Care Coordinator Caseloads

Care coordination caseload allocation is challenging due to the variety of roles, scopes of practice, and responsibilities, and this ultimately impacts patient outcomes and care coordinator retention.

How is your clinic/organization approaching patient caseload and what have you learned?

Participants Input & Suggestions at Workshop:

- Average case load for embedded clinic care coordinator varies greatly from clinic to clinic.
- Some half time care coordinators have 20 – 30 patients
- Full time care coordinators vary – discussed a wide range of caseloads: from 30 – 160, 90-150, 60-70 in newer programs, 100 – 150 in more established programs.
- Consensus during discussion – a lot of frustration trying to find the correct caseload they can handle.
- Variation due to many factors, complexity of patients, mental health issues, and social determinants of health needs.
- Many care coordinators in clinics are tackling multiple roles.
- Hard to figure out exactly how many you can handle on a caseload.
- Haven't found anything defined out there, only ranges due to the variations in patient populations and care coordination staff roles.
- Would be nice to learn how every system is tackling caseload issues.
- Many care coordinators get pulled into doing work beyond care coordination, caseloads vary.
- Caseload volume sometimes connected with billing issues.
- Question posed – do I add for HCH or just give good care? What makes a good caseload?
- What is your care coordination role with patients if you have a caseload of 30 or your caseload is 100? Is it different?
- Those care coordinators with lower caseloads typically have other roles in the clinic.
- Concluded after discussion – there is no definite caseload number to go by, depends on population served and role of care coordinator.

Resources:

- http://www.cmsa.org/Individual/MemberResources/CaseLoadCapacityCalculator/tabid/675/Default.aspx
- https://aims.uw.edu/sites/default/files/CareManager_CaseloadSize_Guidelines_0.pdf

Patient Activation & Engagement Techniques

Approximately 80% of what makes up HEALTH occurs outside of the clinic walls; with an estimated 30% attributed to health behaviors, including a patient's ability to leverage their self-care against the barriers they face.

What strategies is your clinic/organization using to support patient activation and engagement, and what have you learned?

Participants Input & Suggestions at Workshop:

- Measure patient activation – some use patient activation measure tool (PAM) on a tablet to measure it
- PAM Score= Patient Assessment Motivation score to determine how willing /able the patient is to change. (Tool proprietary with cost)
- Self-Efficacy for Chronic Illness Tool – valid, reliable, no cost.
- Sometimes need provider engagement first to get it started.
- Support from other care team members with patient engagement activities – all work on same goal.
- Example to engage patient when educating them about their diet changes and diet tips – use alternative methods such as having them take a photo of what they eat instead of writing everything down (which a lot won't take time to do) – Can go over picture with them /easier / convenient with cell phone technology.
- Don't be afraid to be creative, try new methods and approaches.
- Meet with their primary care provider to discuss the patient progress and monitor their level of activation / engagement.
- Get patient feedback after the visit on the phone. The patient can tell about their experience, and often expresses appreciations validates engagement is heard in the voice/conversation.
- Engagement starts with the end goal.
- Connect patient with resources.
- Help patients become involved in patient led groups, support groups, classes: diabetes, walking, cooking, etc.
- Teach the patient – it empowers them.
- Listening is key.
- Dietitian who will shop with patient at Cub Foods.
- Billable group wellness visits (PCP, RN, Health Coach) Conduct exercise, a cooking demo, and eat (i.e. salad). This provides peer to peer engagement / activation opportunities.
- Provide patients tablets to take surveys on, or do the Patient Activation Measure

Resources:

- http://www.insigniahealth.com/products/pam-survey
- http://patienteducation.stanford.edu/research/secd6.html

Care Coordinator Turnover & Training

Staff turnover impacts clinic operations, workflows, progression of quality improvement, and creates additional burden. This may be especially true in the care coordinator role, with its unique job functions and training needs.

What types of resources or training has your organization implemented to help reduce care coordination turnover and support the care coordination role?

Participants Input & Suggestions at Workshop:

- Monthly Care Coordinator meetings.
- Motivational interviewing training (resource below)
- 1:1 Care Coordinator training
- Certified Health Coaching training for all care coordinators (resource below)
- Half time Care Coordinator / Half time Medicare Wellness & Refills (embedded staff)
- Adding in chronic care management
- Care Coordination looks very different at different sites.
- Retention is important – engage in training
- Defining roles more closely so care coordinators aren't over worked and get more help.
- Clearly identify roles of RN Care Coordinator vs RN Clinic Nurse
- Define workflows and staff roles
- Care coordinators doing too much beyond care coordination – need to define the role
- Many care coordinators are being stretched beyond, not feeling able to provide quality care.
- Develop a training manual/binder.
- Complexity of care coordination role / many shoes to fill / takes time to train.
- More challenging to formalize training with a manual of information only - care coordination training takes a lot of shadowing and ongoing communication and time.
- Care coordinator roles and training often differ between adults and pediatrics.
- Develop standard documentation for care coordination.
- Information on a Certification Training Program for Care Coordinators: This program is through the National Society of Health Coaches and was recommended by a care coordinator who completed the certification which is a 70 hour Self-Study Course with a Certification Exam and a five year certification cycle.

Resources:

- https://www.nshcoa.com/
- http://motivationalinterviewing.org/
- https://www.icsi.org/learning__events/learning_center/motivational_interviewing/

Establishing Community Partnerships & Resources

Community and social service organizations along with State and local public health agencies can be key partners with health care home clinics to provide whole person - patient centered care, but sometimes it can be challenging to know who these potential partners are and the most effective way to engage them.

What types of community partnerships has your organization formed and how did you accomplish?

Participants Input & Suggestions at Workshop:

- Establishing partnerships and relationship are important to develop. We found they are mutually beneficial.
- Do some networking to find community events, gatherings and attend to learn about resources they provide, share with clinic staff.
- Have found barriers to establishing partnerships from county to county.
- Found that sometimes barriers are our own internal processes – helpful to have an understanding of other organizations role, then can identify how the partnership can be beneficial for our patients/community.
- Suggested making connections directly with frequent community referral locations and establish formal communication processes which benefits partnership.
- Get outside the clinic to establish community partnerships as they don't frequently come directly to us.
- Invite community partners to participate in clinic advisory, patient advisory, or quality councils.

Resources:

- http://www.strengtheningnonprofits.org/resources/e-learning/online/communitypartnerships/
- http://dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_ACH

Different Care Coordinator Roles at Your Clinic

Care coordination as a function to meet the needs of the population served and the organization in which they work means there is variation in roles, qualifications, and job scope. Most care coordinators are trained in a field related to healthcare (i.e. social work, medical assistant, nursing), including emerging professions such as community health workers.

What types of roles support the care coordination functions at your clinic and how have they changed over the years to meet the needs of your patients and care team?

Participants Input & Suggestions at Workshop:

- Learned there are many care coordinator roles in the clinics.
- Some use a prevalence model to determine needs
- Most prevalent role was the RN's care coordinator
- Other care coordinator roles identified were: Medical Assistant, LPN, MTM, Social Worker, Health Coach, Utilization Review, and Licensed Counselor for Behavioral Health, Community Paramedic, and Community Health Worker.
- Many of newer roles have developed toolkits to help guide.
- Learned many are constantly exploring the role of care coordinator based on needs.
- Variety in functions – no matter what the role of the care coordinator is they wear lots of hats.
- Patients appreciate their care coordinators and become attached.
- Added a care coordinator assistant to the team – a lot of help to our care coordinator.

Resources:

- http://www.health.state.mn.us/divs/orhpc/workforce/emerging/chw/2016chwtool.pdf
- http://www.health.state.mn.us/divs/orhpc/workforce/emerging/cp/2016cptoolkit.pdf
- http://mnchwalliance.org/

Identifying Patient Centered Goals

Patient Centered Goals: We know it is essential to patient engagement. We know patients and families, as members of the care team, share in decisions about their care. We know this means developing goals *with* our patients and not *for* patients. We also know how challenging this can be in practice and that there are opportunities to do better.

How do you work with patients and families to develop goals that are patient centered yet will help them achieve optimal health and be clinically relevant?

Participants Input & Suggestions at Workshop:

- Have a patient centered plan.
- Goals are what they want not what clinic wants
- Be a cheerleader and supervise patients achieving their goals
- "Platinum Rule" - Do unto others as they wish you to do unto them.
- Get provider input on patient goals to build patient goals off of.
- New idea – mail out patient goals – ask them for additional input. Make it back and for the communication.
- Doesn't work when goal comes from someone else.
- Have the patient in the driver's seat.
- Ask the patient where do they want to be in 1 year or 5 years? Set small goals to get there.
- Long term versus short term goals – help them know the difference.
- When working on goals staff needs to provide same support and responses to patient for consistency.
- Know your patient first in order to help them.
- You need to know what they understand (are they able to read, write, understand, hear etc.)?
- Know them as a person!
- May use SMART goals template to get goal conversation started.

Resources:

- https://www.verywell.com/smart-goals-for-lifestyle-change-2224097
- http://www.smart-goals-guide.com/smart-goal.html
- http://topachievement.com/smart.html

Transitions of Care

Care transitions take place between departments, across health care systems, and within the community. It has been said that any transition raises the risk of losing critical information to maintain optimal health.

What are the processes your organization has implemented to address any of these transitions of care?

Participants Input & Suggestions at Workshop:

- Communication between all facilities is very important and sometimes a barrier.
- Education between health care and families is also a barrier.
- Electronic health record – access to medical records between facilities can be a barriers
- Sharing plan of care across systems can be a barriers
- Up to date care team / care plan with all information and a release of information on file is great.
- Behavioral health transitions are hard.
- Pacer Center – Champions for Children with Disabilities
- Communication between facilities is important.
- Transition classes – medical and all about housing, jobs, etc.
- Work with residents and conduct a home visit so that they can better understand what families live with / identify needs.
- Working with Pediatric clinics to start the process
- Medical advisory board tackling the issue of transitions to come up a consistent process.
- Have home care nursing conversations.

Resources:

- http://pacer.org/
- http://www.familyvoicesofminnesota.org/health-care-transition-toolkit/for-health-care-providers/
- http://www.familyvoicesofminnesota.org/health-care-transition-toolkit/for-families-youth-and-caregivers/
- http://www.gottransition.org/about/index.cfm

Identifying & Dealing with Social Determinants

Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes, these are known as social determinants of health.

What tools do you use to identify social determinants of health and what resources do you provide to help address the social determinants identified?

Participants Input & Suggestions at Workshop:

- Conduct an assessment for social determents (i.e. transportation, food insecurity, housing etc.)
- Utilize resources to address the patient's social determents needs.
- There are evidence based health care programs i.e. .Living Well With Chronic Conditions that patients participate in.
- Keep a master resource list of those involved in health care database.
- Connect people to resources within their community.
- Use motivational interviewing techniques to identify issues.
- Can use the P-CAM tool from the U of M (free tool) to identify the social determinants of health and determine resources needed.
- Can use "NOW POW" database for resources. This is a resource portal integrated into electronic health records. The tool has built in filters to narrow down areas of resources. Piloting in NW Metro Alliance Partnership.
  - NOW POW:
  - Powering Communities with Knowledge
  - We Make Self Care Simple
  - Better Access to the Right Resources
- Recognized challenges of recording this information in electronic health records.
- Agencies and services available in Minnesota – searchable by location, category and offered in 100 different languages at Minnesota Help website.

Resources:

http://www.pcamonline.org/

https://wihealthyaging.org/living-well

http://nowpow.com/

https://www.minnesotahelp.info