NATIONAL ASSOCIATION OF Community Health Centers®

HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

CARE MANAGEMENT (102) INTERMEDIATE TRAINING, POWERED BY

HealthTeamWorks® Health. Equity. Resilience.

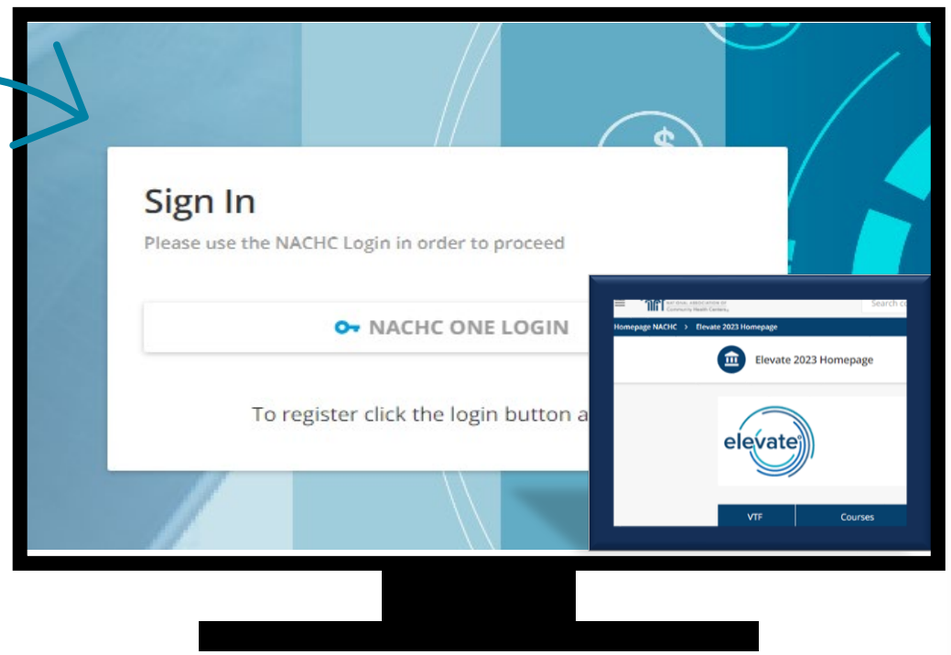
SESSION #3
SEPTEMBER 27, 2023
12:30 PM ET

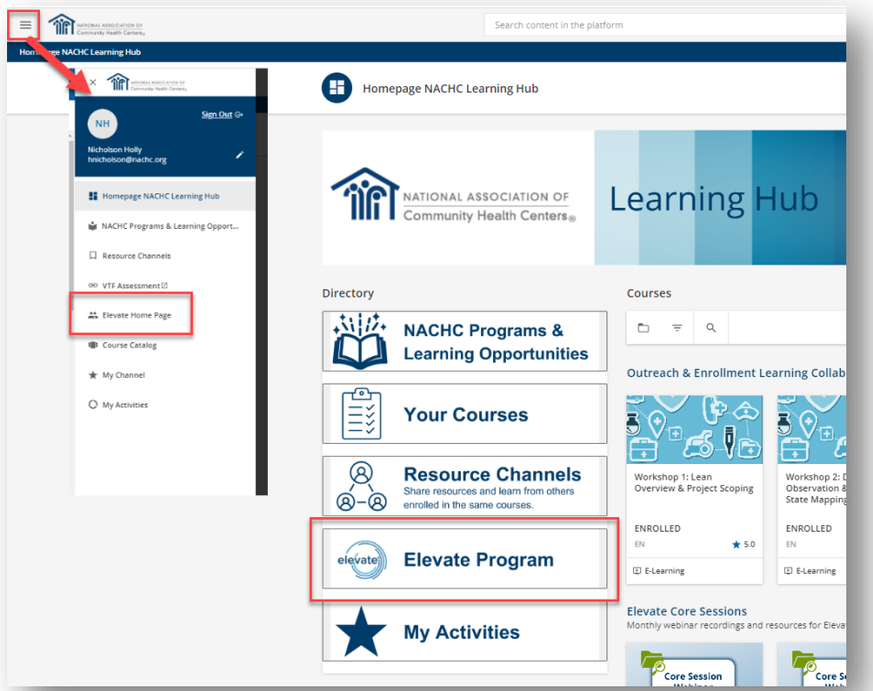
NACHC's Online Learning Hub

Session will be recorded and available in the Learning Hub

If you already have a 'NACHC One' login (the login used for NACHC conferences), use this to sign in.

*If you do not yet have a 'NACHC One' login, **register for free**!*





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Intermediate (102) Care Management
Session 3

Session 2 Recap

- SDOH Screening
  - Value statement – identifying obstacles optimal health is first step to removing obstacles
  - SDOH Tools – what works/what doesn't
  - SDOH screening – Workflow & Accountability- who is responsible to ensure this information is gathered; What does accountability look like at your clinic.
- SDOH Data
  - Value of SDOH data - impact on Care Manager priorities
- Maslow's Hierarchy of Needs
  - Impact on individuals' ability to address health needs (NC focus group data)
- Engaging the Vulnerable patient
  - Understanding patient activation
  - Readiness to change (engage) ruler
  - Teach back – reflective listening
  - Motivational Interviewing Overview

Course 2

Integrating into the Care Team & Managing Care Team Relationships

Module 1

Integration vs Isolation within the Primary Care Team

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Introduction & Learning Objectives

- Compare and contrast integration into and isolation from the care team
- Summarize what integration into the care team looks like

Models of Care Management

	LOCATION	INTERACTIONS	ADVANTAGES	DISADVANTAGES
Hospital Based	Centralized	Virtual or In-Person	Timing Opportunity for in-person while hospitalized	Can be very targeted programs: TCM, CC, Readmit reduction, ED reduction
Payor Based	Centralized	Virtual	Greater flexibility Access to financial data Access to all payor resources	Difficult to engage patients Limited to payor members
System Based	Centralized	Virtual or In-Person	Central oversight Economy of scale Peer learning	Many times limited to individuals for whom the system is at risk
ACO Based	Centralized	Virtual or In-Person	Central oversight	Limited to ACO members
Vendor	Centralized	Virtual	Central oversight	Typically targeted to specific population – typically billable CM: TCM, CCM
Practice Based	Integrated/ Centralized	In-Person or Virtual	Integrated team model	CM gets pulled into primary team tasks
PCP Team (CM performed by primary clinical team)	Integrated	In-Person or Virtual	Integrated team model Optimizes team Knowledge of team	Multitude of tasks may limit true CM tasks

Importance of Teaming

*As we shift from fee-for-service (FFS) models and journey into **value**-based and alternative payment models, care delivery models must also adapt. This is a challenging **paradigm shift**. While important, it is no longer sufficient to think about team-based care in terms of brick-and-mortar buildings, staffing ratios, and workflows based on the visit. Nor is it sufficient to think about team-based care across a medical neighborhood. In order to truly improve healthcare, we must **meet persons and families where they are** and approach team-based care from a place of **community integration and wider determinants of health**.*

Integration Versus Isolation

Integration (optimal)

- Shared focus on the patient, outcomes, and whole health needs
- Team members optimize communication methods *(EHR, huddles, co-management, staff meetings, cross-team interactions, interdisciplinary conferencing)*
- Interest in each other's success
- Seamless processes
- Higher patient, provider and care team satisfaction
- Psychological safety
- Sense of contribution and belonging

Isolation (unhealthy)

- Teams and/or individuals members work independently of one another
- Communication loops are not closed
- Symptoms often include duplication of work, increased patient and administrative burden
- Elevated frustration and burnout, often described broadly by members of the team as 'organizational culture issues'
- Negativity, fear, competition, or sabotage
- Psychological discomfort
- Taking the work back, burnout
- Turnover

Integrated care differs from traditional care in the following ways:

- It is **collaborative** rather than competitive
- It **works across organizational and professional boundaries** rather than in rigid ‘silos’
- It is **concerned with broad health outcomes** rather than specific processes, procedures, and services
- It is **flexible and evolutionary in nature**, designed to **respond to local needs** and **build on success**
- It is rather than formal nationally-imposed structures **characterized by a ‘bottom-up’, team-led approach**
- It is **patient-centered** and rooted in primary care

Achieving the Provision of Integrated Care (2018, June)

Characteristics of INTEGRATED Care Management

- Aligned Goals
- Defined Roles & Responsibilities
- Effective Communication
- Measure for Success – Celebrate or Adapt

Shared Goals

- Data Informed Population Goals
- Aligned goals
  - Patient-centered goals with quality goals with organizational goals
- Engaging the team to ensure goals are meaningful

Risk without Aligned Care Management Goals

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Group Discussion of Care Management Goals

- ✓ What are you working to accomplish with care management?
- ✓ How does this align with the team?

Clear Roles & Responsibilities

Roles:

- Clear Job Descriptions

Responsibilities:

- Best Practice Workflows
- Care Manager Panel

Accountability:

- Process Goals & Measure to Success

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Effective Communication

- Care Management Team Communication
  - Huddles
  - Rounding for success
  - Celebrations & accountability
  - Defined message response time
- Communication with the Primary Team
  - Huddles
  - Care conferences
  - Defined message response time
- Do you adapt based on communication preferences of your team?

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Effective Communication Discussion

- How does your team communicate?
- Does this work well for the team?

Measure for Success

- Regular data review
- Process measures
  - % of ED/Hospital discharge with a completed outreach within 72 hrs
  - % of patients in CM with SDOH screening in previous 6 months
  - # of patients enrolled in care management
- Outcome measures
  - % improvement in patients in CM with Diabetes poor control (HgbA1c >9)
  - % of patients with identified SDOH need and a completed referral

Celebrate or Adapt

Small Group Breakout Discussion

- What's does an IDEAL Integrated Teaming environment look like?
- How does your vision differ from your current state work environment?
- What would you prioritize to close any gaps between vision and current state?

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Small Group Breakout Sharing

Discussion

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Questions and Discussion

Course 2

Integrating into the Care Team & Managing Care Team Relationships

Module 2

Building Relationships with the Care Team

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Introduction & Learning Objectives

- Define emotional intelligence
- Describe behaviors that contribute to team building
- Evaluate examples of common healthy and unhealthy team behaviors
- Identify ways to foster integration

Emotional Intelligence

Emotional Intelligence

What is it and why does it matter so much?

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Emotional Intelligence Discussion

Answer these 5 questions together:

1. *What are the strengths of your style? (3-4 adjectives)*
2. *What are the limitations of your style? (3-4 adjectives)*
3. *What style do you find the most difficult to work with and why?*
4. *What do people from other "directions" or styles need to know about you so you can work together effectively?*
5. *What's one thing you value about the other 3 styles?*

How are Teams Evolving in Healthcare?

Practice-Based Care Team

- Patients, Families, Caregivers
- Physician
- MA
- Front Desk
- EHR

Population Health

- Patients, Families, Caregivers
- Care Managers and Navigation
- Health Coaches
- Behavioral Health (BHI models)
- Comprehensive Medication Management (CMM)
- Oral Health
- Palliative care
- Data Analytics
- HIE, Registry (QCDR), Population Management tool

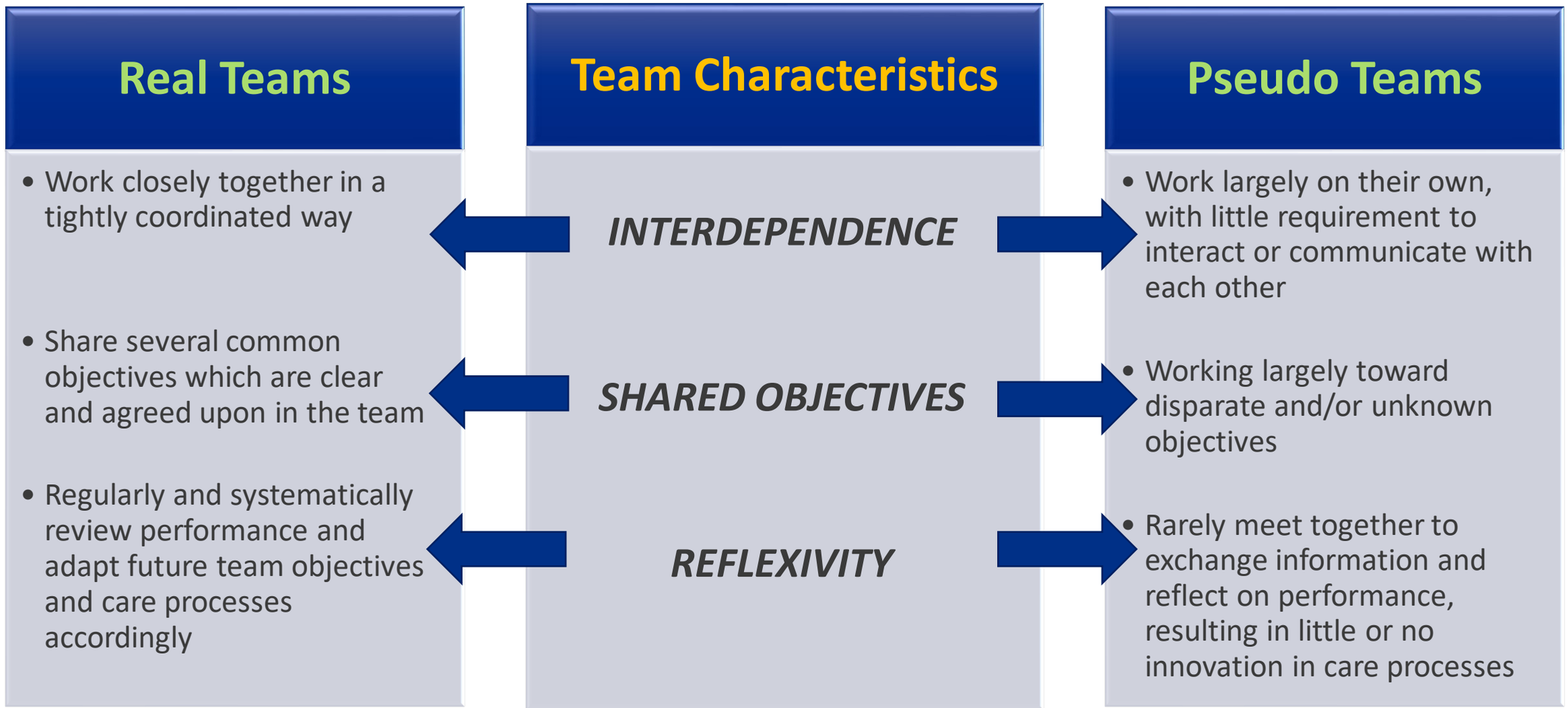
Community-Clinical Linkages

- Patients, Families, Caregivers
- Medical Neighborhood
- Social Determinants of Health (SDoH)
- Community Based Organizations (CBO)
- Telehealth
- Community Health Workers (CHW)
- Community Platform (community resources and referral tracking)

Optimizing Teams & Fostering Integration

- Interdisciplinary teams – interprofessional competence
- Top of license and ability
- Leveraging Your Front Desk Receptionist: Warm hand-offs, endorsing fellow team members
- Community Health Workers (CHW) interacting outside the walls of the practice
- Interdisciplinary Care Conferences

A Few Words About Teams…



West, M.A. (2004). Effective Teamwork: Practical lessons from organizational research. Oxford: Blackwell/British Psychological Society

*Sample Care Team for **Low-Risk** Patients*

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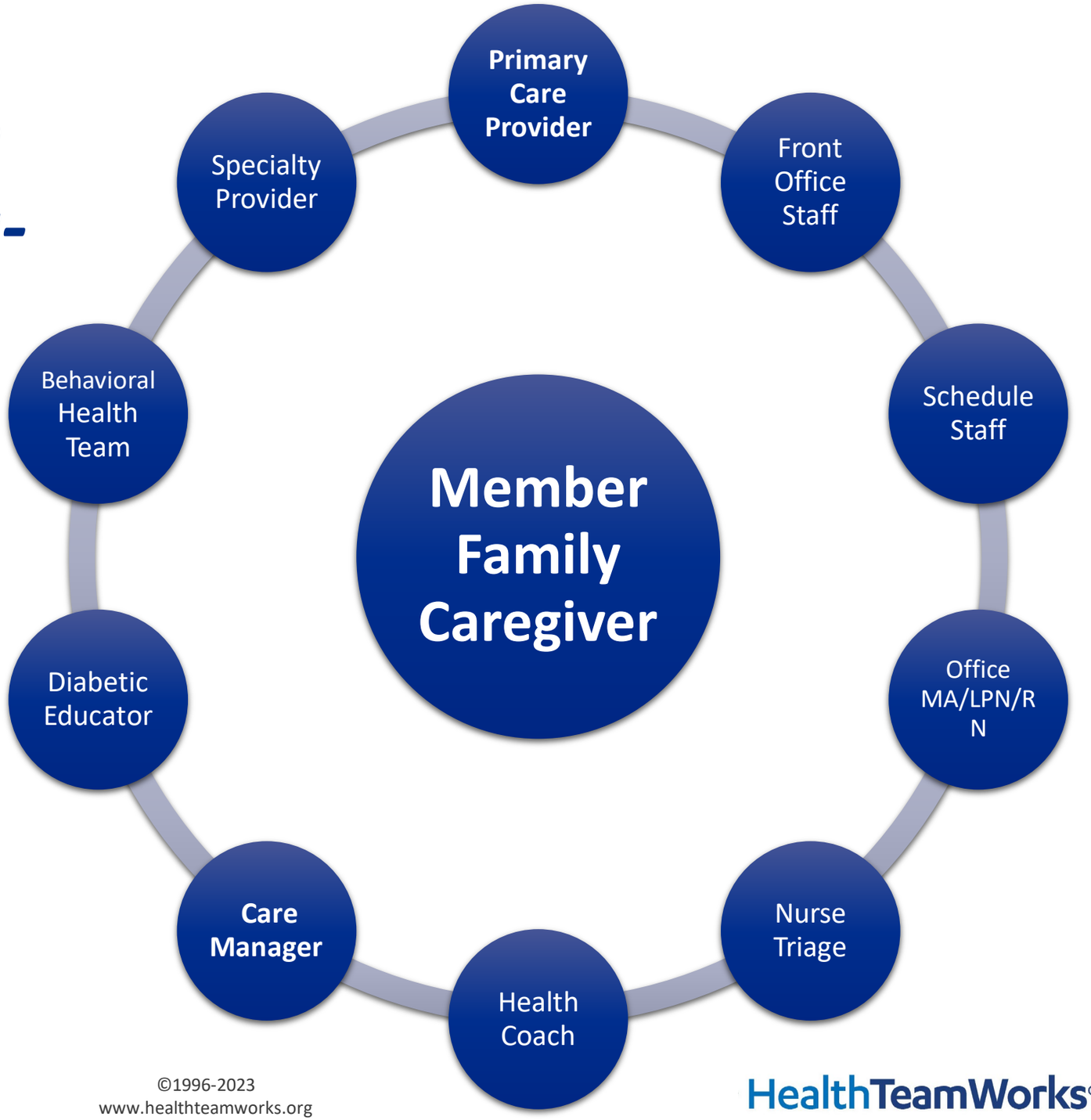
*Sample Care Team for **High- or Rising-Risk** Patients*



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Healthy & Unhealthy Behaviors

Overcome Resistance

- Collaborate to address issues the team member identifies as important or challenging
- Ask for their input or help
- Consider and address turf issues
  - Who's affected by the change?
  - How do they currently contribute to the patient experience?
  - What skills or knowledge do they have that have not been utilized? How can you leverage those skills?

Overutilization

- Define a set of criteria and process for referring patients
- Define workflows and accountabilities

Value of Roles

- Some may feel they are already doing the work of a care manager
- Define common goals

Interdisciplinary Care Conferencing

- Protected time for a deep dive regarding a specific patient with complex needs or challenges in recognizing progress
- Ideally in-person meeting, convened and facilitated by the Care Manager – creating space for multiple perspectives
- Include all members of the patient's team (e.g., provider, pharmacy, social work, behavioral health, community health worker, specialists)
- Prepare a synopsis or summary of patient status, test results, medications, and whole person needs for review with the interdisciplinary team
- Note and track action items that emerge from the group and track impact

Directions Activity: Pick the direction that is most like you

	North *Acting – "Let's do it;" Likes to act, try things, plunge in.*	
West *Paying attention to detail —likes to know the who, what, when, where and why before acting.*		**East** *Speculating – likes to look at the big picture and the possibilities before acting.*
	South *Caring – likes to know that everyone's feelings have been taken into consideration and that their voices have been heard before acting.*	

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Key Takeaways

Increased awareness opens the door to empathy

Our preferences have their strengths & their limitations

A diversity of preferences is what makes for better teamwork and results

Questions and Discussion

Course 2

Integrating into the Care Team & Managing Care Team Relationships

Module 2

Building Effective Provider Champions

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Introduction & Learning Objectives

- Describe the characteristics of a physician champion
- Identify common reasons for physician/provider disengagement
- Discuss strategies to increase provider engagement and advocacy for CM

Characteristics of a Successful Champion

- Respected by colleagues
- High emotional intelligence
- Effective communication
- Adaptive to change
- Problem-solving skills
- Team player

Reasons Providers Disengage

Change creates unknowns and can prompt anxiety or fear

No opportunity to have a voice or inform change

Lack of clear communication

Misalignment or no alignment to other work and goals

Competing priorities

What It Means To Be An Advocate For Care Management

Interest in Learning

Articulating the value of CM, for example:

- Identification and engagement of patients needing additional support

- Improving the efficacy of PCP visits

Positive Change Agent

Change is hard. Providers and members of the care team have a unique opportunity to anticipate concerns and lend key insights.

Questions and Discussion

Course 2

Integrating into the Care Team & Managing Care Team Relationships

Module 2

Healthy Boundaries and Setting Limits

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Introduction & Learning Objectives

- Discuss the importance of healthy boundaries
- Identify and discuss common examples of a Care Manager being asked to complete non-CM activities
- Apply effective strategies to set boundaries and say ‘no’

Establishing Healthy Boundaries

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Types of Boundaries

INTELLECTUAL

EMOTIONAL

TIME

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Traits of Boundaries

Porous Boundaries	Healthy Boundaries	Rigid Boundaries
Overshares personal information	Values own opinions	Not my job
Difficulty saying “no” to the requests of others	Doesn’t compromise values for others	Unlikely to ask for help
Overinvolved with other’s problems	Shares personal information in an appropriate way (does not over or under share)	Works alone
Dependent on the opinions of others	Knows personal wants and needs and can communicate them	Very protective of personal information
Accepting of abuse or disrespect	Accepting when others say “no” to them	May seem detached
Fears rejection if they do not comply with others		Keeps others at a distance to avoid the possibility of rejection

Where Boundary Lines Often Get Crossed for Care Managers

- Unrelated duties
- Filling in
- Task dumping
- Inappropriate referrals

Common Reasons for Boundary Violations

- Practice care team doesn't understand the CM role
- Care Manager is unclear of her/his own role
- Short staffed (vacant positions, someone calls in sick, someone on vacation)
- Care Manager has difficulty saying ‘no’ or wants to be helpful
- Culture of pressure or bullying to get what individuals want
- Initial culture of CM program was to just be ‘useful’ and ‘fit in’

The Art of Saying “No”

Practice	Expect the request	Don’t over apologize
Be nice to yourself	Take time to respond	Do you have time later?

Solutions to Common Boundary Violations

- ✓ Talk with your manager
- ✓ Clarify job description
- ✓ Educate care team
- ✓ Gain leadership buy-in
- ✓ Be realistic
- ✓ Communicate effectively
- ✓ Identify alternative solutions and define appropriate referral types
- ✓ Develop workflows
- ✓ Implement interdisciplinary care conferences
- ✓ Align leadership

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Task Inventory

CARE MANAGER Task List	Current Priority 0,1,2 or 3	Ideal CM Priority 0,1,2 or 3	Avg. time spent/ week
EXAMPLE: Fill-in for MA when MA is out on PTO or sick	*2*	*0*	*1-2hrs*
Care Management Tasks			
Referral for imaging appointment: CT/MRI			
Referral for imaging appointment: Other (please list)			
Referral for preventive screening : Colonoscopy, mammo, etc			
Referral for specialty provider / clinic appointment			
Prior authorization for imaging, pharmacy-Rx or specialty care			
Referral for physical therapy appointment			
Referral for community resources: Home health			
Referral for community resources: Housing or transportation			
Referral for community resources; Other			
ED or Hospital Discharge Follow up for med or high risk pts			
Work with member to ensure they have skills/ resources to manage their health - self management resources for chronic conditions			
Assess or address social needs (SDoH)			
Develop/review/update patient identified goals			
Develop/update a personalized care plan with patient			
Provide education on a members health condition/conditions			
Provide follow up after a specialty consult			

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Why Are Boundaries Important?

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The Impact of Burnout on Patients

- Poorer Health & Engagement
- Increased Errors
- Increased Safety Events
- Decreased Quality
- Increased Overall Cost

The Impact of Burnout on the Care Team

- De-personalization
- Depression, Fatigue
- Appetite Changes
- Job Dissatisfaction
- Decreased Quality of Life
- Reduced Productivity
- Turnover

Questions and Discussion

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Key Takeaways

Components of integrated teaming

Emotional intelligence impacts the ability to build effective team

Boundaries are important to prevent burnout

Session #4

Course 3. Building Your Community Network
October 4, 12:30 – 2:30 PM EST

Module 1. Identify Community Resources

- Identify common community resources to assist patients enrolled in Care Management in meeting social needs
- Discuss effective approaches to community partnerships
- Analyze sample data to identify prevalent social needs in the population that can then be translated into strategies in practice

Module 2. Identifying Community Partners

- Assess leading community support needs of your patient population
- Discuss effective strategies to select community partners for effective collaboration
- Evaluate and enhance or Build a social services inventory

Module 3. Tools to Collaborate with Community Partners

- Identify tools and resources that support community-clinical linkages
- Discuss strategies to outreach and establish relationships with community partners
- Discuss system impacts and strategies to move toward upstream solutions

Module 4. Building Collaborative Care Agreements

- Vet community-based organization's capabilities to close referrals and provide customer service
- Discuss the difference between formal and informal collaborative agreements
- Document shared expectations in a compact or collaborative care agreement with community partners

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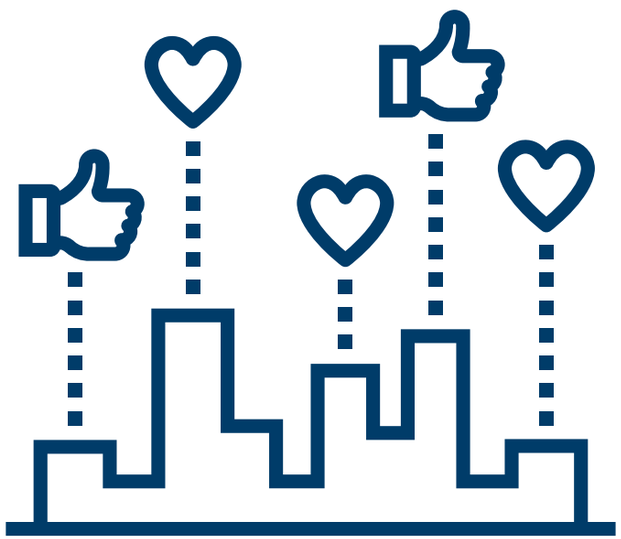

Provide Us Feedback

Contact Us!

The NACHC Quality Center team is here to help!

Questions on how to access online content? VTF Assessment?

Contact **QualityCenter@NACHC.org**

Thank You!

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