NATIONAL ASSOCIATION OF Community Health Centers®

HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

CARE MANAGEMENT INTERMEDIATE TRAINING,
POWERED BY HealthTeamWorks® Health. Equity. Resilience.

CARE MANAGEMENT INTERMEDIATE: LIVE SESSION 2
SEPTEMBER 20, 2023
12:30 – 2:30 PM ET

Care Management (102) Intermediate
Session 2

HealthTeamWorks®

Session #1 Recap

- Group Summary of What is Important in Care Management
- Population Data provides valuable information to guide identification of Population Needs
- Foundational step is knowing who is in your Care Management panel/population– Clarity on who is in your CM panel/population -- who are you responsible to provide care for?

Course 1

Caring for Vulnerable Populations

Module 3

Identifying and Addressing Social Needs in your Patient Population

HealthTeamWorks®

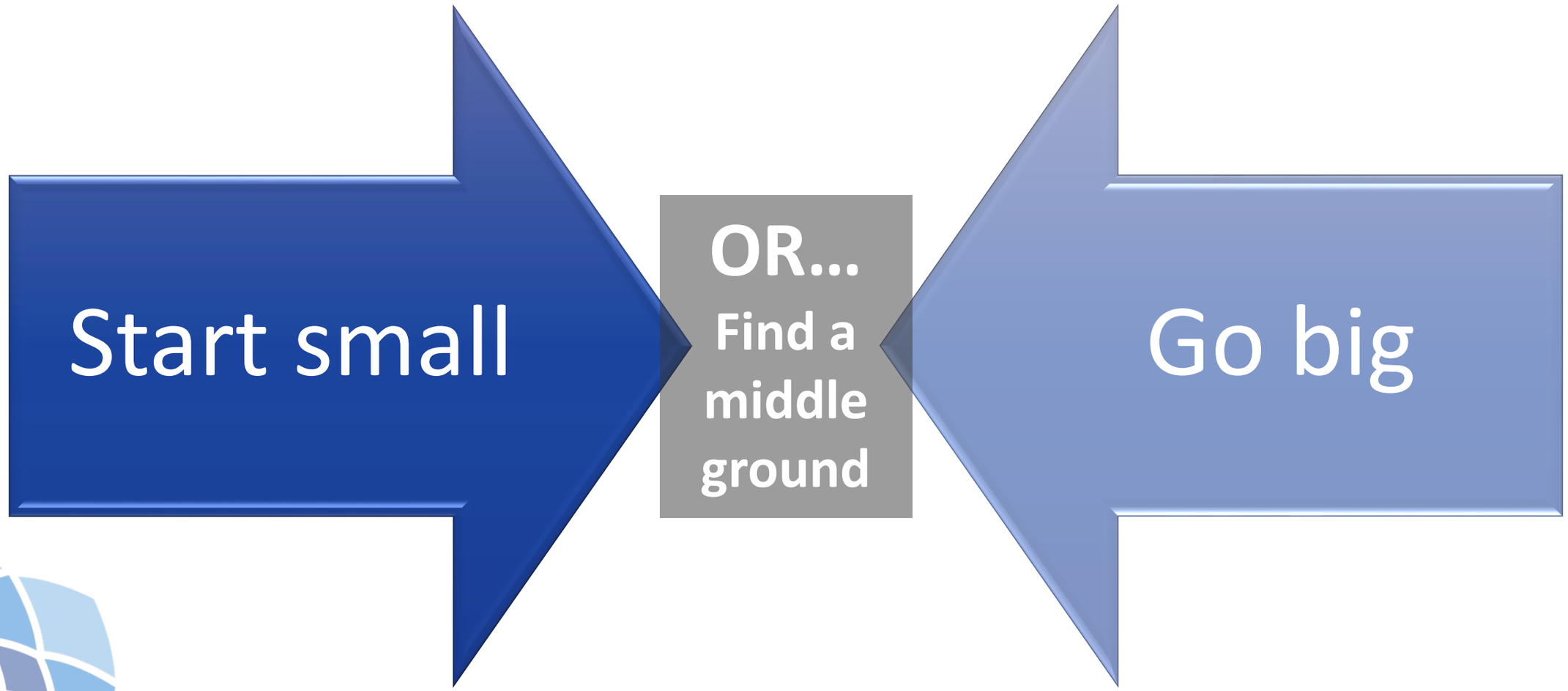
Evidence-Based Social Needs Screening Discussion

- Does the Social Needs Screening Tool capture the information you need?
- Is Social Needs Data captured on a consistent basis?
- Are you able to review Social Needs Population Data?
- What is the value or potential value of Social Needs Population Data?

Social Needs Screening Process

- Value of screening – Confirming the WHY
- Social Determinants of Health TOOLS
- SDOH data – What does it tell you

Assessing Your Social Needs Screening Resources



HealthTeamWorks®

When to Complete Social Needs Screening

- Check-In
- Rooming
- Patient Portal
- Home Visit

From Process to Impact

Depression and Behavioral Health Screening Tools

Process

PHQ-2, PHQ-9 workflows

Treatment or Referral

Impact

Addressing identified needs

Integrating Behavioral Health

Whole-person approach

Normalizing treatment of anxiety and depression as part of a comprehensive primary care model

Social and Wider Determinants of Health Screening Tools

Process

SDoH Screening Tool

Community Resource Referral

Impact

Use of FindHealth.org or other community platforms and resource tools to support referrals

Root cause analysis

Community-Clinical Linkages

Whole-person approach

Engaging with community resources and social support teams to inform gaps in services and/or capacity challenges

Partnering in solutions

CM and CHW models

“No wrong door’ and one-stop solutions

HealthTeamWorks®

Common Challenges & Solutions to Implement Social Needs Screening

Care team not on board	• Educate on importance and impact of social needs (Caring for Vulnerable Populations: Addressing Social Needs) • Find a champion in the practice to help support the effort • Share examples of social needs that were obstacles to achieving goals
Difficulty incorporating tool into EHR	• Work with HIT vendor • Inquire if there is already a social needs screening in the existing EHR • Consider ease of location; Consider a hard stop
Where to incorporate screening into workflows?	• Patient complete screening on a tablet at time of check-in • CM administer screening during assessment for CM • Patient complete screening via portal • MA administer screening during rooming process

Common Challenges & Solutions to Implement Social Needs Screening *(continued)*

Pandora's box	• Start with small tests of change (PDSA) • Educate team about importance of addressing needs
Lack of community resources	• Identify online resource lists such as FindHelp.org, Unite Us, HIE • Engage community contacts and/or community health workers

Considerations

All high-risk patients can be considered vulnerable; but not all vulnerable patients will be identified as high-risk in a risk stratification algorithm

- Embed the social screening tool in the EHR as structured data, and add it to the the risk stratification algorithm for more accurate results
- Until the screening tool is embedded and captured by the risk stratification algorithm, upgrade or downgrade risk based on new information

Social Needs Data Discussion

Sharing examples of social needs data impacting a care manager's role:

1. 33% of individuals with an avoidable ED visit had no 'Trusted support person" (for this data point trusted social support was defined as *a trusted person/resource I could call at or after 10 PM).*

2. 65% of individuals with Diabetes poor control did not have easy access to healthy food (defined as *fresh or frozen fruit and vegetables within 30 minutes of my home).*

3. *28%* of individuals who were not taking their medications regularly did not have sufficient money to buy groceries until the next payday.

Small Group Discussion

Time: 15 minutes
Lead: : Identify 1 person to take notes and report out to larger group

TOPICS:

- Topics will be placed in the chat
- Your breakout room will determine your discussion question. Your breakout room number is in the upper left corner of your screen.

e.g.-If you are in breakout room #1 you will discuss and answer question #1

Social Needs Data Discussion

HealthTeamWorks®

Course 1
Caring for Vulnerable Populations

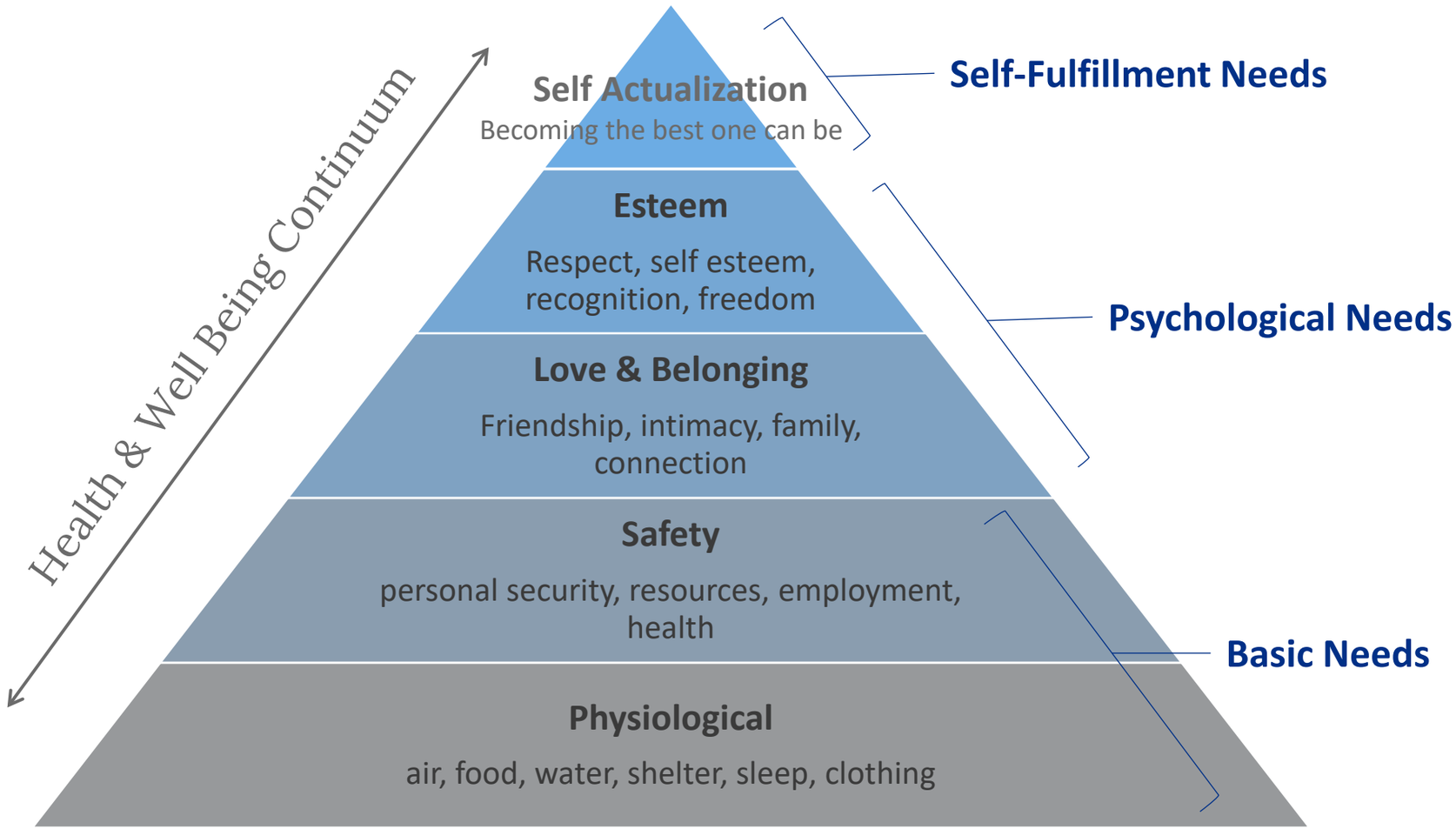
Module 4
Applying Principles of Maslow's Hierarchy of Needs

HealthTeamWorks®

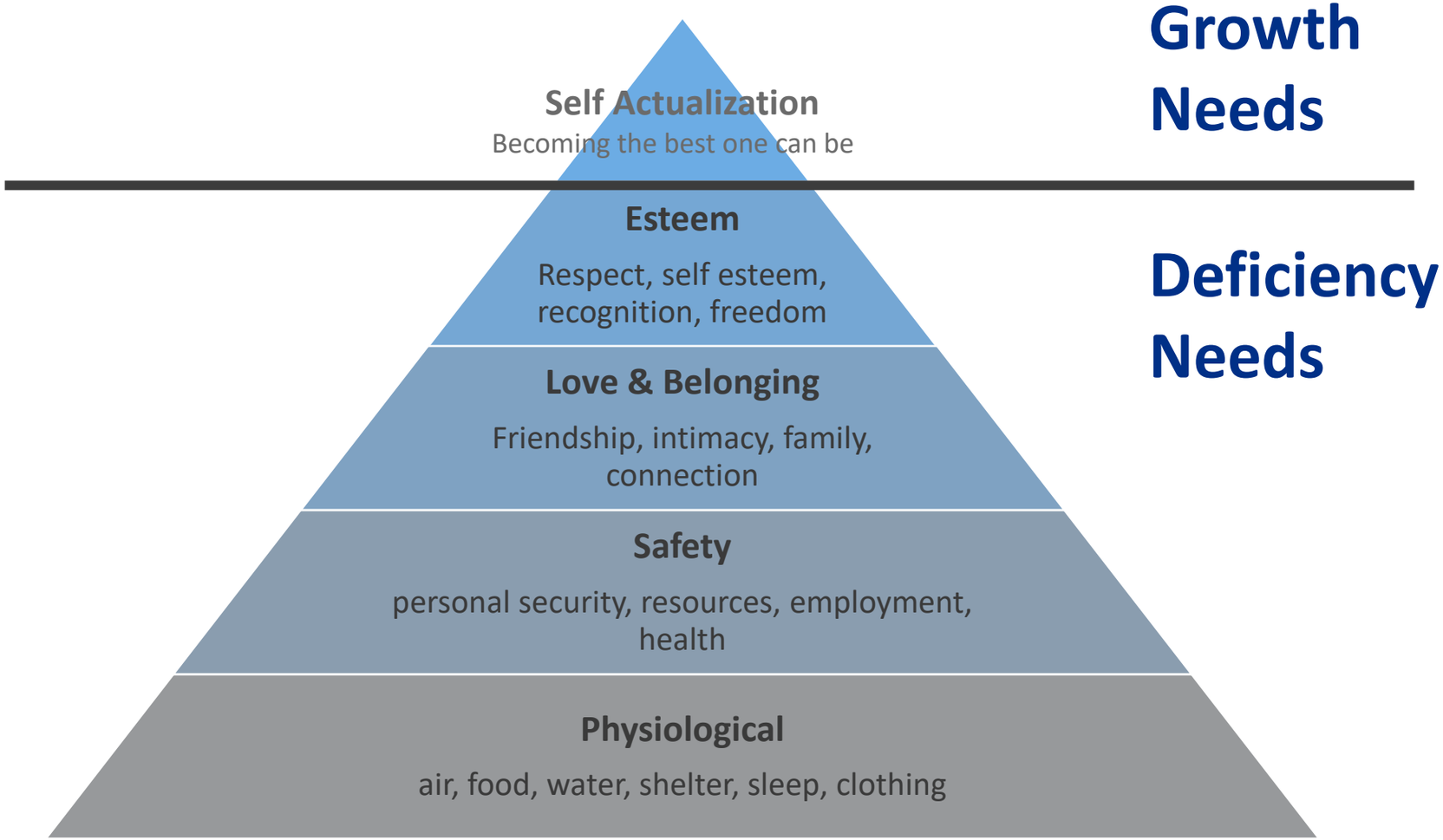
Objectives

- Discuss the impact of motivations for human behavior, such as Maslow's hierarchy of Needs, on health status.
- Apply case examples of vulnerable and high-risk patients to a daily care management strategy.
- Analyze and discuss the importance of an informed approach to providing competent care for this population in your community.

Maslow's and Social Needs

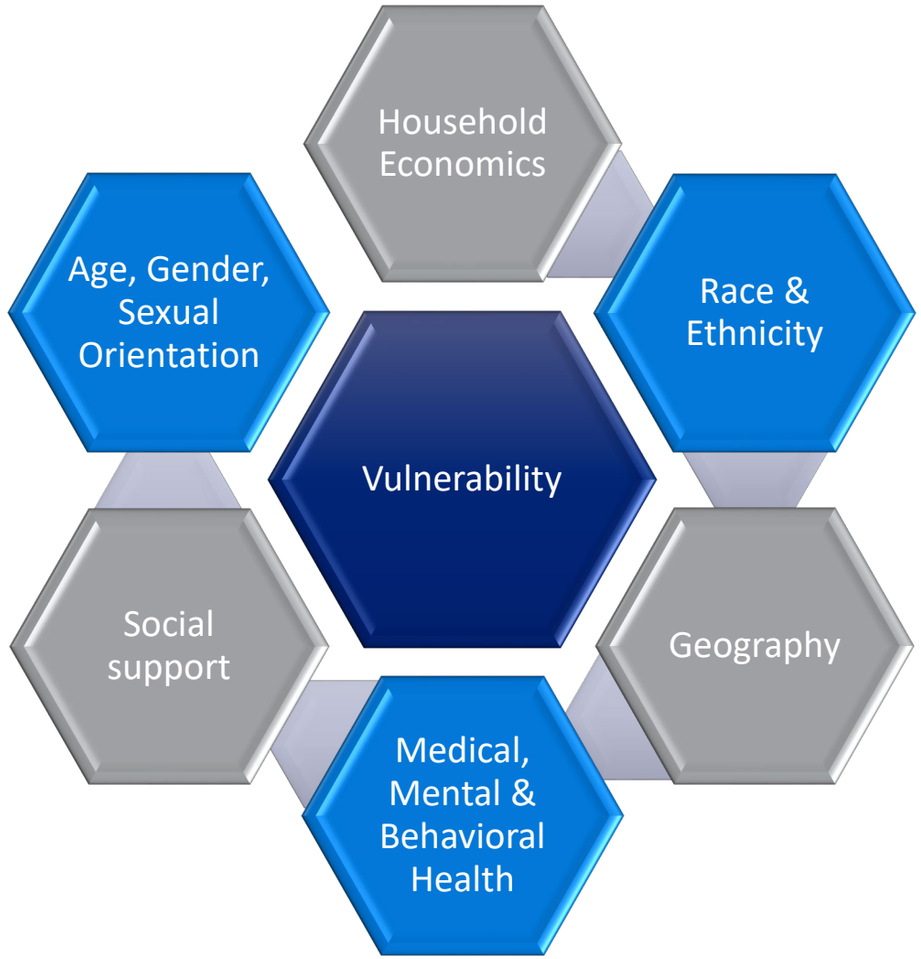


Deficiency & Growth Needs



Case Example #1: Ruby Johnson

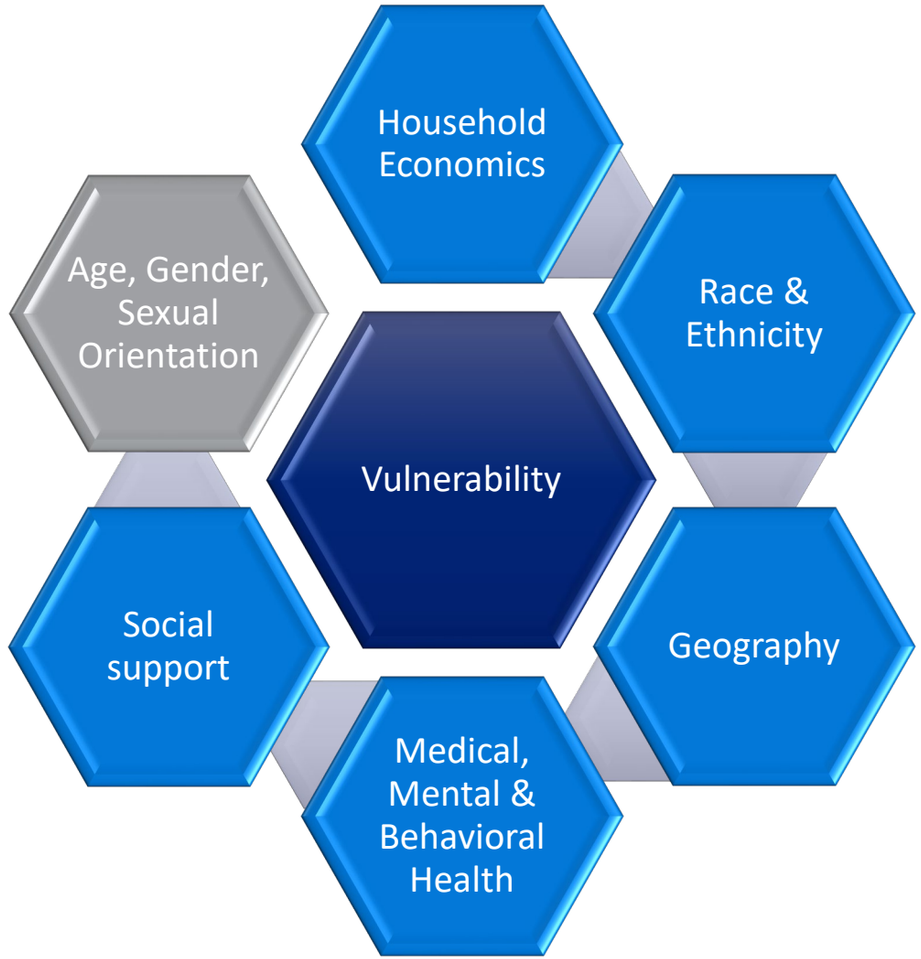
- 76-year-old African American female
- Dx: Hypertension, end-stage renal disease
- Receives hemodialysis three times/week; stable
- Widowed for 8 years
- Lives in an Assisted Living facility; transportation to and from dialysis is provided by the facility
- Great family and social support; family visits her at the assisted living facility every week
- Has a women's club at assisted living, where she plays bridge, knits, and pursues other crafty interests
- Social worker at dialysis center and social worker at assisted living collaborate to address needs



HealthTeamWorks®

Case Example #2: Jonathan Smith

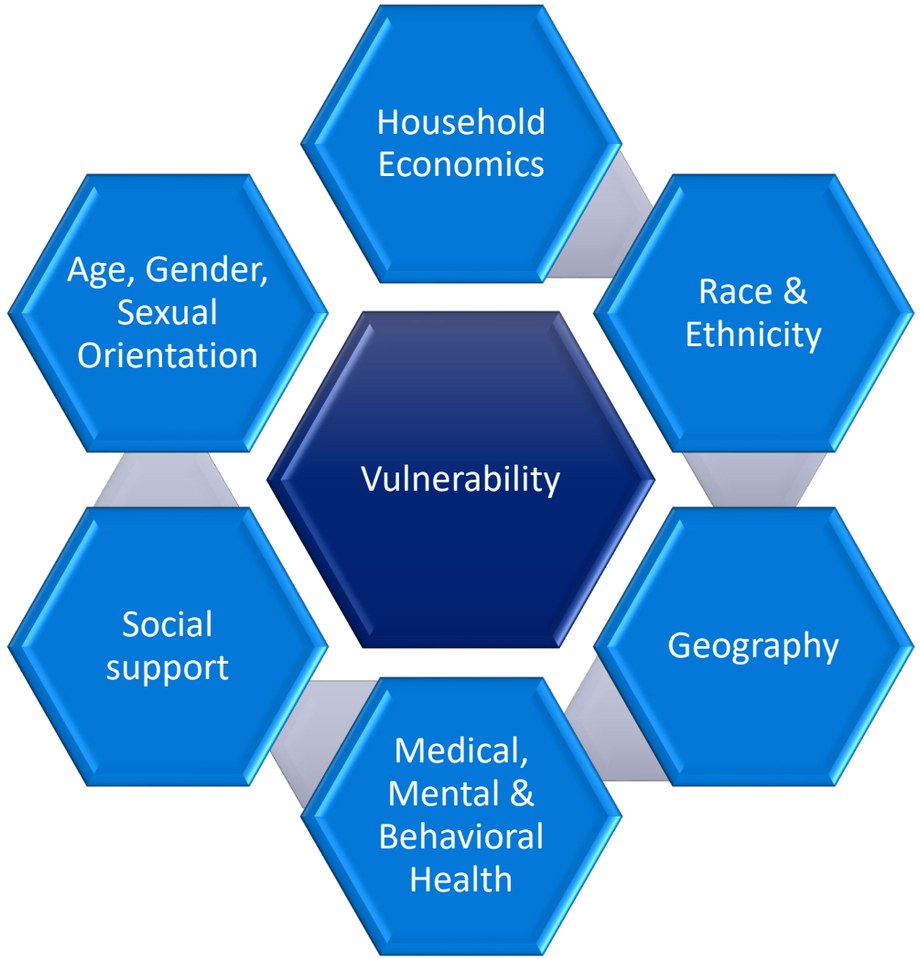
- 22-year-old bi-racial male
- Dx: schizophrenia, destabilized due to stopping medications. Auditory hallucinations, homicidal toward neighbor
- Currently homeless – mom just kicked him out due to destabilization and homicidal ideation
- Mom raised him alone – she had a series of boyfriends, several of whom were abusive toward Jonathan and his siblings
- Unstable housing throughout his life in the inner city with poor living conditions
- Education – dropped out of school in 11th grade and has not completed the GED



HealthTeamWorks®

Case Example #3: Alex Rodriguez

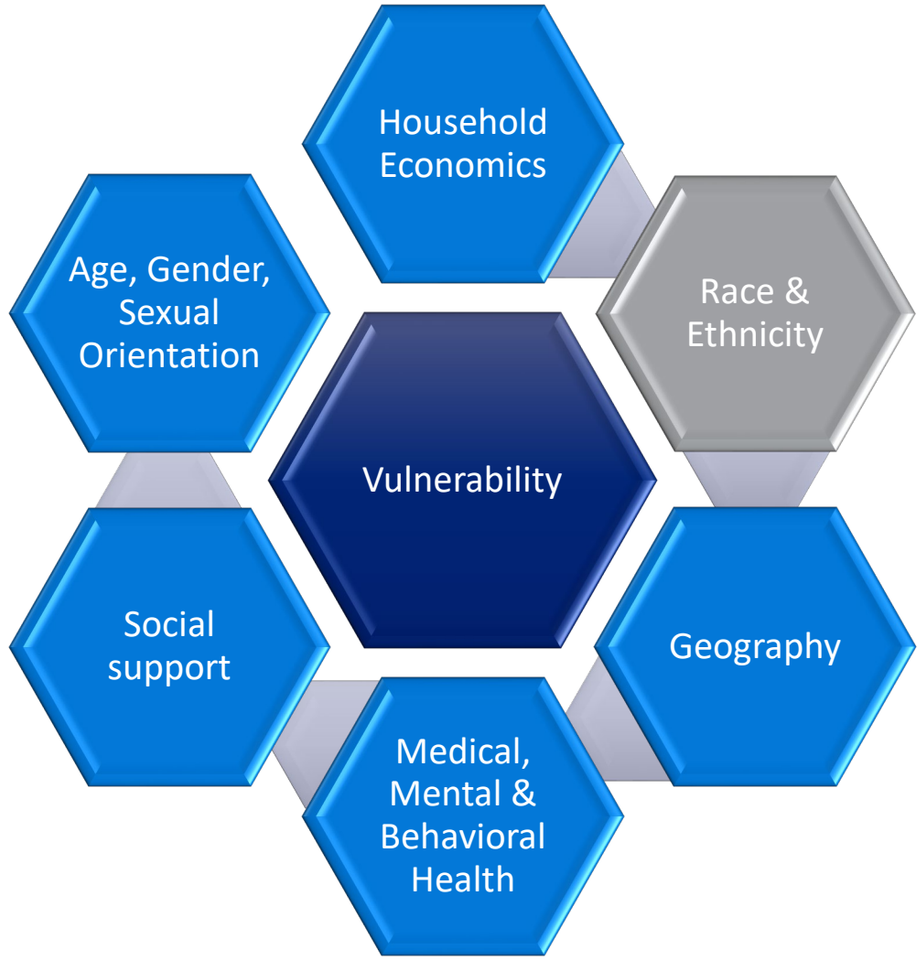
- 7-year-old Hispanic male
- Dx: Severe asthma and allergies
- Multiple visits to ED for asthma
- No health insurance
- Father is employed, mother is not
- Poor nutrition, due to lack of finances
- Family unable to afford medications for asthma
- Lives with mom, dad, and 1 older sister
  - All are undocumented
  - Very limited English
  - Need legal help applying for green cards
- Housing
  - Lives with extended family in a crowded apartment in a densely populated urban area.
  - The apartment building is old and needs repair. Possible mold issues in building.



HealthTeamWorks®

Case Example #4: Dana Walsh

- 32-year-old Caucasian female
- Dx: osteomyelitis, substance abuse (addicted to IV heroin, alcohol)
- Homeless (sleeps in a city park)
- Has burned all bridges with family and friends
- Unemployed; prostitution to sustain heroin addiction
- Medicaid
- Recent hospitalization and a new diagnosis of osteomyelitis; New order for daily IV antibiotics for the next 2 weeks (possibly longer)



Case Discussions

HealthTeamWorks®

Course 1
Caring for Vulnerable Populations

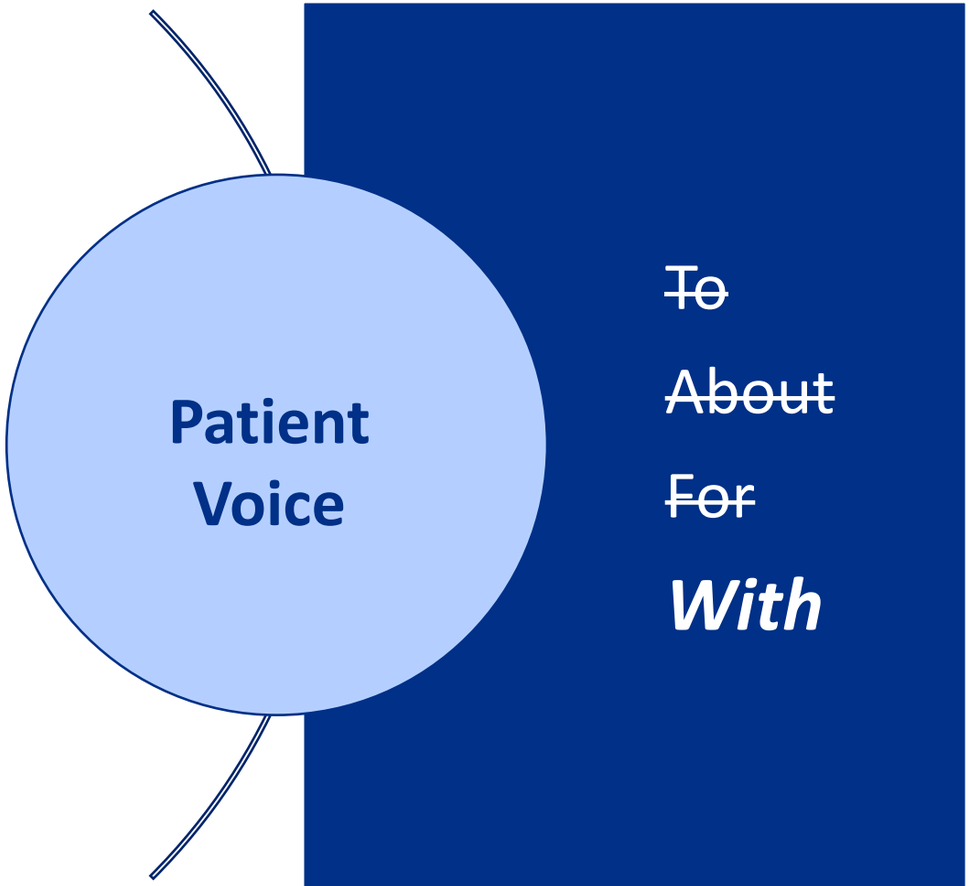
Module 5
Effectively Engaging the Vulnerable Patient

HealthTeamWorks®

Objectives

- Discuss the value of engaging the vulnerable patient to identify what brings value to them
- Develop an understanding of basic motivational interviewing techniques

Determine Patient Readiness for Support



HealthTeamWorks®

Patient Activation

A patient's willingness and ability to take independent actions to manage their health and care.

Hibbard, Judith H.; Greene, Jessica, What the Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data On Costs, Health Affairs, Vol. 32, Iss. 2, February 2013

Patient Activation

Patient Activation Levels

- **Level 1**
- Believing the patient role is important
  - **Level 2**
- Having the confidence and knowledge to take action
  - **Level 3**
- Taking action
  - **Level 4**
- Staying the course

Stages of Change

- Pre-Contemplation
- Contemplation
- Preparation
- Action
- Maintenance

Examples of PAM Statements

I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition.

I am confident I can tell when I need to go get medical care and when I can handle a health problem myself.

I am confident I can maintain lifestyle changes, like diet and exercise, even during times of stress.

I have been able to maintain the lifestyle changes I have made for my health.

I know what each of my prescribed medications does.

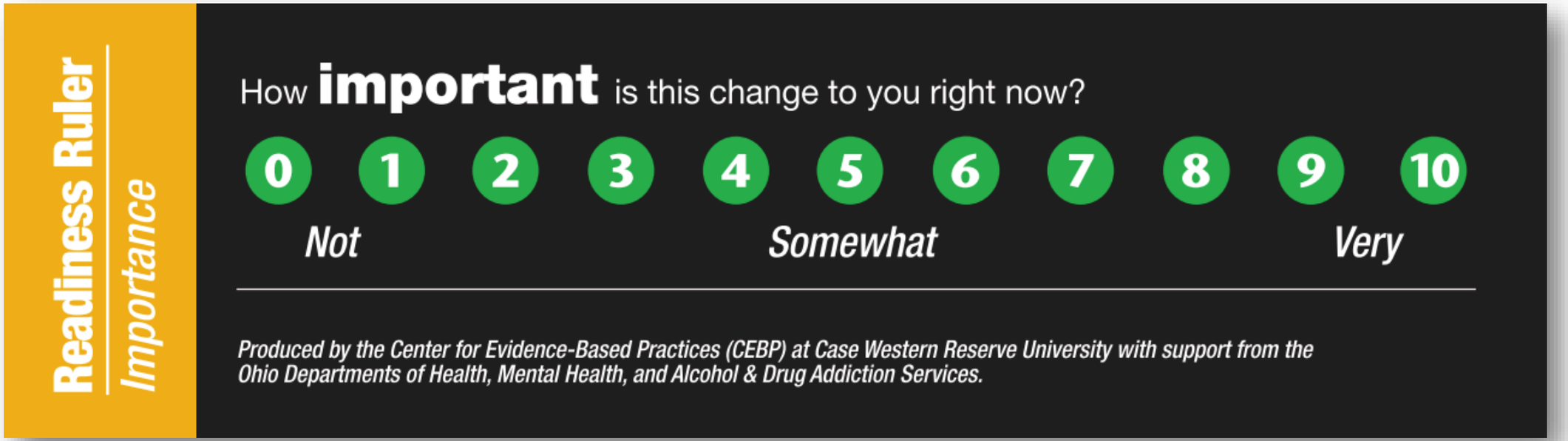
Teach Back – Reflective Listening

Opportunity:

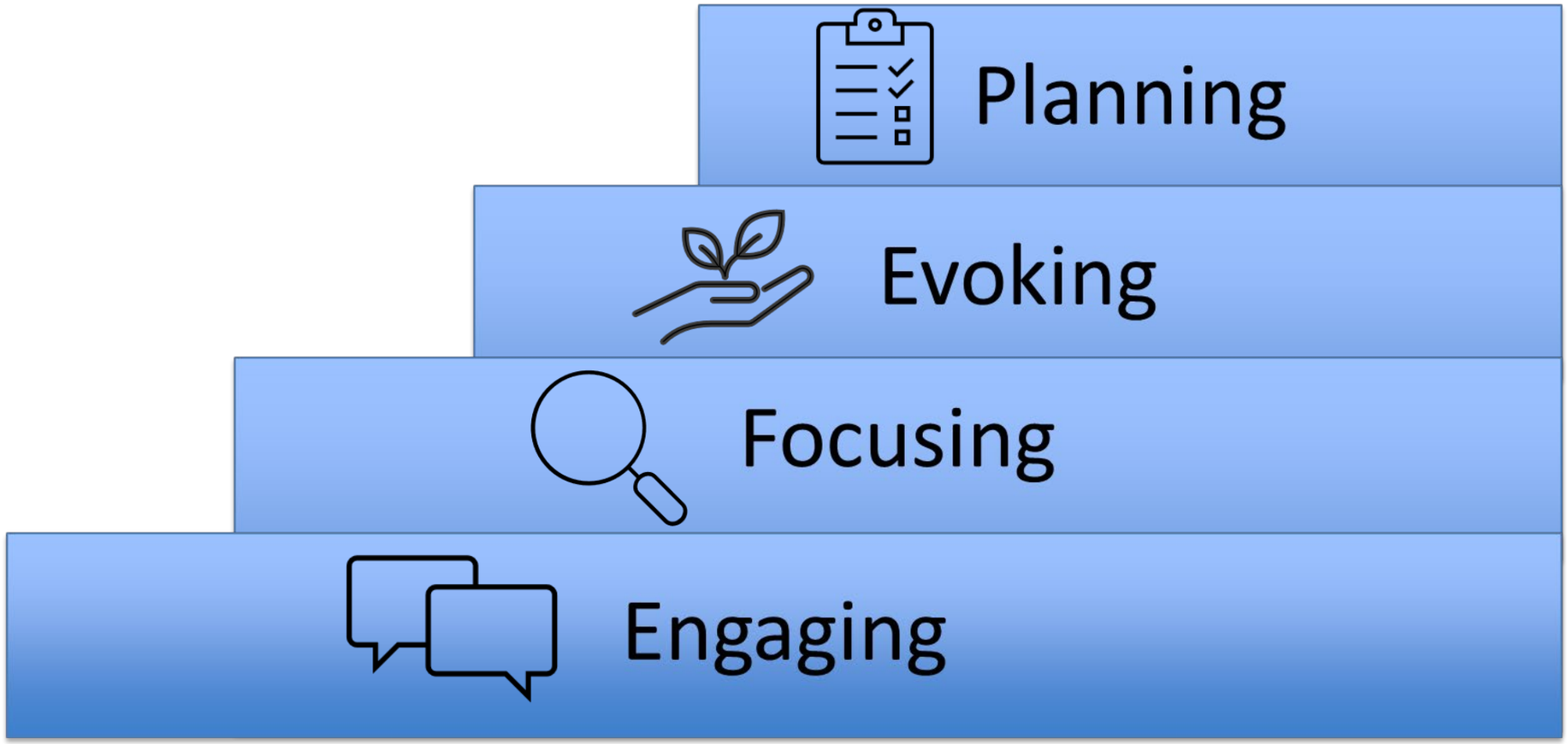
- Lack of information
- Lack of understanding
- Lack of confidence
- Lack of resources

HealthTeamWorks®

Readiness for Change Ruler



Foundational Processes of Motivational Interviewing



Motivational Interviewing

- Spirit:
  - **R**esist righting reflex
  - **U**nderstand motivation
  - **L**isten
  - **E**mpower
- Skills:
  - **C**ompassion
  - **A**cceptance
  - **P**artnership
  - **E**vocation

Motivational Interviewing

- Change Talk
  - Reference Readiness for Change
  - Identify ambiguity
  - Create a focus
  - Best if member initiated
- Recognize DARN – CAT
  - **D**esire
  - **A**bility
  - **R**eason
  - **N**eed
  - **C**ommitment
  - **A**ctivation
  - **T**aking Steps

Questions and Discussion

HealthTeamWorks®

Wrap-up & Next Steps

Takeaway

Squared Away

Circle Back

Activity

SESSION #2 ACTIVITY: SOCIAL NEEDS AS OBSTACLES TO ACHIEVING OPTIMAL HEALTH

During your Care Management patient interactions, identify a patient interaction where you:

- Suspect that a social need is interfering with the patient's ability to achieve their goals or improve their health status (No social needs screening done or current social need screen does not capture this information).

- Have captured a social need via social need screening and have a specific example of a social need that is interfering with the patient's ability to improve their health status (for example, not enough money to buy food so does not fill Rx, no transportation so uses ED in the evening when a source of transportation is available, etc.)

- Have an example of a patient with a social need that you identified a social need, supported the patient to problem solve and were able to partner with the patient to overcome the obstacle.

PLEASE DO NOT SHARE ANY PHI (name, address, birthdate, ANY ID numbers, etc.)

Connect With HealthTeamWorks

Diane Cardwell
Dcardwell@healthteamworks.org

Angie Schindler-Berg
Aschindlerberg@healthteamworks.org

Hanna Moffett
hmoffett@healthteamworks.org

HealthTeamWorks®

Time for a Poll!

HealthTeamWorks®

Care Management Intermediate Training: Course Timeline

Pre-Work

- ✓ Register for Elevate
- ✓ Block calendar for sessions

Course: September 13, 2023 – October 18, 2023

Sep 13th Kick-Off Session

Sept 20th Live Session 2

Sep 27th Live Session 3

Oct 4th Live Session 4

Oct 11th Live Session 5

Oct 18th Closing Session

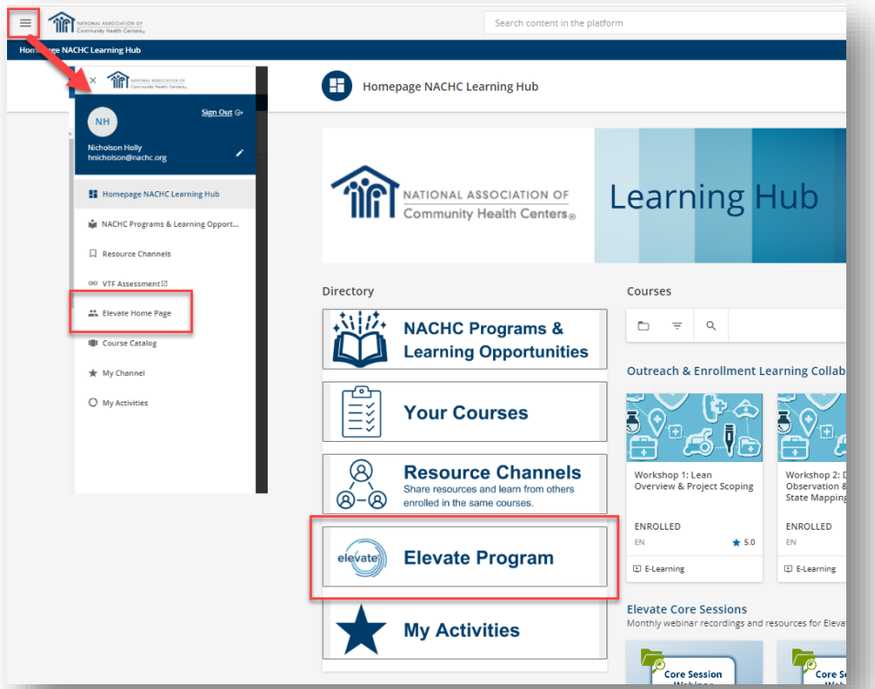
You are here! Congratulations, you have completed the Pre-Work and Session 2! Next steps:

- ✓ Access online course content
- ✓ Complete VTF Assessment
- ✓ Attend remaining courses

NACHC's Online Learning Hub

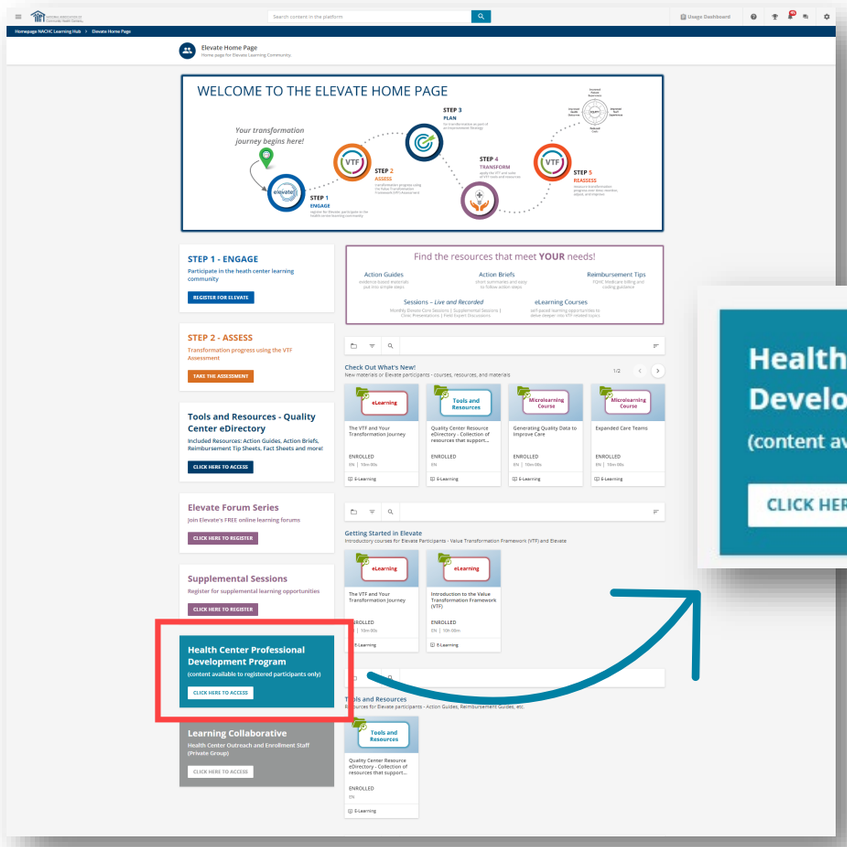
If you already have a 'NACHC One' login (the login used for NACHC conferences), use this to sign in.

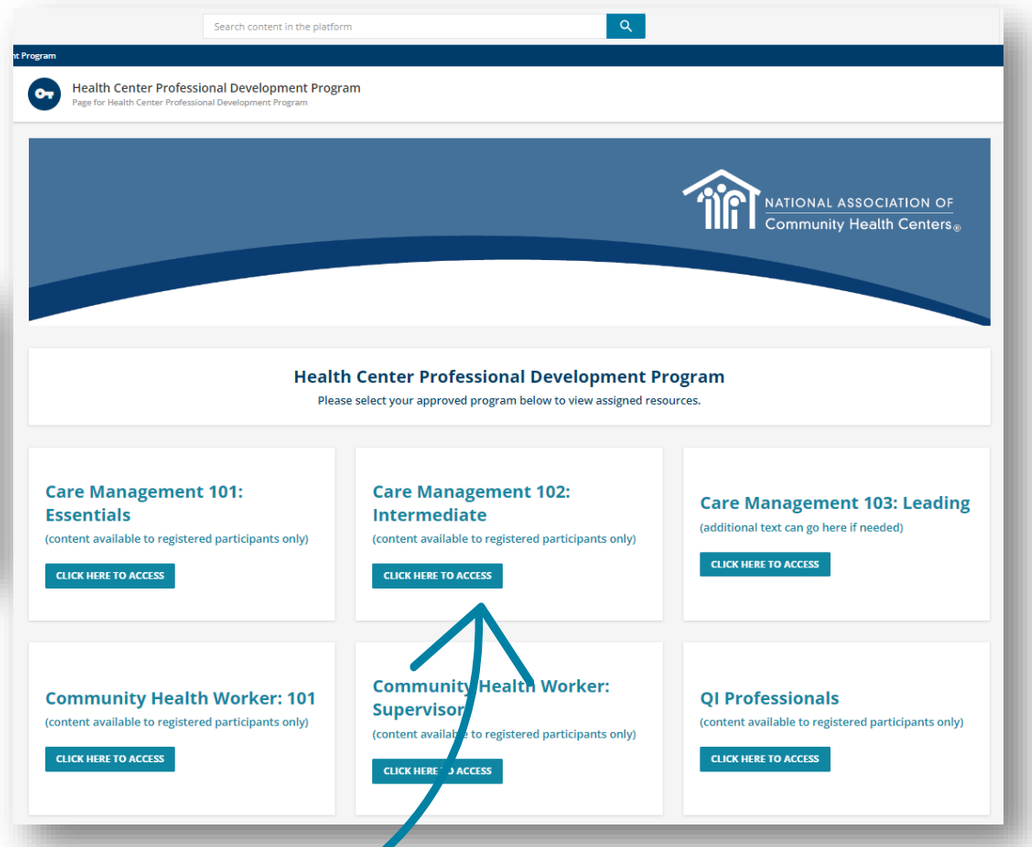
*If you do not yet have a 'NACHC One' login, **register for free**!*



Access NACHC's Learning Hub at
https://nachc.docebosaas.com/learn/signin

NACHC's Online Learning Hub





Select your course!

Contact Us!

The NACHC Quality Center team is here to help!

Questions on how to access online content? VTF Assessment?

Contact **QualityCenter@NACHC.org**

Session #3

Course 2. Integrating into the Care Team & Managing Care Team Relationships September 27, 12:30 – 2:30 PM EST
Module 1. Integration vs Isolation within the Primary Care Team • Compare and contrast integration into and isolation from the care team • Summarize what integration into the care team looks like
Module 2. Building Relationships with the Care Team • Define emotional intelligence • Describe behaviors that contribute to team building • Evaluate examples of common healthy and unhealthy team behaviors • Identify ways to foster integration
Module 3. Garnering Provider “Buy-In” and Working with ‘Difficult’ Providers • Describe the characteristics of a physician champion • Identify common reasons for physician/provider disengagement • Discuss strategies to increase provider engagement and advocacy for CM
Module 4. Healthy Boundaries and Saying ”No” • Discuss the importance of healthy boundaries • Identify & discuss common examples of a Care Manager being asked to complete non-CM activities • Apply effective strategies to set boundaries and say ‘no’

Thank You!

HealthTeamWorks®