Optimizing Care Management: Teaming for the Best Outcomes

Welcome to Today's Webinar

We will begin shortly

Take a moment to familiarize yourself with the chat box.

Let us know who you are and where you are from!

Clinical Health Coach®

Transform the Conversation. Transform the Care.

Optimizing Care Management: Teaming for the Best Outcomes

Featuring:

Diane Cardwell, Practice Facilitator

Amanda Phillips, Practice Facilitator

HealthTeamWorks

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Our Journey

IOWA CHRONIC CARE CONSORTIUM

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CORE
COACHING | OUTREACH | RELATIONSHIP | ENGAGEMENT
Skills Development for Community Health Workers

HealthTeamWorks Facilitators

Diane Cardwell

Amanda Phillips

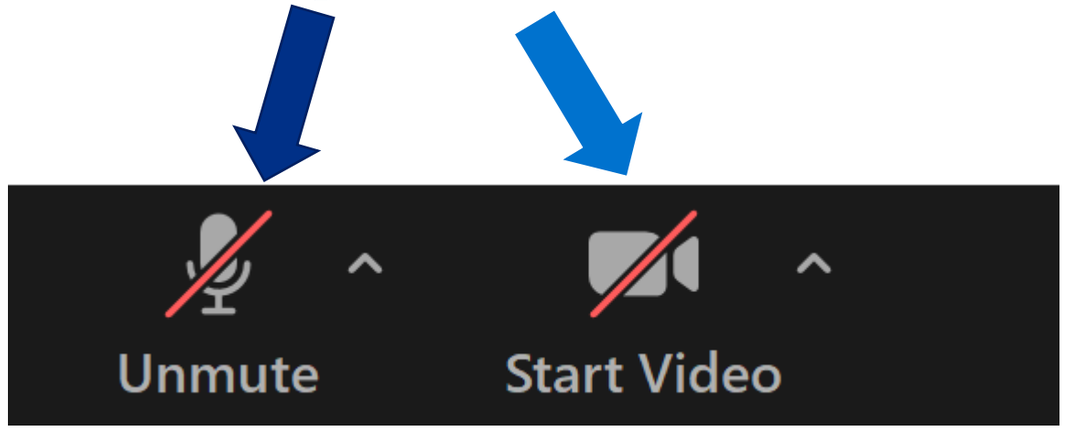
Zoom Features (audio/video)!

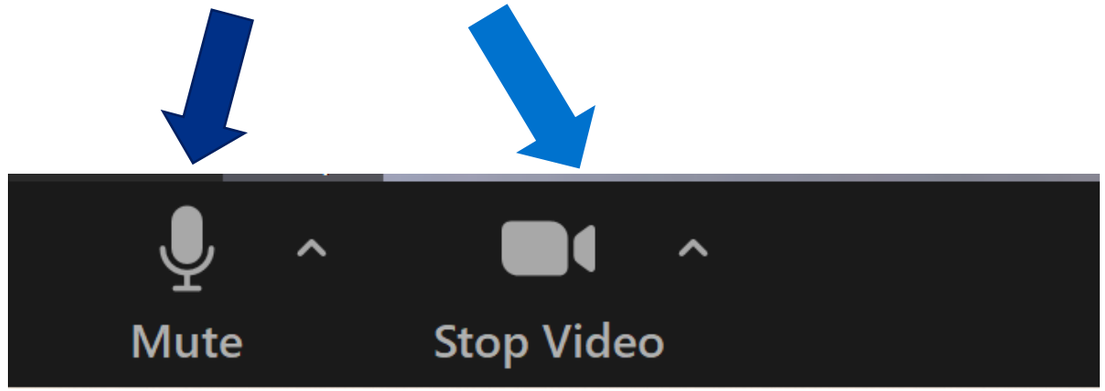
Audio

- To mute your audio, click the microphone icon to the bottom left of your screen (icon will have a red strike through).
- To unmute, click the microphone icon again (icon will no longer be red).

Video

- To turn on your video, click the camera icon again (icon will no longer be red).
- To turn off your video, click the camera icon to the bottom left of your screen (icon will have a red strike through).





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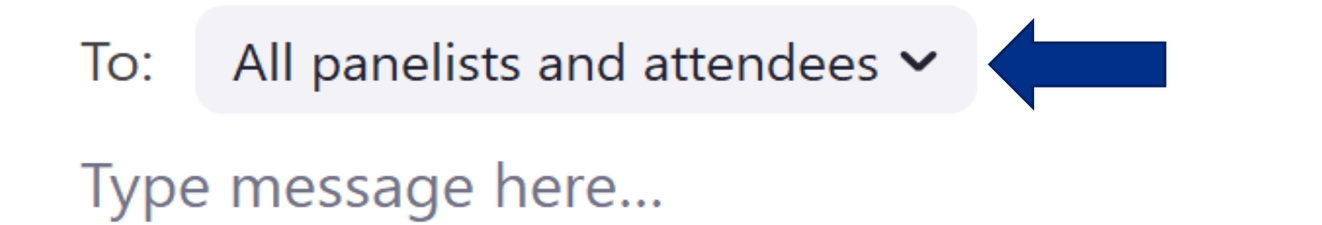
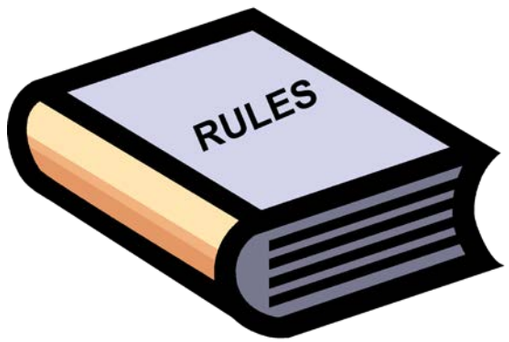
Zoom Features (chat)!

- To send a question or comment:
  - Select “Everyone” from the **To:** dropdown list
  - Click in the chat box and type a question or comment
  - Hit **Enter**
  - You can also send a private chat by clicking on the carrot next to “everyone” and selecting a specific person's name.



Discussion ABCs

- **A**ssume Positive Intent
- **B**e Here Now
- **C**ome Prepared to Ask Question
- **D**ecrease Distractions and Respect Time
- **E**veryone Teaches, Everyone Learns



Learning Objectives

- Identify steps to build a strategic approach to care management
- Discuss key tactics to making care management part of the culture of your practice
- Prioritize workflows that promote cross-teaming and collaboration based on the needs of your patients

Defining Care Management Innovation

Poll

How consistent is care management at your practice?

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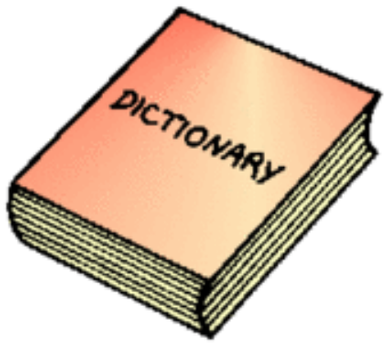
Poll

What is your current role?

a set of activities intended to improve patient care and reduce the need for medical services by helping patients and caregivers to more effectively manage health conditions



Defining Care Management

Goodell S, Bodenheimer TS, Berry-Millett R; "Care Management of Patients with Complex Health Care Needs" Robert Woods Johnson Foundation, 2009

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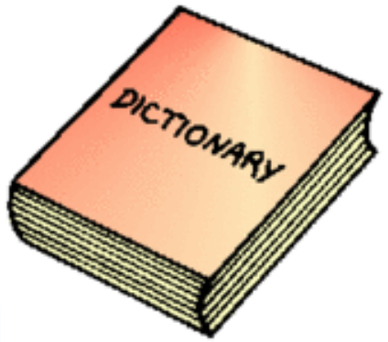
Use of evidence-based skillful conversation, clinical strategies, and interventions to actively and safely engage clients in health behavior change to better self-manage their health, health risks and acute or chronic health conditions. Resulting in optimal wellness, improved health outcomes, lowered health risk and decreased health cost.

Defining Health Coach



Huffman, M., & Miller, C. (2015). *Evidence-based health coaching for healthcare providers* (3rd ed.). Winchester, TN: Miller & Huffman Outcome Architects, LLC.

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Bring it all together (defining care collaboration)!

> *A set of activities intended to improve individual's health and reduce the need for medical services by collaboration with individuals and caregivers to more effectively manage and promote health*

Care Management Models

Episodic

- ‘Care provided to otherwise stable patients undergoing transitions in care; a new, serious illness or injury involving complex treatment regimens; a newly unstable chronic illness; or undergoing transition in the setting of care from hospital or nursing home’

Longitudinal

- 'Care provided per protocol and tailored to the specific needs, circumstances, and conditions of the patient. Routine and acute visits are augmented by intentional, proactive outreach at regular intervals by a care manager who can then intensify touches during exacerbations and transitions.’

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Care Management Models

Embedded – Facility Based

- 1: 125 high risk patients
- 1: two/three Providers (MD/DO/NP/PA)
- 1: every 2,000 – 3,000 patients (average risk)

Central / Community based

- Located off site from primary clinical setting

Vendor based / Remote

- Telephonic

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Care Collaboration: Next Generation

Understanding the Population

- Strategic approach with data
- Demographics
- Chronic disease incidence
- Risk stratification
- Mental health condition
- Substance use/ abuse
- Complex medication use
- Social needs
- Health inequity

Poll

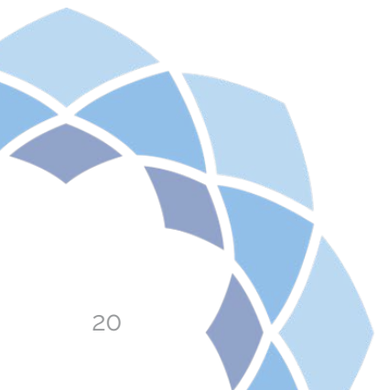
What data is **currently used** to inform the work you do?

What data would you **value** to inform the work you do?

- Driving community networking (i.e. number of pharmacists needed).
- Informing composition of your team (i.e. how many LCSW do we need, etc?)
- Primary Care Clinic engagement (team-based care)

What data would you **value** to inform the work you do?

- Time to chat in your thoughts!



Care Management Accountability

Operational

- Patient interactions/ types
- Time spent
- Tasks completed

Clinical

- Quality measures
- ED /Hospital utilization measures
- Re-hospitalization rates

Financial Measures

- Value payment optimization
- Reduced cost

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Care Management (Collaboration) Across the Team

- Culture of health management across the team
- Patient is truly seen as an active member of the team
- Tasks apply to all patients – not just high risk
- Care management workflows applied across the team members
- Value is defined by the patient

Care Management (Collaboration) Across the Team

- Tasks that apply to all patients
  - Accurate medical record
    - Accurate problem list
    - Accurate medication list
  - Care plan
  - Patient identified goal/s

- Care management workflows to apply across the team
  - Workflows documented and available to all team members
  - Priority workflows

HealthTeamWorks Resources

HTW Resources and Trainings:

1. HealthTeamWorks LMS-Home Page
2. HealthTeamWorks Essentials of Care Management Online Training Modules
3. HealthTeamWorks Facilitating Quality Improvement Online Training

HTW/ICCC Training

1. **Advancing Best Practice in Health Coaching and Care Management**
   - January 7-February 18, 2021
   - Weekly 90-minute Virtual Classes
   - Additional Small Group Health Coaching Practice
   - Contact: Kathy Kunath@kathy.Kunath@iowaccc.com or call 515.971.3234

Iowa Chronic Care Consortium Trainings

Clinical Health Coach v-Fusion Training

12-week Class combining online curriculum with weekly virtual classes

www.clinicalhealthcoach.com/vfusion

A new class begins each month

Clinical Health Coach Training Online

26-hour asynchronous self-paced training

www.clinicalhealthcoach.com/online-overview

Enroll at any time

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Q&A/Discussion

Leaving in Action

THINK: Based on what you learned today, review with your colleague's the strategies for redefining culture for your practice and your patients.

LINK: Collaborate with those you met today to further explore a strategic population approach to care through use of data and key practice points.

INK: Set (and document) a timeline to discuss what you learned in todays session and implement changes with your team.

Contact HealthTeamWorks!

- Amanda Phillips: aphillips@healthteamworks.org
- Diane Cardwell: dcardwell@healthteamworks.org

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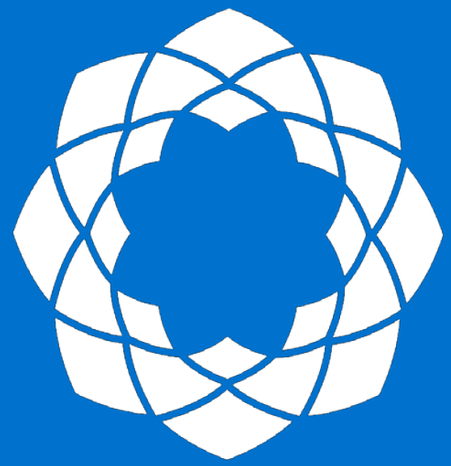

Thank You