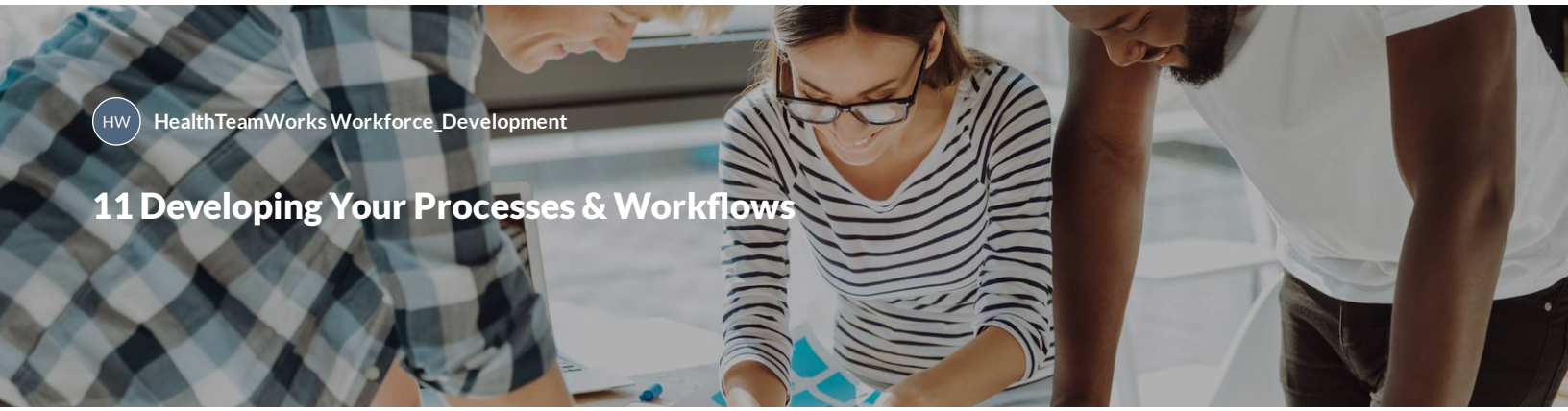

HW HealthTeamWorks Workforce_Development

11 Developing Your Processes & Workflows

- Introduction & Learning Objectives
- Processes and Workflows for Episodic Care Management
- Considerations for Developing a Process and Workflow to Prioritize Patients for ECM
- Processes and Workflows for Longitudional Care Management
- Considerations for Developing a Process and Workflow to Prioritize Patients for LCM
- Developing a Longitudinal Care Management Process
- Balancing ECM and LCM Responsibilities
- Test Your Knowledge
- Activity Instructions

Lesson 1 of 9

Introduction & Learning Objectives

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01:05

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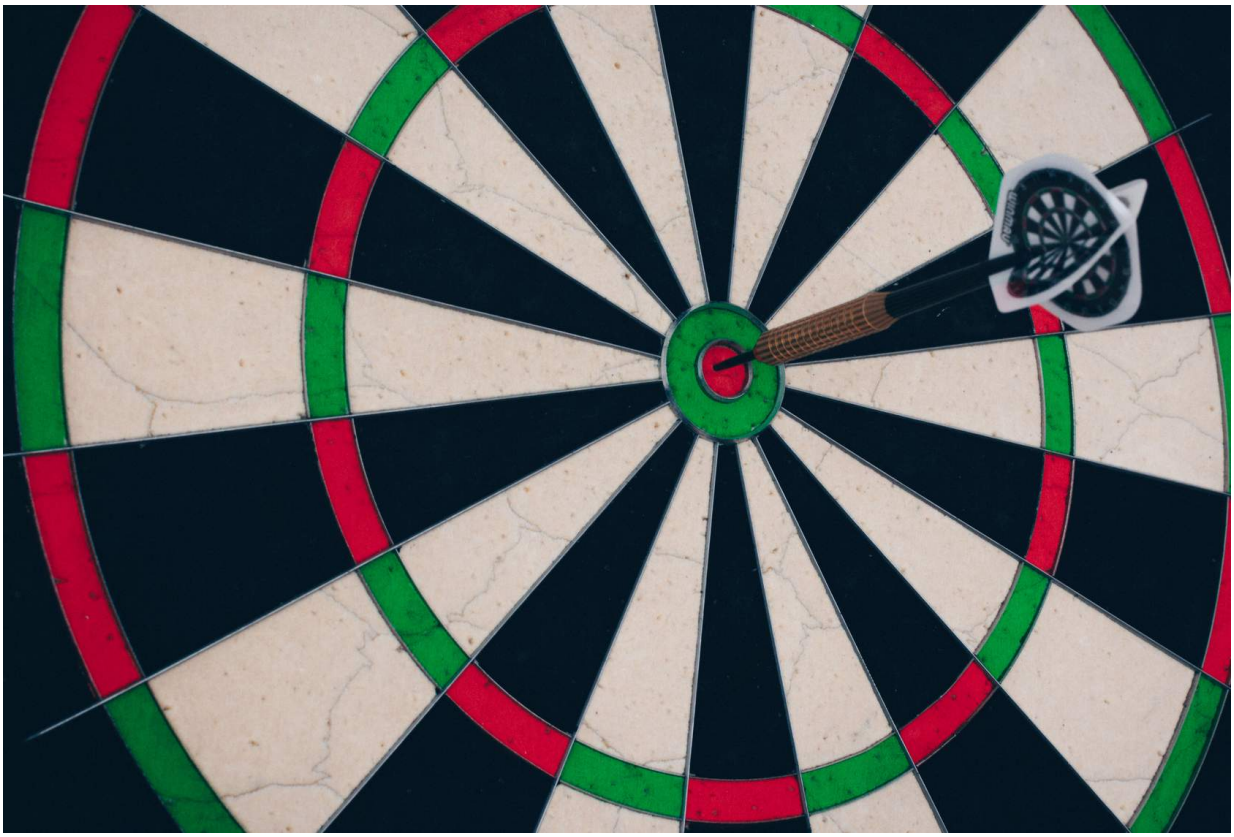

Now that you have learned how to process map, you see how this will inform your workflows. Workflows can be developed for any process that takes place on a regular basis. Staffing a mix of the care management team when possible will impact how a process is developed for prioritizing patients who need Episodic Care Management or Longitudinal Care Management. Work with leadership to ensure that any workflows developed are in alignment with payer contracts, shared savings programs, or other programs in which the practice is participating.

Learning Objectives

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

- Develop strategies for documenting workflows that will adhere to practice or organizational standards.
- Identify the key considerations in developing processes and workflows for Episodic as well as Longitudinal Care Management.

Processes and Workflows for Episodic Care Management

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04:46

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Documenting a process into a workflow is helpful for several reasons. The top two reasons include:

1. It solidifies the process and can be referred back to for onboarding and training.
2. In documenting the process, you can easily identify if there are steps that aren't essential or a waste of time, and then remove that step from the process.

If you are the first Care Manager in a practice, more than likely it will be up to you to figure out your different processes and develop the workflows. On the other hand, if there are already workflows established, you can examine them with a critical eye and see if modifications need to be made.

Keep in mind that developing processes IS a process and things may need to adapt over time!

Following are some ideas to get you started in thinking about what kinds of workflows you may want to develop for Episodic Care Management:

- How to identify patients that need Episodic Care Management (ECM) - if you receive electronic notifications, document how these come through, how often, when you receive the data, etc.
- How to prioritize patients that need ECM. E.g., In-patient discharges should be first in the order of priority, then ED visits, etc.
    - Do you have several members on the care management team? If so, how do assignments get made? Once assignments are made, how does each team member prioritize the patients?
    - Are patients prioritized by risk level? By reason for being in ECM such as in-patient discharge or ED visits, etc.
    - Do you use a combined approach to prioritizing? What does that look like?
- A process to conduct outreach
    - This workflow can be similar to the "4 Steps" that were discussed in the Patient Assessment and Documentation for Episodic Care Management course. You can document the different steps you need to take, pertinent details around documentation, etc.
    - You may also include your requirements for how many times to attempt to reach a patient, and what to do if it is unsuccessful.
        - Many practices have a process for making three attempts then sending a letter after the third attempt.
        - You may also build into the workflow details about seeking different contact information from another source or reaching out to a designated contact in the EHR if the phone number is not working.
- How to notify and engage the PCP when concerns are identified
    - Is there a way to flag a note in the EHR to indicate it's a high priority?
    - If not, do you need to just walk down the hall and speak with the provider? Does it depend on the circumstance whether you walk to the provider or route through the EHR?
    - Can the PCP hand off the follow up to their MA or should the care manager be the one to follow up? Does it depend on certain factors? If so, what does this look like? If it can be followed up on by the MA, how will the care manager be brought in the loop once the issue is resolved?

- How to collaborate with care managers in target facilities
    - What does this look like?
    - Is it a regular event or just as needed? If it is regular, is there a conference line?
- Process for transitioning a patient from ECM to Longitudinal Care Management (LCM)
    - This is for patients that you're following in ECM and realize that they will need longer-term care management services. What does it look like to transition them over? Do you need to do some type of enrollment in the EHR? Should you flag the patient? Does the patient get a letter, specific information about the LCM program?

These are just a few ideas to get you started thinking about the different workflows to establish for ECM. One helpful tip is to start with a relatively small workflow while you're learning how to do this. You can even engage members of the care team for their input. Sometimes people outside of the process can see things that we aren't able to see because we're so close to it which makes it difficult to remain objective.

Considerations for Developing a Process and Workflow to Prioritize Patients for ECM

HW HealthTeamWorks Workforce_Development

03:37

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Earlier in this learning path, you learned about identifying patients for ECM and using risk stratification to prioritize the patients that you've identified. Now, we're going to put these concepts together and look at how you might develop a process & workflow to show the order in which patients should receive outreach.

Some important things to keep in mind as you develop a process to prioritize patients for ECM:

- Staffing mix of the Care Management Team will influence how the work is divided and prioritized. If your practice has more than one care manager, it's helpful to align the different skill sets/licensure of each individual care manager to the patient's risk level (e.g., RNs work with more complex patients, MAs work with less complex patients). If you are the only care manager in your practice, then developing the workflows will be a bit more straightforward.
- Remember that high-risk patients are generally the first priority in any workflow. Regardless of the reason they were referred in for ECM, if they are high risk, they should be addressed first in your workflow. This is because in general, high-risk patients

are more likely to have complex needs and therefore have many opportunities for a care transition to not go as planned.

- In practices with an exceptionally large population and only one care manager, sometimes you need to take a creative approach to address the volume of patients in ECM:

  - Some practices have successfully used the patient portal or automated calls for outreach to SOME low and medium risk patients that have had an ED visit.
  - If you opt to use something like automated calls or a message through the portal, be sure that this is NOT used for any inpatient discharge or for high-risk patients that have been to the ED. Patients in those categories require phone outreach to assess the individual's status and determine if anything is needed to manage the transition.
  - Not all low and/or medium risk ED patients would be a candidate for an automated outreach like a portal message or robocall. You will need to look at the record from their visit and use critical thinking to determine if an automated contact is appropriate. For example:
    - A patient that was seen in the ED for a head contusion or concussion should be contacted by phone, no matter what the risk score.
    - A patient that used the ED for something simple like a subbed toe likely does not need phone contact
  - If you are going to consider using an automated approach for some of the patients, it's helpful to standardize this in the workflow. Include details like what would qualify someone to be contacted in this way and what might disqualify them from an automated outreach.

- As a general rule of thumb, all inpatient discharges should receive telephonic outreach.

As you begin to look at developing workflows, it will be a good idea to work with leadership in your practice to establish criteria for which patients are a priority. For example, many practices participate in shared savings programs and alternative payment models, like CPC+ and PCF, and have specific requirements regarding outreach and utilization. The care management program should align with these initiatives, and the leadership team will be able to help ensure that everything is aligned.

Processes and Workflows for Longitudinal Care Management

HW HealthTeamWorks Workforce_Development

03:04

Click to Play Audio

Below are a few ideas to get you started in thinking about what kinds of workflows can be developed for Longitudinal Care Management (LCM) and things to consider with each item. This is not a complete list, but a few ideas to get you started.

- ☐ Identification of patients
- ☐ Enrollment into LCM
- ☐ Outreach to patients
- ☐ Addressing concerns when patient unstable
- ☐ Care Plan Follow Up
- ☐ Graduation from LCM

- How to identify patients that may benefit from LCM
  - This might include running a report once a month of the high-risk patients and reviewing the top ten for each provider to determine eligibility.
  - It may also include eligibility criteria and how to work through a process to determine if the patient is eligible for LCM.
- Enrollment into LCM
  - Is there a defined set of steps?
  - Is patient verbal consent one of the steps or is written consent to participate required?
  - Are there any specific paperwork requirements for the patient and/or Care Manager in the enrollment process?
  - Is there a step to "flag" the patient in the EHR so all care team members know the patient is care managed?
- A process to conduct outreach

- This workflow can be similar to the "5 Steps" discussed in the LCM module. You can document the different steps you need to take, pertinent details around documentation, etc.
- You may also include this in your requirements for how many times to attempt to reach a patient (and what to do if you are unsuccessful).

- How to notify and engage the PCP when concerns are identified

  - Is there a way to flag a note in the EHR to indicate it's a high priority?
  - Do you need to just walk down the hall and speak with the provider? Does it depend on the circumstance whether you walk to the provider or route it through the EHR?
  - Can the PCP hand off the follow up to their MA or should the care manager be the one to follow up? Does it matter? If so, what does this look like? If it can be followed up on by the MA, how will the care manager be brought in the loop that the issue was resolved?

- How to follow up on the patient's care plan

  - Is there a requirement for how often this needs to be completed? Once a month? More frequently? Are there dependencies? If so, what are they?
  - Do you need to document on the record that the care plan was reviewed and updated?
  - Are you required to add new goals each month?
  - How do you document the completion of a goal?

- Graduation from LCM

  - Is there a set of criteria for graduation?
  - Do all patients graduate? Are there some patients discharged due to lack of engagement? If a patient can be discharged, what are the criteria for this?
  - Does a "flag" need to be removed in the EHR when a patient graduates?

Lesson 5 of 9

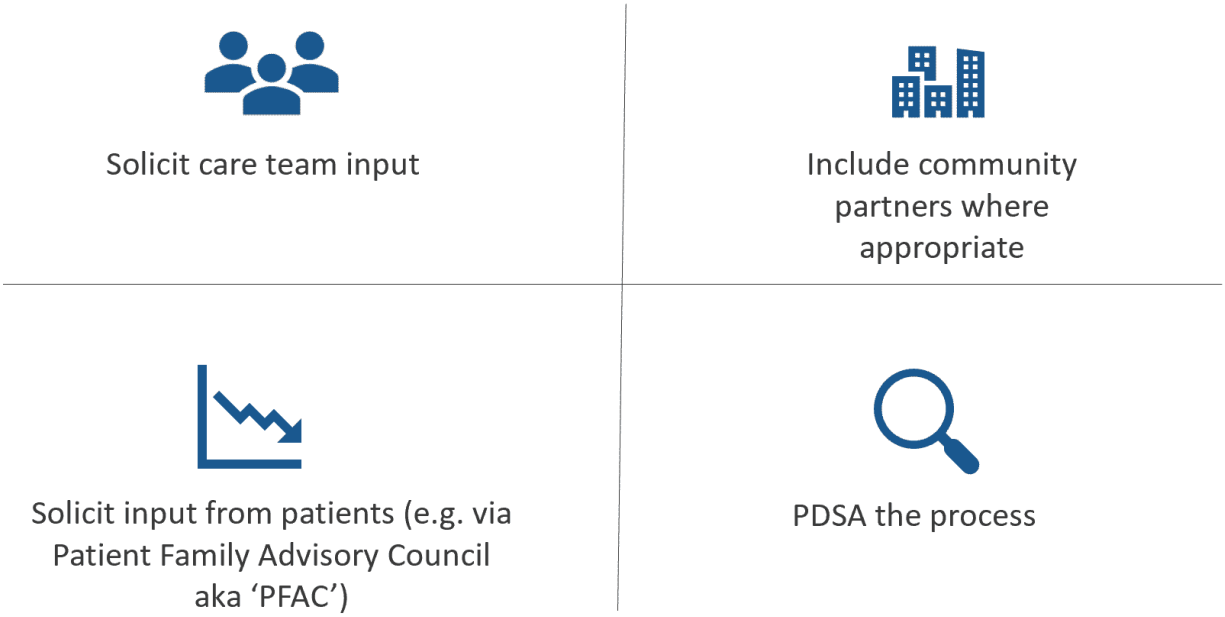
Considerations for Developing a Process and Workflow to Prioritize Patients for LCM

HW HealthTeamWorks Workforce_Development

02:31

When developing workflows for LCM, remember that you're not on an island. Everything you do impacts the entire team, the flow, and their processes. Due to this, gathering the input from the entire care team is incredibly valuable. Oftentimes, they will have insight into how a new workflow will impact their work or efficiency and you can work together to address this up front.

It's also helpful to ask for input from the patients you serve. This can be done via the Patient Family Advisory Council (PFAC). Many practices that have implemented an effective PFAC report that the input from this team is invaluable and they often have a perspective that the care team might not be privy to on their own. A PFAC's input can help avoid mishaps in certain processes and workflows.



- For example, the PFAC may provide great insight as to what information to include in a welcome letter for LCM.
- They may also have helpful ideas about the process for outreach and enrollment into LCM, especially for cold calls.

- Share phone scripts with the PFAC for input. Simple ideas like changing a few words can make all the difference in having content that will speak to your unique population.

Additionally, don't forget to include community partners in developing workflows that impact them. For example, a workflow addressing coordination of care for a patient in home health should include input from the home care agencies that your population commonly use. They will have insight as to the timing of calls to their field RNs when information is needed. They will also be able to provide good ideas about effective ways to exchange information.

Last, but not least, "PDSA" or test the process. PDSA stands for "Plan, Do, Study, Act". Approach the development of new processes with an open mind and an intention to revisit the process within a specified amount of time to evaluate its effectiveness. Be fearless in your approach and be willing to adjust based on your findings from the evaluation. Remember that everything we do is a process and it's important to continuously learn and grow.

Developing a Longitudinal Care Management Process

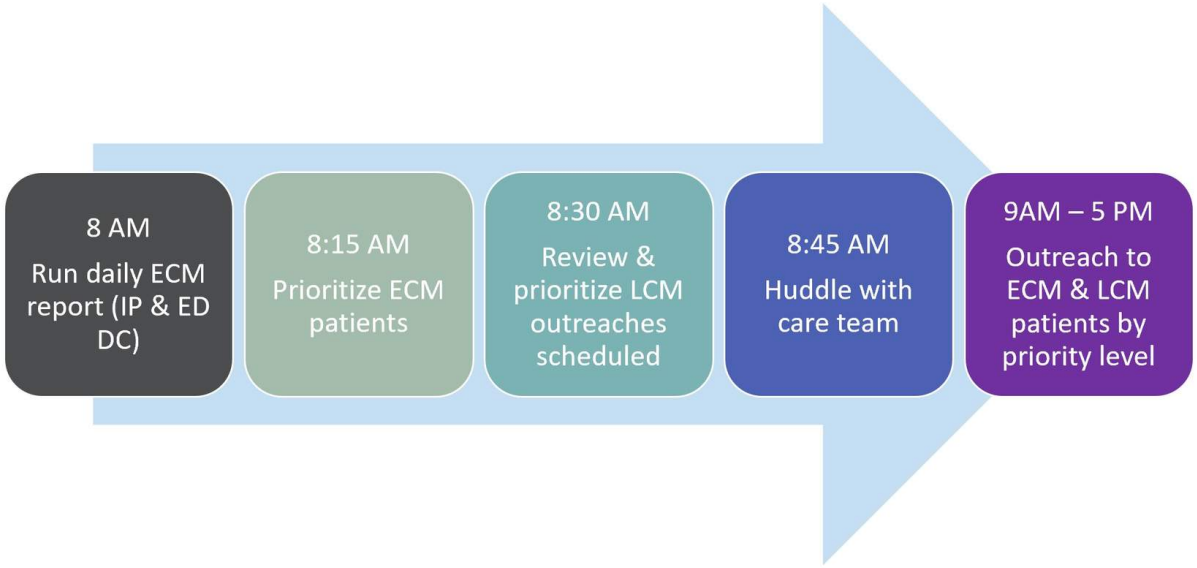
HW HealthTeamWorks Workforce_Development

02:20

Click to Play Audio

In order to develop an effective process for LCM, the Care Manager needs to be able to envision what the average day should entail.

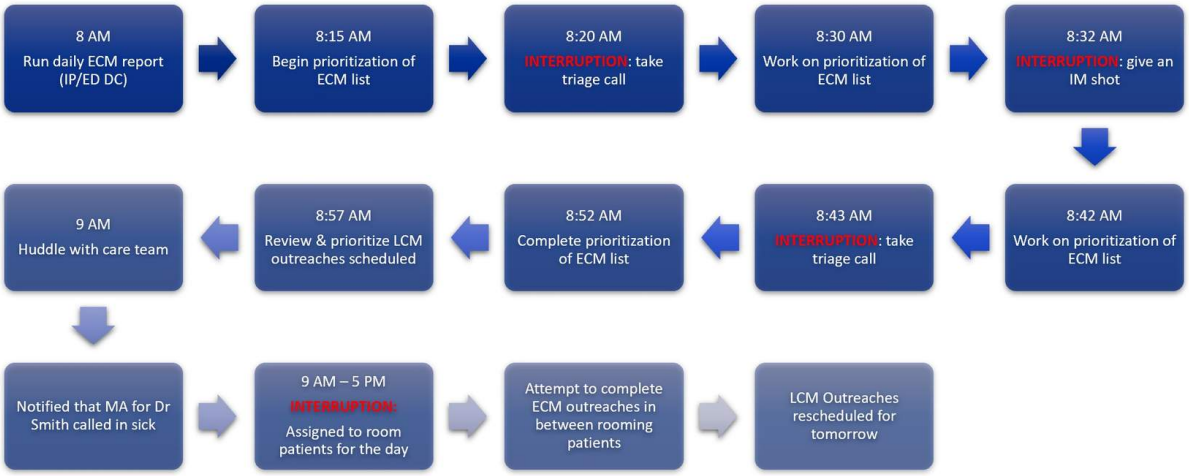
In an ideal world, and what is conveyed to most Care Managers when they are hired, it would look similar to this:



1. First, the day starts off by running the daily report of ED and IP discharges and is followed up by a quick prioritization of these patients.
2. Next, the Care Manager looks at the list of patients in LCM that are scheduled for outreach that day.
3. Next, the Care Manager huddles with the care team to review the run of day, discuss which patients are coming in and which ones might be referred to the Care Manager for a warm hand-off (this allows the Care Manager to know when she/he might get pulled into an exam room for a few minutes, thereby allowing adjustment of outreach calls that may take longer).
4. After the huddle, the Care Manager begins outreach to ECM and LCM patients by priority.

Ideally, the Care Manager is able to maintain focus on the ECM and LCM patients that need outreach – and this focus is able to be maintained for the entire day, with some occasional interruptions for new referrals to LCM, or phone calls from ECM/LCM patients that have concerns.

However, for most CM's, the typical day does not look like this. For the majority of Care Managers in primary care, the average day looks more like this.



In looking at this, we imagine that you see both the humor and the absurdity of this. And that you recognize how truly challenging it can be to complete the work that you're tasked with.

Most likely, this isn't an exact replica of where your challenges lie with prioritizing and completing the work of a Care Manager. But this does get to the heart of the issue, and how the Care Manager role has been diluted with tasks that could be completed by others in the practice. It is imperative that you gain the support of your leadership team. In order to do this, it will be important to show them how and where you are pulled into non-care management tasks and are unable to complete the care management tasks for which you're responsible.

Balancing ECM and LCM Responsibilities

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02:08

Click to Play Audio

Care Managers that are responsible for both Episodic and Longitudinal Care Management face particular challenges in balancing both of these tasks.

Challenges	Solutions
Volume of ECM patients is too high to juggle both ECM & LCM responsibilities	Engage other care team members to assist with ED & Inpatient follow up calls
Frequently asked to complete non-Care Management tasks, causing multiple interruptions and making it difficult to focus on CM responsibilities	Engage leadership to help protect CM time ***And*** Non-Care Management tasks moved to low priority (e.g. administering IM injections, phlebotomy) or completely removed from job responsibilities
Too much time spent on chart review or other tasks that can be streamlined	Streamline processes & build in efficiency (e.g. standardized chart review method to save time)

For practices with high inpatient and/or ED utilization, the sheer volume of patients that require Episodic Care Management may fill up the majority of the day, especially if one or more of the patients is decompensating or has complex needs that require significant effort to coordinate and manage.

An additional challenge is the simple reality of working in a practice where patients need to be seen on time, and where there are staffing challenges like role turnover, people calling in sick, and vacation days that need to be covered. Many Care Managers are tasked with the additional responsibility of completing numerous non-care management tasks, like filling in when the team is short staffed, giving IM injections, taking triage calls, and drawing blood.

We can't stress enough the importance of having the support of your leadership team to help protect your time as the Care Manager, and to help hold the line when you are being pulled into non-care m tasks.

Because Episodic Care Management typically has specific dollar amounts tied to outreach (utilization of TCM codes, shared savings from insurance companies (aka "payers") when Inpatient and ED utilization is decreased), it is often prioritized before LCM. Additionally, the urgency of outreaching to a patient after an acute event creates a certain pressure to prioritize ECM over LCM.

That said, it's important to maintain sight of the urgency of working with patients that will benefit from LCM. Often, these are patients with serious conditions and a potential threat for high utilization, and if intervention occurs early through an LCM program, this threat can be avoided in many circumstances.

Test Your Knowledge

Question

01/05

Considerations when developing an ECM process include...

- [ ] Prioritize highest risk patients first
- [ ] Using automated calling is not a good use of your time
- [ ] Wait for calls from recently discharged patients...don't call them
- [ ] Align staff skill set to the patient's risk level

Question

02/05

When developing an LCM process, it is a good idea to solicit feedback from a PFAC (Patient Family Advisory Council).

- ◯ True
- ◯ False

Question

03/05

PDSA stands for...

- Plan
  Do
  Sustain
  Activate

- PFAC
  Doctor
  Study
  Ambulatory

- Plan
  Do
  Study
  Act

- Plan
  Document
  Study
  Attitude

Question

04/05

Envisioning your ideal work day and sharing it with leadership in the practice will ensure that no non-care management tasks are given to you.

- ◯ True
- ◯ False

Question

05/05

When balancing LCM and ECM, build process and workflows that can be standardized in order to increase efficiency as you contact and visit with patients.

- ◯ True
- ◯ False

Activity Instructions

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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.