HW HealthTeamWorks Workforce_Development

1 Defining Care Management

Lesson 1 of 12

Introduction and Learning Objectives

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01:24

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Welcome to the first course in HealthTeamWorks' Introductory Care Management Training!

Effective care management is a key driver to increased quality, lower costs, improved patient quality of life, and optimal patient and care team satisfaction. Having a dedicated resource for care management allows for targeted interventions to achieve cost and quality objectives. In this learning path, participants will acquire skills for integrating into the care team, establishing and implementing care management processes, tools, and resources, and educating and activating patients to address their health care needs.

Learning Objectives

Following the completion of this course, the learner should be able to:

- Accurately define Care Management and how the role integrates into the day-to-day activities of the practice.
- Distinguish the types of care manager roles that can exist in a primary care setting through online discussion.
- Compare the critical differences between Episodic and Longitudinal Care Management and identify the differences by reviewing case studies.

In this course, you will be introduced to Care Management and the role it can take in a practice. You will be encouraged to participate in discussions with other learners and share your thoughts and experiences. We will also include resources that you can download as supplements to this training and improve your skills in this role.

CONTINUE

Lesson 2 of 12

Establishing a Definition for Care Management

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In this course, our focus is on Care Management and the associated functions, tasks, and roles. In order to develop a strong foundation, we must first understand the definition of care management. One of the most common definitions of care management was developed by the Agency for Health Research and Quality (AHRQ).

"Care management is a promising team-based, patient-centered approach designed to assist patients and their support systems in managing medical conditions more effectively. It also encompasses those care coordination activities needed to help manage chronic illness."

"Care Management" and "Care Coordination" are terms that are often used interchangeably. In the definition above from AHRQ, care coordination is an aspect of care management. Care coordination is specifically about the organization of patient care activities and sharing information across all providers of care; primary care, specialty care, home care or skilled nursing facility (SNF), a council on aging, other community agencies involved, etc. This coordination ensures safe, appropriate, effective care (i.e., right care, right place, right time).

Care Management ties coordination in with other important concepts such as:

- **Patient-centric** - based on where the patient is right now in their own continuum, patient preferences, and where they would like to be.
- **Team-based Care** - Working together as a cohesive team, the PCP, practice team support staff such as Medical Assistants (MA), front office, triage, care manager, social worker, behavioral health specialist, dietitian, specialists involved.
- Focusing on including the support systems of the patient, whether this is a spouse, family caregivers, community agencies, the support systems are engaged (or even initiated through care management) to ensure WHOLE person care is delivered and includes addressing psychosocial needs.

- Having a clinical focus on managing medical conditions.

What aspects of the care management definition stand out to you? Post your thoughts in the discussion for this course and then move on to the next module.

Lesson 3 of 12

Roles of the Care Manager in Practice

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What does the Care Manager do? What are the required credentials of the Care Manager? Often in primary care practices, the role is held by one or more of the following:

1. Registered Nurse (RN)
2. Social Worker (SW)
3. Licensed Practical Nurse (LPN)
4. Community Health Worker (CHW)
5. Medical Assistant (MA)

These roles work with all members of the care team to develop and sustain collaborative partnerships that will benefit their patients. However, each role has specific functions. The functions of each role will be explored in the next four modules.

It is important to keep in mind that functions can vary widely, depending on how the practice is staffed. Some practices only have an RN Care Manager. Some may have an RN and a Social Worker(SW). Other practices may employ a Community Health Worker(CHW) instead of an RN or SW.

In the latter case, the CHW would typically function in a manner where they are predominantly addressing psychosocial needs, and perhaps completing outreach to patients after hospitalization or Emergency Department visits. For outreach calls, it is

important that the CHW is trained on signs for concern and clinical decompensation as well as warning signs/symptoms to be alert to. This allows the CHW to know when to forward a patient to the practice nurse for triage.

Over the next few modules, you will learn more about the specific functions of each role.

Lesson 4 of 12

Functions of the RN Care Manager

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The RN often has visibility to the entire panel of patients. Think of the RN as the conductor for population health and all things related to care management. They understand how the population is broken down into risk tiers and has a general understanding of the prevalent conditions and needs of the population.

In addition to the functions above, the RN is the go-to for questions and concerns for any patients enrolled in Longitudinal Care Management. Other functions could include:

- Assignment of portions of a patient's care plan (and provide oversight) to an LPN if the office has an LPN Care Manager
- Delegation and oversight of tasks from the care plan to an MA/CHW if employed by the practice

Some practices and programs also have the RN Care Manager conduct home visits. This depends on the program's model and the expected panel sizes. For an RN completing both episodic and longitudinal care management, it is not feasible to add home visits into the mix unless the panel sizes are exceptionally small. Home visits might be feasible for RN Care Managers whose sole responsibility is longitudinal care management; however, the panel size will need to be smaller than average. An example of this is the Guided Care Nurses from Johns Hopkins. They conduct home visits and typically manage a panel size of 50-60 patients.

Functions of the Social Worker

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Care Managers who have Social Work degrees or backgrounds often have tasks that are quite different than that of an RN Care Manager. If the RN is the conductor of care management and population health in the practice, the Social Worker (SW) is the first chair of the woodwinds section.

The SW has oversight of all things related to addressing the psychosocial needs and barriers of patients in care management. They conduct psychosocial assessments and provide support for the practice. This could mean assisting with developing tools and sharing them with the care team, working with Health Information Technology (HIT) to embed assessments into the Electronic Health Record (EHR). Assessments can include social needs screening tools or the PHQ assessment.

Depending on the practice model for care management, the SW may conduct home visits. Conducting home visits are exceptionally valuable as they allow a different view into the patient's life, enabling the SW to identify areas of concern/need for assistance that is often missed when the patient comes to the office. For example, a patient with frequent COPD exacerbations who reports that they are taking medications as prescribed may find out through a home visit by the SW that there are environmental concerns in the home that may be contributing to the exacerbations such as multiple pets, pest infestation, or dusty cat litter.

Ultimately, the SW can be the bridge between the clinical and social needs of the patient.

Functions of the LPN Care Manager

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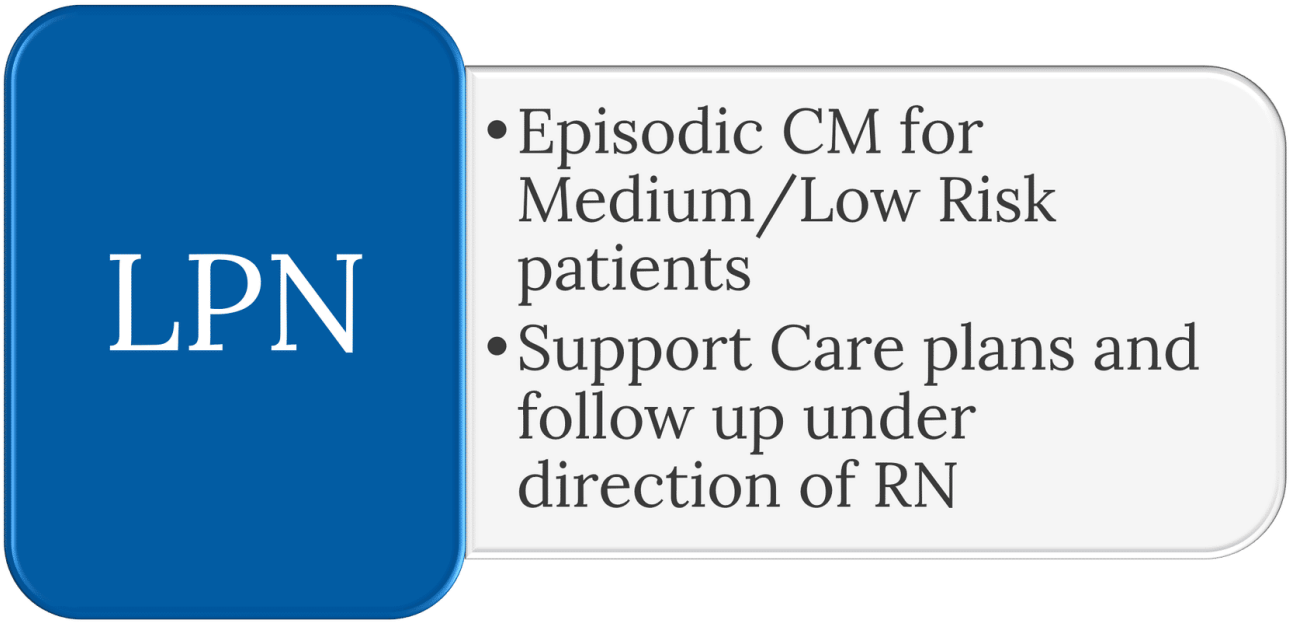
For practices that are fortunate enough to have a comprehensive care management team, the Licensed Practical Nurse (LPN) provides robust assistance in completing Episodic care management for medium and low-risk patients. The LPN is also the role that will refer patients to the RN who have been deemed high risk and/or complex.

The LPN also can provide support for RN designed care plans. This includes following up with patients, providing self-management support, collecting patients' self-reported data for blood glucose or blood pressures, etc.



Additionally, for efficiency and depending on the practice staffing, the LPN may conduct all Episodic care management, including the high-risk patients. Any concerns would be referred to the RN. This flow frees up the RN to focus on Longitudinal care management, thereby expanding the available panel size for Longitudinal care management.

Functions of the MA and Community Health Worker

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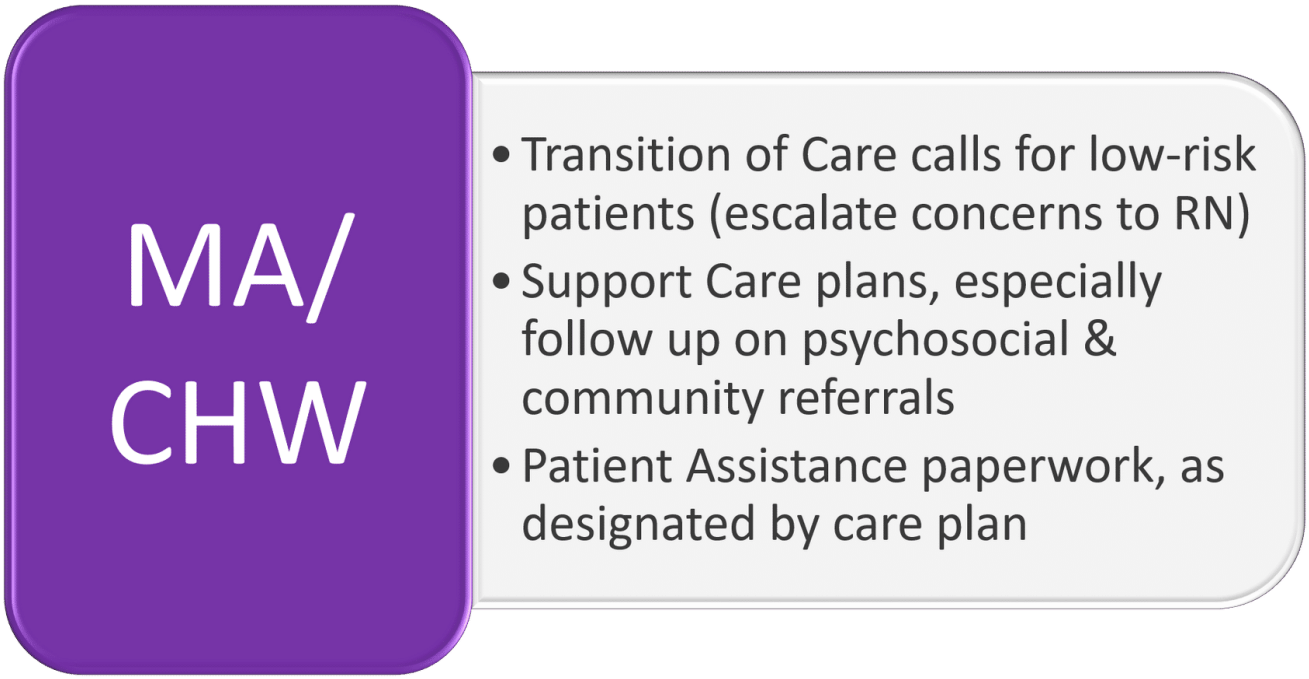
The same practices that have a comprehensive care management team may include a Medical Assistant (MA) and/or a Community Health Worker (CHW). Though the requirements of each role may differ, they have similar functions. Some of the functions include:

1. Conduct Transition of Care calls for low-risk patients and escalate any concerns to the RN.
2. Screen for social needs with an evidence-based screening tool and refer to the Social Worker if necessary.
3. Perform follow-up tasks for the psychosocial aspect of care plans. These include assisting patients with paperwork for medication assistance, or applications for Medicaid or disability.



This role can also be extremely valuable in helping patients intersect with community agencies and resources. For example, meeting a patient at a Free Store/Food Bank to help them get established with assistance. This is especially helpful for patients who are afraid to make this first step on their own.

As an added benefit, CHWs who have been specially trained through a licensure program are especially valuable in working with community partners. They can develop and nurture relationships in the community where the patients are served and help to establish and sustain referral processes between the practice and partners.

Lesson 8 of 12

Episodic vs. Longitudinal Care Management

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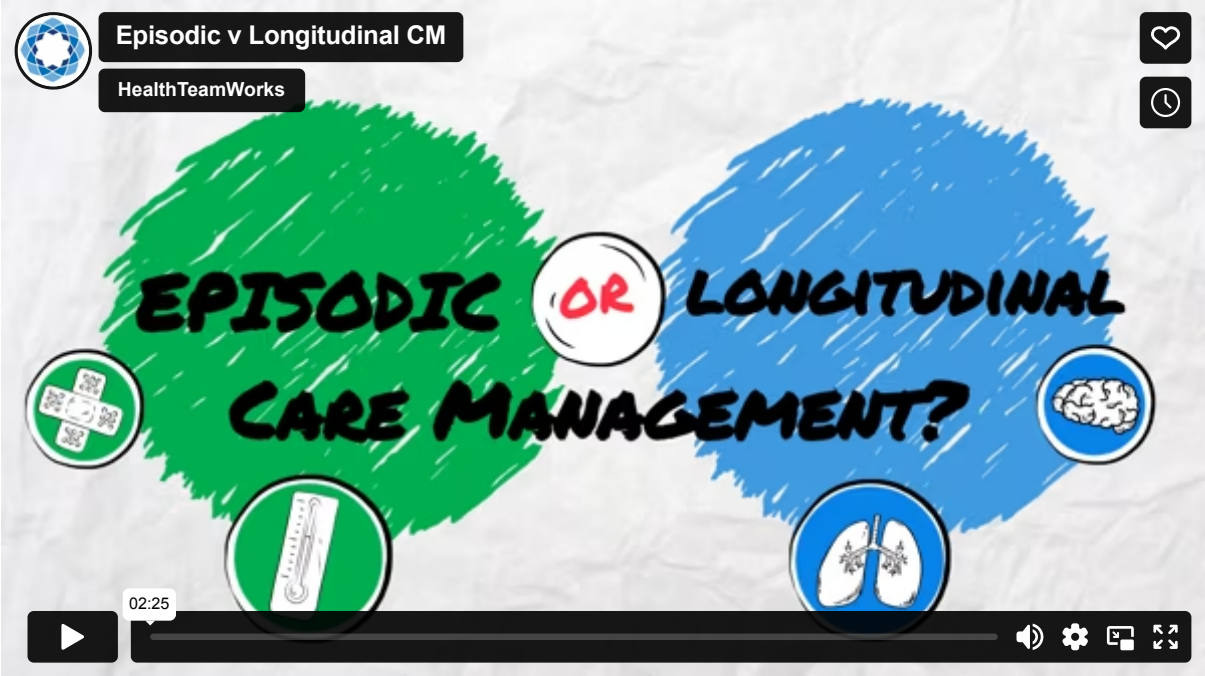

Episodic or Longitudinal Activity

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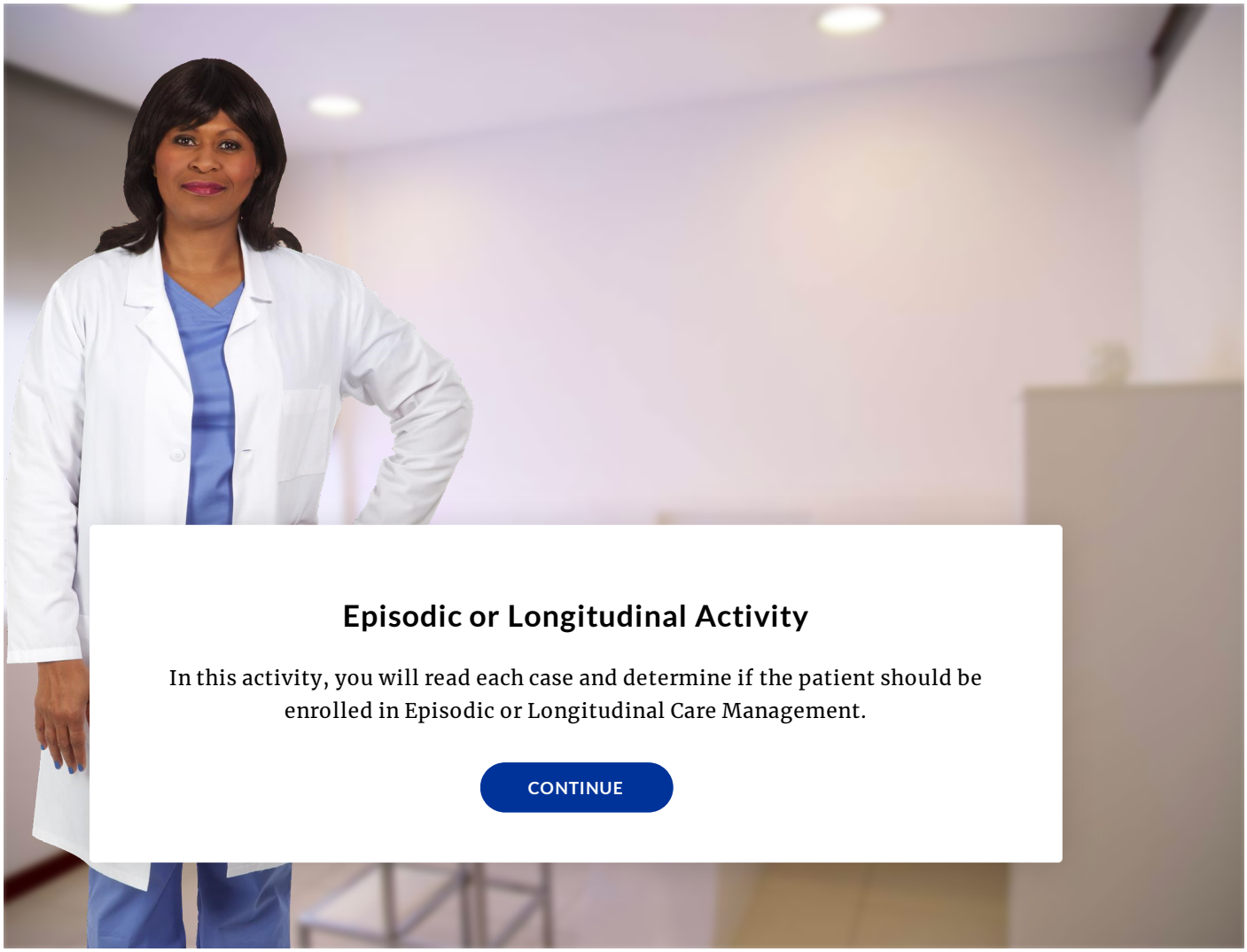

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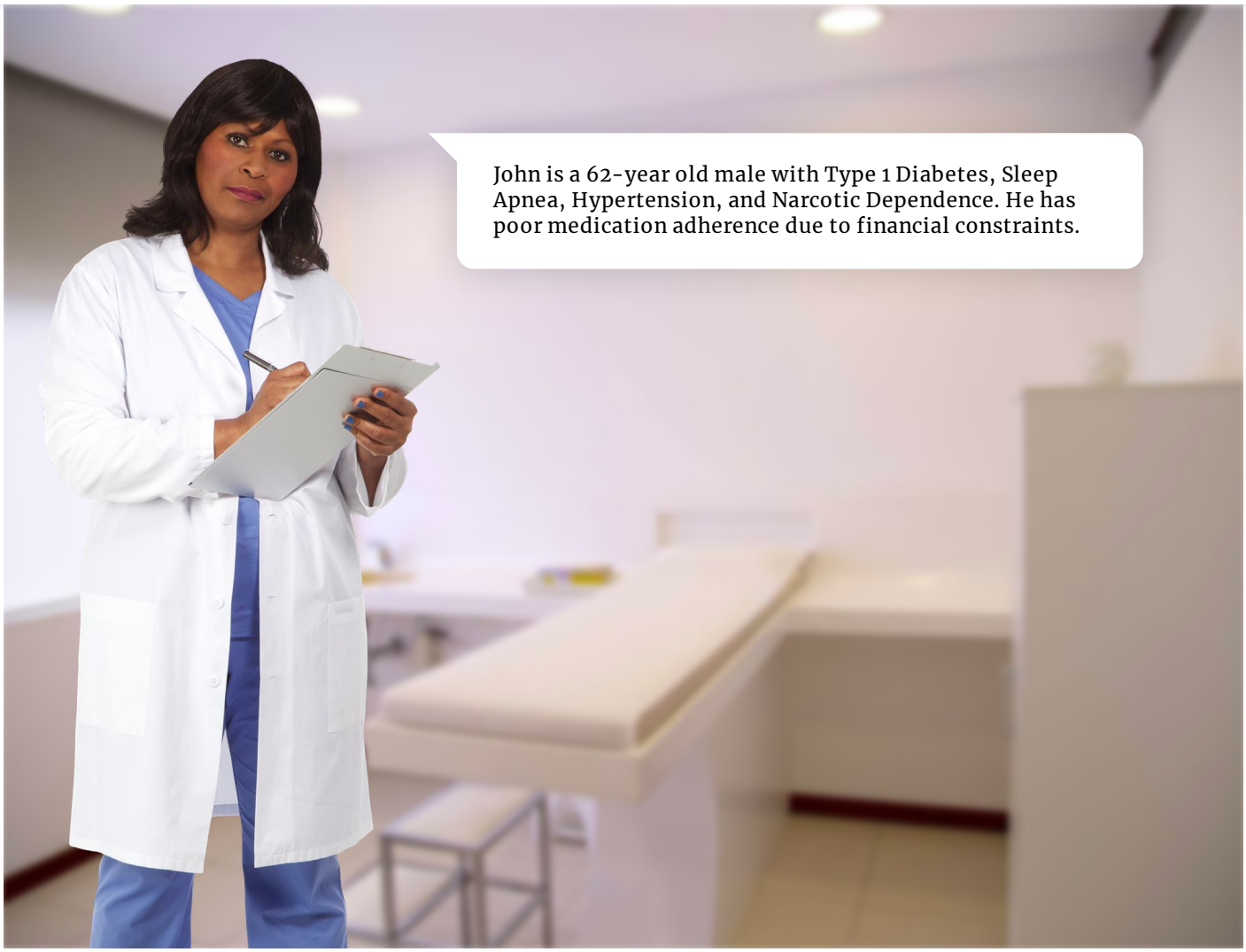

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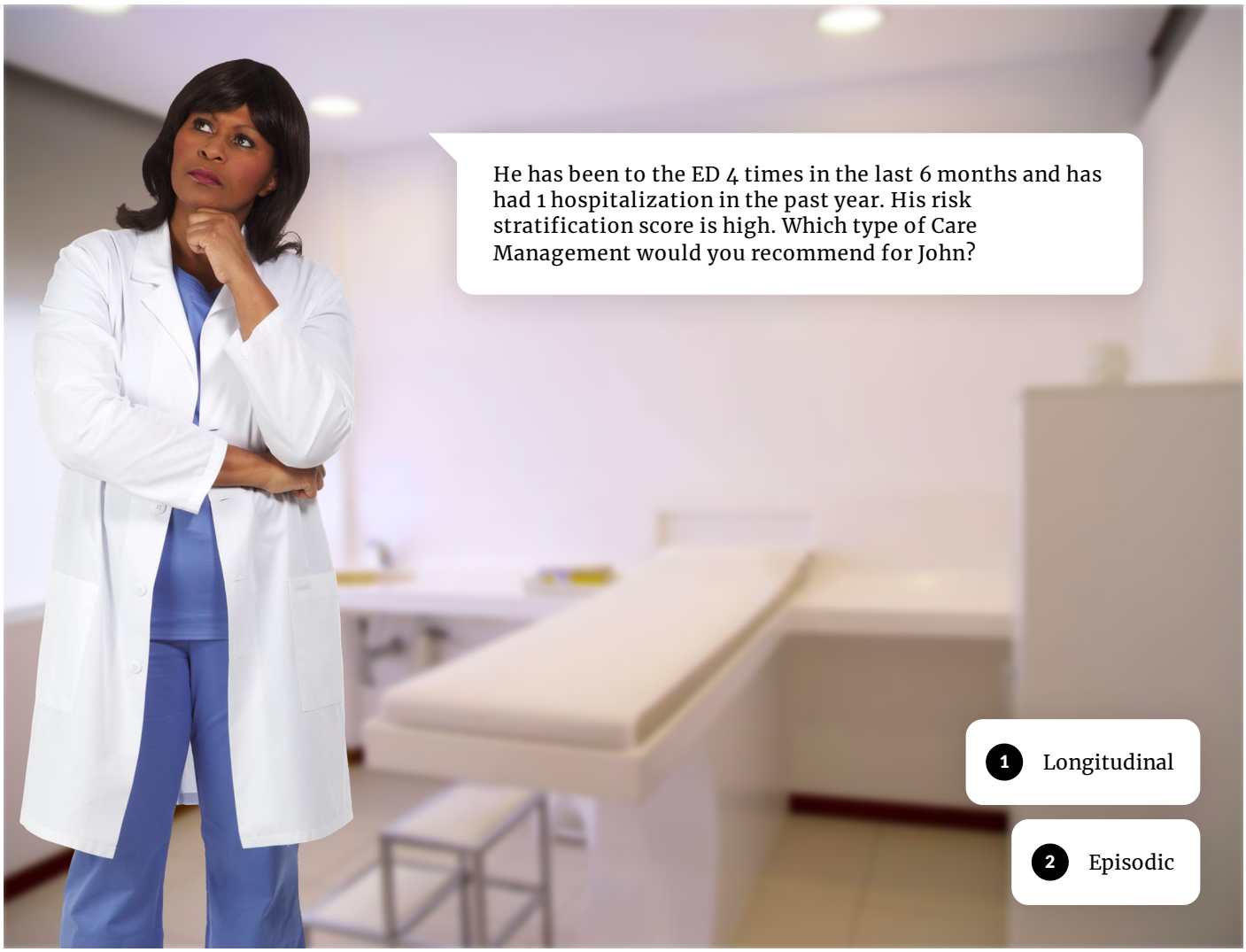

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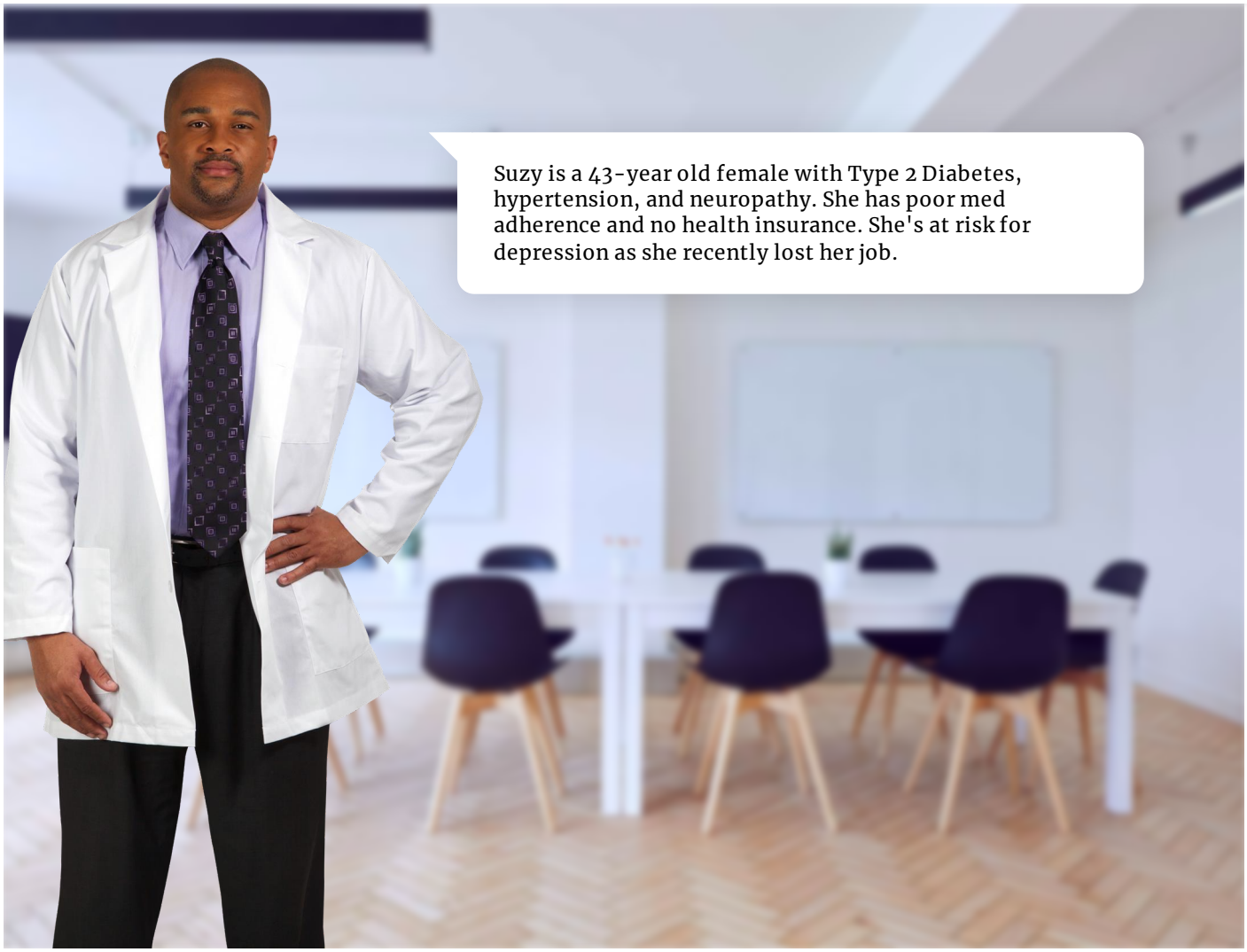

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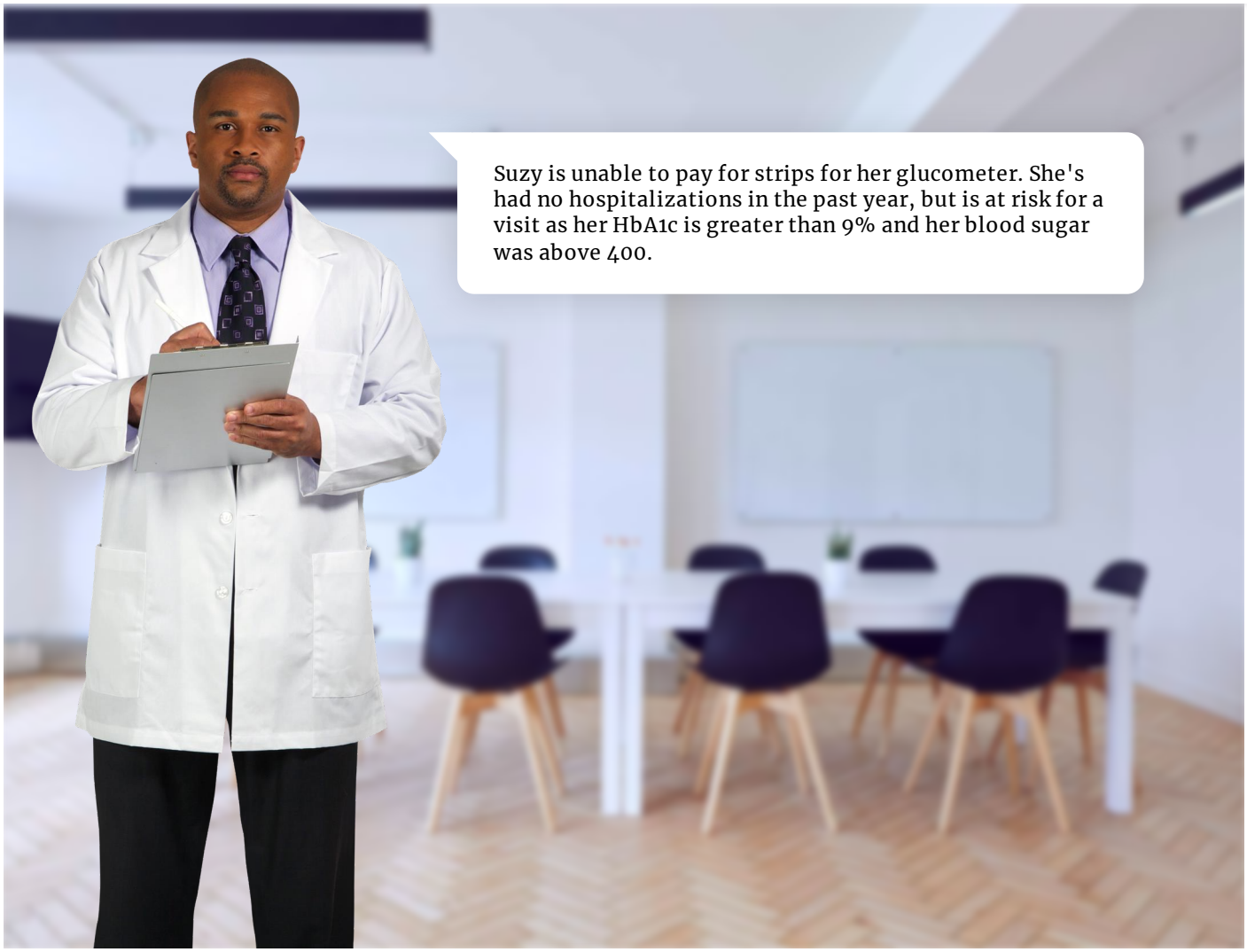

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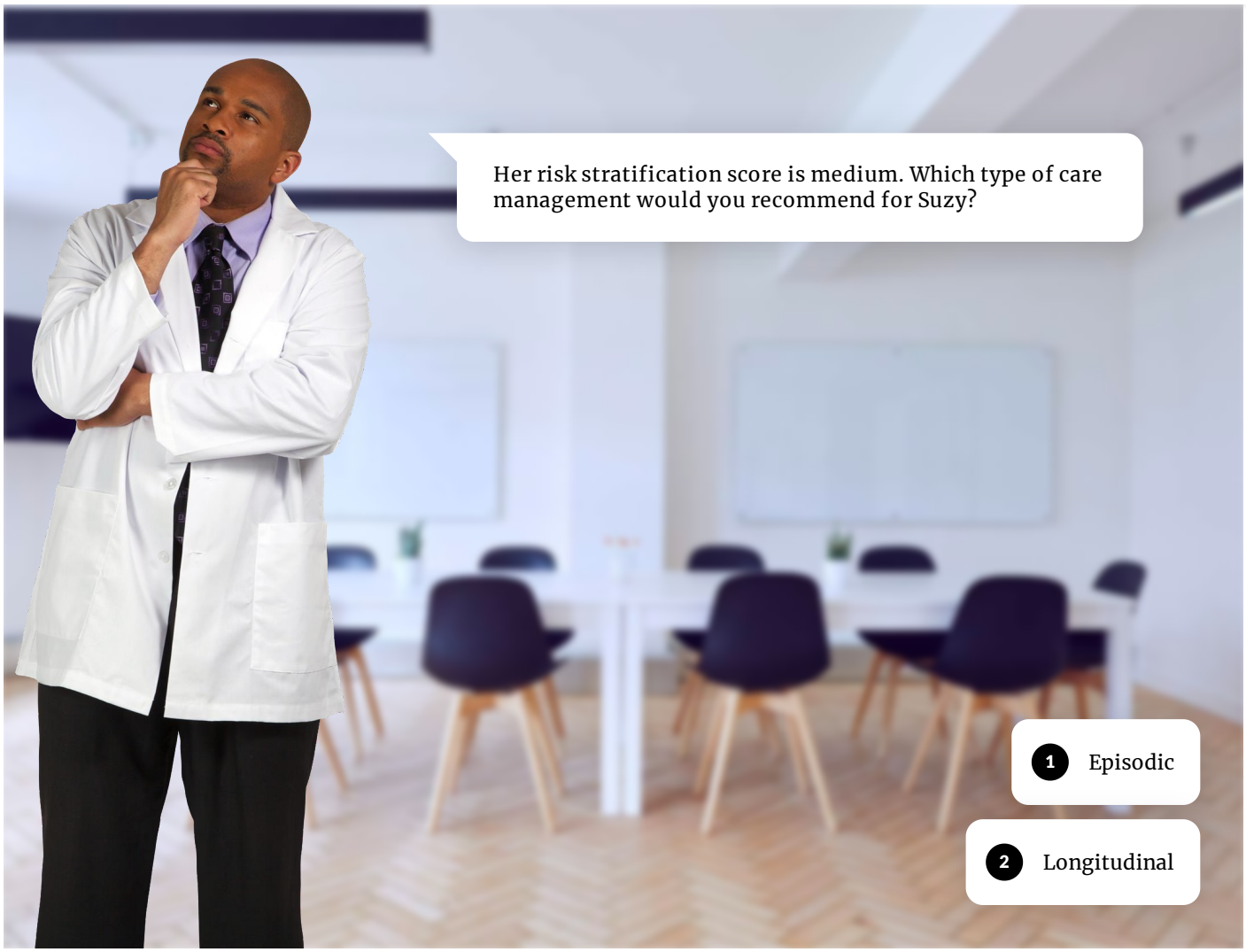

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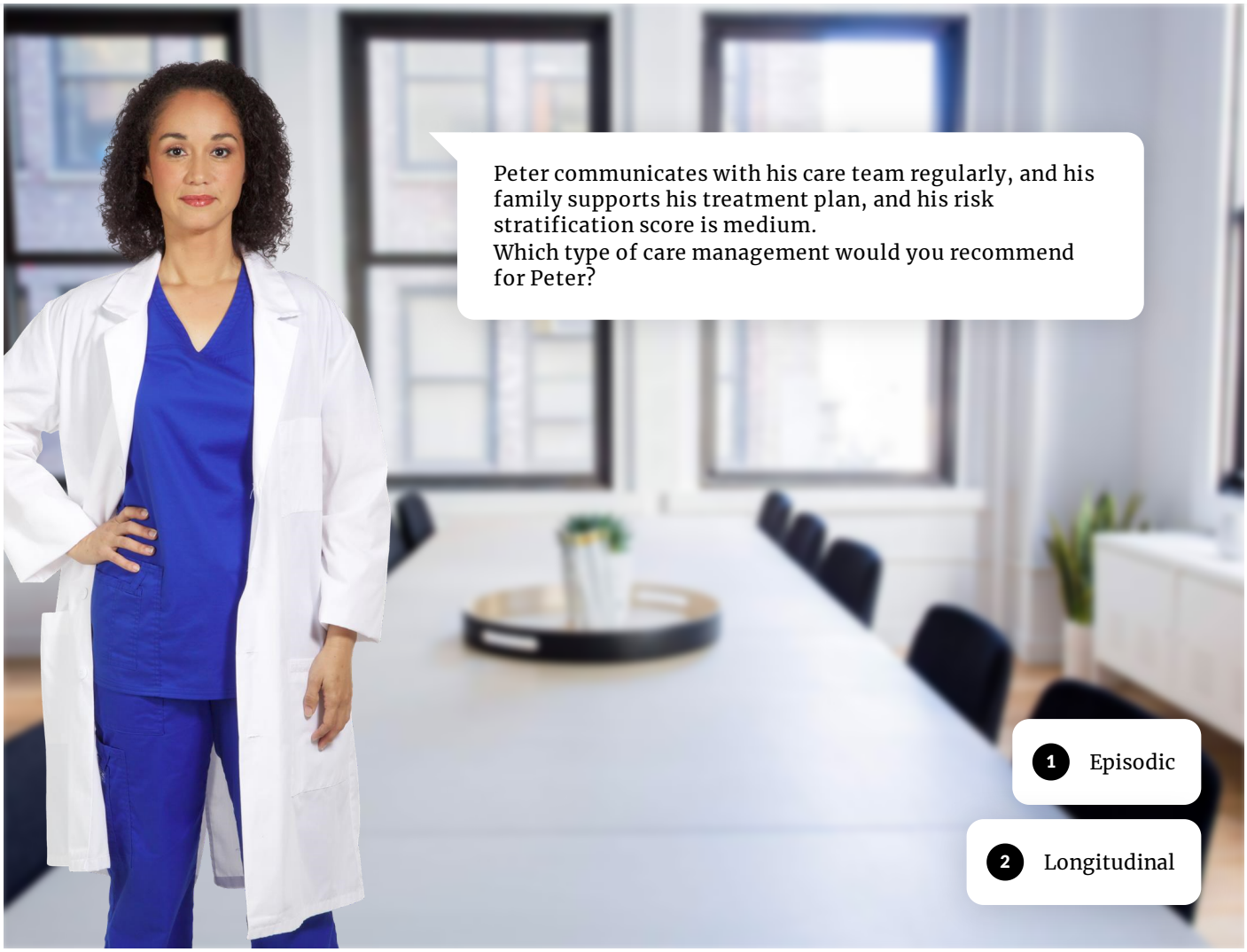

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Interacting with the Community

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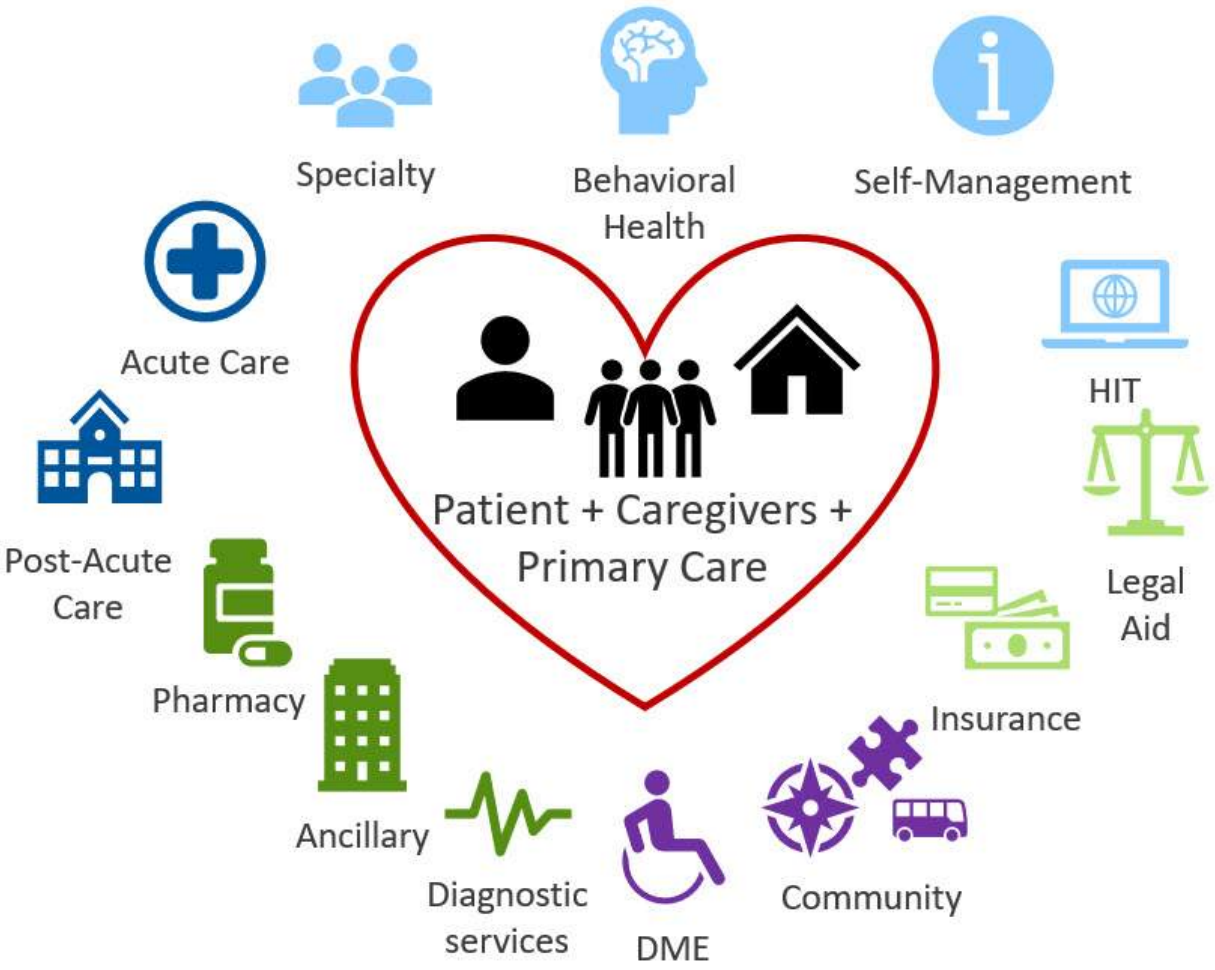
As a Care Manager, it's important to think about the work that you do with and for your patients in terms of THEIR experience on the health care continuum. No matter if they have a chronic condition, an acute illness that requires a long recovery, mental health, and/or social needs – think about the patient's EXPERIENCE of care from their perspective.

As you look at the graphic below, consider one of the complex patients that you have cared for in the past. Which areas of the healthcare community did they interact with? Primary care…. Hospital…. Home care…. SNF…. Lab…. All of these? Some of these? Other areas?



Now, as you consider that, think about the emotional impact of the complex condition. Think about the uncertainty the patient may feel. Are they fearful? Do they have worries about finances? There may be worries about who might care for their children, or aging loved ones. The 'not knowing' what will happen next, or figuring out how to get to an appointment can be stressful. Consider how it feels trying to make sense of all of the appointments and treatments, and requirements to self-manage. It can be overwhelming for patients. Now looking at it from this perspective, it's easier to see why someone isn't 'compliant.'

Patients don't necessarily make a conscious choice to not be compliant. They may make a conscious choice between paying the rent and buying medications. They may have to choose between paying for childcare or a co-pay for a specialist visit. Individual circumstances impact a patient's ability to follow the prescribed treatment plan.

It is precisely these circumstances that call for a Care Manager.

Understanding the patients' experience in this way will give you the empathy needed to help facilitate their care in the best way possible.

Knowledge Check

Question

01/05

Which of the following statements are key parts of a strong definition of Care Management? Choose all that are correct.

- [ ] Team-based
- [ ] Effective management of medical conditions
- [ ] Care Coordination
- [ ] Patient-centered

Question

02/05

All care management teams MUST include an RN, LPN, Social Worker, MA, and a Community Health Advocate.

- ○ True
- ○ False

Question

03/05

Functions of the role of a Care Manager include (choose all that are correct):

- [ ] Psychosocial assessments
- [ ] Transitions of care calls
- [ ] Care plan support
- [ ] Referrals to community resources

Question

04/05

Choose the most accurate example(s) of Episodic Care Management from the following list (choose all that are correct):

- [ ] The patient has multiple chronic conditions.
- [ ] The patient has had one recent hospitalization or ED visit in the past 12 months.
- [ ] The patient has been diagnosed with a serious mental illness.
- [ ] The patient is experiencing a transition to a new care setting.

Question

05/05

Care management functions are optimally often performed by one or more of the following (choose all that are correct):

- [ ] Registered Nurse
- [ ] Lead Provider
- [ ] Front Desk Staff
- [ ] Medical Assistant

Activity Instructions

Practical application of what you are learning helps with skill development and retention. We have created an activity that will guide you in that type of application.

- [ ] Visit https://www.healthteamworks.org/resource/essentials-care-management-activities-and-resources.
- [ ] Find and download the activity assigned for this course.
- [ ] Complete the activity. You are encouraged to work with your team to complete the activity.
- [ ] Email the completed activity to caremanagement_nachc@healthteamworks.org.

- [ ] Make sure to add the Course Activity Title you are submitting and your full name to the Subject Line of your email.
- [ ] You will receive feedback on your completed assignments.