NATIONAL ASSOCIATION OF Community Health Centers®

HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

CARE MANAGEMENT (103) LEADING TRAINING, POWERED BY

HealthTeamWorks®
Health. Equity. Resilience.

SESSION #5
OCTOBER 11, 2023
3 PM ET

Care Management (103) Leading
Session 5

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Session 4 Recap

- Professional/Clinical Skill Development Value
  - Impact on retention
  - Opportunity for ongoing Best Practice
- Retention/Turnover trends & how to impact this
- Burnout – impact on patients/impact on work
- Identifying & leading skills improvement for team members
- Effective CM team integration into the primary team
- Value of an effective provider champion

Course 5

Supporting Care Team Integration, Part II

Module 1

Supporting Care Team Integration

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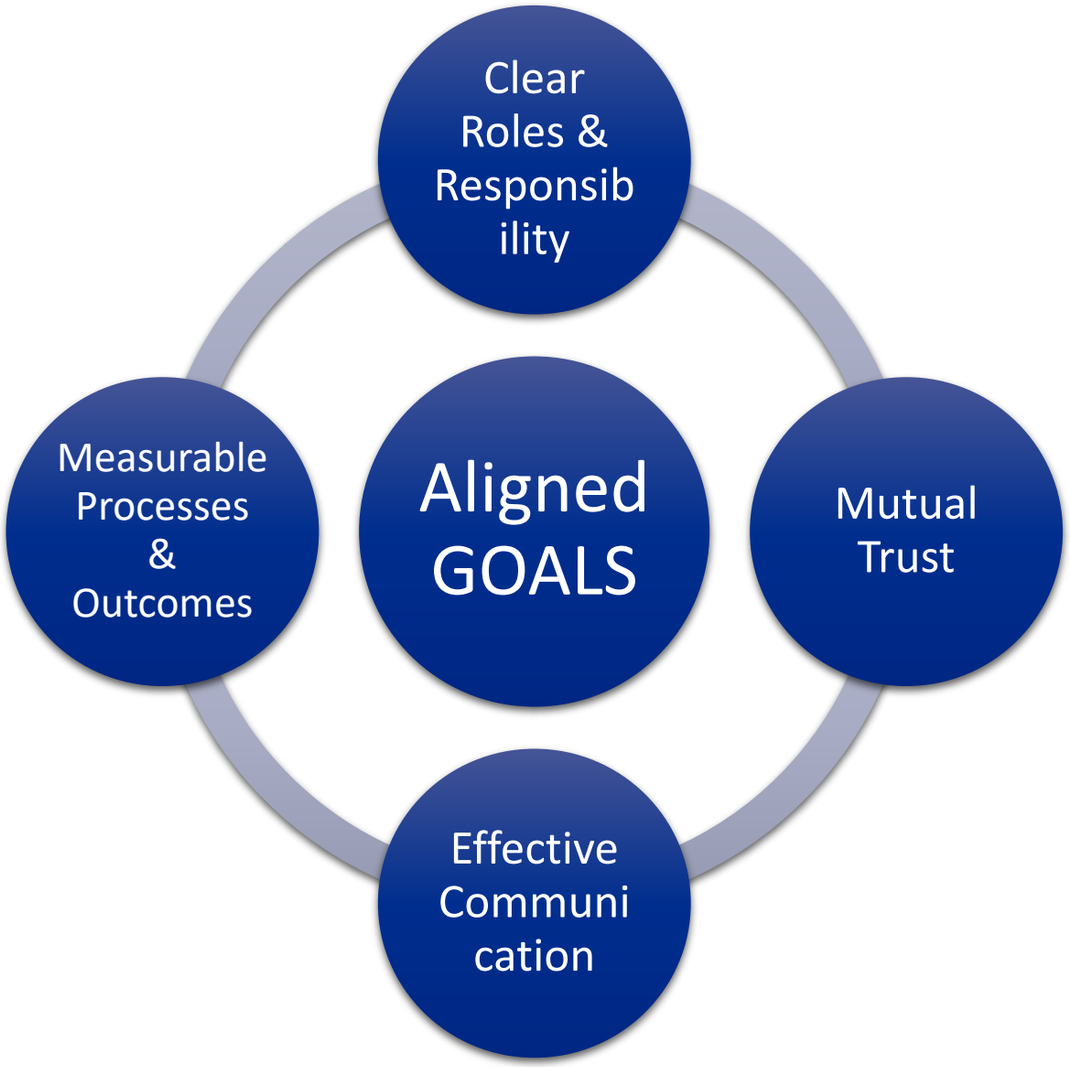
Objectives

- Develop strategies to ensure successful integration in your practice care team.
- Identify common challenges when integrating care management into the care team.

BASICS: Characteristics of Effective Teams



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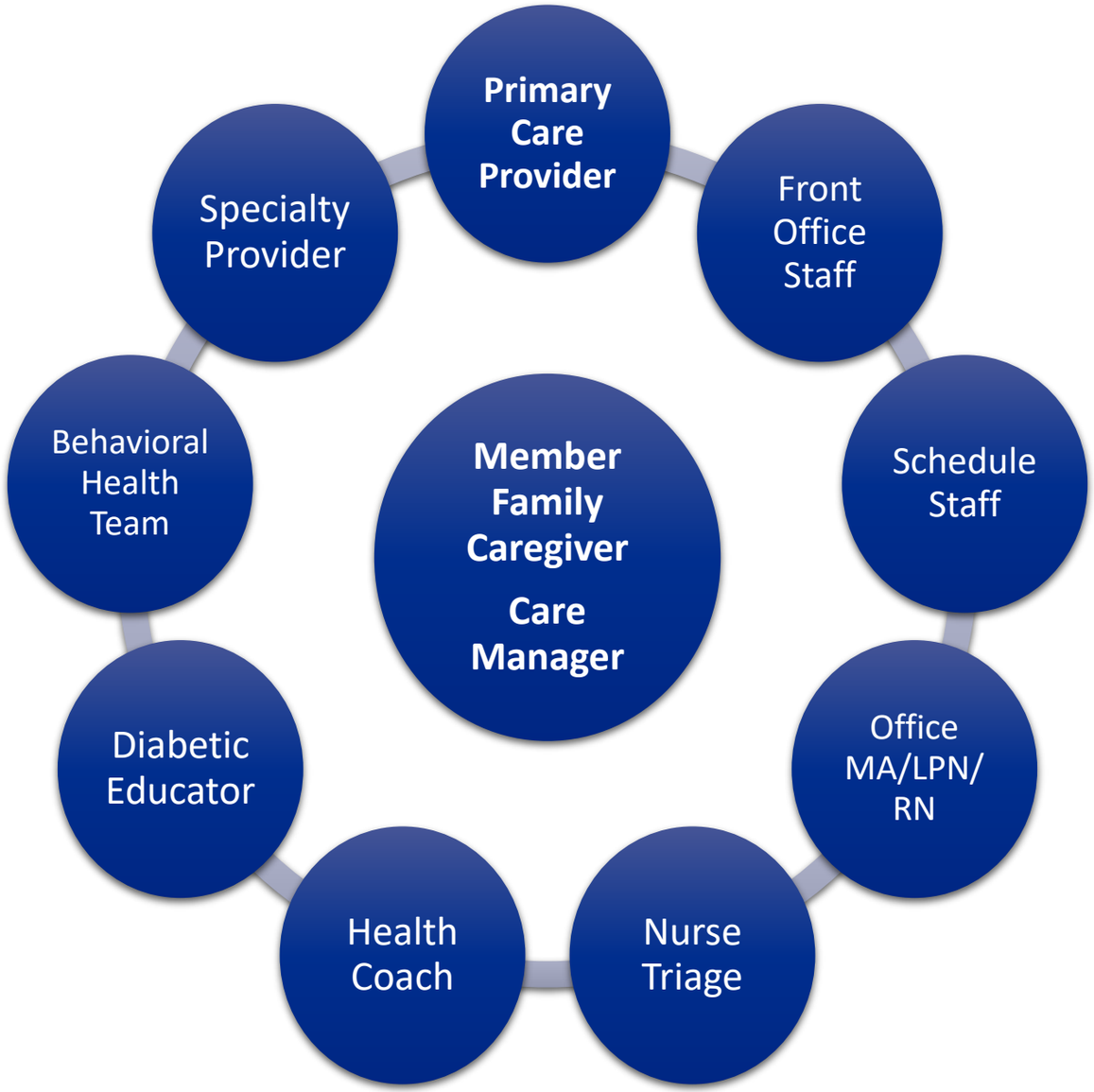
Effective Care Management Integration



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Effective Care Management Integration

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Effective CM Integration Discussion Points

Aligned Goals	Clear Roles & Responsibilities	Effective Communication	Measures of Success
• System or Clinic Goals • Population needs • Measures impacting Revenue • Measures impacting provider salary	• CM Enrolled • CM visits or touches • Med List updated • ED/Hosp notes available • Consult notes available	• Risk Status • CM Enrolled • CM screenings • CM Documentation • Task vs in person or phone • SBAR	• Process • Outcomes • Frequency of Data Review by CM • All Team Data Review

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Common Challenges with Integrating into the Practice

- Practice culture
- Lack of clarity on value of Care Management
- Care Manager isn't a "fit"
- Inappropriate referrals
- Workflow designed without input
- Reporting structure

POLL

What do you see as the biggest challenge to effective Care Management integration with the primary care team? (select all that apply)

- ❑ Care Managers work in a silo with limited interaction with PCP team
- ❑ Primary team tendency to use CM for PCP tasks (overstep boundaries)
- ❑ Primary team does not understand the value of Care Management or role of Care Managers
- ❑ Care managers do not have clarity on their priorities
- ❑ Other (type in chat)

Holistic Integration

In order to be successful, the Care Manager must integrate into both the practice culture ***and*** the practice operations.

Strategies to Help the Care Manager Integrate into Practice Culture

Define role/ align with practice

Share mission&vision of practice

Communicate

Communicate

Communicate

Shadow roles in practice/others shadow CM

Regular check-ins with manager

Strategies to Help the Care Manager Integrate into Practice Operations

- Engage team on patients for CM
- Collaborate to develop workflows with the team
- Staff Meetings & Huddles
- Share success stories and/or case studies
- Care Conferences
- Provider ‘Top 10’ patients
- Large system: Manager of CM meet with Practice Managers

Group Discussion

- What does the ideal Care Management integration model look like?
- What do you see as the obstacles (or strengths) of care management integration at your clinic?
- Discuss 1-2 action steps to improve or sustain your current model of care management integration.

Wrap-up & Take Aways

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Course 5

Supporting Care Team Integration, Part II

Module 2

Addressing the Challenges of Care Team Integration

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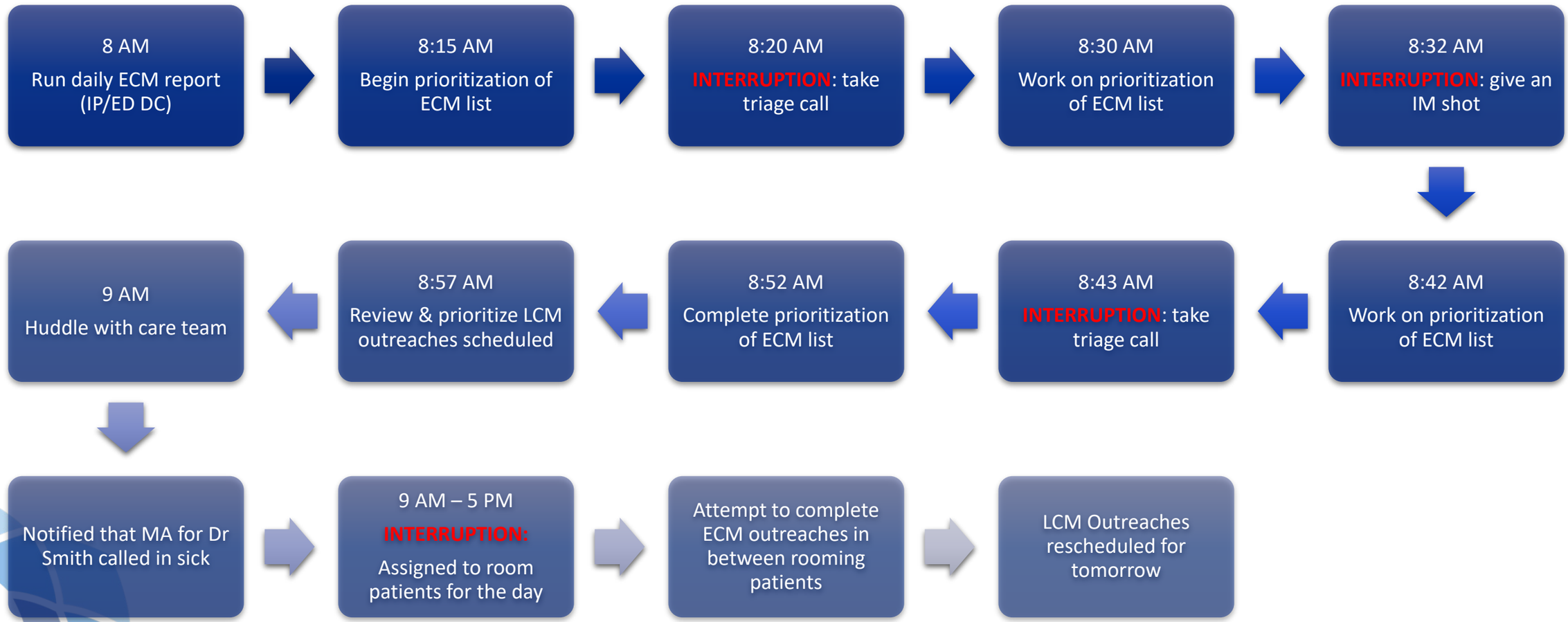
Objectives

- Evaluate common scenarios of the implications of the Care Management role being too broad.
- Appraise the available data sources and choose the most appropriate ones that will support this communication.
- Identify key strategies in communicating care management role creep and the impact it has upon ROI in a practice.

Role Creep – A Typical Day in the Life of a Care Manager



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Common Scenarios of Care Manager's Role Being too Broad *(aka 'role dilution')*

- Care Manager is expected to fill in for other staff (call-ins, vacation, open position)
- Care Manager is the only nurse in the practice, and is pulled to complete vaccinations, testosterone injections, and education for patients with new diagnoses of diabetes; essentially, the Care Manager is pulled to complete all nursing-type duties in the practice in addition to the CM role
- CM role began in the practice as a pilot, where one of the triage nurses took on the 'extra work'; much time passed and the value of the role is proven, but the expectation is that this is now part of the triage nurse's duties
- Nurse in the practice is elevated to the new role of CM. However, the nurse has been with the practice for many years and knows how to do everything – so the team continues to rely on her for all of the ancillary things that she can do better than anyone in the practice
- Very large practice with more than 5 providers – Care Manager is expected to conduct Episodic CM for all hospital discharges & all ED visits, plus conduct Longitudinal CM for high-risk patients

Approaches to Identify & Manage Role Creep

- CM Time Task Study
- Clearly defined Care Management goals
- # Patients enrolled in Care Management
- Care Manager touches with patients enrolled in CM
- Readmissions
- Inpatient utilization
- ED visits
- % Patients enrolled in CM with A1C >9

Effective Communication

Aligned goals between primary team & Care Management team

Define Priorities

Clarify Roles/Responsibilities

Patient Experience Scores

Ability to manage my health

Metrics:

PEC Question

% of patients in CM with Green-Yellow – Red resources for leading ED/Hospital Discharge diagnosis

% of patients with patient identfied goals

SDOH Screening

SDOH Screen Completion

- Workflow defining when SDOH is completed
- Review of SDOH screening measures monthly

Depression and Behavioral Health Screening & Treatment

Process

PHQ-2, PHQ-9 screening rates

Define workflow for screening & result documentation

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

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Key Strategies to Impact CM Role Creep

- Define the role creep- what are the non-CM task requests
  - Task Inventory
- Confirm accurate workflows/ roles & responsibility resources
  - Opportunity to do collaborative workflow mapping
- Align task to priorities/goals/measures of success & define appropriate owner
- Consider team efficiency opportunities
- Communicate CM Goals/Measures of success & priorities
  - Clarify priority tasks
- Align leadership messages – providers, managers, clinic/system leader's goals/measures

Validate CM Role Creep: 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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Small Group Discussion

Small Group Breakouts

Identify/Recognize leader: Take notes & be prepared to report back

- Discuss areas of role creep within your Care Management team or clinic

- Define 2-3 steps you as a leader can take to better manage the role creep for your team (or your role).

Sharing Small Group Take Aways

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Course 5

Supporting Care Team Integration, Part II

Module 3

Monitoring & Mitigating Care Manager Burnout

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Objectives

- Distinguish the impact burnout can have on the Care Manager, care team, and patients
- Identify tools to assess burnout
- Through utilization of assessment tools, identify common contributors that can alert to current or future Care Manager burnout.
- Develop effective strategies to mitigate Care Manager burnout

Recognizing Burnout on Care Team Members

- Depression, fatigue
- Appetite changes
- Job dissatisfaction
- Turnover
- Lack of clearly defined self-care activities
- Reduced productivity
- Turnover
- Other – self-care

Tools to Assess for Burnout

- Measures: Emotional exhaustion, depersonalization, & personal accomplishment
- Validated with US health and human services workers
- Cost associated per individual or group

Maslach Burnout Inventory – Human Services Survey

- Geared toward physicians
- Benchmark data not available
- No cost – free to the public (AMA Steps Forward)

Mini-Z

What Contributes to CM Burnout?

- Lack of role clarity
- “Other duties as assigned”
- Understaffing, and having to “fill in” for other staff
- Inappropriate referrals
- Heavy workload
- Ineffective or lack of self care

Strategies to Mitigate CM Burnout

- Align practice leadership and CM leadership if CM has centralized reporting structure
- Clarify (or re-write) job description, workflows, roles & responsibilities, educate & support
- Education on role of Care Manager & appropriate referrals
- Training for CM on ‘Crucial Conversation’ skills
- Identify alternate solutions for tasks that need completed when staff out sick or on vacation
- Develop workflows for referrals that are declined
- Promote and practice self - care & wellness

Strategies to Enhance Care Team Wellness

- Remaining optimistic, even in the face of difficulty – The Art of Leadership
- Cultivating a supportive social network
- **Self Care**
  - Mindfulness
  - Exercise – consider outdoor walking meetings
  - What do you do to fill up your bucket
  - Modeling Wellness / Self Care

Promoting Wellness

GROUP DISCUSSION

- What are specific steps to support your CM team in preventing or addressing burnout?

- Define how you will integrate these steps into your CM program (or workflow if you are a solo CM).

Wrap Up & Take Aways

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Session #6

Course 6. Evaluating Success
October 18, 3:00 – 5:00 PM EST

Module 1. Developing Metrics to Monitor Success

- Define the three major categories of measurement for a care management program.
- Describe data sources that are available in a practice for each category of measurement.
- Identify when and how to apply each category of measurement in a practice.

Module 2. Qualitative Measurement of a Care Management Program

- Define qualitative data.
- Describe methods to collect qualitative data that anyone can use.
- Develop strategies to collect qualitative data that can be immediately implemented in the practice.

Module 3. Outcomes Reporting

- Describe methods of sharing data with various stakeholders in the organization based on their role.
- Develop tactics to demonstrate ROI for care management program that can be easily implemented into the practice.

Module 4. Coaching for Performance

- Identify possible causes of poor ROI in a care management program.
- Develop strategies for interventions and solutions when ROI is not as expected.

ASSIGNMENT – SESSION #6

In preparation for Session #6:

- Identify a challenge or a problem you would like to use to identify a solution using the knowledge from this course.
  - Examples
    - I struggle with identifying actionable goals that resonate for our CM population and team
    - I struggle with the primary team recognizing the value of the CM team and what they do.
    - My CM team does not seem to know how to prioritize tasks and all have 'mountains of work' on their plate.
- Email your challenge or problem to Diane and Angie by COB Monday, October 16th.
- NACHC will send a reminder email to all on Friday.

Connect With Us

Diane Cardwell
Dcardwell@healthteamworks.org

Angie Schindler-Berg
Aschindlerberg@healthteamworks.org

Hanna Moffett
Hmoffett@healthteamworks.org

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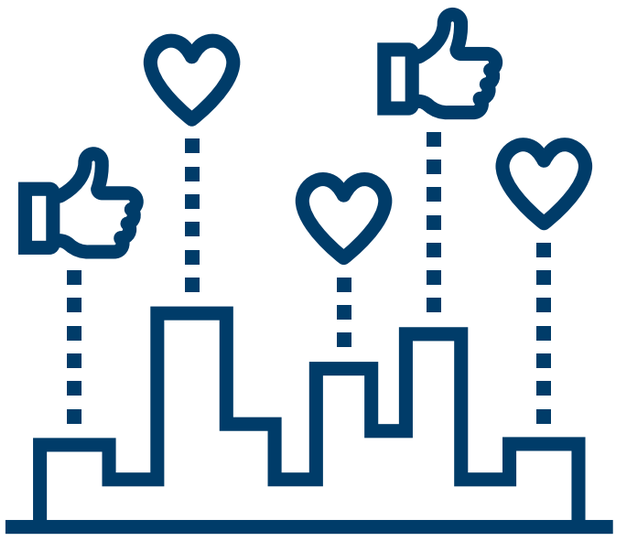

Provide Us Feedback

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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