Division of Mental Health and Addiction

Funded by SAMHSA through NASMHPD

Indiana Community Health Worker Training Manual

ASPIN

Day 1	Day 2	Day 3	Day 4 (CRS)	Day 5 (CRS)
1. Introduction **8:30 – 9:30**	**7. Communication Skills** **8:30 – 9:30**	**13. Motivational Interviewing** **8:30 – 9:30**	**19. Role of Peer Support** **8:30 – 9:30**	**25. Mental Disorders** **8:30 – 9:30**
2. Core CHW and CHW/CRS Skills **9:30 – 10:30**	**8. Practices That Promote Health and Wellness** **9:30 – 10:30**	**14. Coaching Consumers for Positive Health Outcomes** **9:30 – 10:30**	**20. Personal Safety** **9:30 – 10:30**	**26. Addiction Overview** **9:30 – 10:30**
BREAK: 10:30 – 10:45	BREAK: 10:30 – 10:45	BREAK: 10:30 – 10:45	BREAK: 10:30 – 10:45	BREAK: 10:30 – 10:45
3. Ethics **10:45 – 11:45**	**9. Physical Health/Chronic Disease Overview** **10:45 – 11:45**	**15. Tobacco Treatment** **10:45 – 11:45**	**21. Home Visits** **10:45 – 11:45**	**27. Co-occurring Disorders and Recovery** **10:45 – 11:45**
LUNCH: 11:45 – 12:45	LUNCH: 11:45 – 12:45	LUNCH: 11:45 – 12:45	LUNCH: 11:45 – 12:45	LUNCH: 11:45 – 12:45
4. Diversity/Cultural Competency **12:45 – 1:45**	**10. Behavioral Health Overview** **12:45 – 1:45**	**16. Group Facilitation Skills** **12:45 – 1:45**	**22. Securing Employment as a CHW/CRS** **12:45 – 1:45**	**28. Wellness Recovery Action Plan** **12:45 – 1:45**
5. Conflict Management **1:45 – 2:45**	**11. Substance Use Disorders** **1:45 – 2:45**	**17. Advocacy, Collaboration and Teamwork** **1:45 – 2:45**	**23. Personal Supports: Medical Appts. and PAD** **1:45 – 2:45**	**29. Telling Your Recovery Story** **1:45 – 2:45**
BREAK: 2:45 – 3:00	BREAK: 2:45 – 3:00	BREAK: 2:45 – 3:00	BREAK: 2:45 – 3:00	BREAK: 2:45 – 3:00
6. Technology **3:00 – 4:00**	**12. Integrated Care Model** **3:00 – 4:00**	**18. Wrap-Up Test Preparation (CHW)/ Building Your Recovery Story (CRS)** **3:00 -4:00**	**24. Managing Finances** **3:00 – 4:00**	**30. Wrap-Up/Test Preparation** **3:00 – 4:00**

Module 1

Introduction

Module 1
Introduction

Indiana
Community Health Worker
Integrated Care
Training Program

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Objectives

1) Introduce students and instructor
2) Establish classroom expectations
3) Clarify schedule and course work
4) Identify common experiences to build group relationships

We Are Glad You Are Here!

Tasks

1. Sign in
2. Introductions
3. Orientation to the facility
4. Create our Ground Rules
5. Understand our Connectedness
6. Complete module evaluation
7. Look ahead

Meeting Our Needs

- Restroom location
- Breaks throughout the day
- Lunch schedule
- Ending time

Schedule

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How Can We Get the Most from Class?

What rules do we need to maintain a respectful environment for all of us?

Personal Experience Worksheet

- Complete Personal Experience Worksheet
- Meet in pairs
- Share from worksheets
- Introduce one another

How Are We Alike?

Evaluation Process

- Complete for each module – documents you stayed for the whole module
- Course evaluation at end of Day 3 (CHWs) or Day 5 (CRSs)
- Evaluations help the program to improve!

Conclusion

In this module we:

- Introduced students and instructor
- Established classroom expectations
- Clarified schedule and course work
- Identified common experiences to build group relationships

Evaluation

Please complete the module evaluation.

Name: _____

Personal Experience Worksheet

Please respond to the following questions using the space provided. If you do not have enough space, you may write on the back of this sheet.	
1. Provide an example of a situation where you received help from someone from within your community (not your own family) that was particularly meaningful.	
2. Considering the situation above, what assisted you in trusting the person who helped you?	
3. Name a circumstance where you provided help to someone outside of your family. (Please omit identifying information.)	
4. What was the person's reaction to you in the situation from Question 3?	
5. Describe an instance when you taught someone something. What feedback did you get as a teacher?	

Module 2

Core CHW and CHW/CRS Skills

Module 2
Core CHW and CHW/CRS Skills

Indiana
Community Health Worker
Integrated Care
Training Program

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Objectives

1) Understand the role of a CHW and CHW/CRS
2) Understand the public health approach to community wellness
3) Recognize health disparities specific to Indiana

Watch Video

Community Health Worker - CA4Health
California Health Workforce Alliance

Community Health Worker

The common elements of definitions of a Community Health Worker included:

- Membership in, or a special relationship with, a defined community
- Defines roles and functions
- Suggests an underlying purpose, such as to:
  - Improve access and promote equity

Certified Recovery Specialist

- Certified Recovery Specialists are in recovery from mental illness and/or addiction and are dedicated to assisting others in recovery with a lens for whole health.
- The Certified Recovery Specialist is a special designation of a Community Health Worker. They are also:
  - Trusted members of, deeply understands the community he/she serves
  - Liaison between health and social services and the community

Why the Interest in CHWs?

The current interest in CHWs can be attributed to:

- Diversity of population
- Growing prevalence of chronic diseases
- Growing complexity of health care
- Recognition of social/behavioral determinants of health
- Commitment to reducing health inequities
- Cost pressures on system
- Shortages of clinical personnel limiting time with patients

CHW Core Skills

1. Outreach and engagement
2. Individual and group teaching skills
3. Whole health coaching, action planning, documentation skills and use of technology
4. Interpersonal & communication skills
5. Confidentiality skills
6. Advocacy skills
7. Service coordination and navigation
8. Capacity building skills
9. Financial management
10. Motivational interviewing skills
11. Cultural adaptation skills

CHW Integration into the Workforce

- Already in the field under various titles
- If new position:
  - Regularly scheduled meetings/huddles
  - Focus on relationship building amongst staff
  - Clearly define CHW role within particular organization

Indiana's Certified Workforce

Commonly cited activities:

- Peer support
- Integrated care support
- Social/leisure skill development
- Goal setting
- Referrals
- Group facilitation
- Case management

You Are Qualified!

As a future Community Health Worker, you will use your newly equipped skills and life experiences to improve the health status of the population you serve.

A community health worker is a front line public health worker.

Social Determinants of Public Health

- Works to promote the health of communities and populations
- Illness relates to access to the Social Determinants of Health
  - Healthy food
  - Housing
  - Education
  - Employment
  - Transportation
  - Personal safety
  - Affordable health care
  - Cultural resources
  - Recreation
  - Clean air and water
  - Protection from discrimination

Public Health Achievements in the 20th Century

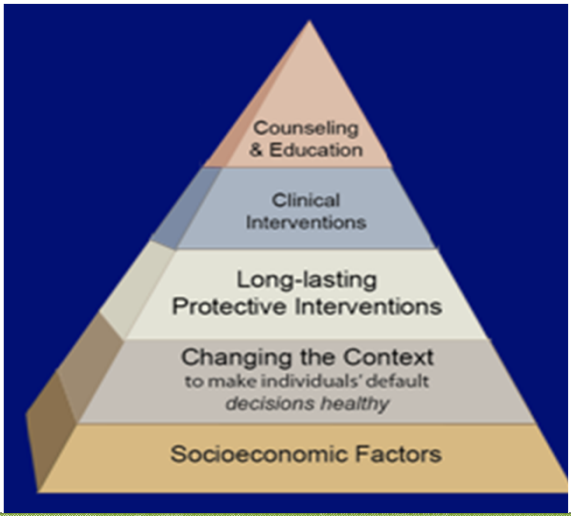
According to the CDC, public health has been credited with adding 25 years to the life expectancy of people living in the 20th century.

Ten Great Public Health Achievements in the 20th Century

1. Vaccination to reduce epidemic diseases
2. Improved motor vehicle safety
3. Safer workplaces
4. Control of infectious diseases
5. Decline in death from cardiovascular disease
6. Food safety
7. Improvements in maternal and child health
8. Family planning
9. Fluoridation of drinking water
10. Reductions in prevalence of tobacco use

Public Health – 10 Essential Services

Looking at this graphic, what seems to have the biggest impact on health?



Indiana Health Rankings

In 2015, Indiana ranked as the 41st healthiest state in the United States.

- Declined by two spots since 2014.

Strengths:

- High rates of high school graduation
- High immunization among adolescents for MCV4
- Low incidence of Salmonella

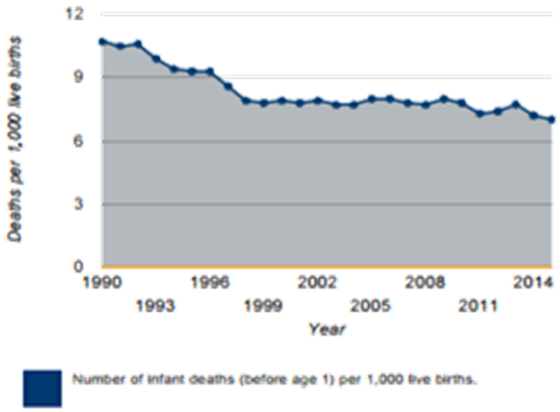
Challenges:

- Low per capita public health funding
- High prevalence of smoking
- High levels of air pollution

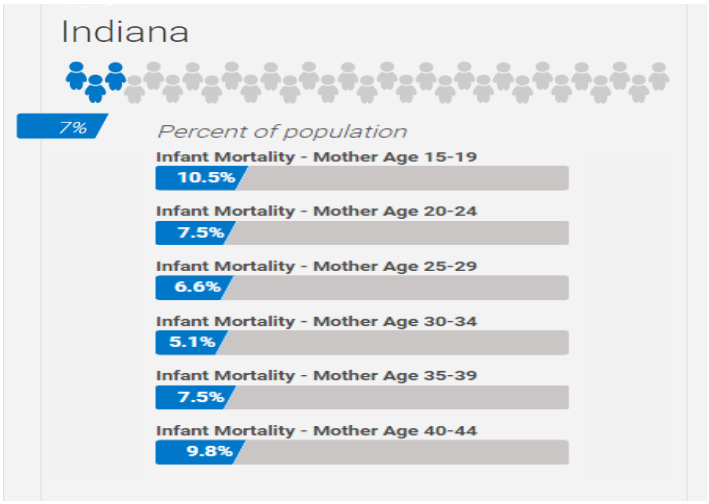
Indiana Health Rankings

Measure	Rank
All Determinants	41
Heart Disease	32
High Blood Pressure	33
High School Graduation	8
Infant Mortality	36
Diabetes	32
Physical Inactivity	41
Lack of Health Insurance	31

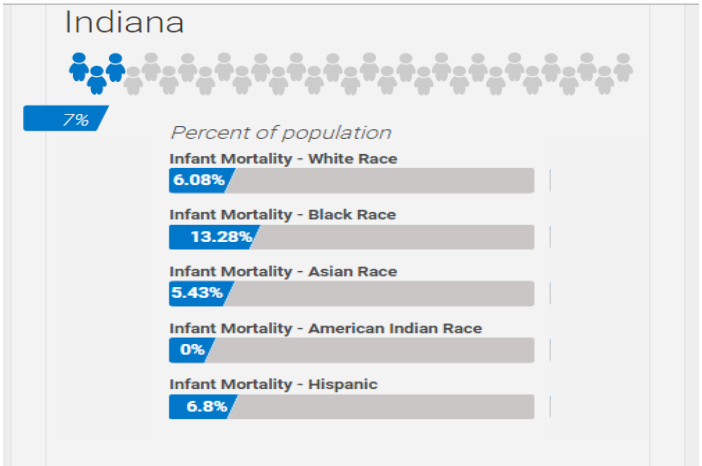
Indiana Infant Mortality



Infant Mortality - Age



Infant Mortality - Race



LEAD POISONED IN INDIANA

Watch Video

Sources of Lead

- Paint
- Toys
- Water
- Soil
- Household dust
- Pottery
- Traditional cosmetics
- Traditional medicines

Low-Level Exposure Effects

- Decline in IQ
- Hyperactivity
- Disinterest
- Social withdrawal
- Delayed growth
- Kidney damage
- Infertility
- Seizures

Injury in Indiana

- Unintentional injury is the leading cause of death from ages 1- 44
- Unintentional Injury and Homicide are 2 of the top 5 causes of death for ages 1-4
- Unintentional Injury, Homicide, and Suicide are 3 of the top 6 causes of death for ages 5-44
- Suicide is in the top 10 causes of death for all age groups in Indiana (#2 15-34; #9 75+)

Prevalence of Mental Illness

- Mental illness is one of the leading causes of disability in the United States.
- An estimated 43.6 million adults aged 18 or older had any mental illness in the past year.
- Among adults aged 18 or older, the rate of serious mental illness nationally was 4.1% which equates to 9.8 million adults with serious mental illness (SMI).

What about Alcohol?

- Alcohol is the most frequently used drug in Indiana and the United States.
- Among Hoosiers ages 12 and older, 51.6% drank alcohol in the past month and 22.3% engaged in binge drinking.
- Alcohol use is a major factor in homicides (47%).
- Over-concentration of alcohol outlets is part of neighborhood economic and social disintegration. The area's economic base loses its diversity and becomes less attractive to both residents and potential retail customers.

Illicit Drug Use in Indiana

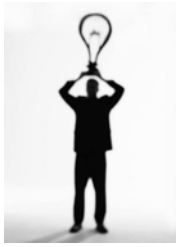
- The number of meth lab seizures in the state of Indiana increased from 314 incidents in 2000 to 1,530 incidents in 2015

  Source: 2015 Indiana Law Enforcement Annual Clandestine Lab Stats
- Southern Indiana was faced with an opioid epidemic in 2015; almost 200 people were diagnosed with HIV after sharing needles to inject the prescription medication.

  Source: Indy Star News, 2015
- The rate of drug-induced deaths in Indiana is above the national average.
- Marijuana is the most commonly cited illicit drug among primary drug treatment admissions in Indiana.

Brainstorm

Given the CHW skills and statistics we just learned, where might CHWs and CHW/CRSs fit into the community to support improved health outcomes in Indiana?



Group Activity

1. Individuals with low literacy
2. Individuals with no health insurance
3. Individuals in poverty
4. Individuals who are new to this country

Questions

- How could you find your population to share information?
- How would you approach individuals about health behaviors?

Conclusion

In this module we:

- Learned about the role of a CHW and CHW/CRS
- Reviewed the public health approach to community wellness
- Identified health disparities specific to Indiana

Evaluation

Please complete the module evaluation.

References

- Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50).
- Center for Disease Control and Prevention.(2014). The Public Health System and the 10 Essential Public Health Services
- Indiana State Department of Health (2015). National and State Injury Facts
- Mayo Clinic. (2014) Diseases and Conditions: Lead poisoning
- *The Center for Health Policy, Richard M. Fairbanks School of Public Health, IUPUI (2015). Substance Abuse in Indiana*
- United Health Foundation. (2015). America's Health Rankings - Indiana

Module 3

Ethics

Module 3
Ethics

Indiana
Community Health Worker
Integrated Care
Training Program

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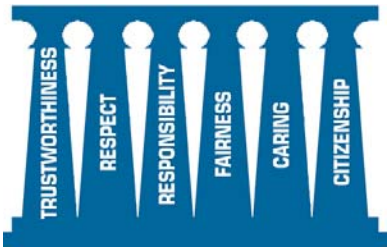
Objectives

1) Learn applicable ethics and their purpose
2) Become aware of common ethical challenges
3) Review the Community Health Worker Code of Ethics
4) Learn an ethical decision-making model
5) Understand the scope of practice for CHWs, and how it relates to an ethical practice

Ethics

Derived from Greek word "ethos"

which means: Character



(Principled Reasoning Based on the "Six Pillars of Character" , Josephson Institute)

Ethics Definition

1. A system of moral principles: the ethics of a culture.
2. The rules of conduct recognized in respect to a particular class of human actions or a particular group, culture, etc.: medical ethics; Christian ethics.
3. Moral principles, as of an individual.
4. Branch of philosophy dealing with values relating to human conduct, with respect to the rightness and wrongness of certain actions and to the goodness and badness of the motives and ends of such actions.

Ethics

- The rules or standards governing the conduct of a person or the conduct of the members of a profession.
- This is the context in which we will discuss ethics in this module.

The Purpose of Ethics

- Articulate basic values, principles, and standards of practice for a profession or organization.
- Provide a guide for when professional obligations conflict.
- Provide standards to which one can be held accountable for their actions
- Protect the provider and recipient of services from harm.

ETHICAL GUIDELINES FOR CHWs

Ethical Behavior Requires Constant Attention !

- Silence is not golden within the ethics arena. The two most frequent reasons for silence are:
  - the inability of a CHW to recognize ethical issues that are arising
  - his or her failure to bring those issues up for fear it will reflect negatively on their performance.
- Most breaches in ethical conduct in human services are made by good people **who often didn't even know they were in territory that required ethical decision-making.**
- Continued vigilance and open discussion will promote improved ethical sensitivity.
- Knowledge of, and adherence to, the CHW Code is invaluable to maintaining ethical behavior.

CHW Code of Ethics

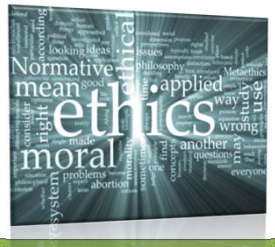
American Association of Community Health Workers Code of Ethics

CHW Code of Ethics

"The Code of Ethics is based upon commonly understood principals that apply to all professionals within the health and social service fields (e.g. promotion of social justice, positive health, and dignity)."

CHW Code of Ethics

The following principles will guide you as a Community Health Worker in your various roles, relationships, and levels of responsibility in which you will function professionally.



The CHW Code of Ethics

- **Honesty**: Community Health Workers are professionals that strive to ensure the best health outcomes for the communities they serve. They communicate the potential benefits and consequences of available services, including the programs they are employed under. The CHW will maintain high standards of personal conduct.

The CHW Code of Ethics

- **Confidentiality**: Community Health Workers respect the confidentiality, privacy, and trust of individuals, families, and communities that they serve. They understand and abide by employer policies, as well as state and federal confidentiality laws that are relevant to their work.

The CHW Code of Ethics

- **Scope of Ability & Training**: Community Health Workers are truthful about qualifications, competencies and limitations on the services they may provide, and should not misrepresent qualifications or competencies to individuals, families, communities, or employers.
- **Quality of Care**: Community Health Workers strive to provide high quality service to individuals, families, and communities. They do this through continued education, training, and an obligation to ensure the information they provide is up to date and accurate.
- **Referral to Appropriate Services**: Community Health Workers acknowledge when client issues are outside of their scope of practice and refer clients to the appropriate health, wellness, or social support services when necessary.

The CHW Code of Ethics

- **Legal Obligations**: Community Health Workers have an obligation to report actual or potential harm to individuals within the communities they serve to the appropriate authorities. Additionally, Community Health Workers have a responsibility to follow requirements set by states, the federal government, and/or their employing organizations. Responsibility to the larger society or specific legal obligations may supersede the loyalty owed to individual community members.

The CHW Code of Ethics

- **Cultural Humility**: Community Health Workers possess expertise in the communities in which they serve. They maintain a high degree of humility and respect for the cultural diversity within each community. As advocates for their communities, Community Health Workers have an obligation to inform employers and others when policies and procedures will offend or harm communities, or are ineffective within the communities where they work.

The CHW Code of Ethics

- **Maintaining the Trust of the Community**: Community Health Workers are often members of their communities and their effectiveness in providing services derives from the trust placed in them by members of these communities. Community Health Workers do not act in ways that could jeopardize the trust placed in them by the communities they serve.



The CHW Code of Ethics

- **Respect for Human Rights**: Community Health Workers respect the human rights of those they serve, advance principles of self-determination, and promote equitable relationships with all communities.


The CHW Code of Ethics

- **Anti-Discrimination**: Community Health Workers do not discriminate against any person or group on the basis of race, ethnicity, gender, sexual orientation, age, religion, social status, disability, or immigration status.
- **Client Relationships**: Community Health Workers maintain professional relationships with clients. They establish, respect and actively maintain personal boundaries between them and their clients.

The CHW Code of Ethics

- **Cooperation**: Community Health Workers place the well-being of those they serve above personal disagreements and work cooperatively with any other person or organization dedicated to helping provide care to those in need.
- **Conduct**: Community Health Workers promote integrity in the delivery of health and social services. They respect the rights, dignity, and worth of all people and have an ethical obligation to report any inappropriate behavior (e.g. sexual harassment, racial discrimination, etc.) to the proper authority.
- **Self-Presentation**: Community Health Workers are truthful and forthright in presenting their background and training to other service providers.

The CHW Code of Ethics

- **Continuing Education**: Community Health Workers should remain up-to-date on any developments that substantially affect their ability to competently render services. Community Health Workers strive to expand their professional knowledge base and competencies through education and participation in professional organizations.
- **Advocacy for Change in Law and Policy**: Community Health Workers are advocates for change and work on impacting policies that promote social justice and hold systems accountable for being responsive to communities. Policies that advance public health and well-being enable Community Health Workers to provide better care for the communities they serve.

The CHW Code of Ethics

- **Enhancing Community Capacity**: Community Health Workers help individuals and communities move toward self-sufficiency in order to promote the creation of opportunities and resources that support their autonomy.
- **Wellness and Safety**: Community Health Workers are sensitive to their own personal well-being (physical, mental, and spiritual health) and strive to maintain a safe environment for themselves and the communities they serve.
- **Loyalty to Profession**: Community Health Workers are loyal to the profession and aim to advance the effo Community Health Workers worldwide.

The CHW Code of Ethics

- **Advocacy for the Profession**: Community Health Workers are advocates for the profession. They are members, leaders, and active participants in local, state, and national professional organizations.
- **Recognition of Others**: Community Health Workers give recognition to others for their professional contributions and achievements.

More about Dual Relationships

Avoid relationships or commitments that:

- Conflict with the interests of individuals served or imply a conflict of interest
- Impair professional judgment
- Create risk of harm

- When dual relationships are unavoidable, it is the responsibility of the CHW to conduct himself/herself in a way that does not jeopardize the integrity of the helping relationship

Practice within Your Scope

Core Roles

- Enhance access and coordinated patient and peer-centered care
- Manage patient/consumer tracking and continuity of care
- Facilitate cultural bridging
- Provide social and peer support for self-management
- Support community mobilization and advocacy

Examples of "Out of Scope" Activities

The CHW is not a:	You are moving out of scope if you:
Sponsor or equivalent	Perform AA/NA or other mutual help work in role of CHW. Guide someone through steps or recovery principles of a particular program
Therapist/ Counselor	Provide counseling Refer to your own work as therapy or counseling Attempt to address trauma, feelings, psychological symptoms
Nurse/ Physician	Suggest/express disagreement with medical diagnosis Offer medical advice Make statements about prescribed medications
Priest/ Clergy	Promote a particular religion/church Interpret religious doctrine Offer absolution/forgiveness

Not Sure? What Should You Do?

- Review your job description
- Seek guidance from a supervisor
- Make referrals to another caregiver
- Clearly tell clients what you can and cannot provide for them

CONFIDENTIALITY

Overview: What is HIPAA?

The ***Health Insurance Portability and Accountability Act of 1996*** (HIPAA) is a multifaceted piece of legislation covering insurance portability, fraud enforcement (accountability), and administrative simplification (reduction in health care costs) and to provide patient confidentiality and protection of health information.

What is Considered Protected Health Information (PHI)?

- Patient name
- Health plan beneficiary number
- Street address, zip code, city
- Certificate/license number
- Phone number
- Vehicle ID number, license plate number
- Fax number
- Device identifier number and serial number
- Email address
- Web Universal Resource Locator number

What is Considered Protected Health Information (PHI)?

- Birth date, admission date, discharge date, date of death
- Internet Protocol (IP) address
- Social security number, fingerprints, voice prints, other biometric identifier
- Medical record number
- Full face photographic image
- Account number
- Any other unique identifying number, characteristic or code

Confidentiality of Alcohol and Drug Abuse Patient Records

42 CFR Part 2

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall be confidential.

Ways to Protect Patient Privacy

- Close doors when discussing patients protected health information.
- Move away from any conversation about a specific patient's care.
- Avoid discussions about patients in elevators and cafeteria lines.
- Do not leave messages on answering machines regarding patients protected health information.
- Avoid paging patients using identifiable information, such as their conditions, names of physician or unit, that could reveal their health issues.

Confidentiality vs. Mandated Reporting

Share limits early!

The State of Indiana **requires** mandated reporting in the following cases:

Abuse of Children:

- Under Indiana law any individual who has a reason to believe a child is a victim of abuse or neglect has the duty to make a report; therefore, each citizen of Indiana is considered a "mandated reporter."

Confidentiality vs. Mandated Reporting

Abuse of the Elderly or Disabled:

- Any person who believes or has reason to believe that another individual is an endangered adult.
- **"Endangered adult" means an individual who: Is at least 18 years of age;**
- Is incapable by reason of mental illness, mental retardation, dementia, habitual drunkenness, excessive use of drugs, or other physical or mental incapacity of managing or directing the management of the individual's property or providing or directing the provision of self-care; and
- Is harmed or threatened with harm as a result of:
  - Neglect;
  - Battery; or
  - Exploitation of the individual's personal services or property.

Confidentiality vs. Mandated Reporting

If The Patient Is A Danger To Themselves Or Others:

The Codes: IC 34-30-16-1 & IC 34-30-16-2

IC 34-30-16-1

If you become aware that a client is a danger to themselves , i.e. has threatened suicide or others, i.e. treated to kill or harm someone , the CHW **MUST** report this to the proper authority . Most health organizations will already have a policy regarding who to notify, but remember the responsibly is ultimately yours.

Confidentiality vs. Mandated Reporting

IC 34-30-16-2

If a client portrays violent or other serious behavior, you have a **duty to warn**.

You are immune from civil and criminal liability statutes that protect patient privacy and confidentiality *IF* you take reasonable precautions to **warn the victim(s) and/or law enforcement**.

Ethics and the Limits of Confidentiality

Case Study

Scenario

Case #1: Susan is a therapist in the ER of a city hospital, and she has just heard that a fellow employee is pregnant. The other staff members would like to give her a baby shower, but nobody knows when the baby is due or if it is a boy or a girl. Susan has access to the records, and could easily find the answers to both questions.

Question: Should Susan try to get information about the pregnancy and share it with the staff?

Scenario

Case #2: You are downtown at the mall shopping on the weekend; you are walking down the stairs and see a client. You are unsure if you should greet them, or whether you should be discreet and walk by.

Question: What should you do?

Scenario

Case #3: Mr. Olsen, a patient in the facility, has had an adverse reaction to his medications. The nurse tries several times to reach the patient's physician for instructions, with no success. Finally, she reaches the club where the physician is attending a social event. She asks the receptionist to tell the physician that Mr. Olsen has had an adverse reaction to his medications, and she urgently needs the physician to call.

Question: What should the nurse have done differently?

Client Records

- Do not leave records unattended in an area where others can see it.
- When you are done using paper patient information, return it to its appropriate location, i.e., the Health Information Management department or to a file at a nursing station.
- When you are done accessing electronic patient information, log off the system. Do not leave the information visible on an unattended computer monitor.
- When discarding paper patient information, make sure the information is shredded and preferably locked in a secure bin.

Faxes

- If you must fax patient information, fax to a dedicated fax machine in a secure location.
- Make certain that the person to whom the information is being faxed actually receives the fax.
- If you know you will receive a fax that contains patient information, tell the person faxing the information to warn you ahead of time so that you can be present to receive it.
- Do not let faxed patient information lay around a fax machine unattended. Immediately dispose of or file faxed information before others can see it.

More Situations

What about these?

1. Your client asks you if you know her sister who also goes to the clinic
2. Your elderly client asks if you would take her picture on your phone and send it to her daughter's phone
3. You check who was seen at the clinic today out of curiosity
4. You check date of birth on your client to see if he qualifies for a senior program
5. You put on Facebook that your client's cat had kittens that need to be adopted. You share a picture of the litter with the phone number where they can be seen.

What about?

1. Attending the same church as clients.
2. CHW and clients' children go to same school.
3. Being an AA sponsor for your client.
4. Client is related to you.
5. Helping a client outside of work hours, and scope of work.
6. Accepting garden produce or other gifts.
7. Giving $10 to homeless client for food.

Decision-Making Model

Three Questions:

1. The test of justice

Would I treat others the same in this situation?

2. The test of publicity

Would I want my behavior reported in the press?

3. The test of universality

Would I recommend the same course of action to another professional in the same situation?

A Real World Situation

One of your clients closed today's discussion by stating that they really liked coming to the clinic to see you. While at their appointment, it had snowed significantly and gotten dark. Now they indicate that they are afraid to drive home. They ask you for a ride.

Conclusion

In this modules we:

- Learned applicable ethics and their purpose
- Become aware of common ethical challenges
- Reviewed the Community Health Worker Code of Ethics
- Learned an ethical decision-making model
- Covered the scope of practice for CHWs, and how it relates to an ethical practice

Evaluation

Please complete the module evaluation.

References:

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- Code of Ethics for Community Health Workers – American Association of Community Health Workers -2008
- Community Health Worker/Certified Recovery Specialist Code of Ethics – ASPIN CHW/CRS Program 2016
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- Indiana code sections related to confidentiality (current as of 5/8/2008).
  - A. Health Records (IC 16-39-1-9)
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The American Association of Community Health Workers Code of Ethics

A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understating of the community she or he serves. This trusting relationship enables the CHW to sever as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community edge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.

Purpose of This Code

The CHW Code of Ethics is bases on and supported by the core values adopted by the American Association of SHWs. The Code of Ethics outlines in this document provides a framework for SHWs, Supervisors, and employers of CHWs to discuss ethical issues facing the profession. Employers are encouraged to consider this Code when creating CHW programs. The responsibility of all CHWs is to strive for excellence by providing quality service and the most accurate information available to individuals, families, and communities.

The Code of Ethics is based upon commonly understood principles that apply to all professionals within the health and social service fields (e.g., promotion of social justice, positive health, and dignity). The Code, however, does not address all ethical issues facing CHWs and the absence of a rule does not imply that there is no ethical obligation present. As professionals, CHWs are encourages to reflect on the ethical obligations that they have to the communities that they serve, and to share these reflections with others.

Article 1. Responsibility in the Delivery of Care

CHWs build trust and community capacity by improving the health and social welfare of the client they serve. When a conflict arises among individuals, groups, agencies, or institutions, CHWs should consider all issues and give priority to those that promote the wellness and quality of living for the individual/client. The following provisions promote the professional integrity of CHWs.

1.1 Honesty

CHWs are professionals that strive to ensure the best health outcomes for the communities they serve. They communication the potential benefit and consequences of available services, including the programs they are employed under.

1.2 Confidentiality

CHWs respect the confidentiality, privacy, and trust of individuals, families, and communities that they serve. They understand and abide by employer policies, as well as state and federal confidentiality laws that are relevant to their work.

1.3 Scope of Ability and Training

CHWs are truthful about qualifications, competencies, and limitations on services they may provide, and should not misrepresent qualifications or competencies to individuals, families, communities or employers.

1.4 Quality of Care

CHWs strive to provide high quality of services to individuals, families, and communities. They do this through continued education, trainings, and an obligation to ensure the information they provide is up-to-date and accurate.

1.5 Referral of Appropriate Services

CHWs acknowledge when client issues are outside of their scope of practice and refer clients to the appropriate health, wellness, or social supper services when necessary.

1.6 Legal Obligations

CHWs have an obligation to report actual or potential harm to individuals within the communities they serve to the appropriate authorities. CHWs have a responsibility to follow requirements set by states, the federal government, and/or their employing organizations. Responsibility of the larger society or specific legal obligations may supersede the loyalty owed to individual community members.

Article 2. Promotion of Equitable Relationships

CHWs focus their efforts on the well-being of the whole community. They value and respect the expertise and knowledge that each community member possesses. IN turn, CHWs strive to create equitable partnerships with communities to address all issues of health and well-being.

2.1 Cultural Humility

SHWs possess expertise in the communities in which they serve. They maintain a high degree of humility and respect for the cultural diversity within each community. As advocates for their

communities, CHWs have an obligation to inform employers and others when policies and procedures will offend or harm communities, or are ineffective within the communities where they work.

2.2 Maintaining the Trust of the Community

CHWs are often members of their communities and their effectiveness in providing services derived from the trust placed in them by member of these communities. CHWs do not act in ways that could jeopardize the trust placed in them by the communities they serve.

2.3 Respect for Human Rights

CHWs maintain professional relationship with clients. They establish, respect, and actively maintain personal boundaries between them and their clients.

2.4 Anti-Discrimination

CHWs do not discriminate against any person or group on the basis of race, ethnicity, gender, sexual orientation, age, religion, social status, disability, or immigration status.

2.5 Client Relationship

CHWs maintain professional relationships with clients. They establish, respect, and actively maintain personal boundaries between them and their clients.

Article 3. Interactions with Other Service Providers

3.1 Cooperation

CHWs place the well-being of those they serve above personal disagreements and work cooperatively with any other person or organization dedicated to providing care to those in need.

3.2 Conduct

CHWs promote integrity in the delivery of health and social services. They respect the rights, dignity, and worth of all people and have an ethical obligation to report any inappropriate behavior (e.g., sexual harassment, racial discrimination, etc.) to the proper authority.

3.3 Self-Presentation

CHWs are truthful and forthright in presenting their background and training to other service providers.

Article 4. Professional Rights and Responsibilities

The CHW profession is dedicated to excellence in the practice of promoting well-being in communities. Guided by common values, CHWs have the responsibility to uphold the principles and integrity of the profession as they assist families to make decisions impacting their well-being. CHWs embrace the individual, family, and community strengths and build upon them to increase community capacity.

4.1 Continuing Education

CHWs should remain up-to-date on any developments that substantially affect their ability to competently render services. CHWs strive to expand their professional knowledge base and competencies through education and participation in professional organizations.

4.2 Advocacy for Chance in Law and Policy

CHWs are advocates for change and work on impacting policies that promote social justice and hold systems accountable for being responsive to communities.

4.3 Enhancing Community Capacity

CHWs assist individuals and communities in moving towards self-sufficiency in order to promote the creation of opportunities and resources that support their autonomy.

4.4 Wellness and Safety

CHWs are sensitive to their own personal well-being (physical, mental, and spiritual health) and strive to maintain a safe environment for themselves and the communities they serve.

4.5 Loyalty to the Profession

CHWs are advocates for the profession. They are members, leaders, and active participants in the local, state, and national professional organizations.

4.6 Advocacy for the Profession

CHWs are advocates for the profession. They are members, leaders, and active participants in local, state, and national professional organizations.

4.7 Recognition of Others

CHWs give recognition to others for their professional contributions and achievements.

Case Study

At the clinic, multiple signs are clearly posted explaining the limits of confidentiality. The CHW begins all client sessions by reviewing the limits of confidentiality and describing the types of information that cannot legally be kept private, including physical and sexual abuse and intended suicide.

After discussion the limits of confidentiality, a fifteen-year-old female client discloses that she is being sexually abused by her stepfather. Legally and ethically, the CHW has a clear duty to report this information to local law enforcement authorities. Despite having discussed the limits of confidentiality previously, the client begs the CHW not to make a report: the client is scared what her stepfather and mother might do.

The CHW listened to the clients experience and concerns, and offers validations and support. The CHW then explains the duty to report the sexual abuse to the police. The CHW emphasizes concern for the client's safety and welfare. The CHW also explains why it would be wrong not to make a report: they have an obligation to do everything they can to protect client from harm. Failing to report the abuse could send a message to the client that she shouldn't talk about what is happening to her or that sexual abuse is acceptable or somehow doesn't matter.

The CHW calmly explains the need to call the police immediately, and asks the client if she would like to make the call or wait with the CHW and speak with authorities at the clinic. The client is also free to leave, although she and her parents will be contacted later by the police. The client decides to listen in on the call to the police. The CHW also asks the client if she would like to call the local rape crisis center and explains the type of services they offer. The client calls the local rape crisis center with the CHW, explains what is happening, and asks for a rape crisis counselor to come to the clinic to be her advocate when she speaks with the police. Throughout the process it is important to assess the client's safety and make an appropriate plan to prevent further harm to her or others.

While the situation was stressful for the client, providing her with choices also aided in giving back to her a measure of control. This is an important feature of working with victims of trauma. It is also a central feature of client-centered practice, discussed below.

Questions:

1. What do you think of the way in which the CHW handled this situation?
2. Is there anything else you would want to do?
3. Anything you would want to do differently?
4. What ethical behaviors did the CHW model?
5. Is there anything that you would have done differently?

Module 4

Diversity/Cultural Competency

Module 4 Diversity/ Cultural Competency

Indiana Community Health Worker Integrated Care Training Program

1

Objectives

1) Increase awareness of personal cultural identity and its impact on behavior, thinking, and communication style
2) Broaden knowledge of the demographic changes in the US and Indiana
3) Be able to approach cultural knowledge gaps tactfully
4) Learn to approach health topics with cultural sensitivity

Self-Awareness

Share with the group:

- One time when you felt like the minority in a group
- How that felt

Core Dimensions of Cultural Influences

Primary Dimensions

- Age
- Race
- Ethnic Heritage
- Gender
- Mental/Physical Abilities/Qualities

These dimensions are considered to be LESS changeable

Secondary Dimensions of Cultural Influences

- Military experience
- Religion
- Income
- Work experience
- Geographic location
- Organizational role and level
- Family status
- Communication style
- Work style
- Education
- First language

ADDRESSING Culture

- A – Age/generational
- D – Developed or acquired
- D – Disabilities
- R – Religion/Spirituality
- E – Ethnicity
- S – Socioeconomic Status
- S – Sexual Orientation
- I – Indigenous
- N – Nationality
- G – Gender Identity

What Shapes Culture?

- Political values
- Experience with oppression or discrimination
- Socioeconomic factors
- Rituals
- Family roles and structure
- Degree of opposition to acculturation
- Response of majority culture

Diversity in Indiana

2014 Census Data from US Census Bureau

Indiana's estimated population in 2014 - 6,596,855

Estimated Racial Makeup	
White	86.1%
Black or African American	9.6%
Hispanic or Latino	6.6%
Two or More Races	6.6%
Asian	2.0%
American Indian and Native Alaskan	0.4%
Native Hawaiian and Other Pacific Islander	0.1%

Race versus Ethnicity

Race

The concept of dividing people into populations or groups on the basis of various sets of physical characteristics (which usually result from genetic ancestry)

Ethnicity

A population group whose members identify with each other on the basis of common nationality or shared cultural traditions

Diversity in Indiana

2009-2014 Census Data from US Census Bureau	
Foreign born persons	4.7%
Language other than English spoken at home	8.2%
Persons below poverty level	15.4%
Persons under 18 years	24%
Persons 65 years and over	14.3%
Female persons	50.7%

Diversity in Language

Number of Counties	Languages Spoken
23 counties	20+ languages
11 counties	10+ languages
69 counties	5+ languages

- Indiana has the highest percentage of Dutch speakers in the United States
- Marion County's 68 languages is tied with the 77th highest number recorded in any county in the U.S.
- Lake County has the highest percentage of Macedonian and Serbian speakers of any county in the U.S.
- LaGrange County ranks first in Dutch speakers in the U.S.

Poverty in Indiana

- 15% of the population lives in poverty
- Counties with the highest poverty rates include:
  - Monroe – 24%
  - Delaware – 22.2%
  - Tippecanoe – 22.1%
  - Marion – 21.3%
  - Vigo – 20.2%
  - Grant – 20%

US Census Bureau 2014

Sexuality in Indiana

About 3.7% of Indiana's population identified as lesbian, gay, bisexual, transgender, or questioning

Sexuality

According to Healthy People 2020...

- Research suggests that LGBTQ individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights
- Discrimination against LGBTQ persons has been associated with high rates of psychiatric disorders, substance abuse, and suicide
- Experiences of violence and victimization are frequent for LGBTQ individuals, and have long-lasting effects on the individual and the community
- Personal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBTQ individuals

15 2016

Military in Indiana

- 20,000+ service members currently on active duty are residents of Indiana
- Over 500,000 veterans of all wars live in Indiana
- Represented in every county in the state

16 2016

Generational Diversity

Traditionalists

(Born 1925-1945)

- More likely to favor stricter laws and longer jail time
- They believe there is one right answer
- Divorce is wrong
- They believe that patience will ultimately be rewarded and are willing to wait
- When they were in school, they lost points for the wrong answer; the teacher didn't care how they solved the problem

Generational Diversity
Baby Boomers
(Born 1946-1964)

- Most grew up in a time of economic expansion, so they believe in growth
- In most cases, they lived in nuclear families, with a stay-at-home Mom
- More college graduates than any generation before them
- Motivated by positions, perks, and prestige in the workplace

Generational Diversity
Generation X
(Born 1965-1983)

- First generation in daycare
- Focus in on personal life
- Focus is on career security not job security
- Must build skills and experiences they can take with them if they need to
- Office politics (power games)are a waste of time
- Sometimes called “Sandwich” Generation

Generational Diversity
Millennials
(Born 1984-2002)

- Parents not only escorted them, they advocated for them (helicopter parents)
- Passionate risk-takers
- Busy, busy, busy – overscheduled
- Loyalty to an organization is not a priority
- A patriotic generation, influenced by violence
- Tend to be more accepting of different cultures and lifestyles
- Technology focused

The Generations: Pop Culture Influences

	Traditionalists Born 1925-1945	Baby Boomers Born 1946-1964	Generation X Born 1965-1983	Millennials Born 1984 -2002
Music				
Technology				
Movies				
Major Events				

Cultural Awareness vs. Cultural Competence

Cultural Awareness

Sensitivity and understanding toward members of other ethnic groups

Cultural Competence

The ability to effectively operate within different cultural contexts. Implies having the capacity to function effectively.

National Association of School Psychologists

Cultural Humility

"A lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually-beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations"

(Tervalon & Murray-Garcia, 1998, p.123)

Continuum of Cultural Competence

1. Cultural Destructiveness → 2. Cultural Incapacity → 3. Cultural Blindness

4. Cultural Pre-Competence → 5. Cultural Competence → 6. Cultural Proficiency

Review handout

What Do You Think?

Is America a soup or a salad?

The Influence of Cultural and Social Factors

- Health-seeking behavior
- Perceived causes of illness
- Understanding of disease process
- Treatment decision

Health-Seeking Behavior

- Is the symptom serious?
- How long has the symptom lasted?
- Is there a cause for the symptom?
- Anyone else with similar symptoms?
- Whom should I seek help from?

Perceived Causes of Illness

Some people believe that the cause of their disease is the result of some "other" force outside the individual (supernatural or spiritual forces such as punishment for behaviors, etc.)

Understanding the Disease Process

- Cultural beliefs can affect how medical information is received
- Health literacy can be influenced by cultural beliefs
- Communication barriers with healthcare providers
- Minority and low-income clients may have more difficulty accessing quality health information

Treatment Decisions

- What is necessary for healing to occur?
- Risk assessment (cost-benefit analysis)
- Lifestyle factors
- Healthcare worker/patient interactions

Approaching with Cultural Humility

1) What do you call the problem?
2) What are the signs and symptoms of the illness that you are experiencing?
3) What are your concerns or fears?
4) Where do you think the problem came from?
5) How does the illness affect you and your family?

Approaching with Cultural Humility (Cont.)

6) How do you think this should be treated?
7) How do you want us to assist you?
8) Who do you turn to for assistance?
9) Who should be involved in decision-making?

Why is Culture Important in Healthcare?

- A lack of knowledge about or sensitivity to health beliefs and practices of different cultures can limit one's ability to provide quality healthcare
- Cultural forces are powerful determinants of health-related behavior
  - Value versus mistrust of the healthcare system

Spirituality

Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.

Required Skills

- Knowledge of patient population
- Acceptable social behaviors
- Knowledge of cultural health beliefs
- Conveying respect
- Working with interpreters
- Cultural sensitivity

What is the advantage for Community Health Workers?

Working with Interpreters

- In a medical/behavioral health setting, use of a trained, medical interpreter is necessary
- Avoid use of family or non-medically trained staff to interpret

Working with Interpreters

- Introduce self to interpreter & client – set ground rules for interpretation and confidentiality
- Address client directly, in the first person and make appropriate eye contact
- Check that interpreter is engaged in working with client; keep pace appropriate and direct
- Avoid local jargon and phrases

How to Convey Respect

- Build rapport and trust
- Explain why you must ask personal or sensitive questions (suspicion of TB, HIV status); may require an expression of sympathy for doing so
- Watch for verbal and non-verbal cues; allow client to ask questions at frequent intervals
- Check for understanding

Knowing Who is Most Vulnerable

- Non-US born
- Migrant workers
- Persons with international travel history
- Racial and ethnic minorities
- Elderly
- Refugees

Examples of Cultural Beliefs

- Illness or disease is caused by stress or working too hard or as a punishment for something
- Psychiatric illness comes from a loss in faith of God or possession by evil
- Eating protein (meat or egg) will counteract the effects of x-rays
- Everyone has dormant diseases in body, whether or not they develop depends on how well you take care of yourself
- Importance of balancing Yin and Yang, e.g. hot/cold theory

Case Study: Marie

A CHW is working with Marie regarding health education. Marie has diabetes and her health is getting worse. Throughout the session, the CHW is compassionate; however, the client reacts negatively to the manner in which the CHW explains health nutrition and eating. While Marie doesn't say anything, the information is in conflict with her dietary traditions and family practices. Marie feels the CHW does not respect her traditions. Offended, she leaves the session early.

What mistakes were made?
What would you do to fix the issue?

Case Study: Marie

As a CHW, you can:

- Talk with supervisor
- Examine own behavior
- Recognize where mistakes were made
- Apologize to client
- Send another worker of Marie's culture to re-engage her

Conclusion

In this module we:

- Increased awareness of personal cultural identity and its impact on behavior, thinking, and communication style
- Broadened knowledge of the demographic changes in the US and Indiana
- Learned to approach cultural knowledge gaps tactfully
- Learned to approach health topics with cultural sensitivity

Evaluation

Please complete the module evaluation.

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Continuum of Cultural Competency

Destructiveness	•Assume one race is better •Purposely destroy a lesser culture
Incapacity	•Disproportionately apply resources; discriminate against people of color •May support segregation; may have unrealistic fear of people of color
Blindness	•Provide services with philosophy of being unbiased •Ignore cultural strengths; blame victim for their problems •View themselves as unbiased; however, bias is reflected in attitude, policy and practice
Pre-Competence	•System realizes its weaknesses in serving minorities and attempts to improve their services to a specific population •Hire minority employees, train employees on cultural sensitivity •Recruit minority individuals for boards or advisory committees
Competence	•Accept and respect differences; continuing self assessment regarding culture •View minority groups as distinctly different from one another •Work to hire unbiased employees; seek advice from minority community
Proficiency	•Hold culture in high esteem •Hire staff who are specialists in culturally competent practices

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Module 5

Conflict Management

Module 5 Conflict Management

Indiana Community Health Worker Integrated Care Training Program

ASPIN

Objectives

1) Identify the three levels of conflict
2) Recognize some signs of dangerous situations developing
3) Understand the generalized differences among generations, in order to decrease misunderstandings, conflicts, stress, discomfort, frustration, and miscommunication
4) Name the four types of workplace violence

WHAT IS WORKPLACE CONFLICT?

What is Workplace Conflict?

There are two types of workplace conflict.

- The first type is an undesirable type of conflict called **relationship conflict**, which is based in dislike and distrust. It has a strong emotional component and manifests itself in disrespectful behavior and speech, which result in nonproductive and disruptive interactions
- We will talk more about this type of conflict in a few minutes....

What is Workplace Conflict?

The second type of conflict is called **task conflict**

- This type of conflict originates from differences in perspective about how to perform a task

Task Conflict

- Task conflict can illuminate the overlooked issues, biases and sources of opinion differences
- When teammates view problems differently, the group explores the definitions, assumptions, logic and biases that underlie the differences of opinion

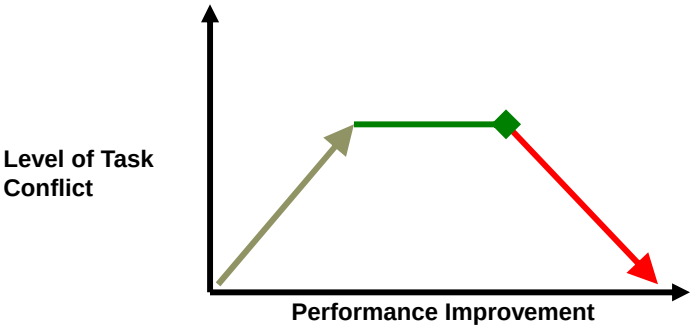
THE BENEFITS OF CONFLICT

Benefit of Conflict

"If we manage conflict constructively, we harness its energy for creativity and development."

Kenneth Kaye

Benefit of Task Conflict



More Benefits of Task Conflict

- Cause people to listen
- Enables people to find new solutions
- Results in participation and commitment to the group or person

Engaging in Constructive Conflict

- Create the right climate
- Groups need to foster trust, safety and emotional intelligence
- Another challenge for the group is to make sure disagreements don't derail the progress of the discussion

What Happens If We Don't Manage Task Conflict Well?

- It is likely to degenerate into relationship conflict
- That's why most of us avoid generating any type of conflict

Characteristics of Relationship Conflict

Stage 1:

"Daily Events"

Stage 2:

People are unable to separate the problem from the personality

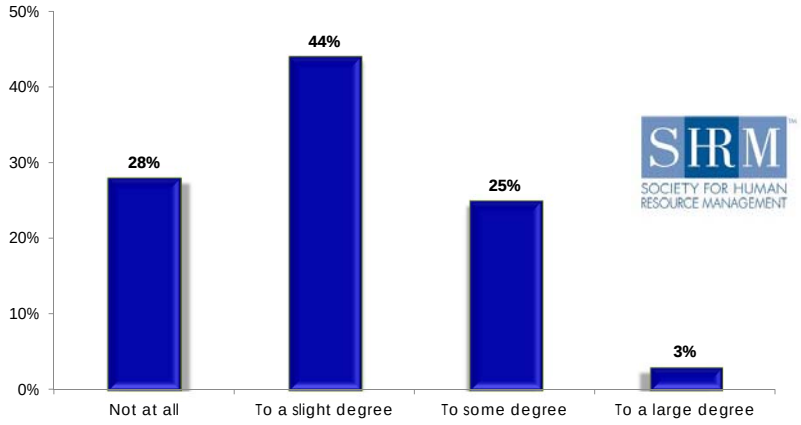
Stage 3:

Serious level of conflict in which parties are "out-to-get" each other

You need to intervene, or find a supervisor to intervene at Stage two, before conflict gets out of hand!

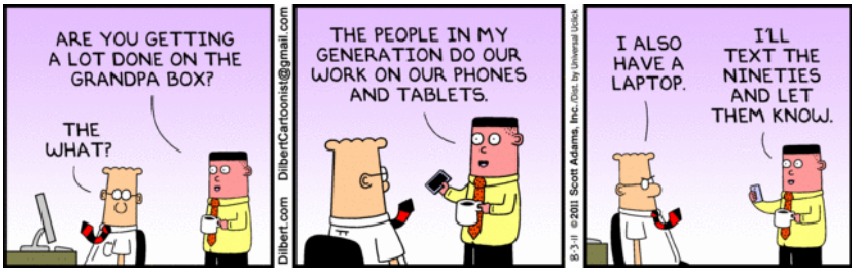
GENERATIONAL CONFLICTS

To What Extent Is Intergenerational Conflict an Issue in Your Workplace?



A recent poll by the Society for Human Resource Management (SHRM)

Generational Conflict in The Work Place



Generational Conflicts

Conflicts frequently have generational issues as their cause:

According to a survey by the Lee Hecht Harrison Company, 70 percent of older employees are dismissive of younger workers' abilities, and 50 percent of Millennial workers are dismissive of older workers' abilities.

Generational Conflict

Then there's the technology issue:

- The SHRM survey found that 38 percent of older workers raised concerns about younger employees "inappropriate use or excessive reliance on technology"
- Thirty-one percent of younger workers responded that their managers had an "aversion to technology"

Poll

What is the #1 complaint from "older" management, regarding the performance of younger workers?

A. **Inability to balance work and life**
B. **Low productivity**
C. **Inappropriate dress**
D. **Lack of respect for authority**

What complaints or concerns have people managers in your organization raised about the performance of younger workers?

Inappropriate dress	55%
Poor work ethic	54%
Excessively informal language and/or behavior	38%
Need for supervision	38%
Inappropriate use of or excessive reliance on technology	38%
Lack of respect for authority	36%
Lack of respect for organizational hierarchy	35%
Inability to balance work and life	28%
Inability to navigate office politics	24%
Inability to work within a defined structure	22%
Low productivity	19%
General skills deficiencies	18%
Inability to work as part of a team	17%

Poll

What complaints or concerns have younger workers in your organization raised about older managers?

A. **Micromanaging**
B. **Inflexibility**
C. **Aversion to technology**
D. **Resistance to change**

What complaints or concerns have younger workers in your organization raised about older managers?

Resistance to change	47%
Low recognition of workers' efforts	45%
Micromanaging	44%
Rigid expectations of following authority/chain of command	38%
Aversion to technology	31%
Low respect for workers' work/life balance	31%
Generally poor management skills	29%
Inflexibility	29%
Poor training/coaching skills	28%
Unfair or excessive criticism	26%
"Out of touch" with the reality of the job	26%
Excessive workload	24%
Excessively formal expectations for dress	17%

Generational Conflicts

- Seemingly, the generation that is **having the most conflict** with **Millennials** is the **Baby Boomers**
- This development is most likely due to the disconnect between each generations' work process
- Understanding how these two generations differ is the beginning of mediating any sort of conflict that may arise

THE TYPES OF WORKPLACE VIOLENCE

OSHA Classifications

- Type I - Criminal intent
- Type II - Customer/Client/Patients
- Type III - Co-worker
- Type IV - Personal

Type I - Criminal Intent

- In this kind of violent incident, the perpetrator has no legitimate relationship to the business or its employee(s).
- Rather, the violence is incidental to another crime, such as robbery, shoplifting, or trespassing. **Acts of terrorism also fall into this category.**

Type I

The vast majority of workplace homicides (85 percent) are Type I violence. Your workplace may be at higher risk of Type I violence if your business handles cash or drugs or could be a target for terrorists.

Type II - Customer/Client/Patients

- When the violent person has a legitimate relationship with the business—for example, the person is a customer, client, patient, student, or inmate—and becomes violent while being served by the business, violence falls into this category.
- A large portion of customer/client incidents occur in the healthcare industry, in settings such as nursing homes or psychiatric facilities; the victims are often patient caregivers.

Type II

- Only about 3 percent of all workplace homicides result from Type II violence, but this category accounts for a majority of nonfatal workplace violence incidents.
- Your workplace may be at risk for Type II violence if your business involves dealing with individuals such as criminals or those who are mentally ill or individuals who are confined and under stress, such as airplane passengers who have been sitting on the tarmac or customers waiting in long lines for a store to open.

Type III - Co-worker

- The perpetrator of Type III violence is an employee or past employee of the business who attacks or threatens other employee(s) or past employee(s) in the workplace.
- Worker-on-worker fatalities account for approximately 7 percent of all workplace homicides.

Type III

All workplaces are at risk for this type of violence, but workplaces at higher risk include those that do not conduct a criminal background check as part of the hiring process, or are downsizing or otherwise reducing their workforce.

Type IV - Personal

The perpetrator usually does not have a relationship with the business but has a personal relationship with the intended victim. This category includes victims of domestic violence who are assaulted or threatened while at work and accounts for about 5 percent of all workplace homicides.

Type IV

This type of violence can occur in all workplaces but is most difficult to prevent in workplaces that are accessible to the public during business hours, such as retail businesses, and/or have only one location, making it impossible to transfer employees who are being threatened.

Question

- As a CHW, what type of workplace violence might you be most at risk from?
- Why?

35 2016

DIFFICULT SITUATIONS

Dealing with difficult situations as a CHW

36 2013

Difficult Situations

- How would you describe a “difficult co-worker?”
- What situations can make a co-worker difficult to deal with?
- Is it fair to label someone as “difficult “?

Difficult Situations

- Be aware of your own feelings
- Don't "give up" on someone unless you feel unsafe or the relationship has impacted your own wellness.
- Develop a plan BEFORE you encounter a difficult situation to preserve your safety and the safety of others
  - Most agencies have emergency procedures, know those procedures
- Maintain control over yourself and the session. If unable to do so, act on your Safety Plan!
- Understand your limitations
- Involve your supervisor if you feel uncomfortable

The Red Flags

- Change in appearance, hygiene
- Rapid speech
- Agitated mood
- Change in life situation
- Not oriented to either time, place or person
- Threatening

Crisis Management

- Most effective tool is prevention, however, that is not always possible
- If unable to defuse situation, obtain assistance from another professional
- Always have a predetermined "get away plan"
- It is not your job to "solve" a crisis
- Help the person explore possible solutions and feel empowered
- **Ensure safety**

Conclusion

- We have identified the three levels of conflict
- You are now able to recognize some signs of dangerous situations developing
- We are now able to understand the generalized differences among generations in order to decrease misunderstandings, conflicts, stress, discomfort, frustration, and miscommunication
- We are able to name the four types of workplace violence

Evaluation

Please complete the module evaluation.

References

- **Why Are You Not Like Me? The Generational Gap In The Workplace** Psychology Today, Ray Williams 2009
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- **ASIS/SHRM WVPI.1-2011** American National Standard - 09/2/11
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- **The Real Cost of Workplace Conflict** - We reveal how much office drama cuts into your bottom line. Jennifer Lawler Entrepreneur 6/21/10
- **Workplace Violence – Issues in Response FBI Academy** 6/14/02
- **Generational Conflict: Millennials in the Workforce** James C. Price · 7/3/12
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- **Making it work: Four generations in the workplace,** Sue Newbry Haynie June 24, 2013

Module 6

Technology

Module 6 Technology

Indiana
Community Health Worker
Integrated Care
Training Program

ASPIN

Objectives

1) Understand the importance of technology in healthcare
2) Receive an overview of electronic medical records
3) Learn about phone application and health monitoring device resources
4) Learn ways to use the internet for community referrals

HOW IS TECHNOLOGY USED IN THE HEALTHCARE INDUSTRY?

The Importance of Technology and Healthcare

- Staying informed on the technologies that are currently in use in the field of healthcare is critical
- The software and hardware that is currently used within healthcare institutions is constantly changing
- Up to date knowledge of the technology can afford you an increased amount of job security
- Can help with signing up for and accessing your health insurance coverage

Top 10 Technologies Used in Healthcare

1. **The Electronic Health Record**

An (**EHR**) is an **electronic** version of a patient's medical history, that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular provider.

Top 10 Technologies Used in Healthcare

2. **mHeath**

Is an abbreviation for mobile **health**, a term used for the practice of medicine and public **health** supported by mobile devices.

Top 10 Technologies Used in Healthcare

3. **Telemedicine/ Telebehavioral health**

The remote diagnosis and treatment of patients by means of telecommunications technology.

Top 10 Technologies Used in Healthcare

4. **Portal technology**

A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password.

Top 10 Technologies Used in Healthcare

5. **Self-service kiosks**

Patient self-service kiosks are in use in healthcare facilities to speed the check-in process, collect copays, and perform other tasks.

Top 10 Technologies Used in Healthcare

6. **Remote monitoring tools**

(RPM), also called homecare telehealth, is a type of ambulatory healthcare that allows a patient to use a mobile medical device to perform a routine test and send the test data to a healthcare professional in real-time.

Top 10 Technologies Used in Healthcare

7. **Sensors and wearable technology**

Wearable devices such as activity trackers (Fitbits) are a good example of wearable technology embedded with electronics, software, sensors and connectivity to enable objects to exchange data with a manufacturer, operator and/or other connected devices, without requiring human intervention.

Top 10 Technologies Used in Healthcare

8. **Wireless communication**

The use of wireless devices by caregivers to communicate in real time.

Top 10 Technologies Used in Healthcare

9. Real-time locating services

Hospitals can implement electronic tracking systems for instruments, devices and even clinical staff.

Top 10 Technologies Used in Healthcare

10. Pharmacogenomics/genome sequencing

Pharmacogenomics is a branch of pharmacology concerned with using DNA and amino acid sequence data to inform drug development and testing. An important application of **pharmacogenomics** is correlating individual genetic variation with drug responses.

THE ELECTRONIC HEALTH RECORD

EMR vs EHR – What is the Difference?

- Some people use the terms "electronic medical record" and "electronic health record" (or "EMR" and "EHR") interchangeably
- The EMR term came along first, and indeed, early **EMRs were "medical."** They were for use by clinicians mostly for diagnosis and treatment
- **EHRs go a lot further than EMRs.** EHRs focus on the total health of the patient—going beyond standard clinical data collected in the provider's office and inclusive of a broader view on a patient's care
- EHRs go with the patient!

Definition (from CMS)

An Electronic Health Record (EHR) is an electronic version of a patient's medical history, that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports.

The Electronic Health Record

- The EHR automates access to information and has the potential to streamline the clinician's workflow
- The EHR also has the ability to support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management, and outcomes reporting
- EHRs are the next step in the continued progress of healthcare that can strengthen the relationship between patients and clinicians

The Electronic Health Record

The EHR can improve patient care by:

- Reducing the incidence of medical error by improving the accuracy and clarity of medical records
- Making the health information available, reducing duplication of tests, reducing delays in treatment, and patients well informed to take better decisions

Benefits of EHRs

With fully functional EHRs, **all members of the team** have ready access to the latest information allowing for more coordinated, patient-centered care. With EHRs:

- The information gathered by the primary care provider tells the emergency department clinician about the patient's life threatening allergy
- A patient can log on to his own record and see the trend of the lab results over the last year

Benefits of EHRs

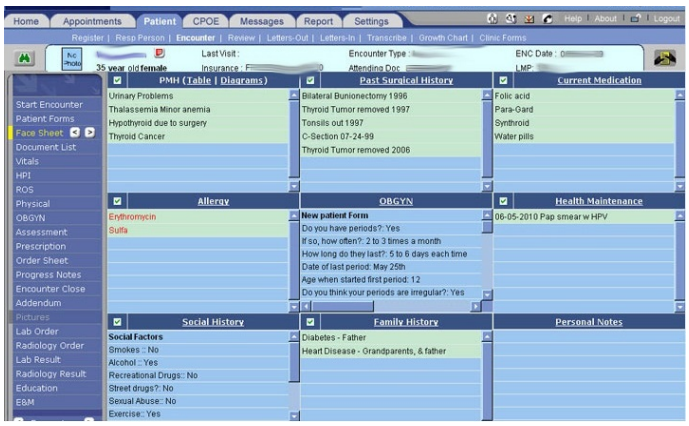
- The lab results run last week are already in the record to tell the specialist what she needs to know without running duplicate tests.
- The clinician's notes from the patient's hospital stay can help inform the discharge instructions and follow-up care and enable the patient to move from one care setting to another more smoothly.

The Electronic Health Record

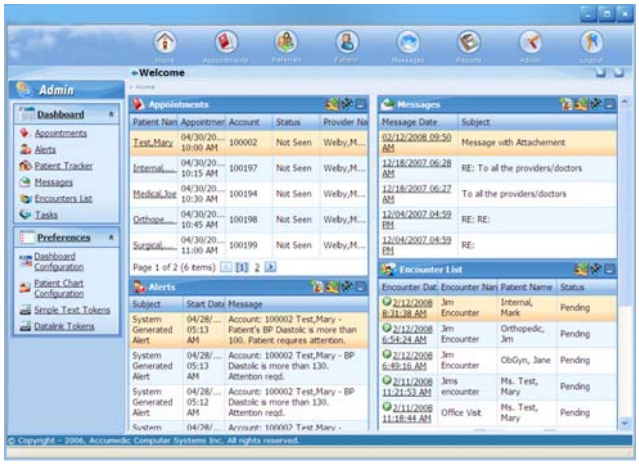
- As a CHW, you very well have responsibilities that involve entering patient data in an EHR!
- There is not one standard EHR software package, each organization purchases, or develops, their own system
- **There are 100's of Vendors!**
- So what do they look like?

The Electronic Health Record

Some examples of EHR records:



The Electronic Health Record



EHR Interface Example: The Pathways Community HUB

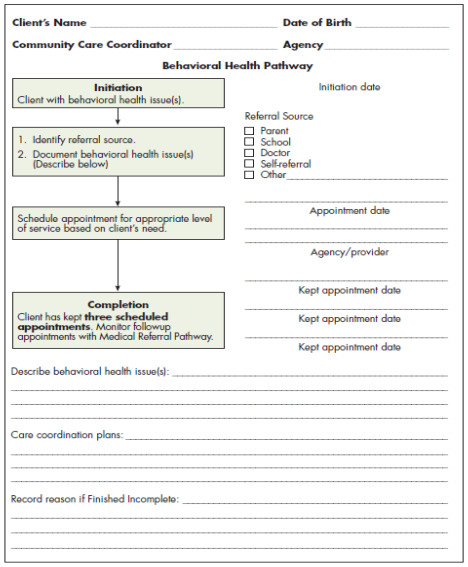
- The HUB relies on community care coordinators (CCCs)—community health workers, nurses, social workers, and others—who reach out to at-risk individuals through home visits and community-based work
- Once an at-risk individual is engaged, the CCC completes a comprehensive assessment of health, social, behavioral health, economic, and other issues that place the individual at increased risk
- Each identified risk factor is tracked as a standardized Pathway that confirms the risk is addressed through connection to evidence-based and best practice interventions

The Pathways Community HUB

The Pathways Community HUB model is best summarized in three steps:

1. Find
2. Treat
3. Measure

Behavioral Health Pathway Example



Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Behavioral Health Pathway

Initiation
Client with behavioral health issue(s).

Initiation date

1. Identify referral source.
2. Document behavioral health issue(s) (Describe below)

Referral Source
- ☐ Parent
- ☐ School
- ☐ Doctor
- ☐ Self-referral
- ☐ Other_____

Schedule appointment for appropriate level of service based on client's need.

Appointment date

Agency/provider

Completion
Client has kept **three scheduled appointments**. Monitor followup appointments with Medical Referral Pathway.

Kept appointment date

Kept appointment date

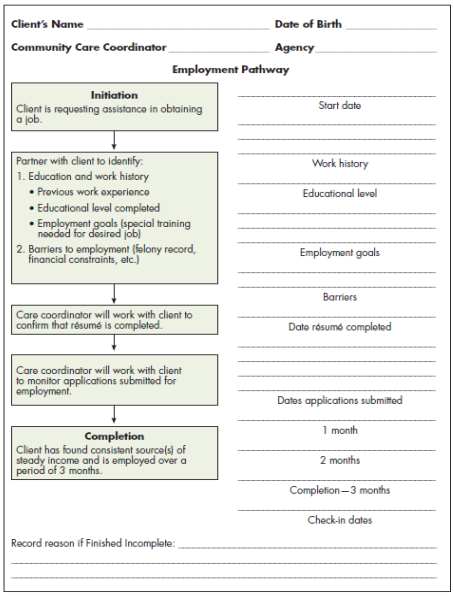
Kept appointment date

Describe behavioral health issue(s): _____

Care coordination plans: _____

Record reason if Finished Incomplete: _____

Employment Pathway Example



Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Employment Pathway

Initiation
Client is requesting assistance in obtaining a job.

Start date

Partner with client to identify:
1. Education and work history
   - Previous work experience
   - Educational level completed
   - Employment goals (special training needed for desired job)
2. Barriers to employment (felony record, financial constraints, etc.)

Work history

Educational level

Employment goals

Barriers

Care coordinator will work with client to confirm that résumé is completed.

Date résumé completed

Care coordinator will work with client to monitor applications submitted for employment.

Dates applications submitted

Completion
Client has found consistent source(s) of steady income and is employed over a period of 3 months.

1 month

2 months

Completion—3 months

Check-in dates

Record reason if Finished Incomplete: _____

PHONE APPLICATION AND HEALTH MONITORING DEVICES

The Use of Apps in Healthcare

- A mobile app is a computer program that is designed to run on smartphones, tablet computers and other mobile devices and can be easily moved from place to place.
- These products, which may count steps, calculate burned calories, or record heart rates and sleep cycles, all have the goal of helping individuals to live a healthy lifestyle.

Smartphones

- As of January 2014, 90% of Americans own a cell phone with 64% owning a smartphone (Pew Research Center, 2014). The use of cell phones has made it universally easier for people to stay in contact with each other regardless of their physical location.
- The use of mobile technology is spreading into the healthcare field as well, as it enables clinicians to assist their clients in their everyday lives and provides tools for regular self-care and behavior modification.

The Use of Apps in Healthcare

These Apps can:

- Reduce the Hospitalizations Days and/or Emergency Department Visits
- Improve clients' physical health
- Decrease clients' social needs
- Improve clients' mental health
- Increase clients' satisfaction with services

Some Examples

- Fitbit
- S Health
- BP Watch
- LifeSum
- Sworkit
- Mental Health 'WATS'
- Code Blue Allergy
- Eats
- Healthy Out
- Lumosity
- Calm
- Realifex
- Twenty Four Hours a Day
- Sugar Sense
- Sleepio
- CBT
- Breathe2Relax
- WebMD
- SparkPeople
- 7 Minute Workout

Be Careful!

- Behavioral health apps are not extensively regulated for the most part, and not all apps available in app stores are evidence-based. Since there is limited regulation in regard to apps, there is no guarantee that the information an app presents is accurate!

- For updated information on the regulation of mobile applications by the FDA, visit: www.fda.gov/forconsumers/consumerupdates/

USING THE INTERNET FOR COMMNITY REFERALLS

Google It!

- Yield results quickly through search engines like Google, Yahoo, etc.
- You can use the internet to find local resources in areas such as:
  - Healthcare/Insurance
  - Education
  - Housing
  - Childcare Services
  - ...and other Social Services

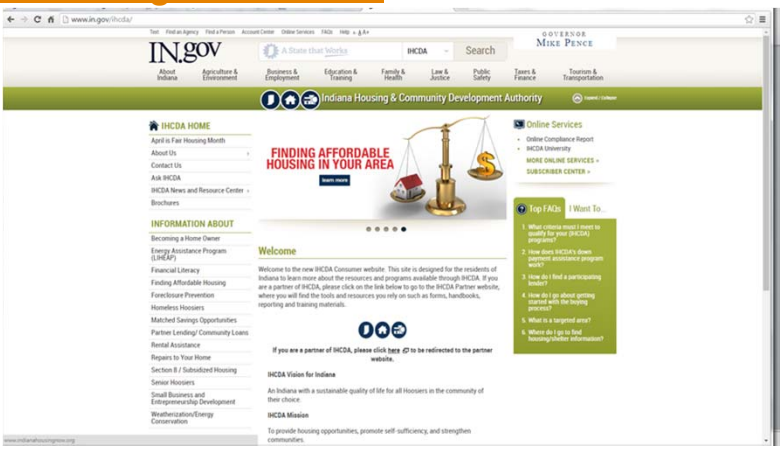
Health Insurance – ASPIN Health Navigator Program

www.aspinhealthnavigator.org

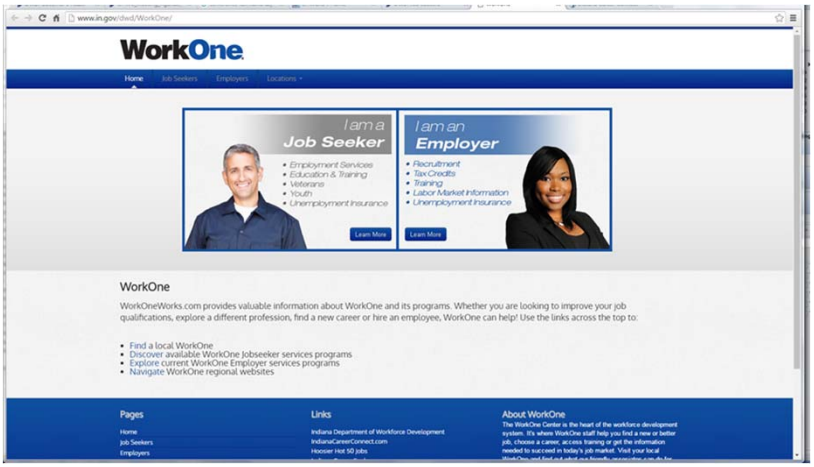
Behavioral Health- Family and Social Services (FSSA)

www.in.gov/fssa/dmha/index.htm

Housing – Indiana Housing & Community Development Authority
www.in.gov/ihcda/



Employment – WorkOne
www.in.gov/dwd/WorkOne/



Education – Indiana Department of Workforce Development www.in.gov/dwd/adulted.htm

Conclusion

In this module we have discussed:

- The importance of technology in healthcare
- Electronic medical records
- Phone application and health monitoring device resources
- Ways to use the internet for community referrals

Evaluation

Please complete the module evaluation.

Resources

- The Medical Technologies That Are Changing Health Care- H&HN Online, John Morrissey 4/14/15
- The Importance of Staying Up-To-Date with Healthcare – New Directions Staffing Online, 2/16/16
- 10 Biggest Technological Advancements for Healthcare in the Last Decade – Becker's Health IT & CEO review , Akanksha Jayanthi 1/28/15
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- EMR vs EHR – What is the Difference? – Health IT Buzz, Peter Garrett Joshua Seidman PhD 1/4/11
- Smart Ways to Manage Health Need Smart Regulation, FDA Voice, Bakul Patel, M.S., M.B.A. &Jeffrey Shuren, M.D., J.D. 2/6/15
- A Framework for Mobile Technology in Behavioral Healthcare, Centerstone Research Institute, 10/12/14
- Replication of the Pathways Community HUB Model – Legislative Briefing, Ohio Commission on Minority Health, HUB Replication Team 8/15/15
- Connecting Those at Risk to Care The Quick Start Guide to Developing Community Care Coordination Pathways, U.S. Department of Health and Human Services January 2016

Healthcare App Resources

The following list of healthcare phones apps were collected on a CHW/CRS Connect Call in 2016 with CHWs /CRSs.

- **Fitbit**- physical health monitoring device worn on the wrist.
- **S Health** – physical heath tracker.
- **MyFitnessPal** – calorie, nutrition/physical health tracker
- **BP Watch** – track and analyze blood pressure.
- **LifeSum** - Healthy living & eating app. Includes recipes
- **Sworkit** – smart phone app. Exercise/circuit training app
- **Mental Health 'WATS'** – interactive mental health app including info, videos, & support groups.
- **Code Blue** - for young people experience depression & bullying. Launching in the spring
- **Allergy Eats –** locate food allergy-friendly restaurants
- **DBT Skills app** (Unsure of name?) – allows you to keep a diary
- **Healthy Out –** healthy nutrition app
- **Lumosity -** Mind exercises, brain training
- **Calm –** Meditation, sleep, & relaxation app
- **Realifex** – personal diary to track moments in your daily life
- **Twenty Four Hours a Day** – app useful in NA. meditation, motivational sayings & prayers
- **Sugar Sense** – Diabetes app. Track blood sugar & includes graph to show stats
- **Sleepio** – CBT app to help with sleep tracking
- **CBT -** for kids, teens, and adults. Track negative thoughts and feelings
- **Breathe2Relax –** stress management app
- **WebMD –** basic health condition information including symptoms & treatment tools
- **SparkPeople –** Healthy lifestyle app including nutrition information
- **7 Minute Workout –** physical activity app
- **Omvana –** meditation, focus, and sleep app. Includes calming music
- **Nike Training Club** – physical activity app
- **iPhone Health app** – Medical ID & information that can be shared with healthcare professionals
- **MapMyWalk –** utilizes GPS to track walking/fitness activities
- **MapMyRide –** utilizes GPS to track biking/fitness activities
- **HealthTap –** immediate access to a doctor for advice, answers, & tips
- **VA App Store –**veteran healthcare apps https://mobile.va.gov/
- **Joe & Charlie (Alcoholics Anonymous) –** lifestyle support for alcoholism
- **One Recovery on the Go –** apps for members of 12 step programs
- **Drugs.com Medication Guide –** look up drug info, identify pills, check interaction, etc.
- **120+ Mental Health Disorders –** breakdown of the DSM 5
- **Runkeeper –** GPS tracker for running and walking
- **Pacify –** support for pregnant women and new mothers including video consultations

Module 7

Communication Skills

Module 7 Communication Skills

Indiana Community Health Worker Integrated Care Training Program

1

Objectives

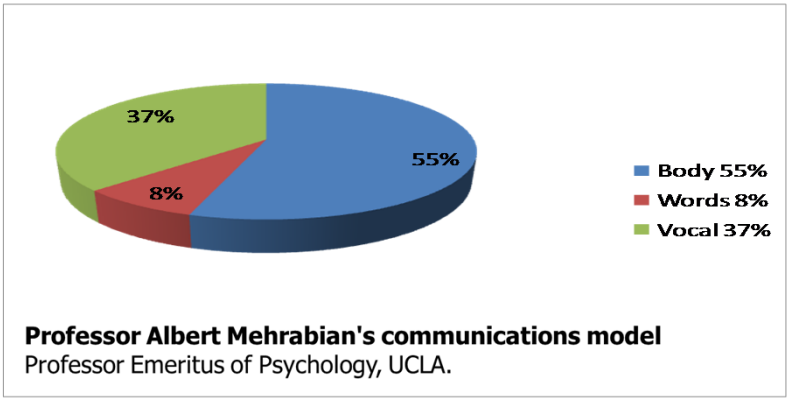
1) Understand the importance of verbal and non-verbal communication
2) Understand the benefits of and practice reflection as a communication tool
3) Learn and practice ice-breaking, self-introductions, and person-centered listening
4) Discuss how the different generations communicate

What is Communication?

- It is through communication that one learns about the strengths/problems of others.
- Through communication one conveys meaning, emotion, and importance.
- Good communication allows for an understanding of others' feelings and thoughts.
- Through communication, by telling their own story, consumers also "process" information about themselves.
- Perhaps most importantly, effective communication is vital in instilling hope in others.

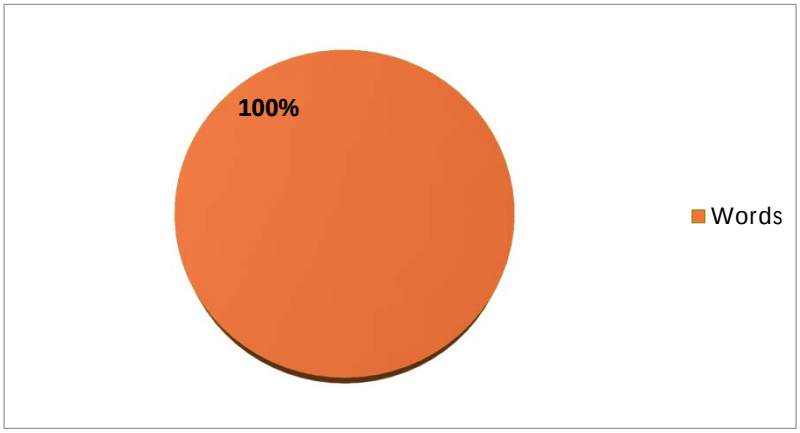
Verbal and Non-Verbal Communication

Only 8% of what is communicated is verbal



Professor Albert Mehrabian's communications model
Professor Emeritus of Psychology, UCLA.

Meaning of a Message via Text or Email



Other Non-Verbals

- Posture - Crossing arms and legs may be a clue to the consumer you are not paying attention
- Eye Contact - Concentrate (without staring) on making eye contact during conversations
- Facial Expressions - What can Facial Expressions say?
- Tone or Volume of Voice
- Any others?

Dress and Non-Verbal Communication

Would you wear this in a session with a client? Why or why not?

1

2

Dress and Non-Verbal Communication

Would you wear this in a session with a client? Why or why not?

1

2

Dress and Non-Verbal Communication

Would you wear this to a session with a client? Why or why not?

How Do We Meet Each Other?

- Introductions by others
- Introduction by self
- Handshakes

CULTURAL COMMUNICATION

Cultural Differences in Non-verbal Communication

Non-verbal communication or body language is an important part of how people communicate and there are differences from culture to culture. Hand and arm gestures, touch, and eye contact (or its lack) are a few of the aspects of nonverbal communication that may vary significantly depending upon cultural background.

Cultural Differences in Non-verbal Communication

Gestures: Pointing with one finger is also considered to be rude in some cultures and Asians typically use their entire hand to point to something.

Touch: In the Middle East, the left hand is reserved for bodily hygiene and should not be used to touch another or transfer objects.

Eye Contact: In many cultures, including Hispanic, Asian, Middle Eastern, and Native American, eye contact is thought to be disrespectful or rude

Cultural Differences in Communication

Of special note when working with babies:

Although it is common in Western culture for adults to admire babies and young children and comment upon how cute they are, this is avoided in Hmong and Vietnamese cultures for fear that these comments may be overheard by a spirit that will try to steal the baby or otherwise cause some harm to come to him or her.

GENERATIONAL COMMUNICATION

Generational Communication

- Effective communication across the generations is needed to create and maintain healthy relationships.
- Many people struggle with a generational disconnect when it comes to communication.
- Half the battle is being aware each generation has a different way of communicating. It can help you anticipate miscommunication and tailor your message.

Traditionalists: 1927- 1945

- Traditionalists, like formal, respectful verbal communication.
- By nature Traditionalists are private, the "silent generation". Don't expect members of this generation to share their thoughts immediately.
- They prefer written communication as opposed to electronic.
- They could be offended by a shout across the room.

Baby Boomers: 1946 - 1964

- Boomers are the "show me" generation, so your body language is important when communicating.
- Speak in an open, direct style but avoid controlling language.
- Answer questions thoroughly and expect to be pressed for the details.
- Present options to demonstrate flexibility in your thinking.

Gen Xers: 1965 - 1983

- Use email as a primary communication tool if allowed.
- Talk in short sound bites to keep their attention.
- Ask them for their feedback and provide them with regular feedback.
- Share information with them on a regular basis and strive to keep them in the loop.
- Use an informal communication style.

Millennials: 1984 - 2002

- Millennials are driven by technology, and they use technology whenever possible to communicate; If allowed by your employer.
- Use action words and challenge them at every opportunity.
- They will resent it if you talk down to them.
- They prefer electronic communication.
- Use humor
- Don't take yourself too seriously.

Generation – 2002 On

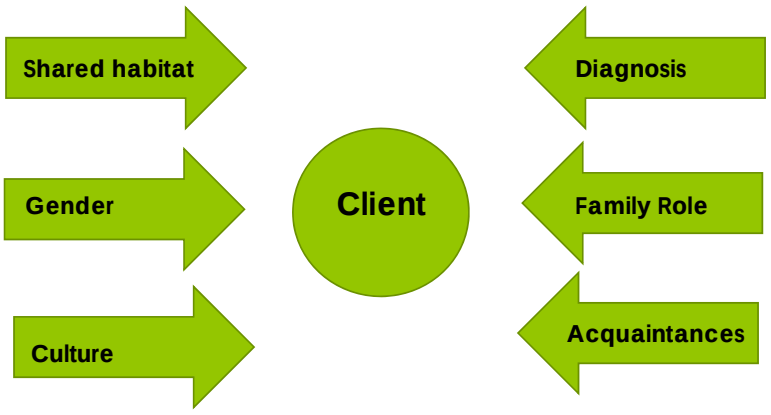
- Gen Z communicates with images and they multi-task across 5 screens as opposed to Millennials preferring to communicate on 2 screens and via text.
- Gen Z's attention spans are getting shorter as well, explaining their preference for video and images rather than text.
- They communicate in symbols. They speak in emoticons and emojis.

Generational Communication Summary

- Five very different generations.
- In the workplace, we all work towards a common goal and must communicate.
- Communicating effectively between the generations can help you be more productive.

HOW DO WE RELATE?

How Do We Relate?



Listening: An Important Communication Tool

How one listens is a learned skill and influenced by one's social environment.

- It is possible that persons of one gender may listen differently from persons of another gender.
- Persons with disabilities may demonstrate active listening in a different manner.
  - A person with cerebral palsy may not be able to make eye contact.
  - A person with autism may have difficulties maintaining eye contact.

Irritating Listening Habits

Here are some examples of irritating listening habits:

- Interrupting the speaker.
- Not looking at the speaker.
- Rushing the speaker and making him feel that he's wasting the listener's time.
- Showing interest in something other than the conversation, such as your phone.
- Getting ahead of the speaker and finishing her thoughts.

Irritating Listening Habits

Here are some more examples of irritating listening habits:

- Not responding to the speaker's requests.
- Saying, "Yes, but . . .," as if the listener has made up his mind.
- Topping the speaker's story with "That reminds me..." or "That's nothing, let me tell you about..."
- Forgetting what was talked about previously.
- Asking too many questions about details.

Irritating Listening Habits Exercise

- As a self assessment, on your own time, assess your listening habits on the Listening Self-Inventory. Place a check mark next to the issues you believe you may need to work on
- If most of your answers were a or b you probably possess good listening skills and the ability to concentrate and to recognize the speaker's emotions. If most answers were c, d, or e, you need to develop these characteristics more fully

How to Be a Better Listener

- Block out distractions.
- Examine the full message.
- Avoid responding in a manner that closes communication. (i.e. “You’re wrong. You need to..”)
- Ask questions that invite the person to say more.
- Respect the speakers’ right to feel the way they feel and think they way they think.
- Practice non-judgmental attitude.
- Eliminate electronic distractions.

Roadblocks to Communication

- Not observing or listening to the client will demonstrate lack of total commitment, which is unacceptable.
- Responding with continual empathetic responses without the use of other responses might cause a client to lose interest, and will detract from the session.
- Mechanical responses, particularly when responding with empathy, will detract from the session.

Roadblocks to Communication

- Labeling a feeling involves listening, watching, and understanding. If you are not accurate in labeling a feeling, do not let that deter you from the skills described.
- If you are not genuine in your responses, the client will know eventually. Creating an atmosphere of honesty and caring will help.
- Be aware of the client's comfort level. Do not bombard or coerce the client with questions if he or she seems reluctant to answer.

Roadblocks to Communication

- Use open-ended and closed questions at the appropriate times.
- Failure to account for cultural differences will affect the way one listens and/or expresses him or herself.
- Differing values can become a barrier if the CHW is more focused on preserving his or her own value system and is uncomfortable with other perspectives.

REFLECTING

Role Play

I really want to get a new job, but my partner is keeping me busy at home right now. I can't do both. She is keeping me from doing what I want to do.

Try the Reflection Technique

- Divide into pairs as assigned.
- Obtain a role play scenario from your instructor.
- One of you is the client, the other the CHW.

You will have 5 minutes to complete the role play.

Conclusion

In this module we:

- Learned the importance of verbal and non-verbal communication
- Looked at the benefits of and practiced reflection as a communication tool
- Learned and practiced ice-breaking, self-introductions, and person-centered listening
- Discussed how the different generations communicate

Evaluation

Please complete the module evaluation.

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- Cultural Differences in Nonverbal Communication Joanne Ikeda, M.A., R.D.; University of California, Berkley, Charles Tidwell Jr. Ph.D.; Andrews University, Berrien Springs, Michigan, The Protocol School of Washington
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- Listen Up: How to Improve Relationships, Reduce Stress, and Be More Productive by Using the Power of Listening - Larry Barker & Kittie Watson, 2000

Listening Self Inventory

1. Research suggests that you think four times faster than a person usually talks to you. Do you use this excess time to turn your thoughts elsewhere while you are keeping track of the conversation?
    A. No
    B. Sometimes
    C. Usually
    D. Yes
    E. Don't know/unaware
2. Do you listen for the feelings behind facts when someone is speaking?
    A. Almost always
    B. Most of the time
    C. Not as much as I should
    D. Almost never
    E. Don't know/unaware
3. Do you generally talk more than listen in an interchange with someone else?
    A. No
    B. Sometimes
    C. Usually
    D. Yes
    E. Don't know/unaware
4. When you are puzzled or annoyed by what someone says, do you try to get the question straightened out immediately, either in your own mind or by interrupting the speaker?
    A. No
    B. Sometimes
    C. Usually
    D. Yes
    E. Don't know/unaware
5. If you feel that it would take a lot of time and effort to understand something, do you go out of your way to avoid hearing about it?
    A. Seldom
    B. Sometimes
    C. Often
    D. Very frequently
    E. Don't know/unaware
6. Do emotions interfere with your listening?
    A. No
    B. Sometimes
    C. Usually
    D. Yes
    E. Don't know/unaware

7. Do you deliberately turn your thoughts to other subjects when you believe a speaker will have nothing particularly interesting to say?
    A. Seldom
    B. Sometimes
    C. Often
    D. Very frequently
    E. Don't know/unaware
8. When someone is talking to you, do you try to make him/her think you're paying attention when you are not?
    A. Seldom
    B. Sometimes
    C. Often
    D. Very frequently
    E. Don't know/unaware
9. When you are listening to someone, are you easily sidetracked by outside distractions (people and events)?
    A. Seldom
    B. Sometimes
    C. Often
    D. Very frequently
    E. Don't know/unaware
10. Do you listen carefully to the opinions of others, though you may intend to take exception to something later on?
    A. Almost always
    B. Most of the time
    C. Not as much as I should
    D. Almost never
    E. Don't know/unaware
11. When listening to someone who speaks with an accent, do you make a greater effort to concentrate on what the person is saying?
    A. Almost always
    B. Most of the time
    C. Not as much as I should
    D. Almost never
    E. Don't know/unaware
12. When you are listening to someone speak, do you make a conscious effort to make and keep ye contact with the speaker?
    A. Almost always
    B. Most of the time
    C. Not as much as I should
    D. Almost never
    E. Don't know/unaware

Scoring: If most of your answers were a or b you probably possess good listening skills and the ability to concentrate and to recognize the speaker's emotions. If most answers were c, d, or e, you need to develop these characteristics more fully. Reproduced from "50 Activities for Diversity Training" by Jonamay Lambert and Selma Myers. HRD Press, 1994

Module 8

Practices That Promote Health and Wellness

Module 8 Practices that Promote Health and Wellness

Indiana Community Health Worker Integrated Care Training Program

ASPIN

1

Objectives

1) Become familiar with community resources
2) Practice empowerment approaches
3) Understand how to make effective referrals
4) Practice follow-up strategies

Let's Brainstorm

What gets in the way of healthy living?

BECOME FAMILIAR WITH COMMUNITY RESOURCES

Handout – Community Resources

What CHWs Do to Support Change

- Remove barriers
- Make referrals for special assistance
- Empower
- Develop hope
- Share information
- Assist in formation of the picture of the changed life

PRACTICE EMPOWERMENT APPROACHES

Powerlessness

At the individual level, powerlessness can be seen as the expectation of the person that his/her own actions will be ineffective in influencing the outcome of life events.

What is Empowerment?

- Empowerment is a collaborative method where those 'facilitated' participate in the change process.
- Empowerment respects the participant's right to autonomy, increases the ability for autonomy, increases other coping skills.

Key Empowerment Targets

- Collaboration – attention to the relationship
- Client takes the lead
- Attentive communication
- Ask permission to share new information
- Reflect on the strengths that you see
- Help client get in touch with ways he/she adjusted or achieved goals in the past
- Acknowledge steps taken

How would you empower Bill?

Bill is a 60 year old white male, recently diagnosed with cataracts. He is deciding about whether to have surgery in the near future. His concerns include: belief that he will have to take off weeks of work that he cannot afford; belief that his eyes are not bad yet; belief that he will have to wear contacts or really thick glasses after surgery; has no one to take him to/from appointments as he and wife are recently divorced; believes that he is physically falling apart as this comes after additional diagnoses of diabetes and hypertension.

Tracy

Tracy is a 28 year old African American female who is pregnant with her third child. She is frazzled by her 4 and 5 year olds; is morbidly obese, with gestational diabetes, and a diagnosis of bi-polar disorder. Tracy has stopped attending her pre-natal visits and received a DUI in the recent past. Fortunately, her children were not in the car at the time. Tracy feels that her life is out of control, and that the doctor is another person who will lecture her and make her feel worse.

Understand the Barriers

- Time
- Transportation
- Insufficient information
- System distrust
- Access
- Cultural lens

UNDERSTAND HOW TO MAKE EFFECTIVE REFERRALS

Making Effective Referrals

- Should be of strong interest to the client
- Client should be a good fit (eligibility, culture, purpose)
- Have all needed contact information – Write it down!
- Know the personal contact

Making Effective Referrals (Cont.)

- Anticipate the follow-up with the client
- Support the client in making the connection whenever possible
- Support the client in pulling together required documents
- Provide agency with documents you provide (must have client consent)

When Referring

- Explain the purpose
- Describe the services
- Know a specific contact person
- Write down all information
- Gauge readiness
- Ask what might hold the client back
- Support the immediate connection

PRACTICE FOLLOW-UP STRATEGIES

Barb

Barb is a 53 year old white female who has decided that she is ready to work on her health. She would like to learn more about available, low cost exercise programs near her home. She is very stressed about her husband's alcoholism, and avoids "rocking the boat" at home. He may not approve of her exercise plan, especially if it interferes with her responsibilities at home.

Follow-Up

- What was the client's impression of the agency's ability to help?
- Would the client recommend the agency to others?
- Thank the client for taking the step. Let him/her know that you are still available to them.
- Set up another check-in point.

Conclusion

During this module:

- We became familiar with community resources
- Practiced empowerment approaches
- Learned how to make effective referrals
- Practiced follow-up strategies

Evaluation

Please complete the module evaluation.

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Community Resources

Focus	Organization/Description	Contact
Parenting	**Childhelp** (child abuse victims, parents, concerned individuals) **Darkness to Light** (for local information or resources about sexual abuse) **National Parent Helpline** (parents/caregivers needing emotional support and links to resources) 10-7 weekdays PST **Careline** (stressed parents/caregivers) **Nineline** (parents/caregivers of teens making life-changing decisions or crisis)	800-422-4453 866-367-5444 855-427-2736 800-244-5373 800-999-9999
Food		
Clothing		
Recreation/Networking		
Transportation		
Special Populations		
Spirituality		

Community Resources

Mental Health/Suicide	**NAMI** (individuals, families, professionals) 10-6 weekdays Eastern **Suicide Prevention Lifeline** (families, individuals)	800-950-6264 800-273-8255; TTY: 800-799-4889
Medical		
Employment		
Child Care		
Physical Activity		
Financial Counseling		
Homeless Resources		
Military		

Community Resources

Elderly		
Legal		
Housing		
Special Needs		
Abuse Reporting	**Child Abuse** **Elder Abuse**	800- 800-5556 800-992-6978
Domestic Violence	**National Domestic Violence Hotline**	800-799-7233; TTY: 800-787-3224
Addiction		
Human Trafficking	**National Human Trafficking Hotline** (victims and reporting of potential situations)	888-373-7888

Community Resources

General/Multiple	**Indiana 2-1-1** (food, shelter, clothing, more) **Indiana Family Helpline** (referral for maternal/child health, WIC, dental providers. Bilingual)	211 800-433-0746

Community Resources

Module 9

Physical Health/Chronic Disease Overview

Module 9 Physical Health/Chronic Disease Overview

Indiana Community Health Worker Integrated Care Training Program

ASPIN

1

Objectives

1) Identify lifestyle components of health
2) Describe how lifestyle choices are frequently limited by environmental and intrinsic factors
3) Identify leading causes of death linked to common chronic diseases prevalent in Indiana
4) Demonstrate basic understanding of healthy guidelines for nutrition, physical activity, tobacco, and stress management

LIFESTYLE COMPONENTS OF HEALTH

United States versus "Peer" Countries

According to findings documented in a 2013 National Research Council and Institute of Medicine report (Woolf & Aron, 2013), when compared with 16 other high-income "peer" countries, the U.S. is **less healthy** in key areas, including obesity, diabetes, heart disease, chronic lung disease, and disability.

US Burden Summary

Chronic diseases

- Are principal causes of suffering, disability, and death.
- Account for most health care expenditures.

CDC: "Chronic diseases are the leading causes of death and disability."

As of 2012:

- About half of all adults—117 million people—have one or more chronic health conditions.
- One of four adults has two or more chronic health conditions.

117 Million Adults	≥1 Chronic Condition

Chronic Diseases

In 2013:

- Seven of the top 10 causes of death were chronic diseases.
- Two of these, **heart disease** and **cancer,** together accounted for 46% of all deaths.

Chronic Diseases

Diabetes is the leading cause of:

- Kidney failure
- Lower-limb amputations other than those caused by injury
- New cases of blindness among adults

Chronic Diseases

Obesity is a serious health concern.

- More than 1/3 of adults were obese (defined as body mass index [BMI] ≥30 kg/m^2)
- Nearly 16% of youth aged 2 to 19 years were obese (BMI ≥95th percentile)

Chronic Diseases

Arthritis is the most common cause of disability.

- About 1 out of every 5 US adults has doctor-diagnosed arthritis.
- Symptoms include pain, aching, stiffness and swelling around joints.
- Some forms may affect multiple organs and cause widespread symptoms.

LIFESTYLE CHOICES ARE FREQUENTLY LIMITED BY ENVIRONMENTAL AND INTRINSIC FACTORS

Health Risk Behaviors

Health risk behaviors are unhealthy behaviors that can be changed. Four of these behaviors cause much of the illness, suffering, and early death related to chronic diseases and conditions:

- Lack of exercise or physical activity
- Poor nutrition
- Tobacco use
- Drinking too much alcohol

Health Risk Behaviors: Heart Disease and Stroke

About half of adults (47%) have at least one of the following major risk factors for heart disease or stroke:

- Uncontrolled high blood pressure and 90% of Americans consume too much sodium, increasing their risk of high blood pressure
- Uncontrolled high LDL cholesterol
- Are current smokers

Health Risk Behaviors: Lack of Exercise or Physical Activity

In 2011:

- 52% of adults aged 18 years or older did not meet recommendations for aerobic exercise or physical activity
- 76% did not meet recommendations for muscle-strengthening physical activity

Health Risk Behaviors: Poor Nutrition

In 2011:

- About a third (36%) of adolescents and 38% of adults said they ate fruit less than once a day
- While 38% of adolescents and 23% of adults said they ate vegetables less than once a day

Health Risk Behaviors: Tobacco Use

- According to the CDC in 2012, Cigarette smoking accounted for more than 480,000 deaths each year.
- More than 42 million adults—close to 1 of every 5—said they currently smoked cigarettes.

Each day:

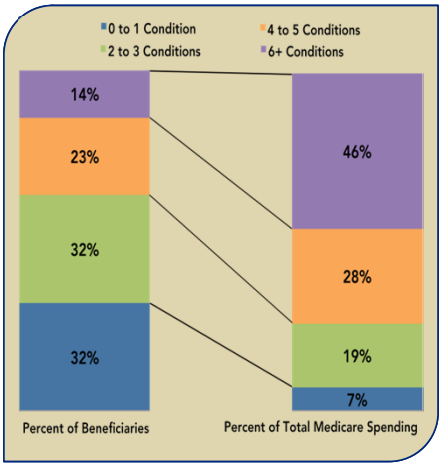
- More than 3,200 youth younger than 18 years smoke their first cigarette.
- Another 2,100 youth and young adults who smoke every now and then become daily smokers.

Health Risk Behaviors: Drinking Too Much Alcohol

- Drinking too much alcohol is responsible for 88,000 deaths each year, more than half of which are due to binge drinking.
- About 38 million adults report binge drinking an average of 4 times a month, and have an average of 8 drinks per binge, yet most binge drinkers are not alcohol dependent.

Chronic Diseases Are Costly

- In 2010, total spending for the Medicare population (largely aged ≥65 years) was more than $300 billion.
- 93% of Medicare spending was for people with ≥2 chronic conditions.



Chronic Diseases: Cause of Disability and Lost Productivity

- 12.6% of the population have a disability, including 43.8% of those aged 75 or older.
- Lost productivity resulting from chronic conditions and risk factors is associated with enormous costs for those remaining in the workforce and for those who leave the workforce prematurely because of disability.

Chronic Diseases: Unequal Distribution

The burden is associated with:

- Education/income
- Race/ethnicity
- Geography

Chronic Diseases: Unequal Distribution

Examples:

- Stroke death rates highest in Southeast.
- Smoking prevalence highest among some American Indian tribes.
- Cardiovascular disease death rates highest among African Americans.
- Obesity rates highest among those with low education or low income

LEADING CAUSES OF DEATH LINKED TO COMMON CHRONIC DISEASES PREVELANT IN INDIANA

Chronic Disease in Indiana

Chronic diseases - What are they?

- Illnesses and health conditions with prolonged impact on a person's health
- Chronic diseases are the leading causes of death and disability in Indiana and the U.S.
- In addition to the human cost, the economic burden reaches into the $ billions
- Estimated billions of dollars are lost due to decreased workplace productivity related to chronic diseases

Chronic Disease in Indiana

- Majority of Indiana's 6.5 million people affected by one or more chronic diseases
- Many of these cases directly linked obesity and tobacco use in Indiana - 32% of Hoosier adults report being obese and Indiana ranks among the highest in states in adult smoking (BRFSS 2014)
- Chronic diseases are often preventable and manageable through early detection:
  - improved nutrition
  - increased physical activity
  - avoiding tobacco use and exposure to secondhand smoke
  - and treatment therapy

Most Common Chronic Diseases in Indiana

Heart Disease and Stroke

- Heart disease was the leading cause of death (22.7%, or 13,630 deaths) in Indiana in 2013; stroke was the fourth leading cause of death (4.9% or 3,061 deaths).
- In 2011, more than 33% of Indiana residents reported having high blood pressure, and nearly 40% of those screened reported having high blood cholesterol, a risk factor for developing heart disease and stroke.

Most Common Chronic Diseases

Cancer

- Cancer was the second leading cause of death (nearly 22% of deaths or 13,258 deaths) in Indiana in 2013.
- According to the American Cancer Society, more than 35,500 new cancer cases were diagnosed in Indiana in 2013, which includes nearly 4,540 new cases of breast cancer among women and about 3,250 new cases of colorectal cancer.

Most Common Chronic Diseases

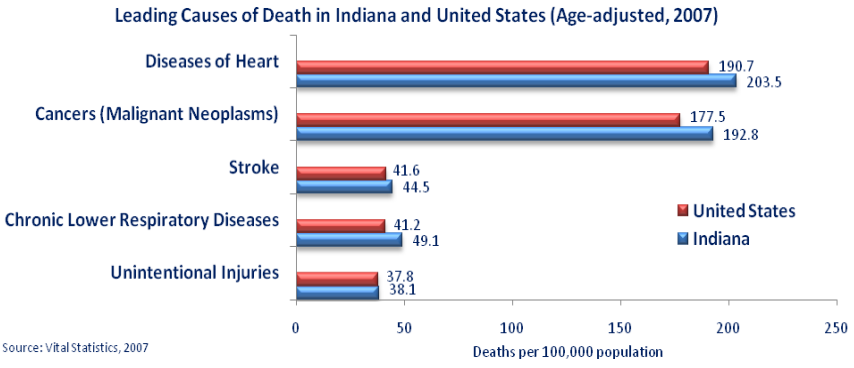
Diabetes

- Diabetes was the seventh leading cause of death (1,943 deaths) in Indiana in 2013. Although diabetes is considered to be underreported as the primary cause of death, risk of death among people with diabetes is about twice as high as people of similar age without diabetes.
- In 2013, more than 9% of adults reported being diagnosed with diabetes.

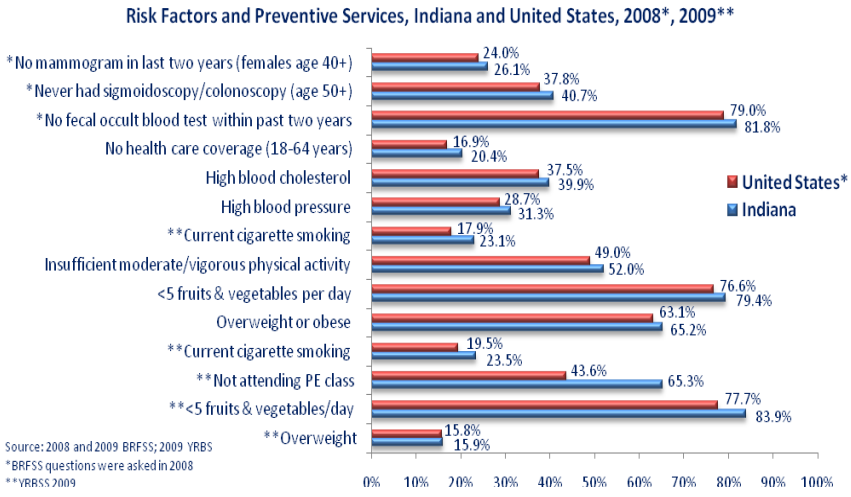
Arthritis

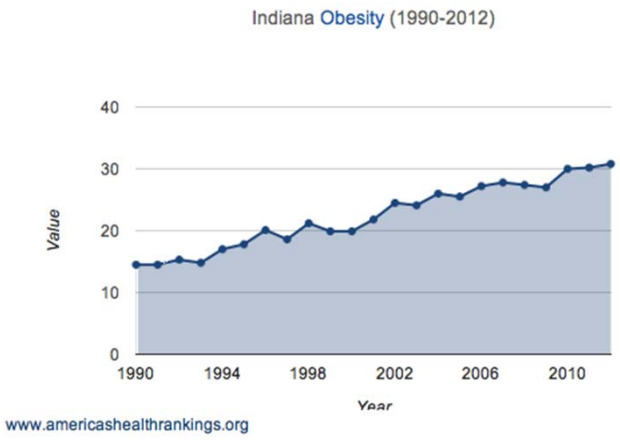
- Arthritis is one of the most common causes of disability in Indiana, with 30% of adults being diagnosed with the disease.

Leading Causes of Death



Risk Factors





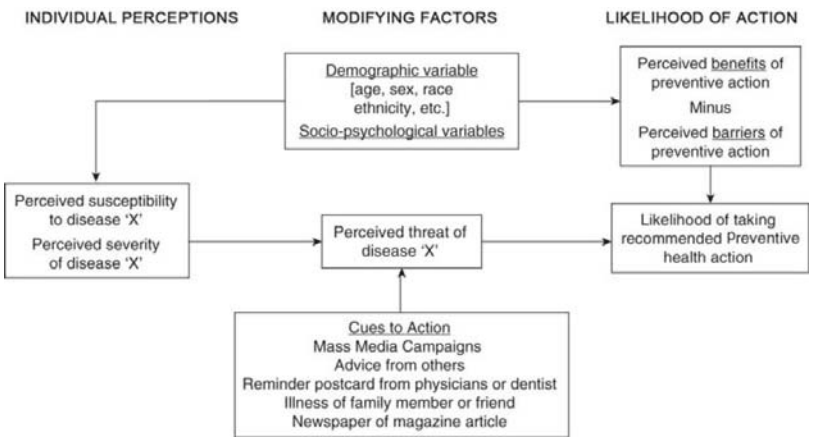
United Health Foundation
America's Health Rankings - 2012

F is for Fat

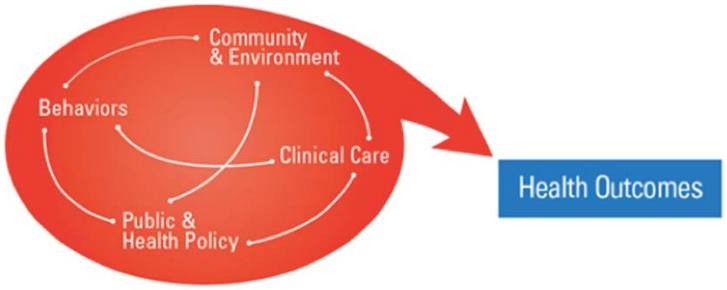
"If BMIs were lowered by 5 percent, Indiana could save 7.1 percent in health care costs, which would equate to savings of $13,400,000,000 by 2030."

The Robert Wood Johnson Foundation and Trust for America's Health

Health Belief Model



Health Outcomes



How Much "Self" in Self-Management?

- "Most human behavior . . . is determined by many interacting factors, and so people are contributors to, rather than the sole determiners of, what happens to them." (Bandura, 1997)
- "Whether one is engaging in a health promoting activity such as exercise or is living with a chronic disease such as asthma, he or she is responsible for day-to-day management." (Lorigand & Holman, 2003)

Health System Opportunities

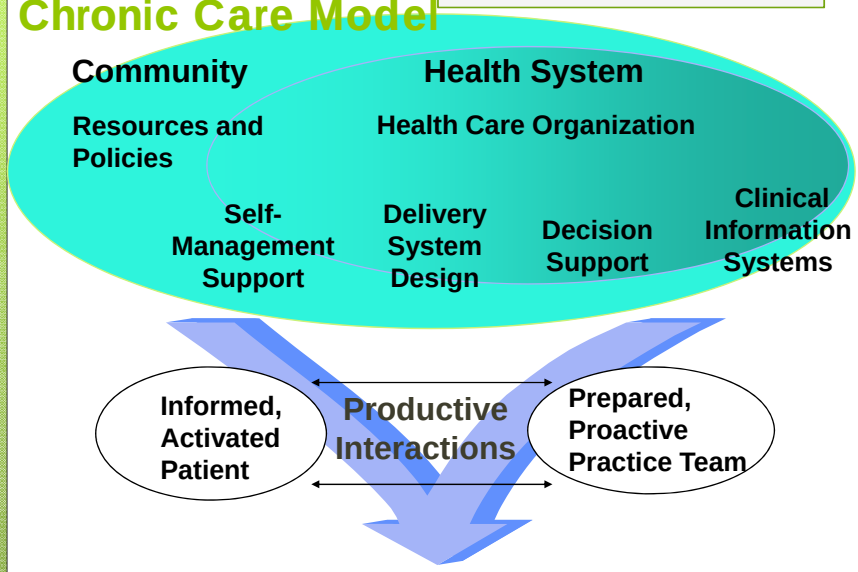
- Changes in the organization of and payment for care
- Enhanced involvement of a broad range of health professionals in delivering care
- Increased deployment and use of health information technology and associated tools (e.g., reminders and clinical decision support)
- Increased measurement and reporting of successes and shortfalls

Roles for Public and Community Health Organizations

Governmental public health and community health organizations can foster better health care system utilization by:

- Defining high-impact services and priorities
- Conducting surveillance of high-priority health outcomes
- Assuring that the hardest-to-reach populations receive the clinical care they need by addressing access barriers
- Using education and other efforts to more fully engage the public in its own health care

Chronic Care Model



Prepared Practice Team

Prepared Practice Team

At the time of the visit, they have the patient information, decision support, people, equipment, and time required to deliver evidence-based clinical management and self-management support.

Informed, Activated Patient

Informed, Activated Patient

Patient understands the disease process, and realizes his/her role as the daily self manager. Family and caregivers are engaged in the patient's self-management. The provider is viewed as a guide on the side, not the sage on the stage!

Conclusion

In this module we:

- Identified lifestyle components of health
- Covered how lifestyle choices are frequently limited by environmental and intrinsic factors
- Identified the leading causes of death linked to common chronic diseases in Indiana
- Learned healthy guidelines for nutrition, physical activity, tobacco, and stress management

Evaluation

Please complete the module evaluation.

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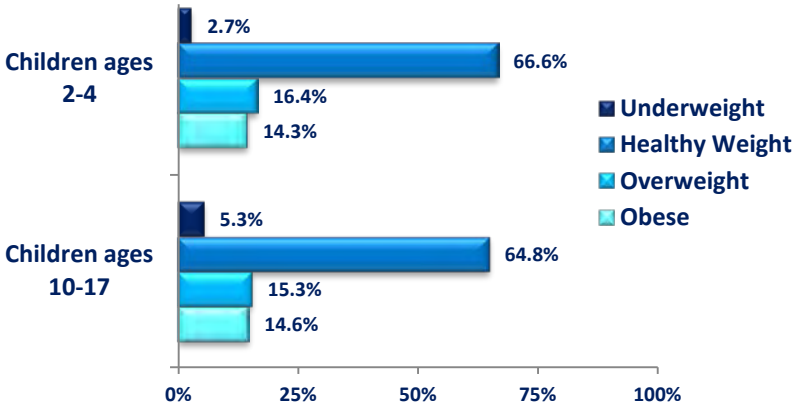
Overweight and Obesity

Indiana State Department of Health

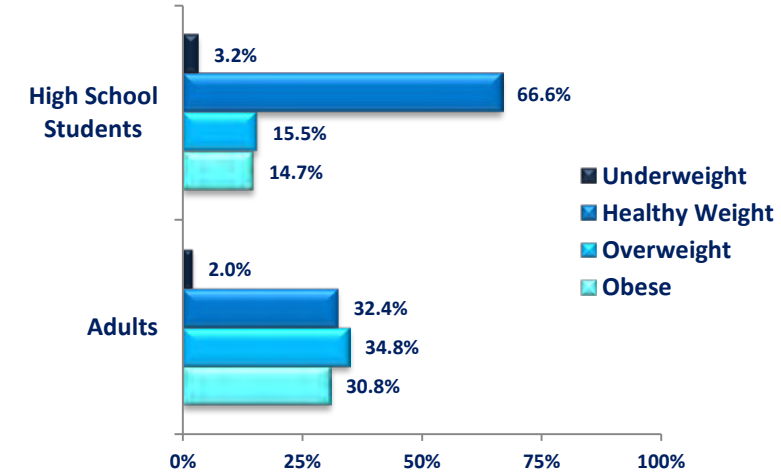
OVERWEIGHT AND OBESITY are terms for ranges of weight that are greater than what is generally considered healthy for a given height. The terms also identify weight ranges that have been shown to increase the risk for certain diseases and other health problems. In 2011, 30.7% of children ages 2–4 in the Indiana Special Supplemental Nutrition Program for Women, Infant, and Children (WIC) were considered overweight or obese [Fig 1].[1] In 2007, an estimated 30% of Indiana youth ages 10–17 were considered overweight or obese [Fig 1].[2]

Figure 1. Percent of children by age group and weight status, Indiana* [1, 2]



In 2011, 30.2% of Indiana high school students were considered either overweight or obese [Fig 2].[3] Additionally, 65.6% of Indiana adults† were considered either overweight or obese [Fig 2].[4] This amounts to over 3 million Hoosier adults, which is equal to the population of the state of Iowa.

Figure 2. Percent of high school students and adults† by weight status, Indiana, 2011 [3, 4]



*Data for children ages 10–17 from 2007

†Adults are people ages 18 years and older

Calculating weight status: Body Mass Index (BMI)

- People's weight status is determined by using their weight and height to calculate their BMI.
- For most people, their BMI is closely related to the amount of body fat they have.
- Because children's body composition varies with age and sex, their BMI is determined using age- and sex-specific percentiles for BMI rather than the BMI categories used among adults.

Adult BMI categories

- Underweight: Below 18.5
- Healthy Weight: 18.5–24.9
- Overweight: 25.0–29.9
- Obese: 30.0 and above

Child BMI categories

- Underweight: Less than the 5th percentile
- Healthy Weight: 5th percentile to less than the 85th percentile
- Overweight: 85th percentile to less than the 95th percentile
- Obese: Greater than or equal to the 95th percentile

Risk factors for becoming overweight or obese[5]

- Physical inactivity
- Unhealthy diet and eating habits
- Social and economic issues
- Family lifestyle
- Genetics
- Age
- Not breastfed as an infant[6]

Health consequences of being overweight or obese[7]

- Hypertension (high blood pressure)
- High total cholesterol, low HDL cholesterol, and/or high levels of triglycerides
- Type 2 diabetes
- Coronary heart disease
- Stroke
- Gallbladder disease
- Osteoarthritis
- Sleep apnea and respiratory problems
- Some cancers (e.g., endometrial, breast and colon)

For additional information on the role of nutrition, physical activity and obesity in Indiana, please visit: www.in.gov/isdh/20060.htm

Overweight and Obesity

Indiana State Department of Health

Economic consequences

Indiana

- During an average year, Hoosiers pay $3.5 billion in obesity-related medical costs.[8]
  - 36.9% of these costs are financed by the public sector through Medicare and Medicaid.[8]

United States

- In 2008, obesity-related health care costs were estimated at $147 billion.[9]
  - This equals 9.1% of annual medical spending.[10]
- If obesity rates remain level, there would be a $550 million savings in medical expenses over the next two decades.[10]
- If obesity rates continue to rise following current trends, total health care costs attributable to obesity and overweight will more than double every decade by 2030.[10]
  - This would equate to $860 to $956 billion, or 15.6% to 17.6% of total health care costs.[11]

Take Action: Steps you can take to prevent or manage being overweight or obese

- Maintain a proper diet and nutrition
  - Eat more fruits and vegetables and less high-fat, high-sugar, and high- sodium foods.
  - Drink more water and fewersugary drinks
- Be physically active
  - Adults should have 150 minutes of moderate-intensity aerobic activity OR 75 minutes of vigorous-intensity aerobic activity each week.
  - Children should have 60 minutes or more of moderate- or vigorous-intensity aerobic activity each day.
  - Limit screen time (TV, computer and video games) for children to less than two hours per day.
- Support Breastfeeding
  - New mothers are recommended to continue breastfeeding for at least 12 months.

Community resources

- Calculate your or your child's BMI at: www.cdc.gov/healthyweight/assessing/bmi.
- To help Hoosiers and their families eat better, move more, and avoid tobacco visit INShape Indiana.
- Recommended Community Strategies and Measurements to Prevent Obesity in the United States contains 24 recommended obesity prevention strategies focusing on environmental and policy level changes.
- Stories from the Field highlights what state programs, including Indiana's, are doing to prevent obesity and other chronic diseases.
- *Burden of Obesity in Indiana 2011 Report* provides a roadmap for targeting interventions for at-risk groups and others in order to improve weight status, physical activity levels, and fruit and vegetable consumption.
- Youth Risk Behavior Survey posters illustrate the impact of overweight and obesity on Indiana high school students.
- For more information on what is being done in Indiana, visit the Indiana Healthy Weight Initiative website.
- For more tips, check out *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010–2020*.

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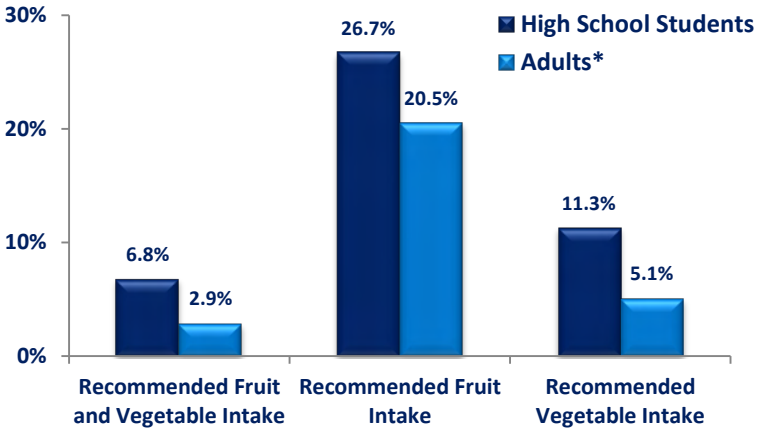
NUTRITION

Indiana State Department of Health

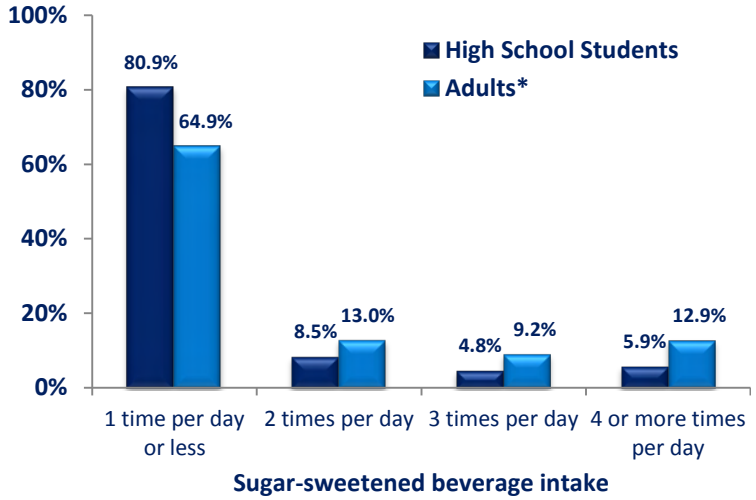
A **HEALTHY DIET** can reduce the risk of chronic diseases such as cardiovascular disease, hypertension, type 2 diabetes, osteoporosis and some cancers.[1] In 2011, 6.8% of Indiana high school students and 2.9% of Indiana adults reported eating the recommended amount of fruits and vegetables during the past week [Fig 1].[2,3] The recommended amounts are based on the U.S. Department of Agriculture's MyPlate age- and sex-specific guidelines.

Figure 1. Percent of high school students and adults* who ate the recommended servings of fruit and vegetables per day, Indiana, 2011



Based upon age and sex, an individual should consume no more than 120–330 "empty" calories per day. One can (12 fl. oz.) of regular soda contains an estimated 136 empty calories. In 2011, 80.9% of Indiana high school students and 64.9% of Indiana adults drank a sugar-sweetened beverage 1 or fewer times per day during the past week [Fig 2].[2,3]

Figure 2. Percent of high school students and adults* by sugar-sweetened beverage intake per day, Indiana, 2011



Obstacles to a healthy diet

Food insecurity[4]

- Defined as the limited or uncertain availability of nutritionally adequate and safe foods or the limited or uncertain ability to acquire acceptable foods in socially acceptable ways.
- In 2007, 36.2 million U.S. residents (12.2%) lived in food-insecure households. 12.4 million were children under age 18.

Food deserts

- Defined as an area with limited access to affordable and nutritious food.[5]
  - 7% of Hoosiers have limited access to healthy food.[6]
  - Indiana has 120 food deserts in 33 counties.[7]

Fast-food restaurants

- Full-service and fast-food restaurants account for about 77% of all food-away-from-home sales in the U.S.[8]
- 50% of restaurants in Indiana are fast-food establishments.[6]

How to add fruits and vegetables to your diet

Farmers markets[9]

- Provide community members with access to fresh fruits and vegetables that are often locally grown.
- Currently, Indiana has 163 farmers markets in 60 counties.

Community gardens

- Gardens on shared open spaces that are maintained by a group of community members.
- Include healthy and affordable fresh fruits and vegetables.

Farm-to-School programs

- Schools (K–12) serve students produce purchased from local farms. The programs help:
  - Make school cafeteria meals more healthful
  - Improve student nutrition
  - Provide agriculture, health and nutrition educational opportunities
  - Support local and regional famers

*Adults are people ages 18 years and older

For additional information on the role of nutrition, physical activity and obesity in Indiana, please visit: www.in.gov/isdh/20060.htm

Health benefits of a healthy diet[10]

- Eating a diet rich in vegetables and fruits as part of an overall healthy diet may:
  - Reduce risk for cardiovascular disease, including heart attack and stroke;
  - Protect against certain types of cancers.
- Diets rich in foods containing fiber, such as some vegetables and fruits, may reduce the risk of heart disease, obesity and type 2 diabetes.
- Eating vegetables and fruits rich in potassium as part of an overall healthy diet may lower blood pressure and may also reduce the risk of developing kidney stones and help to decrease bone loss.
- Eating foods such as fruits that are lower in calories per cup instead of some other higher-calorie food may be useful in helping to lower calorie intake.

TAKE ACTION: Steps you can take to eat a healthy diet

- Eat the recommended daily servings of each food group[11 †]
  - 2 ½ cups of vegetables
  - 2 cups of fruits
  - 6 ounces of grains
  - 3 cups of dairy
  - 5 ½ ounces of protein foods
- Eat a variety of fruits and vegetables. Try new recipes while increasing your daily fruit and vegetable intake.
- Drink water instead of sugar-sweetened beverages. This lowers the amount of calories you consume from other beverages.
- Reduce or limit the following in your diet:
  - Sodium
  - Saturated fatty acids
  - Trans fatty acids

† *Daily recommended values may vary by sex and age*

Community resources

- *Dietary Guidelines for Americans 2010* is the federal government's evidence-based nutritional guidance to promote health, reduce the risk of chronic diseases, and reduce the prevalence of overweight and obesity through improved nutrition and physical activity.
- ChooseMyPlate.gov features practical information and tips to help Americans build healthier diets.
- *Burden of Obesity in Indiana 2011 Report* provides a roadmap for targeting interventions for at-risk groups and others in order to improve weight status, physical activity levels, and fruit and vegetable consumption.
- Youth Risk Behavior Survey posters provide an illustration of Indiana high school students' nutritional levels.
- For more information on what is being done in Indiana, visit the Indiana Healthy Weight Initiative website.
- For more tips, check out *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020*.

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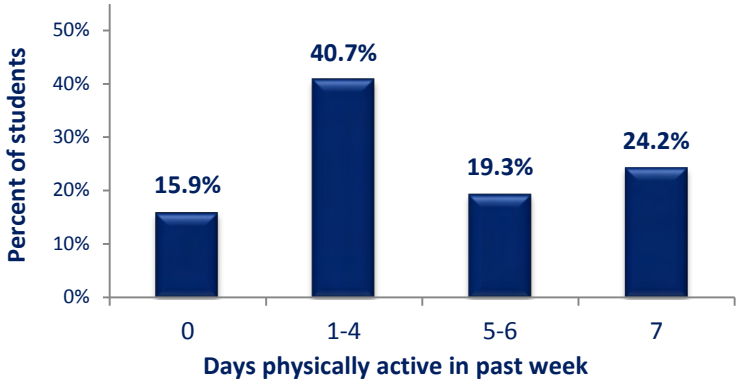
PHYSICAL ACTIVITY

Indiana State Department of Health

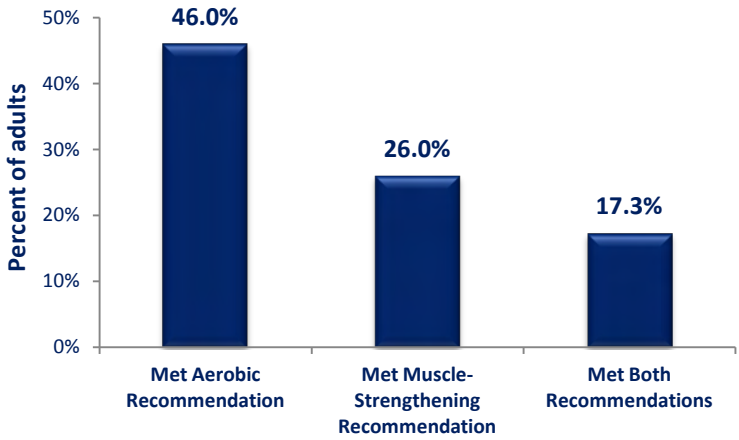
PHYSICAL ACTIVITY, including both aerobic and strength-training activities, is part of a healthy lifestyle and plays a vital role in achieving and maintaining a healthy weight. Regular physical activity reduces the risk of chronic disease and helps to improve overall health. In 2011, 24.2% of Indiana high school students reported being physically active for at least 60 minutes each day during the past week, meeting the Centers for Disease Control and Prevention's (CDC) physical activity recommendations for children [Fig 1].[1] Almost 16% reported no physical activity during the past week.

Figure 1. Percent of high school students by days physically active, Indiana, 2011[1]



In 2011, 17.3% of adults* met the CDC's physical activity recommendations for adults of 150 minutes or more of moderate-intensity aerobic activity each week AND muscle strengthening activities on 2 or more days per week [Fig 2].[2] Almost 29.2% reported no physical activity outside of their normal work.[2]

Figure 2. Percent of adults* meeting physical activity recommendations, Indiana, 2011[2]



Obstacles to physical activity

Screen time (2011)[1]

- 51.4% of Indiana high school students watched 2 or more hours of TV per day on an average school day.
- 44.2% of Indiana high school students played video games or used a computer for something not school-related 2 or more hours per day on an average school day.

Commuting

- The average commute time for Indiana residents is 23.2 minutes.[3]
  - Each hour spent in a car per day is associated with a 6% increase in the risk for obesity.[4]
- Only 2.2% of the population indicated walking as their mode of transportation to work.[3]

Unsafe environments

- Only 20% of people in Indiana are currently covered by Complete Streets policies.[5]
- Complete Streets are roadways designed to safely and comfortably provide for the needs of all users, including, but not limited to, motorists, cyclists, pedestrians, transit and school bus riders, movers of commercial goods, persons with disabilities, seniors and emergency users.

Examples of types of physical activity

Moderate-intensity aerobic activity[6]

- Walking fast
- Doing water aerobics
- Riding a bike on level ground or with few hills
- Playing doubles tennis
- Pushing a lawn mower

Vigorous-intensity aerobic activity[6]

- Jogging or running
- Swimming laps
- Riding a bike fast or on hills
- Playing singles tennis
- Playing basketball

*Adults are people ages 18 years and older

For additional information on the role of nutrition, physical activity and obesity in Indiana, please visit: www.in.gov/isdh/20060.htm

Physical Activity

Indiana State Department of Health

Health benefits of physical activity in adults*[7]

- Strong evidence of reduced rates of:
  - All-cause mortality
  - Coronary heart disease
  - High blood pressure
  - Stroke
  - Metabolic syndrome
  - Type 2 diabetes
  - Some cancers (e.g., breast and colon)
  - Depression
  - Falling
- Strong evidence of:
  - Increased cardiorespiratory and muscular fitness
  - Healthier body mass and composition
  - Improved bone health
  - Increased functional health
  - Improved cognitive function

Economic consequences[8]

- The annual cost directly attributable to inactivity in the United States is an estimated $24 to $76 billion.
  - These amounts equal 2.4% to 5% of the total expenditure on health care.

Take Action: Steps you can take to be physically active

- Add physical activity to your life
  - Choose a variety of activities to reach recommended physical activity levels
  - Make physical activity a regular part of your day at home, work, or for leisure
  - Engage in physical activity with family and friends
- Limit total non-educational screen time (computer and television use) to no more than 2 hours per day for children[9]
- Commute actively when possible
  - Add movement on your way to and from work to increase your physical activity level
- Support active environments
  - Promote the adoption of urban design, land use and transportation policies that plan, build and maintain communities that are more walkable and bikeable for all residents
  - Make walking and bicycling to school safe for children
  - Promote and support parks, playgrounds and trails

Community resources

- INShape Indiana has programs for all types of people seeking to increase their physical activity level.
- 2008 Physical Activity Guidelines for Americans provides guidelines to help individuals ages 6 and older improve their health through appropriate physical activity.
- Community Health Resources highlight the CDC's best resources to help you plan, implement and evaluate community health interventions and programs to address chronic disease and health disparities issues.
- *Burden of Obesity in Indiana 2011 Report* provides a roadmap for targeting interventions for at risk groups and others to improve weight status, physical activity levels, and fruit and vegetable consumption.
- Indiana Youth Risk Behavior Survey posters provide a visual depiction of the level of physical activity among Indiana's high school students.
- For more information on what is being done in Indiana, visit the Indiana Healthy Weight Initiative website.
- For more tips, check out *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020*.

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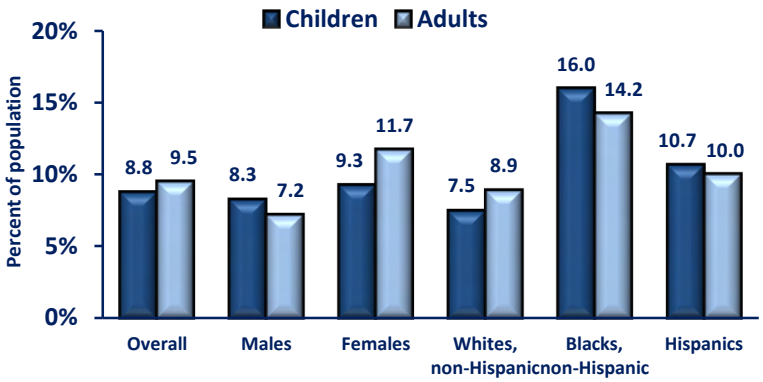
ASTHMA

Indiana State Department of Health

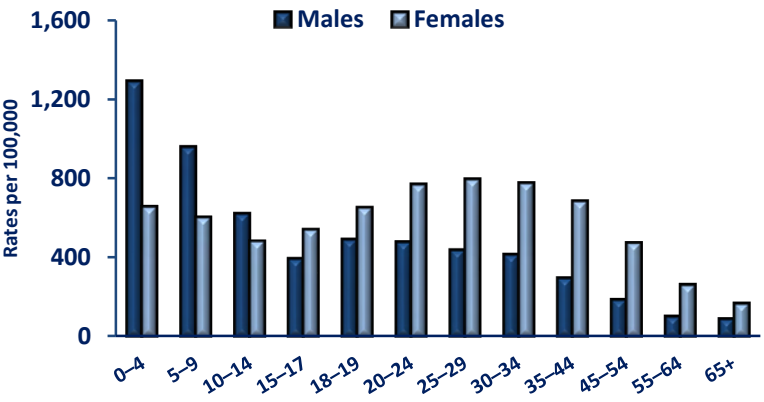
ASTHMA is a chronic inflammatory disease that affects the airways and lungs, causing recurring periods of wheezing, chest tightness, shortness of breath and coughing. It is a serious public health concern that affects approximately 7 million children and 18.7 million adults in the United States.[1] In Indiana, an estimated 136,202 (1 in 13) children and 457,670 (1 in 11) adults currently* have asthma.[2] The burden of asthma is highest among black children and adults [Fig 1].

Figure 1. Current asthma* prevalence, adults and children, Indiana, 2010[2]



The rates of emergency department (ED) visits among males and females are different across the lifespan. Most male ED visits occur during childhood, and the highest rate of female ED visits occurs during the middle adult years [Fig 2]. In 2010, the age-adjusted asthma ED visit rate among females was 541.2 per 100,000 and 417.4 per 100,000 among males.[3]

Figure 2. Asthma emergency department rates by age and sex, Indiana, 2010[3]



*Current asthma was measured by asking if the child/adult still had asthma

Asthma triggers

The cause of asthma is unknown, but people with asthma have inflamed airways which cause them to be more reactive and sensitive to triggers.

Common triggers include:

- Pet hair or dander
- Changes in weather, usually cold weather
- Chemical irritants
- Cockroaches, dust mites and pests
- Exercise
- Food
- Mold
- Outdoor air pollutants and ozone
- Pollen
- Respiratory infections, such as the common cold
- Stress
- Tobacco and wood smoke

Emergency department (ED) visits

ED visits have increased among Indiana residents significantly since 2004, but leveled off during the past 3 years. During 2010:[3]

- 30,192 people visited the ED with a principal diagnosis of asthma—a decrease of nearly 1,000 visits from 2009.
- The overall age-adjusted ED visit rate was 480.7 cases per 100,000 people.
- 38.0% of the asthma-related ED visits were among children.
- Black residents (1,297.9 per 100,000 people) visited the ED for asthma at a much higher rate than white residents (333.6 per 100,000 people).

Hospitalizations

While the rate of asthma-related hospitalizations in 2010 was the lowest since 2007, it was still the 4th leading cause of hospitalization due to illness among Indiana children under age 18. During 2010: [3]

- 8,351 asthma-related hospitalizations occurred, down 8.7% from 2009.
- Overall, females had higher rates of hospitalization than males (153.1 versus 98.3 per 100,000 people); however, male children had higher rates than female children (172.2 versus 103.5 per 100,000 people).
- Black residents (351.4 per 100,000 people) were hospitalized nearly 4 times more often than white residents (94.4 per 100,000 people).

For additional information on the impact of asthma in Indiana, please visit: www.chronicdisease.isdh.in.gov

Asthma

Indiana State Department of Health

Mortality[4]

- In 2009, 71 Indiana residents' deaths had asthma listed as the underlying cause.
  - 31 were males and 40 were females
  - 46 were whites and 25 were blacks
  - 9 were children

Management among persons with current asthma[5]

- Although asthma is rarely fatal, poorly controlled asthma can lead to missed school or work and the inability to participate in daily activities.
  - During 2006–2010, 60.5% of Indiana children had their usual activities limited due to their asthma, and 44.7% of school-aged children missed 1 or more days of school because of it.
  - In 2010, 34.7% of Indiana adults missed work or could not participate in daily activities due to their asthma.
- Creating an Asthma Action Plan is important in learning how to control asthma long-term and in recognizing early symptoms of an attack, yet only 28.6% of adults and 47.7% of children with asthma had an action plan during 2006–2010.
- Routinely seeing a health care provider is one way to manage one's asthma. During 2006–2010, 50.0% of adults and 24.0% of children did not see their doctor for routine visits concerning their asthma.

TAKE ACTION: Steps you can take to prevent or control asthma

- While there is no cure for asthma, make sure to manage your (or your child's) asthma by knowing and attempting to avoid asthma triggers
- Avoid smoking or secondhand smoke
- Limit outdoor exercise on Ozone Action Days or days with poor air quality
- Take medications prescribed by your health care provider
- Work with your health care provider to create an Asthma Action Plan—these plans include information concerning daily treatment, medications, short- and long-term control measures, and explain when to seek medical treatment
- Know early asthma warning signs to head off an episode before it gets worse
- Ensure students and employees have immediate access to quick-relief medications
- Encourage schools, child care centers, and workplaces to participate in no-idle zones, Ozone Action Days and other environmental health actions

Community resources

- Fly a Flag for Clean Air Program: a program for schools to create public awareness of outdoor air quality conditions so children can continue to play while protecting themselves.
- Indiana Joint Asthma Coalition (InJAC): a voluntary group of people and organizations working to reduce the burden of asthma in Indiana.
- For a list of asthma coalitions, programs and resources in Indiana, go to InJAC's Resources page, or call the Indiana Family Helpline at 1-855-HELP-1ST (855-435-7178). Additional information can be found at the Asthma Community Network.
- To get help with tobacco cessation, call the Indiana Tobacco Quitline at 1-800-QUIT-NOW (800-784-8669), or visit www.quitnowindiana.com.
- AIRNow: an index for reporting daily air quality in local regions.
- Knozone: a program to improve Indianapolis' air quality.

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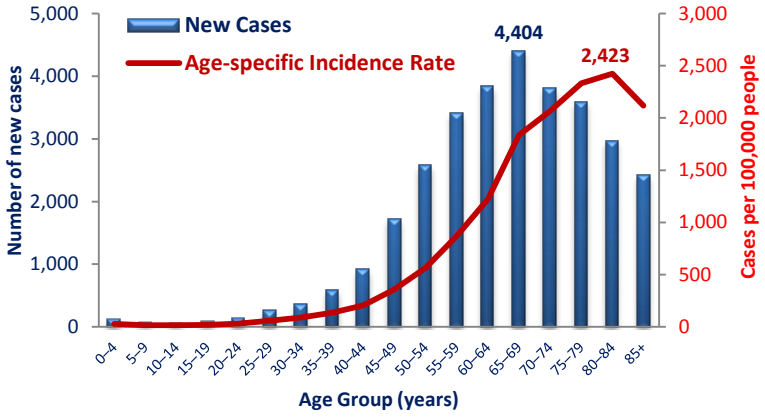
CANCER

Indiana State Department of Health

CANCER is a group of diseases characterized by uncontrolled growth and spread of abnormal cells. Anyone can get cancer at any age; however, middle and older aged people are most likely to develop cancer. In Indiana, during 2008, 70% of all cancers cases occurred among people ages 55–84, including 23% among people ages 55–64, 26% among people ages 65–74, and 21% among people ages 75–84 [Fig 1].

Figure 1. Number and rate of new cancer diagnoses, Indiana, 2008



INDIANA'S age-adjusted cancer incidence rate during 2004–2008 was 475.6 per 100,000 people. This was statistically higher than, but very similar to, the national rate of 471.8 per 100,000 people (<1% difference) [Table 1]. However, during the same period, Indiana's age-adjusted mortality rate was 8% higher than the national rate (195.8 versus 181.3 deaths per 100,000 people). This included being over 10% higher among Indiana males and almost 7% higher among Indiana females.

Table 1. Incidence and death rate comparisons between Indiana and the United States by sex and race, 2004–2008*

	Incidence rates			Mortality rates		
	Indiana	United States	Difference (%)	Indiana	United States	Difference (%)
Total	475.6†	471.8	+0.8	195.8†	181.3	+8.0
Males	556.2	552.1	+0.7	245.8†	223.1	+10.2
Females	422.4†	415.9	+1.6	163.6†	153.3	+6.7
Whites	470.0	470.9	-0.2	194.1†	180.0	+7.8
Blacks	490.7	483.1	+1.6	236.3†	220.9	+7.0

**Age-adjusted rates per 100,000 people*
†Indiana rate is significantly higher (P<.05) than the U.S. rate
Sources for Table 1: Indiana State Cancer Registry (Indiana data); U.S. Cancer Statistics Working Group. United State Cancer Statistics: 1999-2008 Incidence and Mortality Web-based Report. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2011. Accessed at wonder.cdc.gov on Dec 21, 2011 (U.S. data)

Chances of getting cancer

- On a national level,
  - Males have almost a 1 in 2 chance of developing cancer during their lifetime
  - Female's lifetime risk of developing cancer is slightly more than 1 in 3
- About 2.4 million Indiana residents, or 2 in 5 people now living in Indiana, will eventually develop cancer.
- On average, during 2004–2008, 30,272 Hoosiers were diagnosed with cancer each year.
  - 15,434 of those were male
  - 14,838 of those were female

Most common cancers in Indiana (2008)

- Breast cancer is the most common among females (116.6 cases per 100,000 females).
- Prostate cancer is the most common among males (124.0 cases per 100,000 males).
- Lung, including bronchus, and colon cancers are the next most common among both sexes.

Deaths from cancer in Indiana

- Cancer is the second leading cause of death (2008: 13,126 deaths) following heart disease.
- About 12,960 Indiana residents were expected to have died of cancer in 2011. This translates to approximately 36 people every day or almost 2 people every hour.
- Annually, lung cancer is responsible for the most cancer-related deaths among both sexes (2008: 4,166 deaths).
- Although rare, cancer is the second leading cause of death following deaths from accidents among children ages 5 to 14 (2008: 137 deaths).

Economic impact of cancer in Indiana

- $1.01 billion was spent on the direct costs of treating Indiana residents with cancer in 2003.
- $2.76 billion is the estimate of what will be spent on the direct costs for cancer care in 2023 if current trends continue.

For additional information on the impact of cancer in Indiana, please visit: www.chronicdisease.isdh.in.gov

CANCER

Indiana State Department of Health

Cancer screening

- Many cancers can be prevented or identified at an early stage if people obtain early detection screenings.
- In Indiana, during 2010:
  - 80.2% of women ages 18 and older had a Pap test during the past 3 years (cervical cancer).
  - 71.3% of women ages 40 and older had a mammogram during the past 2 years (breast cancer).
  - 64.4% of men ages 40 and older had ever had a prostate-specific antigen (PSA) test (prostate cancer).
  - 62.8% of people ages 50 and older had ever had a colonoscopy or sigmoidoscopy (colorectal cancer).

Burden of cancer among blacks in Indiana (2004–2008)

- Incidence: 490.7 cases per 100,000 people
- Mortality: 236.3 deaths per 100,000 people
- The overall disparities between blacks and whites in cancer incidence and mortality rates have been gradually decreasing.
- However, blacks still had almost a 5% greater incidence of cancer and over a 21% higher mortality rate than whites.

Burden of cancer among Hispanics in Indiana

- Incidence (2004–2008): 341.3 cases per 100,000 people
- Mortality (2002–2006): 88.7 deaths per 100,000 people
- In Indiana and the United States, for all cancers combined, and for the most common cancers (prostate, female breast, colorectal, and lung), incidence and mortality rates have been lower among Hispanics than among non-Hispanic whites.

TAKE ACTION: Steps you can take to prevent or control cancer

- Be tobacco free
- Avoid secondhand smoke
- Limit alcohol consumption
- Maintain a healthy weight throughout life
- Consume a healthy diet that:
  - Emphasizes plant sources
  - Supports a healthy weight
  - Includes 5 or more servings of a variety of vegetables and fruit each day
  - Includes whole grains in preference to processed (refined) grains
  - Has minimal processed and red meats
- Adopt a physically active lifestyle
- Protect yourself from too much sun exposure
- Talk to your primary health care provider about:
  - Any potential signs and symptoms of cancer, including unexplained weight loss, fever, fatigue, pain and skin changes
  - Cancer screening options for breast, cervical, colorectal and prostates cancers
  - Vaccine options that can protect you from developing cancer, like against hepatitis B and human papillomavirus (HPV)

GET INVOLVED: Join the Indiana Cancer Consortium (ICC)

- The ICC is a statewide network of over 100 agencies including the Indiana State Department of Health.
- Seeks to reduce the cancer burden in Indiana through the development, implementation, and evaluation of a comprehensive plan that addresses cancer across the continuum from prevention through palliation.
- Become a member at www.indianacancer.org.

Community resources

- To get help with tobacco cessation, call the Indiana Tobacco Quitline at 1-800-QUIT-NOW (800-784-8669), or visit www.quitnowindiana.com.
- To help Hoosiers and their families eat better, move more, and avoid tobacco go to INShape Indiana at www.inshapeindiana.org.
- To learn more about how to support healthy eating and physical activity throughout Indiana visit the Indiana Healthy Weight Initiative at www.inhealthyweight.org.
- To learn more about cancer, visit the American Cancer Society at www.cancer.org.

Reference: Indiana Cancer Consortium, Indiana State Department of Health and the American Cancer Society Great Lakes Division; *Indiana Cancer Facts and Figures 2012.* March, 2012. Available at http://indianacancer.org/resources-for-indiana-cancer-consortium-members/indianacancerfactsandfigures2012/.

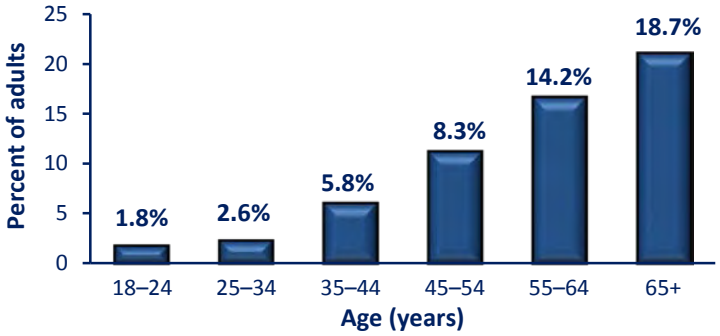
DIABETES

Indiana State Department of Health

DIABETES is a group of diseases resulting in high levels of blood glucose (form of sugar) due to defects in insulin production, action, or both. Diabetes can lead to serious complications and premature death. People who have diabetes can work with health care providers and support systems to take action, control the disease, and lower their risk for complications.

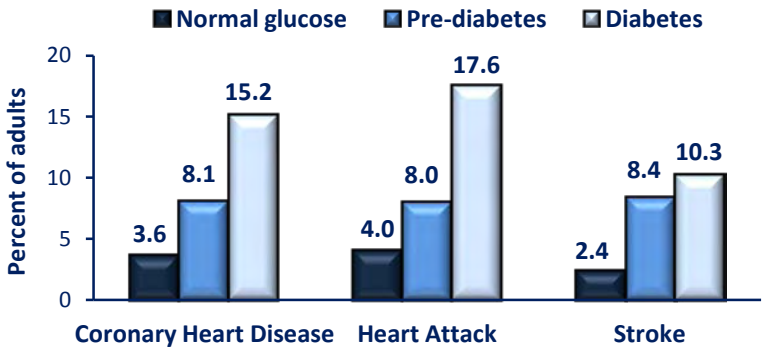
- In 2011, 10.1% of Indiana adults reported having some form of diabetes[1*†]
- Type 1 diabetes is the result of the body's inability to produce insulin and typically develops in childhood or adolescence (approximately 5% of cases).
- Type 2 diabetes, the most common form, occurs when the body is no longer able to effectively produce or use insulin (approximately 95% of cases).

Figure 1. Diabetes prevalence by age, Indiana, 2011[1*]



Diabetes prevalence increases with age [Fig 1]. Individuals with diabetes have higher rates of premature death, functional disability, and other conditions such as coronary heart disease (CHD), heart attack and stroke [Fig 2].[1] Diabetes was the seventh leading cause of death in Indiana in 2009. This was consistent across most racial and ethnic groups in Indiana, except among black residents, where it was the fourth leading cause of death.[2]

Figure 2. Prevalence of cardiovascular disease by diabetes status, Indiana, 2009[1†]



Depression[3]

- People who have diabetes are twice as likely to develop depression as those who do not.
- People who have depression are 60% more likely to develop diabetes than those who do not.

Diabetes and cardiovascular disease (CVD)

- In 2011, 71.9% of Indiana residents who have diabetes reported having high blood pressure, and 69.4% reported having high cholesterol.[1]
- Adults who have diabetes are 2 to 4 times more likely to die from a heart attack or stroke than those without diabetes.[4]

Gestational diabetes mellitus (GDM)

- GDM is a condition where females develop high blood glucose levels during pregnancy.
- In 2008, 4.5% of Indiana births involved GDM.[5]
- Females with a history of GDM have a lifetime risk 7 times higher of developing type 2 diabetes than females with normal blood sugar levels during pregnancy.[6]

Kidney disease

- Diabetes is the leading cause of kidney failure, accounting for 44% of known cases of end-stage renal disease among Indiana residents in 2010.[7]

Nervous system disease[4]

- About 60% to 70% of people with diabetes have mild to severe forms of nervous system damage due to diabetes (diabetic neuropathy).
- Diabetic neuropathy may result in impaired hand or feet sensation, pain, digestive disturbances, sexual dysfunction or other conditions.

Vision

- Diabetes is the leading cause of new blindness among adults.[4]
- In 2011, 18.1% of Indiana adults with diabetes reported vision problems due to diabetes.[1]

Wounds and amputation

- Foot ulceration and lower-limb amputation are common outcomes of poorly managed diabetes.
- Diabetes is the leading cause of non-traumatic amputations, responsible for 44% of lower-limb amputations among Indiana residents in 2010.[8]

** Unless specified otherwise, diabetes refers to both type 1 and type 2 diabetes, but not gestational diabetes.*

† Prevalence figures are for adults 18 and older.

For additional information on the impact of diabetes in Indiana, please visit: www.chronicdisease.isdh.in.gov

Risk factors for type 2 diabetes[4]

- Impaired glucose tolerance or impaired fasting glucose, also known as pre-diabetes
- A parent or sibling with diabetes
- Physical inactivity
- Being overweight or obese
- Certain races—American Indians, blacks, Hispanics, and Asian Americans—are at higher risk of developing type 2 diabetes.
- Women who have delivered a baby weighing nine pounds or more or with a history of GDM
- Women with polycystic ovarian syndrome
- History of low HDL cholesterol, high triglycerides, or high blood pressure
- Visceral fat distribution, such as abdominal storage of fat
- Smoking
- Some medications prescribed for other conditions increase the risk for insulin resistance, which may lead to diabetes.
  - Some steroids and atypical antipsychotics are associated with increased weight gain, hyper-triglyceridemia, and diabetes.[3]

TAKE ACTION: Steps you can take to prevent or manage diabetes

- Manage your diabetes with guidance from your health care provider
- Maintain a healthy blood pressure
- Maintain a healthy cholesterol level
- Be tobacco free (www.in.gov/quitline)
- Maintain a healthy weight
- Eat a healthy diet
- Participate in regular physical activity
- Learn to recognize the onset of symptoms or physical changes due to diabetes
- Monitor any changes in health status when being treated or taking medications for other conditions
- If you have diabetes and are planning a pregnancy, consult a health care provider
- If you are pregnant and have not been previously diagnosed with diabetes, get screened for GDM at 24–28 weeks gestation
- If you had GDM during pregnancy:
  - Get screened for persistent diabetes at 6–12 weeks postpartum
  - Thereafter, get screened for diabetes or pre-diabetes at least every three years

Community resources

- For a listing of diabetes programs by county, visit the Indiana Diabetes Education and Support Program Directory or call the Indiana Family Helpline at 1-855-HELP-1ST (855-435-7178).
- Diabetes Prevention Program (DPP): a program that aids in prevention of type 2 diabetes for individuals who are at risk of diabetes. Contact the "Y" (formerly YMCA) in Bloomington, Fort Wayne, and Indianapolis.
- Diabetes Education Empowerment Program with Tobacco Cessation (DEEP TC): helps people with diabetes develop the skills to better manage the disease (Offered in English and Spanish).
- Living a Healthy Life: a 6-week workshop for people with chronic illnesses, which empowers them to manage their disease, control symptoms, and learn how health problems affect their lives.
- For mental health services, call the Indiana Family Helpline at 1-855-HELP-1ST (855-435-7178) or visit the Community Mental Health Services Locator.

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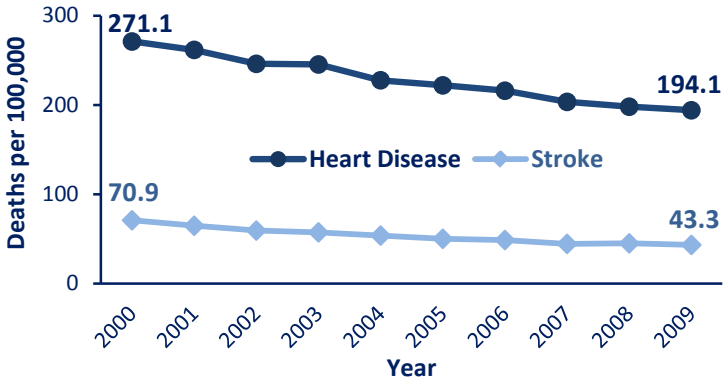
For additional information on the impact of diabetes in Indiana, please visit: www.chronicdisease.isdh.in.gov

Heart Disease and Stroke

Indiana State Department of Health

Cardiovascular Disease (CVD) is a term used to describe a group of diseases that affect the heart or blood vessels, including those in the brain. While CVD includes many conditions, this fact sheet focuses on heart disease and stroke. Although their respective mortality rates have declined over time, heart disease and stroke are still responsible for almost one-third of all Indiana deaths and remain a major public health issue [Fig 1].[1*]

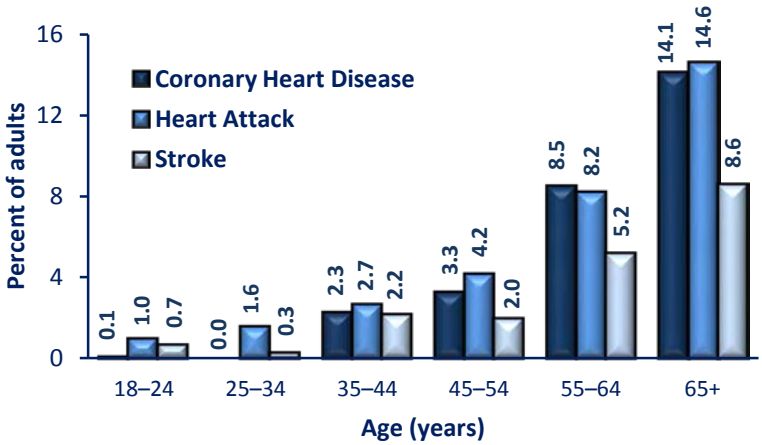
Figure 1. Mortality* from heart disease and stroke, Indiana, 2000–2009[1†]



Indiana prevalence (2011)[2]

- Prevalence of coronary heart disease (CHD), heart attack, and stroke typically increased with age [Fig 2].[‡]
- Males experienced CHD and heart attacks more often than females, but stroke prevalence was comparable.
- Higher income and educational levels were associated with lower prevalence of CHD, heart attack, and stroke.

Figure 2. Cardiovascular disease prevalence by age and type, Indiana, 2011[2‡]



Heart attacks and **strokes** are typically sudden events caused by a blockage that prevents normal blood flow to the heart or brain (ischemic stroke), respectively.[3]

- The most common cause of blockage is **atherosclerosis**, the hardening and narrowing of arteries due to the accumulation of fats, cholesterol and other substances.
- Strokes can also result from a ruptured or leaking blood vessel in the brain (hemorrhagic stroke).

Transient ischemic attacks (TIA) occur when the brain's blood supply is briefly interrupted. Symptoms produced are similar to a stroke, but are usually short-term with no permanent damage.

- TIAs are sometimes called "mini-strokes."
- Almost one in three ischemic strokes is preceded by a TIA.[4]

Heart disease and stroke emergency department (ED) visits and hospitalizations (Indiana, 2010)[5]

- Accounted for 12.0% of all ED visits.
  - The overall age-adjusted ED visit rate was 61.3 per 10,000 people.
- Accounted for 7.0% of all in-patient hospitalizations.
  - The overall age-adjusted in-patient hospitalization rate was 45.3 per 10,000 people.

Heart disease and stroke mortality (Indiana, 2009)[1]

- 13,442 Indiana residents died of heart disease, making it the leading cause of death overall.
  - Heart disease was the leading cause of death among white residents, and the second leading cause of death among black and Hispanic residents.
- 2,991 Indiana residents died of stroke, making it the fourth leading cause of death overall.
  - Stroke was the fourth leading cause of death among white residents, third leading cause among black residents, and sixth leading cause among Hispanic residents.

** For heart disease mortality, all forms of CVD are included, except stroke, essential hypertension, hypertensive renal disease, atherosclerosis, and vessel disease.*
† Mortality rates are age-adjusted per 100,000 people using the 2000 U.S. Standard Population.
‡ For prevalence, coronary heart disease is captured as angina or ischemic heart disease exclusive of myocardial infarction (heart attack).

For additional information on the impact of heart disease and stroke in Indiana, please visit: www.chronicdisease.isdh.in.gov

Heart Disease and Stroke

Indiana State Department of Health

Heart disease and stroke risk factors[2]

Managing risk factors is a key component of a comprehensive CVD prevention or management plan.

In Indiana, during 2011:

- 33% of adults reported having ***high blood pressure***.
- Nearly 40% of adults reported having ***high cholesterol***.
- 25.6% of adults currently ***smoked cigarettes***.
- 46% of Indiana adults indicated that they met the aerobic ***physical activity*** recommendation of at least 150 minutes of moderate aerobic exercise per week.
- 66% of Indiana adults were considered ***overweight*** or ***obese***.
- Proper ***nutrition*** plays an important role in managing risk.
  - 20.5% of adults ate the recommended servings of fruits.
  - 5.1% of adults ate the recommended servings of vegetables.
- ***Diabetes*** is a major risk factor for negative CVD outcomes.
  - 31.9% of people with CHD reported having diabetes.
  - 31.9% of people who had a heart attack reported having diabetes.
  - 32.8% of people who had a stroke reported having diabetes.

TAKE ACTION: Steps you can take to prevent or manage heart disease and stroke

- Be tobacco free (www.in.gov/quitline)
- Maintain a healthy blood pressure
- Maintain healthy cholesterol levels
- Ask your health care provider if aspirin therapy will help reduce your risk of heart attack or stroke
- Properly manage your diabetes with guidance from health care professionals
- Eat a healthy diet
- Avoid excess sodium (salt)
- Participate in regular physical activity
- Maintain a healthy weight
- Manage stress
- Practice good hygiene
  - Regular hand washing can help prevent viral or bacterial infections that can place stress on your heart
  - Regular brushing and flossing can help prevent viral or bacterial infections that can increase the risk of cardiovascular events
- Get an annual flu shot
  - If you have a cardiovascular condition, having the flu places you at greater risk for a heart attack
- Learn to recognize the warning signs of a heart attack or stroke. Fast response can save lives.

Community resources

- Living a Healthy Life: a 6-week workshop for people with chronic illnesses, which empowers them to manage their disease, control symptoms, and learn how health problems affect their lives.
- Million Hearts: a national initiative to prevent 1 million heart attacks and strokes over 5 years.
- Diabetes Prevention Program (DPP): a program that aids in prevention of type 2 diabetes for people who are at risk of diabetes. Contact the "Y" (formerly YMCA) in Bloomington, Fort Wayne, and Indianapolis.
- Indiana Tobacco Quitline: a free phone-based counseling service to help Indiana smokers quit. For support call 800-QUIT-NOW (800-784-8669).
- For mental health services, call the Indiana Family Helpline at 1-855-HELP-1ST (855-435-7178) or visit the Community Mental Health Services Locator.

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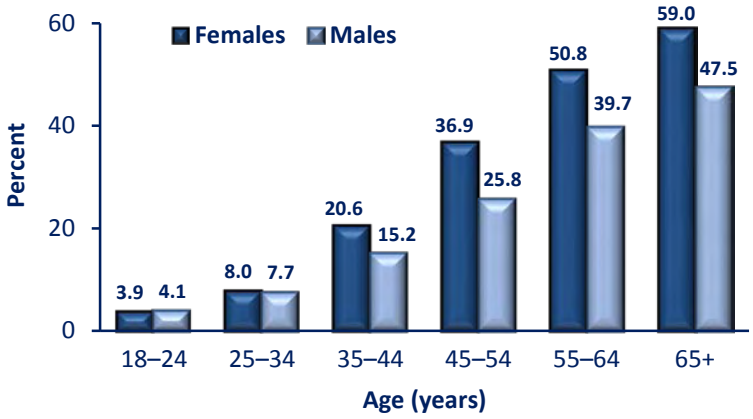
ARTHRITIS

Indiana State Department of Health

ARTHRITIS is inflammation of one or more joints. The primary symptoms associated with arthritis are joint pain and stiffness. Arthritis is the leading cause of disability in the United States, and can significantly impact productivity and quality of life.[1] For public health purposes, arthritis includes all of the diseases and conditions that affect joints and the tissues in and around the joints. Overall, the burden of arthritis in the United States is considerable and accounts for an estimated $128 billion in direct and indirect costs annually.[2]

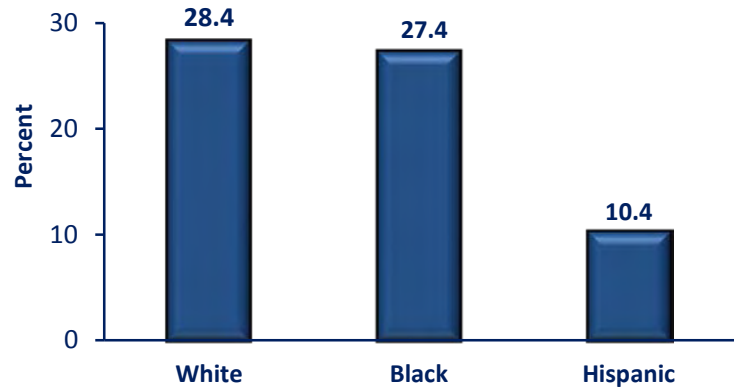
Figure 1. Prevalence of arthritis by age and sex, Indiana, 2011[3*]



Indiana Prevalence (2011)[3*†]

- 27.5% of Indiana adults reported having some form of arthritis.
- Arthritis prevalence increased with age and was reported more commonly among females [Fig 1].
- Prevalence of arthritis was comparable between whites and blacks, but lower among Hispanics [Fig 2].

Figure 2. Prevalence of arthritis by race and ethnicity, Indiana, 2011[3*†]



Osteoarthritis (OA):

- Most common form of arthritis.
- Results from the erosion of joint cartilage and underlying bones.
- Most often caused by long-term wear and tear, a specific injury, or an illness.

Rheumatoid arthritis (RA):

- Occurs when the body's immune system attacks joints and causes inflammation.
- Can affect anyone and at any age, but is most common among women and older individuals.
- May lead to joint deformity and disability.

Risk factors for arthritis

- **Age**—The risk of developing most types of arthritis increases with age [Fig 1].[4]
- **Sex**—In 2011, more female Indiana residents (31.6%) reported having arthritis than male residents (23.0%).[3]
  - Additionally, several arthritis-related conditions, including fibromyalgia, lupus and osteoporosis, occur more commonly among females.
  - Gout is more common among males.
- **Genetics**—Specific genes are associated with certain types of arthritis, including RA, lupus, and ankylosing spondylitis.[5]
- Being **overweight** or **obese**—Knees, hips and the spine are particularly at risk to stress caused by excess body weight.[6]
- Previous joint **injury.**[6]
- **Occupation**—Jobs with activities that apply repetitive stress on joints.[7]
- Certain types of **infections**, including gonorrhea, Lyme disease, *Staphylococcus aureus,* and tuberculosis.[8,9]
- Certain **medical conditions**, including conditions mentioned above, inflammatory bowel disease, psoriasis and sickle cell anemia.[8,9]
- Certain **medicines**, including corticosteroids and other drugs that suppress the immune system.[8,9]

**Arthritis prevalence is defined as having arthritis, rheumatoid arthritis, gout, lupus or fibromyalgia.*
†Prevalence figures are for adults 18 years and older.

For additional information on the impact of arthritis in Indiana, please visit: www.chronicdisease.isdh.in.gov

ARTHRITIS

Indiana State Department of Health

Effects of arthritis on Indiana adults' activity levels (2011)[3†]

- 50.5% of adults (one out of two) with arthritis reported activity limitations (disability) compared to only 14.5% of those without arthritis.
- Of those with arthritis:
  - 21.1% reported that it greatly interfered with their normal social activities.
  - 37.0% reported that it affected their work.
  - 20.2% needed to use special equipment (e.g., cane, wheelchair).

Arthritis-related hospitalizations (2010)[10]

- Over 41,000 Indiana residents received inpatient treatment listing arthritis as one of the three primary reasons for needing care.
- These stays accounted for almost $1.6 billion in medical charges.
- The most common procedures include joint replacement or revisions for knees, hips, shoulders, and elbows and spinal fusions or other spinal procedures.

TAKE ACTION: Steps you can take to prevent or manage arthritis

- Manage your arthritis with guidance from your health care provider
- Learn arthritis management strategies
  - Learning techniques to reduce pain and physical limitations can be beneficial.
- **Be active**
  - Research has shown that physical activity decreases pain, improves function, and delays disability.
- Maintain a **healthy weight**
- Eat a **healthy diet**
  - Talk to your health care provider about foods that may help protect your joints and prevent flare-ups.
- **Be tobacco free** and limit alcohol consumption
  - Both weaken the structure of bones, which increases risk for fractures and joint damage.
- Protect your joints
  - Avoid positions or movements that apply excess stress to your joints.
  - Use larger, stronger joints to bear weight or carry items.

Community resources

- Living a Healthy Life: a 6-week workshop for people with chronic illnesses, which empowers them to manage their disease, control symptoms, and learn how health problems affect their lives.
- Restart Living: a 6-week self-management program for people with chronic illnesses, including arthritis, with workshops available in person or through the Internet.
- INShape Indiana: a resource that motivates, educates, and connects Hoosiers to services that help them eat better, move more, and avoid tobacco.
- Indiana Tobacco Quitline: a free phone-based counseling service to help Indiana smokers quit. For support call 800-QUIT-NOW (800-784-8669).

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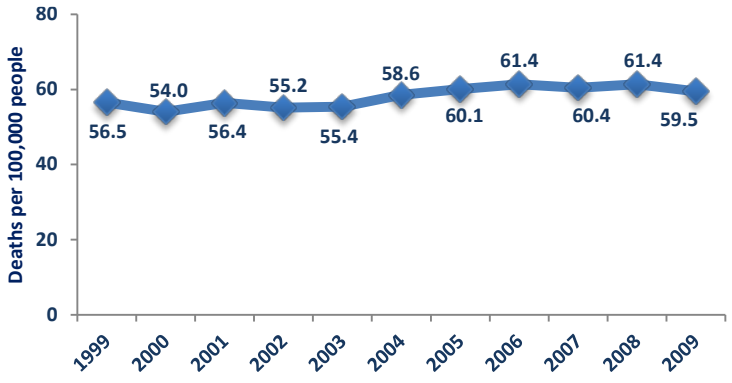
Injury and Violence

Indiana State Department of Health

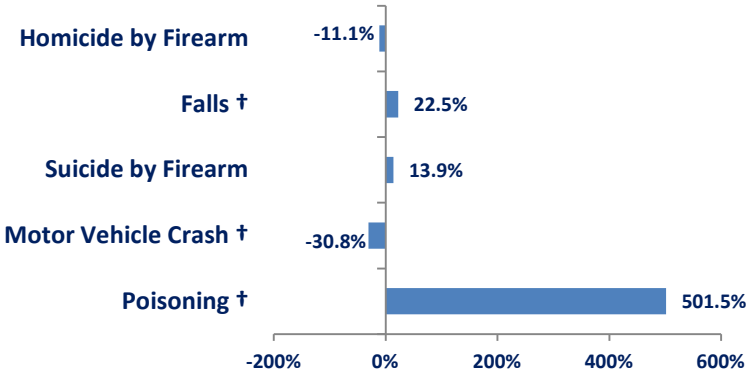
INJURY is the leading cause of death among Indiana residents ages 1–44 and the fifth leading cause of death overall.[1] The majority of injuries are unintentional; however, some can be inflicted intentionally through self-harm or by another individual. Injuries are not the result of an accident, but are correctable events with specific risks for occurrence. Injuries affect all groups of people, regardless of age, race or economic status. In 2009, 3,886 Hoosiers were fatally injured and an additional 50,800 were hospitalized.[1,2] Figure 1 shows the age-adjusted injury death rates during 1999 to 2009.

Figure 1. Injury death rates* by year, Indiana, 1999–2009[1]



In Indiana, unintentional poisonings, unintentional falls and suicides by firearm are leading causes of injury death that increased from 1999 to 2009 [Fig 2].[1] Unintentional poisoning deaths among adolescents, young adults and adults have sharply increased in recent years, mostly as a result of prescription drug misuse and abuse. Unintentional fall deaths have also increased and are expected to continue to increase as Indiana's population ages.

Figure 2. Percent change in death rates* by injury type, Indiana, 1999 vs. 2009[1]



*Age-adjusted rates
† Unintentional

Unintentional poisonings

A poison is any substance, including medication, that is harmful to your body if too much is eaten, inhaled, injected, or absorbed through the skin.[3] Nationally, 91% of unintentional poisoning deaths result from drug overdoses.[3] Annually, the nonmedical use of prescription painkillers (e.g., opioids or narcotic pain relievers) causes more deaths than heroin and cocaine combined and totals more than $50 billion in economic costs.[4,5]

***In the United States** (2010):*

- On average, 87 people died each day as a result of unintentional poisonings; 2,277 were treated in emergency departments.[3]
- Enough painkillers were prescribed to medicate every adult around-the-clock for a month.[4]
- About 12 million people, ages 12 and older, reported nonmedical use (i.e., misuse or abuse) of prescription painkillers during the last month.[4]

***In Indiana** (2009):*[1]

- Unintentional poisoning is the leading cause of injury death overall and surpassed motor vehicle crashes as the leading cause in 2009.
- There were 790 unintentional poisoning deaths, accounting for 20% of all injury deaths.
- The unintentional poisoning death rate increased 502% from 1999 to 2009 [Fig 2].
- Adults ages 25–64 are at greatest risk of death due to unintentional poisoning.

Motor vehicle crashes (MVC)

MVC deaths have declined in recent years; however, they still remain a leading cause of injury death in the United States and Indiana.[1]

In the United States:

- MVCs are the leading cause of death among those ages 10–34.[6]
- In 2010, nearly 33,000 people were killed in MVCs and an additional 2.2 million were injured.[7]

***In Indiana** (2010):*[8]

- There were 754 MVC fatalities, an 11% increase from 2009.
- The economic costs of MVCs exceeded $4.4 billion.

For additional information on the impact of injury in Indiana, please visit: www.in.gov/isdh/19537.htm

Unintentional falls

Falls are among the most frequent and preventable causes of injury. Common results of falls, including hip fractures, head traumas, lacerations and limited mobility, increase the risk of early death, specifically among older adults.[9]

***In the United States** (adults ages 65 and older):*

- An estimated 1 out of 3 will fall each year, but less than half will discuss the fall with a healthcare provider.[10,11]
- In 2000, the total direct medical costs of all fall injuries exceeded $19 billion. Approximately $0.2 billion of this cost was associated with fatal deaths while $19 billion was for nonfatal falls.[12]

***In Indiana** (2009):*

- Falls were the leading cause of injury hospitalization for all ages, totaling over 11,000 hospitalizations.[2]
- There were 303 fall-related deaths among adults ages 65 and older, which accounted for 81% of the total fall-related deaths (Total = 374 deaths).[1]
- The unintentional falls death rate increased 22.5% from 1999 to 2009 [Fig 2].[1]

TAKE ACTION: Steps you can take to prevent or manage injuries

Medication safety

- Only take prescription medications that are prescribed to you by a healthcare provider
- Never take larger or more frequent medication doses
- Never share or sell your medications
- Properly dispose unused, unneeded or expired medications (National Drug Take Back Days)
- Put the Poison Help number, 1-800-222-1222, on or near your home phone and save it on your cell phone

Fall prevention

- Begin a regular exercise program that includes balance exercises
- Have your health care provider review your medicines
- Have your vision routinely checked
- Make your home safer by completing an in-home assessment of fall hazards (Checklist)

Motor vehicle safety

- Always wear a seatbelt and ensure proper use of car seats for infants and children
- Eliminate driving distractions, including use of cell phones for text messaging
- Never drive impaired or ride with impaired drivers
- Report drivers who are exhibiting signs of impaired driving to law enforcement

Community resources

- To find an addiction or mental health services provider, visit the county listing of providers.
- For poisoning information and educational materials visit the Indiana Poison Center website.
- For a listing of permanent car seat fitting stations and upcoming clinics in Indiana, visit Indiana's Automotive Safety Program website.
- To learn more about traffic safety efforts and child passenger safety training in Indiana, visit the Indiana Criminal Justice Institute website.
- Local Area Agencies on Aging offer fall prevention programming for older adults. Contact information for agencies can be found online or by calling: 317-205-9201.
- SilverSneakers is an innovative health, exercise and wellness program that helps older adults live healthy, active lifestyles and is offered at health centers throughout the state.

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For additional information on the impact of injury in Indiana, please visit: www.in.gov/isdh/19537.htm

Module 10

Behavioral Health Overview

Module 10 Behavioral Health Overview

Indiana Community Health Worker Integrated Care Training Program

1

Objectives

1) Dispel myths that perpetuate stigma attached to mental illness
2) Understand the historical perspective of mental health treatment
3) Recognize that recovery from mental illness is possible

FROM THE CONSUMER'S PERSPECTIVE

Guest Speaker

DAVID'S STORY

Watch Video

What Is Mental Illness?

- ***Mental illness*** refers to a wide range of mental health conditions — disorders that affect your mood, thinking and behavior.
- Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviors.

How Common Is Mental Illness?

- 1 in 5 adults experiences a mental health condition every year.
- 1 in 20 lives with a serious mental illness such as schizophrenia or bipolar disorder.
- In addition to the person directly experiencing a mental illness, family, friends and communities are also affected.

Why don't people seek mental health treatment?

- Perceived high financial costs of treatment
- Lack of mental health care providers

Can you guess the number one reason?

Stigmatization of Mental Illness

Stigma

"Stigma leads to isolation, and discourages people from seeking the treatment they need. Political leaders, health care professionals, and all Americans must understand and send this message: Mental disability is not a scandal; it is an illness. And like physical illness, it is treatable, especially when the treatment comes early."

President George W. Bush, April 29, 2002

Effects of Stigma

- Avoid treatment due to labeling
- Mental disorders are not seen as valid, treatable health conditions
- People avoid socializing, employing, working with, renting to or living near people who have a mental disorder
- The public typically does not want to pay for care which leads to less availability of services for those with a mental illness

Sources of Stigma

- Historical view and treatment of mental illness
- Belief that those with mental illness are violent or dangerous
- Media portrayals of mental illness

Mental Illness Myths

- There is no effective treatment for mental illnesses
- People who have a mental illness are dangerous
- There is a great deal to learn before interacting with a person with a mental illness
- People with mental illnesses cannot contribute to society

More Myths

- Adults with mental illness have problems with thinking and problem-solving because they often have a low IQ
- People with a mental illness can pull themselves out of it
- Mental illnesses do not affect the average person

Important Definition

- ***Adults with a serious mental illness*** – aged 18 or older who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria, that has resulted in functional impairment which substantially interferes or limits one or more major life activities.

Pros and Cons of Labeling

- Labels are needed because they identify people who need extra help to thrive. +
- Labels harm people because they keep others from seeing the person behind the label and may limit what we think they can do. −

People Are More Than Their Disabilities

Use *Person First Language*

For Example:

- Rodrigo is one of my schizophrenic clients. −

Vs.

- Rodrigo is my client who has been diagnosed with schizophrenia. +

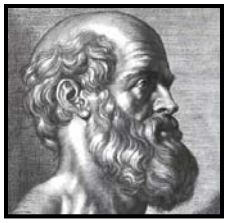
Person First Language Practice

- Here comes Bill, he's bipolar.
- Blind John the guitar player, paid up all his dues.
- Is Sally a diabetic?
- You may need to give the learning disabled students extra time on their exams.

WHERE WE HAVE BEEN AND WHERE WE ARE GOING

Historical Beliefs about Mental Illness

- Trepanning
- Attributed to Supernatural Forces
- Victim Blaming
- Hippocrates
  (1st to Theorize that Mental Illness was Medically Based)



Moral Management

- Introduced by Europeans
- Role of the Environment in Treatment
- Work and Recreation

Fashionable Asylums?

- Ornate and Picturesque
- Charming
- Development of Confidence in Care

Overcrowding

- There were no established guidelines for admittance into asylums
- Community used institutions as an easy means to remove unwanted people from society

Conditions That Resulted from Overcrowding

- Use of Restraints
- Triple Occupancy
- Controversial Treatments
- Lobotomy Development

Developments in Pharmaceuticals

- 1954 Thorazine introduced
- Allowed for shorter hospital stays
- Medication lead to a decline in asylum populations
- Gradual disuse of less humane treatments and procedures

1960s and Beyond

- Mental illness viewed as a disorder of the brain
- New belief decreased stigma resulting in the development of more medications and treatments
- Large numbers of patients were discharged from State Hospitals

Community Mental Health Centers Act of 1963

- Provided funding for outpatient, inpatient, emergency, consultation and education, and partial hospitalization services
- 1500 centers were to be funded; 789 were actually funded
- Funding was supplemented by Medicare (Title VIII) and Medicaid (Title XIX) insurance

Major Characteristics of the New Model

- Principles of psychotherapy use an insight-oriented, developmentally focused, non directive approach (psychoanalysis).
- Responsibility for change is placed on the patient.
- Medication maintenance for "chronically disabled patients"

Psychosocial Rehabilitation Defined

Psychosocial Rehabilitation is the process of restoration of community functioning and well-being of an individual diagnosed with a mental or emotional health disorder.

Psychosocial Rehabilitation

- Emphasizes strengths and wellness.
- Services encompass whole life of consumer.
- Hope, empowerment, and positive expectations emphasized.
- Staff/member relationships are egalitarian and respectful.
- Skill building and focus on work are stressed.

The Evolution of the Recovery Movement

- The current movement is a result of consumer involvement in systems for over 30 years.
- It is based on the belief that consumers can and do recover from mental illnesses.

Mental Health Recovery Movement

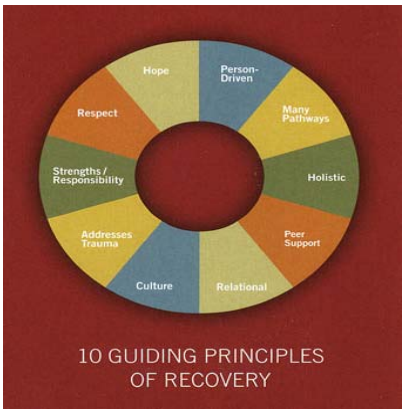
"Consumers are beginning to ask for more than a survival, maintenance, stay-out-of-the-hospital concept of life. Consumers are asking for hope - that life will be of quality, productive, and based on equality."

-- Colleen Jaspers, M.A., Consumer Affairs Director, Michigan Dept. Of Mental Health

What is Recovery?

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

SAMHSA's Guiding Principles of Recovery



SAMHSA's Guiding Principles of Recovery

1. Recovery emerges from **hope**
2. Recovery is **person-driven**
3. Recovery occurs via **many pathways**
4. Recovery is **holistic**

SAMHSA's Guiding Principles of Recovery

5. Recovery is **supported** by **peers** and allies
6. Recovery is supported through **relationship** and social networks
7. Recovery is **culturally-based** and influenced

SAMHSA's Guiding Principles of Recovery

8. Recovery is supported by **addressing trauma**
9. Recovery involves individual, family, and community **strengths** and **responsibility**
10. Recovery is based on **respect**

Fact Sheets

At the end of this module there are several fact sheets on mental health.

- Children Mental Health Facts
- General Mental Health Facts
- Multicultural Mental Health Facts

Conclusion

In this module we:

- Dispelled myths that perpetuate the stigma attached to mental heath diagnoses
- Discussed the history of mental health treatment
- Learned that recovery from mental illness is possible

Evaluation

Please complete the module evaluation.

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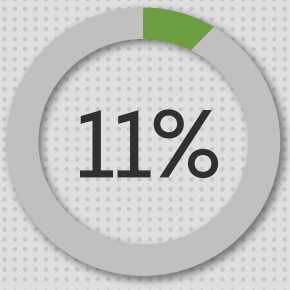
Mental Health Facts
CHILDREN & TEENS

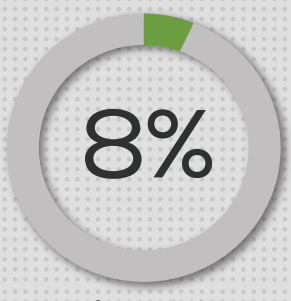
Fact: 1 in 5 children ages 13-18 have, or will have a serious mental illness.

20% of youth ages 13-18 live with a mental health condition



11% of youth have a mood disorder

10% of youth have a behavior or conduct disorder

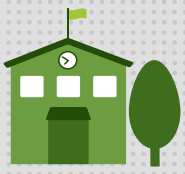


8% of youth have an anxiety disorder

Impact

50% of all lifetime cases of mental illness begin by age 14 and 75% by age 24.

10 yrs — The average delay between onset of symptoms and intervention is 8-10 years.



50% — Approximately 50% of students age 14 and older with a mental illness drop out of high school.

70% of youth in state and local juvenile justice systems have a mental illness.

Suicide

2nd — Suicide is the 2nd leading cause of death in youth ages 10 - 24.

90% — 90% of those who died by suicide had an underlying mental illness.

Warning Signs

- Feeling very sad or withdrawn for more than 2 weeks (e.g., crying regularly, feeling fatigued, feeling unmotivated).
- Trying to harm or kill oneself or making plans to do so.
- Out-of-control, risk-taking behaviors that can cause harm to self or others.
- Sudden overwhelming fear for no reason, sometimes with a racing heart, physical discomfort or fast breathing.
- Not eating, throwing up or using laxatives to lose weight; significant weight loss or gain.
- Severe mood swings that cause problems in relationships.
- Repeated use of drugs or alcohol.
- Drastic changes in behavior, personality or sleeping habits (e.g., waking up early and acting agitated).
- Extreme difficulty in concentrating or staying still that can lead to failure in school.
- Intense worries or fears that get in the way of daily activities like hanging out with friends or going to classes.

4 Things Parents Can Do

Talk with your pediatrician

Get a referral to a mental health specialist

Work with the school

Connect with other families

This document cites statistics provided by the National Institute of Mental Health. www.nimh.nih.gov
This document cites statistics provided by the Centers for Disease Control and Prevention. www.cdc.gov

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Mental Health Facts
IN AMERICA

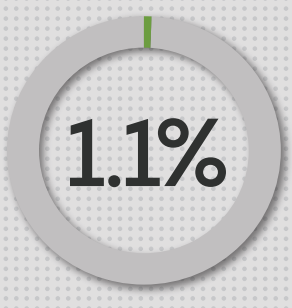
Fact: 43.8 million adults experience mental illness in a given year.

1 in 5 adults in America experience a mental illness.

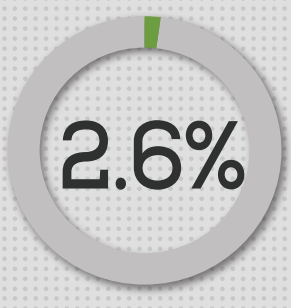
Nearly 1 in 25 (10 million) adults in America live with a serious mental illness.

One-half of all chronic mental illness begins by the age of 14; three-quarters by the age of 24.

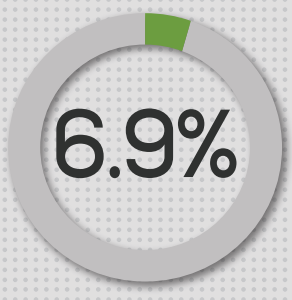
Prevalence of Mental Illness by Diagnosis



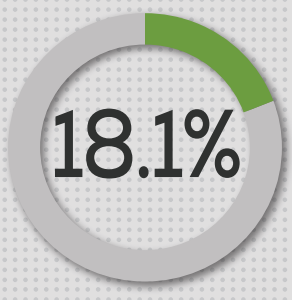
1 in 100 (2.4 million) American adults live with schizophrenia.[1]



2.6% (6.1 million) of American adults live with bipolar disorder.[1]



6.9% (16 million) of American adults live with major depression.[1]



18.1% (42 million) of American adults live with anxiety disorders.[1]

Consequences

10.2m

Approximately 10.2 million adults have **co-occuring** mental health and addiction disorders.[1]

26%

Approximately 26% of **homeless** adults staying in shelters live with serious mental illness.[1]

24%

Approximately 24% of **state prisoners** have "a recent history of a mental health condition".[2]

Impact

1st

Depression is the leading cause of disability worldwide, and is a major contributor to the global burden of disease.[1]

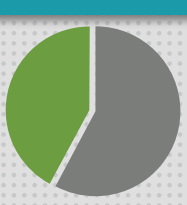
-$193b

Serious mental illness costs America $193.2 billion in lost earning every year.[3]

90%

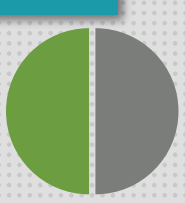
90% of those who die by suicide have an underlying mental illness. Suicide is the 10th leading cause of death in the U.S.[3]

Treatment in America



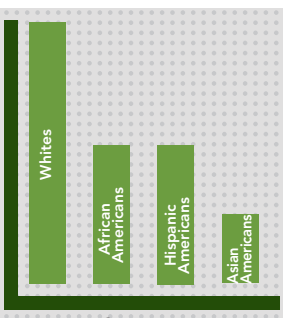
60%

Nearly 60% of adults with a mental illness didn't receive mental health services in the previous year.[4]



50%

Nearly 50% of youth aged 8-15 didn't receive mental health services in the previous year.[1]



African American & Hispanic Americans used mental health services at about 1/2 the rate of whites in the past year and Asian Americans at about 1/3 the rate.[1]

Ways to Get Help

Talk with your doctor

Connect with other individuals and families

Learn more about mental illness

Visit NAMI.org

1 This document cites statistics provided by the National Institute of Mental Health. www.nimh.nih.gov
2 Statistics provided by Department of Justice.
3 American Journal of Psychiatry and U.S. Surgeon General's Report, 1999.
4 Substance Abuse and Mental Health Services Administration

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Mental Health Facts
MULTICULTURAL

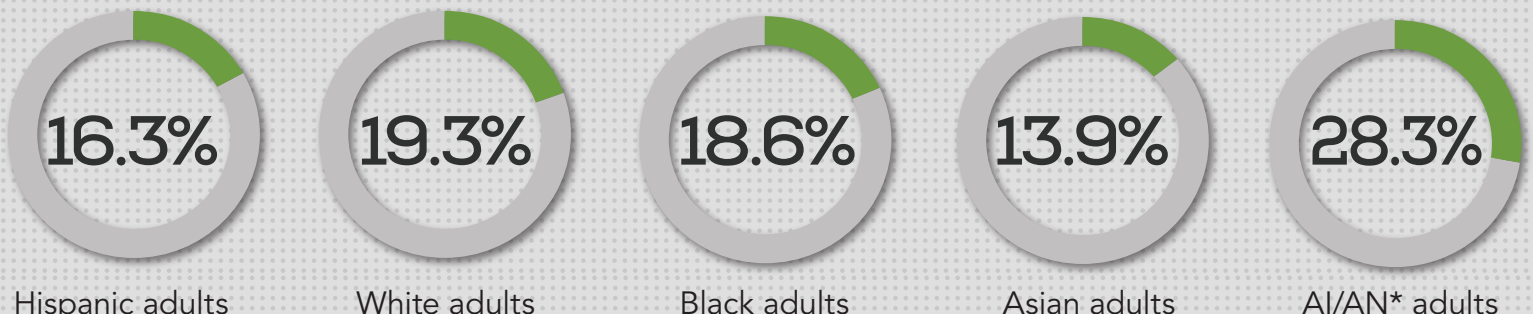
Fact: Mental health affects everyone regardless of culture, race, ethnicity, gender or sexual orientation.

1 in every 5 adults in America experience a mental illness.

Nearly 1 in 25 (10 million) adults in America live with a serious mental illness.

One-half of all chronic mental illness begins by the age of 14; three-quarters by the age of 24.

Prevalence of Adult Mental Illness by Race



Hispanic adults living with a mental health condition.

White adults living with a mental health condition.

Black adults living with a mental health condition.

Asian adults living with a mental health condition.

AI/AN* adults living with a mental health condition.

*American Indian/Alaska Native

LGBTQ Community

2X

LGBTQ individuals are 2 or more times more likely as straight individuals to have a mental health condition.

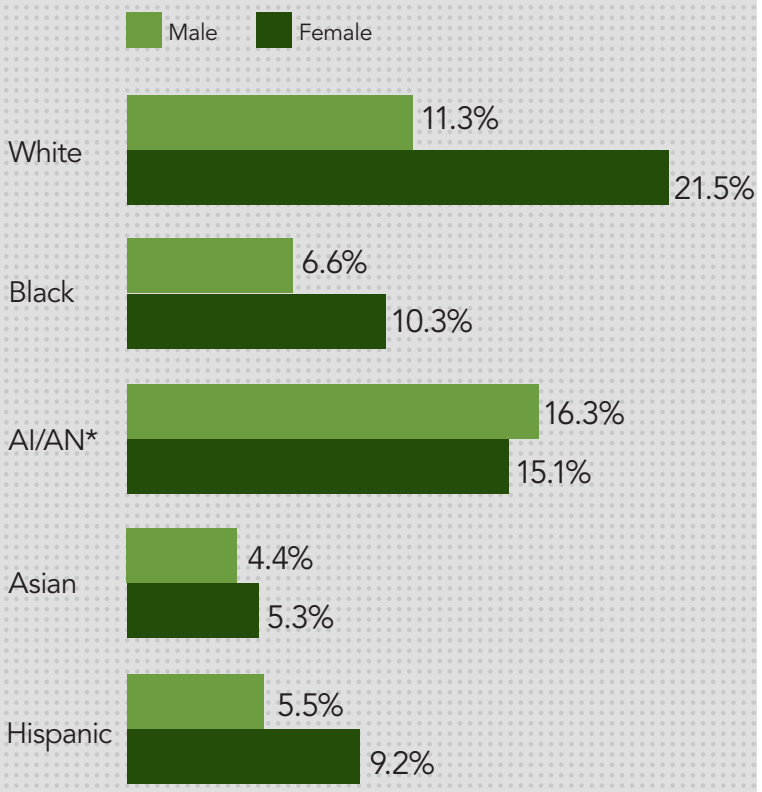
11%

11% of transgender individuals reported being denied care by mental health clinics due to bias or discrimination.

2-3X

Lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth are 2 to 3 times more likely to attempt suicide than straight youth.

Use of Mental Health Services among Adults (2008-2012)



*American Indian/Alaska Native

Critical Issues Faced by Multicultural Communities

- ✓ Less access to treatment
- ✓ Less likely to receive treatment
- ✓ Poorer quality of care
- ✓ Higher levels of stigma
- ✓ Culturally insensitive health care system
- ✓ Racism, bias, homophobia or discrimination in treatment settings
- ✓ Language barriers
- ✓ Lower rates of health insurance

Ways to Get Help

Talk with your doctor

Connect with other individuals and families

Learn more about mental illness

Visit NAMI.org

[1] This document cites statistics provided by the National Institute of Mental Health. www.nimh.nih.gov, the Substance Abuse and Mental Health Services Administration, New Evidence Regarding Racial and Ethnic Disparities in Mental Health and Injustice at every Turn: A Report of the National Transgender Discrimination Survey.

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Module 11

Substance Use Disorders

Module 11 Substance Use Disorders

Indiana Community Health Worker Integrated Care Training Program

1

Objectives

1) Define Substance Use Disorder (SUD)
2) Understand the characteristics of various SUDs
3) Learn about commonly abused substances
4) Recognize that recovery is possible through multiple approaches

Substance Use Disorder

Substance Use Disorder (SUD): the DSM-5 combines the DSM-4 categories of *substance abuse* and *substance dependence* into a single (drug specific) disorder measured on a continuum from mild to severe.

Substance Use Disorders

- **Alcohol**
- **Cannabis**
- **Phencyclidine (PCP)**
- **Other Hallucinogen**
- **Inhalant**
- **Opioid**
- **Sedative, Hypnotic, Anxiolytic**
- **Stimulant**
- **Tobacco**
- **Other (or Unknown) Substance**

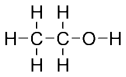
Vocabulary

- **Dependence**: A psychological craving for, habituation to, abuse of, or physiological reliance on a chemical substance.
- **Tolerance**: A progressive reduction in the effect of a drug, following repeated exposure to it, so that it no longer has the desired effect in the original dose.
- **Withdrawal**: A psychological and/or physical syndrome caused by the abrupt cessation of the use of a drug in a drug dependent person.

COMMONLY ABUSED SUBSTANCES

Alcohol

Drug Name: Ethanol Alcohol



Class of Drug: Depressant

Examples: Beer, Wine, Liquor

Dependence:

- Physical High
- Psychological High

Effects of Alcohol

Possible effects of drinking:

- Euphoria, relaxation, giddiness, reduced social anxiety, increased sociability, analgesia, slurred speech, drowsiness, difficulty focusing eyes, and reduced impulse control.

Possible effects with increased use:

- Decreased coordination, nausea/vomiting, reduced ability to judge own impairment, emotional volatility, blackouts, hangovers, and death.

What is a "Drink"?

A standard drink contains 0.6 ounces of pure alcohol. Generally, this translates to:

- 12-ounces of beer (5% ABV)
- 5-ounces of wine (12% ABV)
- 1.5-ounces of 80-proof (40% ABV) distilled spirits or liquor

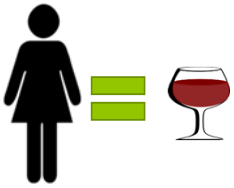
Categories of Drinking

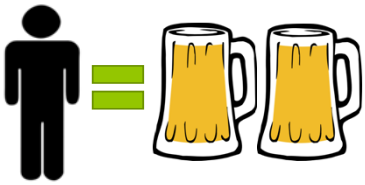
The Centers for Disease Control and Prevention (CDC) identifies alcohol drinking as either:

- Moderate Drinking
- Excessive Drinking
  - Binge Drinking
  - Heavy Drinking

Moderate Drinking

The *Dietary Guidelines for Americans* defines moderate drinking as up to 1 drink per day for women and up to 2 drinks per day for men.





Binge Drinking

For Women

- 4 or more drinks during a single session

For Men

- 5 or more drinks during a single session

Heavy Drinking

For Women

- 8 or more drinks per week

For Men

- 15 or more drinks per week

Short-Term Health Risks

- Injuries, such as motor vehicle crashes, falls, drownings, and burns
- Violence, including homicide, suicide, sexual assault
- Alcohol poisoning
- Risky sexual behaviors

Long-Term Health Risks

- High blood pressure, heart disease, stroke, liver disease
- Learning and memory problems
- Mental health problems, including depression and anxiety
- Social problems

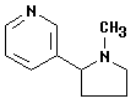
Alcohol Use Disorder

To be diagnosed with an Alcohol Use Disorder (AUD), individuals must meet certain diagnostic criteria. Some of these criteria include:

- Problems controlling intake of alcohol
- Continued use despite problems resulting from drinking
- Development of a tolerance or withdrawal symptoms

Tobacco

Drug Name: Nicotine



Class of Drug: Stimulant

Examples: Cigarettes, Vaporizers, Chewing Tobacco

Dependence:

- Physically High
- Psychologically High

Effects of Tobacco

Possible short-term effects:

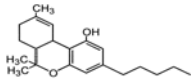
- The effects of nicotine can be perceived as both stimulating and relaxing
- Those new to nicotine may experience nausea, dizziness, and increased blood pressure (These effects dissipate quickly due to the rapid tolerance rate associated with nicotine)

Long-Term Health Risks

Possible long-term effects of tobacco use:

- Smoking causes cancer, heart disease, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD), which includes emphysema an chronic bronchitis
- Smoking increases the risk for tuberculosis, certain eye diseases, and problems of the immune system, including rheumatoid arthritis

Cannabis

Drug Name:	Dlelta-9 Tetrahydrocannabinol (THC) 
Class of Drug:	Cannabinoids
Examples:	Marijuana, Hashish, Hash Oil, “Edibles”
Dependence:	
• Physically	Possible
• Psychologically	Moderate

Effects of Cannabis

- Dry mouth and red eyes
- Altered sense of time
- Changes in mood (ex. paranoia)
- Impaired short-term memory
- Slowed reaction time

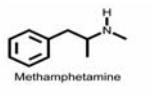
Health Risks

Cannabis may cause and/or exacerbate:

- Lung cancer (when smoked)
- Lower birth weights/premature births (in ladies)
- Lower testosterone/fertility (in gentlemen)
- Mental health issues

Stimulants

Drugs:	Amphetamine-type, Cocaine, Other or unspecified
Class of Drug:	Stimulant
Examples:	Meth, Crack, Bath Salts

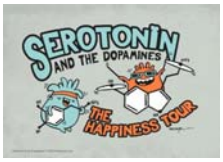


Dependence:

- Physically — Possible
- Psychologically — High

Effects of Stimulants

- Stimulant use can initially cause the user to feel euphoria due to the abrupt increase in the production of dopamine (a brain chemical responsible for pleasure and happiness).

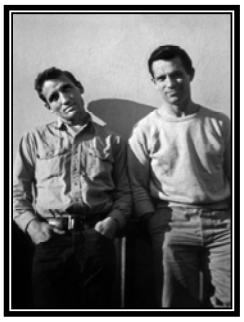


- With repeated use, the pleasurable effects diminish because the overload of dopamine can cause the brain to cease dopamine production.
- As a user becomes addicted to stimulants, they begin to only feel good or happy by taking stimulants.

Short-Term Effects

Possible short-term effects of stimulant use:

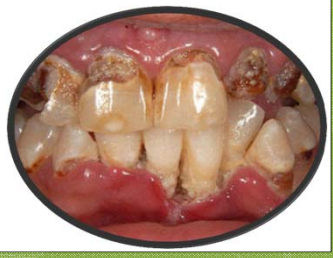
- Increased heart rate and blood pressure
- Increased temperature
- Nausea
- Dilated pupils
- Muscle spasms



Long-Term Effects

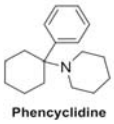
Potential long-term effects of stimulant use:

- Anorexia or extreme weight loss
- Difficulty concentrating or focusing
- Paranoia or anxiety
- Hallucinations
- Dental problems



Hallucinogens

Drugs:	LSD, PCP, Psilocybin, Mescaline
Class of Drug:	Hallucinogen
Examples:	Acid, Angel Dust, Magic Mushrooms, Peyote



Phencyclidine

Dependence:

- Physically — None* (PCP exception)
- Psychologically — Possible-Low

Effects of Hallucinogens

Hallucinogens work by temporarily interfering with the neurotransmitters and receptor sites within the brain. While under the influence of hallucinogens, the user may:

- Have changes in sensory perceptions (ex. *Synesthesia* - see sounds or hear colors)
- Feel intense emotions (moods can change quickly)
- Have changes in response to environment

Short-Term Effects

Short-term effects of hallucinogens may include:

- Increased heart rate
- Confusion and/or disorientation
- Mixed-up speech
- Dilated pupils

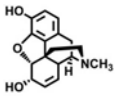
Long-Term Effects

Long-term hallucinogen use may cause:

- Flashbacks (weeks, months, or even years after drug use)
- Decreased motivation
- Psychosis
- Development of Hallucinogen Persisting Perception Disorder

Opioids

Drugs:	Opium, Synthetic Opiates
Class of Drug:	Opiates
Examples:	Vicodin, Morphine, Heroin, Methadone
Dependence:	
• Physically	High
• Psychologically	High



Morphine

Effects of Opioids

- Opiates activate the opiate receptors that are widely distributed throughout the brain and body.
- The effects produced by opiates are pleasure and pain relief. These effects generally last from 2-4 hours.
- Most opiate addicts progress through series of ingestion methods that begins with orally abusing the substance, then snorting, and finally injecting the drug.

Possible Effects of Opioids

Short-term

- Euphoria
- Sedation
- Nausea
- Slow or shallow Breathing
- Death

Long-term

- Tolerance
- Physical dependence
- Psychological dependence
- Health Problems

Opioid Withdrawal

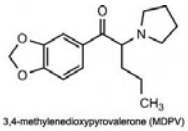
- Anxiety
- Chills
- Sweating
- Vomiting
- Diarrhea

- Runny nose
- Watery Eyes
- Cramps
- Tremors
- Muscle spasms

Famous People Lost to Overdose

Other (or Unknown) Substance

Drugs:	Research Chemicals
Class of Drug:	Multi (Dependent upon Specific Chemical)
Examples:	Spice, Bath Salts Smiles, Flakka
Dependence:	
• Physically	Varies (Depends on Chemical)
• Psychologically	Varies (Depends on Chemical)



3,4-methylenedioxypyrovalerone (MDPV)

Research Chemicals

- About 10-15 years ago, research chemicals were marketed and sold as “legal highs”. Once a specific chemical was banned, the drug producers would switch to another similar, non-banned substance.

- With the passage of recent state and federal laws, these products are no longer sold legally.

Research Chemicals

- A current and dangerous trend is for drug dealers to misrepresent the drug they are selling.

- Dealers are substituting less expensive, and potentially lethal chemicals with more well known and relatively safer compounds.

SUD TREATMENT

SUD Recovery

There is no one 'correct' way that people recover from substance use disorders. People can and do recover from SUDs (and mental disorders) by using a variety of methods.

SUD Treatment Service Components

SAMHSA has identified the service components that are effective in treating SUDs.

- Individual and group counseling
- Inpatient and residential treatment

SUD Treatment Service Components (Cont.)

- Intensive outpatient treatment
- Partial hospital programs
- Case or care management
- Medication – (Medicated-Assisted Treatments (MATs) are approved for alcohol, tobacco, and opioid use disorders)

SUD Treatment Service Components (Cont.)

- Recovery support services
- 12-Step fellowship
- Peer supports

Substance Abuse and Mental Health Services Administration SAMHSA

Conclusion

In this module we:

- Defined substance use disorder (SUD)
- Discussed the charateristics of different SUDs
- Looked at some commonly abused drugs
- Recognized that there are various ways people recover from SUDs

Module Evaluation

Please complete the module evaluation.

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Module 12

Integrated Care Model

Module 12 Integrated Care Model

Indiana Community Health Worker Integrated Care Training Program

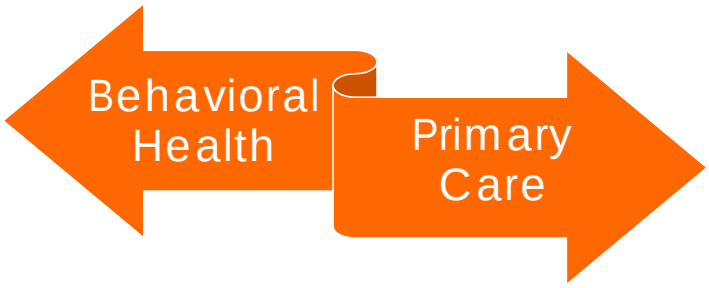
1

Objectives

1) Define integrated care – the combination of behavioral and primary health care

2) Learn about three different integrated care models

3) Understand the role CHWs play in the integrated care models



Defining Integrated Care

SAMHSA

Definition

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines integrated care as "the systematic coordination of general and behavioral health. Integrating mental health, substance abuse and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs."

HEALTHCARE INTEGRATION

Watch Video

Why Integrated Care?

People with mental and substance abuse disorders may die decades earlier than the average person mostly from untreated and preventable chronic illnesses like:

- hypertension
- diabetes
- obesity
- cardiovascular disease

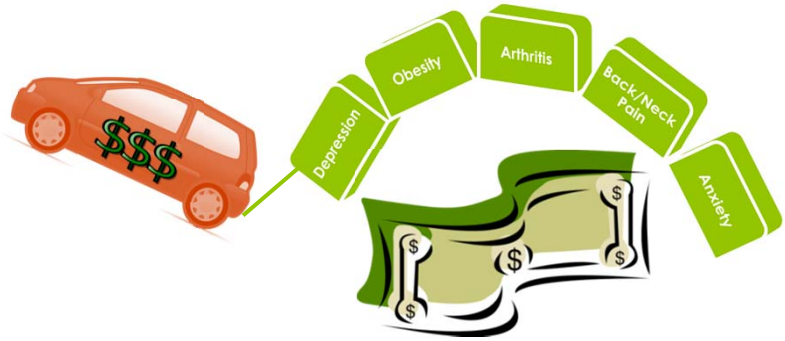
Gateway to Behavioral Health

Primary care settings have become the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with behavioral and general healthcare needs.

Prevalence of Co-Occurring Conditions and the Importance of Integration

- Efforts to improve population health and reduce costs must adequately address behavioral health.
- Primary care providers have experienced challenges with regards to treating chronic illness among individuals with mental health/substance abuse disorders.
- Neuropsychiatric disorders are now the number one cause of disability.
- Depression and other Mental Health/Substance Use Disorder are associated with high health care costs.

Major Conditions Driving Healthcare Spending



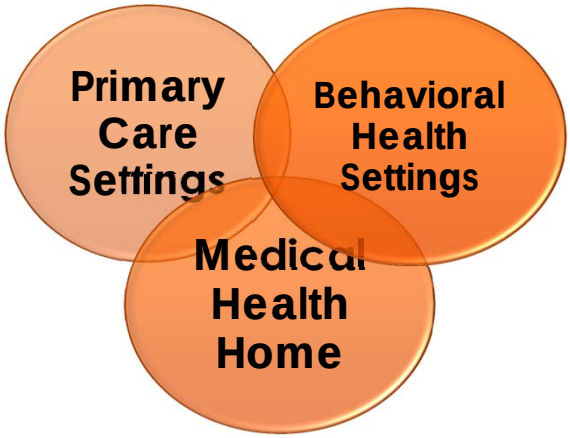
Co-Occurring Conditions

- Physical and behavioral health conditions have high rates of co-occurrence, with unmet behavioral health needs frequently complicating treatment for medical practitioners.
- One out of five patients with coronary heart disease and one out of three patients with congestive heart failure also experience depression but are not diagnosed or treated.
- The interaction between a person's psychiatric status and health is dramatic: one in three patients who go to the emergency room with chest pains is actually experiencing panic disorder or depression.

Integrated Model Benefits

- Purchasers are **creating incentives.**
- Health plans and MBHOs are **developing systems** of care.
- Accountable Care Organizations (ACOs) and Community Care Organizations (CCOs) are **creating provider networks.**
- **Providers are affiliating** across primary and behavioral healthcare.

Three Integrated Care Models



Primary Care Settings

- Medical Hospital
- Physician Offices
- Community Based Outpatient Clinics
- Critical Access Hospital
- Immediate Care Center
- Health Clinics

Primary Care Settings

Why seek MH care in PC settings?

- Uninsured or underinsured
- Cultural beliefs and attitudes
- Limited access to public MH services
- Stigma of seeking Mental Health Services
- Availability of MH services, especially in rural areas

*PC = Primary Care
*MH = Mental Health

Primary Care Settings

Mild to moderate BH issues are common in PC settings:

- Anxiety, depression, substance use in adults
- Anxiety, ADHD, behavioral problems in children

Prevention and early intervention opportunity

- People with common medical disorders have high rates of BH issues: i.e. diabetes, heart disease, & asthma **+** depression

Worse outcomes & higher costs if both problems aren't addressed

Behavioral Health Settings

- Psychiatric Hospital
- Psychiatric Unit of a Medical Hospital
- Psychiatrist, Psychologist or Therapist Office
- Outpatient Clinics
- Addiction Treatment Center
- Domestic Violence Shelter
- Residential Treatment Center

Behavioral Health Settings

- People with serious mental illness (SMI) are dying 25 years earlier than the general population.
- 2/3 of premature deaths are due to preventable/treatable medical conditions such as cardiovascular, pulmonary, and infectious diseases.
- Studies suggest that depression increases the risk of developing Type 2 Diabetes by more than 20% in young adults.

BH Consumers Who Seek Care in PC Settings

- Are less likely to receive effective medical care, including preventive services,
- Report difficulties establishing relationships with PC Physicians,
- Express dissatisfaction in time limitations with PC staff, and
- Feel the stigma of having a MH diagnosis.

Methods for Clinically Aligning PC and BH

- Training for primary care practitioners on identification and treatment of behavioral health conditions

- Screening for behavioral health conditions in primary care settings
- Screening for medical conditions in behavioral health organizations

Methods for Clinically Aligning PC and BH (Cont.)

- Providing consultation services to primary care practitioners
- Creating strategies for increasing patients' health literacy and activation
- Co-locating behavioral health and primary care services
- Delivering integrated team-based behavioral health and primary care

Whole Health Action Management

Promising Practice:

The Whole Health Action Management Program (WHAM) was developed by the SAMHSA-HRSA Center for Integrated Health Solutions and is a peer-led, research-informed program that includes:

- Person-Centered Goals
- Weekly Action Plan
- Daily/Weekly Personal Log
- One-to-One Peer Support
- Weekly Peer Support Group

Medical Health Home Models

- Person-Centered Healthcare Home
- Healthcare home may be a PC or BH setting depending on a person's preference
- Ongoing relationship with a PCP
- Team with collective responsibility for ongoing care
- "Whole person" orientation
- PCMHs need MH and SU capacity – i.e., MH and SU services need to be *integrated* into the medical home

UNDERSTANDING THE ROLE CHWs PLAY IN THE INTEGRATED CARE MODELS

CHWs Primary Role

- Care Coordination
- Patient Engagement
- Health Education
- Treatment Compliance

Overarching Goal: Deliver better patient care for the healthcare systems and reduce costs.

Five Models in Which CHWs Provide Care

1. Member of health care team
2. Navigator of the health care system
3. Screening and health education provider
4. Outreach-enrolling-informing agent
5. Organizer

1. CHW Role in a "Multidisciplinary Team"

- Measuring and monitoring blood pressure, blood glucose
- Providing social support and helping them solve problems
- Creating community-clinical linkages
- Assessing and supporting self-management patient plans
- Increasing the team's cultural competence
- Supporting individualized goal-setting

2. Helping Patients Navigate Health Care Systems

- Insurance Enrollment
- Appointments
- Referrals
- Transportation
- Child Care Arrangements
- Bilingual Providers or Translators

3. Screening and Health Education Provider

Educating patients/families on:

- Lifestyle Changes
- Adherence to Treatments
- Medications Compliance

4. Outreach-Enrolling-Informing Agent

- Providing social support by listening to the concerns of patients and their family members and helping them solve problems
- Creating community-clinical linkages to help create a team based approach through supporting and enhancing the work of healthcare team
- Assessing how well a self-management plan is helping patients to meet their goals

5. Organizer

Playing a role in self-management program administration by leading or supporting self-management programs

Assist with ACA Identified Essential Health Services

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services
- Prescription drugs
- Rehabilitative and habilitative services
- Laboratory services
- Preventative and wellness services and chronic disease management
- Pediatric services

ACA Free Preventative Screening

Educate the consumer in the ACA mandated free preventative screening services that include:

- Cancer
- Chronic conditions
- Immunization health promotion
- Pregnancy related
- Reproductive health

CHWs Impact the Bottom Line

Using their unique position, skills, and an expanded knowledge base, CHWs can help reduce system costs for health care by linking patients to community resources and helping patients avoid unnecessary hospitalizations and other forms of more expensive care as they help improve outcomes for community members.

Example: Primary Care Provider vs. Emergency Department

Primary Care Provider	Emergency Department
• Co-Pay $0-$50	• Co-Pay, co-insurance, deductible $50- $150
• Visit when sick and well	• Visit when injured or very sick
• Call ahead for appointment	• Show up anytime and wait
• Seen around appt. time	• Wait for several hours
• Same provider each time	• Provider working that day
• Access to your health records	• No access to your health records
• Helps with a treatment plan	• Discharges to follow-up with Primary Care Physician

Conclusion

In this module we:

- Defined integrated care - behavioral health combined with primary health care
- Learned about three different integrated care models
- Covered the role CHWs play in the integrated care models

Evaluation

Please complete the module evaluation.

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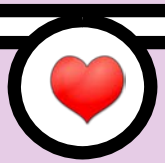
The Affordable Care Act Mandated Free Preventative Services

Cancer

- Breast cancer mammography (women 40+)
- Genetic (BRCA) screening and counseling (women at high risk)
- Pap testing (women 21+)
- HPV DNA testing (women 30 to 65 with normal pap results)
- Lung cancer screening: annual tomography (adults 55 to 80 with history)
- Skin cancer counseling (adults 18 to 24)



Health Promotion

- Alcohol misuse screening and counseling
- Intimate partner violence screening, counseling (women)
- Tobacco counseling and cessation interventions

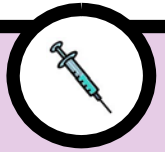
Chronic Conditions

- Hypertension screenings
- Blood pressure screenings
- Behavioral counseling (overweight or obese adults with CVD risk factors)
- Diabetes (Type 2) screening (adults elevated blood pressure)
- Depression screening

Pregnancy Related

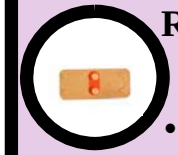
- Alcohol misuse screening and counseling
- Breastfeeding supports, including counseling and consultations with trained provider
- Gestational diabetes screenings

For more information or to meet with an ASPIN Health Navigator call 1-877-313-7215 or visit www.aspin.org.



Immunization

- Hepatitis A (adults with risk factors)
- Hepatitis B (adults with risk factors)
- HPV (women 18 to 26 and men 18 to 21 not previously vaccinated; at risk men 22 to 26)
- Influenza (yearly)



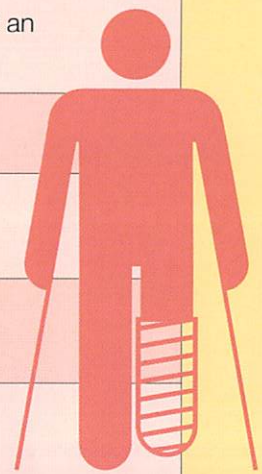
Reproductive Health

- Contraception (women with reproductive capacity)
- All FDA-approved contraceptive methods as prescribed
- Screenings, including chlamydia, gonorrhea, syphilis, and HIV

www.healthcare.gov/coverage/preventive-care-benefits/

Differences Between Your Provider's Office and the Emergency Department

Primary Care Provider	Emergency Department
You'll **pay your primary care copay**, if you have one. This may cost you between $0 and $50.	You'll likely **pay a copay, co-insurance, and have to meet your deductible** before your health plan pays for your costs, especially if it's not an emergency. Your copay may be between $50 and $150.
You go when you **feel sick and when you feel well**.	You should only go when you're **injured or very sick**.
You **call ahead** to make an appointment.	You **show up when you need to and wait** until they can get to you.
You may have a short wait to be called after you arrive but you will generally **be seen around your appointment time**.	You may **wait for several hours** before you're seen if it's not an emergency.
You'll usually see the **same provider each time.**	You'll see the **provider who is working that day**.
Your provider **will** usually have access to your health record.	The provider who sees you probably **won't** have access to your health records.
Your provider works with you to **monitor your chronic conditions** and helps you improve your overall health.	The provider **may not know what chronic conditions you have**.
Your provider will **check other areas of your health**, not just the problem that brought you in that day.	The provider **will only check the urgent problem** you came in to treat but might not ask about other concerns.
If you need to see other providers or manage your care, **your provider can help you make a plan**, get your medicines, and schedule your recommended follow-up visits or find specialists.	When your visit is over you will be **discharged with instructions to follow up** with your primary care provider and/or specialist. There may not be any follow-up support.
In some areas, you may be able to go to an **Urgent Care Center.** If Urgent Care is available in your area, call your health plan before you go to find out how much you will have to pay.	



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Module 13

Motivational Interviewing

Module 13 Motivational Interviewing

Indiana Community Health Worker Integrated Care Training Program

1

Objectives

1) Understand the basic concepts, spirit, and guiding principles of Motivational Interviewing
2) Learn the Stages of Change model
3) Develop skills and strategies for using Motivational Interviewing
4) Learn strategies for encouraging change talk

Motivational Interviewing – What Is It?

What is Motivational Interviewing (MI)?

- "…a collaborative, person-centered form of guiding to elicit and strengthen motivation for change."
- At it's core, motivational interviewing addresses individuals' ambivalence or resistance to change.

Change: What's the Point?

Why do people change their behavior or thought processes?

- To avoid negative consequences
- Their physical or social surroundings change
- Their psychology or physiology changes

Stages of Change

Motivational Interviewing – Where Can It Be Used?

Where can Motivational Interviewing be used?

- Anywhere the need for behavior change exists:
  - Management of chronic disease
    - Medication regimens, monitoring vital signs, reducing stress, dietary management, etc.
  - Substance Use Disorder
    - Quitting smoking, eliminating illicit drug use or alcohol consumption, etc.
  - Psychological Issues
    - Controlling psychosis, compulsive disorders, harmful behavior, etc.

The Spirit of MI

There are three key elements to the spirit of MI:

1. Collaboration instead of confrontation
2. Creating the desire to change rather than imposing a set of ideas
3. Honoring the individual's autonomy in place of forcing submission to authority

The R.U.L.E.s of MI

MI has four guiding principles:

R – resist the righting reflex

U – understand your client's motivations

L – listen at least as much as you speak

E – empower your client to embrace change

The **R**.U.L.E.s of MI

R – resist the righting reflex

- Those that enter helping professions often want to fix a problem by correcting particular courses of action.
  - This approach generally has the opposite effect on the client by increasing resistance to change.
  - Ultimately it is the client who needs to vocalize the desire to correct behavior(s), internalize arguments against past thought patterns, and map the path toward the desired outcome.
- Rather than attempting to direct change, try managing discord and developing discrepancy…

Managing Discord

Discord occurs when:

- A client sees a conflict between his/her view of the need for change (or the solution) and that of the practitioner or
- The client feels their autonomy being compromised.

Managing discord is a practice that allows actions/statements that demonstrate resistance to go unchallenged; especially during early interactions, and is characterized by:

- Allowing the client to define the problem and develop the solution through
  - Exploring client concerns
  - Inviting clients to examine new points of view
  - Not imposing ways of thinking

Developing Discrepancy

Motivation for change occurs when clients realize a mismatch between where they are and where they want to be.

- The practitioner facilitates this by examining discrepancies between current behaviors and future goals.
- The realization that current actions conflict with self-defined goals creates motivation to embrace behaviors that work toward, instead of away from, their desired outcomes.

The R.**U**.L.E.s of MI

U – understand your client's motivations

- Behavior change is largely triggered internally.
- Understanding of the client's perceptions and motivations will help elicit the shift from arguing against (resistance) to arguing for change.
- Asking open ended questions helps clients to voice their internal dialogue :
  - which both fosters understanding of where the client is at in the cycle of change and helps the practitioner more gently guide the change process.

Questioning as a Tool

Type of question used depends on desired outcome

- **Open Ended** questions leave the direction and focus of the response to the one answering.
- **Closed Ended** questions limit the response options to single words or short phrases.

Open Ended Questions

- Ask the respondent to think and reflect.
  - Why do you think you reacted that way?
  - How might the situation have been approached differently?
- Provide a means to examine the respondents' beliefs, wants, and needs.
- Allow for the respondent to express thoughts and feelings.

Closed Questions

- Can be answered with either a single word or short phrase.
- Interrogation type of questions:
  - Did you go to your doctor appointment?
  - Did you take your medications?
- Provide the facts.
- Result in quick answers.

Open or Closed Question Quiz

1. Have you ever used a computer? _____
2. What did you like about your last position? _____
3. How long did it take to become proficient in your current role? _____
4. Why did you apply for your current position? _____
5. When did you graduate from school? _____
6. What do you most like to do in your spare time? _____
7. What did you do the last time someone didn't like an idea you were proposing? _____
8. Do you like exercising? _____
9. What route do you take to get into work? _____

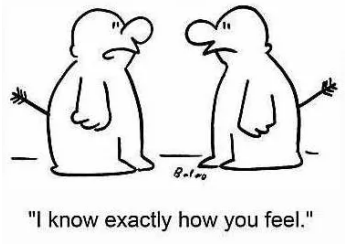
The R.U.L.E.s of MI

L – listen at least as much as you speak

- Good listening requires more than asking questions and providing enough time for the client to respond.
  - To be an excellent listener, the practitioner must have an empathic (vs sympathetic) interest in understanding the client's meaning.
  - When clients feel what they are saying is important and the listener wants to hear more; they are often encouraged to honestly explore and share experiences in more depth.

Empathy vs Sympathy

- Empathy is the ability to recognize and share the emotions of another being and involves:
  - Seeing a situation from another's perspective
  - Sharing of emotions; especially distress
- Sympathy is the ability to feel care and concern for someone combined with the desire to see the person better off or happier
  - Lacks the shared perspective found in empathy
  - Does not convey shared distress



EMPATHY VERSUS SYMPATHY

Watch Video

The R.U.L.**E**.s of MI

E – empower your client to embrace change

- Outcomes are improved when clients have both an active interest and role in the change process.
- A client that is actively engaged in thinking aloud about the why and how of change is more likely to work toward the desired outcome after the session is over.
- A client's belief that change is possible (self-efficacy) instills hope about making difficult changes
  - Self-efficacy is supported by focusing on previous successes and highlighting skills and strengths the client already has.

MI Skills and Strategies

- Use your OARS
- Facilitate Change Talk
- Readiness Ruler

Use Your OARS

OARS is an acronym to help remember the basic approach of MI:

O – Open ended questions

- Use questions that elicit thought provoking responses

A – Affirmations

- Make statements that recognize clients' strengths

R – Reflections

- Express empathy through careful listening and resolve ambivalence by reflective reminders of the negatives of maintaining current behavior and the positives of making change.

S – Summaries

- Recapping what has happened in sessions highlights both sides of ambivalence about change and promotes discrepancy development by focusing on important aspects of the interaction.

Facilitate Change Talk

- Change talk is evidenced by the client discussing the:
  - possibility of,
  - motivation for, or
  - commitment to change.
- Change talk can be seen as having two phases (preparatory and implementing) and is remembered with the mnemonic DARN CAT.

Types of Change Talk: Preparatory and Implementing

- Preparatory Change Talk
  - **D**esire – I want to change
  - **A**bility – I can change
  - **R**eason – It's important to change
  - **N**eed – I should change
- Implementing Change Talk
  - **C**ommitment – I will make changes
  - **A**ctivation – I am ready, willing, and prepared to change
  - **T**aking Steps – I am taking specific steps to change

Strategies for Encouraging Change Talk

- **Ask Suggestive Questions** – use open ended questions guided toward change talk
- **Ask for Elaboration/Examples** – ask for more details when change talk emerges
  - In what ways?
  - Tell me more?
  - What does that look like?
  - When was the last time that happened?

Strategies for Encouraging Change Talk

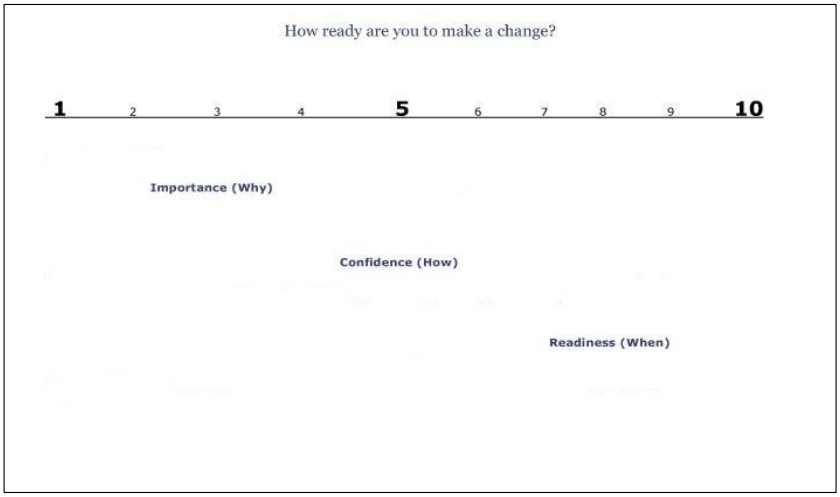
Explore Decisional Balance – ask about the pros and cons of staying the same and changing

- Good Things/Not-So-Good Things – the pros and cons of achieving the desired behavior
- Look Back – ask about a time before the target behavior emerged
- Look Forward – Ask what may happen if things continue as they are:
  - If 100% successful with making desired changes, what would be different?
  - How would you like your life to be in 5 years?

Strategies for Encouraging Change Talk

- **Imagine Extremes** – Ask what the worst and best things that might happen if the change is or isn't made.
- **Come Along Side** – Side with the negative side of ambivalence to change:
  - Maybe (the current behavior) is so important to you that you won't give it up, no matter the cost.
- **Use a Readiness Ruler** – ask client to place a value from 1 to 10 to characterize the importance of making the desired change, how confident they are they can make the change, or how ready they are to work on changing.

Readiness Ruler



Time to Practice

- Using the handout "Modifiable Risk Factors", individually write your responses.
- After completing, divide in groups and share responses.
- Resolve discrepancies on stages of change and note others' suggestions for CHW/CRS response that were good ideas to add to your toolbox.

Conclusion

In this module we:

- Reviewed the basic concepts, spirit, and guiding principles of Motivational Interviewing
- Learned the Stages of Change model
- Developed skills and strategies for using Motivational Interviewing
- Learned strategies for encouraging change talk

Evaluation

Please complete the module evaluation.

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Stages of Change

Stage	Client Response	Motivational Task for the Support Worker
Stage I: **Pre-contemplation**	Does not perceive problems with behavior or need to make changes	Raise doubt and provide information to increase client's perception of risks and problems with current behavior
Stage II: **Contemplation**	Considers change but not ready to commit to changes in behavior	Evoke questions about change, risks of not changing, strengthen client's ability to accept change in current behavior
Stage III: **Determination**	Considers change and develops a commitment to action	Help client determine best course of action to take in seeking change
Stage IV: **Action**	A particular action to solve or change the problem; begins to implement the solution or action plan	Help client take steps toward change
Stage V: **Maintenance**	Develops new behaviors to maintain changes and solutions	Help client identify and use strategies to prevent relapse and reinforce new behavior

*Relapse can occur at any time

Readiness Ruler

How ready are you to make a change?

Importance (Why)

Question: On a scale from 1 to 10, how important is it for you right now to reduce or stop tobacco?

- **Scenario 1:** They answer "8".
  - **Response:** An "8" sounds like it is pretty important to you. Why not 5 or 6?
    - Their answer reveals intrinsic reasons for their particular importance level.
- **Scenario 2:** Their answer is low (2).
  - **Response:** A "2" sounds like it is not very important to you right now. Can you give reasons why you do not feel it is important to you right now? Would you mind if we came back to this in the future?

Confidence (How)

Question: On a scale from 1 to 10, how confident are you that you would succeed at reducing/stopping tobacco?

- **Scenario 1:** They answer "8".
  - **Response:** An "8" sounds like you have lots of confidence that you will succeed. Why not 5 or 6?

  - Their answer reveals how they view their current ability. (self-efficacy)
- **Scenario 2:** Their answer is low (2).
  - **Response:** A 2 sounds like you are not real confident at this time. Can you give reasons why you think your confidence level is at a 2?

Readiness (When)

Question: On a scale from 1 to 10, how ready are you to start making a change at reducing/stopping tobacco?

- **Scenario 1:** They answer "8".
  - **Response:** An "8" sounds like you are ready to begin the change process. Why not 5 or 6?

  - Their answer reveals how they view their current level of readiness.
- **Scenario 2:** Their answer is low (2).
  - **Response:** A 2 sounds like you are not ready to start the change process at this time. Can you give reasons why you feel you are not more ready?

Modifiable Risk Factors

Risk Factor	Possible Client Response	Stage of Change	CHW/CRS Response
Overweight and Obesity	I am tired of having to worry about a whole new wardrobe. I want to wear the cute stuff		
Nutrition	I know I should eat more fruits and vegetables, but I don't eat them fast enough and they rot before I can eat them. That wastes my money.		
Physical Activity	Who wants to be a good looking corpse?		
Tobacco Use	At least I stopped drinking. I have to have one vice.		
Alcohol and Other Drugs	I finished my intensive outpatient program and am going to church every week, and going to at least 3 AA meetings each week. I use my sponsor to help me work my program.		

For each modifiable risk factor above: 1.) Read the client response, 2.) Identify the Stage of Change, 3.) Develop a comment or question that assists client movement.

Module 14

Coaching Consumers for Positive Health Outcomes

Module 14 Coaching Consumers for Positive Health Outcomes

Indiana Community Health Worker Integrated Care Training Program

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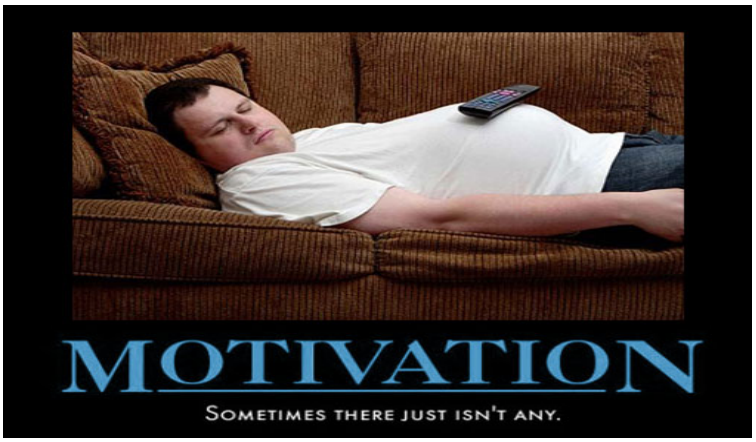
Objectives

1) Learn what positive health outcomes are
2) Identify when someone would need coaching to achieve positive health outcomes
3) Learn strategies to help individuals achieve desired health outcomes

What Motivates Us to Change?



Where to Begin?

- Perception of Problems/Issues
- Self-Talk
- Being in "Control"

SELF COMMUNICATION

The Power of Positive and Negative Messages

Identifying Positive and Negative Self Talk

You are trying to figure out a new computer program, and after hours of work, it still eludes you.

You think:

a) "I will get this, it is just going to take some time."

b) I will never get this; I guess I'm just stupid."

Positive Statements = Positive Results

Make positive statements about what you would like to see manifested, and repeat them enough so that they're part of your way of thinking and seeing the world.

This operates in the same way that negative self-talk does, but in a way that benefits you.

Negative Statements = Negative Results

Negative Self talk and Stress:

Self talk is the internal dialogue we use to view the world, explain situations and communicate to ourselves.

The type of self talk you use (negative self talk or positive self talk) can affect the level of stress you experience.

The type of self talk used can increase or decrease stress levels.

One Negative Thing Can Lead to Another

1. "I am so tired. I feel like ..."
2. "My bank called I am overdrawn. I ..."
3. "I tried to get tickets to the concert but they were all sold out. I ..."

Options

1. **"I am so tired. I feel like ..." I am no good to anyone./ I feel like a brief break would help me to get back on track.**
2. **"My bank called I am overdrawn. I ..." I am no good at handling money./ I am going to work on a budget and start tracking expenses better.**
3. **"I tried to get tickets to the concert but they were all sold out. I ..." I never get to go anywhere./ I will check out other concerts. Maybe I can buy other tickets earlier.**

How Might the CHW Respond?

"I had the worst day, everything is a mess!"
CHW Response: "Sounds like you had a tough day. Tell me about it."

"I do not have any friends!"
CHW Response: "Who do you count on for social support?"

"I hate my life."
CHW Response: What's one thing you would like to change?

"I'm a loser."
CHW Response: "What makes you feel that way?

What Else Can You Do?

What can you do to help others increase their positive feelings and thoughts?

- Use active listening strategies.
- Use reflection strategies.
- Ask what that change would look like, sound like and feel like. This adds clarity and discrepancy.

Other ideas?

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What is Self-Management?

"The individual's ability to manage the symptoms, treatment, physical and social consequences and lifestyle changes inherent in living with a chronic condition." (Barlow et al., 2002)

"Self-management support goes beyond traditional knowledge-based patient education to include processes that develop patient problem-solving skills, improve self-efficacy, and support application of knowledge in real-life situations that matter to patients." (Coleman & Newton, 2005)

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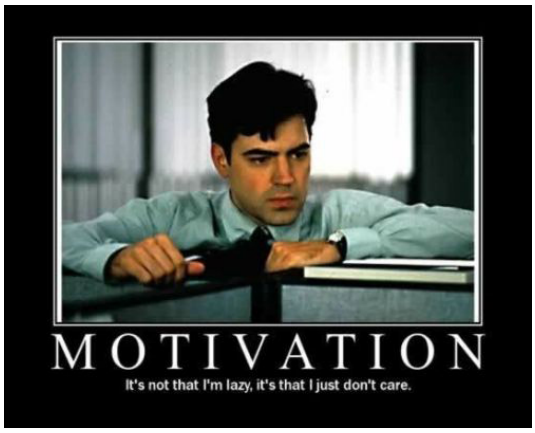
Coaching for Positive Outcomes

What are some reasons a person would need a CHW to assist them with obtaining P.H.O?



Self-Management

- Help the person shift away from obstacles and barriers
- Supporting beliefs in a person - what do they want to see happen?
- Help them craft statements that are positive, self- affirming, realistic, beneficial and short in length

Resistance

The simplest approach to responding to resistance is with non-resistance, by repeating the person's statement in a neutral form.

Client: I don't want to move.

CHW: What I am hearing is that you aren't ready to move now.

Diffuse Resistance

Help the person shift away from obstacles and barriers.

Client: If I move, my mother will be hurt. I'm not sure I even have the money.

CHW: I am hearing that you are concerned about money and hurting your mother's feelings. What do you see on the positive side of making the move?

Engage the Individual

Use the strengths and modes of communication that have shown to work previously

- Use active listening strategies
- Use reflection strategies
- Ask what that change would look like, sound like, and feel like
- Adds clarity and discrepancy

Use effective self-management support strategies

Goal setting, action planning, problem-solving and follow-up.

Self-Management Tasks in Chronic Illness

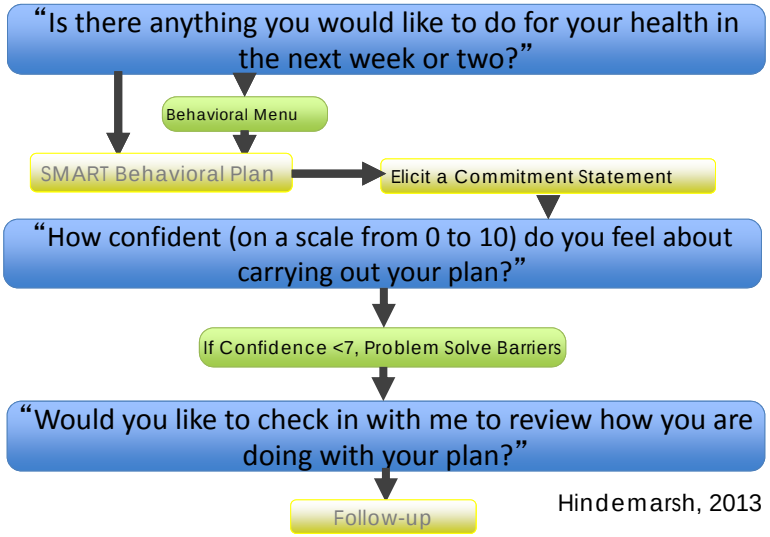
- To take care of the illness
- To carry out normal activities
- To manage emotional changes

(Corbin & Straus, 1988; Hindemarsh, 2013)

Moving toward Action

- Activate client's own motivation for change
- Be collaborative
- Build on strengths and desires
- Respect autonomy
- Listen
- Empower, encourage, be optimistic

Action Planning



Hindemarsh, 2013

Questions

1. Do you expect that clients will immediately make healthy choices when given information and opportunity? Why/why not?
2. Is ambivalence normal?

Five Skills

- Behavioral Menu
- SMART Behavioral Plan
- Elicit a Commitment Statement
- Problem Solving
- Follow-up

Hindemarsh, 2013

Skill #1

Behavioral Menu

Offer a behavioral menu when needed or requested.

This is not used with every client.

It is a tool that must be ready.

Think ahead!

Hindemarsh, 2013

Sample of Behavioral Menu

1. "Is it okay if I share some ideas from other people who are working to improve their health?"
2. If yes, share two or three ideas briefly.
3. "Maybe you have thought of something else while we have been talking?"

Adapted from Stott et al, Family Practice 1995; Rollnick et al, 1999, 2010, Hindemarsh, 2013

Skill #2

SMART Behavioral Plan

Action Planning is "SMART":

- Specific
- Measurable
- Achievable
- Relevant
- Timed

Locke, 1968; Locke & Latham 1990, 2002; Bodenheimer, 2009; Hindemarsh, 2013

Skill #3

Elicit a Commitment Statement

After the plan has been formulated, elicit a final "commitment statement".

Gauge the strength of the commitment and discuss it.

The stronger the commitment, the greater the likelihood of success.

Aharonovich, 2008; Amrhein, 2003; Hindemarsh, 2013

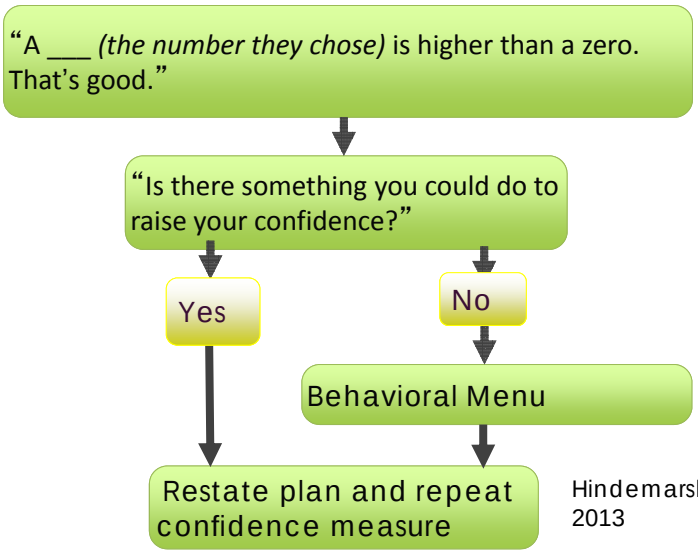
Skill #4

Problem Solving

Problem-solving is used for confidence levels less than 7 on a scale of 10.

(Bandura, 1983; Lorig et al., 2001, Bodenheimer, 2005, 2009; Hindemarsh, 2013)

Problem Solving



Hindemarsh, 2013

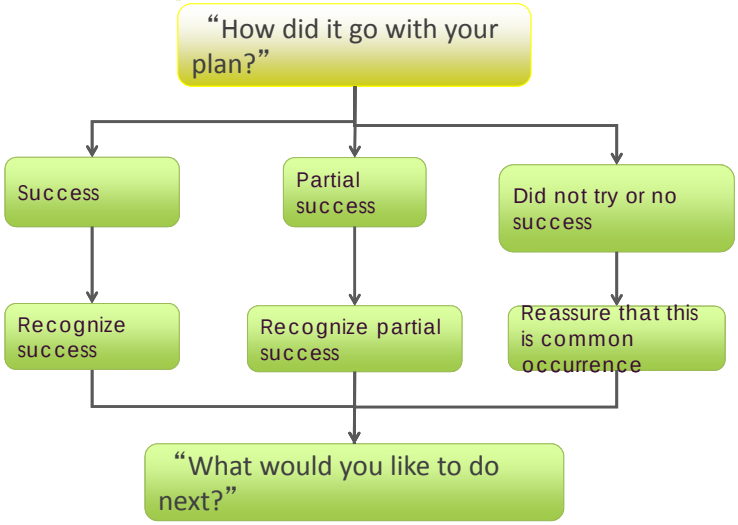
Skill #5

Follow-up

Follow-up builds confidence.
Follow-up builds accountability.
Follow-up builds trust in the relationship.

Resnicow, 2002; Artinian et al.,2010; Hindemarsh, 2013

Follow-Up



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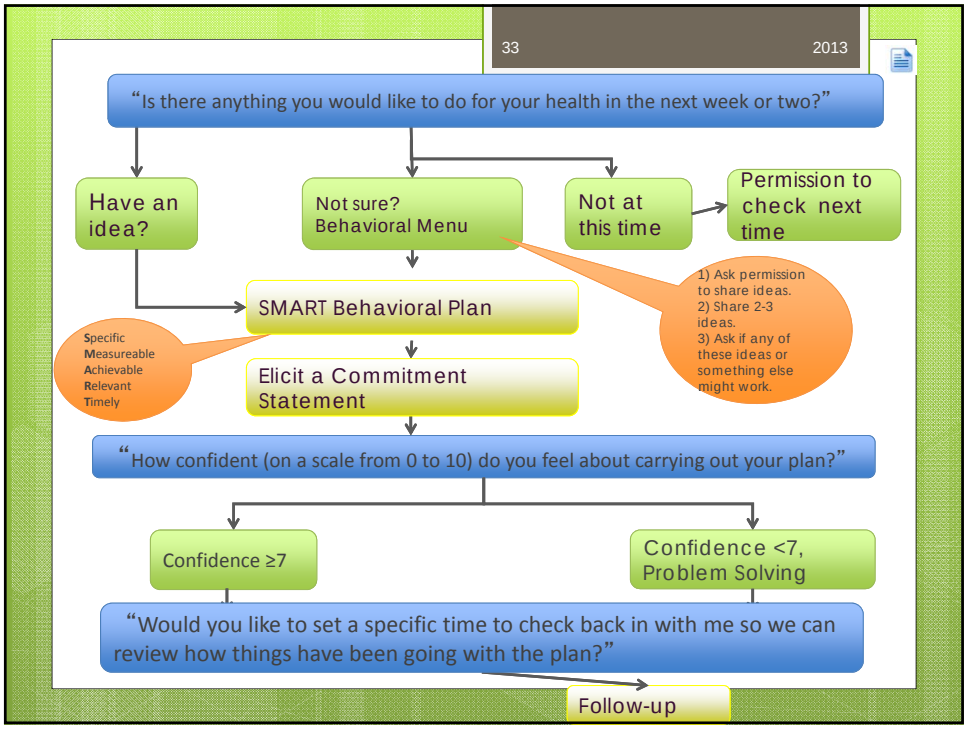
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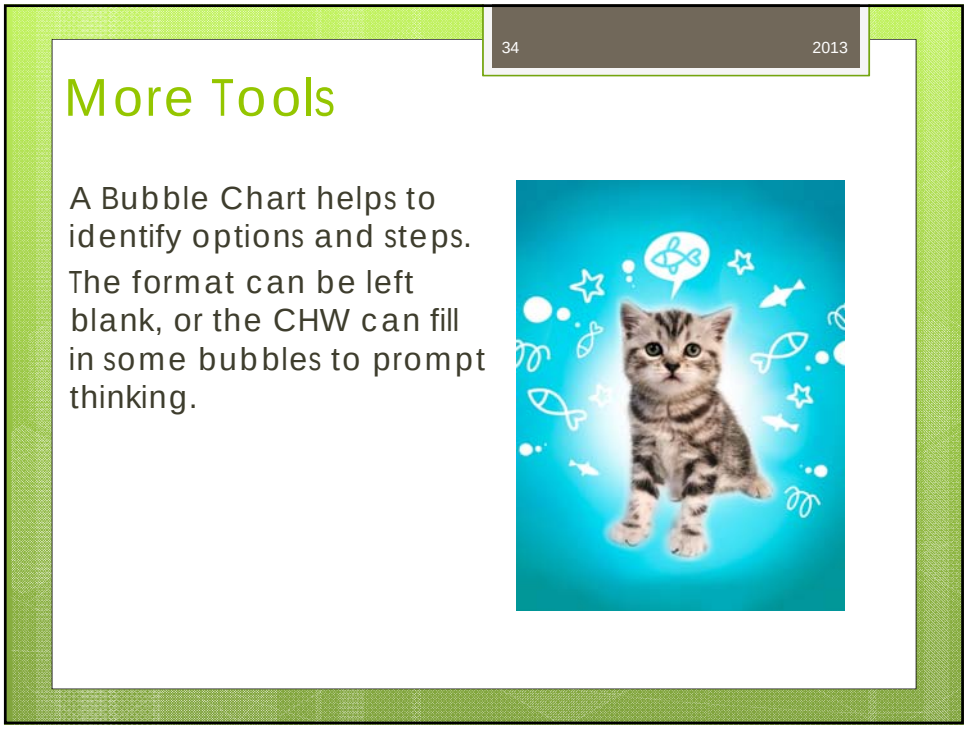
"Is there anything you would like to do for your health in the next week or two?"
Have an idea?
Not sure? Behavioral Menu
Not at this time
Permission to check next time
1) Ask permission to share ideas.
2) Share 2-3 ideas.
3) Ask if any of these ideas or something else might work.
SMART Behavioral Plan
Specific
Measureable
Achievable
Relevant
Timely
Elicit a Commitment Statement
"How confident (on a scale from 0 to 10) do you feel about carrying out your plan?"
Confidence ≥7
Confidence <7, Problem Solving
"Would you like to set a specific time to check back in with me so we can review how things have been going with the plan?"
Follow-up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More Tools
A Bubble Chart helps to identify options and steps.
The format can be left blank, or the CHW can fill in some bubbles to prompt thinking.

"Is there anything you would like to do for your health in the next week or two?"

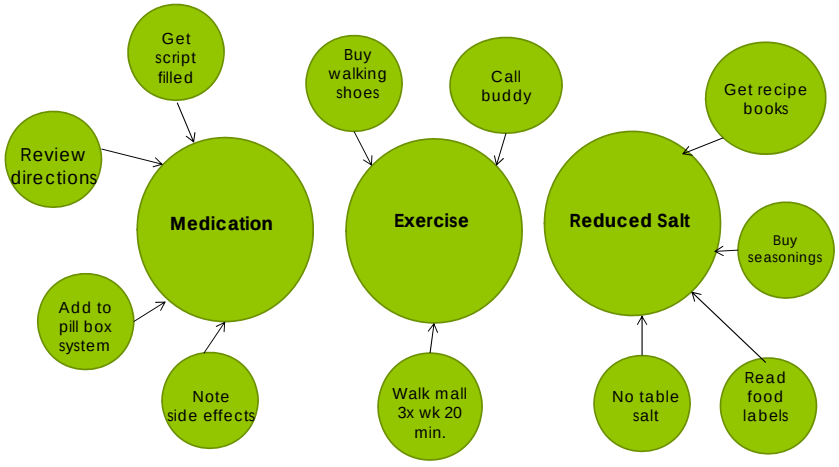
The doctor said I need to take medicine, exercise, and not eat salty food to help my blood pressure.

What do you feel ready to do?

I guess I should do what the doctor says….but I don't really know where to start.

How about if we look at this on paper?

Bubble Chart Graphic



Adapted from Berthold & Somsanith, 2009

Showing Support

- Show attention with your eyes and body
- Check for accurate communication throughout the discussion
- Make lists, write down information to help memory
- Match pace to ability of client
- Reinforce positive thinking and steps
- Express belief that goals can be met

More Supportive Strategies

- Amplify discrepancies to assist client in seeing own contradictions
- Shift approach when encountering resistance
- Be respectful of time and privacy
- Show confidence in person's ability to change
- Summarize at the end of each conversation

Engagement Strategies

- Be respectful and supportive
- Build upon strengths and successes to create hope
- Reflect back what you are seeing/hearing
- Encourage the individual to talk about current real-life experiences, feelings, perceptions, and interests

Additional Engagement Strategies

- Respond with empathy
- Listen to words and watch body language
- Develop more opportunities to interact
- Stay in the “here and now”
- Encourage use of existing supports
- Communicate that you believe the person can change

Discussion

1. **I can't remember what you told me to do last time. My medications always mess me up.**
2. **It's too late to teach an old dog new tricks. I have always been overweight.**
3. **I really want to exercise, but there are not enough hours in the day.**
4. **Everything the doctor told me to do to manage my diabetes is so overwhelming. Whenever I try, I get frustrated and give up.**

Coaching for Positive Outcomes

- Remember that the person trying to change is **in charge**.
- Repeat statements to self often.
- Recognize accomplishments as they happen.

Conclusion

In this module we:

- Learned what positive health outcomes are
- Identified when someone would need coaching to achieve positive health outcomes
- Learned strategies to help individuals achieve desired health outcomes

Evaluation

Please complete the module evaluation.

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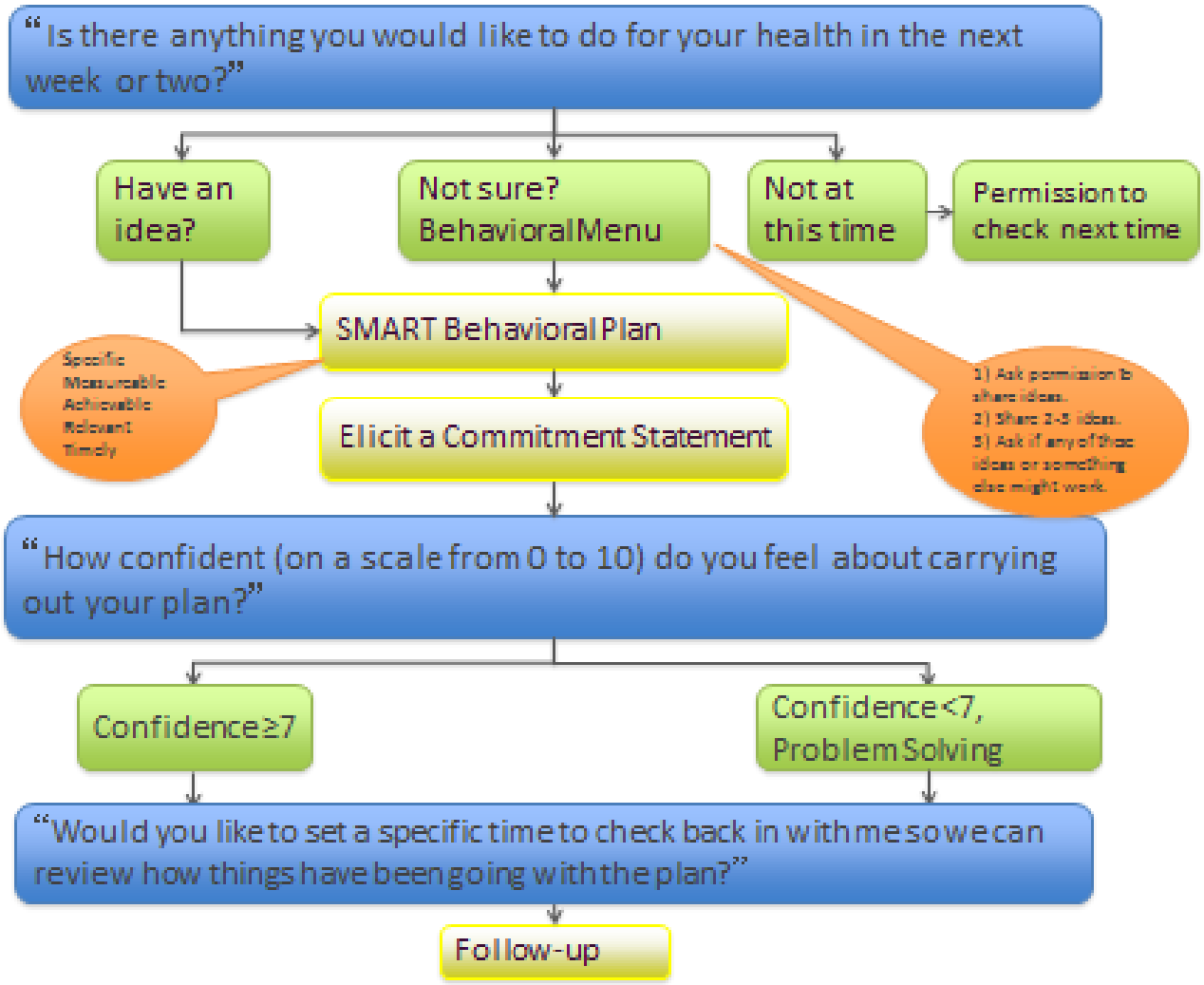
Self-Management Support



(Hindemarsh, 2013)

Module 15

Tobacco Treatment

Module 15 Tobacco and Treatment

Indiana Community Health Worker Integrated Care Training Program

ASPIN

1

Objectives

1) Participants will understand the economic/social impact of smoking
2) Participants will understand why clients may smoke
3) Participants will receive smoking cessation resources

Starting with the Facts

- On average, smokers die 13 to 14 years earlier than nonsmokers
- Lung cancer is the leading cause of cancer death among both men and women in the United States, and 90% of lung cancer deaths among men and approximately 80% of lung cancer deaths among women are due to smoking

Did You Know?

"Tobacco is the only legal product that kills one-half of its users when used as directed."
(World Health Organization, 2012)

Did You Know?

- More individuals addicted to alcohol die from tobacco related disease than from alcohol-related diseases
- The founders of Alcoholics Anonymous both died from smoking-related disease: lung cancer and emphysema

Economic Costs

- Smoking-related illness in the United States costs more than $300 billion each year, including:
  - Nearly $170 billion for direct medical care for adults
  - More than $156 billion in lost productivity, including $5.6 billion in lost productivity due to secondhand smoke exposure
- In the United States, each pack of cigarettes sold costs society an estimated $18.05

Economic/Social Costs

- Smokers are finding it difficult to “fit in” to mainstream society
- Landlords prefer to rent to non smokers
- Smokers take an average of 3 smoke breaks per day, lasting 39 minutes, resulting in 21 days of lost time per year, per smoker
- Absenteeism from smoking costs American businesses between $97 and $125 billion every year

Economic/Social Impact

- Tobacco products are expensive!
- The 175 billion cigarettes sold each year to people with psychiatric disorders earn the tobacco companies approximately $39 billion dollars annually (Hall & Prochaska, 2009)
- Individuals diagnosed with schizophrenia were found to spend at least 1/3 of monthly disability income on cigarettes
- Smokers have less money available for clothing, housing, and other basic needs

Second-Hand Smoke

- There is no safe level of exposure to second-hand tobacco smoke
  - This includes e-cigarettes
- In adults, second-hand smoke causes serious cardiovascular and respiratory diseases, including coronary heart disease and lung cancer
- In infants, it causes sudden death
- In pregnant women, it causes low birth weight

Chemicals

Tobacco smoke contains over **4,000** chemicals

Nicotine

- Highly addictive!
- When inhaled through the lungs, nicotine will reach the brain in just six seconds
- In small doses, nicotine acts as a stimulant but in large doses it acts as a depressant

So what about e-cigarettes? Those are safe, right?

E-Cigarettes

- Allow users to inhale an aerosol (vapor) containing nicotine or other substances
- Entirely unregulated by the FDA at this time
- No safety check requirements for what goes into an e-cigarette

E-Cigarettes

- Although they do not produce “smoke”, they can still expose others to secondhand emissions
- Aggressively marketed to youth through various flavors (ie: bubble gum, gummy bears, fruit flavors)

Why Clients May Smoke

- Nicotine affects the actions of the user's brain chemistry
- Nicotine enhances concentration for some
- Nicotine has positive effects on mood, feelings of pleasure and enjoyment
- Tobacco use may temporarily relieve feelings of tension and anxiety and is often used to cope with stress
- Clients develop a daily routine of smoking
- Clients may smoke to feel "part of a group"
- Smoking is often associated with social activities

Why Clients Living with Mental Disorders May Smoke

Researchers believe there are many reasons individuals living with mental health disorders smoke.

- Individuals with mental disorders have unique brain chemistry that may increase their tendency to use nicotine, making it more difficult to quit and complicating withdrawal symptoms.

Tobacco and Mental Health

According to the CDC…

- 31% of all cigarettes are smoked by adults with a mental health condition
- 40% of men and 34% of women with a mental health condition smoke
- 48% of people with a mental health condition who live below the poverty level smoke, compared with 33% of those with a mental health condition who live above the poverty level

Effects of Smoking on Psychiatric Medications

- Smoking makes the liver process medications more quickly
- This means that the medications are less effective
- People who smoke will then need more of the medication
- This results in more side effects and higher costs

Effects of Smoking on Patients with Psychiatric Disorders

- Most inpatients are treated in smoke-free environments
- When discharged, they often start smoking again
- This affects how their medications work (not as well)
- Patients may end up back in the hospital again just because they started smoking again

Quitting Is Possible!

- Many different treatment options and resources available
- There are more former smokers than there are current smokers
- People who stop smoking greatly reduce their risk for disease and early death

Changes to Body After Quitting

Quit Time	Physical Improvement
20 Minutes After Quitting	•Your heart rate drops.
12 hours After Quitting	Carbon monoxide level in blood drops to normal.
2 Weeks-3 Months After Quit	Heart attack risk begins to drop. Lung function begins to improve.
1-9 Months After Quitting	Coughing and shortness of breath decrease.
1 Year After Quitting	Added risk of coronary heart disease is half that of a smoker's.
5 Years After Quitting	Stroke risk is reduced to that of a nonsmoker's 5-15 years after quitting.
10 Years After Quitting	Lung cancer death rate is about half that of a smoker's. Risk of cancers of mouth, throat, esophagus, bladder, kidney, and pancreas decreases.
15 Years After Quitting	Risk of coronary heart disease is back to that of a nonsmoker's.

Treatment Considerations

- Quitting quickly can confuse diagnosis and treatment
- Withdrawal can mimic psychiatric disorders or medication side-effects
- Medications can be affected
- **Everyone on the treatment team needs to know the client is quitting!**

Proven Methodologies

For Clients Willing to Quit:

- The 5 A's – Ask, Advise, Assess, Assist, Arrange
- The U.S. Public Health Service Clinical Practice Guideline: Treating Tobacco Use and Dependence provides healthcare clinicians a strategy for smoking cessation treatment that is built around the "5 A's".
- Knowing that providers have many competing demands, the 5 A's were created to keep steps simple.

The Five A's – Willing to Quit

Ask about tobacco use during every office visit

Advise all smokers to quit

Assess the patient's willingness to quit

Assist the patient in his or her attempt to quit

Arrange follow-up contact

Proven Methodologies

For Clients Un-Willing to Quit

- The 5 R's – Relevance, Risks, Rewards, Roadblocks, Repetition
  - *From Treating Tobacco Use and Dependence. Quick Reference Guide for Clinicians, October 2000. U.S. Public Health Service.*
  - The "5 R's" Relevance, Risks, Rewards, Roadblocks and Repetition, are designed to motivate smokers who are unwilling to quit at this time.

U.S. Department of Health & Human Services
Office of the Surgeon General

The Five R's – Unwilling to Quit

Relevance: Tailor advice and discussion to each patient.

Risks: Outline risks of continued smoking.

Rewards: Outline the benefits of quitting.

Roadblocks: Identify barriers to quitting.

Repetition: Repeat messages at every visit.

Case Study: Seiko

Seiko is scheduled to meet with you today for an appointment. You notice that she smells like cigarette smoke when she arrives. When you ask her if she is a current smoker, she says yes. She reveals to you that even though she knows that smoking is bad for her, she doesn't really care because it helps her keep extra weight off.

How could you help Seiko as a CHW or CHW/CRS?

Case Study

- Seiko seems unwilling to quit
- The risks of smoking need to be relevant to her own life
- Come up with alternatives for her perceived barriers (weight management)
- Some helpful tools could be:
  - The Five R's
  - Motivational Interviewing
  - Reflection

Resource: 1-800-QUIT-NOW

- Call **1-800-QUIT-NOW (1-800-784-8669)** if you want help quitting.
- This is a **free** telephone support service that can help people who want to stop smoking or using tobacco. Callers are routed to their state QUITLINEs, which offer several types of quit information and services. These may include:
  - Free support, advice, and counseling from experienced QUITLINE coaches
  - A personalized quit plan
  - Practical information on how to quit, including ways to cope with nicotine withdrawal
  - The latest information about stop-smoking medications
  - Free or discounted medications (available for at least some callers in most states)
  - Referrals to other resources
  - Mailed self-help materials

Government Resources

- **Smokefree.gov** A Web site dedicated to helping you quit smoking.
- **SmokefreeTXT** Free 24/7 quit help for adults and young adults texted to your phone!
- **Smokefree Women** A Web site that helps women quit smoking.
- **Smokefree Teen** A Web site that helps teens quit smoking.
- **Smokefree.gov en Español** A Web site in Spanish dedicated to helping you quit smoking.
- **Smokefree QuitGuide App** Track your progress, receive encouraging reminders, and more on your smartphone. Available from iTunes.
- **Help for Smokers and Other Tobacco Users** Booklet that tells you about ways you can quit.

More Resources!

- **Pathways to Freedom: Winning the Fight Against Tobacco** Guide that addresses tobacco issues specific to African Americans.
- **FDA 101: Smoking Cessation Products** Article discussing FDA approved products that help you quit smoking.
- **Quit Tobacco—Make Everyone Proud** A DoD-sponsored Web site for military personnel and their families.
- **SmokefreeVet** A mobile text messaging service for veterans getting health care through the VA.
- **What you Need to Know About Quitting** **5 Quit Tips** Five tips to help you quit
- **BeTobaccoFree.gov** One-stop shop with quit guidance for tobacco users, parents, educators, and health professionals.
- **Bringing Indiana Along** Tobacco control experts available for organization consultation.

Conclusion

In this module we have discussed:

- The economic/social impact of smoking
- Why clients may smoke
- Smoking cessation resources

Evaluation

Please complete the module evaluation.

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Five Major Steps to Intervention (The "5A's")

Successful intervention begins with identifying users and appropriate interventions based upon the patient's willingness to quit. The five major steps to intervention are the "5 A's": Ask, Advise, Assess, Assist, and Arrange.

Tobacco is the single greatest preventable cause of disease and premature death in America today.

"Starting today, every doctor, nurse, health plan, purchaser, and medical school in America should make treating tobacco dependence a top priority."

David Satcher, MD, Ph.D.
Former U.S. Surgeon General
Director, National Center for Primary Care, Morehouse School of Medicine

Ask

Identify and document tobacco use status for every patient at every visit. (You may wish to develop your own vital signs sticker, based on the sample below).

Advise

In a clear, strong, and personalized manner, urge every tobacco user to quit.

Assess

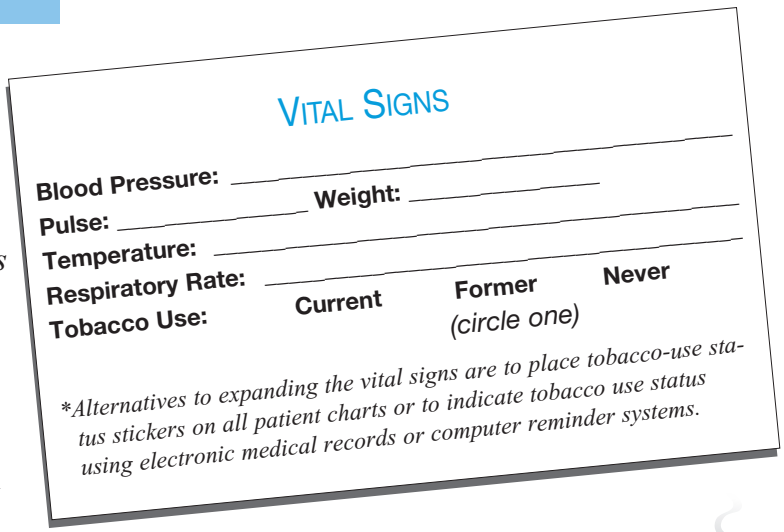
Is the tobacco user willing to make a quit attempt at this time?

Assist

For the patient willing to make a quit attempt, use counseling and pharmacotherapy to help him or her quit. (See *Counseling Patients To Quit* and pharmacotherapy information in this packet).

Arrange

Schedule followup contact, in person or by telephone, preferably within the first week after the quit date.



Patients Not Ready To Make A Quit Attempt Now (The "5 R's")

Patients not ready to make a quit attempt may respond to a motivational intervention. The clinician can motivate patients to consider a quit attempt with the "5 R's": Relevance, Risks, Rewards, Roadblocks, and Repetition

Approximately 46 percent try to quit each year. Most try to quit "cold turkey." Of those, only about 5 percent succeed. Most smokers make several quit attempts before they successfully quit for good.

Relevance

Encourage the patient to indicate why quitting is personally relevant.

Risks

Ask the patient to identify potential negative consequences of tobacco use.

Rewards

Ask the patient to identify potential benefits of stopping tobacco use.

Roadblocks

Ask the patient to identify barriers or impediments to quitting.

Repetition

The motivational intervention should be repeated every time an unmotivated patient has an interaction with a clinician. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

Module 16

Group Facilitation Skills

Module 16 Group Facilitation Skills

Indiana Community Health Worker Integrated Care Training Program

Objectives

1) Identify types of groups that may be used and their purpose in supporting wellness
2) Obtain a basic understanding of group structure and process
3) Learn attributes of an effective group leader
4) Learn core skills needed to facilitate groups

Why Provide Groups?

- Efficient – allows more people in treatment
- Cost effective –able to work with more people at one time for one facilitator cost
- Offers more resources and points of view
- Allows advanced members model for new members
- Enhances feelings of belonging
- Provides forum to practice new behaviors
- Creates safe environment in which to learn social skills/practice relationships
- Vicarious learning occurs through experiences of others
- Members learn commitment to the group

Kinds of Groups

- Education (diabetes self-management, interviewing skills, nutrition, etc.)
- Discussion (book club, hobby/interests, lifestyle, etc.)
- Growth or Experiential (marriage enrichment, parenting, self-awareness, etc.)
- Counseling/Therapy (DBT, coping skills, eating disorders)
- Support Groups (chronic diseases, divorced parents, grief)
- Self-Help (AA, GA, SA, Alanon, relationships)

Therapeutic vs. Therapy

Often group lines get blurred because groups types are rarely mutually exclusive – groups tend to be of more than one kind such as educational/support

Therapeutic

Assists in healing

All groups by their nature are therapeutic

It is the result of the group dynamic - A byproduct of the process

Groups are useful for many common life issues and not necessarily designed to heal specific disorders per se unless they are a therapy group

Therapy

Treatment of physical, mental, or social disorders or disease using a defined methods that require specific application. Tends to have some risk associated with it.

- Requires advanced training
- Must have a license to practice
- Uses active listening, reflection, encouraging, summary, empathy, etc. but go further
- Uses specific techniques designed to directly treat a specific disorder

Group Leadership vs. Facilitation

- Some prefer the term Facilitator
- Leader implies that you are in charge, make all the rules, and all should follow you
- Facilitator implies that you have some authority but it is simply to make the group run smoothly
- Should be a balance of direction between facilitator and the group

What is a Facilitator

One who contributes structure and process to interaction so groups are able to function effectively and make high quality decisions

Core Facilitation Practices

- Stay Neutral
- Listen Actively
- Ask Questions
- Paraphrase
- Synthesize Ideas
- Manage Digression
- Summarize
- Provide Feedback

Brainstorm

- What are the qualities of an effective facilitator?

Qualities of an Effective Facilitator

- Caring
- Openness
- Flexibility
- Warmth
- Objectivity
- Trustworthiness
- Honesty
- Patience
- Sensitivity

Qualities of an Effective Facilitator

- Comfort with self and others
- Liking people
- Comfort with being in authority
- Able to deal directly with feelings, reactions, moods, and words of others
- Able to engage with and handle conflict directly, firmly, and sensitively

Qualities of an Effective Facilitator

- Attending to own psychological well- being
- Planning/organizational skills
- Knowledge of topic
- Skilled in reading people's feelings and reactions through non-verbal cues
- Able to engage others

Basic Skills for Group Facilitators

- Active listening
- Reflection
- Clarification and questioning
- Summarizing
- Mini-lecturing/information giving
- Encouraging/supporting
- Tone setting

Basic Skills for Group Facilitators

- Modeling self-disclosure
- Holding focus
- Use of eyes
- Use of voice
- Use of leader's energy
- Identifying allies
- Multicultural understanding

Facilitator Functions

- Provides emotional support and stimulation
- Provides empathy
- Provides protection
- Models acceptance
- Provides, elicits interpretation
- Provides/elicits further explanation
- Models appropriate self-disclosure
- Sets limits
- Enforces rules
- Manages logistics- time, talk flow, schedules, etc.
- Manages group's content and process functions

Content and Process Function

- Content = task or purpose of the group
- Process = relationship between members and how members participate in the group = group dynamics

Content and Process

Delicate balance

- Too much focus on content:
  - eliminates important “learning” moments occurring in the process between members
  - allows relationships between members to go unaddressed and can “poison” the group
- Too much focus on process:
  - blurs the purpose
  - prevents tasks from being accomplished
  - can leave members frustrated

THE THREE STAGES OF GROUPS

The Beginning

- Helping members get acquainted
- Setting a positive tone
- Clarifying purpose of group
- Explaining leader's role
- Explaining how group will be conducted (including group rules)
- Helping members verbalize expectations
- Drawing out members
- Checking out comfort levels
- Focusing on content a little more
- Addressing questions
- Watching for initial group dynamics that need to be addressed

Set Group Rules

- Come to initial group with an initial set of basics rules
- Read and build group consensus around rules
- Have group add and agree on any additional rules they suggest
- Provide rules in writing to take with them and/or post

Some Basic Group Rules

- Attendance expectations - be there and be on time
- Respect for each other
- One person talks at a time
- Whether eating and drinking are acceptable and how
- Confidentiality
- If homework, will complete
- Participation expectation
- Appropriate sharing

The Working Stage

- Focus on purpose
- Learn new things
- Discuss topics thoroughly
- Complete exercise or tasks
- Engage in personal sharing
- Core stage = members benefit from being in group

The Closing Stage

- Focus on what has been learned
- Focus on how they have changed
- Discuss where they go from here
- Share feelings about group ending

IMPORTANT TECHNIQUES FOR A FACILITATOR

Cutting Off and Drawing Out

Cutting Off

- Interrupting a member in order to preserve group flow and dynamics
  - Uses:
    - When a member has the floor but is long-winded, rambling, storytelling (beyond what is necessary for their point), or avoiding going deeper
    - When member is being inappropriate
- Goal is not to criticize but to stop something that is not helpful

Cutting Off: Ways to Accomplish

- Non-verbal signals
  - Use of eyes as already discussed
  - Use of hand gesture to indicate you would like the person to pause or wind down
- Interrupting the speaker with a question:
  - Can you tell me how this relates to the topic?
  - Sounds like you're struggling with where you want to go with this, can we help?
  - Are you just wanting to tell us about this or would you like feedback?
  - How can the group help you with this?
  - Did you notice how this person reacted when you said that?
- Cutting off and explaining the reason you did so
- Explain at beginning of group
- As group develops, sometimes other members will do this

Drawing Out

- Eliciting a group member's participation
  - Uses:
    - Help members who struggle with group to participate
    - Get a member to take a topic deeper
- Goal is not to put someone on the spot, but to elicit optimal participation for benefit of all

Drawing Out: Ways to Accomplish

- Non-verbals
  - Use of eyes as discussed previously
- Direct questions
  - Would you like to comment?
  - What is your reaction to what was just said?
  - Ask question above but to 2 or 3 people including the person you want to draw out.
- Pairs
  - Break into pairs to discuss topic
  - May be more willing to talk and then share with group.
- Rounds
  - Go around room occasionally asking for a response from all.

SUPPORT GROUP EXERCISES

Support Group Exercises

- Break the class into groups. Within each group assign:
  - Role 1will volunteer to be the facilitator
  - Role 2 will be the "problem member. The problem member should role play either a quiet member or someone being inappropriate (use one of examples we came up with during discussion)
  - Role 3 will be the observer/recorder. You will observe and provide feedback to group on dynamics after you are done.

Support Group Exercises-continued

- Everyone else are cooperative members doing their part for the discussion!
- Role play group for 5 min and then change leader, problem member, and observer/recorder. This time the problem member will role play the problem member that was not done last time (i.e. if you did an inappropriate member now do a quiet one.)

Wellness Group

The wellness group is in the working stage. Members have set personal wellness goals and are reviewing progress in round-robin style. Jack has a comment for everyone and is starting a high-five, raucous response to reports of progress. Cheranne reports backsliding. Jack responds by saying, “Not everyone is a winner.” How do you respond?

Orientation Group

You are hosting an orientation group for new cancer patients. You are reviewing a handout of contact information and map. Tom is dozing off. Others are asking good questions. What do you do about Tom?

Conclusion

- Identified types of groups that may be used and their purpose in supporting wellness
- Obtained a basic understanding of group structure and process
- Learned attributes of an effective group leader
- Learned core skills needed to facilitate groups

Evaluation

Please complete the module evaluation.

Module 17

Advocacy, Collaboration and Teamwork

Module 17 Advocacy, Collaboration and Teamwork

Indiana Community Health Worker Integrated Care Training Program

ASPIN

1

Objectives

1) Understand the advocacy role filled by CHWs on micro and macro levels
2) Understand the value of Collaboration in the role of a CHW/CRS
3) Identify the components needed to make a team work well
4) Understand the importance of building a diverse team
5) Learn how to create team culture

CHWs as Advocates

Micro Advocacy Tasks

- As a person with lived experience in the health system, share personal experience and impacts to inform decision-makers/providers
- Insist on culturally sensitive and person-first language
- To speak up for clients within the health care organizations and systems to ensure that they are provided with culturally competent services
- Support care coordination, continuity and quality for individuals

CHWs as Advocates

Macro Advocacy Tasks

- Facilitate community participation in the health system
- Work for social justice and the elimination of health disparities
- Ensure that all segments of the community are represented in decision-making affecting the community
- Assist in community health needs assessment and research data gathering
- Support services that match community culture
- Represent needs of community constituents in community health initiatives

What is Power Mapping?

Power Mapping Example

Identified Need – Dental Access

- At the heart of the Power Map is the Decision Maker. This is the person or group with the power to make the change that is the focus of your advocacy effort.
- Where would you start with your advocacy for increased dental access?
- Before making contact, how would you prepare for the discussion?

The Dentist

Influenced by:

Doctor at your clinic

County Health Department official

Office managers of health and dental clinics

Questions

1. What value do you see in the Power Mapping Model?
2. How can the model be used to add momentum after a solution is selected?
3. How can the model be used to raise awareness of a problem that the community is slow to recognize?

WHAT IF OUR HEALTHCARE SYSTEM KEPT US HEALTHY?

Watch Video

What about Advocacy on the Micro Level?

- Where does advocacy fit into her vision?
- What was particularly striking to you as you watched the video?

CHW ADVOCACY ROLES

CHW Advocacy Roles

Enhance access and coordinated patient and peer-centered care; information gathering, patient needs assessment, action planning, care management with emphasis on prevention, self-care and skill building, medication adherence, enrollment and appointment support and lab results follow up.

CHW Advocacy Roles

Support patient/consumer tracking and continuity of care in concert with health home teams and community supportive services such as community-based service organizations, nutritionists, pharmacists, counselors, social workers and holistic health providers; document patient progress toward meeting patient-centered plan with medical homes team.

CHW Advocacy Roles

Facilitate cultural brokering during medical visits and care transitions; navigate patients through health care and social service systems. Ensure community-based supportive services are accessible, relevant and support the patient plan; document as appropriate. Support community-based research.

CHW Advocacy Roles

Provide social and peer support for self-management; teach self-management skills, coach patient toward meeting patient-centered plan; liaise with medical home in bidirectional documentation practices. Leverage peer camaraderie and shared experiences as it relates to patient plan, peer support and recovery.

CHW Advocacy Roles

Support community mobilization and advocacy. Recognize, inform and address community-wide needs to prevent, manage and treat population health. Liaise with community partners to address the social determinants of health.

TEAMBUILDING

Definition

The basic definition of a Team is: "a small number of people with complementary skills who are committed to a common purpose, performance goals, and an approach for which they hold themselves mutually accountable."

This is a good starting point for defining your desired outcomes!

Five Components for Teams to Work Well

1. Teams must have clearly defined purposes and goals that serve the organization.

Five Components for Teams to Work Well

2. Teams need clearly defined parameters within which to work.
   - Expectations
   - Timelines
   - Resources
   - Decision Authority

Five Components for Teams to Work Well

3. Teams need to be able to communicate within an organization.
   - How does the team get the information it needs?
   - How does the team let the organization know what they are doing?

Five Components for Teams to Work Well

4. Teams need to have people with the necessary knowledge and skills to accomplish their tasks.

Five Components for Teams to Work Well

5. Teams need to know how they are going to accomplish their tasks.

Building the Team

Identify Characteristics for a Balanced Team

- Diversity
- Skills and Expertise
- Learning Styles

Benefits of a Multi-Generation Work Team

- The team can be more flexible.
- Decisions are stronger because they are broad-based.
- The team can be more innovative.
- The team can meet the needs of a diverse work environment.

Team Outcome Checklist

- What is our ideal size?
- What skills do we have, need to add?
- What is our mission and purpose?
- How does each individual contribute to it?
- Do we mutually set, track, and meet specific performance goals?

Team Outcome Checklist (Cont.)

- Do we regularly self-evaluate?
- Do we set and live by behavioral ground rules?
- Do we hold ourselves accountable?
- Do our results come from a collective effort?

Establish Team Ground Rules

- Everyone will be open and honest.
- Everyone will have a vote and be heard.
- Everyone will listen without argument or negative reaction.
- Opinions and feelings must be supported by facts or specific behavior.

Creating Team Culture

Be the Leader and lead by example.

- Create a constructive and winning environment
- Provide feedback and recognition
- Deal with people who do not carry their load
- Set the pace for your team to be successful

Share Goals and Outcomes

Team Type	Goal or Outcome
Departmental	Budget Goal
Community Committee	Dollars to be Raised or Attendance Numbers
Performance Improvement	Starting point, benchmark measure, ending point
Customer Service	% Customer Satisfaction

Monitor Progress

- Plot Action Steps to Reach Goals
- Address Team Conflicts
- Confront Individual's Shortcomings
- Celebrate Success

Team Problems

- Allow ventilation to defuse emotions
- Suggest ground rules
- Ask open-ended questions to explore all sides
- Listen objectively
- Offer feedback to ensure understanding
- Define the problem and get commitment to solve it

Team Problems: Things to Avoid

- Making judgment about the conflict
- Mentally rehearsing what the conflicting parties will say and do next
- Assuming you know all the facts
- Interrupting or completing sentences
- Telling how conflicts should be resolved without involving parties in the solution

Ten Ways to Maintain the Team

1. Set up a Team Support System
2. Spotlight Team Progress
3. Teach Team Members New Skills
4. Identify New Team Goals
5. Improve the Team Process and Procedure

Ten Ways to Maintain the Team

6. Rotate Team Assignments
7. Create a Culture that takes Teamwork Serious
8. Compensate Teams for the Extra Work
9. Keep Team Members in the Loop
10. Bring in Outsiders to Refresh the Team

Conclusion

In this module we have:

- Discussed the advocacy role filled by community health workers on macro and micro levels
- Determined the value of Collaboration in the role of a CHW/CRS
- Identified the components needed to make a team work well
- Understood the importance of building a diverse team
- Learned how to create and maintain team culture

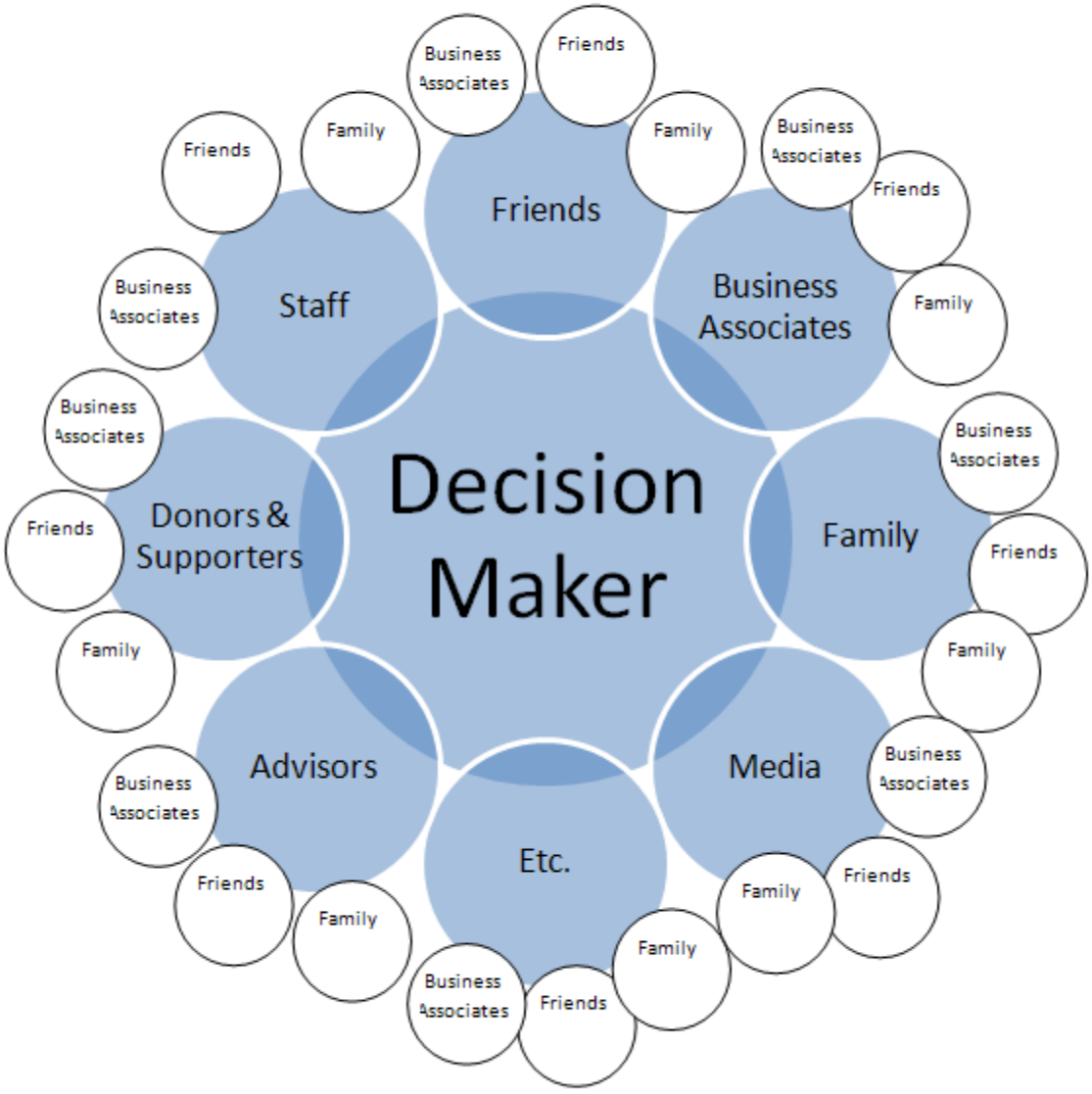
Evaluation

Please complete the module evaluation.

References

- http://www.ted.com/rebecca_onie_what_if_our_healthcare_sytem_hept_us_healthy.html
- "Power Mapping for Effective Collaboration – Community Health Systems " – Georgia Health Policy Center - www.ruralhealthlink.org
- Power Mapping: A Tool for Utilizing Networks - Bonner Curriculum – www.bonner.org
- "Embrace Diversity to Build Effective Teams" Dr. Marilyn Manning - The Consulting Team, LLC

Power Mapping



Advocacy is about building personal relationships

Module 18

Wrap-Up/Test Preparation

Module 18 Wrap-Up/Test Preparation

Indiana Community Health Worker Integrated Care Training Program

ASPIN

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Objectives

1) Review content from the course
2) Discuss final exam process
3) Receive overview of CHW certification general information

Congratulations - You Made It!!!

Module 1: Introduction

In this module we:

- Introduced students and instructor
- Established classroom expectations
- Clarified schedule and course work
- Identified common experiences to build group relationships

Module 2: Core CHW and CHW/CRS Skills

In this module we:

- Learned about the role of a CHW and CHW/CRS
- Reviewed the public health approach to community wellness
- Identified health disparities specific to Indiana

Module 3: Ethics

In this modules we:

- Learned applicable ethics and their purpose
- Become aware of common ethical challenges
- Reviewed the Community Health Worker Code of Ethics
- Learned an ethical decision-making model
- Covered the scope of practice for CHWs, and how it relates to an ethical practice

Module 4: Diversity/Cultural Competency

In this module we:

- Increased awareness of personal cultural identity and its impact on behavior, thinking, and communication style
- Broadened knowledge of the demographic changes in the US and Indiana
- Learned to approach cultural knowledge gaps tactfully
- Learned to approach health topics with cultural sensitivity

Module 5: Conflict Management

- We have identified the three levels of conflict
- You are now able to recognize some signs of dangerous situations developing
- We are now able to understand the generalized differences among generations in order to decrease misunderstandings, conflicts, stress, discomfort, frustration, and miscommunication
- We are able to name the four types of workplace violence

Module 6: Technology

In this module we have discussed:

- The importance of technology in healthcare
- Electronic medical records
- Phone application and health monitoring device resources
- Ways to use the internet for community referrals

Module 7: Communication Skills

In this module we:

- Learned the importance of verbal and non-verbal communication
- Looked at the benefits of and practiced reflection as a communication tool
- Learned and practiced ice-breaking, self-introductions, and person-centered listening
- Discussed how the different generations communicate
- Identified positive and negative statements
- Recognized the power of positive and negative messages

Module 8: Practices That Promote Health and Wellness

During this module:

- We became familiar with community resources
- Practiced empowerment approaches
- Learned how to make effective referrals
- Practiced follow-up strategies

Module 9: Physical Health/Chronic Disease Overview

In this module we:

- Identified lifestyle components of health
- Covered how lifestyle choices are frequently limited by environmental and intrinsic factors
- Identified the leading causes of death linked to common chronic diseases in Indiana
- Learned healthy guidelines for nutrition, physical activity, tobacco, and stress management

Module 10: Behavioral Health Overview

In this module we:

- Dispelled myths that perpetuate the stigma attached to mental heath diagnoses
- Discussed the history of mental health treatment
- Learned that recovery from mental illness is possible

Module 11: Substance Use Disorders

In this module we:

- Defined substance use disorder (SUD)
- Discussed the characteristics of different SUDs
- Looked at some commonly abused drugs
- Recognized that there are various ways people recover from SUDs

15 2016

Module 12: Integrated Care Model

In this module we:

- Defined integrated care - behavioral health combined with primary health care
- Learned about three different integrated care models
- Covered the role CHWs play in the integrated care models

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Module 13: Motivational Interviewing

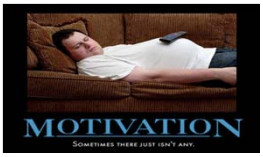
In this module we:

- Reviewed the basic concepts, spirit, and guiding principles of Motivational Interviewing
- Learned the Stages of Change model
- Developed skills and strategies for using Motivational Interviewing
- Learned strategies for encouraging change talk

Module 14: Coaching Consumers for Positive Health Outcomes

In this module we:

- Learned what positive health outcomes are
- Identified when someone would need coaching to achieve positive health outcomes
- Learned strategies to help individuals achieve desired health outcomes



Module 15: Tobacco Treatment

In this module we have discussed:

- The economic/social impact of smoking
- Why clients may smoke
- Smoking cessation resources

Module 16: Group Facilitation Skills

- Identified types of groups that may be used and their purpose in supporting wellness
- Obtained a basic understanding of group structure and process
- Learned attributes of an effective group leader
- Learned core skills needed to facilitate groups

Module 17: Advocacy, Collaboration and Teamwork

In this module we:

- Discussed the advocacy role filled by community health workers on macro and micro levels
- Determined the value of Collaboration in the role of a CHW/CRS
- Identified the components needed to make a team work well
- Understood the importance of building a diverse team
- Learned how to create and maintain team culture

Final Exam

See handout

This is an open book test!!

Objective Portion (70% of exam)

- Consists of 35 multiple choice/ true or false questions
- Questions are randomized on each attempt – pulled from a bank of 100+ questions
- 2 hours to complete

Essay Portion (30% of exam)

- Consists of 4 questions that require a written response - Will count best 2 responses
- Please write in complete sentences and use correct grammar
- 1 hour to complete

Final Exam (Cont.)

- Use same username and password from the pretest to login
- You have **2 weeks** to complete the exam – *mark your handout with deadline date*.
  - You have **two attempts** at each portion– you may complete your attempts in any order/day
  - We STRONGLY encourage completing both attempts as we will take the higher score of the two.
- Must get an 80% to pass the exam and receive your state certification

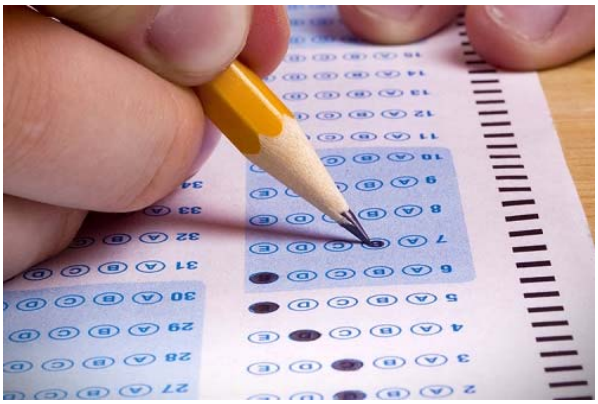
Final Exam (Cont.)

- Please allow ASPIN staff 30 days after the testing period has ended to distribute results
- You will be notified of your passing/failing via email
- There is a retest process at an additional cost for those who do not pass exam
- If passed, you will receive your official certificate via mail around July 1st

General Program Information

- Must acquire 14 continuing education units annually
- Will be placed on certified emailing list
  - CEU & employment opportunities

Post-Test



Final Questions/Thoughts?

Conclusion

In this module we:

- Reviewed content from the course
- Discussed the final exam process
- Reviewed CHW and CHW certification general information

Evaluation

Please complete the module evaluation and course evaluation.

CHW or CHW/CRS Certification
After the Course is Complete

The Final Exam consists of 35 objective questions (T/F or multiple choice) and two essay questions that require sentence answers, totaling 100 points. Students will complete the test online at www.chwcrs.org. Students have a total of two (2) hours to take the objective portion of the test. All students must achieve a combined score of 80% on the T/F, multiple choice and essay portion of the final exam to receive certification.

Part two, the essay portion, must be completed in one hour. There are a total of 4 questions (two questions per attempt). The two highest scoring questions of both attempts combined will be counted. If a student goes over the 60 minutes allotted per attempt, his/her answers will not be submitted, thus receiving a 0 on that attempt of the exam. Students MUST click the 'submit and finish ALL button' at the bottom of the essay screen once the essays have been answered, or the answers will not be submitted.

Some helpful suggestions to consider when formulating an essay response:

- Use complete sentences and accurate grammar (no bullet point responses).
- Be sure to answer each component of the essay question.
- Identify key micro-counseling concepts learned in the training (Examples: Motivational Interviewing, Reflection, and Active Listening).
- Identify the risks and challenges each individual is facing.
- Identify strengths of each individual.
- Be specific when identifying referral resources.
- Do not create imaginary scenarios within response – stick to the question.

Please do not call or email to check the status of your certification. Students can expect to receive a notification via email within 30 days of test close as to the status of his/her certification.

<u>The test MUST be taken within 2 weeks from the end of the training</u>
MY EXAM DEADLINE DATE IS: _____

All power points are available online for students to review once the class has ended. The students will have a review of each module online that they can access with their username and password. Student manuals (including handouts) and notes may also be used as study guides and be referred to during the test.