NATIONAL ASSOCIATION OF Community Health Centers®

HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

CARE MANAGEMENT (102) INTERMEDIATE TRAINING, POWERED BY

HealthTeamWorks® Health. Equity. Resilience.

SESSION #4
OCTOBER 4, 2023
12:30 PM ET

Care Management (102) Intermediate
Session 4

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Session # 3 Recap

- Discussed Integration vs Isolation with Primary Clinical Team
- Characteristics of effective integration
  - ✓Aligned Goals
  - ✓Defined Roles & Responsibilities
  - ✓Effective Communication
  - ✓Measuring for Success – Celebrate or Adapt
- Building Effective Relationships
  - ✓Emotional Intelligence
  - ✓Effective teams many times modeled via CM
  - ✓Start small, share & build
- Identifying or Building effective provider champions
  - ✓High EI
  - ✓Effective communicator
  - ✓Team Player

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

- Clearly defined Care Management Goals
- Talk with your manager
- Job description & workflow clarity
- Educate care team
- Be realistic & Communicate effectively
- Identify alternative solutions and define appropriate referral types
- Implement interdisciplinary care conferences
- Align leadership & Ensure CM champion support

Validate workload: 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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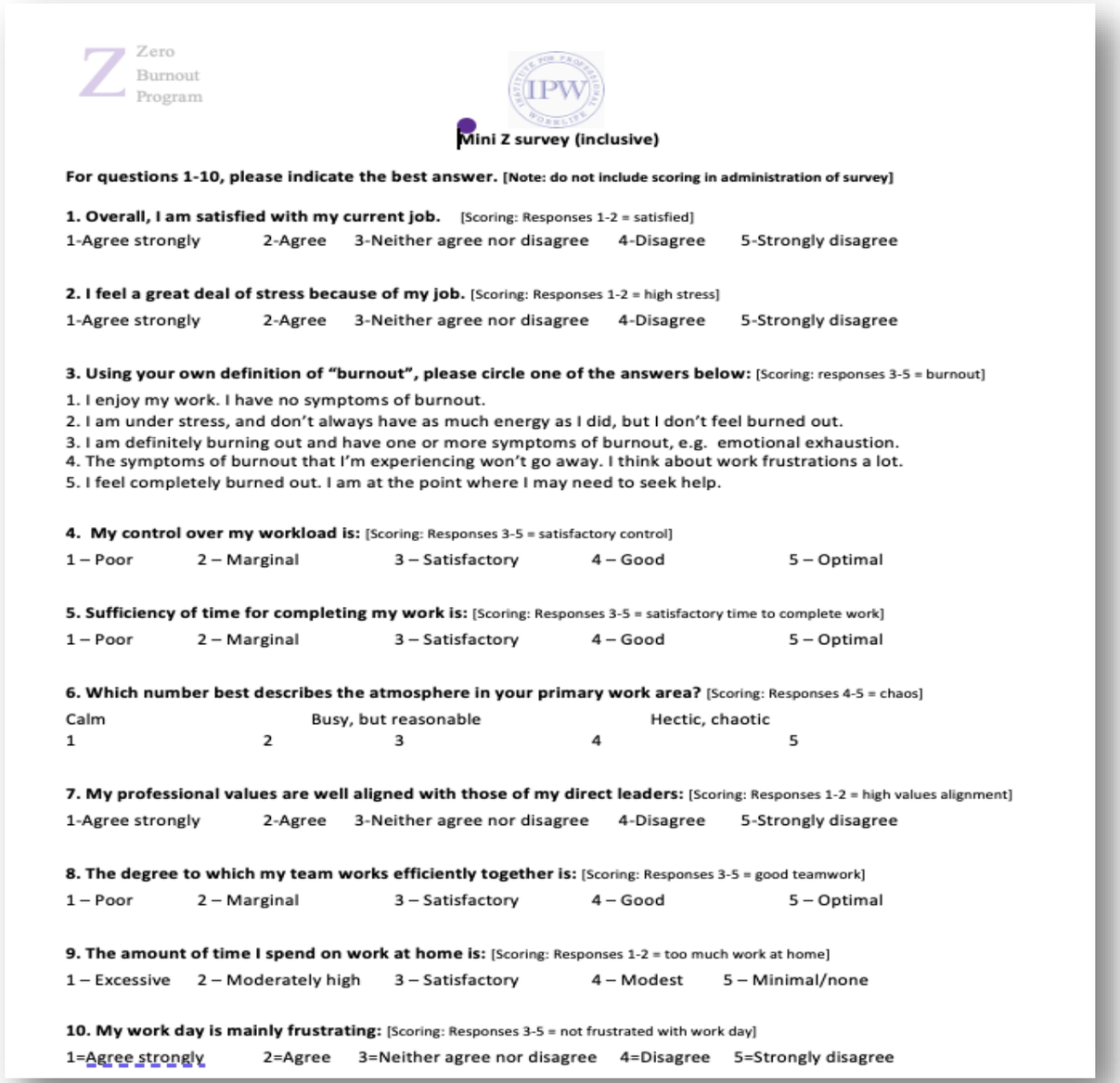
The Impact of Burnout on Patients

- 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

Assessing Burnout



Zero Burnout Program

IPW

Mini Z survey (inclusive)

For questions 1-10, please indicate the best answer. [Note: do not include scoring in administration of survey]

1. Overall, I am satisfied with my current job. [Scoring: Responses 1-2 = satisfied]

1-Agree strongly 2-Agree 3-Neither agree nor disagree 4-Disagree 5-Strongly disagree

2. I feel a great deal of stress because of my job. [Scoring: Responses 1-2 = high stress]

1-Agree strongly 2-Agree 3-Neither agree nor disagree 4-Disagree 5-Strongly disagree

3. Using your own definition of "burnout", please circle one of the answers below: [Scoring: responses 3-5 = burnout]

1. I enjoy my work. I have no symptoms of burnout.
2. I am under stress, and don't always have as much energy as I did, but I don't feel burned out.
3. I am definitely burning out and have one or more symptoms of burnout, e.g. emotional exhaustion.
4. The symptoms of burnout that I'm experiencing won't go away. I think about work frustrations a lot.
5. I feel completely burned out. I am at the point where I may need to seek help.

4. My control over my workload is: [Scoring: Responses 3-5 = satisfactory control]

1 – Poor 2 – Marginal 3 – Satisfactory 4 – Good 5 – Optimal

5. Sufficiency of time for completing my work is: [Scoring: Responses 3-5 = satisfactory time to complete work]

1 – Poor 2 – Marginal 3 – Satisfactory 4 – Good 5 – Optimal

6. Which number best describes the atmosphere in your primary work area? [Scoring: Responses 4-5 = chaos]

Calm Busy, but reasonable Hectic, chaotic

1 2 3 4 5

7. My professional values are well aligned with those of my direct leaders: [Scoring: Responses 1-2 = high values alignment]

1-Agree strongly 2-Agree 3-Neither agree nor disagree 4-Disagree 5-Strongly disagree

8. The degree to which my team works efficiently together is: [Scoring: Responses 3-5 = good teamwork]

1 – Poor 2 – Marginal 3 – Satisfactory 4 – Good 5 – Optimal

9. The amount of time I spend on work at home is: [Scoring: Responses 1-2 = too much work at home]

1 – Excessive 2 – Moderately high 3 – Satisfactory 4 – Modest 5 – Minimal/none

10. My work day is mainly frustrating: [Scoring: Responses 3-5 = not frustrated with work day]

1=Agree strongly 2=Agree 3=Neither agree nor disagree 4=Disagree 5=Strongly disagree

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Questions and Discussion

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Course 3
Building your Community Network

Module 1
Identifying Community Resources

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Objectives

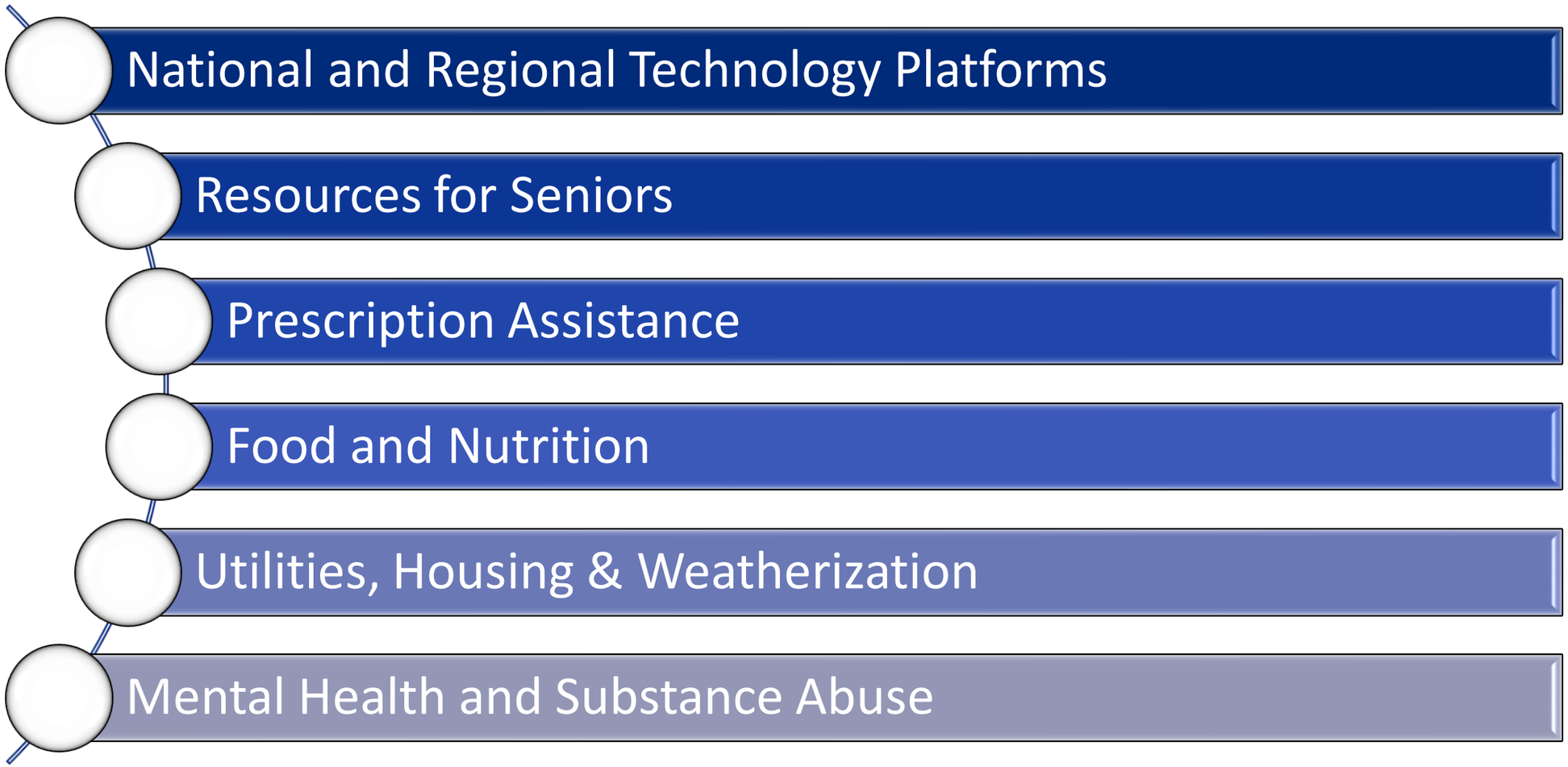
- Identify common community resources to assist patients enrolled in Care Management in meeting social needs.
- Discuss effective approaches to community partnerships.
- *Analyze sample data to identify prevalent social needs in the population that can then be translated into strategies in the practice*.

Data Informed Community Resource Discussion

- How many use data to identify what community resources are most valuable to your CM Population?
  - Structured data/reports
  - Anecdotal data – or Qualitative data

- How do you currently identify community resources to meet your patients' need?

Community Resources



Resources for Seniors

Area Agency on Aging

Local Senior centers

Meals on Wheels

Prescription Assistance

- Pharmaceutical Companies
- RxAssist
- Needy Meds
- GoodRx
- Disease Specific Organizations

Food and Nutrition

- FOOD BANKS & FOOD PANTRIES
- SOUP KITCHENS
- WIC
- SNAP

Utilities, Housing, and Weatherization

Mental Health and Substance Abuse

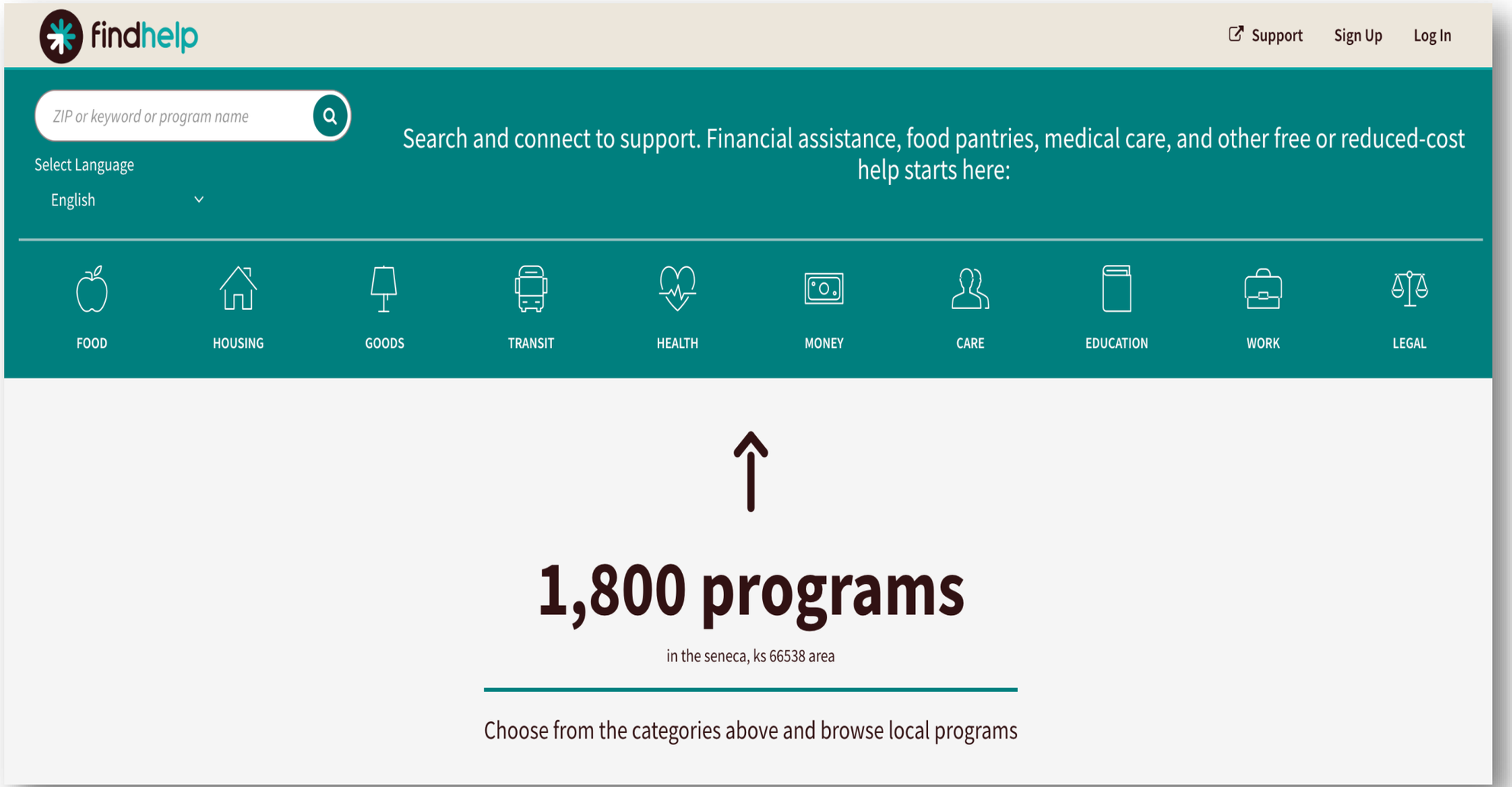
National Alliance on Mental Illness

National Suicide Prevention Lifeline

Identifying Resources Specific to Your Community

- Community Action Agencies
- Legal Aid Society
- YMCA
- Library
- Churches

Resources



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Data to Identify Prevalent Needs

- EHR Reports
- Care Team Anecdotal Information
- Patient and Family Advisory Councils
- Community Needs Assessment
- Zip Code Data
- Payor Resources

Be a CONNECTOR…

Activity: Connector or Fixer? Ownership or Attachment?

Scenario 1: *Is Delilah Being a Connector or a Fixer?*

Jack Sparrow is 63 years old – meeting with Delilah his RN Care Manager today

- long-term alcoholic, now starting to suffer from cirrhosis and other complications
- little family/friend support because he has burnt most of his bridges over the years
- Recently kicked out of daughter's house – no place to live (it is winter and very cold outside)

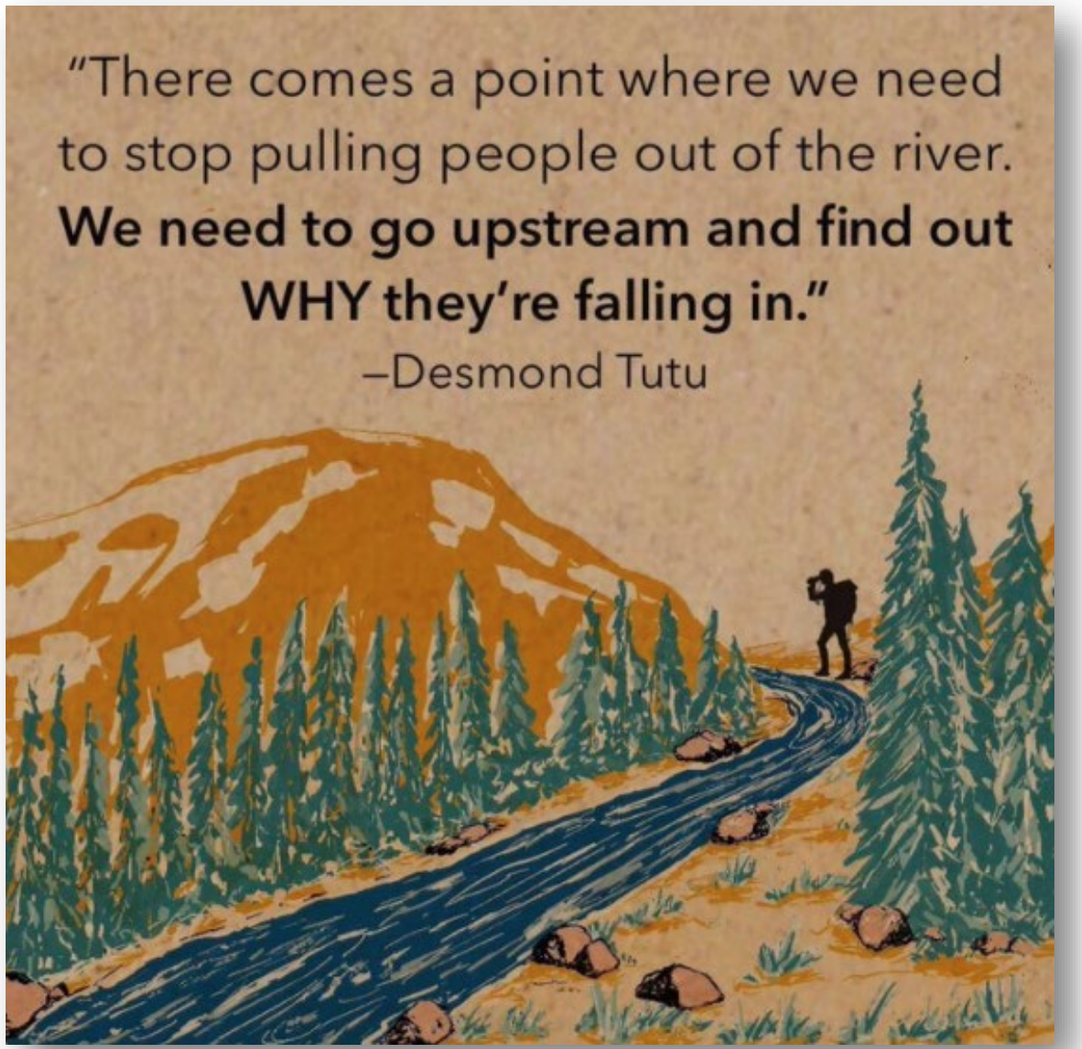
CM Actions/ Reactions – Delilah

- Unsuccessful in getting Jack into a shelter for the night
- Jack reminds Delilah of her own father, who became homeless due to mental health & substance abuse, she has lost touch with her father and is uncertain if he is still alive. Jack's situation is tugging on her heart strings – she's worried that, unless if she takes charge and finds a solution, Jack will sleep on the streets in the cold.
- Delilah makes a reservation for Jack at a local motel and calls a cab to pick him up. She pays for this out of her own pocket.
- She tells Jack that she will work on finding a solution for him and to follow up with her the next day.

Scenario 2: *Is the Care Manager Being a Connector or a Fixer?*

Lila is a 24-year-old single mom with an infant and a two-year-old. During the office visit for her two-year-old today, the MA learns that Lila does not have enough money to buy food or diapers until she receives her next paycheck, which isn't for another 5 days. The Care Manager meets with Lila and provides information about a local food pantry connected with a church that also has diapers and household items. Lila says she feels ashamed and can't go to a pantry asking for help. The Care Manager empathizes with Lila and takes extra time with Lila to talk about the shame she's feeling, and to help Lila work through these feelings. Lila leaves the office feeling stronger and goes to the pantry to pick up the items she needs.

Look Upstream



Questions and Discussion

Course 3
Building your Community Network

Module 2
Identifying Community Partners

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Introduction & Learning Objectives

- 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

Effective Community Partners

- ✓ Addresses a known CM population need – think impact to the population both in numbers and value
- ✓ Provides an opportunity to create the community partner model
- ✓ Willing to brainstorm and innovate
- ✓ Equally interested in understanding the impact on population or patient outcomes

Effective Community Partner Strategy

- ✓ Build on current relationships – build new relationships
- ✓ Network with community leaders
- ✓ Align goals – understand their needs and the needs of your population
- ✓ Promote the value of understanding the impact on population and/or individual outcomes

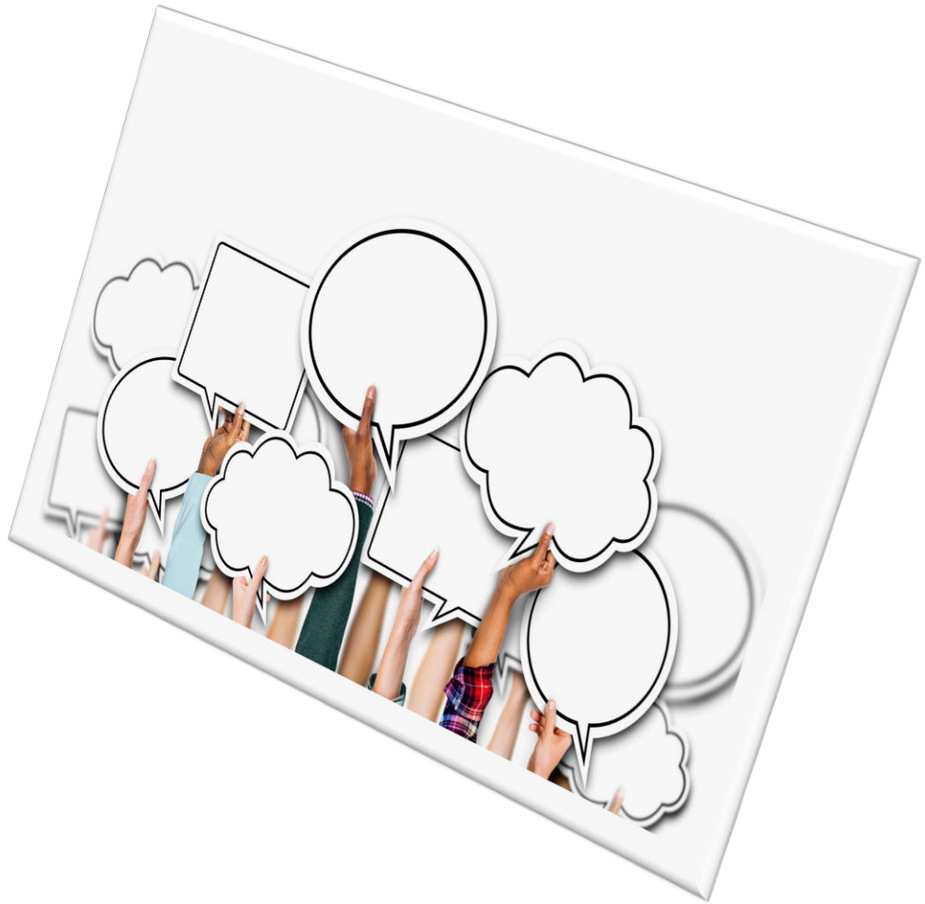
Breakout: Community Partnership Discussions

Breakout Groups – 10 min

Identify a leader who will record and report back.

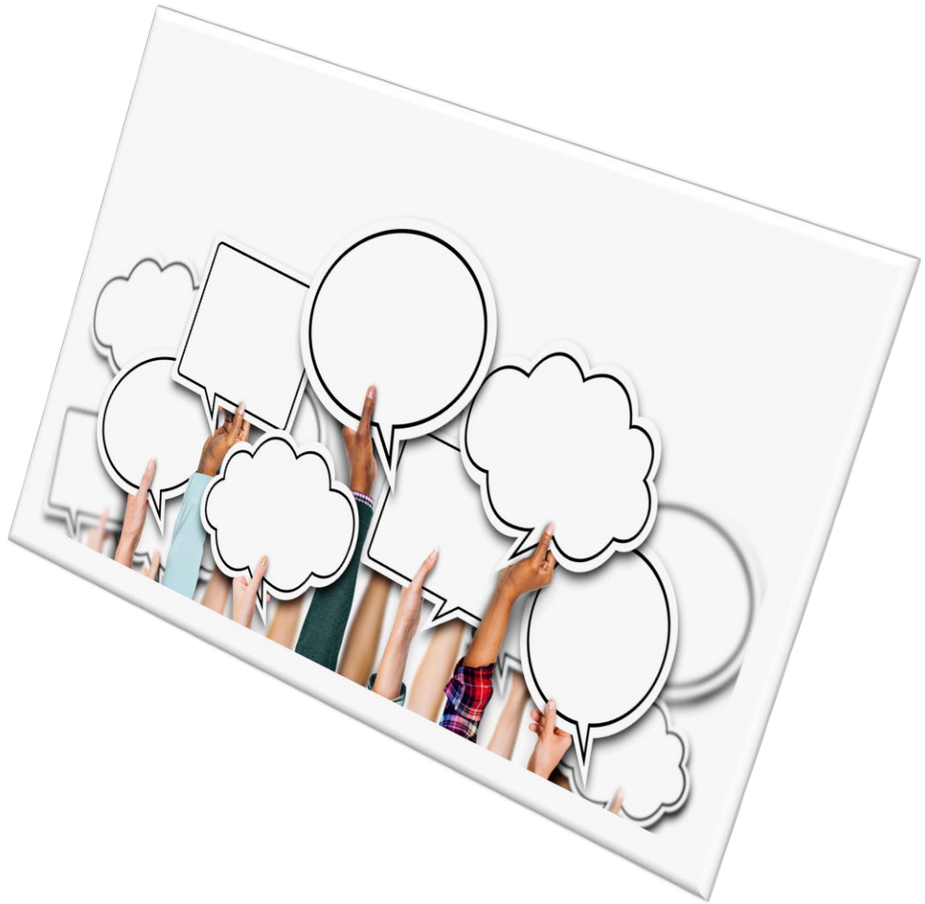
Topics for discussion

- Discuss a population need that requires a community partnership.
- What worked in engaging the community partner
- What did not work well?



Community Partnership Discussions

- Scenario #1: Population data: 32% with avoidable ED visit had no effective social support.
- Scenario #2: No population data, anecdotal reports from ‘most CM patients’ that limited financial resources make it difficult to fill Rx for medications such as inhalers, diabetes Rx, and cardiac Rx.



Effective Community Partner: Scenario #1

Care Management Group A has captured data that reflects the following: 32% of ED individuals with an *avoidable* ED visit were identified as lacking effective social support. You (CM) have been tasked with leading a partnership to address this need and impact the avoidable ED visit rate. You (CM) have identified three community resources that may partner to provide social support.

A. Church-based group that wants to provide social support to individuals in the community.
B. YMCA initiative to improve social connection in the region.
C. Agency for Aging with an established social support program for the elderly that is well known in the region.

You (CM) have met the leader of the Agency for Aging program, and she is committed to their program and a well-known leader in the community. Your CHW knows the leader of the church-based group and is aware that this is a volunteer-run program.

Effective Community Partner: Scenario #2

Care Manager B has been asked to make recommendations for improving chronic disease compliance in the patients enrolled in Care Management. There is no population data, but CM B has numerous anecdotal reports from CM patients that limited financial resources make it difficult to fill Rx for medications such as inhalers, diabetes Rx, and cardiac Rx.

CM B is unaware of any prescription or financial assistance programs in the community. The CM program is new, and CM B has been working at this clinic for only 4 mos.

Questions and Discussion

Course 3
Building your Community Network

Module 3
Tools to Collaborate with Community Partners

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Introduction & Learning Objectives

- Identify tools and resources that support community-clinical linkages
- Discuss strategies to outreach and establish relationships with community partners

Technology:
Social Needs Referral Platforms

211
(United Way)

Find Help
(formerly Aunt Bertha)

Unite Us

Regional Platforms

Community Partner Resources

- Shared Google Doc
- Community Resource Binder
- Regional Resource – CO Regional Health Connector
- Other

Questions and Discussion

Course 3
Building your Community Network

Module 4
Building Collaborative Care Agreements

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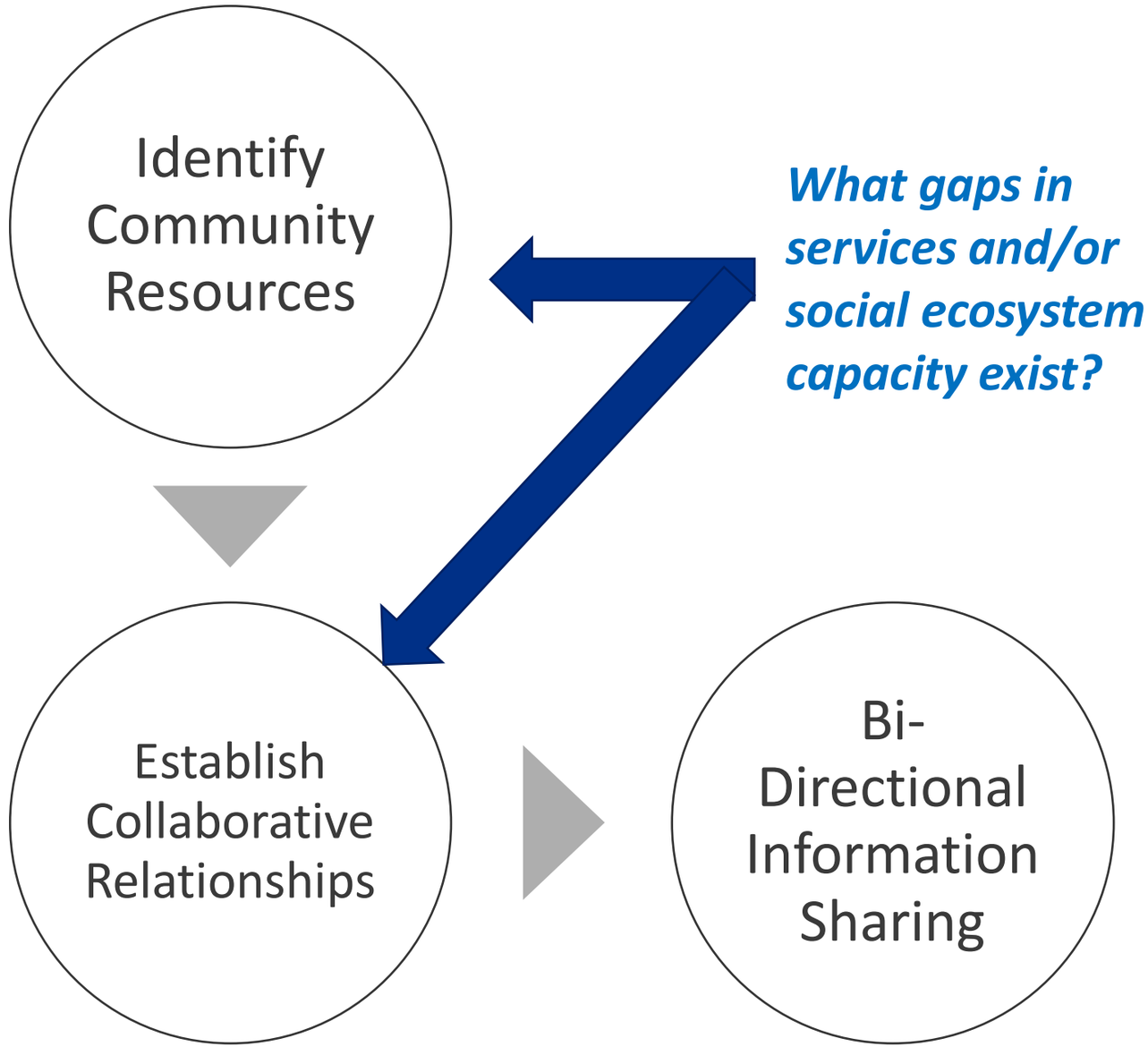
Introduction & Learning Objectives

- 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

Addressing Social Needs



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Collaborative Agreement Discussion Points

Practice

- We will send you a patient who understands why they are being referred.
- We will follow-up with patients to ensure they have made contact.
- We will communicate any challenges such as reports of challenges around timely access or poor experiences.
- We will continue to assess for health-related social needs and give patients the opportunity to identify if they would like to receive services.
- We will share information as appropriate, mindful of privacy requirements.
- We will partner in determining upstream barriers to patient success.

Community-Based Organization

- We will partner in a mutually agreeable referral process.
- We will provide timely access and support.
- We will communicate any challenges such as reports of challenges around timely access or poor experiences.
- We will let you know if there are ongoing challenges in delivery of support and services.
- We will share information as appropriate, mindful of privacy requirements.
- We will partner in determining upstream barriers to patient success.
- We will participate as appropriate in interdisciplinary care conferences.

Questions and Discussion

Session #5

Course 4. Demonstrating the Value of the Care Management Program
October 11, 12:30 – 2:30 PM EST

Module 1. Data Sources to Assess the Effectiveness of the CM Program

- Discuss the importance of strategic alignment for Care Management Program
- Review data types and how they relate to measures of success for care management
- Identify key data sources

Module 2. Methods to Assess the Effectiveness of the CM Program

- Identify different methods to analyze CM impact
- Identify when each methodology is appropriate to use Lead (Process and Interventions) and Lag (Outcomes)

Module 3. Communicating Program Success

- Outline a CM Communication Plan and strategies for communicating to various audiences
- Discuss opportunities to promote the value of Care Management
- Identify quantitative and qualitative measures of success to review with leaders

Course 5. Demonstrating the Value of the Care Management Program

Module 1. Review Key Characteristics of an Effective Care Management Program

- Understanding your population
- Defining your Priorities
- Measuring for Success

Module 2. Group Case Study Discussion

- Understanding your population
- Defining your Priorities
- Measuring for Success

Connect With Us

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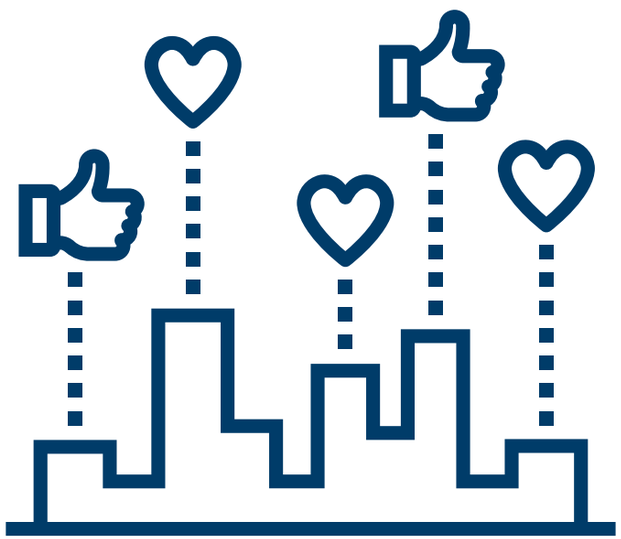

Provide Us Feedback

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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