TCPi | Transforming Clinical Practice Initiative

nrhi Network for Regional Healthcare Improvement

High-Value Care Support and Alignment Network

Advancing Care Management

Power Up for Managing a Population

Institute for Clinical Systems Improvement

Tani Hemmila, MS, BSW

Todd Hinnenkamp, BA, RN

Program launched December 13, 2017

Ready, Set, Engage

Chat Box:

- Chat questions to "**Everyone**" so participants can view and panelists can respond
- Panelists will respond to your questions during the Q and A discussion

Live Polling:

- Watch for our interactive polls: Quick multiple choice options with results in real time

Follow-up:

- Following the presentation, participants will receive a follow-up email with the slide deck, recording, and a link to access additional resources

NRHI SAN Faculty and Topic Areas

NRHI High-Value Care SAN Learning Program Topics
Measuring and Understanding Total Cost of Care
Behavioral Health Integration
Reducing Unnecessary Utilization
Navigating Payment Reform
Designing and Evaluating Quality Improvement Programs
Advancing Care Management
Improving Person and Family Engagement
Resources can be accessed here: https://nrhisan.healthdoers.org/home

Advancing Care Management

Topic	Expert Instructor	Launch Date
Care Management Through Registries	ICSI Institute for Clinical Systems Improvement Transforming health care, together	**12/7/17**
Power Up For Managing a Population	ICSI Institute for Clinical Systems Improvement Transforming health care, together	**12/13/17**

Addresses Key Elements of TCPi Change Package

1.3 Population Management

- 1.3.4 Develop registries
- 1.3.5 Identify care gaps

1.5 Coordinated Care Delivery

- 1.5.1 Manage care transitions
- 1.5.3 Coordinate care
- 1.5.4 Ensure quality referrals

Presenters: From Institute for Clinical Systems Improvement (ICSI)

Tani Hemmila, MS, BSW
Director, Institute for Clinical Systems Improvement
Minneapolis MN

- Leads health care collaborative initiatives in Minnesota, emphasis on BH
- Practice facilitator in COMPASS, a national CMMI collaborative care initiative
- Broad-based experience: social work in mental health, community systems change, business, and training / learning environments.

Presenters: From Essentia Health

Todd Hinnenkamp, BA, RN
RN Ambulatory Supervisor and Depression Care Management

- RN for 21 years - with the past 11 years in an Ambulatory Care Clinic
- RN Supervisor of General Internal Medicine, Integrative Health, Elder Care, and Memory Clinic as well as Depression Care Management
- Partnered with ICSI on both the DIAMOND and COMPASS Collaborative Care models
- Working group member for ICSI depression guideline

Objectives for Today

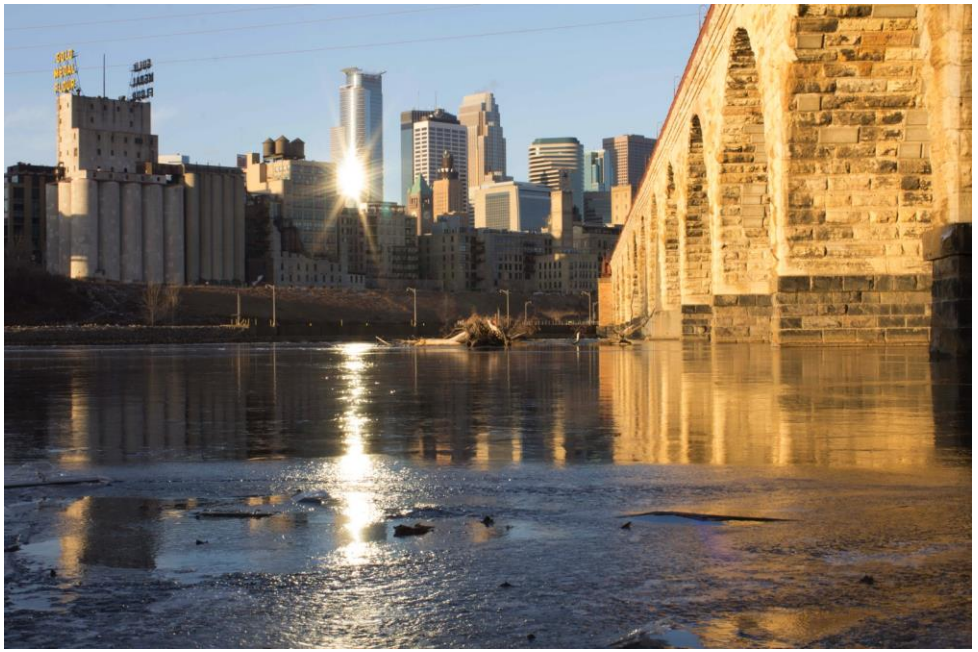
In this module you will learn about:

- Five components of highly effective care management programs for patients with complex / comorbid needs with a goal of improving population health.
- Lessons from the field, including from the successful collaborative care program, COMPASS.
- Tactics and tools for moving from basic care management to 'powering up' for population health management for patients with complex needs.
- How to partner with patients and team members in new ways to improve care management support.

ICSI
Institute for Clinical Systems Improvement

An independent, non-profit healthcare improvement organization focused on the Triple Aim goals of better care, smarter spending, and healthier people. ICSI has served the people of Minnesota (and other communities) for 21 years.

www.icsi.org



Poll Questions

- Are you familiar with the DIAMOND or IMPACT Collaborative Care Models?
- Are you familiar with the Team Care or COMPASS Collaborative Care Models?

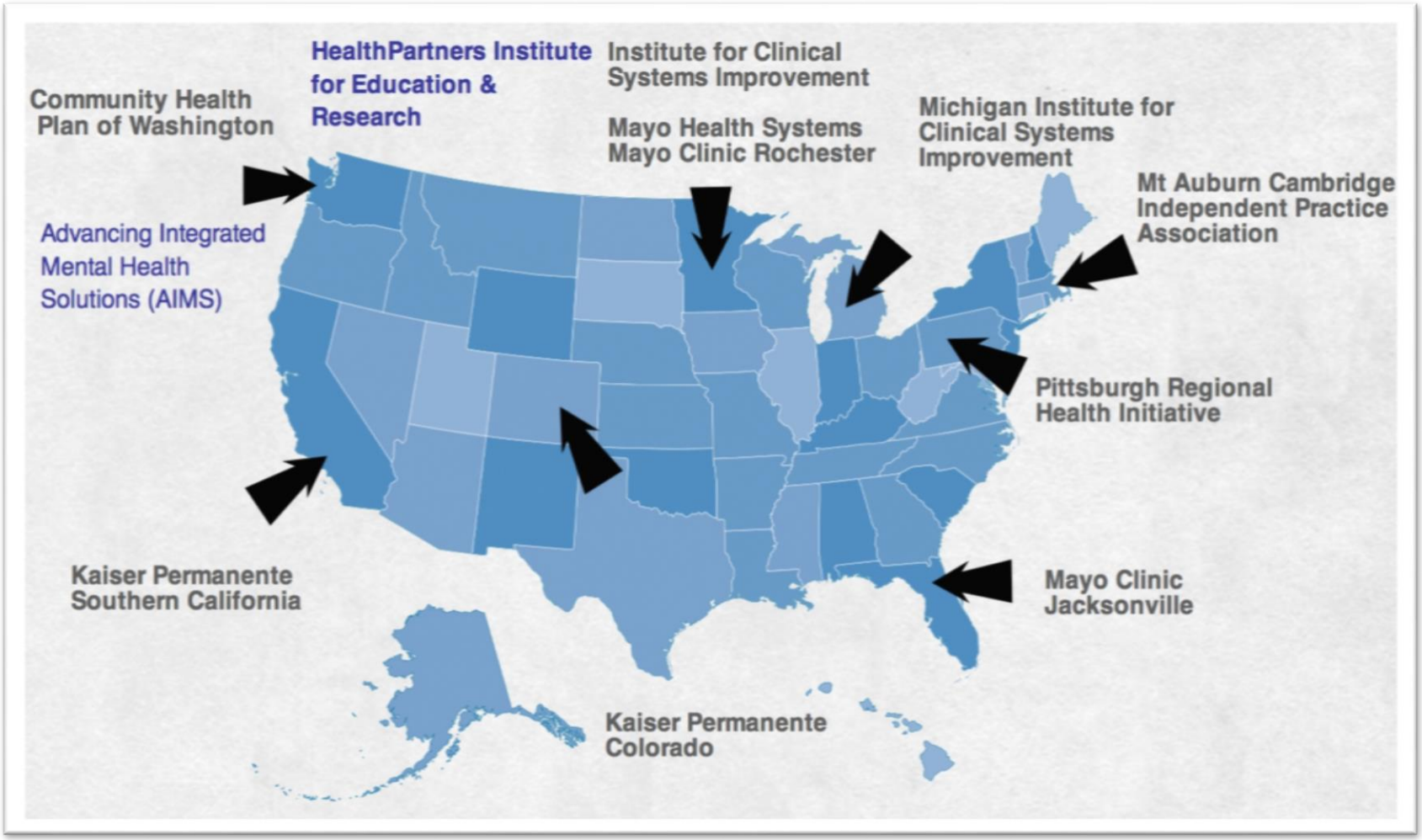
Chat in if you have been directly involved with any of these initiatives, we'd love to hear from you!

COMPASS

COMPASS is a national dissemination and implementation initiative for a collaborative care management model for the integration of behavioral health into primary care, drawing on information from clinical trials and other implementation projects.

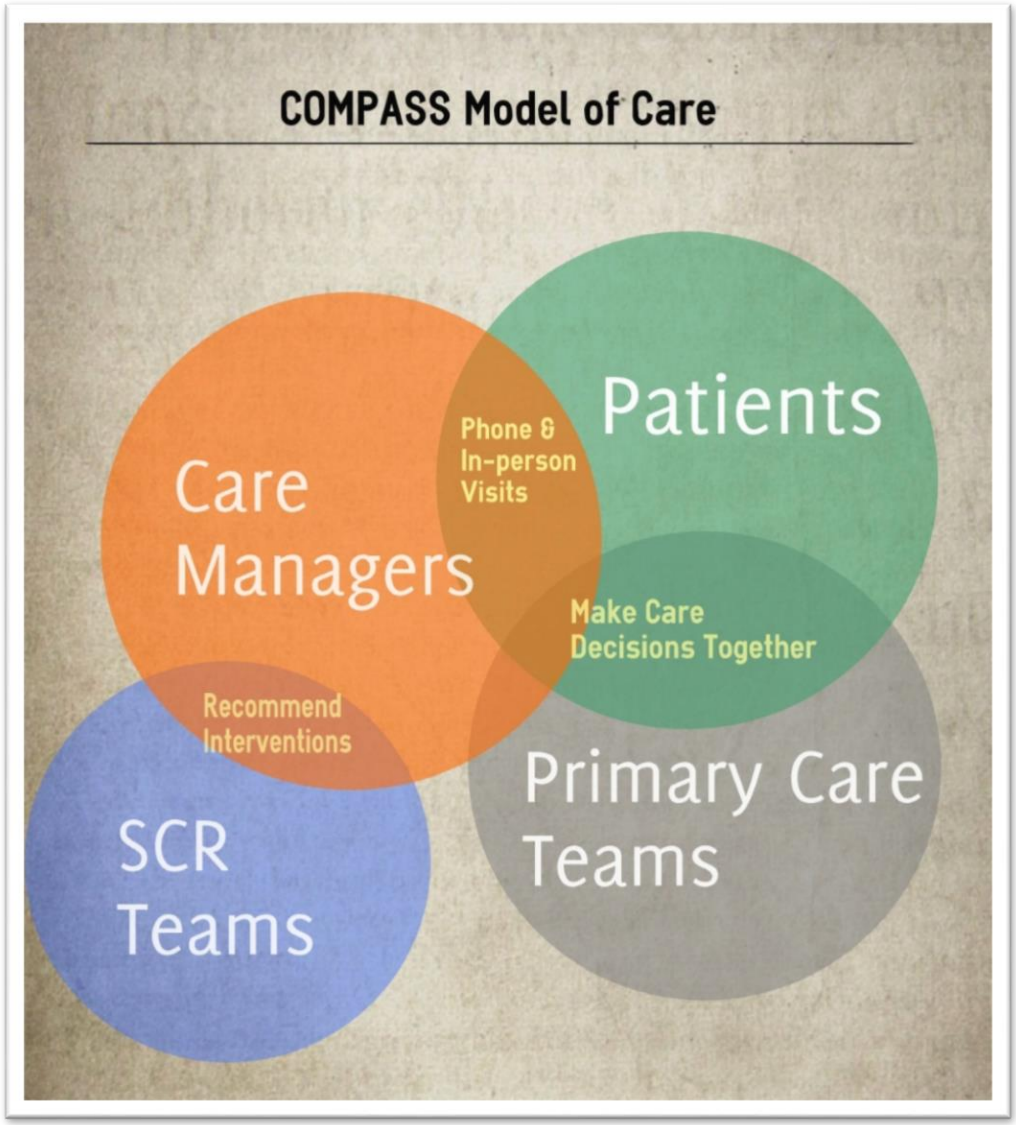
ICSI

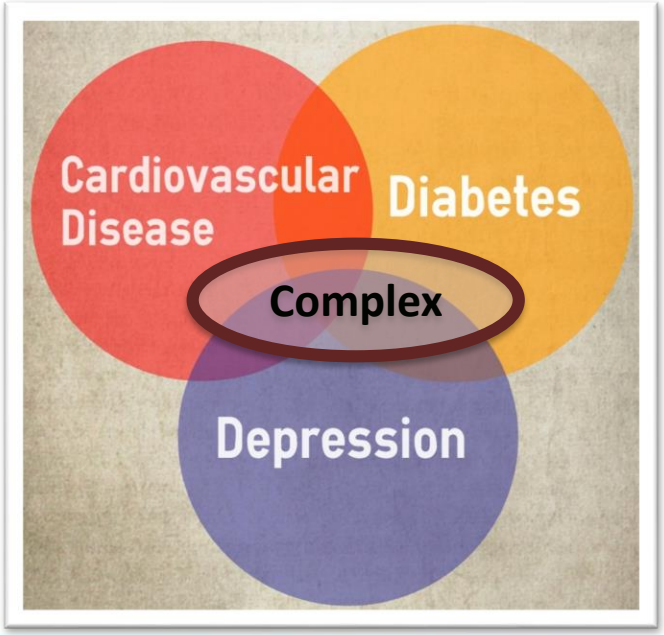
COMPASS Consortium: Ten National Partners



COMPASS Outcomes Summary
3854 patients

	Outcome Goals	Analytic Outcomes
Depression	Improve control for 40% of patients	**61%** have shown significant improvement (decrease in PHQ9 by 5 points or a PHQ9 of less than 10)
Diabetes	Improve control rates by 20%	**23%** absolute improvement in patients with a HgbA1c <8
Hypertension	Improve control rates by 20%	**58%** of those who entered with uncontrolled hypertension have blood pressure in control


COMPASS Model of Care
Patients
Care Managers
Phone & In-person Visits
Make Care Decisions Together
Recommend Interventions
SCR Teams
Primary Care Teams


Cardiovascular Disease
Diabetes
Complex
Depression

A Systematic Case Review Team discusses both the medical and mental health needs of a patient to build an integrated care plan to achieve patient goals.

COMPASS Patient Characteristics

- Total number: 3854
- 59.7 average age; 64% female
- All had already failed “usual care” in their system

- Insurance mix
  - Commercial: 28%
  - Medicaid 22%
  - Medicare 48%
  - Dual 5%

Defined Care Management Processes

- Intensive and personalized
- Standard initial evaluation and screening
- Patient readiness for self-management support
- Baseline testing
- Medical goal-setting
- Patient-determined goals
- Routine monitoring for progress to goal

What did we learn about Care Management in COMPASS?

COMPASS Care Manager Characteristics

Design

- RN
- Medical knowledge of key importance

Adaptations

- RN
- LCSW
- Psychologists
- Pharmacists
- Health Coaches
- Ability to build and maintain relationships is key

Lessons Learned: COMPASS CM Study

- Depression improvement was directly related to frequency of care management contact
- Patient outcomes did not vary with care manager degree or background
- Need for administrative support; all working at top of license

Lessons Learned: COMPASS CM Study

Beneficial across settings:

- Social work; administrative support (e.g. patient lists)
- Registries integrated into electronic medical records
- Education such as motivational interviewing

Patients and clinicians were satisfied with COMPASS care

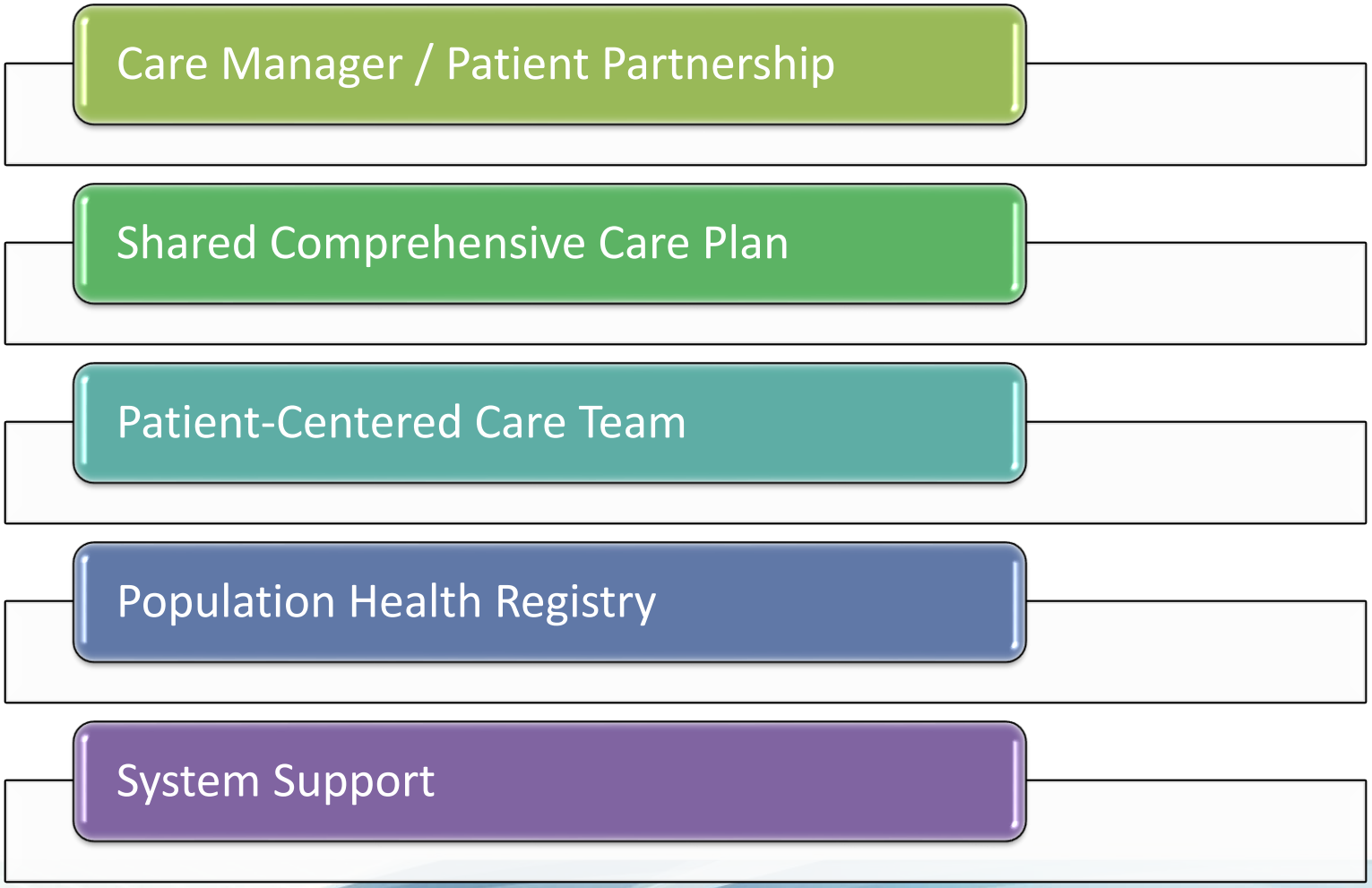
Q and A

Ask a question via the “chat box”

Tani Hemmila
ICSI
Minneapolis MN

Todd Hinnenkamp
Essentia Health,
Duluth MN

High Value Care Management



Poll Question

Which component are you most interested in?

- Care Manager / Patient Partnership
- Shared Comprehensive Care Plan
- Patient-Centered Care Team
- Population Health Registry
- System Support

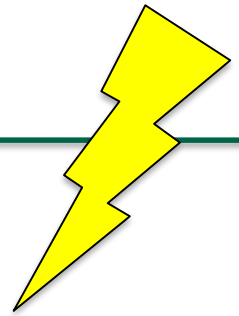
Care Manager : Patient Partnership

- Skills Needed
  - Understanding of diseases, multiple condition implications and behavior change
  - Laser focus on treat-to-target
  - Dedicated time for care management
  - Interpersonal skills, engaging and trust-building
  - Use of registry and planning contacts

Care Manager / Patient Partnership

- Characteristics – Attitudes and Values
  - Flexibility and adaptability
  - Taking the long view; therapeutic relationship
  - Respecting patient autonomy, strengths, supporting their self-management
  - Creative and tenacious problem-solving
  - Purposeful relationships with team, community

Powering up your partnership



You've got the basics

- Understanding of conditions, behavior change
- Support from the team

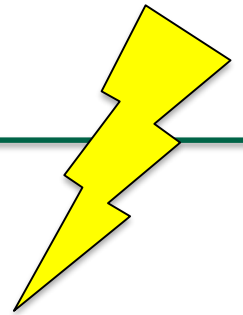
To power up:

- Give the power to the patients
  - Make your goals shared
  - May need to educate, it's not me telling you what to do

(Primary) Care Teams

- Care manager is part of team; clear roles
- Team constructed around patient needs
- Useful communications channels
- Valuing contributions of all
- Transparent communication
- Expertise, not hierarchy

Powering up the Care Team



You've got the basics:

- A team
- Communication channels

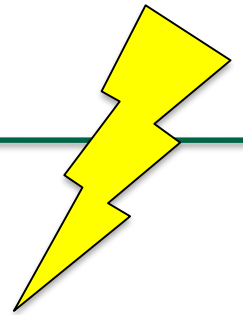
To power up:

- Check your communications channels
- Much as you partner with patients, partner with providers
- Vary approach with different teams

Shared Comprehensive Care Plan

- Comprehensive; including social, relapse prevention
- Medical goals with targets
- Patient-determined goals, targets, self-management supports
- Incident plan: what to do, who to call if problems?
- Shared (With whom and how? How/who modifies?)
- Patient goals have high priority
- Mindful of ‘fit’ with patient life

Powering up the Care Plan



You've got the basics:

- Medical goals with targets

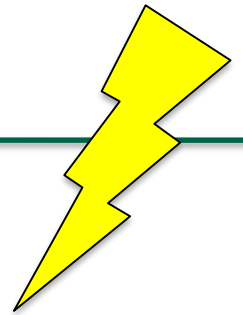
To power up:

- Patient-determined goals, targets, self-management supports
- Patient goals have high priority
- Mindful of 'fit' with patient life

Population Health Registry

- More than a patient list
- Structural support for care managers
- Provides evidence-based tools
- Allows custom, real-time reports
- Tracking patient progress toward goals

Powering up use of the Registry



You've got the basics:

- Data entry for reports
- Seeing individual patient progress

To power up:

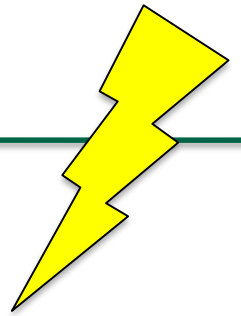
- Ensure it's fully functional, to manage population
- Educate staff so they can use it fully
- See population trends and outcomes at a glance
- Keeps it in your face

System Support

Simply dropping in a Care Management program is not enough

- Leadership support
- Valuing the role of care manager
- Willingness and effort to connect across siloes
- Linkages to community agencies
- Orientation toward outcomes; population, individual value-based care

Powering up System Support



You've got the basics:

- Minimal support from organizations
- Basic understanding of role and connections

To power up:

- Individuals working at the top of their licensure
- Connecting with internal and external resources (Social Work, Pharmacy, Billing, etc.)

Organizational Attitudes and Beliefs

- Patient-centered - patient goals have high priority
- Orientation toward outcomes; population, individual
- Orientation toward value-based care
- Expertise, not hierarchy
- Valuing the contributions of all
- Willingness and effort to connect across siloes
- Transparent communication
- Valuing the role of care manager

Tools, and Takeaways

- Situation, Background, Assessment, Recommendation (SBAR)
- Systematic case review (SCR)
- Scripting, follow-up contact tips

Tools and Takeaways

Communication and engagement with team

- Improving team communication
  - Spend time on team – address it together
  - Truly partnering around the patient
  - Motivational Interviewing good here too!

Tools and Takeaways

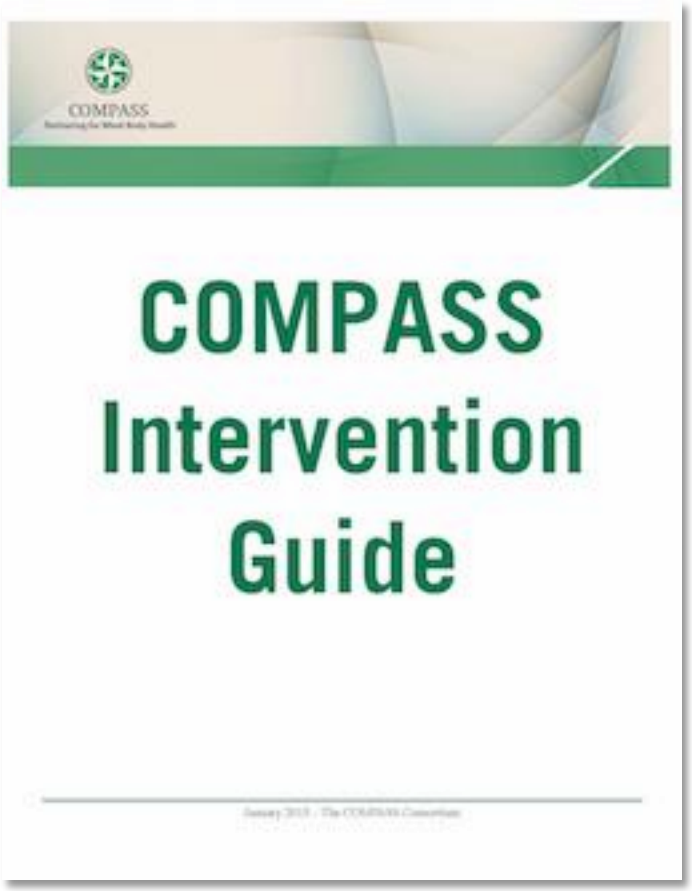
Communication and engagement with patients

- Improving patient engagement
  - Motivational Interviewing & behavioral activation
  - Small successes
  - Don’t give up

COMPASS Guide and Training Resources

Provides the following:

- Clinical workflow
- Supporting annotations and appendices for primary care systems
- Evidence and best practices
- Links to recommended tools



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Additional Resources

Enhanced Communication for Practice Transformation: *use of SBAR and huddles*

Delivered by: **National Nurse-Led Care Consortium SAN**

Length: 1-1.5 hour interactive webinar

Attendees receive a comprehensive materials guide filled with content and tools for immediate use.

Objectives:

- Recognize characteristics of high performing teams.
- Identify outcomes of effective and ineffective team communication.
- Demonstrate effective communication and huddle strategies.
- Select at least 2 measures to evaluate team communication and huddles in your setting.
- Identify at least 1 teaching-learning strategy to use to improve communication and huddles in your setting.

For more information: Tiffanie Depew, tdepew@nncc.us

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Additional Resources

'Formation & Optimization of Interdisciplinary Care Teams for Practice Transformation'

Delivered by: **National Nurse-Led Care Consortium SAN**

Length: 4 hour in-person interactive workshop **Cost:** FREE

Description:

Module 1	Defining your team; Recognizing high-performing teams; Communicating effectively: SBAR, Huddles
Module 2	Defining team roles and responsibilities: Swim Lanes, Role Maps; Optimizing team roles for workflow efficiency
Module 3	Building continuity with patients and families; Shared care planning

Attendees receive a comprehensive materials guide filled with content and tools for immediate use.

For more information: Tiffanie Depew, tdepew@nncc.us

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Additional Resources

'Optimizing Care Coordination Through Teams & Teamwork'

Delivered by: **National Nurse-Led Care Consortium SAN**

Length: 4 hour in-person interactive workshop **Cost:** FREE

Description:

Module 1	Decision points for effective care coordination: mapping the medical neighborhood; Working with patients and families.
Module 2	Explore selected strategies and tools that support effective care coordination in primary care: Risk screening; Shared care plan; Huddles and team meetings; Transfer of information/transitional care.
Module 3	Teamwork and recognizing care coordination success: Optimizing care coordination on the primary care team; Working with care coordinators/case managers; Recognizing successful care coordination processes and outcomes

Attendees receive a comprehensive materials guide filled with content and tools for immediate use.

For more information: Tiffanie Depew, tdepew@nncc.us

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Additional Resources

NRHI SAN Motivational Interviewing Resources		
Learning Module: Using Motivational Interviewing and Shared Decision Making Tools to Facilitate Change	Pittsburgh Regional Health Initiative Spreading Quality, Containing Costs.	**Recording and slides archived and available in NRHI SAN online community**
Learning Labs on Motivational Interviewing and Collaborative Communication available	ICSI Institute for Clinical Systems Improvement Transforming health care, together Pittsburgh Regional Health Initiative Spreading Quality, Containing Costs.	**Learning Labs available to PTNs upon request. Reach out to elevi@nrhi.org**

Q and A: Ask a question via the “chat box”

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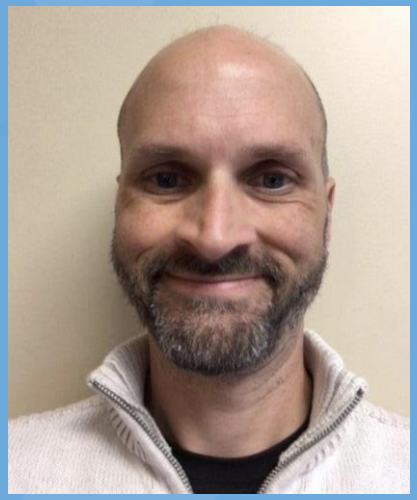
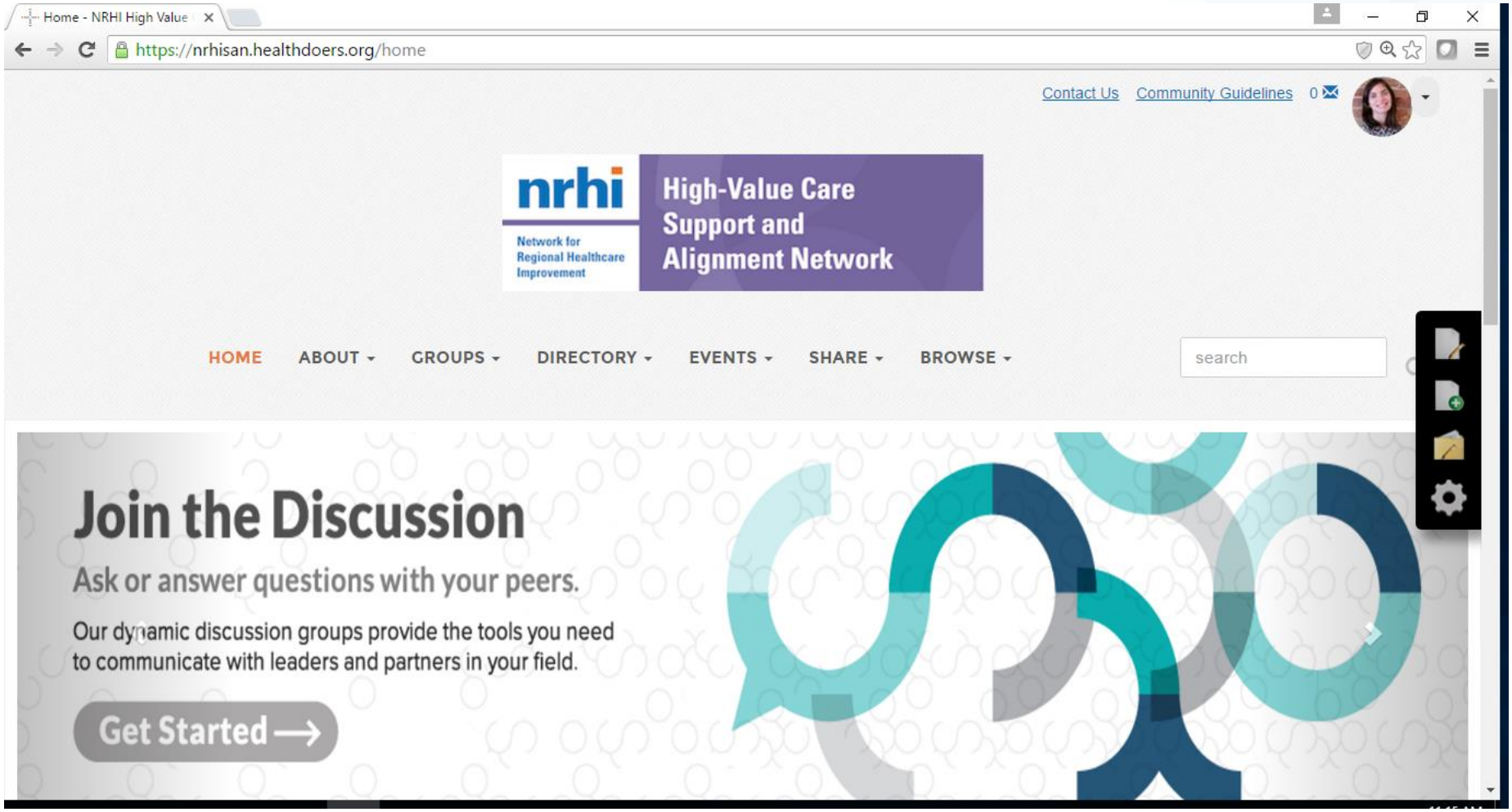


Todd Hinnenkamp,
Essentia Health,
Duluth MN

Join our online Community!



Thank you for participating in this NRHI SAN Learning Program:

Powering Up Your Care Management

Thank you for taking a few minutes to complete our survey! Your feedback is important to the continuous development of our programming!

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