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Care Management in HBPC – Discussion Guide with Facilitator Notes

Thank you for leading a group discussion regarding key learning points from the HCCI online education activity, *Care Management in HBPC.* This guide is intended to help you prepare to facilitate this discussion.

OVERVIEW

Purpose: The discussion's purpose is to understand and apply best practices for meeting patient needs through care management in HBPC.

Audience: This discussion is intended for learners who have successfully completed the online education activity, *Care Management in HBPC.* The discussion should take no longer than 60 minutes to complete.

Materials:

- Hard copies of the *Next Steps* handout from the Resources screen in the course.
- A flipchart to capture comments and ideas for discussion.

Instructions: Use the question prompts provided to initiate group discussions.

Learning objectives:

- Define and apply care management practices in home-based medicine.
- Recognize and collaborate with the different roles on interdisciplinary teams.
- Identify and employ the use of care management tools, such as transition logs, to effectively implement care management strategies.
- Apply intervention strategies to prevent complications and potential readmissions.
- Utilize care management methods to identify and address gaps in care.

AGENDA

#	Topic	~Minutes
1	Healthcare Transformation Frameworks	5 min
2	Care Management and Care Coordination	10 min
3	Optimal Teams	5 min
4	Care Management Interventions	10 min
5	Identifying Gaps In Care	5 min
8	Debrief	10 min

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TOPIC 1: HEALTHCARE TRANSFORMATION FRAMEWORKS

Question prompts:

- The course introduced transformation frameworks as a key element of care management in home-based primary care. Does your practice use a transformation framework? If so, what kind of framework is it?
- What transformation framework are the 4Ms in the care of older adults? In what ways can you consider the 4Ms in your daily work?
    - Answer: Mentation, Mobility, Medication, What Matters
- How have you used a transformation framework to inform past decisions when treating patients?
- If you don't currently use a transformation framework at your practice, how could implementing one help in the development of a care management program?

TOPIC 2: CARE MANAGEMENT AND CARE COORDINATION

Question prompts:

- Care management and care coordination are described as being similar but having distinct differences at the beginning of the course. What are some of those differences?
    - Disclaimer: "Care management" was used throughout the course to refer to the use of *both* care management and care coordination.
    - Possible answers: Care management focuses on targeted interactions for identified risks. It tends to be episodic. Care coordination is a more holistic approach focused on long-term, personalized care.
- What are the core components of care management?
    - Answer: Engagement, Proactive Strategies, Team-Based Strategies, Education, and Best Practices
- Out of the core components, which areas do you feel HBPC providers are strong in? Which do you think providers could address more that would benefit patients and caregivers? Give examples for both to elaborate.
    - Opportunity to dive into each component if time allows. Change the question to, "Regarding the engagement component, how do you feel HBPC providers are already strong? How do you think providers can strengthen this component?"
- Take a moment to reflect on challenges or situations you experience as an HBPC provider when it comes to care management. *(Record responses on a flipchart, if possible. These will be addressed again during the debrief.)*

TOPIC 3: OPTIMAL TEAMS

Question prompts:

- Interdisciplinary teamwork is noted in the course as an effective strategy for healthcare teams when providing effective care management. How does the course describe

interdisciplinary teams as helping with care management? In what ways have you personally seen interdisciplinary teams aid in care management?
    - Possible answers: Patient-focused, eliminates redundancies, efficient problem-solving, diverse and varied perspectives, includes the patient, family, and/or caregivers as members of the team, etc.
- What are some roles you would find on an interdisciplinary team?
    - Possible answers: Provider, RN (Registered Nurse), LPN/MA (Licensed Practical Nurse/Medical Assistant), SW (Social Worker), patient and caregivers/family, service-specific providers such as pharmacist

TOPIC 4: CARE MANAGEMENT INTERVENTIONS

Question prompts:

- Care management interventions are proactive steps the care manager can take to address needs and gaps in care. What are a few of the interventions mentioned in the course? What interventions do you already see at your practice? How could you implement some of these interventions into your practice?
    - Answers: Comprehensive assessment, in-home medication management, transition management, proactive communications, implementation of the disease-specific care pathway, interdisciplinary team rounds
- The course describes transition management as the intentional support of patients and families as they move through different care settings. What method did the course suggest in helping manage these transitions?
    - Answer: Coleman's Four Pillars
- What are Coleman's Four Pillars of transitional care?
    - Medication self-management, personal health record (PHR), timely primary care/specialty care follow-up, and knowledge of red flags that indicate a worsening condition
- Proactive communication is vital in successful care management. What are some examples of proactive care management from the course that you feel HBPC providers could address more or already do a good job of? Are there any others you would add to the list?
    - Possible answers: Provide frequent calls, create reliable communication channels, reach out to specialists, create documentation templates, etc.
- When it comes to care management tools, what is a transition log? How can it help you successfully implement care management? How do you think a transition log could help you?
    - Answer: Transition logs are tools used to measure existing interventions, identify transition patterns, and help develop new care management interventions and strategies.

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TOPIC 5: IDENTIFYING GAPS IN CARE

Question prompts:

- To close a gap in care, you must first be able to identify it. What methods did the course mention that can help identify gaps in care? How do you think these strategies can be implemented into your practice? What strategies are already in place?
    - Answer: Use health plan data, collect your own data, use risk stratification, and create thresholds for elevating risk levels
- What is risk stratification? How can risk stratification help focus on care management strategies for your population?
    - Answer: A system for categorizing patients based on their health status and other factors.

TOPIC 8: DEBRIEF

Question prompts:

- Refer to the flipchart of challenges identified at the beginning of this discussion. Identify at least one strategy you have learned in this course to overcome each challenge.
- List and share any next steps you may have identified from taking the online course and participating in this discussion. Share your ideas for implementation.