03 -TBC Basics

Care Management And Care Coordination Part II

Today's Presenters

Susan J. Vos BSN, RN, CCM

Licensed RN in the State of Michigan with expertise in practice transformation, care management, quality improvement, and understanding of models of care and payment models in respect to the healthcare industry.

Lynn Klima DNP, APRN, CNE, ANP-BC

Dr. Klima is an adult nurse practitioner and academic nursing professor with over 40 years of experience spanning clinical practice, executive leadership, and nursing education. Her work focuses on leadership development, patient-centered care, and integrating evidence-based practices to improve outcomes across diverse care settings.

AGENDA

1	TBC Basics – Historical and Current TBC Model (1.5 hours)
2	Care Management & Care Coordination (1.5 hours)
3	Care Management & Care Coordination (1.5 hours)
4	Aims / Measurement / Quintuple Aim (1.5 hours)

Presenter	Topic	Time
Sue and Lynn	Welcome and Introduction to Care Management Care Coordination Part II	5 minutes
Team	Debrief – Report Out on Patient Identification and Assessments	10 Minutes
Lynn	Information Exchange: Communication Tools to promote Team Based Care	15 Minutes
Sue	Care Planning Overview	5 Minutes
Lynn	Care Planning: Health Literacy and Cultural Needs	10 Minutes
Sue	Care Planning: Symptom Management and Self-Management Action Plans	10 Minutes
Sue	Care Planning: Follow-up, Monitoring and Case Closure	10 minutes
Team	Application Care Management and Communication Tools	20 minutes
Sue	Next Steps	5 Minutes

Care Management & Care Coordination

Follow Up on Patient Identification and Assessments

Review Risk Stratification for Patient ID.

- Based on the practice goals and desired outcomes, **how will the team identify patients who will benefit from care management activities?**
- Based on the Risk Stratification model, **which care management activities will be delegated to the different team roles?**
  - Such as low, moderate or high- risk patients.

As a team:

- Determine **which conditions the team will screen or are currently screening for.**
  - For new screenings**, decide which screening tool you can reasonably start using**
  - Determine if the screening tool is available in the EHR or other resources. If yes, is the tool sufficient, or do you need to embed a new tool.
- **Establish a plan for administering the screening tool to the patient. Who will do this?**
- Establish a plan to share the results with the provider and determine what actions will/can occur for any positives.

Assessments

- From step 1 (to include screening) what is the team process for referral to the care manager to initiate step 2 (gathering of subjective information) during the comprehensive assessment?
  - How will you know who will require step 2 (conducting the comprehensive assessment by gathering subjective information) to verify complexity?
  - **Discuss how the assessment will be documented and communicated across the team.**
    - Where or how will this take place? (In person, telephonically, virtual)
- How will the patient be assigned to the appropriate team member based on the complexity and needs of the patient (align with the roles and responsibilities table).
- Who and how will you monitor these actions to validate the process is being followed?
  - Will there be a policy/workflow created and an auditing process to identify challenges that may require modifications to the process?

Information Exchange Resources and Tools

- Policies/Procedures
- Huddles and Team Conferences
- Situation – Background – Assessment – Recommendation or Request (SBAR)
- Call-Out
- Check-Back
- Teach-Back
- Ask Me Three
- Handoffs (including I-PASS)

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Tools to Promote Team Based Care

Policies & Procedures

In primary care, policies and procedures are formal, documented instructions and guidelines that define how specific tasks, processes, and situations should be handled. They aim to standardize care, ensure consistency, improve quality, and mitigate risk.

Policies are high-level statements that guide decision-making and establish overall direction. Procedures are detailed, step-by-step instructions for completing specific tasks or handling specific situations. Both are crucial for a well-functioning clinical setting.

EXAMPLES

Comprehensive Assessment

Scheduling practices

Medication Reconciliation

Documentation

Meeting Examples

Huddle	Team Meeting
Short, patient centered	Has an agenda, operational
Frequent, even daily	Less frequent, but scheduled regularly or ad hoc
Goal is to discuss arising situations that need multi-disciplinary support and are complex enough for a conversation: • High risk patients, complex Plans of Care • ED or IP visits • Requests for different referrals • Concerns for a patient	Goal is to improve the overall program performance: • Review operational opportunities, such as scheduling or standing agreements/orders • Review process for referrals • Review outcomes measures / performance
Participants include the individuals directly involved with the huddle topics	Participants expanded to include all involved with the process on the agenda: front and back office, billing, PCP, Care Team, MA, Office Manager

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SBAR

SITUATION

What is going on with the patient?

"Dr. Lu, this is Alex, a nurse from your 5th Street office. I am calling about your patient, Mr. Webb. He reports being in substantial discomfort and that there is not much urine in his catheter bag."

BACKGROUND

What is the clinical background or context?

"Mr. Webb is an 83-year-old patient that has a catheter in place during his recovery from bladder cancer treatment."

ASSESSMENT

What do I think the problem is?

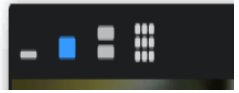
"He also reports a temperature of 100.4 and that the urine in his bag is cloudy and slightly red. I am concerned he may have an infection and that his catheter may be clogged."

RECOMMENDATION OR REQUEST

What would I do to correct it?

"I would like him to come into the office this morning for you to see him. When he arrives, would you like us to get labs, including blood cultures, to check for infection?"

- Do not forget to introduce yourself—you should not assume that everyone knows who you are.
- SBAR is adaptable. Think of it as a menu: the parts you choose to use and the order in which they are used depend on your team's unique needs. Determine which parts of SBAR are relevant to your team's needs and use those when communicating critical information among your team members.
- SBAR can be modified for use by the patient or family caregivers to communicate with the care team. For example, your facility could provide patients with a summary of SBAR to enable them to share information about their own situation, background, assessment, and recommendations or to ask the care team about their care.
- Consider saying the actual words to keep yourself on track: "The situation is..., The background is..., My assessment is..., I recommend..."



AHRQ: https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/sbar.html

Team Communication
Call-Out

A strategy used to communicate important or critical information:

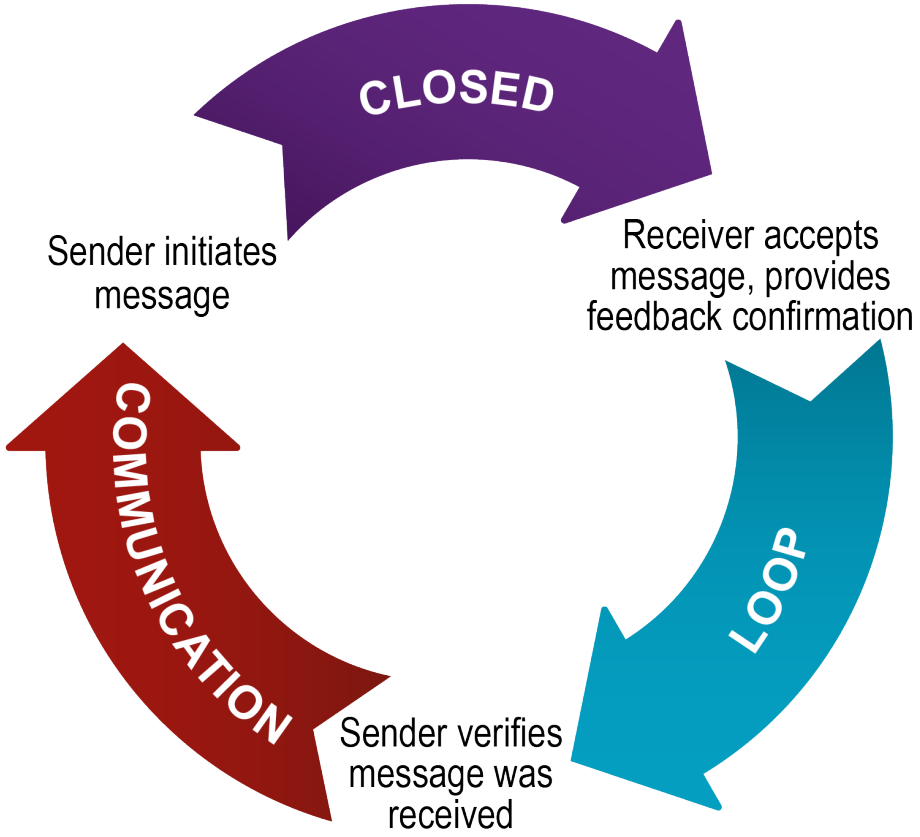
- It informs all team members simultaneously during emerging situations.
- It helps team members anticipate next steps.

Team Communications

Check-Back

Sometimes also called a Repeat-Back.

TeamSTEPPS also includes a Teach-Back tool, which can be used with patients and family caregivers.



Check-Back

A closed-loop communication strategy used to ensure that information conveyed by the sender is correctly understood by the receiver.

Example:

Dr. Moss:
"Mary, please share the information pamphlet on cholesterol management with Mr. Garcia and arrange for him to come for a followup visit in a month."

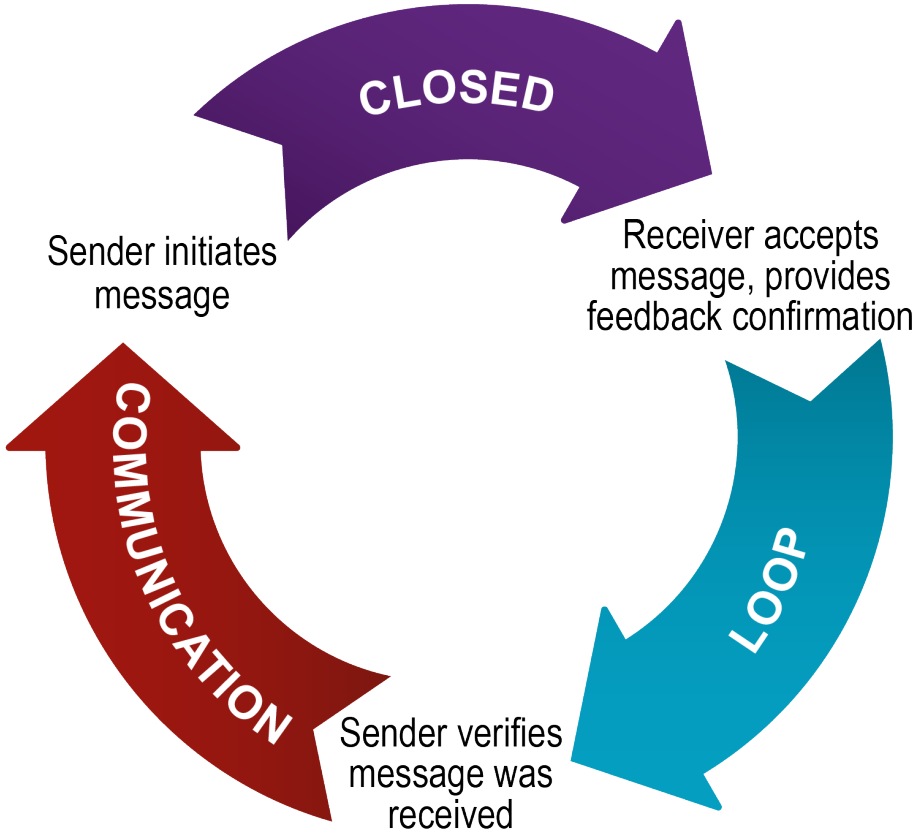
Mary:
"Confirmed. I'll share the information pamphlet on cholesterol management and arrange a followup visit for Mr. Garcia in a month."

Dr. Moss:
"Correct."

https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/index.html

Team Communications
Teach Back

- Evidence-Based Health Literacy Intervention
- Promotes patient engagement, adherence, and safety
- A way to confirm that you have explained information clearly
- Assess family/caregivers understanding



https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/index.html

Ask Me 3 is a patient education program that was created to help:

- Enhance communication between patients and providers
- Encourage patients to become active participants in their own care
- Gather a better understanding of one's health conditions, and of how to stay healthy

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Team Communication

Handoff

The transfer of information during transitions in care across the continuum:

- Includes an opportunity to ask questions, clarify, and confirm.
- Is relevant during shift changes, transfers between departments, and care team transitions.
- Is sometimes done virtually or with e-handoff functions within an electronic health record.

Handoffs include:

- Transfer of responsibility and accountability.
- Clarity of information.
- Verbal communication of information.
- Acknowledgment by receiver.
- Opportunity to review.

https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/index.html

Team Communication

Handoff Tool

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I-PASS:
A Common Handoff Tool

Illness Severity
- Stable, watcher, unstable

Patient Summary
- Summary statement
- Events leading up to admission or care transition
- Hospital course or treatment plan
- Ongoing assessment
- Contingency plan

Action List
- To-do list
- Timelines and ownership

Situation Awareness & Contingency Planning
- Know what's going on
- Plan for what might happen

Synthesis by Receiver
- Receiver summarizes what was heard
- Asks questions
- Restates key actions/to-do items

Care Management Process

Care Planning

Monitoring and Follow-up

Closure Transitioning

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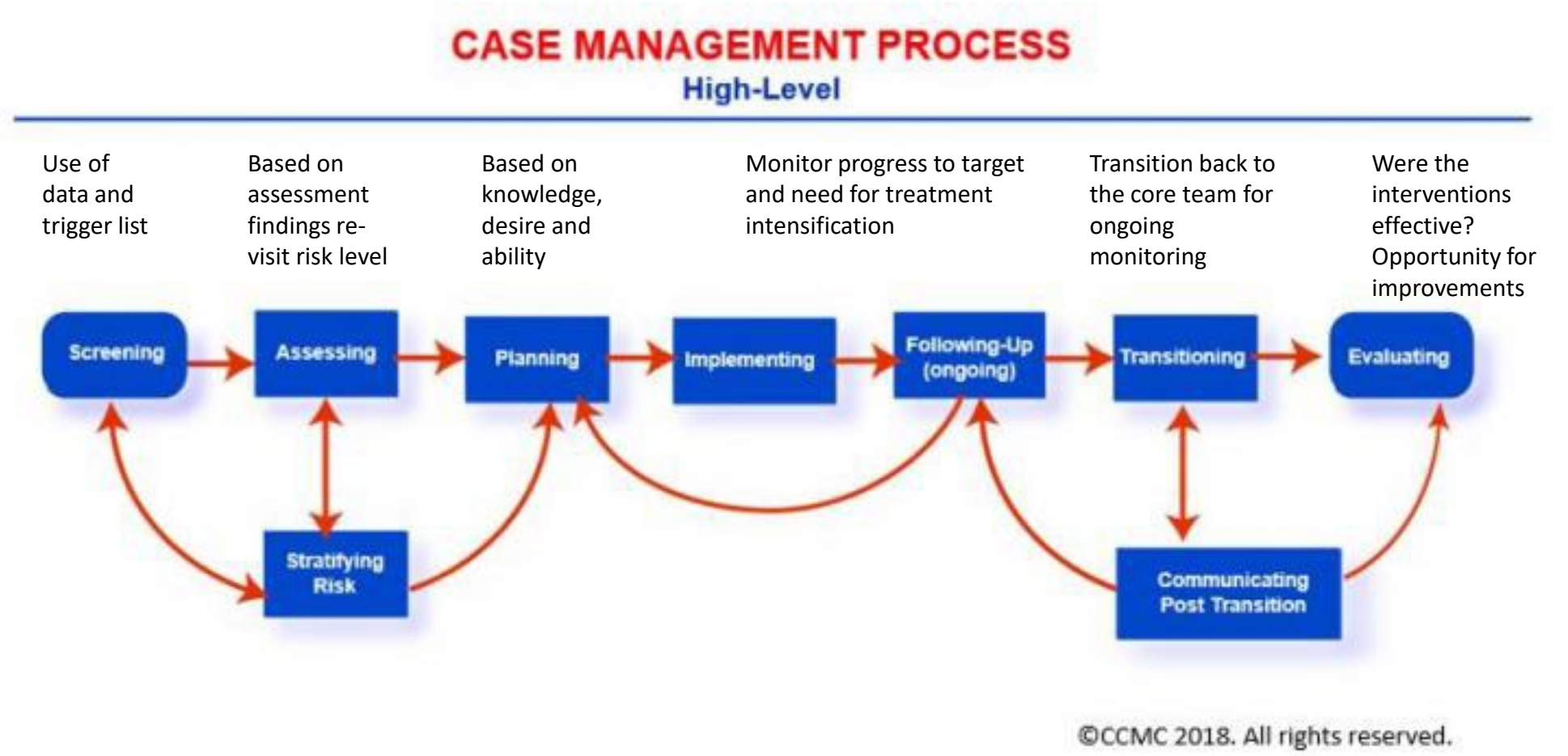
Case Management Knowledge Framework

Creating a Patient Centered Plan Across the Team

https://cmbodyofknowledge.com/sites/cmbok/files/images/2019/KnowledgeFramework-ValueCaseMgmt.v6_1_0.jpg

Care Management Process



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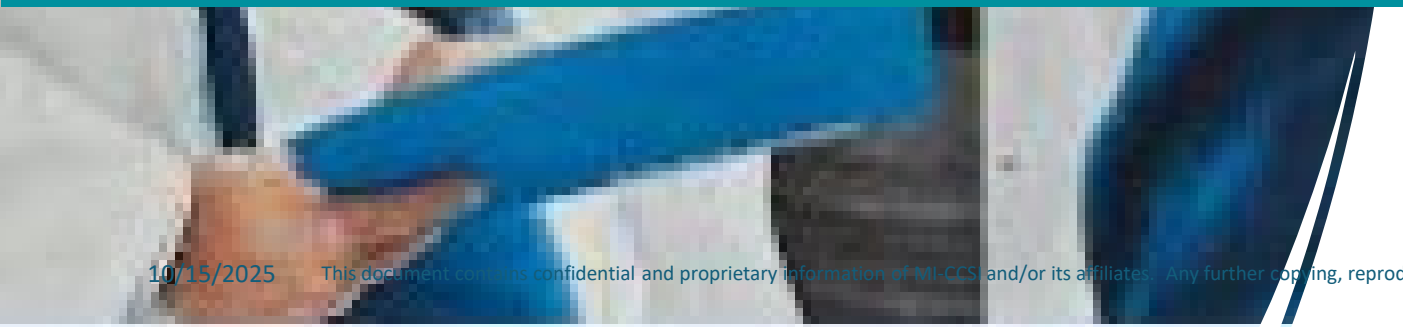
Care Management Process

Care Planning



Definition of Care Planning

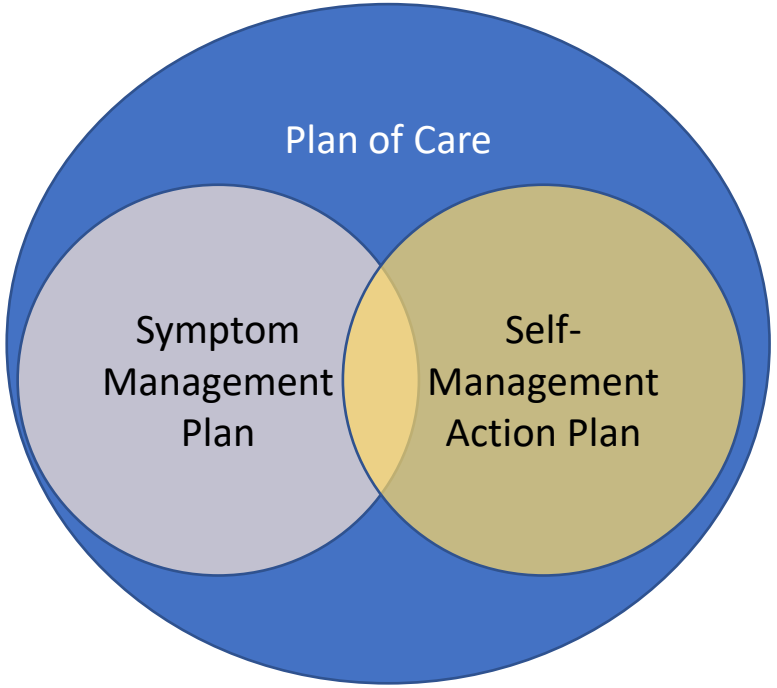
A comprehensive plan of care for an individual that describes:

- The client's **problems, needs, and desires**, as determined from the **findings of** the client's **assessment**.
- The strategies – such as **treatments and interventions** – to be instituted to address the client's problems and needs.
- The **measurable goals** – including specific outcomes – to be achieved to demonstrate resolution of the client's problems and needs, the time frame(s) for achieving them, the resources available and to be used to realize the outcomes, and the desires/motivation of the client that may have an impact on the plan (CMSA, 2016, p. 32).

https://cmbodyofknowledge.com/content/introduction-case-management-body-knowledge

Plans of Care Across the Team

Care Plan Type	Definition	Example
Plan of Care	Clinical care plan that identifies the outcomes goals recommended by the care team. It includes the symptom management plan and the self-management action plan. A follow up plan with the care team is part of the Plan of Care.	Mrs. Brown comes into the office with shortness of breath. Peak flow is evaluated; respiratory assessment is done. Provider team develops a plan of care that includes follow up visits and care management visit on a weekly basis for a month. The patient is given an asthma action plan showing symptom management progression and appropriate actions to take if her asthma exacerbates. The patient discussed self-management goals with the care manager. Mrs. Brown's desire is to go walking again with a group of friends without discomfort from shortness of breath. She committed to using her medication regularly as a first step to being able to walk regularly again.
Symptom Management Plan	Identifies the appropriate next steps based on symptoms –i.e. when to use the emergency department, call the office, self-care.	From the above example: The Asthma Action Plan is the symptom management plan. It shows Mrs. Brown when to go to the ED, when to call the office, and when the symptom is something she can handle on her own with an inhaler.
Self-Management Action Plan	Small, usually life-style goals driven by the patient's desired outcomes. Can also include elements of the symptom management plan.	From the Plan of Care: Mrs. Brown committed to using her medication regularly.



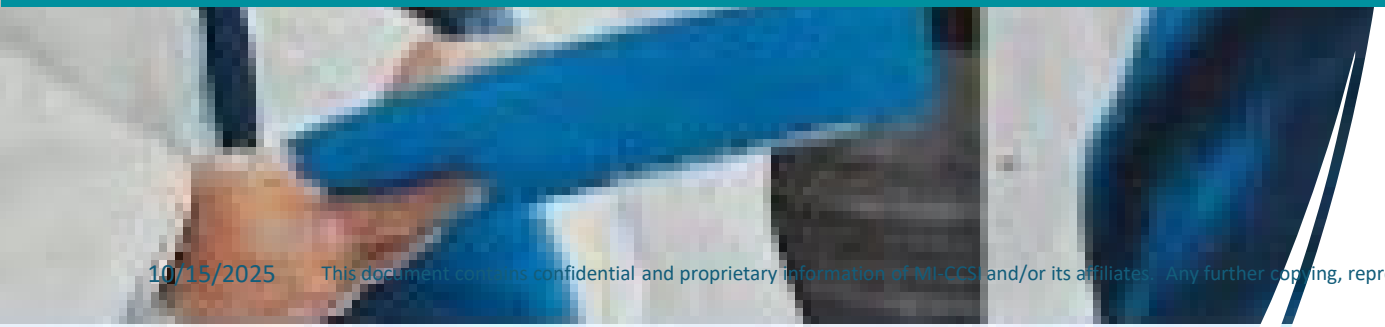
Considerations in Care Planning

Patient Ability

- Health Literacy, Literacy, Understanding, and Culture
- Psychological, Cognitive, and Emotional Factors
- Socioeconomic and Environment Factors
- Patient Provider Relationship and Communication
- Patient Motivating Factors
- Patient Ability to self-management

Care Planning – Patient Ability and Desire

Health Literacy and Cultural Needs



Health Literacy; it takes two!

A **patient's ability** to obtain, understand and act on health information.

A **provider's capacity** to communicate clearly, educate about health and empower their patients.

https://www.cdc.gov/health-literacy/php/about/index.html

Red Flags

- Incomplete or inaccurate registration forms and other paperwork
- Frequently missed appointments
- Non-adherence with medications or assigned treatment programs
- An inability to name their medications or explain why they are taking the medication
- Lack of follow-through with laboratory tests or referrals

https://www.medbridge.com/blog/identifying-patients-with-low-health-literacy

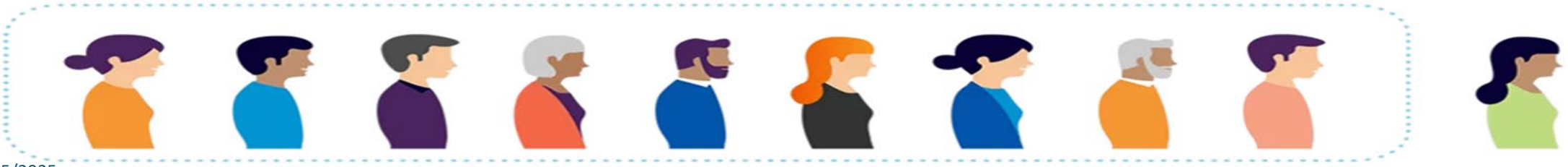
The Impact

Increasing Awareness

Nearly **9 out of 10** adults may not have received the health literacy tools needed to manage their health.

Improving Health Literacy May Help Patients:

- Improve health outcomes and quality of care and lower healthcare costs.
- Find a healthcare provider, like a primary care doctor, specialist, or a service, like a mammogram or an X-ray.
- Fill out complicated medical forms.
- Share information with the healthcare team.
- Understand treatment options and their benefits and risks.
- Work with other members of the healthcare team to decide on a treatment plan.
- Manage treatment options, set goals, and ask questions



Patients with low health literacy often share key risk factors.[3]

Pay particular attention to your patients who:

- Are older adults
- Have a lower income
- Are unemployed
- Did not finish high school
- Belong to a minority ethnic group
- Have recently immigrated to the United States
- Do not speak English or have English as a second language
- People with dementia/cognitive decline

https://www.medbridge.com/blog/identifying-patients-with-low-health-literacy

Health Literacy – AMA

Digital Health Literacy

"The ability to seek, find, understand and appraise health information from electronic sources and apply the knowledge gained to solving or addressing a health problem."

(Norman & Skinner, 2006, p. 2)

Complexities of health literacy *compounded by* complexities of tech literacy

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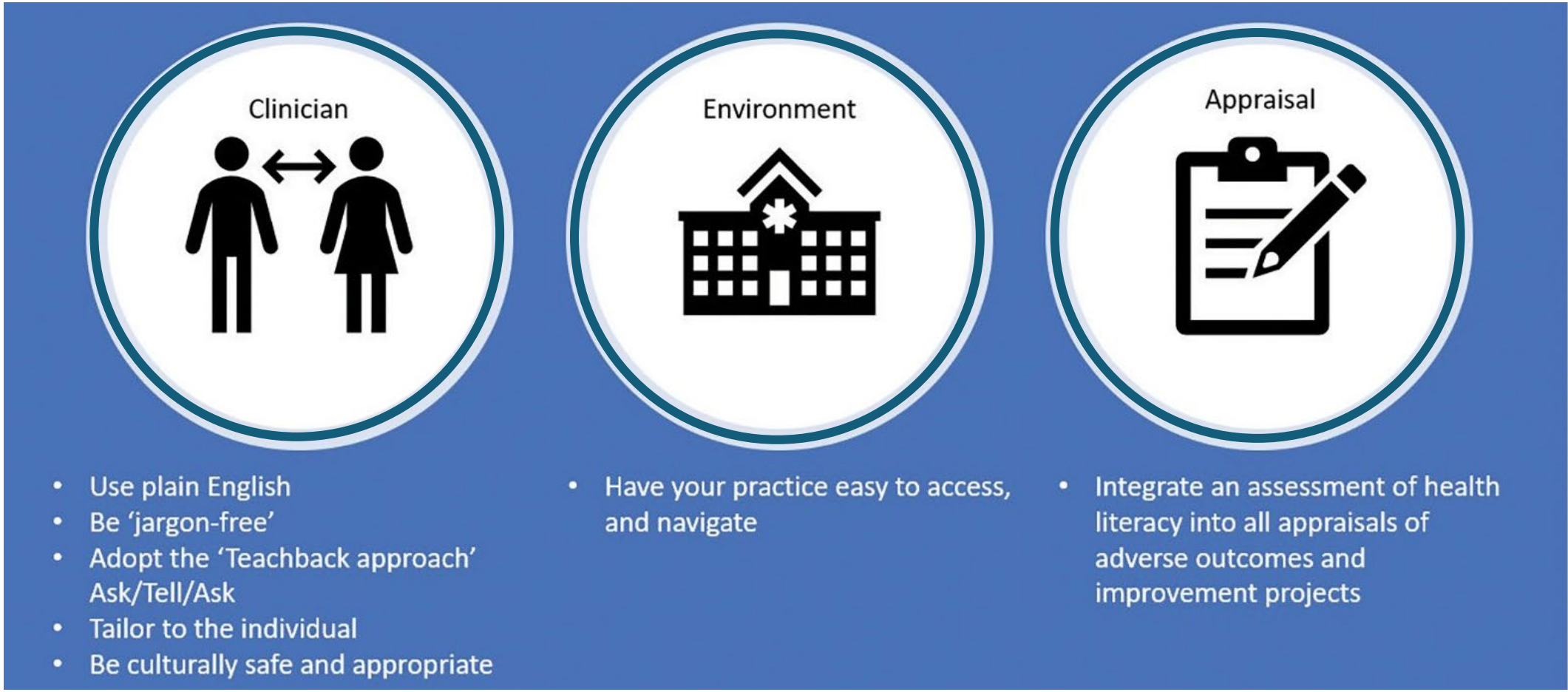
Universal Precautions for Health Literacy

Assume all clients, and their supports, do not find it easy to understand health information, access health care, and navigate health systems.



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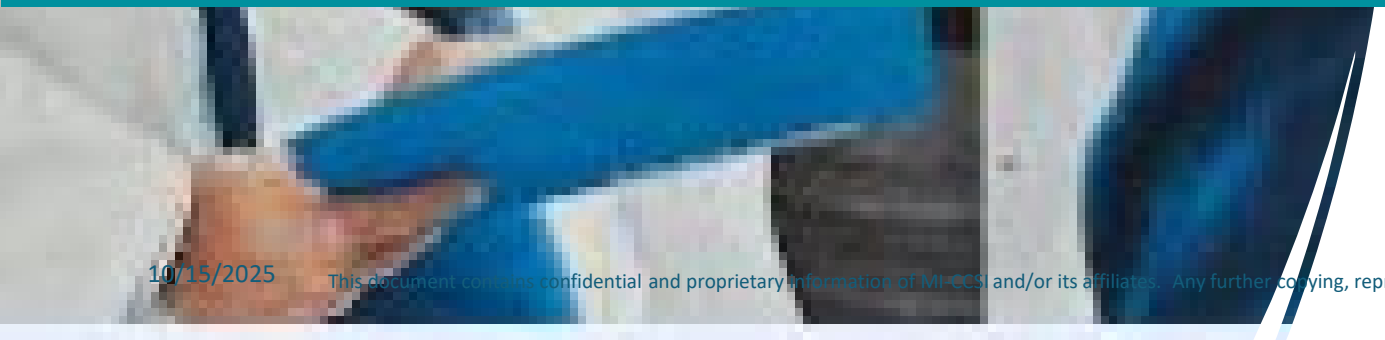
Care Planning – Ability and Desire

Cultural Needs



Culture and Culture Respect

Culture is often described as the combination of a body of knowledge, a body of belief, and a body of behavior.

It involves several elements that are often specific to ethnic, racial, religious, geographic or social groups

This includes personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions.

For the provider of health information or health care, these elements influence beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services.

https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/cultural-respect

Cultural Competence

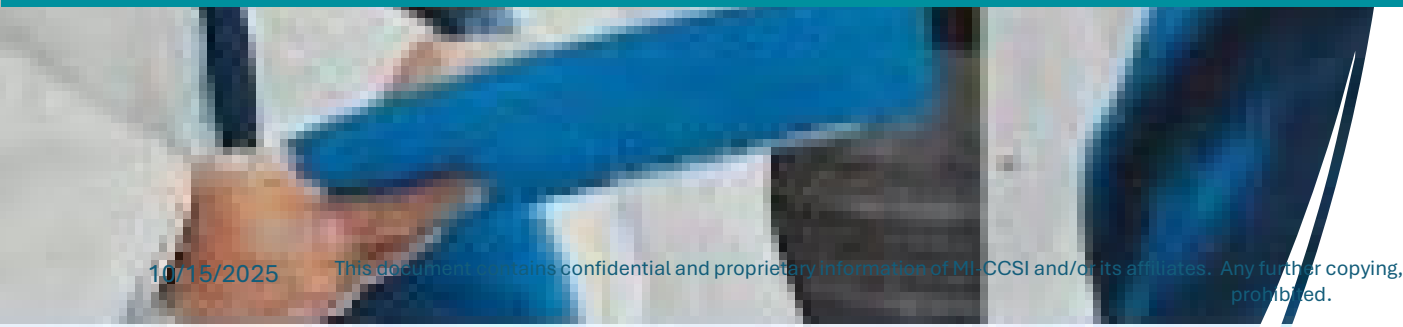
Self Awareness

- Knowledge Level- What do you know?
- Assess Personal Bias
- Avoid stereotypes, assumptions
- Identify areas of mismatch, compromise/modify the approach

https://pmc.ncbi.nlm.nih.gov/articles/PMC5919191/

Care Planning – Ability and Desire

Symptom Management – Action Plans



Promoting Self-management

Care Plan: Symptom Management Action Plans

Helps patients recognize and monitor their symptoms:

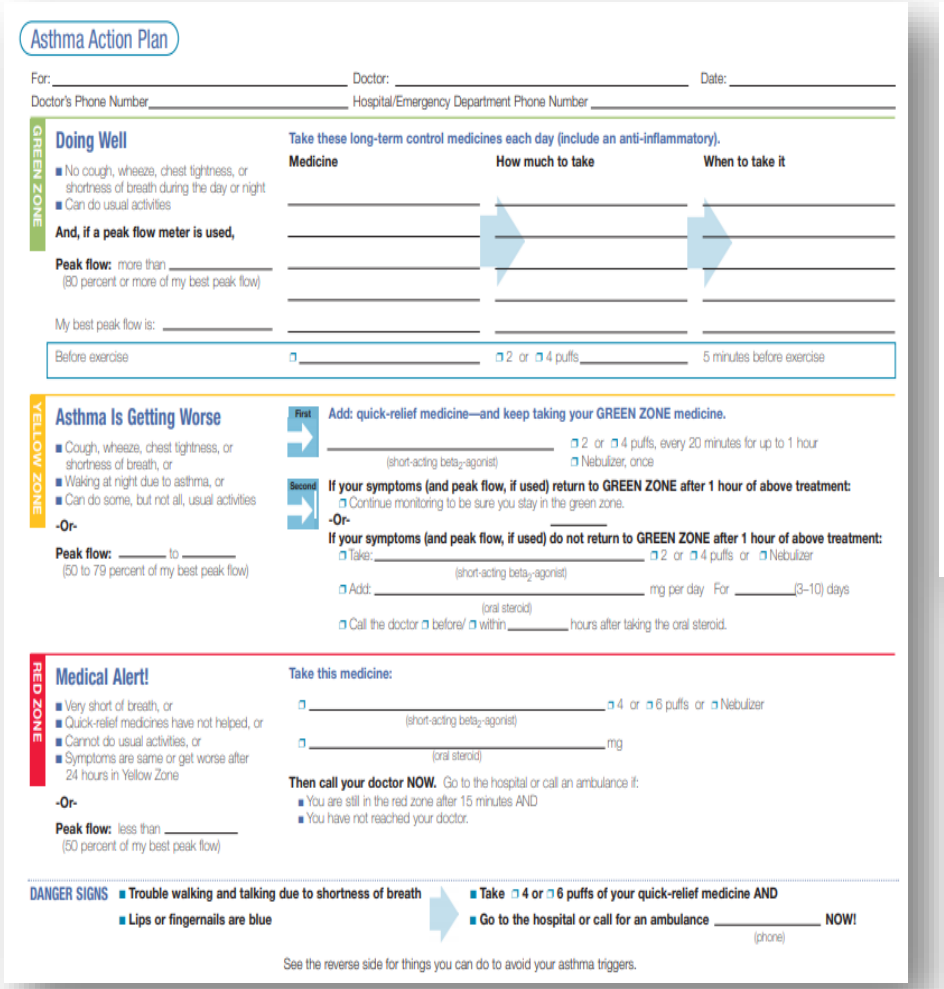
- Assist patients in recognizing early symptoms with the goal of avoiding unnecessary utilization.
- Identifies the symptoms to be aware of and appropriate corresponding actions.

Frequently follows the ‘stoplight’ model:

- **Green**: Maintaining Goal(s)
- **Yellow**: Warning when to call provider/office
- **Red**: Emergency symptoms

Example Action Plans

Asthma



Asthma Action Plan

For: _____ Doctor: _____ Date: _____

Doctor's Phone Number _____ Hospital/Emergency Department Phone Number _____

GREEN ZONE

Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than _____ (80 percent or more of my best peak flow)

My best peak flow is: _____

Take these long-term control medicines each day (include an anti-inflammatory).

Medicine	How much to take	When to take it
Before exercise	❒ _____	❒ 2 or ❒ 4 puffs _____ 5 minutes before exercise

YELLOW ZONE

Asthma Is Getting Worse

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: _____ to _____ (50 to 79 percent of my best peak flow)

First: **Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.**

_____ (short-acting beta$_2$-agonist) ❒ 2 or ❒ 4 puffs, every 20 minutes for up to 1 hour ❒ Nebulizer, once

Second: **If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:**

❒ Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:

❒ Take: _____ (short-acting beta$_2$-agonist) ❒ 2 or ❒ 4 puffs or ❒ Nebulizer

❒ Add: _____ (oral steroid) mg per day For _____ (3–10) days

❒ Call the doctor ❒ before/ ❒ within _____ hours after taking the oral steroid.

RED ZONE

Medical Alert!

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than _____ (50 percent of my best peak flow)

Take this medicine:

❒ _____ (short-acting beta$_2$-agonist) ❒ 4 or ❒ 6 puffs or ❒ Nebulizer

❒ _____ (oral steroid) mg

Then call your doctor NOW. Go to the hospital or call an ambulance if:

- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

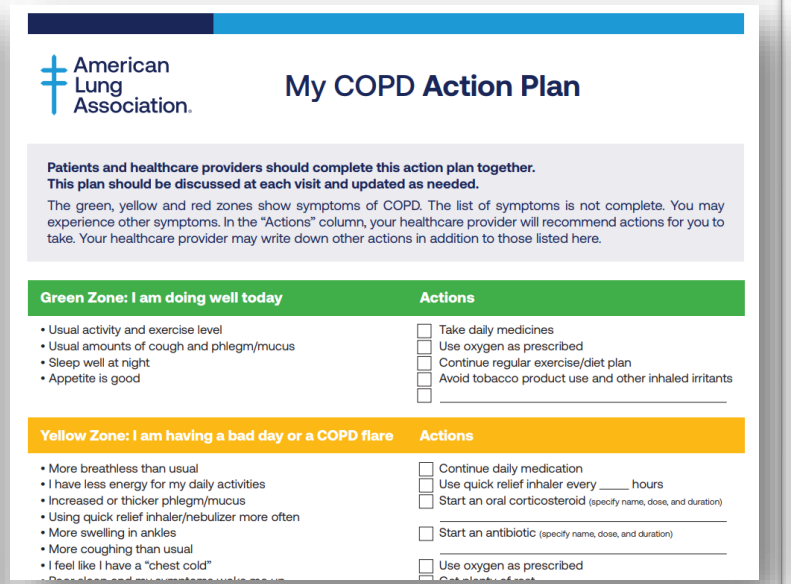
DANGER SIGNS

- **Trouble walking and talking due to shortness of breath**
- **Lips or fingernails are blue**

- **Take ❒ 4 or ❒ 6 puffs of your quick-relief medicine AND**
- **Go to the hospital or call for an ambulance _____ (phone) NOW!**

See the reverse side for things you can do to avoid your asthma triggers.

Gold Standard for COPD



American Lung Association.

My COPD **Action Plan**

Patients and healthcare providers should complete this action plan together.
This plan should be discussed at each visit and updated as needed.

The green, yellow and red zones show symptoms of COPD. The list of symptoms is not complete. You may experience other symptoms. In the "Actions" column, your healthcare provider will recommend actions for you to take. Your healthcare provider may write down other actions in addition to those listed here.

Green Zone: I am doing well today	Actions
• Usual activity and exercise level • Usual amounts of cough and phlegm/mucus • Sleep well at night • Appetite is good	☐ Take daily medicines ☐ Use oxygen as prescribed ☐ Continue regular exercise/diet plan ☐ Avoid tobacco product use and other inhaled irritants ☐ _____

Yellow Zone: I am having a bad day or a COPD flare	Actions
• More breathless than usual • I have less energy for my daily activities • Increased or thicker phlegm/mucus • Using quick relief inhaler/nebulizer more often • More swelling in ankles • More coughing than usual • I feel like I have a "chest cold"	☐ Continue daily medication ☐ Use quick relief inhaler every ____ hours ☐ Start an oral corticosteroid (specify name, dose, and duration) _____ ☐ Start an antibiotic (specify name, dose, and duration) _____ ☐ Use oxygen as prescribed

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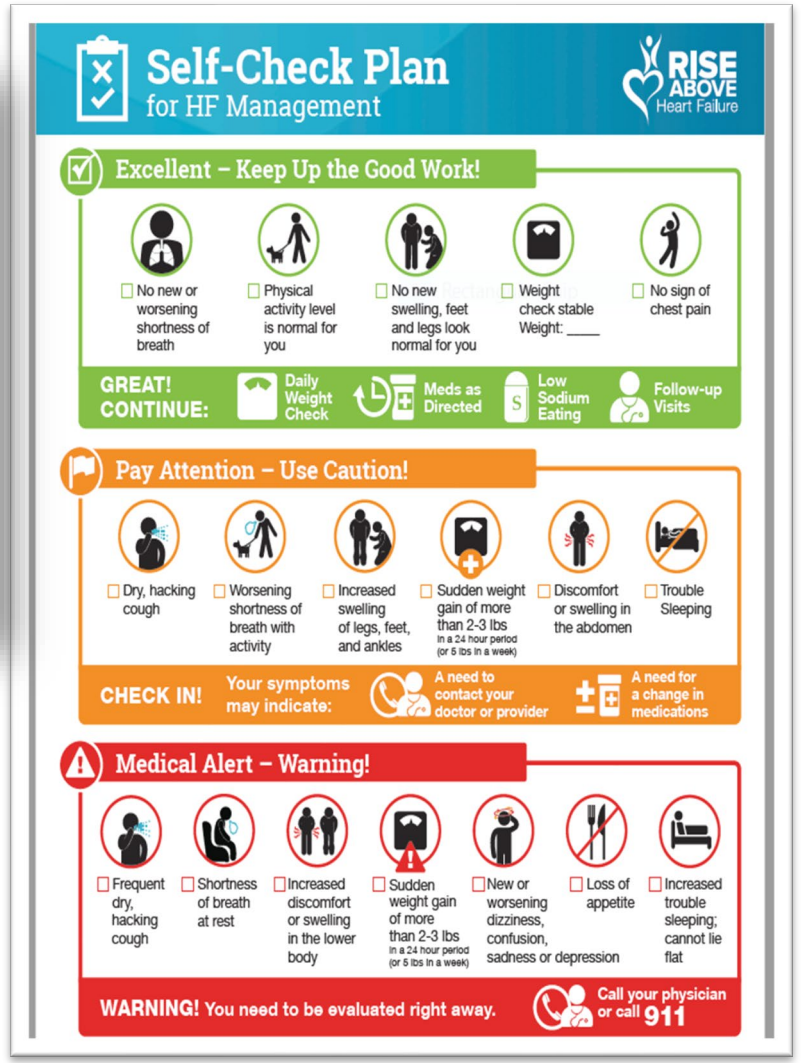
Heart Failure



Self-Check Plan for HF Management

RISE ABOVE Heart Failure

Excellent – Keep Up the Good Work!

- ☐ No new or worsening shortness of breath
- ☐ Physical activity level is normal for you
- ☐ No new swelling, feet and legs look normal for you
- ☐ Weight check stable Weight: ____
- ☐ No sign of chest pain

GREAT! CONTINUE: Daily Weight Check · Meds as Directed · Low Sodium Eating · Follow-up Visits

Pay Attention – Use Caution!

- ☐ Dry, hacking cough
- ☐ Worsening shortness of breath with activity
- ☐ Increased swelling of legs, feet, and ankles
- ☐ Sudden weight gain of more than 2-3 lbs in a 24 hour period (or 5 lbs in a week)
- ☐ Discomfort or swelling in the abdomen
- ☐ Trouble Sleeping

CHECK IN! Your symptoms may indicate: A need to contact your doctor or provider · A need for a change in medications

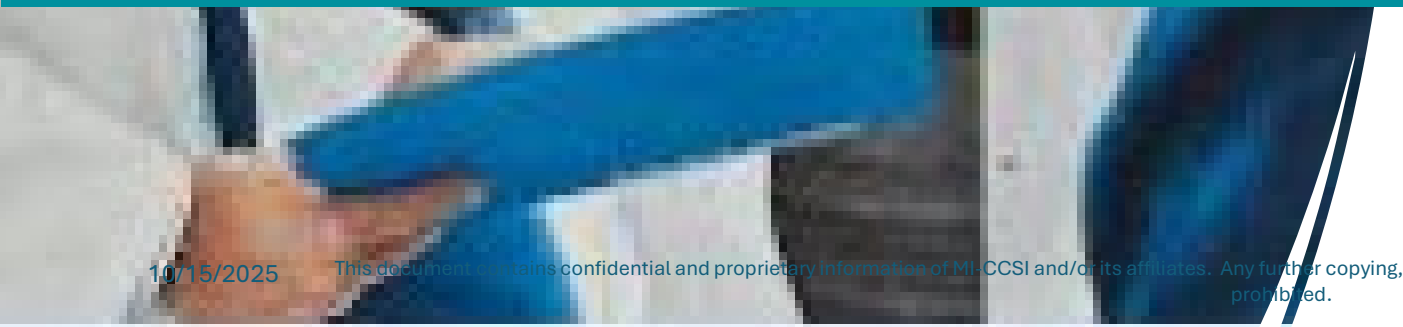
Medical Alert – Warning!

- ☐ Frequent dry, hacking cough
- ☐ Shortness of breath at rest
- ☐ Increased discomfort or swelling in the lower body
- ☐ Sudden weight gain of more than 2-3 lbs in a 24 hour period (or 5 lbs in a week)
- ☐ New or worsening dizziness, confusion, sadness or depression
- ☐ Loss of appetite
- ☐ Increased trouble sleeping; cannot lie flat

WARNING! You need to be evaluated right away. Call your physician or call 911

Care Planning - Desire

Self-management Plan

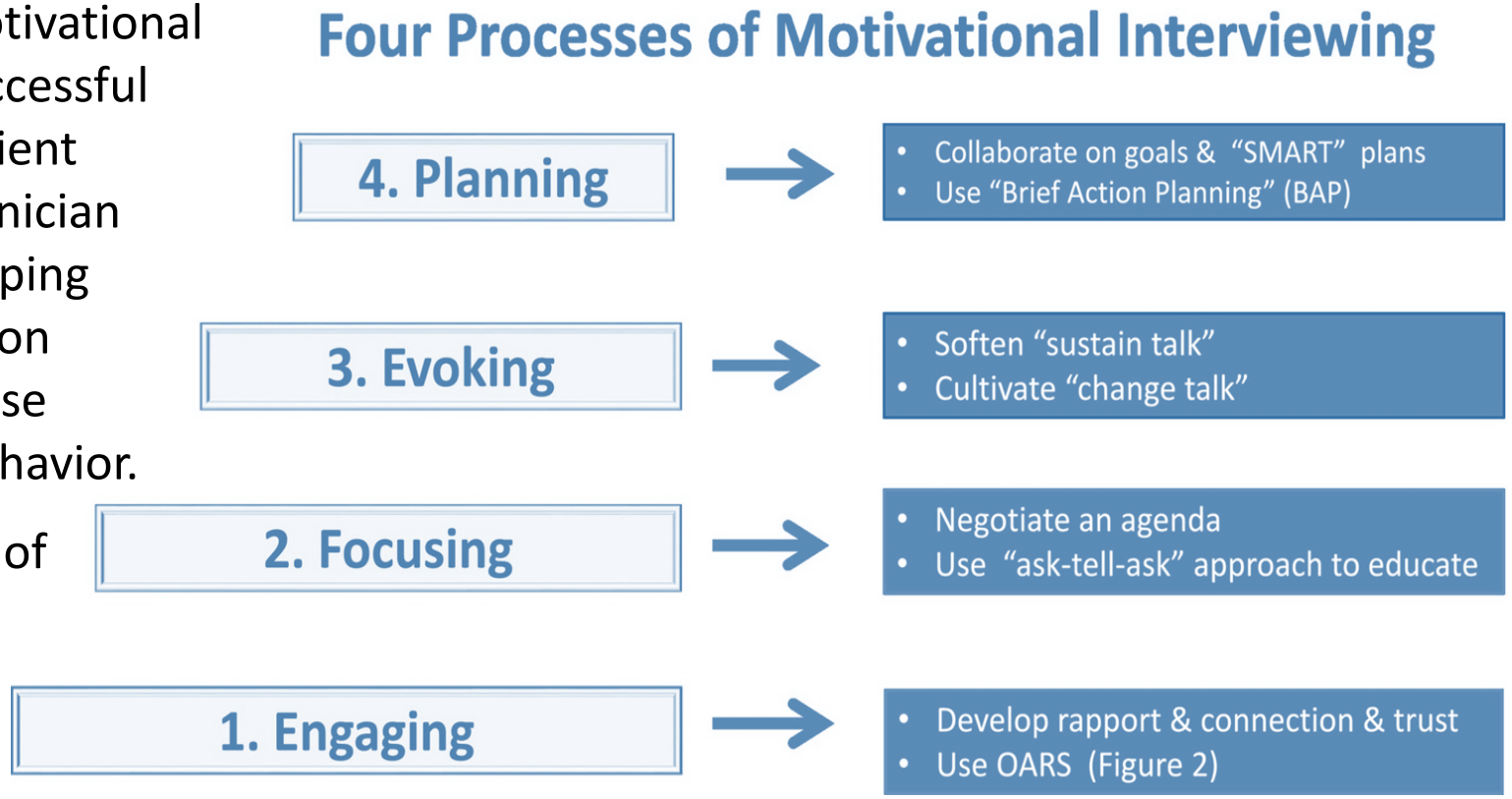


Developing A Patient Self-management Plan

Using the MI Process

If the “evocation” process in the motivational interviewing paradigm has been successful in developing sufficient positive patient language supporting change, the clinician can then move forward towards helping the patient formulate a specific action plan to initiate, improve, or otherwise change towards a desired health behavior.

The MI steps represents a “window of opportunity” emerging from the motivational interviewing process.



Engage the Patient Using Motivational Interviewing Skills
The OARS

- **Open-ended Questions** (Questions that cannot be answered with a yes/no)
- **Affirmations** – acknowledgement that goes beyond praise and impacts patients more powerfully. They are clinician comments that acknowledge and validate positive attributes, efforts, or behaviors of patients, especially ones aimed towards facilitating resilience, coping, or adaptation.
- **Reflections** - using the responses from the open-ended question, reflect back what was heard/understood.
- **Summary** - bundle reflections with insights that have been gathered during the patient visit. They serve multiple purposes. In Motivational Interviewing, summaries can selectively and strategically pull together and reinforce threads of change talk, with relative inattention to sustain talk.

https://www.sciencedirect.com/science/article/pii/S0033062023000099

Considerations

- While the care team may have outcome goals for the patient; it's really the *patient* who decides the goals that they can and want to work on
- The focus, based on the patient's motivational factor(s), is **on behavioral change actions, not outcome goals**
- **The patient**, with support from the care team, **sets the goal and actions**
- The **care team supports** the patient with **regular follow up and monitoring** of progress, using engagement skills centered on change talk

https://www.aandawellness.com/step-one-of-proper-goal-setting-establish-smart-goals/

Assessing confidence, importance, and patient value

Measuring confidence, importance and value

- Use a scale from 1-10
- A value of 7 and above indicates the patient will have success
- A lower value requires additional exploration
- The goal is to set the patient up for success

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See workbook for readiness ruler tool

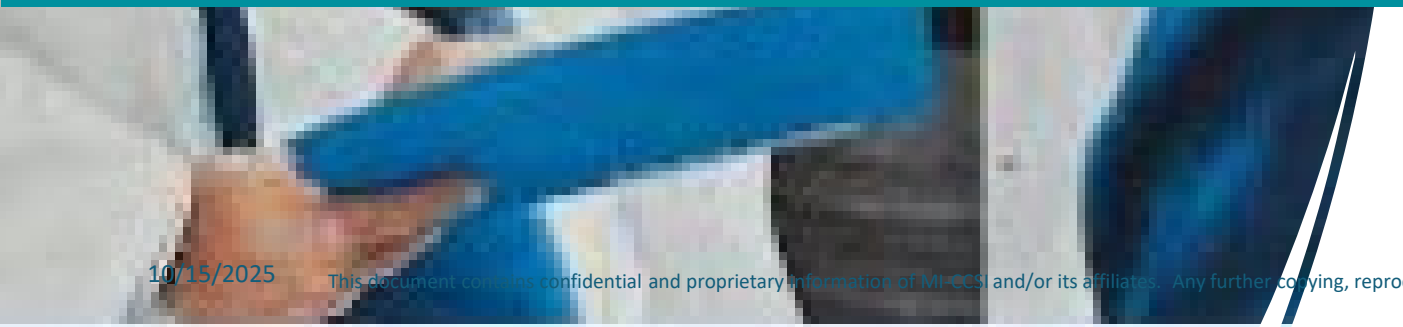
Conducting a Self-Management Plan

Demonstration

1. **Something you'd like to do to improve your wellbeing in the next 2 weeks?**
   - Make it a SMART goal
2. **Determine commitment, confidence, readiness**
   - Assessed through the readiness ruler
3. **Identify Challenges or potential barriers**
   - Have the patient problem-solve the plan(s) to overcome challenges
4. **Set a timeline for follow-up**
   - Within 1-2 weeks to demonstrate importance and establish commitment
   - Review progress or challenges, with emphasis on accomplishments
   - Determine if the plan needs adjusting and set up next follow-up date

Care Planning

Follow-up and Monitoring



Care Planning
Follow-Up and Monitoring

The follow up plan is based on the patient level of:

- Risk or safety issues
- Changes in condition or care: new diagnosis, new or change in medication, unexpected admission or ED visit
- Treatment to target trend and progress to goals
- Support needed to accomplish the patient's self-management goals

Monitoring the Plans of Care Progress

Communication Needs

- Ensure the plan of care is documented and shared in the patient record.
- Communication of the plan of care extend across all team members involved in the patient's care:
  - The patient and his/her designated caregivers
  - The practice care team at **huddles** to include the provider in the office
  - Where relationships exist externally (such as with specialists, care coordinators, home care, etc..)

Implementation and Follow-Up

Frequency

The frequency of follow up is based on patient level of:

- Risk
- Safety issues
- Changes in condition or care: new diagnosis or medication
- Treatment to target goals/trend
- Self-management abilities
- Support needed to accomplish their goals

Consider the use of agenda setting to frame up the follow up visits

- What measures/information to have available (such as PHQ, High/low blood sugars
- Progress with their self-management plan
- Any changes
- Progress with self-managing the condition(s)

Schedule the next interaction, whenever possible!

Incorporating Sustainability
Relapse Prevention – Sustaining Self-management

- How to maintain goals achieved
- Warning signs
- Coping skills
- Contacts

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**See workbook page 15-16 for sample relapse prevention plan*

Reassessing when patients don't meet goals... The patient's needs drive the approach.

- Need for treatment intensification
- Not the right goals; refocus
- Not engaging – not ready for change
- New barriers or challenges
- Exhausted treatment options time to consider transition to another level of care
- Different service or specialty

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Review of the Follow Up Phase

***Note, following-Up may indicate the need for a minor modification or a complete change in the plan of care. You use this phase as an opportunity to identify such needed revisions.*

The Following-Up phase focuses on:

- Review, evaluation, monitoring, and reassessment of:
  - The patient's health condition, needs, ability for self-care
  - Knowledge of condition and treatment regimen
  - Outcomes of the implemented treatments and interventions
- Primary objective:
  - Evaluate the appropriateness and effectiveness of your client's case management plan
  - Its effect on your client's overall health and wellbeing and care outcomes.
- Gather information - all relevant sources.
  - Share information with your patient, patient's support system, healthcare providers, and others as appropriate.
  - Document in the patient's health record findings and modifications made to the care plan, and all recommendations for care.
- Repeat these activities at frequent intervals and as needed.

https://cmbodyofknowledge.com/content/introduction-case-management-body-knowledge

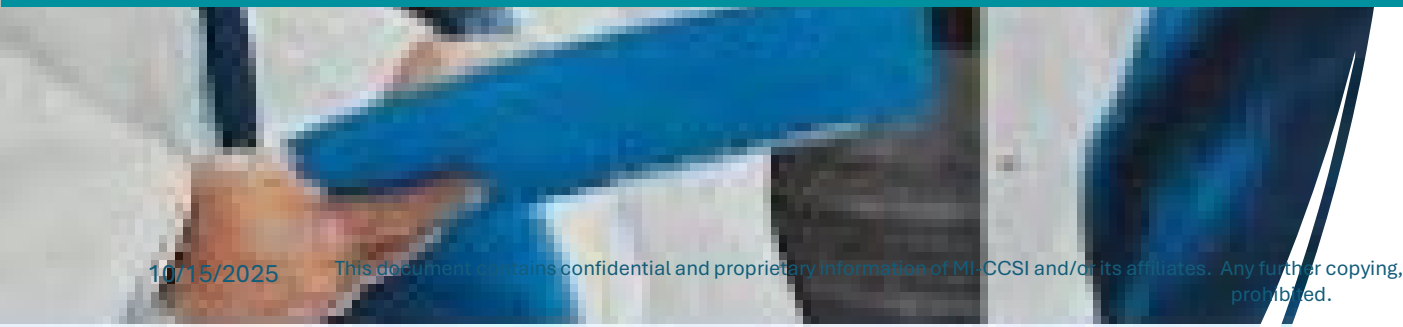
Follow Up Phases Guide

Intake completed, treatment plan established, first SCR completed	Parameters progressing toward target goals	Demonstrated goal attainment and progress towards sustainability

Active Engagement Phase *1st and 2nd contacts*	Active Management Phase *Weekly contacts in the first month* *Every other week during active management phase*	Active Transition Phase *Frequency gradually extended* *Average duration 5-18 weeks*	Maintenance Phase *Monthly to every 3 months* *Average duration 6-12 months*
• Determine eligibility and appropriateness • Introduce COMPASS and set the roadmap for care • Start building relationship with patient to identify preferences, strengths and challenges • Establish primary care team communication strategy, engagement plans, caseload impact and understanding of patient care needs	• Clinical prioritization, assessment of red flag risks and identify patient preferences • Establish treatment plan including both short and long term goals for optimal improvement • Purposeful care management using Motivational Interviewing, Behavioral Activation and goal setting that links treat-to-target clinical plan including med intensification with personal health goals by developing strategies for self-monitoring, treatment (including medications) adherence and problem solving skills • Shared understanding of working toward optimal maintenance of the chronic conditions and the organic but intentional process of outcome oriented care management	• Based on pt's progress with clinical and personal goals and agreement that significant improvement has been made • Less frequent contacts as an opportunity for pt to practice identifying triggers, problem solve and self-monitor • Duration may need to be variable based on patient readiness, unanticipated pitfalls and ongoing coaching needs but overall becomes longer periods of self-management success • Starting to build maintenance plan using patients own words for what has contributed to improvement and problem solve obstacles	• Patient has been practicing and more consistently demonstrating self-management including ability to identify triggers, setbacks and opportunities • Maintenance Plan has been developing along the way and patient can now articulate and complete own written plan for sustainment (example: own personal "yellow zone" and when to contact clinic when things come up and assistance is needed) • Schedule established for PCP follow-up and lab/clinical monitoring intervals • Primary care team understanding of maintenance plan including support role and routine follow-up expectations

Care Planning

Case Closure to CM services



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Case Closure

Reasons for case closure/discharge from care management support:

- Patient can self-manage
- Patient has met his/her goals
- Patient is admitted to hospice care/different level or place of care
- Patient declines further services
- Patient expires

These are a few reasons others have identified.

What will be the reasons in your clinic?

Communicating Case Closure

- Discuss case closure with the provider and other members in the clinic
  - Verify all are in agreement to closing the case
  - Status of treat-to-target goals
    - If not met, reasons and ideas to overcome
  - Next steps
    - Who will monitor for relapse
- Discuss with the patient.
  - Review the patient's journey
    - Lessons learned, goals achieved, symptom management plan.

Best Practices

Follow up with a letter (see sample letter).

- Reviews accomplishments and status
- Should the patient identify they are relapsing, provides actions on who to contact

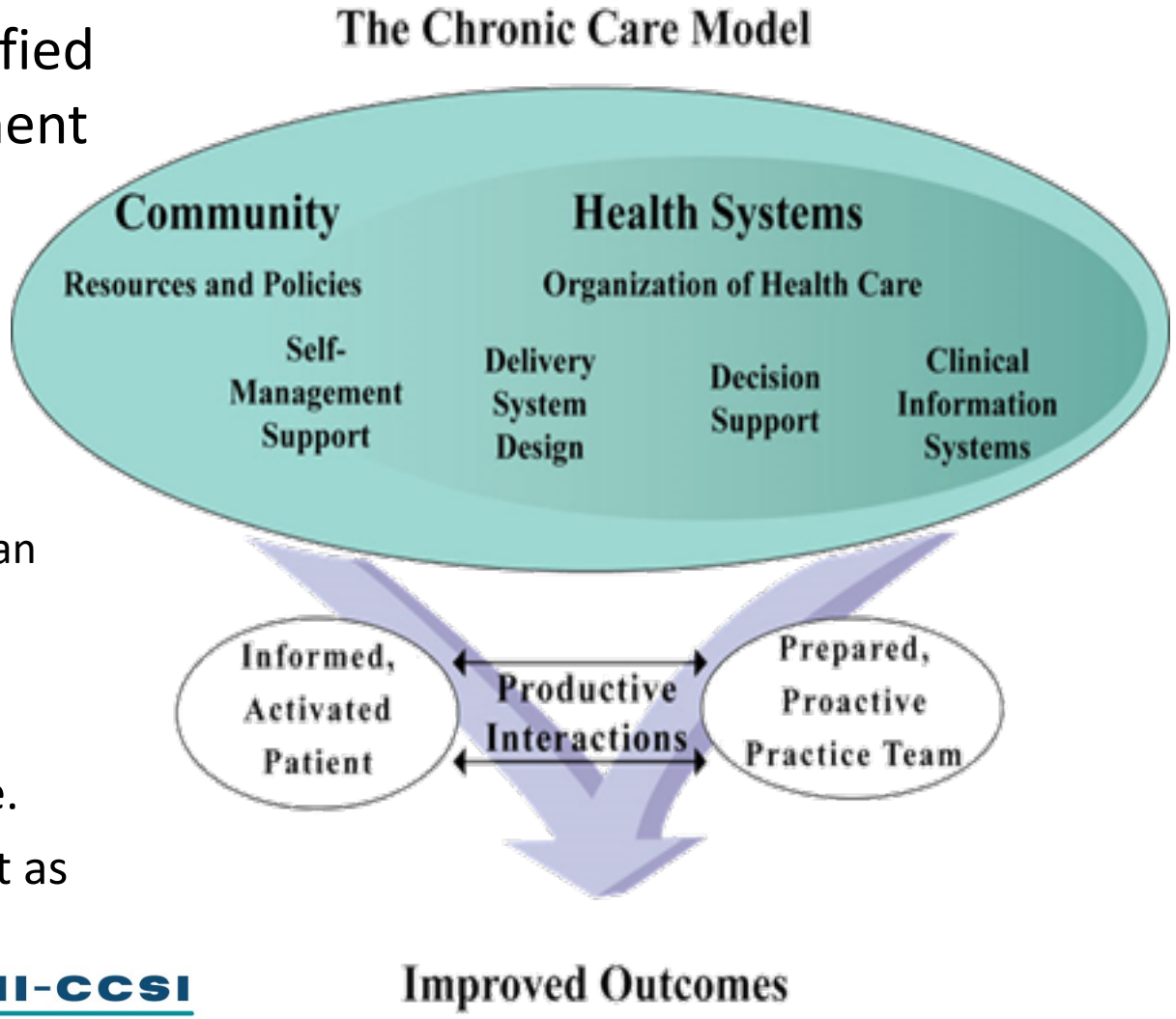
Always keep the door open! The patient may need your services again.

Patient Can Self-Manage

"Informed and Activated Patient" was identified earlier in this course and is a critical component of the Chronic Care Model.

Practically, this means that the patient:

- Has the resources, knowledge to consistently manage his/her own care.
  - This might not mean perfection, but it does mean that the patient understands and has sufficient motivation to take care of themselves.
- Can problem-solve around their health care symptoms without needing additional guidance.
- Knows how to reach their care team for support as needed.



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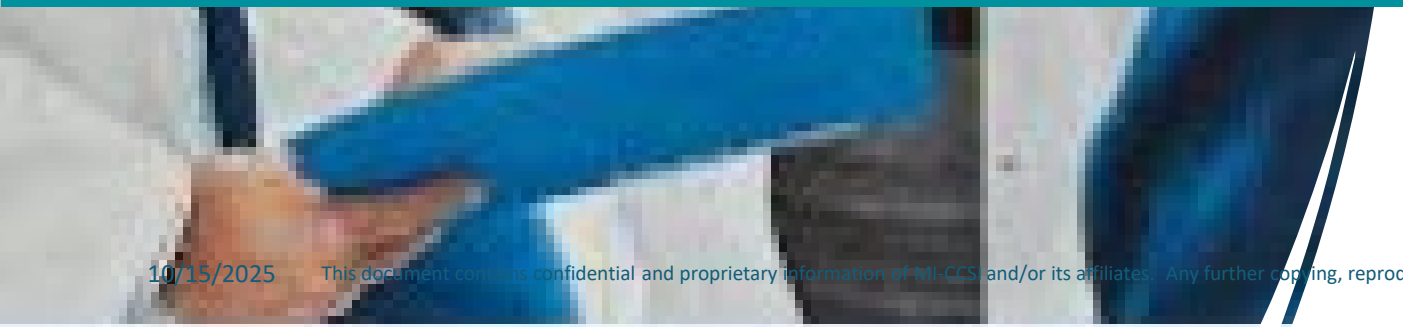
Post Case Closure

- Evaluate the impact of care management:
  - Did the patient get to target?
  - Is the service improving the population as a whole?
- Process improvement opportunities
  - Selecting the wrong patient's
  - Need to refine the trigger list
  - Need to re-evaluate the process
- Internal self-assessment and reflection for patient engagement skills
  - More directing than partnering
  - Minimal use of Motivational Interviewing to support behavioral change
  - Rushing to a plan before the patient is ready

Care Management Process - Application

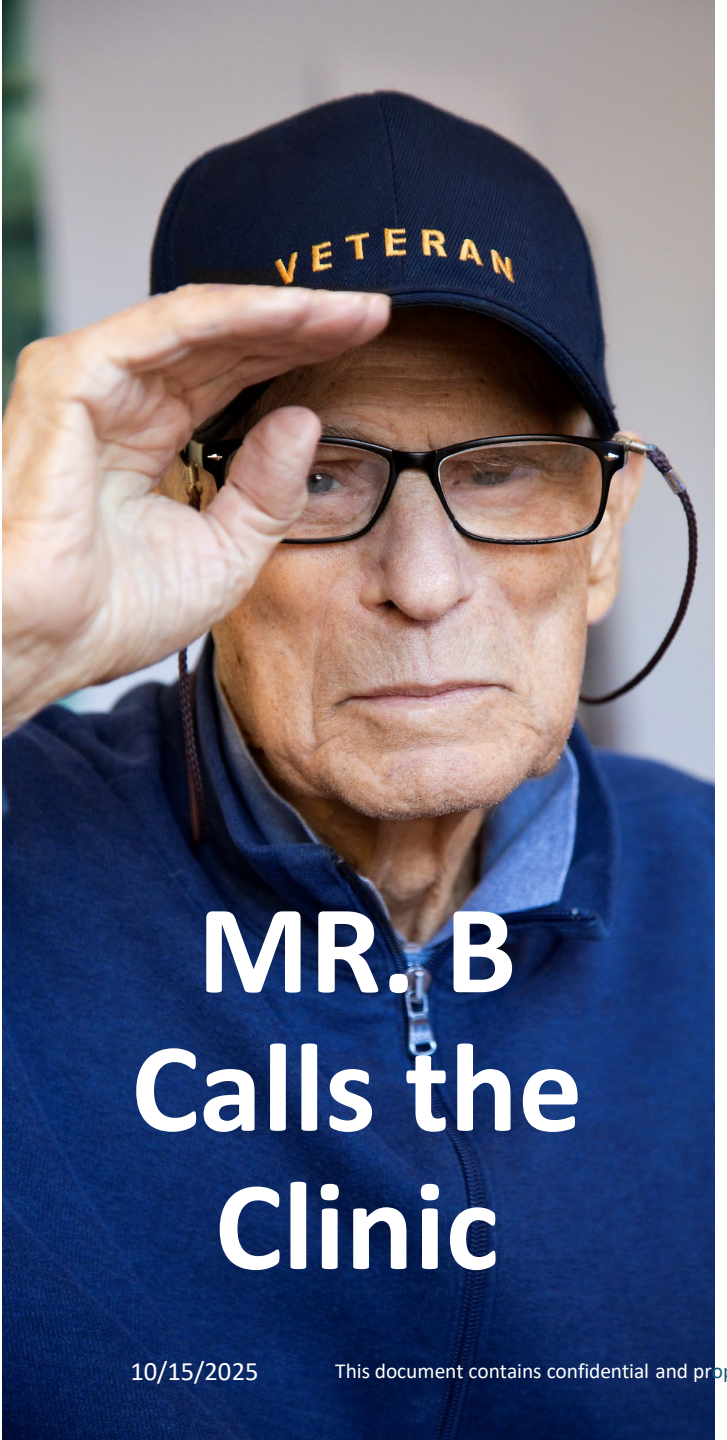
Utilizing Communication Tools Facilitating Team-based Care



Case Study Mr. B

Appling TBC Concepts

**Locate the case study in the workbook*



MR. B Calls the Clinic

Current health status

- Increasing symptoms of fatigue, weakness, and shortness of breath, feeling low
- Difficulty Sleeping
- Has not been prescribed home O2
- Non-smoker

Knowledge of Current Management

- **Medications**: Unsure about his medications
  - Specifically, in the hospital, they held his hydrochlorothiazide, and on discharge, they did not give any directions about continuing to take this medication.
- **Nutrition**
  - Appetite is good. Eating a regular diet. Not restricting any fluids- doesn't recall that he should be limiting fluid intake.
- **Functional Assessment**
  - He has fallen once, no injuries other than bruises on his forehead
  - Does not use a cane or walker- "try to do it on my own"
  - He is unable to complete his own activities of daily living without some assistance ;tires easily; SOB with activity requiring help dressing
  - He can do his hygiene & feed himself
  - Daughter prepares his meals.
- **Social Determinants of Health**
  - Needs assistance with transportation to medical appointments
  - Living with daughter temporarily, wants to go back home, but his daughter is concerned about him living independently
  - Widower, retired, limited income

Group Activity and Discussion

1. From what is retrieved in the call, what key information would be helpful for the provider to decide on actions that will resolve immediate needs/patient safety?
2. With this information, create the SBAR.

1. In addition to the SBAR, what other communication tools could be applied?
2. Based on Mr. B's situation and background, would he benefit from care management?
3. What criteria and triggers could assist the team to make this decision?
4. What will be the goal for Mr. B? What will success look like?

**The SBAR tool is in the handout packet as a reference.*

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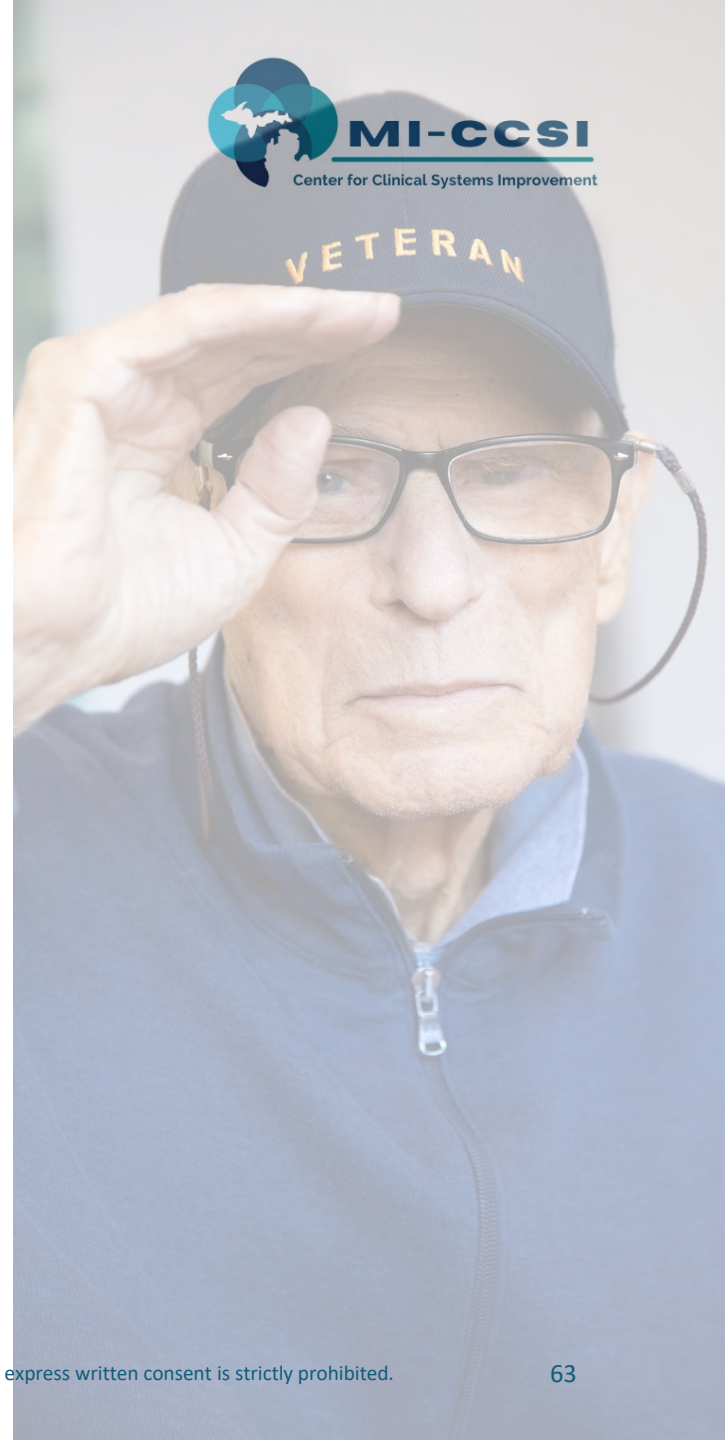
Mr. B Case Study

Findings: Care Manager Assessment

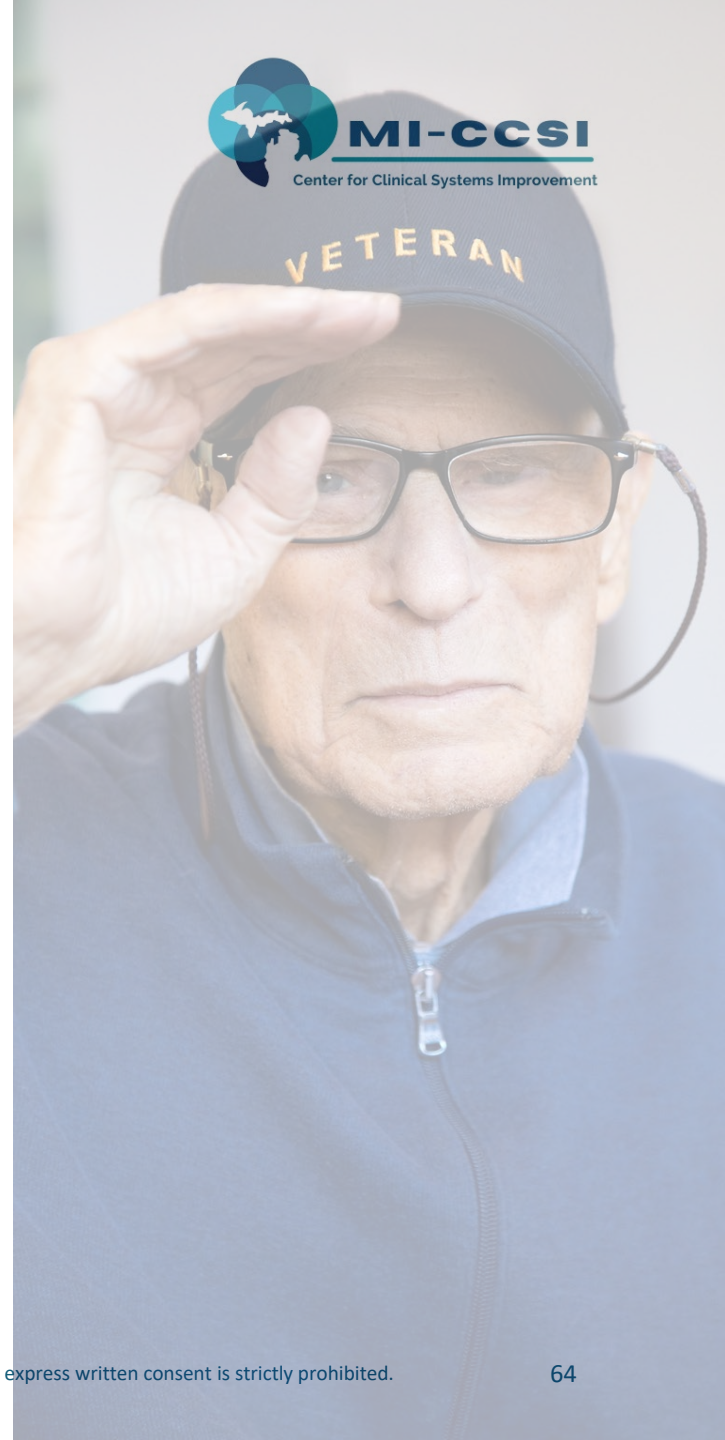
- Mr B. has a knowledge deficit on why he is taking his medications.
- Although he is not currently strong enough to return to independent living, it is a reasonable consideration in the future.
- He was screened for depression with a PHQ score of 12 . The diagnosis was confirmed



Mr. B Case Study

Care Plan

1. Based on the assessment findings, what will be the plan for Mr. B regarding his:
   - Medical needs
   - Behavioral needs
   - Social needs
2. What do you think Mr. B's motivating factor is? And what care plan approach would you use to engage him?
3. What communication tools could be used during these encounters?
4. Which team members will assist with the care management plan?



1. Using the care plan(s) developed, what will be regularly monitored and followed up on to determine Mr. B's progress (the treat-to-target measure)?
2. How often would you recommend the monitoring?
3. How will you determine when Mr. B is ready to be discharged from care management?
4. What will be the process to return Mr. B to having the clinic monitor Mr. B's care?
5. What communication tools could be used during these encounters?

Team Actions

Review the assessment tools available in the medical record today.

- Where are there opportunities for improvement or development of new assessments?
- Identify the team member who will lead this initiative. Such as low, moderate or high- risk patients.

As a team:

- Determine what conditions you will start the initial focus on. For each condition, determine if there are treat-to-target goals that can be regularly monitored (ie PHQ for depression – goal is remission, a score of less than 5, A1C for diabetes – goal below X, …)
- Finalize a self-management action plan that captures the patients motivation for healthy behavioral changes.
- Establish a plan for implementation and use of these documents.
- Establish a plan to share the results with the provider and determine what actions will/can occur for any positives.

Review the communication tools. Select 1 tool to start with.

- Create a PDSA to identify what data you will collect to determine what is working and what requires modifications.
- Create an SBAR for one of the conditions the team would like to focus on (COPD, HF, Depression, Diabetes).
- Discuss with the provider and clinical team members the key information needed from the situation and background for the condition in order to make decisions.