions
2. Assess the current care against clinical practice guidelines in meeting treatment goals
3. Make interventions to remedy gaps in best-practice care which includes but not limited to the patient health care literacy, knowledge of the health care system and timeliness of treatment
4. Establish office-based procedures to consistently monitor and intervene with patients who are not meeting treatment goals
5. Act as a role model for other clinical office staff
6. Provide patient-centric health management goals and education which may include primary prevention, behavior modification programs, and concordance between the patient and the physician/practitioner
7. Provide self-management interventions aimed at influencing the targeted patients with chronic illness to make behavioral changes
8. Lead in continuity of care efforts that may include communications with patient, physicians, health plan and ancillary providers
9. Assist physicians in collecting, coordinating and analyzing patient specific information and data from multiple members of the health care team including the patient themselves
10. Assist physicians in analyzing data across the entire patient population
11. Address cultural sensitivities, psychosocial issues and preferences of individuals
12. Promote complementary care settings and techniques such as nurse visits, group visits, remote patient monitoring, behavior modification and motivational techniques for appropriate patient populations
13. Complement the physician/practitioner and patient relationship and plan of care across all stages, including wellness, prevention, chronic, acute and end of life care

Reference: dmaa – The Care Continuum Alliance – population health improvement model
Getting Started in Care Coordination

1. **Who are your patients?** (REGISTRY) Choose one “high risk”, medically complex, co-morbid patient (hint – pick patients that are scheduled to come in for an appointment in 2 weeks)—use your EMR registry. Run reports on patients with A1c > 9, CHF patients, BP > 140/90, LDLs > 100. You may already know your high risk population due to the process in your office already in place.

2. **Look at their medical record** – are they meeting treatment goals according to guidelines? Before the next appointment, do you have lab work in chart, any specialist referrals or reports to be obtained?

3. **(Previsit planning)** - Call the patients – ask if they had their lab work done since last visit if you do not have the labs in the chart. If no, ask them to get the labs before the visit. Ask patient if they have gone to the ER, hospital, urgent care, specialists (PCP if you are in the cardiologist office doing care coordination) since their last visit – if yes ask where and get the reports in the chart – Ask patients if they have been documenting blood pressures and weights (CHF) or blood sugars, (diabetic) – tell them to bring to office along with all medications they take.

4. **Flag chart** for any labs that need to be ordered at the visit.

5. **Office visit** – do you plan to see the patient at the office for 10 minutes? or follow up call after visit? Let other office staff know your plan.

6. **At meeting discuss your plan** – do you plan to give patient a list of community resources, or a special brochure or education tool? What will you do after you give the patient education materials – will you do a follow up phone call to see if they viewed, attended, understood information and see if they have questions?

*REMEMBER – always check the materials you give the patient to insure that the information coincides with the current guideline treatment goals (consistent with BP, A1c, LDL, etc).
Patient-Centered Primary Care

CARE PLAN DEVELOPMENT

A care plan is a detailed approach to care customized to an individual patient’s needs. Care plans are called for when a patient and their care team can benefit from personalized instruction and feedback to help manage a health condition or multiple conditions. This is a guide to improving and implementing an enhanced care management program for individuals with multiple chronic conditions, limited functional status, and psychosocial needs who account for a disproportionate share of health care costs and utilization.

This guide is meant to serve as a reference for care teams.

Building a Care Plan:
Care plans include, but are not limited to, the following:
  o Prioritized goals for a patient’s health status
  o Established timeframes for re-evaluation
  o Resources that might benefit the patient
  o Planning for continuity of care, including assistance making the transition from one care setting to another
  o Collaborative approaches to health, including family participation

Guiding Principles:
  o A care plan should enhance the patient’s treatment plan by providing a list of identified health conditions or problems with a corresponding prioritized list of interventions to meet the patient’s goals.
  o Holistic assessment should be used as a basis for this list of problems and corresponding goals.

A Systematic Approach to Care Planning: A step-by-step guide
  1. Identify a patient with complex health needs who is at high risk for readmission or an adverse medical event. This can be done during an interview, physical examination, using the elevated HCC patient list CMP provides, obtaining a health history, reviewing diagnostic data, inpatient admissions or multiple co-morbid conditions.
  2. During a patient assessment identify which of the patient’s conditions or health concerns place him or her at the highest health risk.
  3. Create goals for care that address education around patient support and treatment for the conditions or problems identified in the care plan. Place goals in order of priority.
Identifying those most in need of care management support:

Catholic Medical Partners will give you a list of your high-risk patients from HCC (Hierarchical Condition Category scores) which will include:

1. Patients who have had an acute inpatient admission and who are at risk for readmission with the next 90 days.
2. Patients with chronic conditions: heart disease; diabetes; hypertension; asthma, chronic obstructive pulmonary disease (COPD); renal disease, congestive heart failure or cancer.

We recognize that you will have additional opportunities to identify other high-risk members based on your knowledge of your patients.

Patients who can benefit from care management include patients who:

- Are receiving treatment from multiple specialists
- Have complex treatment and management plans
- Are impacted by psycho-social concerns
- Have been diagnosed with multiple chronic conditions
- Are dealing with co-morbid medical and/or behavioral health conditions.

Goal Development

SMART Goals:

Specific: The goal should be specific to the patient’s situation and focused on one desired outcome.

Measureable: the goal must be a measurable evidenced-based outcome.

Achievable: the goal must be reasonably achievable based on patient’s condition.

Relevant: the goal must be individualized to the patient, based on stated needs, desires and assessment findings.

Time Specific: Goals need to include a target date that is achievable.
Goal Concepts
1. Problem statement with an action plan that is measurable, obtainable, and important to the patient.
2. What is highest priority for the patient?
3. Identify what the patient wants to happen/do, when to have it completed, and how you will as the PCP Core Team know that it is done.
4. Barrier(s): Any factor that can limit the patient from achieving the goals set forth in the care plan (i.e., lack of transportation, financial issues, social issues, lack of knowledge).
5. Intervention(s): The steps that need to be taken to assist the patient to reach the goal(s):
   - Intervention must be prioritized and customized for each patient to resolve the issue/problem that will have the highest impact on patient’s health status
   - Continuous reprioritization of the care/interventions for the patient must occur based on the most recent interactions and new information from clinician.
6. Evaluation: Perform ongoing review and revision of the care plan until goals are met. This may include development of new goals.

Resources to Guide Practices in Care Plan Development

Partnering in Self-Management Support: A Toolkit for Clinicians
Self-management support is the care and encouragement provided to people with chronic conditions and their families or caregivers to help them understand their central role in managing their illness, making informed decisions about care, and engaging in healthy behaviors.
Available at http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforClinicians.aspx

*Also included in this publication on pages 38-63*

Guide to Four Pillars of Post-Discharge Care and Readmission Reduction
Eric Coleman, MD, MPH, is a Professor of Medicine and Head of the Division of Health Care Policy and Research at the University of Colorado Anschutz Medical Campus. Dr. Coleman is the Director of the Care Transitions Program, aimed at improving quality and safety during times of care “hands-off.” The following grid is a guide to Coleman’s four pillars. These include medication, reconciliation, follow-up care, any red flags and self care concerns, and communication issues. This document provides a one page detailed explanation of each pillar, which are important in reducing hospital admissions. For more information about the Care Transitions Program and additional resources, you can visit: http://www.caretransitions.org/.
# A Guide to the Four Pillars of Post-Discharge Care and Readmission Reduction

<table>
<thead>
<tr>
<th>Medication Reconciliation</th>
<th>Follow-Up/Usual Source of Care</th>
<th>Red Flags/Self Care</th>
<th>Communications</th>
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<tbody>
<tr>
<td>. Compare list of medications pre-admission &amp; post discharge - assist patient in resolving all discrepancies . Educate patient on indication for use</td>
<td>Ideally follow-up appointment should be made before discharge</td>
<td>Patient/Caregiver received and understands discharge instructions</td>
<td>Encourage patient to bring discharge instructions to primary care provider (PCP)</td>
</tr>
<tr>
<td>. Look for omissions . Look for drug class duplicates . Look for changes in drug formulations such as long acting to short acting medications</td>
<td>Identify date &amp; time of follow-up appointment as well as provider name</td>
<td>Instructions should cover: . Diet . Activity . Medications . Wound Care . Follow-up appointment . Diagnostic tests pending</td>
<td>Encourage patient to PCP aware of: . Pending diagnostic testing results . Changes to medication regimen . Abnormal diagnostic testing results</td>
</tr>
<tr>
<td>Be especially alert when the patient is taking &gt;5 medications, several prescribing physicians or using several pharmacies</td>
<td>Contact patient 2 to 3 days after the follow-up appointment to see if it was kept and assess changes in plan of care, meds, etc.</td>
<td>Provide education specific to diagnosis/disease including red flags of when to call physician and/or seek care</td>
<td>. Provide reinforcement of plan of care and utilize teach back methods to support patient’s understanding . Encourage patient self-management actions . Encourage patient to involve caregivers in their plan of care . Provide appropriate community resources . Consider Social Work referral</td>
</tr>
<tr>
<td>Every prescribed medication should be linked to a disease or diagnosis</td>
<td>Even if patient has no needs, arrange a follow-up call in 5 to 7 days and reassess</td>
<td>Identify if Home Care services were ordered and being received</td>
<td>Assist Patient/Caregiver in developing questions prior to provider visits</td>
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<tr>
<td>Assist in removing barriers</td>
<td><strong>Important Tip:</strong> People with chronic health conditions and multiple co-morbidities as well as the elderly are the most at risk</td>
<td>Ensure all education or instructions are provided at the patients' educational level and in a language they understand</td>
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<tr>
<td>. Look for possible drug-drug, drug-food interactions and side effects . Consider Pharmacy Referral</td>
<td>At discharge, patients/caregivers must take on those activities that were being performed by providers and begin coordinating their own care</td>
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<td></td>
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<tr>
<td><strong>Sample teach back quote:</strong> &quot;I want to be sure I explained your medication correctly. Can you tell me what this medication is for and how you are going to take it?&quot;</td>
<td><strong>Sample teach back quote:</strong> &quot;It's very important that you see your doctor as soon as you can after a hospital stay. So I encourage you to call your doctor and schedule an appointment right away. Now, sometimes there can be more than one doctor providing you with care and it can be confusing to know who you should follow up with. So, let's talk about which doctor you'll be seeing in follow up to your recent hospital stay.&quot;</td>
<td><strong>Sample teach back quote:</strong> &quot;I would like to be sure I explained the potential reason you may want to seek care with your Physician. Could you help me understand when you think you may need to seek care from your Physician?&quot;</td>
<td></td>
</tr>
<tr>
<td><strong>Sample teach back quote:</strong> &quot;It's very important that you see your doctor as soon as you can after a hospital stay. So I encourage you to call your doctor and schedule an appointment right away. Now, sometimes there can be more than one doctor providing you with care and it can be confusing to know who you should follow up with. So, let's talk about which doctor you'll be seeing in follow up to your recent hospital stay.&quot;</td>
<td></td>
<td><strong>Sample teach back quote:</strong> &quot;Having good communications with your Physician is really important, and there may be times that you will have questions for your Physician to answer. Let's talk about what some of those questions may be for your next appointment.&quot;</td>
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</table>
Care Transition Program

The Care Transition Program was designed to improve the coordination of care and patient experience as patients’ transition from the high intensity acute care setting to ambulatory care, to decrease the rates of readmission.

The Care Transition Process consists of four key drivers that are essential for a successful transition from one health care setting to the next.

1. **Patient Identifier:** The identification of the appropriate patient to receive this service will take place while the individual is in the acute or sub acute setting. The Society of Hospital Medicine and Project BOOST (Better Outcomes for Older Adults through Site Transitions) developed an evaluation tool for addressing Geriatric transition risk. The tool known as the 7Ps will be incorporated into the post acute discharge planning process. Any patient that demonstrates two or more of the seven identified risks will be eligible for participation into the program. The seven defined areas include:

   - **Problem Medications** – These are medications that increase the likelihood of adverse events post discharge.
   - **Depression** – Presence of depression either in screening or in history would qualify as a significant risk factor or for potential readmission.
   - **Principal Diagnosis** - Patients with specific disease states or comorbidities.
   - **Poly Pharmacy** - Any Patient with five or more medications
   - **Poor Health Literacy** - Adherence and adverse events are increased among patients with poor health literacy
   - **Patient Support** – Patients with limited or a lack of social supports have demonstrated higher re-hospitalization rates
   - **Prior Hospitalization in the Past six months** - Automatically at high risk for future unplanned admissions.

2. **Transition RN:** The transition nurse will be a Registered Home Care Nurse that is a member of a designated team that has demonstrated exceptional assessment and communication skills. They will visit the patient /caregiver in their home care setting within forty eight hours of their discharge from the hospital or sub acute facility. During the visit a comprehensive assessment will be completed using observation, conversation and interview techniques. The assessment contains 12 specific areas of measure:
- Current providers of care including Community Service Providers
  (Current Diagnosis as understood by the patient as well as a history of past hospitalizations and reasons for admission)
- Falls Risk Assessment
- Current Health Status Systems Review
- Nutritional Risk Assessment
- Support System Profile
- Socialization Scale
- PHQ-9 Depression Scale
- Home Safety Assessment
- ADLs Self Management
- Advance Directives
- Pain Assessment
- Medication Profile

Upon completion of the assessment the RN will develop a summary profile and when appropriate provide symptom management education to the patient. A follow up medical appointment will be scheduled with the Primary Care Physician during the visit. The program goal will be to have the visit occur within seven days of facility discharge. The patient will be receiving coaching related to the role of self management and appropriate physician follow up.

3. Medication Management: The RN will reconcile all medications from pre and post discharge. They will compile a list, assess the patient /caregivers knowledge of the medications and share this information with a designated pharmacist for review. The pharmacist will review the medication profile for potential high risk medications and any potential drug interactions. Any issues that are identified and recommendations will be forwarded to the PCP.

4. Hand off Communication: All patients will be provided with a self management guide to take to their physician appointment. The RN will review this guide and complete valuable information that will help to facilitate a more meaningful follow up with the Primary Care Physician. The guide will contain the updated medication profile as well as a list of questions that the patient may have regarding the management of their disease state.

Any patient that is treated by a Catholic Medical Partners physician practice will have the assessment summary completed by the RN and sent to the office Care Coordinator for review prior to the follow up appointment.
Care Transitions

Discharge Planners discuss program with member and gets consent for referral

Consent obtained

Discharge Planner refers member to McAuley Seton Home Care

McAuley Seton Home Care conducts Home Visit within 48 hours

RN HOME VISIT
Patient Assessment HIPAA Form Care Transition Summary Self-management Guide PCP/SCP appointment
Nurse calls Care Coordinator or clinical office staff to schedule office visit within 7 days of discharge
Nurse faxes summary of patient visit to the physician practice
Pharmacy Review

Physician Office without Care Coordinator
MD office and team determine follow up needed including scheduling visit outreach & follow up within 7 days

Physician Office with Care Coordinator
Follow up completed by Office-based Care Coordinator and Medical Team including scheduling of appointment within 7 days

Physician Office with Disease management
Patient has Disease Management Condition
Place patient on high risk stratification category & plan determined as appropriate for risk and disease including scheduling of appointment within 7 days & follow up call

Discharge Planner identifies members meeting 2 of 7P’s Criteria

Admin Asst to VP of Care Mgmt. to call within 48 hours patients PCP and/or office mgr. that their patient declined care transition services

MD and Team determine follow up and plan of care

Pharmacy
Medication Reconciliation by CT nurse & Pharmacist sent to office to Physician’s attention & Care Coordinator
MD review & fills out form to indicate review of recommendation and disposition
Form faxed to Pharmacist

If critical pharmacy issue, Pharmacist will call office directly. If no response, will call CIPA VPMA

If no response within 48 hours, Pharmacist will contact office.

All other patients, MD and Team determine addtl follow up as needed and schedule appointment

All other patients, MD and Team determine addtl follow up as needed.

Follow high risk intervention & a follow up call after visit

Patient with Diabetes/CHF
Patient determined high risk

Patient with Disease Management Condition

Place patient on high risk stratification category & plan determined as appropriate for risk and disease including scheduling of appointment within 7 days & follow up call
**PROGRAM OVERVIEW**

The Diabetes Program is one of several disease management programs available from the Catholic Health System Home Care telemonitoring program. The focus of the Diabetes Program is to monitor and educate patients on self-management behaviors. The program includes monitoring of blood glucose levels, dietary guidelines, foot care, prevention of complications, and lifestyle modifications. The patients are taught signs and symptoms to report, the disease process, risk factors, and other pivotal aspects of care.

**KEY ASPECTS OF CARE**

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<th>DISEASE PROCESS</th>
<th>PREVENTION OF COMPLICATIONS</th>
<th>COMPLICATIONS</th>
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<tbody>
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<td>Chronic, metabolic</td>
<td>Regular dental visits</td>
<td>Glucose control</td>
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<tr>
<td>Types 1, 2 causes</td>
<td>Vision exam</td>
<td>Heart disease risk</td>
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<tr>
<td>Chronic illness</td>
<td>Regular MD appointments</td>
<td>HDL/LDL</td>
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<td>Self Management</td>
<td>Flu shot</td>
<td>Kidney disease</td>
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<td>Pneumonia vaccine</td>
<td>Hypertension</td>
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<td>Tetanus Booster</td>
<td>Proteinuria</td>
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<td>BLOOD SUGAR TESTING</td>
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<td>Peripheral vascular disease</td>
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<td>Recent blood sugar</td>
<td>EXERCISE</td>
<td>Peripheral neuropathy</td>
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<tr>
<td>Blood sugar testing and range</td>
<td>Benefits of exercise</td>
<td>Autonomic neuropathy</td>
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<tr>
<td>Written records</td>
<td>Exercise time</td>
<td>Periodontal disease</td>
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<tr>
<td>Why keep records</td>
<td>Exercise precautions</td>
<td>Sexual dysfunction</td>
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<tr>
<td>HbA1c indication</td>
<td>Exercise when sick</td>
<td>Monitor complication</td>
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<tr>
<td>HbA1c frequency</td>
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<tr>
<td>MEDICATION MANAGEMENT</td>
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<tr>
<td>Medication compliance</td>
<td>NUTRITION</td>
<td></td>
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<tr>
<td>Refills</td>
<td>Types of food</td>
<td></td>
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<tr>
<td>Monthly medication changes</td>
<td>Meal planning</td>
<td></td>
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<tr>
<td>Difficulty taking medication</td>
<td>Importance of food</td>
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<td>Skipping doses</td>
<td>Regular meals</td>
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<tr>
<td>Benefits of medications</td>
<td>Calorie level</td>
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<tr>
<td>Taking medications as ordered</td>
<td>Food levels</td>
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<tr>
<td>Non-prescription medications</td>
<td>Sweeteners</td>
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<td>Taking medications to</td>
<td>Lipid knowledge</td>
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<td>appointments</td>
<td>Alcohol use</td>
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<td>Effects/side effects</td>
<td>Obesity and diabetes</td>
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<td>Insulin</td>
<td>Reading food labels</td>
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<td>HYPERGLYCEMIA</td>
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<td>Definition of hyperglycemia</td>
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<td>Cause of hyperglycemia</td>
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<td>Signs and symptoms of</td>
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<td>hyperglycemia</td>
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<td>COMPLICATIONS</td>
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<td>Sexual dysfunction</td>
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<td>Monitor complication</td>
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<td>HYPTERTENSION</td>
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<td>Definition</td>
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<td>Blood pressure readings</td>
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<td>Controlling blood pressure</td>
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<td>Individual treatment</td>
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<td>Hypotension</td>
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<td>BEHAVIOR CHANGES AND PRIORITIES</td>
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<td>Patient's responsibility</td>
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<td>Priority and goals</td>
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<td>SOCIAL RESOURCES/STRESS</td>
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<td>Rate level of stress</td>
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<tr>
<td>Stress and blood sugar levels</td>
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<td>Managing stress</td>
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<td>SKIN CARE</td>
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<td>Caring for skin</td>
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<tr>
<td>Products to use</td>
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</table>

The Diabetes Program was developed in collaboration with an endocrinologist and a certified diabetes nurse educator using the ADA Clinical Practice Recommendations for insulin and non-insulin dependent diabetics. It incorporates all categories of assessment, reinforcement and instruction outlined in the ADA Recognition Program and used by diabetes nurse educators.

* The responses to these questions are tracked over time and displayed on a patient trend graph.
# HEART FAILURE PROGRAM

**PROGRAM OVERVIEW**

The Heart Failure Program is one of several disease management programs available from the Catholic Health System Home Care telemonitoring program. The focus of the Heart Failure Program is to monitor and educate heart failure patients on self-management behaviors. The program includes medication reminders, an educational curriculum about medications—effects/side effects, instruction on the importance of taking medications as ordered by the physician, dietary guidelines, and information on activity and psychosocial factors affecting the patient and caregiver(s). Patients are taught signs and symptoms to report, emergency procedures, ways to manage heart failure, the disease process, angina, and risk factors. Each daily session ends with an affirmation or fun trivia question.

## KEY ASPECTS OF CARE

<table>
<thead>
<tr>
<th>Weight</th>
<th>Blood Pressure</th>
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<tbody>
<tr>
<td>Daily weight measurement*</td>
<td>Blood pressure measurement*</td>
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<tr>
<td>How and when to weigh</td>
<td>How to manage blood pressure</td>
</tr>
<tr>
<td>Safety when weighing</td>
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<td>Tips for weighing</td>
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<td>Definition of hypertension</td>
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<tr>
<td>Dyspnea at rest/with activity</td>
<td>Causes of hypertension</td>
</tr>
<tr>
<td>Shortness of breath at rest</td>
<td>Effects and risks of hypertension</td>
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<th>Nutrition</th>
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<td>Salt intake</td>
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<tr>
<td>Causes of orthopnea</td>
<td>Reading food labels</td>
</tr>
<tr>
<td>Use of pillows</td>
<td>Foods high and low in salt</td>
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<td>Fluid intake and restrictions</td>
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<th>Lipids</th>
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<tbody>
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<td>Definition and sources of cholesterol</td>
</tr>
<tr>
<td>Definition</td>
<td>Causes of elevated cholesterol</td>
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<td>Causes of edema</td>
<td>HDL/LDL, and triglycerides</td>
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<td>Salt and edema</td>
<td>Types of fats</td>
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<td>Managing edema</td>
<td>Cholesterol testing</td>
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<td>Reducing cholesterol</td>
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<td>Medication compliance*</td>
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<td>How to manage ascites</td>
<td>How to manage medications</td>
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<tr>
<td></td>
<td>Effects/side effects</td>
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<td>Refills</td>
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<td>Over-the-counter medications</td>
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<td>Importance of taking medications</td>
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<th>Beta Blockers</th>
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<td>Monitors use of beta blockers</td>
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<tr>
<td>Causes of angina</td>
<td>Effects/side effects</td>
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<td>Signs and symptoms</td>
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<td>Angina triggers</td>
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<td>Nitroglycerin</td>
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<th>Oxygen</th>
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<td>Negative effects of smoking</td>
<td>Oxygen safety in the home</td>
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<tr>
<td>Importance of quitting</td>
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<td></td>
</tr>
</tbody>
</table>

* The responses to these questions are tracked over time and displayed on a patient trend graph.
**PHYSICIAN’S REPORTING FORM**

**INSTRUCTIONS:**
- Please provide all of the information requested in **Parts 1 through 3** below, and sign and date the form.
- This form is provided for use by a physician to report an individual whose driving ability may be affected due to some physical or mental impairment.
- This form must be completed and signed by a licensed physician or nurse practitioner.
- Attach a sheet of your stationery (showing your letterhead), or a voided or blank prescription form, as additional verification for this statement, and mail the completed form with the attached stationery or prescription to: Medical Review Unit, New York State Department of Motor Vehicles, 6 Empire State Plaza, Room 337, Albany, NY 12228.
- If additional assistance is needed, please contact the Medical Review Unit at (518) 474-0774, option #3. Hours are 8:30 am to 12:00 pm.
- If your patient is an older driver, you may also visit the Resources for the Older Driver website at [www.dmv.ny.gov/olderdriver](http://www.dmv.ny.gov/olderdriver).

**PART 1 - DRIVER IDENTIFICATION** *(please print)*

<table>
<thead>
<tr>
<th>Last Name*</th>
<th>First Name*</th>
<th>M.I.</th>
<th>Date of Birth (if not known, give approximate age)</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Street Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City*</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Make of Vehicle the Person Normally Drives</th>
<th>Color of Vehicle</th>
<th>License Plate Number</th>
</tr>
</thead>
</table>

* Required information

**PART 2 - DESCRIPTION OF THE DRIVER’S CONDITION**

- **Have you treated this patient?** ☐ YES ☐ NO

  **If Yes:** Date of Last Examination? ______________________

  Please describe the condition that you have treated or are currently treating:

  ________________________________________________________________

  ________________________________________________________________

- **Is the patient receiving medication for this condition?** ☐ YES ☐ NO

  **If Yes:** Please specify the type and dosage:

  ________________________________________________________________

  ________________________________________________________________

- **In my medical opinion, (please check one):**
  - ☐ the patient’s condition may affect the safe operation of a motor vehicle, and the patient should be evaluated by the Department of Motor Vehicles
  - ☐ the patient’s condition prevents the safe operation of a motor vehicle and driving privileges should be suspended.

  Please provide further detail in the space provided or in an attached statement on your letterhead:

  ________________________________________________________________

  ________________________________________________________________

  ________________________________________________________________

  ________________________________________________________________

**PART 3 - IDENTIFICATION AND CERTIFICATION OF THE PHYSICIAN MAKING THIS REPORT**

<table>
<thead>
<tr>
<th>Your name (Print name in full)</th>
<th>Certificate or Lic. No.</th>
<th>Specialty (Please specify)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Your Mailing Address (Include Street &amp; No.)</th>
<th>State Where Licensed</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>(Area Code) &amp; Telephone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Your Signature (Sign name in full)</th>
<th>Date (Month/Day/Year)</th>
</tr>
</thead>
</table>
Motivational Interviewing (MI) is a style of communication helpful when working with all patients but most critical with those who are not as engaged in self management of their condition as they could be. It’s a way of being with people in general, not only in formal treatment settings. MI has a guiding philosophy and understanding of what triggers change.

Three main ideas capture this spirit:

1) **COLLABORATION** - a partnership that honors patient expertise and viewpoint. Care Coordinator creates an atmosphere that leads to change, but does not force change. Opposite approach – Confrontation - overrides patients “sick” perspective by forcing awareness and acceptance of “reality” that patient can’t see or admit.

2) **EVOCATION** – Bringing forth from the patient. The resources for change and the motivation are presumed to reside in the patient. Inner motivation is brought out by drawing on patient’s own perceptions, goals and values. Opposite approach – Education – Patient lacks knowledge, insight of skills that are necessary for change and Care Coordinator provides these necessities.

3) **AUTONOMY** – Care Coordinator affirms patient’s right and capacity for self-direction and helps bring forth informed choice. Direct persuasion is not an effective or appropriate method for resolving ambivalence. Readiness to change is not a patient trait but a fluctuating product of interpersonal interaction. Resistance and “denial” are seen not as patient problems but rather a sign that Care Coordinator may be pushing too hard or too soon.

   Opposite Approach – Authority – Tell patient what to do.

In summary, it is not accurate to think of motivational interviewing as a technique or set of techniques applied to or “used” on people.

**FIVE KEY COMPONENTS**  (USE FROM THE START, AND THROUGHOUT!)

1. **ASK OPEN QUESTIONS** (how are things going?, what’s going on?)
2. **LISTEN ACTIVELY** and **REFLECTIVELY**
3. **AFFIRM**
4. **SUMMARIZE**
5. **ELICIT CHANGE TALK**

**ASK OPEN QUESTIONS**

Patients should do most of the talking with Care Coordinator directing attention to the meaning of the patient’s words. Skillful practitioners of MI talk less than half the time.

*Remember, we’re pulling forth the patient’s clearer understanding.*
Open questions do not invite brief answers. What do you think you will do? What could you do? What are your options? What would be some of the good things about making a change? Of the things we have talked about, which ones concern you most?

These questions are door-openers. When asking about a problem commonly considered undesirable – overeating, drinking, smoking, always ask about the positive side first – “Tell me about your tobacco use. What do you like about it?”

LISTEN ACTIVELY and REFLECTIVELY – A crucial and challenging skill.

EIGHT KINDS OF RESPONSES THAT ARE NOT LISTENING:

1. Giving advice, making suggestions or providing solutions
2. Warning, cautioning
3. Persuading with logic, arguing or lecturing
4. Telling people what they should do; moralizing
5. Disagreeing, judging, criticizing, or blaming
6. Shaming, ridiculing or labeling
7. Interpreting or analyzing
8. Withdrawing, distracting, humoring or changing the subject.

Are there times when these responses are fitting? Yes. There is a time and a place for each. But reflective listening is something different.

Why a statement and not a question? A well-formed statement is less likely to cause resistance. A question requires a response and gets the person off track, rethinking what they just said.

Care coordinators who use reflective listening generally offer 2 to 3 reflections per question asked.

AFFIRM

Directly affirming and supporting the patient during the interaction builds rapport and opens the way to fuller examination of the issues.

Authenticity is important here. Noting the true strengths and assets of a patient requires listening and observing. The patient knows if he is being patronized. One example of a genuine affirmation might be:

“After all the trouble you’ve been through, you’re still trying to work things out.”
Motivational Interviewing

SUMMARIZE

A summary serves to link together and reinforce material that has been discussed.

“You’re someone who likes to eat whenever and whatever he wants. It’s always been your style. You’re quite aware of the consequences you may face given your diabetes. This frightens you and makes you feel you’re not doing right by yourself. Is that a fair summary of the issues you need to resolve?”

ELICITING CHANGE TALK

This is the guiding strategy for resolving ambivalence, is consciously directive and continues to employ the other four skills in its goal to effect change.

In Motivational Interviewing we do not confront the patient with the need to change. That would only cause the patient to defend the no-change position. Our hope is to have the patient present the arguments for change. This is called change talk.

The collaboration between Care Coordinator and patient, their shared decision making and negotiation, forms this change process.

4 kinds of change talk –

RECOGNIZING THE DISADVANTAGES OF THE STATUS QUO
“I guess there’s more of a problem here than I realized.”

RECOGNIZING ADVANTAGES OF CHANGE
“I’d probably be around to enjoy my grandchildren as they grow up.

EXPRESSING OPTIMISM ABOUT CHANGE
“I think I could probably do it if I decided to.”

EXPRESSING INTENTION TO CHANGE
“I definitely don’t want to keep going the way I have been.”

METHODS FOR EVOKING CHANGE TALK

Asking evocative questions: The simplest and most direct approach is to ask the person for such statements. The following questions are aimed at evoking change talk.

- What worries you most about your current situation? (disadvantage of no change)
- How would you like for things to be different? (advantage of change)
- What encourages you that you can change if you want to? (optimism)
- What do you think you might do? (intention)
Self-Management Support Tool
Healthy Changes Plan

Organization Name: ______________________________________________________________

Name: ___________________________ Date: ________________________________

Phone: _______________________________

The healthy change I want to make is (very specific: What, When, How, Where, How Often):
_____________________________________________________________________________
_____________________________________________________________________________

My goal for the next month is: ______________________________________________________
_____________________________________________________________________________

The steps I will take to achieve my goal are: __________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

The things that could make it difficult to achieve my goal include: ______________________
_____________________________________________________________________________
_____________________________________________________________________________

My plan for overcoming these difficulties includes: ________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Support/resources I will need to achieve my goal include: ____________________________
_____________________________________________________________________________
_____________________________________________________________________________

My confidence that I can achieve my goal (scale of 1-10 with 1 being not confident at all, 10
being extremely confident): _____________________

Review Date: ___________________________ with ________________________________
Goal Setting & Action Planning Worksheet

▶ **Goal:** Something you WANT to start trying to do that would be good for you or improve how you feel:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

▶ **Describe:**

What you’ll do: __________________________________________________________

Where you’ll do it: ______________________________________________________

Number of times each day/week: __________________________________________

How long will you commit to doing this? ___________________________________

▶ **Possible barriers to your success:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

▶ **Plan to overcome the barriers:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

▶ **Conviction:**

How **convinced** are you that it is important to work on the goal you identified above? (circle your response)

<table>
<thead>
<tr>
<th>Not at all convinced</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Totally convinced</th>
</tr>
</thead>
</table>

▶ **Confidence:**

How **confident** are you that you will be successful in reaching the goal you identified above? (circle your response)

<table>
<thead>
<tr>
<th>Not at all confident</th>
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<th>4</th>
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<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Totally confident</th>
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▶ **Plan for follow-up:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
CHECKLIST: Healthy Behavior

- Choose one action you feel ready to get started on today.
- Take this list to your next doctor’s appointment: talk over how that action is going, and pick another you’re ready to start on.

- [ ] I will take all of my medications as prescribed.
- [ ] I will not skip meals.
- [ ] I will use smaller plates.
- [ ] I will decrease my portions.
- [ ] I will make half my plate fruit and vegetables.
- [ ] I will eat one vegetable in at least ____ meals a day.
- [ ] I will choose whole grains and high fiber.
- [ ] I will limit fried and processed foods.
- [ ] I will use a food journal.
- [ ] I will ask my doctor about arm exercises I can do while sitting.
- [ ] I will take a walk _____ times a week.
- [ ] I will drink _____ glasses of water a day. One before a meal.
- [ ] I will decrease my intake of sugar drinks. (i.e. juice, pop)

Conviction:
How convinced are you that it is important to work on the goal you identified above? (Circle your response).

<table>
<thead>
<tr>
<th>Not at all convinced</th>
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<th>9</th>
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</table>

Plan for follow-up:
_____________________________________________________________________________
_____________________________________________________________________________

Signature ___________________________     Date: ________________________________
CHECKLIST: CORONARY ARTERY DISEASE

- Choose one or two actions from the list you feel sure you can start doing over the next two weeks.
- After you’ve done those things, you can choose what to work on next.

☐ Ask my doctor to help me put together an exercise plan.
☐ Ask my doctor if I should take daily aspirin.
☐ Find out what my HDL, LDL, and blood pressure goals are.
☐ Use less salt on my food.
☐ Stay away from foods and sauces high in salt (sodium).
☐ Check my blood pressure once a month.
☐ Eat better (fruits, vegetables, whole grains, lean meat).
☐ Get more Omega-3 fatty acids (fish or fish oil capsules).
☐ Get a flu shot.
☐ Stay away from fried and processed foods.
☐ Ask my doctor if I should take any other medications (Beta blockers, ACE inhibitors, ARBs, niacin, statins).
☐ Buy a home blood pressure machine (like an AAM).
☐ Ask my doctor about things that can help me quit smoking.

Conviction:
How convinced are you that it is important to work on the goal you identified above? (Circle your response).

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</table>

Plan for follow-up:
________________________________________________________________________________________
________________________________________________________________________________________

Signature ____________________________________     Date: ______________________________________
CHECKLIST: DIABETES

- Choose one action you feel ready to get started on today.
- Take this list to your next doctor’s appointment; talk over how that action is going, and pick another you’re ready to start on.

☐ I will take all of my medications as prescribed.

☐ I will check my feet for sores and blisters every day.

☐ I will ask my doctor about arm exercises I can do while sitting.

☐ I will take a walk in the backyard _____ times a week.

☐ I will drink _____ glasses of water a day.

☐ I will eat 1 vegetable in at least _____ meals a day.

☐ I will try a sugar-free drink instead of regular soda.

☐ I will write down what I eat (not how much, just what I eat).

☐ I will check my blood sugar _____ times a day _____ times a week.

Conviction:
How convinced are you that it is important to work on the goal you identified above? (Circle your response).

<table>
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<th>Not at all convinced</th>
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Confidence:
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<th>9</th>
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</tr>
</thead>
</table>

Plan for follow-up:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Signature ___________________________ Date: ______________________________
Heart Failure Zones

**EVERY DAY**
- Weigh yourself in the morning before breakfast, write it down and compare to yesterday's weight.
- Take your medicine as prescribed.
- Have a good understanding why medication is needed.
- Check for swelling in your feet, ankles, legs and stomach.
- Eat low salt food.
- Balance activity and rest periods.
- Which Heart Failure Zone are you today?

**GREEN ZONE**
- **ALL CLEAR** - This zone is your goal.
- Your symptoms are under control. You have:
  - No shortness of breath.
  - No weight gain more than 2 pounds (it may change 1 or 2 pounds some days).
  - No swelling of your feet, ankles, legs or stomach.
  - No chest pain.

**YELLOW ZONE**
- **CAUTION**: This zone is a warning.
- Call your doctor's office if:
  - You have a weight gain of 3 pounds in 1 day or a weight gain of 5 pounds or more in 1 week.
  - More shortness of breath.
  - More swelling of your feet, ankles, legs or stomach.
  - Feeling more tired. No energy.
  - Dry hacking cough.
  - Dizziness.
  - Feeling uneasy, you know something is not right.
  - It is harder for you to breathe lying down. You are needing to sleep sitting up in a chair.

**RED ZONE**
- **EMERGENCY**
- Go to the emergency room or call 911 if you have any of the following:
  - Struggling to breathe. Unrelieved shortness of breath while sitting still.
  - Have chest pain.
  - Have confusion or can't think clearly.
Partnering in Self-Management Support: A Toolkit for Clinicians

New Health Partnerships: Improving Care by Engaging Patients

May 2009

The New Health Partnerships initiative is a national program of the Robert Wood Johnson Foundation at the Institute for Healthcare Improvement funded to develop and test efficient approaches to empower patients and families to manage their chronic conditions. The program also engages patients and families as advisors to improve the design and delivery of health care services.
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“Self-management support is the assistance caregivers give to patients with chronic disease in order to encourage daily decisions that improve health-related behaviors and clinical outcomes. Self-management support may be viewed in two ways: as a portfolio of techniques and tools that help patients choose healthy behaviors; and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership... The purpose of self-management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment.”

Tom Bodenheimer, Helping Patients Manage Their Chronic Conditions
www.chcf.org, 2005

Introduction
Helping patients and families manage chronic conditions is an idea whose time has come. Self-management support is a central focus in the Institute of Medicine Crossing the Quality Chasm report and the patient-centered medical home, and is receiving increasing attention in the continuing education programs of professional organizations, with good reason. Many patients do not understand what their doctors have told them and do not participate in decisions about their care, which leaves them ill prepared to make daily decisions and take actions that lead to good management. Others are not yet even aware that taking an active role in managing their condition can have a big impact on how they feel and what they are able to do. Enabling patients to make good choices and sustain healthy behaviors requires a collaborative relationship, a new health partnership between health care providers and teams, and patients and their families; a partnership that supports patients in building the skills and confidence they need to lead active and fulfilling lives.

The concepts and tools in this toolkit are intended to give busy clinical practices an introduction to a set of activities and changes that support patients and families in the day-to-day management of chronic conditions. Experienced organizations and teams will find tested resources and tools. Practices that are just beginning to reorganize for patient-centered care as well as those experienced in collaborative self-management will find tested resources and tools and high-leverage changes that offer a number of ways to begin trying them with a small number of patients.

Where do I begin?
Finding the time and learning the skills to partner with patients to support healthy behaviors is challenging given the demands on primary care today. But you can use the same skills and tools to change your practice as patients use to change health behaviors. Start small, choose one skill or process to change, try it with just a few patients, and then assess your experience. Engage others in your practice to take a role. Together, you can problem-solve the issues that arise and build on your successes. Below are a few examples of ways to begin.
Build a shared agenda:
- Choose one of the agenda-setting tools in this toolkit and use it with five patients. Did using it help to make the conversation more collaborative? Did it give you more information about each patient’s concerns?
- Mail or link patients to one of the Visit Preparation Forms (see the section on Building Relationships below) to five patients before their scheduled visit. Did the patients have more questions? Was the conversation during the visit more productive?

Provide clear information:
- After providing information about treatment or medication, use the “Closing the Loop” technique (see the section on Provider Exam below) with five patients. Did patients have more questions?

Set goals and make action plans:
- Ask five patients what they would most like to work on to improve their health. Note the goal in their chart, and then ask them to meet with a nurse or medical assistant to complete an Action Plan (see the section on Team Care below). Follow up on their next visit to see how they did.

Choose a “population of focus” such as patients with diabetes with whom to test changes:
- Identify diabetes patients who have upcoming visits scheduled by reviewing the next day’s appointments. Choose one of the tools in this toolkit (e.g., the Action Plan form or other goal-setting tools) to test with this patient population. Place a copy of the tool in the chart in advance of the visit to remind the care team to review the tool with the patient.

Engage other members of the care team:
- Discuss the changes you are testing with the entire practice team. Are there ways that they can help prepare or complete some of the tasks so the visit goes smoothly? Assign roles and tasks to each team member to enhance each patient’s care experience.
- Ask patients how they feel about the changes to the visit that you are testing? Getting their feedback early in your change process will help you become more effective.

Finally, there are a growing number of practitioners and teams experienced in self-management support. You and your care team probably know more than you realize about supporting patients in self-management. As you dive deeper into partnering with patients and families, the links and tools in this toolkit will help you meet their self-management support needs.
**Evidence for Self-Management Support**

Patient-centered self-management support improves health and physical function outcomes as well as patient satisfaction regarding care and can be accomplished with existing staffing models. Our confidence in these techniques and tools comes from the growing number of studies and reviews that provide evidence that helping patients and families manage chronic conditions improves outcomes. The tools and examples come from the experience of teams implementing self-management support in 35 health care systems in New Health Partnerships: Improving Care by Engaging Patients, a Robert Wood Johnson national program located at the Institute for Healthcare Improvement. The following papers provide evidence for the concepts and tools in this toolkit, but do not comprise a formal or comprehensive review of the literature.


Bodenheimer T, Laing BY. The teamlet model of primary care. *Ann Fam Med*. 2007 Sep-Oct;5(5):457-461. The 15-minute visit does not allow the physician sufficient time to provide the variety of services expected of primary care. A teamlet (little team) model of care is proposed to extend the 15-minute physician visit.

Brownson CA, Miller D, Crespo R, et al. A quality improvement tool to assess self-management support in primary care. *Jt Comm J Qual Patient Saf*. 2007 Jul;33(7):408-416. The Assessment of Primary Care Resources and Supports (PCRS) for Chronic Disease Self-Management is a tool designed to apply to a variety of primary care settings across different chronic illnesses. It helps practices self-evaluate their current delivery of resources and supports for self-management and identify areas and ways in which they could enhance these services.


Heisler M. *Building Peer Support Programs to Manage Chronic Disease: Seven Models for Success*. California Health Care Foundation; December 2006. Available at: [http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=127997](http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=127997). Peer support interventions have been found to reduce problematic health behaviors and depression, and they help patients follow their medication prescriptions and adhere to diet and exercise plans.

Actively involving patients and family members in self-management support improves treatment adherence and leads to better physical functioning.


Lay leaders can teach self-management courses with results similar to those taught by professionals.


Lay led self-management courses with participants who have diverse chronic conditions can be as effective as those for participants with arthritis alone.


Self-management education improves HbA1c levels at immediate follow-up and increased contact time increases the effect, although effects fade over time.


In multifaceted interventions to improve chronic care, the addition of patient-oriented interventions, self-management education, and self-management support to professional and/or organizational interventions has been shown to be key to improvements in patient outcomes rather than improvements in process outcomes alone.


Many patients do not understand what their doctors have told them and benefit from specific techniques that help them leave the visit prepared to manage their health.


Many patients do not feel included in decisions about their care.


Whether the care team consists of a solo physician or a large, multi-physician organization, applying basic communications principles and using simple tools can enable patients to take a more active role in improving their health.

Better communication with patients and families helps clinicians and health care organizations improve patient and staff satisfaction and staff retention.
High Impact Changes for Self-Management

Skills and tools to transform the patient/caregiver relationship into a collaborative partnership

Before, During, and After the Visit
- Help patients understand their central role in managing their conditions and that the entire health care team is there to help.

Before the Visit
- Make time for self-management by gathering clinical and patient experience data in the chart.
- Ask patients to bring questions and concerns and health monitoring information.

During the Visit
- Collaboratively develop a visit agenda with the patient and family, handling as many concerns as possible, and plan return visits as appropriate.
- Engage the entire practice team in supporting patients, use “warm handoff” introductions, and explain team member roles to patients.
- Ask about patient goals to improve their health and help them make action plans that build confidence in their ability to reach these goals.
- Use “ask-tell-ask” to provide just the right information at just the right time and “close the loop” to ensure patients know how to use the information.
- Prepare a written care plan or visit summary that includes goals and action plans to ensure patients and families know what to do when they leave the visit.
- Use group medical appointments, peer-led support groups, or patient education classes to provide opportunities for patients to share experiences and support.

After the Visit
- Organize follow-up support to help patients sustain healthy behaviors between visits.
- Extend care into the community by linking patients to community programs.

Build a Team
- Designate and train a lead coach for self-management support who will support ongoing staff development of skills.
- Assign responsibility for self-management tasks to all team members, extending the work out from the physician.
- Use daily team huddles to review the schedule of patient charts, anticipate care needs, and enhance the flow of care.
The challenge to delivering optimal care for chronic conditions lies partly in the need to sustain vigilant monitoring of health indicators to optimize treatment, and also the need to develop collaborative relationships with patients and families that support them in the day-to-day management of their conditions. These activities can be viewed as a cycle of care and support that has as its center the maintenance of a shared care plan.

A continuous healing relationship outlined in the Institute of Medicine Crossing the Quality Chasm report extends care beyond the office visit to the home and community, and beyond the primary care physician to the multidisciplinary care team—a team that now includes patients and their families and caregivers. This cycle of self-management support details the preparatory, relational, and follow-up activities that sustain this relationship and provide patients with the information, skills, and confidence needed to lead fuller lives. The cycle also helps care teams feel the joy in practice.
Before, During, and After the Visit

Building Relationships

Team Support
Managing one or more chronic conditions is ongoing hard work. One very basic support that practice teams can provide to patients and families is to acknowledge the work patients and families do to manage illness and recognize their central role in staying healthy. Every practice team member can support patients in this way. Physicians can help patients and family members understand that providers and practice staff work together as a team by introducing team members and explaining their roles, either in person or with a letter. Provide a “warm handoff” by introducing key team members in person and explaining the special role that a nurse or medical assistant plays. This increases patient confidence that the whole team is there to help and engenders trust. With training, all care team members can take a role in supporting patients, for example, greeting patients with a visit preparation form (see Bubble Diagram, Dinner Plate Menus, Doc Talk Form, How’s Your Health link, or Ask Me 3 below) that asks about progress with self-management tasks, and providing self-management information and skills training to patients.

Coping with Stress and Negative Emotions
Clinicians are rightfully focused on the clinical indicators and outcomes of chronic illness care, but for patients and families the central experience of chronic illness is often one of physical limitation, loss of function, and uncertainty in daily life. The fatigue and stresses of the disease and adapting life roles to accommodate changing capacities generate emotional responses that make a huge impact on the ability to self-manage. When clinical teams recognize this difference of perspective and acknowledge the everyday burden of illness and negative emotions (anger, fear, frustration) that so often accompany managing chronic diseases, patients and families feel heard and understood and are more willing to collaborate with clinical teams.

- You might say:
  - “Most of my patients who have chronic conditions have trouble at times coping with the changes and difficulties in managing their condition. How are you feeling about your (diabetes) and taking care of yourself?”

Over time, these interactions support the collaborative relationship that helps patients become more active managers of their health and keeps them going during challenging times. Sometimes the psychosocial burdens require help from behavioral health specialists. Care visits that regularly utilize depression screening questions such as the Patient Health Questionnaire 2 can ensure that those who need more intensive help will be identified.
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<td>Involve family members</td>
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<td>National Family Caregivers Association</td>
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<td>Ask about preferences, experience</td>
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Before the Visit

Gathering Clinical and Patient Experience Data
Physicians rarely have time in a visit to adequately support patients in managing chronic conditions. Designate a member of the care team to gather both clinical and patient experience information in advance of the visit. Having all information readily available in the patient chart frees up time for the clinician and patient to communicate about issues of concern to each. Visit time can then be spent on recommendations about treatment and collaborating to develop a care plan to help the patient and family members manage better at home.

Consider the flow of a planned care visit and the staff available in your practice, and determine tasks for each member of the care team. With standing orders, medical assistants can prepare for the visit by arranging for screenings and labs to be done in advance and ensuring that this information is readily available in the chart. Receptionists can help the patient prepare in advance for the visit by mailing a Visit Preparation Form, asking them to bring medications or records of medication use to the visit, and asking them to make a note of successes and problems they had in achieving their health improvement goals and action plans. Because depression is such a common co-morbidity in people with chronic conditions, you may also wish to include depression screening questions in the Visit Preparation Form. Beyond Ask Me 3 provides examples of additional questions useful in serving patients with chronic conditions.

Having current information, both clinical indicators and patient concerns, prepared in advance provides the clinician with more time to address clinical concerns and the patient’s own goals, and the time to build a collaborative relationship that supports self-management. Care teams often find it useful to hold a brief “huddle” at the beginning of the day to review the patient schedule and prepare for each patient’s visit.
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<td>Screen for depression</td>
<td>The MacArthur Foundation Initiative on Depression and Primary Care: <em>Depression Management Tool Kit</em></td>
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<td>Palo Alto Medical Foundation: <em>Planned Care Visit Workflow</em></td>
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<td>Use planned care</td>
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During the Visit

Provider Exam

Sharing Information
One of the most important roles of clinicians is to provide information, including answering patients’ questions about a disease or its symptoms, interpreting clinical data or lab results, and explaining the appropriate use and methods for taking medication. Information about the illness, symptoms, treatment, and medications is central to patients’ ability to manage well, but information alone is not enough. The goal in sharing information for self-management support is to ensure that patients not only understand but are also prepared to act on the information in daily life.

Of course, telling patients what they need to know is not a guarantee that they will be able to use the information, and conveying all critical information during a short visit may not have the desired outcome if patients are not able to understand and use it. Try the following techniques:

- Share clinical information based on patients' lab or other screening values and interpret that information to connect their understanding of how healthy behaviors keep clinical indicators in range.

  - You might say:
    - “What do you think is going on?”
    - “What is your understanding of this (condition, issue)?”
    - “What worries you the most?”
    - “What else are you concerned about?”
    - “What do you know about (treatment, self-management)?”

- Use the “Ask-Tell-Ask” technique to assess patients’ information needs and provide precise, tailored information they can use.

  - First, Ask for Permission – You might say:
    - “Is it ok if I share some information about the importance of physical activity?”
    - “I’d like to show you how to check your feet for problems related to diabetes. Would this be a good time?”
    - “There are a number of things I want to tell you about the new medication. Ready?”

  - Then provide information, considering the following tips;
    - Address gaps in understanding
    - Use language the patient can understand, and avoid jargon
    - Share information in small bits, tailored to patients questions or concerns
- Use graphics, charts, models when possible (see the Body Outline Diagram below)
- Use decision tools when applicable (See Center for Shared Decision Making Tools)
- Monitor whether the patient is tracking nonverbally
- Encourage family/significant other involvement

Finally, Ask for Understanding – You might say:

- “What questions do you have?”
- “Please tell me what you now understand about diabetes and how you think we need to proceed to get this under control.”
- “When you go home, what will you say to (family member, other caregiver) about what we talked about today and what you plan to do?”

Use the “Closing the Loop” technique to ensure patients receive and understand health information, and know what to do to fulfill treatment recommendations.

Setting Healthy Goals

Studies show that patients rely on physician advice in determining health goals. Collaboratively setting health improvement goals with patients is an important step in motivating healthy behaviors. Physicians or other providers set treatment priorities and make recommendations about changes that would enhance health. To be effective in engaging the patients and families toward healthy behaviors, physicians will also ask about patient concerns and priorities, and then they will collaboratively arrive at a plan for self-management.

Using agenda-setting tools such as the Bubble Diagram can introduce the collaborative process of establishing healthy goals. It is important that patients’ priorities in goal setting lead the decision about which goals are established. Keep in mind that achieving small successes toward a goal that is important to patients will enhance their confidence and sense of control in managing their illness, and this will pave the way to achieving goals in other areas.

- Use a variety of tools such as the Bubble Diagram or Dinner Plate Menus to engage the patient in setting a health goal.

You might say:

- “Which of the healthy change activities on this form seems most important to you right now.” (If none do, ask what other area they might choose to address.)

The Bubble Diagram or Dinner Plate Menu could be provided to the patient at the reception area; ensure that front office staff have training in introducing the form

You might say:

- “We are working on improving our care for people with (diabetes). Dr. Smith would like to discuss your health goals. This form has some ideas you might consider.”
• The provider may choose to simply open the conversation with an open-ended question, which can also be very effective.

• You might say:
  o “What would you like to do in the next few weeks on behalf of your health?”

• Use the Conviction Confidence Ruler to assess how important the health goal is to the patient.

• You might say:
  o “On a scale of 0 to 10, with 0 being not at all confident and 10 being as confident as you can be, how convinced are you that it is important to (insert patient’s goal)?”

• Depending on the patient’s response – You might say:
  o “What makes you say 3?”
  o “Why 3 and not zero?”
  o “What might lead you to rate this as a 4 or 5?”
  o “What would have to happen for you to rate it higher?”

After collaboratively establishing health goals, providers might then make a “warm handoff,” introducing the patient and family to another member of the care team who is trained in action planning for behavior change.

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<td>Body Outline Diagram</td>
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During the Visit

Team Care: Nurse and Medical Assistant Coaching and Support

Goal Setting, Action Planning, and Problem Solving
Helping patients know what to do to stay healthy is important, but the goal of self-management support is to help them adopt the behaviors that will keep them healthy over time. Motivating and coaching healthy behaviors is one method of supporting self-management that can be done very effectively by non-clinicians. By developing skills through training and practice, tasks required to support patients and families—such as making a specific plan of action, anticipating barriers, and connecting them with community resources—can be the responsibility of members of the care team other than the physician, often with equivalent results.

For patients with chronic conditions, setting health goals with the help of a physician is an important step, but few patients achieve goals without more specific planning. Additional behavior change coaching—specifying action planning steps and anticipating barriers—is needed to develop patient confidence in reaching goals. Medical assistants, nurses, nutritionists, behavioral health professionals, health educators or trained lay people, if trained in action planning and problem solving strategies, can effectively work with patients to define their action plans.

- Assist the patient in completing an Action Plan form and give them a copy to take home.

  - You might say:
    - "This form has helped many people begin to make healthy changes by spelling out small, doable steps and anticipating problems. I see you have decided with Dr. Smith to work on being more active. Would you be willing to work with me to complete the form and establish goals for becoming more active?"

- Use a Conviction and Confidence Ruler to help assess the patient’s likelihood of success.

  - You might say:
    - "On a scale of 0 to 10, with 0 being not at all confident and 10 being as confident as you can be, how confident are you that you can (describe the activities on the action plan here)?"

- Depending on the patient’s answer – You might say:
  - "What makes you say 6?"
  - "What led you to rate it as high as a 6?"
  - "What has helped you to be confident in the past?"
  - "What might help you get to a 7 or 8?"
• “What could I do to help you feel more confident?”

• Anticipate barriers and consider strategies to overcome them.

  • You might say:
    o “What might get in the way of completing your action plan?”
    o “Anything else?”
    o “What might help you to overcome.. (barrier)?”
    o “What has helped in the past?”
    o “What else?”
    o “What or who might help you?”
    o “Here is what others have done...”

Patient Education and Skill Building

Patients and families need clear information to understand the signs and symptoms of the disease(s) and treatments, and training to build the skills to monitor clinical indicators such as glycemic control or peak flow volume. This clinical content distinguishes self-management education from self-management support, which helps people make behavior changes and sustain them over time. Physicians, nurses, or other clinicians with appropriate training can provide self-management education. Primary care teams may have difficulty finding time and appropriate staff to provide patient education sessions in the course of an office visit, but providing just the right information in response to patient needs or questions is a very effective way to incrementally increase their understanding and skills. For in-depth education, programs offered by public health entities or hospitals are an underused referral resource. Psychosocial and emotional stressors as well as physical symptoms should be considered in these programs.

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<td>American Heart Association</td>
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After the Visit

Providing Ongoing Follow-Up
Sustaining healthy behaviors for a lifetime requires courage and tenacity, most often involving small, incremental changes that build over time into bigger successes. Even the best plans of action require adjustment to work effectively. Medications may produce side effects or not produce the desired effect, requiring further support and explanation or alterations to make the plan workable. For all of these reasons, making regular contact with patients after a visit or change in treatment is central to sustaining positive change. Studies in depression, in particular, document the need to follow up with patients to assist them in succeeding with the action plan.

- Schedule and record a time for a follow-up call with the patient while making the action plan
  - You might say:
    ○ “I’d like to call to see how you are doing with your action plan. Would that be OK with you? When would be a convenient time?”

- Connect patients with sources of support in the community such as recreation or senior centers, support groups, and voluntary community organizations
- Locate or develop a peer program in your clinic or community

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<td>See also Community Partnerships below</td>
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Sustaining Self-Management Support: Training for Practice Teams

Just as patients require ongoing support for changing health behaviors, practice teams need repeated opportunities to learn new skills and change their communication and practice patterns in support of patient self-management. Many practices find that designating a self-management support coach who provides ongoing training to all care team members is the best way to establish skills over time. The coach should be a staff member with talent and inclination to work with health behavior change—or, at minimum, be “a people person” who receives the appropriate training to support him or her in such a role, including in-depth training in behavior change.

Often, the coach can do focused trainings as brief as 15 minutes during a regular care team meeting to demonstrate a particular skill or introduce a new tool. A series of these shorter trainings over time may be more effective than a one-time only training of several hours. The trainings can be tailored to specific staff roles and tasks, giving participants an opportunity to try a technique, get feedback, and develop skills over time.

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Sustaining Self-Management Support: Community Partnerships

People live with chronic conditions 24/7/365, so much of the work of self-management takes place between health care visits during the course of daily life at home and in the community. Community resources for self-management support provide convenient access, and also increase the likelihood of success since patients are learning about their condition with and from people like themselves. Holding culturally competent programs in community settings encourages participation and increases satisfaction. Clinic/community partnerships that offer programs can promote self-management more comprehensively and seamlessly than any one organization could do alone. Partnerships that sponsor activities such as year-round walking programs and farmers' markets also help individuals access these resources at the community level.

<table>
<thead>
<tr>
<th><strong>Key Change</strong></th>
<th><strong>Key Reference or Tool</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify community resources</td>
<td>National Council on Aging</td>
</tr>
<tr>
<td><strong>Designate a staff member or</strong></td>
<td>Agency for Healthcare Research and Quality:</td>
</tr>
<tr>
<td>patient/family advisor to be a</td>
<td>Health Care Innovations Exchange: Linking Clinical Practices and the Community for Prevention</td>
</tr>
<tr>
<td>“community resource expert”</td>
<td>The Diabetes Initiative: Stories and Descriptions of 14 Programs to Improve Self-Management</td>
</tr>
<tr>
<td><strong>Partner with organizations to provide care</strong></td>
<td>Tools for Building Clinic/Community Partnerships to Support Chronic Disease Control and Prevention</td>
</tr>
<tr>
<td><strong>Use peer-led programs</strong></td>
<td>YMCA Activate America</td>
</tr>
<tr>
<td><strong>Partner with organizations to provide care</strong></td>
<td>Stanford Patient Education Research Center:</td>
</tr>
<tr>
<td><strong>Use peer-led programs</strong></td>
<td>Chronic Disease Self-Management Program</td>
</tr>
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</table>
Sustaining Self-Management Support: Partnering with Patients and Families

If given the opportunity, patients and family members themselves can contribute substantially to the quality and effectiveness of health care. Particularly in the realm of self-management, where patients and family members are the active agents in care and collaboration is key, simply asking them what type of support would be helpful is a good place to begin. Of course, not every patient will know what they need and want. Many are still passive about their role in their own care, and others are too distracted by concerns to know what may be more helpful. But a growing subset of people with chronic conditions are actively engaged in managing their conditions and are uniquely capable of improving care for themselves and others, if offered an opportunity. Patient education materials and classes, clinician communications training, and peer-led support groups are areas in which patient and family members may contribute to make care truly responsive to patient and family needs.

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<tr>
<th>Key Change</th>
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<tr>
<td>Involve patients and family members in improving care delivery</td>
<td><em>Institute for Patient- and Family-Centered Care</em></td>
</tr>
<tr>
<td>Use patient- and family-centered feedback instruments</td>
<td><em>Agency for Healthcare Research and Quality: Consumer Assessment of Healthcare Providers and Systems (CAHPS)</em></td>
</tr>
<tr>
<td></td>
<td><em>National Partnership for Women and Families</em></td>
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</table>
Sustaining Self-Management Support: The Chronic Care Model
In order to sustain changes in care delivery that support self-management, it is helpful to engage the entire system of care. The Chronic Care Model, which includes self-management support as one of six essential elements, can be helpful in planning these system supports. The following adaptation of the Chronic Care Model outlines the key concepts that have been utilized to implement self-management support in many quality improvement initiatives. For more information and examples of key changes see the full [Self-Management Support Chronic Care Model Change Package](http://www.improvingchroniccare.org/).

Adaptation of the Chronic Care Model:*
Using Components to Enhance Self-Management

Patients engage in effective self-management

* Adapted from the Chronic Care Model, developed by Dr. Ed Wagner of the MacColl Institute for Healthcare Innovation in partnership with colleagues at the Improving Chronic Illness Care program. [http://www.improvingchroniccare.org/](http://www.improvingchroniccare.org/)
Key Change Concepts to Implement Self-Management Support

SELF-MANAGEMENT SUPPORT Core Competencies

*What can we do at every interaction with the patient and family to promote the patient as the expert in managing his or her chronic condition?*

- **Describe and promote** self-management by emphasizing the patient’s central role in managing his/her health.
- **Include family** members at the patient’s discretion.
- **Build a relationship** with each patient and family member.
- Explore patient’s **values, preferences**, and cultural and personal beliefs.
- The patient and providers **share information** and communicate in a way that meets the patient’s and family’s needs and preferences.
- **Collaboratively set goal(s)** and develop action plans. Document the patient’s confidence in achieving goals, and use **skill building** and **problem-solving** strategies that help the patient and family identify and overcome barriers to reaching goals.
- **Provide follow-up** on action plans and connect the patient with community programs to sustain healthy behaviors.

**System Supports for Self-Management Support (SMS)**

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<tr>
<th>Delivery System Design</th>
<th>Decision Support</th>
<th>Clinical Information System</th>
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<tr>
<td>How can the care team provide patient- and family-centered SMS and whose role is it?</td>
<td>How can SMS consistently occur with evidence-based care?</td>
<td>How can we organize and use patient and population data to facilitate SMS?</td>
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<tr>
<td>- Determine the process and define roles and responsibilities of individual care team members to support self-management.</td>
<td>- Share evidence-based care guidelines with patients and families so they recognize optimal care.</td>
<td>- Create easy access to all clinical and patient-oriented information.</td>
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<tr>
<td>- Use planned visits for delivering self-management support.</td>
<td>- Train the practice team (including peer trainers, community health workers, and specialists) to use effective self-management support strategies.</td>
<td>- Create capacity to identify and contact relevant subpopulations for proactive care.</td>
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<tr>
<td>- Plan peer interactions.</td>
<td>- Provide support and coordination according to the level of need.</td>
<td>- Provide a written care plan or visit summary to ensure patient knows how to manage at home.</td>
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</table>

**Health Care Organization**

How can we accomplish a comprehensive system change—in culture and mechanisms—to promote safe, high-quality SMS?

- **Partner with patients and families** in a variety of improvement, advisory, and leadership roles.
- Visibly and vocally **promote improvement of self-management support** at all levels of the organization.
- **Ensure resources** to sustain and spread self-management support.

**Community**

How can we mobilize the community to strengthen SMS?

- **Identify** effective community programs as SMS resources.
- **Partner** with community workers.
- **Raise community awareness** of self-management support through networking, outreach, and education.
Partnering in Self-Management Support: A Toolkit for Clinicians

Acknowledgements
Support for this toolkit was provided by a grant from the Robert Wood Johnson Foundation through New Health Partnerships, a national program of the Robert Wood Johnson Foundation located at the Institute for Healthcare Improvement.

The Robert Wood Johnson Foundation (RWJF) focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful, and timely change. For more than 30 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime.

The Institute for Healthcare Improvement (IHI) is a not-for-profit organization leading the improvement of health care throughout the world. Founded in 1991 and based in Cambridge, MA, IHI is a catalyst for change, cultivating innovative concepts for improving patient care and implementing programs for putting those ideas into action. Thousands of health care providers, including many of the finest hospitals in the world, participate in IHI’s groundbreaking work.

The California HealthCare Foundation (CHCF) is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, CHCF’s goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford.

The New Health Partnerships initiative is a national program of the Robert Wood Johnson Foundation located at the Institute for Healthcare Improvement funded to develop and test efficient approaches to empower patients and families to manage their chronic conditions. The initiative also engages patients and families as advisors to improve the design and delivery of health care services.
New Health Partnerships Faculty
Marie Abraham, MA, Policy Specialist, Institute for Family-Centered Care
Seth Emont, PhD, MS, Research and Evaluation Consultant, White Mountain Research Associates
Martha Funnell, MS, RN, CDE, Director for Administration, Michigan Diabetes Research and Training Center
Shari Gioimo, CMA, Medical Assistant, St. Peter Family Medicine
Alan Glaseroff, MD, Chief Medical Officer, Humboldt Del Norte IPA
Russ Glasgow, PhD, Senior Scientist, Kaiser Permanente Colorado
Angela Hovis, MA, Improvement Advisor
Beverley Johnson, President and CEO, Institute for Family-Centered Care
Wayne Katon, MD, Professor and Vice Chair, University of Washington Medical School Department of Psychiatry
Kerry Kilpatrick, MBA, PhD, University of North Carolina at Chapel Hill
Penny Lane, MPH, Maximus, The Center for Health Literacy
Veronica Richardson, RN, MBA, FCHCEM, Vice President of Quality Improvement, Grace Hill Neighborhood Health Centers, Inc.
Devin Sawyer, MD, St. Peter Family Medicine
David Spero, RN, Lead Writer and Faculty, New Health Partnerships
Karen Tate, Family Consultant, Children’s Hospital of Philadelphia

Toolkit Authors
Judith Schaefer, MPH, Senior Research Associate, MacColl Institute for Healthcare Innovation, the National Program Office for Improving Chronic Illness Care
Doriane Miller, MD, Director, Center for Community Health and Vitality, University of Chicago Medical Center
Michael G. Goldstein, MD, Chief, MHBSS, Department of Veterans Affairs
Laurel Simmons, SM, Associate Director for Quality Improvement, Stockport NHS Foundation Trust, formerly a Deputy Director at the Institute for Healthcare Improvement.

How to Cite This Document:
ICIC Improving Your Practice Manual

Step 6 To Do List

☐ Watch the Planned Care Video with your whole team.
☐ Assign roles and tasks using the team roles grid.
☐ Talk about who would like to do what as part of the team
☐ Call patient tomorrow to schedule a planned visit
☐ Consider using standing orders for some care processes
☐ Prepare a plan for role changes if patient shows for an acute visit.

STEP SEVEN:
- Building Self-management Support into the Planned Visit

What is Self-management?
"The individual's ability to manage the symptoms, treatment, physical and social consequences and lifestyle change inherent in living with a chronic condition." Barlow et al, Patient Educ Couns 2002;48:177

What is Self-management Support?
Supporting patients in the tasks of managing their own chronic condition(s) calls for more than education, in which patients gain knowledge about their condition. Patients need to have the skills and confidence to effectively manage the condition on their own. Researchers have described three categories of tasks that patients with chronic conditions perform. The first is managing the illness (such as learning to take medications and monitor the condition), the second is to carry on normal roles and activities and the third is to manage the emotional impact of the illness. Since every patient with a chronic condition is a self-manager, responsible for most of his or her own care, support of self-management is an ongoing activity for the health care team. The goal of self-management support is to assist and sustain the patient's ability to engage in self-management behaviors that fit within their own life patterns. The creation of a personal action plan is an important way in which providers can support their patients’ self-management goals. Another key skill is to help patients learn to solve problems.

Getting Started
Prepare to introduce the concept of self-management to the patient. Help the patient understand that they are the managers of their health with your assistance.

Help the patient determine his or her own priorities. Ask about and understand their health beliefs, and address problems from the perspective of the patient. Ask the patient about their living circumstances. Asking about these issues and working to understand the patient’s perspective will allow you to collaboratively set self-management goals that the patient wants, versus based solely on your clinical priorities, if the two are not congruent. (NOTE: Once you have the patient achieving success in setting their own personal health care goals, you can weave in your desired goals over time.) Assess the patient’s confidence in carrying out a plan, and be sure to follow-up to help them achieve the goal and problem-solve barriers.

It is recommended that the physician, nurse practitioner or physician’s assistant introduce this concept as a prescription for care to increase acceptance by the patient. The provider may then
want to pass the patient to someone who can set help set goals. There are tools on page xx for setting goals with patients.

Collect data about goals set and achieved to be used in the next visit. The patient encounter form from the registry or a structured encounter form of your making is critical to successful data capture. Make sure these data are entered in the registry or are easily accessible for use at the next visit.

Agree on when and how you and patient will follow-up on the self-management goals that were set, and write this in the patient plan. Agree on an interval between planned visits based on clinical need and patient preference. Make sure follow-up to all clinical and self-management task is part of your daily practice of care and that the patient receives a copy of the plan.

**Making a specific plan**
The plan should contain all of the following steps:

- **Exactly what are you going to do?** How will you eat less, how far will you walk, what meditative technique will you practice?
- **How much will you do?** Will you walk 2 blocks walk for 20 minutes, not eat between meals for 2 days, practice yoga for 10 minutes?
- **When will you do this?** Will you do this before lunch, in the shower, when I arrive home from work?
- **How often will you do the activity?** It’s recommended to decide to do something three or four times a week. If you do more, so much the better but the goal is to do your activity often enough to be successful, and yet not feel pressured on a daily basis.
- **Anticipated barriers** Help the patient imagine what might get in the way of their plan.
- **Potential solutions for barriers** Have the patient come up with ideas that might help them overcome the barriers
- **Follow-up plan** When, where and how will you check in with the patient about their experience with the plan
- **Confidence rating** On a scale of 1-10, with 1 being no confidence that the plan can be completed to 10 being absolutely certain that they can complete the plan, have the patient rate their confidence level.

When implementing an action plan, the start slowly and build successes. If they can walk only for one minute, suggest walking one minute once every hour or two, not with walking a mile all at once, start the program. If the goal is to lose weight, set a goal based on existing eating behaviors, such as not eating after dinner, rather than drastically changing eating patterns.

**Tips for Creating a Successful Action Plan**

- Begin with something the patient wants to do
- Make the goal reasonable (something the patient can reasonably expect to be able to accomplish this week)
- Strive for a change that is behavior-specific (losing weight is not a behavior; not eating in the evenings while watching television is a behavior)
Ensure that the plan answers these questions: what; how much; when (think about the day/the week – which days, what times, etc.); how often?
Start when the patient has a confidence level of 7 or greater (this is the belief that they can, and will, complete the entire contract)

Goals versus behavior-specific changes
Keep in mind the difference between a healthy change, a goal that is set to reach that change and the behavior required to attain that goal. For example:

- **Healthy Change:** Lose weight  
  **Goal:** lose 4 pounds in the next month  
  **Behavior:** eating carrots for a snack, not chocolate

- **Healthy Change:** Exercise more  
  **Goal:** exercise for 20 minutes twice a week  
  **Behavior:** walk to work

- **Healthy Change:** reduce stress levels  
  **Goal:** spend 15 minutes a day relaxing  
  **Behavior:** listen to meditation tape

---

**Example Action Plan**

Name: Joe Smith  
Phone: (206) 555-1234  
Date: June 22, 2004

The healthy change I want to make is: **Start a walking program**

My goal for the next month is: **To walk three times per week**

The steps I will take to achieve my goal are (what, when, where, how much, how often):

- I will walk around my neighborhood for 15 minutes, directly after I get home from work on Monday, Wednesday, and Friday.

The things that could make it difficult to achieve my goal include:

  - My sister may need to talk on the phone after work, and it might be too late to go after we talk.

My plan for overcoming these difficulties includes:

  - I can ask my sister if she absolutely needs to talk that day. If I have to miss a regular walking time, I can make up that day by driving to the park on the weekend and walk for 15 minutes in the morning, then resume my regular plan the following week.

Support/resources I will need to achieve my goal include:

  - I need to buy a new pair of sneakers and extra-cushioned socks so that my feet don’t get blisters. I would feel more comfortable walking if I had a dog with me. I can ask my neighbors if I can ‘borrow’ Sparky, their dog.
Improving Your Practice Manual

My confidence level (scale of 1-10, 10 being completely confident that you can achieve the entire plan.) 8

Review date: June 29, 2004 (in one week) Review method (phone, email, in-person): In-person

Problem-solving Techniques
It can be helpful to remind patients that change often takes time and effort. Hearing a health care provider reiterate that self-management can require persistence, and that success is possible – even when obstacles are encountered – can be just what the patient needs when the going gets a bit rough. The following method has been shown to help patients find solutions to problems.

- **Identify the problem**
  Help the patient get to the root of the issue. For example, is it that they have problems maintaining a diet when they eat out, or their family doesn’t understand their wishes to eat a healthier diet?

- **List ideas to solve the problem**
  Help the patient come up with many ideas, some they have tried before to some that may seem ridiculous, and to come up with a list of ideas that might work.

- **Choose one method to try**
  Out of all the options listed, help the patient choose one, or a combination of ideas that they think will work for them.

- **Try it for 2 weeks.** Encourage patients to give each idea a good trial period to see if it will work.

- **Evaluate the results**
  After the patient’s given the idea a fair trial, assess the outcome.

- **Try another idea if the first one doesn’t work**
  Have the patient return to their list of ideas and try another.

- **Locate other resources**
  Resources can be friends, family, members of their health care team, or a community link such as the public library or a health fair.

- **Accept that the problem may not be solvable right now**
  Remind the patient that if the solutions they came up with this time haven’t worked, that it doesn’t mean that other solutions won’t be effective at another time, or that different problems can’t be solved using this solution. Encourage them to keep trying; do your best to foster hope and persistence.

Other useful resources for delivering self-management support can be found on page xx of the appendices.

Much of the content above has been adapted from Lorig et al, *Living a Healthy Life with Chronic Conditions*. Bull Publishing Company, 2000.
Every time you talk with a doctor, nurse, or pharmacist, use the Ask Me 3 questions to better understand your health.

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

When to Ask Questions

You can ask questions when:
• You see your doctor, nurse, or pharmacist.
• You prepare for a medical test or procedure.
• You get your medicine.

What If I Ask and Still Don’t Understand?

• Let your doctor, nurse, or pharmacist know if you still don’t understand what you need to do.
• You might say, “This is new to me. Will you please explain that to me one more time?”

Who Needs to Ask 3?

Everyone wants help with health information. You are not alone if you find things confusing at times. Asking questions helps you understand how to stay well or to get better.

The Ask Me 3 questions are designed to help you take better care of your health. To learn more, visit www.npsf.org/askme3
Your Doctor, Nurse, and Pharmacist Want to Answer 3

Are you nervous to ask your health provider questions? Don’t be. You may be surprised to learn that your medical team wants you to let them know that you need help.

Like all of us, doctors have busy schedules. Yet your doctor wants you to know:
- All you can about your condition.
- Why this is important for your health.
- Steps to take to keep your condition under control.

Asking these questions can help me:
- Take care of my health
- Prepare for medical tests
- Take my medicines the right way
- I don’t need to feel rushed or embarrassed if I don’t understand something. I can ask my doctor again.
- When I Ask 3, I am prepared. I know what to do for my health.

Bring your medicines with you the next time you visit your doctor or pharmacist. Or, write the names of the medicines you take on the lines below.

Like many people, you may see more than one doctor. It is important that your doctors know all the medicines you are taking so that you can stay healthy.

Write Your Doctor’s Answers to the 3 Questions Here:

1. What is my main problem?

2. What do I need to do?

3. Why is it important for me to do this?

Ask Me 3™ is an educational program provided by the Partnership for Clear Health Communication at the National Patient Safety Foundation™ – a coalition of national organizations that are working together to promote awareness and solutions around the issue of low health literacy and its effect on safe care and health outcomes.

www.npsf.org/askme3
For Better Health: Rate Your Plate

- Picture, in your mind, your usual lunch or dinner.
- Draw in lines on the plate below, and label each area for these food groups: carbohydrates, proteins, and vegetables.

Now look at the next page...
Does your plate look like this?

The Healthy Plate
One half vegetables, one quarter protein, one quarter carbohydrates

- Is your plate covered with colorful vegetables—dark green, orange, red, and yellow?
- Is the fat trimmed off your meat and the skin removed? Did you choose leaner cuts of meat, poultry, or fish?
- Did you choose whole grain pasta or breads? Brown rice or potato with skin?
- How much fat was used in cooking or added to your plate? Instead of frying, try to boil, steam, grill, or bake.

Adapted from Rate Your Plate. The Joslin Diabetes Center.
**BLOOD SUGAR LOG**

Week of: ____ / ____ / ____ thru ____ / ____ / ____

Belongs to: ____________________________________________

Healthcare Professional: ________________________________

Phone: _______________________________________________

<table>
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<tr>
<th>Monday</th>
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My target blood sugar ranges are:

- _______ mg/dL to _______ mg/dL before meals
- _______ mg/dL to _______ mg/dL 2 hours after meals

My A1C Level is: _______ My A1C Goal is: _______
PATIENT NAME: 

DATE OF BIRTH: 

PHYSICIAN: 

MEDICATIONS: 

***INSTRUCTIONS***

✓ Please take your blood pressure #_____ times per week/month
✓ Bring your BP Diary to your next follow-up visit

BP RECORD

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Right Arm</th>
<th>or</th>
<th>Left Arm</th>
<th>BP Reading</th>
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Questions?

1. What if my Blood Pressure is higher than 130/80?
   [130/80 for Diabetic Patient, heart disease, coronary artery disease, & chronic kidney disease]
   
   Answer: Repeat taking Blood Pressure the next day.

2. What if my Blood Pressure is consistently higher than 130/80?
   [130/80 for Diabetic Patient, heart disease, coronary artery disease, & chronic kidney disease]
   
   Answer: Please call our office ___________ to report these readings to your physician.

Questions and comments to discuss at your next follow-up appointment:
Understanding Cholesterol

Did you know that cholesterol comes from 2 sources?
You probably know that cholesterol comes from food. But what you might not know is that your bad cholesterol also has a lot to do with your family history. Everyone’s bad cholesterol comes from 2 sources: the cholesterol that is absorbed from food and the cholesterol your body produces naturally, based on heredity.

What is cholesterol?
Cholesterol is a soft, waxy substance that can build up in your artery walls. This restricts blood flow and can cause a heart attack or stroke. The higher your LDL (bad) cholesterol number; the greater your chances for heart disease.

Know your LDL (bad) cholesterol number.
Your LDL (bad) cholesterol number is important. It gives you and your doctor a standard for good health – much like your temperature, pulse, or blood pressure. Your LDL (bad) cholesterol goal number is based on your current and historical medical situation and any risk factors you may have for heart disease. If you have heart disease or diabetes, your goal should be less than 100 mg/dL. If you don’t know what your individual LDL (bad) cholesterol goal should be, ask your doctor.

Ask your doctor for your LDL cholesterol goal, then fill out this chart to help you keep track.

<table>
<thead>
<tr>
<th>Date</th>
<th>LDL Cholesterol</th>
<th>Total Cholesterol</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

My LDL (bad) cholesterol goal is ________.

For more information, please visit 2sourcesofcholesterol.com
Lowering Cholesterol

**There may be more you can do.**
Stay focused on lower-fat and lower-cholesterol foods. Many people have difficulty with high cholesterol simply because their body produces too much of it. But foods that are high in cholesterol or fats also contribute to the problem.

Eat healthy when you’re out. Try oil-and-vinegar dressing on salads; ask the chef to remove excess fat from beef and to trim the skin from the chicken. If in doubt, ask your waiter for recommendations on foods that are low in fat.

**Make exercise a regular part of your life.**
The principle of adjusting your diet also applies to exercise. To help you develop a healthy lifestyle, we’ve included a few tips that can help you get started (see the list below). When you’re ready, remember that it’s important to increase your activities gradually. Be sure to talk with your doctor before starting any exercise regimen.

**Do what you can to help your medications work**
When diet and exercise alone are not enough, several types of cholesterol-lowering medications are available. Remember that medicines need to be taken as directed by your doctor.

<table>
<thead>
<tr>
<th>If you usually eat:</th>
<th>Try:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steak</td>
<td>Fish</td>
</tr>
<tr>
<td>Hamburgers</td>
<td>Turkey Burgers</td>
</tr>
<tr>
<td>Fried Chicken</td>
<td>Baked Seasoned Chicken</td>
</tr>
<tr>
<td>Whole Milk or 2% Milk</td>
<td>Skim Milk or 1% Milk</td>
</tr>
<tr>
<td>Cheese or Sour Cream</td>
<td>Low-Fat Cheese or Low-Fat Sour Cream</td>
</tr>
<tr>
<td>Sauces Over Vegetable</td>
<td>Steamed Vegetables</td>
</tr>
<tr>
<td>Potato Chips</td>
<td>Rice Cakes</td>
</tr>
<tr>
<td>Pastries</td>
<td>Fat-Free Pastries</td>
</tr>
<tr>
<td>Sweets/Chocolate</td>
<td>Fat-Free Sweets/Chocolate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inactive</th>
<th>Mildly Active</th>
<th>Active</th>
</tr>
</thead>
</table>
| • Walk on your lunch hour or coffee break | • Join a gym or recruit an exercise partner  
• Increase the frequency of your exercise sessions  
• Create an exercise schedule-and stick to it  
• Explore new sports that interest you | • Exercise at least 3 times a week, 30 minutes a day  
• Choose activities that use the large muscle group(s) such as swimming and biking  
• Vary your routine to avoid burnout |
**Food and Exercise Diary**

Keeping a written record of what you do and eat can help you reach your goals. Try using this diary for a week to record your changes. Pick one or two at a time. Did you reach your goals? If so, reward yourself. If not, try something else and try again!

My goal for this week is:

- [ ] Eat more fruit and vegetables
- [ ] Decrease portion sizes
- [ ] Eliminate fried foods
- [ ] Exercise for ___ minutes ___ days per week
- [ ] Decrease salt intake
- [ ] Increase whole grain foods/fiber

Other: ____________________________________________

---

### My Weekly Food and Exercise Diary

<table>
<thead>
<tr>
<th>Date</th>
<th>What times did you eat?</th>
<th>What foods did you eat and drink? (List portion size)</th>
<th>What exercise did you do?</th>
<th>How long did you exercise?</th>
</tr>
</thead>
<tbody>
<tr>
<td>One example: Feb. 8</td>
<td>7:30 AM</td>
<td>1 bowl whole wheat cereal with 1/2 cup skim milk</td>
<td>walked</td>
<td>35 minutes</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
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<th>What times did you eat?</th>
<th>What foods did you eat and drink? (List portion size)</th>
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<th>Date</th>
<th>What times did you eat?</th>
<th>What foods did you eat and drink? (List portion size)</th>
<th>What exercise did you do?</th>
<th>How long did you exercise?</th>
</tr>
</thead>
</table>
How Do I Manage My Medicines?

Taking medicine may be new to you, and there may be a lot to remember. For example, why are you taking it? What time should you take it? How often do you take it, and how many pills do you take?

It’s very important to take medicine the right way — just as your doctor tells you.

If you don’t follow your doctor’s directions, what could happen? First of all, if medicine isn’t taken the right way, it may not work. It could also cause side effects that may be mild — or very harmful. Without knowing it, you could counteract one medicine by taking it with another. Not taken properly, medicine can also make you feel sick or dizzy.

How can I remember to take my medicine?

- Take it at the same time every day.
- Take it along with meals or other daily events, like brushing your teeth.
- Use special pill boxes that help you keep track, like the day-of-the-week divided ones found at drugstores.
- Ask the people who are close to you to help remind you.
- Keep a “medicine calendar” near your medicine and note every time you take your dose.
- Put a sticker or reminder note on your medicine cabinet or refrigerator.

What else should I know?

- Store your medicine the way your doctor or pharmacist tells you. Keep medicine in original containers, or label new containers.
- Keep track of what pills you can and can’t take together, including over-the-counter medicines.
- Always get your prescription filled on time, so you don’t run out.
- Try to see the same pharmacist each time.
- Don’t take more of your medicine than the prescribed dose.
- Ask your doctor or pharmacist before buying a new over-the-counter medicine, such as an antihistamine or “cold tablets,” to be sure they won’t interfere with your prescribed medicine.
- Always check with your doctor before you stop taking a medicine.
- If you have any questions about your pills, make a note to remind yourself to ask your doctor or pharmacist.
- Tell your doctor if you have any side effects.
• Write down the names and doses of medicines you are taking. If you go to more than one doctor, take your updated medication list with you to each visit.

• Keep all medicines out of the reach of children.

My medicine
Ask your healthcare professional to help you fill in the blanks below.

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>What it looks like</th>
<th>Dose</th>
<th>What it’s for</th>
<th>When to take it</th>
<th>Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

How can I learn more?
1. Talk to your doctor, nurse or other health-care professionals. If you have heart disease or have had a stroke, members of your family also may be at higher risk. It’s very important for them to make changes now to lower their risk.
2. Call 1-800-AHA-USA1 (1-800-242-8721) or visit americanheart.org to learn more about heart disease.
3. For information on stroke, call 1-888-4-STROKE (1-888-478-7653) or visit StrokeAssociation.org. We have many other fact sheets and educational booklets to help you make healthier choices to reduce your risk, manage disease or care for a loved one. Knowledge is power, so Learn and Live!

Do you have questions or comments for your doctor?
Take a few minutes to write your own questions for the next time you see your doctor. For example:

How long should I take my medicine?

What if I forget to take a medicine?

Should I avoid any foods or other medicines?
### Cultural and Linguistically Appropriate Services (CLAS)

<table>
<thead>
<tr>
<th>Definitions</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Culture</strong> Systems of beliefs (including religious), values, and lifestyles</td>
<td>Impacts patients’ responses to medical and preventive interventions as well as how physicians deliver services.</td>
</tr>
<tr>
<td>that are developed. They are dynamic, responsive and coherent.</td>
<td></td>
</tr>
<tr>
<td><strong>Cultural Competence</strong> Having knowledge, awareness, and respect for other</td>
<td>Those who integrate their culture and the patients’ culture into the clinical encounter create effective cross-cultural interactions.</td>
</tr>
<tr>
<td>cultures; the ability to recognize how your own culture pays a role in the</td>
<td></td>
</tr>
<tr>
<td>encounter.</td>
<td></td>
</tr>
<tr>
<td><strong>Racial and Ethnic Healthcare Disparities</strong> Differences in the quality of</td>
<td>Research shows that racial and ethnic minorities tend to receive lower quality of healthcare than whites, even when they have the same insurance and access to a provider.</td>
</tr>
<tr>
<td>care received by minorities and non-minorities even though they have equal</td>
<td></td>
</tr>
<tr>
<td>access to care (same insurance, same access to a provider).</td>
<td></td>
</tr>
<tr>
<td><strong>Stereotyping</strong> Mistakenly assuming that all members of a given culture are</td>
<td>Providers may unconsciously use stereotypes when trying to understand their patients.</td>
</tr>
<tr>
<td>alike.</td>
<td></td>
</tr>
</tbody>
</table>

Ethnic/racial composition of US population (2005 census data): Latinos: 42.7 million, Blacks: 39.7 million, Asians: 14.4 million, Others: 5.4 million, Non-Latino whites: 198.4 million

<table>
<thead>
<tr>
<th>US minority population</th>
<th>98 million or one-third of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected minority population by 2050</td>
<td>49.9% of population</td>
</tr>
<tr>
<td>Individuals who speak a language other than English at home</td>
<td>47 million in 2000</td>
</tr>
<tr>
<td>Persons with disabilities</td>
<td>18% of population</td>
</tr>
<tr>
<td>US Physicians by race and ethnicity</td>
<td>47.8% white, non Latino; 2.3% African American, 3.2% Latino; 8.3% Asian; 0.06% Alaskan; 2.3% other; 36% unknown</td>
</tr>
<tr>
<td>US nurses by race and ethnicity</td>
<td>88.4% white, non Latino; 4.6% African American; 3.3% Asian; 1.8% Latino; 0.4% Alaskan; 1.5% mixed</td>
</tr>
</tbody>
</table>
# Key Cultural Norms of Selected Diverse Groups

<table>
<thead>
<tr>
<th>Cultural Groups</th>
<th>Norms</th>
<th>Impact on the Clinical Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Americans</td>
<td>Religious Healing</td>
<td>Faith and prayer can be a powerful influence and can often be the first resort to improve health for devout black Christians. African Americans are reported to have a more favorable attitude toward seeking mental health services for depression than whites.</td>
</tr>
<tr>
<td></td>
<td>Mental health issues</td>
<td></td>
</tr>
<tr>
<td>Asians</td>
<td>Traditional Chinese medicine</td>
<td>For Chinese people, cold water and cold air are considered unhealthy. Many Asians consider mental health issues shameful and are less likely to seek care.</td>
</tr>
<tr>
<td></td>
<td>Mental health issues</td>
<td></td>
</tr>
<tr>
<td>Latinos</td>
<td>Personal Space</td>
<td>Latinos prefer less interpersonal space than Anglos. Illness is sometimes conceptualized as an imbalance between natural and supernatural and may be believed to be caused by God or other external forces. Latinos may select folk healers as a first option for treatment.</td>
</tr>
<tr>
<td></td>
<td>Explanatory model of illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Folk diseases and folk healers</td>
<td></td>
</tr>
<tr>
<td>Native Americans</td>
<td>Illness</td>
<td>Native Americans may perceive illness as a loss of harmony with the forces of life and may readily accept illness and prefer for nature to take its course. They may use traditional remedies, which they guard as secrets. Native Americans may appear stoic regarding pain because they’ve been taught to avoid expressing pain.</td>
</tr>
<tr>
<td></td>
<td>Traditional remedies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expression of pain</td>
<td></td>
</tr>
<tr>
<td>Lesbian, Gay, Bisexual, Transgendered (LGBT) Individuals</td>
<td>Family structure</td>
<td>Understanding that LGBT individuals often maintain their own family structure can help in identifying the patient’s caregivers and dependents and be important as it relates to healthcare decisions and health insurance.</td>
</tr>
<tr>
<td>Persons with Disabilities</td>
<td>Daily-life Issues</td>
<td>Persons with disabilities often face isolation and reduced activities of daily living. Persons with disabilities have been identified as having higher smoking rates and being more sedentary than people who do not have disabilities. Persons with disabilities have been reported to receive insufficient routine preventive care.</td>
</tr>
<tr>
<td></td>
<td>Health Issues</td>
<td></td>
</tr>
</tbody>
</table>
## Communicating with Culturally Diverse Patients

<table>
<thead>
<tr>
<th>Communication Style</th>
<th>Impact on the Clinical Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Silence</td>
<td>Among Latinos, silence may indicate a lack of understanding or disagreement</td>
</tr>
<tr>
<td>Body Language</td>
<td>Many Asians believe that exposing the sole of the foot, pointing with the foot or touching the head are repugnant actions</td>
</tr>
<tr>
<td>Touching</td>
<td>Asians are generally low-touch groups...explain exams prior to executing them</td>
</tr>
<tr>
<td>Using the Left Hand</td>
<td>Among many non-Western cultures, the left-hand is considered to be unclean because it’s used for personal hygiene. This, it shouldn’t be used to offer anything to members of these groups</td>
</tr>
<tr>
<td>Eye Contact</td>
<td>In some cultures, avoiding eye contact may be a sign of respect.</td>
</tr>
<tr>
<td>Gestures</td>
<td>Gestures are not universal. For example, some Latinos may consider the “OK” sign (i.e., circle made with thumb and forefinger) to be obscene</td>
</tr>
<tr>
<td>Communicating bad news</td>
<td>In the US, the norm is to tell the truth to patients. In Chinese, Latino and Pakistani cultures, family members protect patients who are terminally ill from knowing their condition</td>
</tr>
</tbody>
</table>
Reported Ethnic and Racial Healthcare Disparities

Compared with white patients, those of ethnic minorities have been reported to be less likely to receive needed services, such as clinically necessary procedures, even after correcting for access-related factors such as insurance status.

African Americans and Latinos have been reported to receive lower quality of care access across a range of disease areas and clinical services.

Compared with whites, African Americans are reported to be more likely to receive less desirable services, such as amputation of all or part of a limb.

According to data from 2000 census, death rates of African American, American Indian, and Puerto Rican infants are higher than the death rates of white infants.

African American women are more than twice as likely to die of cervical cancer than white women and more likely to die of breast cancer than women of any other racial or ethnic group.

Mortality rates related to heart disease were 29% higher and stroke-related rates were 40% higher than those of whites.

In 2000 (census data), compared with non-Latino whites, the likelihood of being diagnosed with diabetes was:

- 2.6 times more likely among American Indians and Alaskan Natives
- 2.0 times more likely among African Americans
- 1.9 times more likely among Latinos

Latinos and African Americans aged 65 and older were less likely than non-Latino whites to report having received an influenza vaccine in 2001.
Interpreter Services

Several options are available to choose from (ATT Language Line, International Institute to name just a few). Each practice is encouraged to choose their own preferred form of assistance in the event that a language interpreter is needed.

ATT Language Line is a “pay-as-you-go” service ($3.95 per minute as of 7/10) available @ 1-800-528-5888 or 1-831-648-7582 when calling from outside North America.

https://www.languageline.com
<table>
<thead>
<tr>
<th>Culture Group Language (and sub-group)</th>
<th>Belief Practices</th>
<th>Nutritional Practices</th>
<th>Communication Practices</th>
<th>Patient Care/Role of Caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muslim - Language of the country and some English.</td>
<td>Believe in one God 'Allah' and Mohammed, his prophet, Five daily prayers. Zakat a compulsory giving to the poor. Fasting during the month of Ramadhan. Marriage to woman is the goal of faith.</td>
<td>No pork or alcohol. Fasting only Halal meat type of kosher.</td>
<td>Limit eye contact. Do not touch while talking. Women cover entire body except face and hands.</td>
<td>Do not force foods when it is religiously forbidden. Abortion before 36 weeks is treated as discarded illness. After 36 days as a human being. Before death, the family has the right to refuse medical treatment.</td>
</tr>
<tr>
<td>Northern European Language of the country and some English.</td>
<td>Very similar to American customs. Protestants with large Catholic populations. Multi-ethnic groups.</td>
<td>Comparable to American diet - meat, vegetables, and starches. Coffee, hot tea, and beer.</td>
<td>Courtesy is of utmost importance. Address by surname and maintain personal space and good eye contact.</td>
<td>Maintains modesty still today. Social regard is maintained in respect, even when talking to family. Patience and families tend to question medical authority.</td>
</tr>
<tr>
<td>Philippine English, Spanish, Tagalog (Filipinis).</td>
<td>Catholic. Soul both body and spirit. Biblical Church and faith. Belief that many diseases are the will of God.</td>
<td>Theory of cold and hot food. Certain foods are traditionally eaten hot or cold, e.g. milk is often taken hot. Fish, rice, vegetables, fruit. Heat must be kept hot.</td>
<td>Value and respect elders. Loving, family-oriented. Set aside time for family.</td>
<td>Family decision important. Ignite health-related issues. Often non-compliant in Western medicine. They often have their own beliefs and are more likely to accept alternative medicine. Home remedies, herbal tea, massage, yoga. Subscribes to supernatural causes of illness.</td>
</tr>
<tr>
<td>Southern European Language of the country and some English.</td>
<td>Roman Catholic, Protestant, Greek Catholic, and some Jewish.</td>
<td>Main meal at midday. Pasta, rice, and fish with dressings and wine. Fresh fruit, espresso coffee.</td>
<td>Talkative, very expressive. Direct and to the point. Emotional. Good eye contact. Like personal physical contacts and holding hands, putting on the back, kissing.</td>
<td>Educated yet reluctant to get medical attention. Very independent. Birth control and abortion are not accepted in some countries and not in others. Family gets involved with caring for the ill family member.</td>
</tr>
<tr>
<td>Vietnamese Vietnamese language has several dialects also French, English, Chinese.</td>
<td>Family is very important. Religions include Buddhism, Confucianism, Taoism, Caodaoism, Catholicism, occasional ancestral worship. General respect and harmony. Supernatural is sometimes used as an explanation for disease.</td>
<td>Rice often with vegetables, fish. Sauce added for flavor. Must eat straight and cut into small pieces. Fish is main beverage. Often lactose and alcohol intolerable.</td>
<td>Communication - formal polite manner; limited use of touch. Respect conveyed by non-verbal communication. Use both hands to give something to an adult. Touch someone, please change down and wait. Don't stamp your fingers to gain attention. Persons name used with titles (e.g. &quot;Mr. Bill,&quot; &quot;Doctor Jones.&quot;) &quot;Yes&quot; includes respect, not agreement.</td>
<td>New restrictions are conveyed by silence and selection over refutation of comments. If angry, head is serious, acrid tasting, feet smell, skin blistering, pinching, and itching. Intolerance of illness is unacceptable. Accommodation is used in front. Nodding head to say yes, shaking head to say no. “Yes” is understood as an agreement.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Culture Group Language (and sub-group)</th>
<th>Belief Practices</th>
<th>Nutritional Practices</th>
<th>Communication Practices</th>
<th>Patient Care/Role of Caregivers</th>
</tr>
</thead>
</table>
### Culture Group and Language

<table>
<thead>
<tr>
<th>Culture Group</th>
<th>Belief Practices</th>
<th>Nutritional Preferences</th>
<th>Communication \n\nAwareness</th>
<th>Patient Care/Handling of Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuban Spanish</td>
<td>Catholic with Protestant minority.</td>
<td>Cuban bread, café con leche, Cuban coffee.</td>
<td>Some may have a tendency to be loud when having a discussion. Use their hands for emphasis and credibility and prefer strong eye contact.</td>
<td>Culture requires visiting the sick. The extended family visits the sick to mediate family. It is an insult to the patient if there is not a large family/friend presence.</td>
</tr>
<tr>
<td>Haitian Creole</td>
<td>Catholic and Protestant. Voodoo is practiced. Large social gap exists between wealthy and poor citizens.</td>
<td>Large breakfast and lunch, light dinner. Rice, red pork, beef, and red beans. Herbs and spices.</td>
<td>Quiet, polite, value touch and eye contact.</td>
<td>Quiet, polite, value touch and eye contact. Be deferent to doctor and nurse, but be prepared to ask questions. Use of oxygen as an indication of severe illness. Occasionally pass respirators and home remedies.</td>
</tr>
<tr>
<td>Hindu Hindi</td>
<td>The belief of cyclic birth and reincarnation lies at the heart of Hinduism. The status, conditions, and caste of each life is determined by the behavior in the last life.</td>
<td>Cow is sacred. No beef. Some are strictly vegetarian.</td>
<td>Limit eye contact. Do not touch while talking.</td>
<td>Do not try to force foods when religiously forbidden. Death, the priest may step into a hole around the neck or with the slightest breath. This hole should not be removed. The priest will pour water into the mouth of the body. Family will request to wash the body. Eldest son is responsible for the funeral rites.</td>
</tr>
<tr>
<td>Jamaican English, Patois (broken English)</td>
<td>Christian beliefs dominate (Catholic, Baptist, Anglican). Strong Bantu, fat influences.</td>
<td>Beef, goat, rice, peas, fish, chicken, vegetables, fish, and lots of spices. Some avoid pork and pork products because of religious beliefs.</td>
<td>Respect for older is encouraged. Reserved, avoided hugging, and show affection in public. Curious and tend to ask a lot of questions.</td>
<td>Will try some home remedies before seeking medical help. Tends to be more concerned with procedures. Respectful of doctor's opinion but is reluctant to admit that they are in pain.</td>
</tr>
<tr>
<td>Japanese Japanese</td>
<td></td>
<td>Food presentation is important. Fish and soybeans are main sources of protein, as well as miso and vegetables (some pickled). Rice and miso soup, soy sauce, Japanese rice lettuce are traditional.</td>
<td>Use attitude, actions, and feelings to communicate. Talkative people are considered showy or insinuative. Openness considered a sign of immaturity, lack of self-control. Sincere non-verbal messages are of central importance. Use concepts of hierarchy and status. Avoid sarcasm. Avoid eye contact and touch.</td>
<td>Family role for support is important. Insulted when addressed by first name. Considerateness is very important for honor. Information about illness kept in immediate family. No need to tell anyone. Clot lip or pale not uncommon. Alcohol may cause flushing. Tendancy to control anger. May be reluctant to admit they are in pain.</td>
</tr>
<tr>
<td>Jewish</td>
<td>Jewish people from eastern European countries. English, Hebrew, Yiddish. Three basic groups: Orthodox (most strict), Conservative, Reform (least strict).</td>
<td>Kosher diet is observed. Kosher food is prepared according to Jewish law under rabbinical supervision. Eating of uncleaned animals is forbidden. Blood and animal fats are taboo (blood is synonymous with life). Do not mix meat with dairy products.</td>
<td>Orthodox and some conservatives maintain a kosher diet. Kosher food is prepared according to Jewish law under rabbinical supervision. Eating of uncleaned animals is forbidden. Blood and animal fats are taboo (blood is synonymous with life). Do not mix meat with dairy products.</td>
<td>Orthodox men do not touch women, except their wives. Touch only for hands-on care. Very talkative and known for their friendliness.</td>
</tr>
<tr>
<td>Korean</td>
<td></td>
<td>Family-oriented. Belief in reincarnation. Religions include: Shamanism, Taoism, Buddhism, Confucianism, Christianity. Belief in balance of forces: hot and cold.</td>
<td>Reserved with strangers. Will use code names with familiar individuals. Tongue is important. First names used only for family members. Proud, independent. Children should not be used as translators due to reversal of parent-child relationship.</td>
<td>Family needs to be included in plan of care. Prefer non-contact. Respond to address.</td>
</tr>
<tr>
<td>Mexican Spanish &amp; people of Indian heritage may speak one or more than 50 languages.</td>
<td></td>
<td></td>
<td>Tend to describe emotions by using dramatic body language. Very expressive with grief, but otherwise diplomatic and tacit. Direct confrontation is not.</td>
<td>May believe that culture of circumstances when the patient is ill. Very expressiveness may influence patients compliance with health care. Women do not express their bodies to men or other women.</td>
</tr>
</tbody>
</table>

HRF-07
Rev: 2.4.2013
# A Checklist for Your Medicare Wellness Annual Visit

Please complete this checklist before seeing your doctor or nurse. Your answers will help you receive the best health care possible.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
<th>Date of Birth:</th>
</tr>
</thead>
</table>

1. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
   - Not at all
   - Slightly
   - Moderately
   - Quite a bit
   - Extremely

2. During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors or groups?
   - Not at all
   - Slightly
   - Moderately
   - Quite a bit
   - Extremely

3. During the past 4 weeks, how much bodily pain have you generally had?
   - No pain
   - Very mild pain
   - Mild pain
   - Moderate pain
   - Severe pain

4. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.
   - Yes, as much as I wanted
   - Yes, quite a bit
   - Yes, some
   - Yes, a little
   - No, not at all

5. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
   - Very heavy
   - Heavy
   - Moderate
   - Light
   - Very light

6. Can you get to places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?
   - Yes
   - No

7. Can you shop for groceries or clothes without help?
   - Yes
   - No

8. Can you prepare your own meals?
   - Yes
   - No

9. Can you do your own housework without help?
   - Yes
   - No

10. Can you handle your own money without help?
    - Yes
    - No

11. Do you need help eating, bathing, dressing, or getting around your home?
    - Yes
    - No

12. During the past 4 weeks, how would you rate your health in general?
    - Excellent
    - Very good
    - Good
    - Fair
    - Poor

13. How have things been going for you during the past 4 weeks?
    - Very well, could hardly be better
    - Pretty good
    - Good and bad parts - about equal
    - Pretty bad
    - Very bad – could hardly be worse

14. Are you having difficulties driving your car?
    - Yes, often
    - Sometimes
    - No
    - Not applicable, I do not use a car

Catholic Medical Partners
INDEPENDENT PRACTICE ASSOCIATION
15. Do you always fasten your seat belt when you are in a car?  
- Yes, usually  
- Yes, sometimes  
- No  

16. How often during the past 4 weeks have you been bothered by any of the following problems?  

<table>
<thead>
<tr>
<th>Problem</th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall or dizzy when standing up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble eating well</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teeth or dentures</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Problems using the telephone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tired or fatigued</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. Have you fallen in the past year?  
- Yes  
- No  
If yes, how many times? ________  

18. Are you afraid of falling?  
- Yes  
- No  

19. Are you a smoker?  
- No  
- Yes, and I might quit  
- Yes, but I’m not ready to quit  

20. During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have?  
- 10 or more per week  
- 6-9 per week  
- 2-5 per week  
- 1 drink or less per week  
- No alcohol at all  

21. Do you exercise for about 20 minutes 3 or more days a week?  
- Yes, most of the time  
- Yes, some of the time  
- No, I usually do not exercise that much  

22. Have you been given any information to help you with the following?  
- Hazards in your house that might hurt you?  
  - Yes  
  - No  
- Keeping track of your medications?  
  - Yes  
  - No  

23. How often do you have trouble taking medicines the way you have been told to take them?  
- I do not have to take medicine  
- I always take them as prescribed  
- Sometimes I take them as prescribed  
- I seldom take them as prescribed  

24. How confident are you that you can control and manage most of your health problems?  
- Very confident  
- Somewhat confident  
- Not very confident  
- I do not have any health issues  

25. How old are you?  
- 65–69  
- 70–75  
- 80 or older  

26. Are you male or female?  
- Male  
- Female  

27. What is your race? (Check one or more than one)  
- White  
- Black/African American  
- Asian  
- Native Hawaiian/Other Pacific Islander  
- American Indian/Alaskan Native  
- Hispanic or Latino origin or descent  
- Other  

Patient Signature: ___________________________  Date: ________________
The Healing Time Line

A realistic look at how long it takes for your body to recover after your last puff

- Twenty minutes after quitting, your blood pressure decreases.
- Eight hours: The amount of carbon monoxide in your blood drops back to normal while oxygen increases to normal.
- Forty-eight hours: Your nerve endings start to regenerate, and you can smell and taste things better.
- One to nine months: Coughing, sinus congestion, fatigue, and shortness of breath decrease.
- One year: The added risk of heart disease declines to half of that of a smoker.
- Five years: Your stroke risk may be reduced to that of someone who never smoked.
- Ten years: Your risk of all smoking-related cancers such as lung, mouth, and throat decreases by up to 50 percent.
- Fifteen years: Your risk of heart disease and smoking-related death is now similar to that of someone who never smoked.

Source: American Lung Association
Smoking: 'Why Do I Smoke?' Quiz

Why do I smoke?

If you know the answer to this question, it will be easier to stop smoking because you can find ways to make up for the things you may miss when you stop.

Most people smoke for different reasons at different times. Reasons for smoking include psychological issues, habits, social pressures and physical dependence on nicotine. The questionnaire that follows will help you decide which reasons are important in your smoking.

The 'Why Test'

Next to the following statements, mark the number that best describes your own experience. (5=Always, 4=Most of the time, 3=Once in a while, 2=Rarely, 1=Never)

___ A. I smoke to keep myself from slowing down.
___ B. Handling a cigarette is part of the enjoyment of smoking it.
___ C. Smoking is pleasant and relaxing.
___ D. I light up a cigarette when I feel angry about something.
___ E. When I am out of cigarettes, it's near-torture until I can get more.
___ F. I smoke automatically, without even being aware of it.
___ G. I smoke when people around me are smoking.
___ H. I smoke to perk myself up.
___ I. Part of my enjoyment from smoking is preparing to light up.
___ J. I get pleasure from smoking.
___ K. When I feel uncomfortable or upset, I light up a cigarette.
___ L. When I'm not smoking a cigarette, I'm very much aware of the fact.
___ M. I often light up a cigarette when one is still burning in the ashtray.
___ N. I smoke cigarettes with friends when I am having a good time.
___ O. When I smoke, part of the enjoyment is watching the smoke as I exhale.
___ P. I want a cigarette most often when I am comfortable and relaxed.
___ Q. I smoke when I am "blue" and want to take my mind off what's bothering me.
___ R. I get a real hunger for a cigarette when I haven't had one in a while.
___ S. I've found a cigarette in my mouth and haven't remembered it was there.
___ T. I always smoke when I am out with friends at a party, bar, etc.
___ U. I always smoke cigarettes to get a lift.

Now Score Yourself

Step 1: Transfer the numbers from the quiz to the scorecard that follows by matching up the letters. For example, take the number you wrote for question A on the quiz and enter it on line A of the scorecard.

Step 2: Add each set of 3 scores on the scorecard to get the total for each different category. For example,
to find your score on the "Stimulation" category, add together the scores for questions A, H and U.

The score for each category can range from a low of 3 to a high of 15. A score of 11 or above on any set is high and means that your smoking is probably influenced by that category. A score of 7 or below is low and means that this category is not a primary source of satisfaction to you when you smoke.

'Return to top'

'Why Test' scorecard

"It stimulates me." You feel that smoking gives you energy and keeps you going. Think about alternative ways to boost your energy, such as brisk walking or jogging.
___ A
___ H
___ U
___ "Stimulation" Total

"I want something in my hand." There are a lot of things you can do with your hands without lighting up a cigarette. Try doodling with a pencil, or playing with putty or a fake cigarette.
___ B
___ I
___ O
___ "Handling" Total

"It feels good." You get a lot of physical pleasure from smoking. Various forms of exercise or other activities can be effective alternatives.
___ C
___ J
___ P
___ "Pleasure/Relaxation" Total

"It's a crutch." It can be tough to stop smoking if you find cigarettes comforting in times of stress, but there are many better ways to deal with stress.
___ D
___ K
___ Q
___ "Crutch/Tension" Total

"I'm hooked." In addition to having a psychological addiction to smoking, you may also be physically addicted to nicotine. It's a hard addiction to break, but it can be done. Talk with your doctor about using nicotine replacement therapy (the gum, patch, inhaler or nasal spray) to control your withdrawal symptoms.
___ E
___ L
___ R
___ "Craving/Addiction" Total

"It's part of my routine." If cigarettes are merely part of your routine, stopping should be relatively easy. One key to success is being aware of every cigarette you smoke. Keeping a smoking diary is a good way to do this.
___ F
___ M
___ S
___ "Habit" Total

"I am a social smoker." You smoke when people around you are smoking and when you are offered cigarettes. It is important for you to avoid these situations until you are confident about being a nonsmoker. If you cannot avoid a situation in which others are smoking, remind them that you are a nonsmoker.
___ G
___ N
___ T
Now how do I quit?

Hopefully, this quiz has given you some insight into the reasons why you smoke. You can use this information to help yourself stop smoking. Talk to your doctor about how to stop and how to stay tobacco-free.

Source

Written by familydoctor.org editorial staff.
American Academy of Family Physicians

Reviewed/Updated: 01/08
Created: 09/00
Congratulations on your decision to quit smoking! Quitting is one of the best actions you can take to improve your health. You may be concerned about gaining weight, but try not to worry about it as you quit. Focus on stopping smoking first, and then continue to improve your health in other ways, such as reaching and maintaining a healthy weight for life.

Will I gain weight if I stop smoking?

Not everyone gains weight when they stop smoking. Among people who do, the average weight gain is between 6 and 8 pounds. Roughly 10 percent of people who stop smoking gain a large amount of weight—30 pounds or more.

What causes weight gain after quitting?

When smokers quit, they may gain weight for a number of reasons. These include:

- **Feeling hungry.** Quitting smoking may make a person feel hungrier and eat more than usual, but this feeling usually goes away after several weeks.

- **Having more snacks and alcoholic drinks.** Some people eat more high-fat, high-sugar snacks and drink more alcoholic beverages after they quit smoking.

- **Burning calories at a normal rate again.** Every cigarette you smoke makes your body burn calories faster, but is also harmful to your heart. Once you quit, you are no longer getting this temporary effect. Instead, you are burning slightly fewer calories on a daily basis.
Can I avoid weight gain?

Physical activity and a healthy eating plan may help you control your weight. In addition, being physically active may ease withdrawal symptoms during smoking cessation and help reduce the chances of relapsing after quitting.

While it is a good idea to be physically active and eat healthy foods as you quit smoking, try not to worry about your weight. It may be easier to quit first and focus on controlling your weight when you are smoke-free.

To lower your chances of gaining weight when you stop smoking:
- Accept yourself.
- Get regular, moderate-intensity physical activity.
- Limit snacking and alcohol.
- Consider using medication to help you quit.
- Consider getting professional advice about weight control.

Accept yourself.

If you gain a few pounds when you quit, do not dwell on it. Instead, feel proud that you are improving your health. Quitting smoking may make you feel better in many ways.

Quitting smoking may help you have:
- more energy
- whiter teeth
- fresher breath and fresher smelling clothes and hair
- fewer wrinkles and healthier-looking skin
- a clearer voice

Get regular, moderate-intensity physical activity.

Regular physical activity may help you avoid large weight gains when you quit smoking. It may also boost your mood and help you feel more energetic. It is likely that you will be able to breathe easier during physical activity after you quit smoking.

Aim for at least 30 minutes of moderate-intensity physical activity...
on most days of the week, preferably every day. You can accomplish this by breaking it up into shorter sessions—it does not need to be done all at once. After you quit smoking and are ready to lose weight, you may need to do more than 30 minutes of physical activity a day to achieve your weight loss goals. The ideas below may help you be active.

**Ideas for Being Active Every Day**

- Use your lunch break to walk around and stretch, or take a walk after dinner.
- Sign up for a class such as dance or yoga. Ask a friend to join you.
- Get off the bus one stop early if you are in an area safe for walking.
- Park the car further away from entrances to stores, movie theaters, or your home.
- Take the stairs instead of the elevator. Make sure the stairs are well lit.

**Limit snacking and alcohol.**

Having more high-fat, high-sugar snacks and alcoholic drinks may lead to weight gain when you quit smoking. The ideas below may help you make healthy eating and beverage choices as you quit smoking.

**Tips for Healthy Eating and Beverage Selections as You Quit**

- Do not go too long without eating. Being very hungry may lead to less healthy food choices.
- Eat enough at meals to satisfy you, but try not to overeat. Eat slowly so you can pick up on your body’s signals that you are full.
- Choose healthy snacks, such as fresh fruit or canned fruit packed in juice (not syrup), air-popped popcorn, or low-fat yogurt when you are hungry between meals.
- Do not deny yourself an occasional treat. If you crave ice cream, enjoy a small serving, which is 1/2 cup.
- Choose an herbal tea, hot cocoa made with fat-free milk, or sparkling water instead of an alcoholic beverage.
Consider using medication to help you quit.

Talk to your health care provider about medications that may help you quit smoking. Some people gain less weight when they use medication.

**Medications That May Help You Quit Smoking**

- nicotine replacement therapy, including the patch, gum, nasal spray, and inhaler
- antidepressant medication

The patch and gum are available without a prescription from your health care provider.

Consider getting professional advice about weight control.

You may find it easier to control your weight with the help of a health professional. Ask your health care provider if there is a weight management program in your area. You may also consider speaking with a registered dietitian, nutritionist, or exercise professional about becoming physically active and adopting a healthy eating plan.

**Will weight gain hurt my health?**

Although gaining weight is not desired after you stop smoking, keep in mind that the overall health benefits of quitting outweigh the health risks of weight gain.

**Health Risks of Smoking**

- **Cancer.** Smoking greatly increases the risk of lung cancer, the leading cause of cancer death in the United States. Smoking is also linked to cancer of the esophagus, larynx, kidney, pancreas, and cervix.

- **Other health problems.** Smoking increases the risk of lung disease and heart disease. In pregnant women, smoking is linked to premature birth, low birth weight babies, and delivery complications.

By quitting smoking, you are taking a big step to improve your health. Instead of worrying about weight gain, focus on quitting. Once you are tobacco-free, you can work toward having a healthy weight for life by becoming more physically active and choosing healthier foods.
**Additional Reading**

These brochures from the Weight-control Information Network (WIN) can help you adopt healthy eating and physical activity habits:


*Just Enough for You: About Food Portions.* NIH Publication No. 03–5287.


*Tips to Help You Get Active.* NIH Publication No. 06–5578.

*Walking...A Step in the Right Direction.* NIH Publication No. 04–4155.


**For more information on quitting smoking, contact:**

**American Cancer Society**  
Phone: 1–800–ACS–2345 (800–227–2345)  
Internet: [http://www.cancer.org](http://www.cancer.org)

**American Heart Association**  
Phone: 1–800–AHA–USA1 (800–242–8721)  
Internet: [http://www.americanheart.org](http://www.americanheart.org)

**American Lung Association**  
Phone: (212) 315–8700  
Internet: [http://www.lungusa.org](http://www.lungusa.org)

**National Cancer Institute**  
Phone: 1–800–4–CANCER (800–422–6237)  
1–800–332–8615 (TTY)  
Internet: [http://www.nci.nih.gov](http://www.nci.nih.gov)

**National Institute on Drug Abuse**  
Phone: (301) 443–1124  

**Office of the Surgeon General**  
Internet: [http://www.surgeongeneral.gov/tobacco](http://www.surgeongeneral.gov/tobacco)

**Smokefree.gov** (a partnership of the American Cancer Society, the Centers for Disease Control and Prevention, and the National Cancer Institute)  
Phone: 1–800–QUITNOW (800–784–8669)  
Internet: [http://www.smokefree.gov](http://www.smokefree.gov)
The Weight-control Information Network (WIN) is a service of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) of the National Institutes of Health, which is the Federal Government's lead agency responsible for biomedical research on nutrition and obesity. Authorized by Congress (Public Law 103–43), WIN provides the general public, health professionals, the media, and Congress with up-to-date, science-based health information on weight control, obesity, physical activity, and related nutritional issues.

Publications produced by WIN are reviewed by both NIDDK scientists and outside experts. This fact sheet was also reviewed by Robert Eckel, M.D., Professor of Medicine, Physiology, and Biophysics, University of Colorado Health Sciences Center.
E-Cigarette: Know the facts

What is an e-cigarette?
• E-cigarettes are battery-powered devices that deliver nicotine through a flavored vapor.
• They are made so users can feel like they are inhaling tobacco smoke, without the burning tobacco that occurs with a cigarette.

Are e-cigarettes safe?
• We do not know if e-cigarettes are safe. The e-cigarette is not currently approved by the FDA as an effective method to help smokers quit.
• E-cigarettes release secondhand vapor (not smoke) that can be seen and smelled. Further research is needed to determine any health related consequences.

What do we know about the e-cigarette?
• The amount of nicotine in an e-cigarette varies. Although the e-cigarette cartridges are advertised with specific amounts of nicotine, the U.S. Food and Drug Administration (FDA) testing has shown that their actual amounts do not always match the labeling.
• More research is needed to find out what other ingredients are in the e-cigarettes and what kind of health or other effects they have on people who use them.

What does this information mean?
• There is no current scientific proof that e-cigarettes can help smokers quit.
• FDA approved medications such as nicotine patches or Chantix® are proven to help smokers quit and should be used.
• Medications approved by the FDA in combination with individual or group counseling are shown to be the most successful ways to help smokers quit.

Can I use the e-cigarette for quitting smoking?
• E-cigarettes may be less risky than smoking cigarettes.
• E-cigarettes may aid in stopping smoking.

It is important to talk with a health care provider when considering alternatives to smoking.
How to Help Your Patients Afford Their Medications: 
And Resources to Do So

T or F? Only very low income patients can get extra help to obtain their medications?
T or F? Medicare D is all the extra help seniors can get?

Both are false. An increasing base of patients is having difficulty affording their medication for numerous reasons. Ranging from inability to afford premiums altogether (uninsured), ever increasing co-pays, misunderstanding insurance coverage, chronic or serious conditions requiring multiple medicines and/or very expensive medications and dare I say, “gas prices”. The obvious predicament is, “If a patient cannot afford the treatment prescribed, ALL the effort, labs, and time spent with patient is essentially pointless”. Thankfully, there is an accumulating base of programs designed to assist patients having trouble obtaining their medications, helping to fill some gaps in care.

Goals of This Document:
• Introduce approach to designing a system in your practice that gets this information to patients in need
• Introduce the various drug cost assistance programs available
• Provide resources to enable you and your staff to provide patient drug cost assistance
• Set the stage for incorporation of resources and “How-to’s” into Pharmacy Section of CIPA’s web page

Range of Programs Available:
Abbott Diabetes Care ➔ Xubex Discount Pharmacy Services ➔ ‘$4-generic’ type programs ➔
Co-pay assistance programs ➔ Sleep apnea supplies for uninsured

• There is wide variation in how each program functions compared to the others. However, building an office based drug cost assistance program IS possible and would certainly benefit your patients.
• Perhaps consider the program like you would a specialist. In other words, just as you’d refer a patient with HIV to see a specialist, a patient who can’t afford their medications is in special need of extra care, or your referral to a ‘specialist’. Either way time and paperwork is involved.

PLEASE NOTE: In seeking cost savings for patient, attempt to obtain all necessary medications from a single location, or as few as possible, to ensure the pharmacist filling the prescription has ALL relevant medical records (to prevent drug interactions, etc.). Alternatively, ensure or enable the patient to carry an UPDATED and COMPLETE list of their medications and relevant medical conditions and provides this information to the pharmacist.

To get started, a few things to consider in your practice:
• For visit check-in utilize a visit checklist (if not already doing so) and add a check off question that will help indicate if patient is having trouble affording their medications (or broaden it by wording as having any difficulty obtaining their medications – cost, insurance, pharmacy issues)
  o This process would also afford a quick measure of compliance at the same time
• Recruiting a Volunteer Patient Advocate (VPA) (other practices around the country have successfully done so)
  o ~8hrs a week of dedicated time at your office
  o This volunteer would work with Care Coordinators and Pharm.D. to assist MD and patient in identifying drug cost assistance programs, applying and finally obtaining medications
• If choosing to start a Drug Cost Assistance program within your practice, start small
  o Develop a Drug Cost Assistance Program Formulary
    ▪ i.e., identify meds you use most that are brand only (Byetta, Actos, etc)
    ▪ Allow staff to become familiar with specific drugs chosen and their program process, then build onto formulary over time as appropriate
• Identify meds that you’re having the most trouble obtaining via insurances, contact drug company representatives and have them do in-service or dinner teaching your staff how to go about obtaining prior auth, etc.
  o If given a list of drugs, Pharm.D. could arrange in-service with drug companies and staff
• Adopt, or develop a ‘Patient Assistance Contract’ (example attached)
• Use drug samples as a last resort; avoid having to rely on these for patients month-to-month
• Last but certainly not least, monitor your prescribing habits.
  o Look to Pharmacy Drug Class Reviews (monthly) or other preferred source to evaluate differences among members of the same class of medicine, etc.
  o Participate in CIPA programs
### Common Things You Will Need From/For Each Patient

*(Pharm.D. will develop form that can be utilized, to be posted on CIPA website, pharmacy section)*

<table>
<thead>
<tr>
<th>Patient Demographics</th>
<th>Rx Specifics</th>
<th>Prescriber Specifics</th>
<th>Signed Patient Assistance Contract</th>
</tr>
</thead>
</table>
| ● Name, Address, Phone  
● SSN  
● DOB  
● Diagnosis  
● Citizenship/Residency  
● Proof of Income  
● Application’s consent forms  
● Medicaid or Insurance Denial letters  
● Signature | ● Drug Name  
● Drug Strength  
● Drug Directions  
● Drug Qty/month | ● License #  
● Degree  
● Phone, Address  
● Signature | ● Use form from AAFP  
● Or develop your own |

#### General Program Descriptions

### Assistance Program Databases

These databases should be the basis of your program. Typically they allow a comprehensive, searchable database that allows you to search by company, brand name, generic name or therapeutic drug class.

In other words, if you have a patient who can’t afford Januvia®, and you feel an alternative is not sufficient, simply type in the drug name in the search field and numerous programs for assistance in obtaining Januvia® will load. All contact information and general program specifics is provided as well. From there it’s a matter of paperwork (remember – Volunteer Patient Advocate) and whether or not the patient qualifies. These sites also contain some general forms, example letters, example appeal letters, etc.

- RxAssist ([www.rxassist.org](http://www.rxassist.org))
- NeedyMeds ([www.needymeds.com](http://www.needymeds.com))
- Partnership for Prescription Assistance – PPA ([www.pparx.org](http://www.pparx.org))
- Pharmaceutical Research and Manufacturers of America ([www.PhRMA.org](http://www.PhRMA.org))
- RxHope ([www.RxHope.com](http://www.RxHope.com))
- Volunteers in Health Care ([www.volunteersinhealthcare.org](http://www.volunteersinhealthcare.org))

#### Patient Assistance Programs (PAPs)

Most companies have one or more PAP(s). Although eligibility requirements vary by company, most require that patients: be US citizens or legal residents, have a household income under **200%** of the Federal Poverty Level (FPL) and have prescription coverage.

Patient assistance programs (PAPs) are programs set up by drug companies that offer free or low cost drugs to individuals who are unable to pay for their medication. These programs may also be called indigent drug programs, charitable drug programs or medication assistance programs. Most of the best known and most prescribed drugs can be found in these programs. All of the major drug companies have patient assistance programs, although every company has different eligibility and application requirements.

The Drug companies offer these programs voluntarily; the government does not require them to provide free medicine.

For PAPs be sure to:

- Fill out every part of application
- Include all required documents with the application
- Sign wherever required
- Copy the entire application
- Follow up w/phone call in 2-3wks–where application is in the process (again, remember VPA!)
- Submit an appeal letter if needed if you think patient has compelling case
- Detail the individuals financial and medical situation in the letter and address it to program supervisor

<table>
<thead>
<tr>
<th>Persons in Family Unit</th>
<th>100% FPL</th>
<th>200% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$10,400</td>
<td>$20,800</td>
</tr>
<tr>
<td>2</td>
<td>$14,000</td>
<td>$28,000</td>
</tr>
<tr>
<td>3</td>
<td>$17,600</td>
<td>$35,200</td>
</tr>
<tr>
<td>4</td>
<td>$21,200</td>
<td>$42,400</td>
</tr>
<tr>
<td>5</td>
<td>$24,800</td>
<td>$49,600</td>
</tr>
<tr>
<td>6</td>
<td>$28,400</td>
<td>$56,800</td>
</tr>
<tr>
<td>7</td>
<td>$32,000</td>
<td>$64,000</td>
</tr>
<tr>
<td>8</td>
<td>$35,600</td>
<td>$71,200</td>
</tr>
<tr>
<td>Each Addtl</td>
<td>$3,600</td>
<td>$7,200</td>
</tr>
</tbody>
</table>
**Generic Drug** Patient Assistance Programs

Rx Outreach and Xubex have patient assistance programs comprising of generic medications. These programs differ from all other patient assistance programs in that they are not offered by the pharmaceutical manufacturer of the drug. Programs include several different generic drugs (~250 to ~360) which are purchased by the company and then made available for a fee to low income individuals.

The income levels are more lenient than most PAPs with Rx Outreach at up to 300% of Federal Poverty Level and Xubex at up to 240% of FPL. These programs also do NOT restrict for age or use of another cost saving program or insurance. Cost of medication ranges from $20 to $40 per 90day supply, (for Rx Outreach - regardless of number of pills required).

**NOTE:** Many of the Retail Pharmacies now offer certain generic medications for around $10 to $15 per 90day supply, regardless of income level but with restrictions on number of pills required.

- Rx Outreach ([www.rxoutreach.com](http://www.rxoutreach.com))
- Xubex ([www.xubex.com](http://www.xubex.com))

**Discount Pharmacy or Pharmacy Services (i.e. $4 generic type)**

Many retail pharmacies are now offering discounted prices on select lists of generic drugs. Some offer discounts on brand name medications as well. Most do not require an enrollment fee, restrict age or income. However, typically do require Rx to be filled in the retail store (i.e., not by mail order). Comparison chart below:

<table>
<thead>
<tr>
<th>Company &amp; Link to site</th>
<th># of generics</th>
<th>Brands?</th>
<th>Enrollment fee?</th>
<th>Cost/Rx Qty Limits*</th>
<th>Mail order or In store?</th>
<th>Online Pricing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costco</td>
<td>&gt;100*</td>
<td>Discounts</td>
<td>Costco member only</td>
<td>Variable</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
<tr>
<td>Kmart</td>
<td>&gt;500</td>
<td>None</td>
<td>None</td>
<td>$5/30day, $10 or $15/90day</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
<tr>
<td>Target</td>
<td>&gt;375</td>
<td>None</td>
<td>None</td>
<td>$4/30day, $10/90day</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
<tr>
<td>Walgreens</td>
<td>&gt;400</td>
<td>Discounts</td>
<td>$20/individual, $35/family</td>
<td>$12/90day</td>
<td>Yes</td>
<td>In Store ONLY</td>
</tr>
<tr>
<td>WalMart/Sams Club</td>
<td>&gt;375</td>
<td>None</td>
<td>None</td>
<td>$4/30day, $10/90day</td>
<td>Yes</td>
<td>In Store ONLY</td>
</tr>
<tr>
<td>Wegmans</td>
<td>&gt;200</td>
<td>None</td>
<td>None</td>
<td>$11.99/90day</td>
<td>Yes</td>
<td>In Store ONLY</td>
</tr>
<tr>
<td>Tops</td>
<td>Does not have a similar plan, however will price match any pharmacy within 4 miles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BJ's Wholesale Club Pharmacy, Rite-Aid, and CVS do not offer $4 generic type, other discounts available.

*(not accounting for multiple strengths); **despite Qty limits most of these pharmacies pro-rate price based on discount when qty exceeded.

**Drug Discount Cards and Manufacturer Discount Cards**

These are discount cards offered by for profit or nonprofit entities or pharmaceutical manufacturers which have made arrangements with pharmacies to discount certain drugs. Cards other than those offered by the pharmaceutical manufacturer may have an annual (between $30 and $60 for families) or monthly fee (from $4.75 to $7.95 per month).

**Together RxAccess** ([www.togetherrxaccess.com](http://www.togetherrxaccess.com))

- This card is sponsored by 12 pharmaceutical manufacturers. It is free and offers a 25%-40% discount on 300+ brand-name and generic prescription drugs as well as other prescription products, such as glucose test strips.
- To apply the patient:
  - Cannot be eligible for Medicare
  - Cannot have prescription drug coverage (public or private)
  - Must have a household income equal to or less than $30,000 for one person, $40,000 for a family of two, $50,000 for a family of three, $60,000 for a family of four or $70,000 for a family of five and
  - Must be a legal US resident

**Merck’s Prescription Discount Program** ([Merck Assistance Website](http://Merck Assistance Website))

This card offers 15% to 40% discount on selected Merck medicines to individuals without prescription coverage. Enrollment is free, but you must be a legal U.S. resident to be eligible.

- This program does NOT have age or income limitations
Pfizer Helpful Answers™ (www.pfizerhelpfulanswers.com)
Pfizer Helpful Answers is a family of programs that helps people without prescription coverage save on many Pfizer medicines, no matter their age or income. People with limited incomes might even qualify to get their Pfizer medicines for free.

NOTE: Lower income individuals who have insurance coverage for prescription medicines – such as Medicare, Medicaid or other private insurance – may still be eligible for assistance for their Pfizer medicines if they are experiencing significant financial or medical hardship.

GlaxoSmithKline (Savings Programs Website)
This site covers Medicare D aspects, Partnership for Prescription Assistance, Together RxAccess, GSK Access, Bridges to Access, Commitment to Access, and GSK coupons and other offers.

Many Chronic Disease States Have Organizations Offering Copay or Other Type of Assistance

If an individual has a specific disease or chronic condition, it is always a good idea to check out the local chapter of the national non-profit organization representing that condition. Local chapters may have specific programs or funds available to assist with treatment, supplies, etc. The following national organizations either provide financial assistance to patients or have local chapters that may do so.

Click here for one assembled List of Diseases with support for copay assistance (from RxAssist.org)

T or F? Those with private insurance are unlikely to have problems affording their medications?

In a striking finding, (a) survey said although those without insurance were more likely to report going without care, those WITH INSURANCE had a greater percentage increase in unmet medical needs. http://www.msnbc.msn.com/id/25393546/from/ET/

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Details on Program</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring Voice Coalition</td>
<td>Current programs include: Insurance Reimbursement and Advocacy, Vital Relief (need based financial assistance limited to certain disorders or medical conditions), Compassionate Care (counseling and counseling referrals) and Public Advocacy.</td>
<td><a href="http://www.caringvoice.org">www.caringvoice.org</a></td>
</tr>
<tr>
<td>The Chronic Disease Fund</td>
<td>Its focus is to provide assistance to those under-insured patients who are diagnosed with chronic or life altering diseases that require the use of expensive, specialty therapeutics.</td>
<td><a href="http://www.cdfund.org">http://www.cdfund.org</a></td>
</tr>
<tr>
<td>The HealthWell Foundation</td>
<td>A non-profit organization established to address the needs of individuals who cannot afford their insurance copayments, premiums, coinsurance, or other out-of-pocket health care costs.</td>
<td><a href="http://www.healthwellfoundation.org">www.healthwellfoundation.org</a></td>
</tr>
<tr>
<td>The National Marrow Patient Assistance Program and Financial Assistance Fund</td>
<td>The Marrow Foundation is the fund-raising partner of the National Marrow Donor Program (NMDP). Funds from this program help patients pay for searching the National Marrow Donor Program (NMDP) Registry and/or some post-transplant costs.</td>
<td>marrow.org website</td>
</tr>
<tr>
<td>The Patient Access Network Foundation</td>
<td>A non-profit organization dedicated to supporting the needs of patients that cannot access the treatments they need due to out-of-pocket health care costs.</td>
<td><a href="http://www.patientaccessnetwork.org/">http://www.patientaccessnetwork.org/</a></td>
</tr>
<tr>
<td>The Patient Advocate Foundation</td>
<td>A national non-profit organization that seeks to safeguard patients through effective mediation assuring access to care, maintenance of employment and preservation of their financial stability. The Patient Advocate Foundation's Co-Pay Relief (CPR) Program provides direct co-payment assistance for pharmaceutical products to insured Americans who financially and medically qualify. The Program offers personal service to all patients through the use of CPR call counselors.</td>
<td><a href="http://www.copays.org">www.copays.org</a></td>
</tr>
<tr>
<td>Patient Services Incorporated</td>
<td>A non-profit organization primarily dedicated to subsidizing the high cost of health insurance premiums and pharmacy co-payments for persons with specific chronic illnesses and rare disorders. PSI is committed to assisting persons with chronic medical illnesses in accessing health insurance and pharmacy co-payment assistance. Families requiring assistance in maintaining the high cost of their health insurance premiums or co-payments are offered assistance based upon the severity of medical and financial need. PSI offers a &quot;safety net&quot; for persons who have expensive chronic illnesses and for those persons who &quot;fall through the financial assistance cracks.</td>
<td>PSI Website</td>
</tr>
</tbody>
</table>
**Low Cost Diabetic and Other Medical Supplies**

Assistance is available for diabetic supplies, as well as other supplies and medical equipment such as braces, prosthetic devices, assistive technology, colostomy supplies, eyeglasses, hearing aids, oxygen, and sleep apnea.

***Abbott Diabetes Care Patient Assistance Program*** ([Abbott Diabetes Care Application](http://www.abbott.com/medcare/patientassistance/))
This program is designed to assist financially disadvantaged individuals who meet certain income criteria.

***iPump.org, Inc.*** ([www.ipump.org](http://www.ipump.org))
This organization offers limited reimbursement for diabetes medications, supplies, and insulin to persons who qualify under their "ERMA" (Emergency Request for Medical Assistance) program. They also offer limited monthly financial assistance to qualifying persons to help cover the cost of insulin, diabetes medications and supplies.

***Islets of Hope*** ([Islets of Hope Website](http://www.islets.org/))
This organization lists comprehensive assistance programs by state, as well as international resources for other countries. It includes private, corporate, and government programs.

**Braces and prosthetic devices**
- Limbs for Life at [www.limbsforlife.org](http://www.limbsforlife.org) or 1-888-235-5462
- The Barr Foundation Amputee Assistance Fund at [http://www.oandp.com/resources/organizations/barr/index2.htm](http://www.oandp.com/resources/organizations/barr/index2.htm) or 561-394-6514
- Local Independent Living Resource Centers; find at [www.virtualcil.net/cils/](http://www.virtualcil.net/cils/)
- Other local service based charities, such as United Way, Catholic Charities, Jewish Family and Children’s Services, Lutheran Social Services, etc.

**Colostomy Supplies**
These organizations may be able to put you in touch with local suppliers who might be willing to donate supplies.
- Convatec at 1-800-422-8811 or Hollister Company at 1-800-323-4060. These companies may help on a case by case basis.
- United Ostomy Association of America at [www.uoaa.org](http://www.uoaa.org)
- American Cancer Society at [www.cancer.org](http://www.cancer.org)

**Eyeglasses (for uninsured)**
- Vision USA at [http://www.aoa.org/visionusa.xml](http://www.aoa.org/visionusa.xml)
- Local Lions clubs; find at [http://www.lionsclubs.org/EN/content/vision_index.shtml](http://www.lionsclubs.org/EN/content/vision_index.shtml)
- For uninsured children, contact Sight for Students at [http://www.sightforstudents.org/](http://www.sightforstudents.org/)

**Hearing Aids (for uninsured)**
- Hear Now, at [www.sotheworldmayhear.org/hearnow/](http://www.sotheworldmayhear.org/hearnow/)
- Local Independent Living Resource Centers; find at [www.virtualcil.net/cils/](http://www.virtualcil.net/cils/)

**Oxygen Supplies (for uninsured)**
- American Lung Association at [www.lungusa.org](http://www.lungusa.org) or 1-800-LUNGUSA
- Local suppliers of durable medical equipment who might be willing to provide donated or reduced cost oxygen.

**Sleep Apnea Supplies (for uninsured)**
- American Sleep Apnea Association at [www.sleepapnea.org](http://www.sleepapnea.org) or 202-293-3650
- Awake in America at [www.awakeinamerica.org/DonateRelief/](http://www.awakeinamerica.org/DonateRelief/)
- Local support groups may have programs that can offer assistance.
- Local sleep clinics, pulmonology practices, pharmacies that sell medical equipment or medical equipment suppliers. These entities might donate new or used equipment (e.g., from a patient who has upgraded.) (Cpap Express, etc)

**Medicare Part D Resources**

***Local Independent Health Medicare Information Centers*** ([IHA website](http://www.ihaimhof.org/))
Medicare Information Center in Cheektowaga, located in the Valu Plaza at Dick Rd. and George Urban Blvd.
Seating is limited for all programs. For dates and times or to make a reservation, please call (716) 635-4900 or 1-800-958-4405. TDD users may call (716) 635-4840.
Resources on www.NeedyMeds.org

- **Patient Assistance Programs (PAPs)** Provide medicine at no cost or at a discount to people who qualify
- **Free/Low-Cost/Sliding Scale Clinics** Medical and dental clinics that offer healthcare at no cost, or for a small fee
- **Diagnosis-Based Assistance** Help with the costs associated with various diseases or medical conditions
- **Coupons, Rebates & More** Rebates, discounts or even trial sizes of a medication
- **State Programs** Various types of assistance with healthcare costs
- **Camps & Scholarships** Based on diagnosis

Find help with the cost of medicine at NeedyMeds

www.NeedyMeds.org

Find assistance with
- The cost of prescriptions
- Co-pays and premiums
- Diagnosis-related expenses

Find Assistance.

Find free information on over 5,000 programs

Education.

Learn how to save on your medications and healthcare costs

Savings.

Save up to 80% on prescriptions with our drug discount card

NeedyMeds is a non-profit organization founded in 1997 as a resource for people who need help with the cost of medicine.

www.NeedyMeds.org
PO Box 219, Gloucester, MA 01931
Email: info@needymeds.org
Toll-Free Helpline: 800-503-6897

Supported by a grant from RxOutreach®
Finding No-Cost/Low-Cost Medicine on NeedyMeds

Find a program for your medicine on www.needymeds.org by:

1. Typing the name of your medication in the Drug Search field, or
2. Looking under Brand Name Drugs or Generic Name Drugs under Patient Savings tab
3. Click on the name of your medication to read about available program(s).
4. If your medicine is not on either list, assistance is not currently available through a PAP.

Tips for Applying

• Always call the program if you have questions.
• Look for programs for all your medications.
• Programs change — check back regularly.
• Don’t leave blank spaces on the application. Write N/A if the question doesn’t apply to you.

NeedyMeds Drug Discount Card

Save up to 80% on prescriptions, over-the-counter medicines, medical supplies and pet prescriptions purchased at a pharmacy.

• Always free — no fees or registration
• Can be used by anyone — no financial, age, or residency restrictions
• Anonymous — no personal tracking
• Accepted at over 62,000 pharmacies nationwide
• Use as often as needed
• Never expires
• Share with friends and family

Medical Crowdfunding with NeedyMeds

HEALfundr

Medical crowdfunding is a new way for friends, family and even strangers to help people overburdened with medical expenses.

HEALfundr takes medical crowdfunding to the next step by:

• Verifying medical need
• Simplifying payment of medical expenses
• Counseling campaigners on other medical resources

For more information on HEALfundr, visit: www.healfundr.org
To change behavior... listen to your patient

Does your patient understand the necessity for commitment?

- Present basic information on illness and treatment
- Confirm your patient’s understanding
- Identify your patient’s barriers to change
- Provide positive benefits and alternatives
- Develop realistic goals and roll with resistance
- Review dosage, possible side effects, and other concerns

How will proposed therapy and lifestyle changes impact their daily routine?

- Consider tailoring medication schedule to fit
- Identify dietary needs and problems
- Evaluate patient’s exercise capability
- Set small, achievable targets in a realistic time frame

Is your patient ready to commit to change?

Ask your patients to sign the commitment to adherence (see next page).

Ask them to use the calendar provided to check off each day they take their medicine.

You can place a copy of the page into their patient chart as a reminder to ask about adherence on their next visit.
For the Patient

Adherence Intervention:

3 good questions to ask about your health:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

I understand and I’m ready to make a change for my health.

Please check here:

I commit...

☐ To filling my prescription
☐ To taking my medicine as directed
☐ To refilling my medicine when needed
☐ To keep taking my medicine until you tell me to stop

___________________________________________________________

Patient signature      Date

Use the calendar on the back to keep track of your commitment. Check off each day you take your medicine as your doctor directed.

Bring the calendar with you to your next appointment.
These are the medicines I take:

_________________________________    _________________________________
_________________________________    _________________________________
_________________________________    _________________________________
_________________________________    _________________________________

Check off every day you take your medication. Bring the calendar to your next doctor visit.
Advance Care Planning - Patients & Families

Advance Care Planning is a process of planning for future medical care in case you are unable to make your own decisions. It is a continual process and not merely a document or isolated event.

Advance Care Planning assists you in preparing for a sudden unexpected illness, from which you expect to recover, as well as the dying process and ultimately death. Advance care planning is a gift to you and your family. It allows you to maintain control over how you are treated and to ensure that you experience the type of care and the type of death that you desire.

The advance care planning process involves the following:

- Become Educated about the topic.
- Exploring, clarifying, and documenting your values, beliefs and goals.
- Choosing a Spokesperson (the “Agent” identified in the “Health Care Proxy”) and an Alternate (the “Alternate Agent” indentified in the “Health Care Proxy”) to work with doctors to make decisions on your behalf in case you are unable to speak for yourself.
- Reviewing your wishes and desires about death and dying with your Spokesperson (“Agent”), Alternate, and the people you trust and/or those whose decisions will impact the manner in which you die, e.g. family, spiritual advisor, doctors, layers.
- Completing the forms that identify your Spokesperson (“Agent”) and Alternate and specify your desires and wishes.
- Reviewing and updating these forms periodically or after major life-altering events.
- Conducting ongoing discussions and updates about your wishes and desires about death with your Spokesperson (“Agent”), Alternate, those you trust and/or those who may care for you when you are approaching death.
- Advance care planning begins with conversations among family and other trusted individuals, such as friends, doctors, etc.
- The process builds trust and establishes relationships among family, close friends, health care professionals and others who will care for you or be with you as you approach death. Advance care planning permits peace of mind for you and your family by reducing uncertainty and helping to avoid confusion and conflict over your care.

Remember: Advance Directives apply only when you are unable to make health care decisions and speak for yourself.

Advance Care Planning Booklets can be used to educate yourself about advances care planning, clarify your values, beliefs, and goals, share your wishes with your family, and choose a spokesperson. The Advance Care Planning Booklets include a Health Care Proxy form and a Living Will for you to complete.

www.compassionandsupport.org
**Introduction**

**Patient preferences are often not known**

Predicting what treatments patients will want at the end of life is complicated by the patient’s age, the nature of the illness, the ability of medicine to sustain life, and the emotions families endure when their loved ones are sick and possibly dying. When seriously ill patients are nearing the end of life, they and their families sometimes find it difficult to decide on whether to continue medical treatment and, if so, how much treatment is wanted and for how long. In these instances, patients rely on their physicians or other trusted health professionals for guidance.

In the best of circumstances, the patient, the family, and the physician have held discussions about treatment options, including the length and invasiveness of treatment, chance of success, overall prognosis, and the patient’s quality of life during and after the treatment. Ideally, these discussions would continue as the patient’s condition changed. Frequently, however, such discussions are not held. If the patient becomes incapacitated due to illness, the patient’s family and physician must make decisions based on what they think the patient would want.

**Research can help guide decisionmaking**

This report is intended to show how physicians and other health care professionals can help their patients with advance care planning and assess patient preferences for care at the end of life. Section 1 discusses research findings from studies funded by the Agency for Healthcare Research and Quality (AHRQ), as well as those from other research. For readers who want more detailed information, Section 2 contains charts and tables showing the quantitative results of the studies supported by AHRQ. While no one can predict exactly what patients will want or need when they are sick or dying, this research can help providers offer end-of-life care based on preferences (both real and hypothetical) held by the majority of patients under similar circumstances.1

**Making a Difference**

Patients need more effective advance care planning...Page 2

Patients value advance care planning discussions...Page 3

Physicians can use a structured process for discussions...Page 4

Patient preference patterns can predict other choices...Page 5

Invasiveness and length of treatment affect preferences...Page 6

Treatment patterns are based on prognoses...Page 11
Section 1. Discussion of research findings

AHRQ research indicates that most patients have not participated in advance care planning, yet many are willing to discuss end-of-life care. One way to determine patients’ preferences for end-of-life care is to discuss hypothetical situations and find out their opinions on certain treatment patterns. These opinions can help clarify and predict the preferences they would be likely to have if they should become incapacitated and unable to make their own decisions.

Patients need more effective advance care planning

Studies funded by AHRQ indicate that many patients have not participated in effective advance care planning. The Patient Self-Determination Act guarantees patients the right to accept or refuse treatment and to complete advance medical directives. However, despite patients’ rights to determine their future care, AHRQ research reveals that:

- Less than 50 percent of the severely or terminally ill patients studied had an advance directive in their medical record.
- Only 12 percent of patients with an advance directive had received input from their physician in its development.
- Between 65 and 76 percent of physicians whose patients had an advance directive were not aware that it existed.
- Having an advance directive did not increase documentation in the medical chart regarding patient preferences.
- Advance directives helped make end-of-life decisions in less than half of the cases where a directive existed.
- Advance directives usually were not applicable until the patient became incapacitated and “absolutely, hopelessly ill.”
- Providers and patient surrogates had difficulty knowing when to stop treatment and often waited until the patient had crossed a threshold over to actively dying before the advance directive was invoked.
- Language in advance directives was usually too nonspecific and general to provide clear instruction.
- Surrogates named in the advance directive often were not present to make decisions or were too emotionally overwrought to offer guidance.
- Physicians were only about 65 percent accurate in predicting patient preferences and tended to make errors of undertreatment, even after reviewing the patient’s advance directive.
- Surrogates who were family members tended to make prediction errors of overtreatment, even if they had reviewed or discussed the advance directive with the patient or assisted in its development.

AHRQ research shows that care at the end of life sometimes appears to be inconsistent with the patients’ preferences to forgo life-sustaining treatment and patients may receive care they do not want. For example, one study found that patient preferences to decline cardiopulmonary resuscitation (CPR) were not translated into do-not-resuscitate (DNR) orders. DNR orders are requests from the patient or the patient’s surrogate to the physician that certain forms of treatment or diagnostic testing not be performed. CPR is a procedure frequently addressed in DNR orders. Another study found that patients received life-sustaining treatment at the same rate regardless of their desire to limit treatment.

Patients with chronic illness need advance planning

Because physicians are in the best position to know when to bring up the subject of end-of-life care, they are the ones who need to initiate and guide advance care planning discussions. Such discussions are usually reserved for

Terms patients should understand

Advance directives are also known as living wills. These are formal legal documents specifically authorized by State laws that allow patients to continue their personal autonomy and that provide instructions for care in case they become incapacitated and cannot make decisions. An advance directive may also be a durable power of attorney.

A durable power of attorney is also known as a health care proxy. This document allows the patient to designate a surrogate, a person who will make treatment decisions for the patient if the patient becomes too incapacitated to make such decisions.

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A durable power of attorney is also known as a health care proxy. This document allows the patient to designate a surrogate, a person who will make treatment decisions for the patient if the patient becomes too incapacitated to make such decisions.
people who are terminally ill or whose death is imminent, yet research indicates that people suffering from chronic illness also need advance care planning.

The majority of people who die in the United States (80 to 85 percent) are Medicare beneficiaries age 65 and over, and most die from chronic conditions such as heart disease, cerebrovascular disease, chronic obstructive pulmonary disease (COPD), diabetes, Alzheimer’s disease, and renal failure. Only about 22 percent of deaths in people age 65 and over are from cancer.

People with terminal cancer generally follow an expected course, or “trajectory,” of dying. Many maintain their activities of daily living until about 2 months prior to death, after which most functional disability occurs. In contrast, people with chronic diseases such as heart disease or COPD go through periods of slowly declining health marked by sudden severe episodes of illness requiring hospitalization, from which the patient recovers. This pattern may repeat itself over and over, with the patient’s overall health steadily declining, until the patient dies.

For these individuals there is considerable uncertainty about when death is likely to occur. Patients who suffer from chronic conditions such as stroke, dementia, or the frailty of old age go through a third trajectory of dying, marked by a steady decline in mental and physical ability that finally results in death. Patients are not often told that their chronic disease is terminal, and estimating a time of death for people suffering from chronic conditions is much more difficult than it is for those dying of cancer.

When patients are hospitalized for health crises resulting from their chronic incurable disease, medical treatment cannot cure the underlying illness, but it is still effective in resolving the immediate emergency and thus possibly extending the patient’s life. At any one of these crises the patient may be close to death, yet there often is no clearly recognizable threshold between being very ill and actually dying. Patients may become too incapacitated to speak for themselves, and decisions about which treatments to provide or withhold are usually made jointly between the patient’s physician and family or surrogate.

**Patients value advance care planning discussions**

According to patients who are dying and their families who survive them, lack of communication with physicians and other health care providers causes confusion about medical treatments, conditions and prognoses, and the choices that patients and their families need to make. One AHRQ study indicated that about one-third of patients would discuss advance care planning if the physician brought up the subject and about one-fourth of patients had been under the impression that advance care planning was only for people who were very ill or very old. Only 5 percent of patients stated that they found discussions about advance care planning too difficult.

AHRQ-funded studies have shown that discussing advance care planning and directives with their doctor increased patient satisfaction among patients age 65 years and over. Patients who talked with their families or physicians about their preferences for end-of-life care had less fear and anxiety, felt they had more ability to influence and direct their medical care, believed that their physicians had a better understanding of their wishes, and indicated a greater understanding and comfort level than they had before the discussion. Compared to surrogates of patients who did not have an advance directive, surrogates of patients with an advance directive who had discussed its content with the patient reported greater understanding, better confidence in their ability to predict the patient’s preferences, and a stronger belief in the importance of having an advance directive.

Finally, patients who had advance planning discussions with their physicians continued to discuss and talk about these concerns with their families. Such discussions enabled patients and families to reconcile their differences about end-of-life care and could help the family and physician come to agreement if they should need to make decisions for the patient.

**Opportunities exist for advance planning discussions**

AHRQ studies indicate that physicians can conduct advance care planning discussions with some patients during routine outpatient office visits. Hospitalization for a serious and progressive illness offers another opportunity. The Patient Self-Determination Act requires facilities such as hospitals that accept Medicare and Medicaid money to provide written information to all patients concerning their rights under State law to refuse or accept treatment and to complete advance directives. Patients often send cues to their physicians that they are ready to discuss end-of-life care by talking about wanting to die or asking about hospice. Certain situations, such as approaching death or discussions about prognoses or treatment options that have poor outcomes, also lend themselves to advance care planning discussions. Predicting when patients are near
death is difficult, but providers can ask themselves the question: are the patients “sick enough today that it would not be surprising to find that they had died within the next year (or few months, or 6 months)”?

A structured process for discussions is helpful

Researchers sponsored by AHRQ have suggested a five-part process that physicians can use to structure discussions on end-of-life care:

1. **Initiate a guided discussion.** During this discussion, the physicians should share their medical knowledge of hypothetical scenarios and treatments that are applicable to a patient’s particular situation and find out the patient’s preferences for providing or withholding treatments under certain situations. The hypothetical scenarios should cover a range of possible prognoses and any disability that could result from treatment. By presenting various hypothetical scenarios and probable treatments and noting when the patient’s preferences change from “treat” to “do not treat,” the physician can begin to identify the patient’s personal preferences and values.19

The physician can also determine if the patient has an adequate understanding of the scenario, the treatment, and possible outcomes.19 One AHRQ-funded study indicated that elderly patients have enough knowledge about advance directives, CPR, and artificial nutrition/hydration on which to base decisions for treatment at the end of life, but they do not always understand their realistic chances for a positive outcome.36 Other research indicates that patients significantly overestimate their probability of survival after receiving CPR and have little or no understanding of mechanical ventilation.37 In one study, after patients were told their probability of survival, over half changed their treatment preference from wanting CPR to refusing CPR.38 Patients also may not know of the risks associated with the use of mechanical ventilation that a physician is aware of, such as neurological impairment or cardiac arrest.23

2. **Introduce the subject of advance care planning and offer information.** Patients should be encouraged to complete both an advance directive and durable power of attorney.19 The patient should understand that when no advance directive or durable power of attorney exists, patients essentially leave treatment decisions to their physicians and family members.13 Physicians can provide this information themselves; refer the patient to other educational sources, including brochures or videos; and recommend that the patient talk with clergy or a social worker to answer questions or address concerns.19

3. **Prepare and complete advance care planning documents.** Advance care planning documents should contain specific instructions. AHRQ studies indicate that the standard language contained in advance directives often is not specific enough to be effective in directing care.5 Many times, instructions do not state the cutoff point of the patient’s illness that should be used to discontinue treatment and allow the person to die.5,16 Terms such as “no advanced life support” are too vague to offer guidance on specific treatments.5 If a patient does not want to be on a ventilator, the physician should ask the patient if this is true under all circumstances or only specific circumstances.19 One AHRQ-funded study found that because patient preferences were not clear in advance directives, life-sustaining treatment was discontinued only when it was clearly medically futile.2

4. **Review the patient’s preferences on a regular basis and update documentation.** Patients should be reminded that advance directives can be revised at any time.19 Although AHRQ studies show that patients’ preferences were stable over time when considering hypothetical situations,39,40 other research indicates that patients often changed their minds when confronted with the actual situation or as their health status changed.1 Some patients who stated that they would rather die than endure a certain condition did not choose death once that condition occurred.1

Other research shows that patients who had an advance directive maintained stable treatment preferences 86 percent of the time over a 2-year period, while patients who did not have an advance directive changed their preferences 59 percent of the time.41 Both patients with and patients without a living will were more likely to change their preferences and desire increased treatment once they became hospitalized, suffered an accident, became depressed, or lost functional ability or social activity.41 Another study linked changes in depression to changes in preferences for CPR.42 Increased depression was associated with patients’ changing their initial preference for CPR to refusal of CPR, while less depression was associated with patients’ changing their preference from refusal of CPR to acceptance of CPR.42 It is difficult for people to fully
imagine what a prospective health state might be like. Once they experience that health state, they may find it more or less tolerable than they imagined.

During reviews of advance directives, physicians should note which preferences stay the same and which change. Preferences that change indicate that the physician needs to investigate the basis for the change.¹⁹

5. Apply the patient’s desires to actual circumstances.
Conflicts sometimes arise during discussions about end-of-life decisionmaking. AHRQ-sponsored research indicates that if patients desired nonbeneficial treatments or refused beneficial treatments, most physicians stated that they would negotiate with them, trying to educate and convince them to either forgo a nonbeneficial treatment or to accept a beneficial treatment. If the treatment was not harmful, expensive, or complicated, about one-third of physicians would allow the patient to receive a nonbeneficial treatment. Physicians stated that they would also enlist the family’s help or seek a second opinion from another physician.⁴³

Many patients do not lose their decisionmaking capacity at the end of life. Physicians and family members can continue discussing treatment preferences with these patients as their condition changes.¹⁴ However, physicians and families may encounter the difficulty of knowing when an advance directive should become applicable for patients who are extremely sick and have lost their decisionmaking capacity but are not necessarily dying.² There is no easy answer to this dilemma. One AHRQ study found that advance directives were invoked only once patients had crossed a threshold to being “absolutely, hopelessly ill.”²² The patients’ physicians and surrogates determined that boundary on an individual basis.² AHRQ studies have shown that patients’ treatment was generally consistent with their preferences if those preferences were clearly stated in an advance directive and the physician was aware that they had an advance directive.²,¹⁴

Even if patients require a decision for a situation that was not anticipated and addressed in their advance directive, physicians and surrogates still can make an educated determination based on the knowledge they have about the patients’ values, goals, and thresholds for treatment.¹⁹ AHRQ research indicates that patients choose treatment based on the quality of the prospective health state, the invasiveness and length of treatment, and possible outcomes.

Patients have preference patterns for hypothetical situations

AHRQ-funded studies indicate that patients are more likely to accept treatment for conditions they consider better than death and to refuse treatment for conditions they consider worse than death.⁹ Results from the study conducted on health states considered worse than death are shown in Figures 1 and 2 of Section 2 in this report. Patients also were more likely to accept treatments that were less invasive such as CPR than invasive treatments such as mechanical ventilation (Figure 3).¹⁷,³⁹,⁴⁴ Patients were more likely to accept short-term or simple treatments such as antibiotics than long-term invasive treatments such as permanent tube feeding (Figures 4-6 and Table 1).

Patient preference patterns can predict other choices

Acceptance or refusal of invasive and noninvasive treatments under certain circumstances can predict what other choices the patient would make under the same or different circumstances. According to AHRQ research, patients’ refusal of noninvasive treatments was predictive of their refusal of invasive treatments, and accepting invasive treatments predicted their acceptance of noninvasive treatments. Refusal of noninvasive treatments such as antibiotics strongly predicted that invasive treatments such as major surgery would also be refused. Decisions with the strongest predictive ability were refusing antibiotics or simple tests and accepting major surgery or dialysis (Table 2).⁴⁵

AHRQ research also reveals that patients were more likely to refuse treatment under hypothetical conditions as their prognosis became worse.⁷,³² For example, more adults would refuse both invasive and noninvasive treatments for a scenario of dementia with a terminal illness than for dementia only (Figure 7). Adults were also more likely to refuse treatment for a scenario of a persistent vegetative state than for a coma with a chance of recovery (Figure 8). More patients preferred treatment if there was even a slight chance for recovery from a coma or a stroke (Figure ⁹).³² Fewer patients would want complicated and invasive treatments if they had a terminal illness (Figure 10). Finally, patients were more likely to want treatment if they would remain cognitively intact rather than impaired (Figure 11).
AHRQ funds studies to improve end-of-life care

AHRQ continues to fund research to improve the quality of care at the end of life. Ongoing AHRQ research includes the following studies.

• **Impact of Ethics Consultation in the Intensive Care Unit**; University of California, San Diego, Grant No. R01 HS10251. This project examines the benefits of ethics consultations between families and hospital staff and whether such consultations reduce resource use.

• **Nursing Home Care at the End of Life: Cost and Quality**; Brown University, Grant No. R01 HS10549. This research project is testing preliminary findings indicating that hospice care in nursing homes positively influences pain management, acute hospitalization rates, and terminal care costs.

• **Improving Physician Skill at Providing End-of-Life Care**; University of Washington, Grant No. R01 HS11425. This study will identify specific strengths and weaknesses in the end-of-life care provided by physicians. Researchers will then develop educational and systemic interventions to improve the quality of end-of-life care.

• **Medical Care at End of Life: Rural vs. Urban Minnesota**; Duluth Clinic, Ltd., Grant No. R03 HS13022. This research project is investigating similarities and differences in end-of-life care among rural and urban nursing home residents with severe cognitive impairment.

• **Center for Patient Safety at the End of Life**; Rand Corporation, Grant No. P20 HS11558. The Center’s focus is to improve the reliability of health care by effecting change and educating providers about safe and correct care of patients with chronic heart failure or chronic obstructive pulmonary disease.

Advance planning helps physicians provide care that patients want

Most people will eventually die from chronic conditions. These patients require the same kind of advance care planning as those suffering from predictably terminal conditions such as cancer. Understanding preferences for medical treatment in patients suffering from chronic illness requires that physicians and other health care providers consider patients’ concerns about the severity of prospective health states, length and invasiveness of treatments, and prognosis. While predicting what patients might want is difficult, AHRQ research offers some insights into treatment patterns and preferences under hypothetical situations that can give providers more insight into their patients’ desires under similar circumstances. By discussing advance care planning during routine outpatient visits, during hospitalization for exacerbation of illness, or when the patient or physician believes death is near, physicians can improve patient satisfaction with care and provide care at the end of life that is in accordance with the patient’s wishes.

Section 2. Patient preferences for treatment

The results from AHRQ research presented in this section were collected from studies conducted with patients, many of whom were suffering from chronic disease, and physicians. Given hypothetical situations, patients described patterns of preferences for care based on health status, invasiveness and length of treatment, and prognosis.

Patients view some health states as worse than death

AHRQ research shows that adults of various ages whose current health states ranged from well to terminally ill differed in their perception of hypothetical health states as being worse than death (Figure 1). For example, 66 percent of younger well adults rated permanent coma as being worse than death, compared to only 28 percent of nursing home residents. However, the proportions of adults rating dementia as being worse than death were similar among all groups, ranging from 18 to 31 percent.

Patients were more likely to accept life-sustaining treatment for states they considered better than death than for states they considered worse than death. For example, of all the hypothetical health states posed, patients were least likely to indicate that they would want CPR if they were in a permanent coma (Figure 2).

Invasiveness and length of treatment affect preferences

Patients were more likely to accept life-sustaining treatment based on how invasive they perceive that treatment to be and how long the treatment is expected to last. Presented with hypothetical scenarios, patients from three AHRQ studies were more likely to want CPR than long-term mechanical ventilation if they were in their current state of health (Figure 3). When given a hypothetical scenario of a stroke, fewer patients would opt for either CPR or mechanical ventilation.
Younger well adults
Older well adults
Persons with chronic illness
Persons with terminal cancer
Persons with AIDS
Stroke survivors
Nursing home residents

Permanent Coma

Percent

20
40
60
80

Younger well adults
Older well adults
Persons with chronic illness
Persons with terminal cancer
Persons with AIDS
Stroke survivors
Nursing home residents

Dementia

Percent

20
40
60
80

Younger well adults
Older well adults
Persons with chronic illness
Persons with terminal cancer
Persons with AIDS
Stroke survivors
Nursing home residents

Severe stroke

Percent

20
40
60
80

Younger well adults
Older well adults
Persons with chronic illness
Persons with terminal cancer
Persons with AIDS
Stroke survivors
Nursing home residents

Severe pain

Percent

20
40
60
80

Younger well adults
Older well adults
Persons with chronic illness
Persons with terminal cancer
Persons with AIDS
Stroke survivors
Nursing home residents

*Sample included 50 well adults ages 21-65 years, 49 well adults older than 65, 49 older adults with chronic illness, 48 adults with terminal cancer, 50 adults with AIDS, 45 stroke survivors, and 50 nursing home residents.

Figure 2. Percent of sampled adults who would want cardiopulmonary resuscitation if in hypothetical health states

- Current health: 77%
- Permanent coma: 15%
- Dementia: 40%
- Severe stroke: 35%
- Severe pain: 37%

*Sample included 50 well adults ages 21-65 years, 49 well adults older than 65, 49 older adults with chronic illness, 48 adults with terminal cancer, 50 adults with AIDS, 45 stroke survivors, and 50 nursing home residents.


Figure 3. Percent of adults who would want cardiopulmonary resuscitation (CPR) or long-term mechanical ventilation if in current health or after hypothetical stroke

- CPR (current health): 77%
- Ventilator (current health): 86%
- CPR (stroke): 42%
- Ventilator (stroke): 23%

*Sample included 50 well adults ages 21-65 years, 49 well adults older than 65, 49 older adults with chronic illness, 48 adults with terminal cancer, 50 adults with AIDS, 45 stroke survivors, and 50 nursing home residents.


*bPatients were 65 years or over with at least 1 chronic disease, at least 1 visit to the physician in the past 6 months and 2 visits in the past year, no dementia, and not terminally ill.


*cPatients were 65 years or over with at least 1 chronic disease, at least 2 visits to the physician in the last 12 months, no dementia, and not terminally ill.

In the AHRQ study examining health states worse than death, patients were more likely to accept short-term mechanical ventilation than long-term mechanical ventilation for all health states (Figure 4).³⁹

When asked to consider a hypothetical scenario of chronic lung disease, the majority of elderly patients wanted resuscitation but not the use of a long-term ventilator.⁴⁴ These results are comparable to the preferences of patients actually suffering from lung cancer or COPD, who were also less likely to want the use of a ventilator than to want resuscitation only (Figure 5).⁴⁷

For all health states, patients were more likely to accept treatment on a trial basis if the treatments were simple, such as receiving antibiotics (Figure 6).³⁹ In another AHRQ-funded study, patients age 64 and over were more inclined to choose simple treatments such as antibiotics and blood transfusion for their current state of health as well as future hypothetical states of being mentally confused or unconscious (Table 1).⁴⁶ Patients also preferred temporary respiration and tube feeding to permanent respiration and tube feeding.⁴⁶

Patterns regarding invasiveness can predict patient preferences

AHRQ studies show that declining antibiotics, noninvasive diagnostics, and intravenous fluids strongly predicted that more invasive treatments such as major surgery would also be refused (Table 2). Conversely, accepting more invasive treatments such as a major operation or dialysis was the strongest predictor that the patient would accept less invasive treatments, although it was not as strongly predictive as refusing a noninvasive treatment. Although refusing CPR or mechanical ventilation has some ability to predict a patient’s refusal or acceptance of other treatments, a patient’s refusal of resuscitation does not necessarily predict that the patient would decline other less invasive treatments.⁴⁵

Treatments that the patient considered comparable were predictive of each other. For example, refusing resuscitation was predictive of refusing major surgery, and refusing mechanical ventilation was predictive of refusing dialysis. Accepting a procedure such as endoscopy was predictive of accepting minor surgery, and accepting intravenous hydration or artificial nutrition were predictive of each other.⁴⁵

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Figure 4. Percent of sampled adults who would want short-term or long-term mechanical ventilation if in hypothetical health states⁶

<table>
<thead>
<tr>
<th>Health State</th>
<th>Short Term</th>
<th>Long Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current health</td>
<td>88</td>
<td>42</td>
</tr>
<tr>
<td>Permanent coma</td>
<td>29</td>
<td>14</td>
</tr>
<tr>
<td>Dementia</td>
<td>56</td>
<td>23</td>
</tr>
<tr>
<td>Severe stroke</td>
<td>59</td>
<td>23</td>
</tr>
<tr>
<td>Severe pain</td>
<td>44</td>
<td>18</td>
</tr>
</tbody>
</table>

⁶Sample included 50 well adults ages 21-65 years, 49 well adults older than 65, 49 older adults with chronic illness, 48 adults with terminal cancer, 50 adults with AIDS, 45 stroke survivors, and 50 nursing home residents.

Figure 5. Percent of adults who would want resuscitation or use of a ventilator for a hypothetical scenario of chronic lung disease

<table>
<thead>
<tr>
<th></th>
<th>Age 65 and older&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Lung cancer&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Chronic obstructive pulmonary disease&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation</td>
<td>73</td>
<td>63</td>
<td>63</td>
</tr>
<tr>
<td>Long-term ventilator</td>
<td>24</td>
<td>19</td>
<td>22</td>
</tr>
</tbody>
</table>

<sup>a</sup>Patients were 65 years or over with at least 1 chronic disease, at least 1 visit to the physician in the past 6 months and 2 visits in the past year, no dementia, and not terminally ill.  


Figure 6. Percent of sampled adults who would want selected treatments if in hypothetical health states<sup>a</sup>

<table>
<thead>
<tr>
<th></th>
<th>Antibiotics</th>
<th>Hemodialysis</th>
<th>Artificial nutrition/hydration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current health</td>
<td>95</td>
<td>75</td>
<td>59</td>
</tr>
<tr>
<td>Permanent coma</td>
<td>38</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Dementia</td>
<td>80</td>
<td>44</td>
<td>36</td>
</tr>
<tr>
<td>Severe stroke</td>
<td>72</td>
<td>37</td>
<td>33</td>
</tr>
<tr>
<td>Severe pain</td>
<td>61</td>
<td>42</td>
<td>33</td>
</tr>
</tbody>
</table>

<sup>a</sup>Sample included 50 well adults ages 21-65 years, 49 well adults older than 65, 49 older adults with chronic illness, 48 adults with terminal cancer, 50 adults with AIDS, 45 stroke survivors, and 50 nursing home residents.  
Treatment preference patterns are based on prognoses

According to AHRQ research, patients were consistently more likely to refuse treatment for a scenario with a worse prognosis. For example, more adult patients would refuse treatment if they had dementia with a terminal illness than if they only had dementia (Figure 7).32 Similarly, more patients would refuse treatment for a persistent vegetative state than they would if they were in a coma with a chance of recovery (Figure 8).32 Prognosis was a significant factor for patients age 65 and over in determining whether or not to accept life-sustaining treatment. Patients were more likely to choose antibiotics, cardiopulmonary resuscitation, surgery, and artificial nutrition/hydration when there was even a slight chance of recovery from a stroke or a coma than when there was no hope of recovery (Figure 9).

Patients also were more likely to want treatment if terminal cancer had no associated pain than if pain medication was required constantly.7

An AHRQ-funded study of patients age 75 and over and patients with chronic disease indicates that as treatments become more complicated and invasive, fewer patients would want them if they had a terminal illness (Figure 10).48 The results of other research on preferences for care in the case of terminal illness conducted among the elderly, the majority of whom had chronic illnesses, are also shown in Figure 10.49

Patients prefer treatment if they will retain cognitive awareness

AHRQ-funded research showed that about two-thirds (66 percent) of patients age 64 and over who were admitted to a hospital’s internal medicine department but were not acutely ill had a cognitive-dependent treatment pattern: they desired less treatment if they were to become more cognitively impaired.46 Another AHRQ-funded study showed that elderly patients are far less likely to accept treatment if presented a hypothetical scenario for a cognitive impairment such as Alzheimer’s disease than for a physical impairment such as emphysema (Figure 11).7

For more information

For further information on care at the end of life, please contact Ronda Hughes, Ph.D., at rhughes@ahrq.gov or by telephone at 301-594-0198.
Figure 7. Percent of adults refusing selected treatments for hypothetical health scenarios of dementia or dementia with a terminal illness

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Dementia</th>
<th>Dementia and terminal illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiopulmonary resuscitation</td>
<td>72</td>
<td>84</td>
</tr>
<tr>
<td>Mechanical respiration</td>
<td>75</td>
<td>84</td>
</tr>
<tr>
<td>Intravenous fluids</td>
<td>73</td>
<td>82</td>
</tr>
<tr>
<td>Artificial nutrition</td>
<td>76</td>
<td>82</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>74</td>
<td>82</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>69</td>
<td>79</td>
</tr>
<tr>
<td>Renal dialysis</td>
<td>75</td>
<td>83</td>
</tr>
<tr>
<td>Major surgery</td>
<td>77</td>
<td>85</td>
</tr>
<tr>
<td>Minor surgery</td>
<td>71</td>
<td>81</td>
</tr>
<tr>
<td>Simple diagnostic procedures</td>
<td>64</td>
<td>75</td>
</tr>
<tr>
<td>Complex diagnostic procedures</td>
<td>73</td>
<td>83</td>
</tr>
</tbody>
</table>

*Sample included adult outpatients of primary care physicians and members of the general public.

Figure 8. Percent of adults refusing selected treatments in hypothetical health scenarios of coma with a chance of recovery or a persistent vegetative state

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Coma with chance of recovery</th>
<th>Persistent vegetative state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiopulmonary resuscitation</td>
<td>55</td>
<td>83</td>
</tr>
<tr>
<td>Mechanical respiration</td>
<td>55</td>
<td>80</td>
</tr>
<tr>
<td>Intravenous fluids</td>
<td>51</td>
<td>77</td>
</tr>
<tr>
<td>Artificial nutrition</td>
<td>60</td>
<td>80</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>53</td>
<td>81</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>49</td>
<td>76</td>
</tr>
<tr>
<td>Renal dialysis</td>
<td>57</td>
<td>80</td>
</tr>
<tr>
<td>Major surgery</td>
<td>61</td>
<td>83</td>
</tr>
<tr>
<td>Minor surgery</td>
<td>56</td>
<td>80</td>
</tr>
<tr>
<td>Simple diagnostic procedures</td>
<td>48</td>
<td>70</td>
</tr>
<tr>
<td>Complex diagnostic procedures</td>
<td>55</td>
<td>78</td>
</tr>
</tbody>
</table>

*Sample included adult outpatients of primary care physicians and members of the general public.

Figure 9. Percent of elderly adults choosing selected treatments in hypothetical scenarios based on chance of recovery or presence of pain

<table>
<thead>
<tr>
<th>Treatment</th>
<th>No Chance</th>
<th>Slight Chance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coma</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Coma (slight chance)</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Stroke (no chance)</td>
<td>26</td>
<td>20</td>
</tr>
<tr>
<td>Stroke (slight chance)</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Terminal cancer (with pain)</td>
<td>22</td>
<td>18</td>
</tr>
<tr>
<td>Terminal cancer (without pain)</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Artificial nutrition/hydration</td>
<td>52</td>
<td>44</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>49</td>
<td>38</td>
</tr>
<tr>
<td>Gallbladder surgery</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Cardiopulmonary resuscitation</td>
<td>58</td>
<td>24</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>58</td>
<td>24</td>
</tr>
</tbody>
</table>


Figure 10. Percent of patients choosing selected treatments in hypothetical scenarios of terminal illness

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Ages 65-99</th>
<th>Age 75 and over or ages 50-74</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization</td>
<td>58</td>
<td>47</td>
</tr>
<tr>
<td>Intensive care</td>
<td>49</td>
<td>34</td>
</tr>
<tr>
<td>Cardiopulmonary resuscitation</td>
<td>44</td>
<td>27</td>
</tr>
<tr>
<td>Artificial nutrition/hydration</td>
<td>37</td>
<td>18</td>
</tr>
<tr>
<td>Ventilation</td>
<td>27</td>
<td>19</td>
</tr>
<tr>
<td>Surgery</td>
<td>15</td>
<td>24</td>
</tr>
</tbody>
</table>


Figure 11. Percent of elderly adults choosing selected treatments in hypothetical scenarios of Alzheimer’s disease or emphysema

AHRQ-Sponsored/Funded Research Projects on End-of-Life Care

Quality-of-Life Factors in Geriatric Medicine Decisions, 1984-86, Grant No. HS05303, University of Washington: Compared similarities and differences among elderly patients, spouses, and physicians regarding their quality-of-life values.

Effects of Advance Directives on Medical Care, 1987-91, Grant No. HS05617, University of California, San Diego: Examined the effect of advance directives on the costs of health care, satisfaction with health care, and well-being among patients with life-threatening illnesses.

Living Wills: For Primary Care, AIDS, and Cancer Patients, 1989-91, Grant No. HS06120, Massachusetts General Hospital: Studied use of living wills, stability of preferences, and discussions between physicians and ambulatory patients.

Long-Term Stability of Treatment Preferences, 1989-95, Grant No. HS06343, University of Washington: Determined the long-term stability and predictive validity of preferences for life-sustaining treatment and health states that patients consider worse than death.

Making Choices and Allocating Resources Near Life’s End, 1990-95, Grant No. HS06655, University of North Carolina: Explored treatment preferences and congruency among elderly patients with severe heart disease, lung disease, and cancer.

Advance Directives—Effectiveness of Mandatory Notice, 1991-94, Grant No. HS07075, Dartmouth College: Investigated the impact of the Patient Self-Determination Act, use of advance directives, and treatment preferences of severely ill patients.

Advance Directives and Communication in Medical Care, 1991-96, Grant No. HS06912, University of California, San Diego: Studied the effects of advance directives on personal autonomy, cost of health care, well-being, and patient-physician communication among patients with life-threatening illness.

Nursing Home Residents’ Treatment Preferences, 1992-95, Grant No. HS06815, University of Pennsylvania: Examined the use of advance directives in nursing homes to ascertain whether there were institutional and/or individual factors associated with treatment preferences.

Advance Directive Discussions With Elderly Outpatients, 1993-95, Grant No. HS07660, Kent State University: Analyzed the impact of physician-initiated discussions regarding advance directives and physicians’ ability to predict treatment preferences of their elderly outpatients.

Ethnicity and Attitudes Toward Advance Care Directives, 1993-96, Grant No. HS07001, University of Southern California: Explored attitudes toward medical technology, withholding and withdrawing treatment, and advance care documents among different ethnic groups.

Advance Directives, Proxies, and Electronic Medical Records, 1993-97, Grant No. HS07632, Indiana University: Studied the ability to encourage discussions about advance directives and documentation of patient treatment preferences through a computer system.

Systematic Application of a Health Care Directive, 1994-98, Grant No. HS07878, McMaster University: Examined the effects of the systematic application of the Let Me Decide directive on patient and family satisfaction with health care, health care use, and health care costs among nursing home residents.

Resource Use in Seriously Ill Medicare Patients, 1995-98, Grant Nos. HS08158/HS09129, Dartmouth College: Investigated Medicare beneficiaries’ utilization of services, the Study to Understand Prognoses and Preference for Outcomes and Risks of Treatment (SUPPORT) intervention to improve decisionmaking, and implementation of the Patient Self-Determination Act.

Testing the Effectiveness of Advance Medical Directives, 1995-2001, Grant No. HS08180, Kent State University: Compared different methods of collecting advance directive information to improve surrogates’ ability to predict patient preferences for life-sustaining treatment and measured stability of patient treatment preferences over time.


A Detailed Profile of End-of-Life Care in Medicare, 1999-2001, Grant No. HS10561, RAND Corporation: Investigated health care use among Medicare beneficiaries at the end of life.
References


*AHRQ-funded/sponsored research


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