# Mindful, Collaborative Leadership:

## Supervising Care Coordinators and Managing a Care Coordination Program

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Vermont Health Care Innovation Project
Karla Silverman, RN, CNM, MS
Primary Care Development Corporation
Julie Barnes, LMHC
Same Boat Consulting

# Welcome, Supervisors and Managers!

- Learning Objectives
  - Identify personal strengths & growth areas as a leader & set goals around continuing to develop professionally
  - Assess the strengths and challenges of your care coordination program
  - List key areas to focus on if you manage a care coordination program Including:
  - Apply & integrate the principles of MI into supervising care coordinators
  - Prevent burnout in your staff
  - Practice Motivational Interviewing tools for strengthening collaboration & giving feedback, including Supervision Brief Negotiated Interview (BNI)

# Welcome, Supervisors and Managers!

- Stretch & Ice Breaker
- Group Agreements

# Best Practices in Care Coordination Leadership

# Leadership Self-Assessment Tool

- Take 10 -12 minutes to think through & write about the questions.
- Share (confidentially) in pair with a peer

- Group discussion:
  - What did you learn about your own strengths & challenges?

*We invite you to think **personally** (attitude, relationships, individual actions) & **programmatically** (policies, processes, structures) about collaborative leadership through the day!

# Your pressing questions:

- What aspects of supervising Care Coordinators are you feeling solid about?
- What concerns or challenges remain for you?

# Sign of a Good Leader

- Mutual respect & trust across team
- Healthy communication & collaboration
- People show up & do what they say they will
- Staff are motivated, productive, creative
- Work stays mission-focused and alive!
- High quality of work and positive environment
- Room to make mistakes, grow & change
- Real conversations about real issues happen ongoing
- Sense of belonging & accomplishment

# Leadership Responsibilities

- Modeling best practices
- Setting clear expectations & accountability
- Inspiring/attending to morale
- Boundary-setting/ maintaining safety for all
- Building team cohesion
- Ensuring service quality & productivity
- Transparency & consistency
- Addressing grey areas/difficult questions
- Support & encouragement/helping staff grow
- Keeping team connected to vision/bigger picture

# Models of Leadership

- Self as Instrument
- Servant Leadership
- Values-based Leadership
- Leadership as a stance & set of behaviors

# Unskilled Leadership

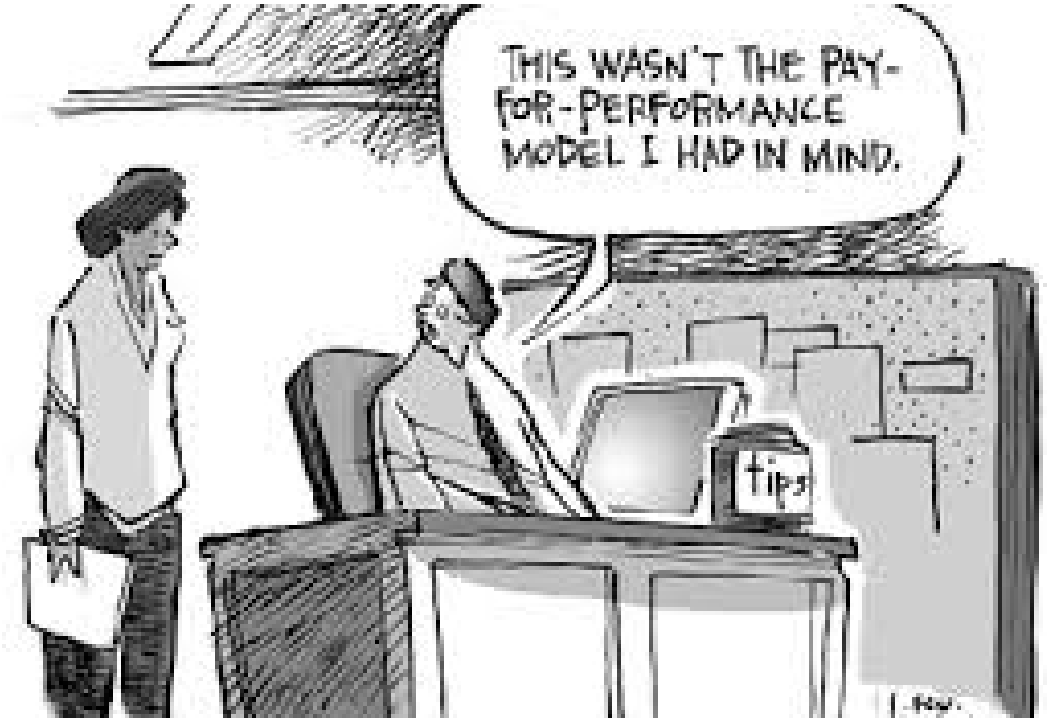
- People pleasing (trouble with no, needing approval)
- Being rigidly ”by the book”
- Absentee landlord (disappearing into your own work)
- Chronic lateness/over-scheduling/distracted
- Power dynamics (race, class, gender, sexual orientation, religion)
- Unwillingness to take a risk
- Gratifying own need for power/control

# What Makes Nonprofit Leadership Hard?

- No training, too few healthy models
- Competing demands
- Broken systems
- Limited resources (time, $) & high expectations
- Very diverse staff & clients
- Personal vulnerabilities/weaknesses get magnified
- Everyone's authority issues!  (Mommy/Daddy projections)
- Undervalued, under-supported work

# Managing Transformation

# Care Coordination Today



# From volume-based to value-based healthcare

- Multi-year journey
- Involves living in two worlds
- Culture change
  - Radically different way of thinking for most in healthcare (doctors, payers, and patients)
  - Incentives are still primarily based on driving more volume and fees

# What this means for you and your staff

- You are tired
- Some days you feel excited because things seem like they are changing
- Other days it appears that nothing has changed

Your needs:

- Clear strategy for your program including managing the transition and supporting your staff
- Time for yourself to think about what this transformation means

# Common Care Coordination successes today

- You and your team are now providing care coordination/management to individuals who haven't previously received those services
- You are part a national movement towards understanding how the social determinants of health affect health outcomes and addressing those issues to improve outcomes
- Payment for care coordination $$$

# Common Care Coordination challenges today

- Still operating in a FFS world
- Training and supporting staff
- High caseloads
- Models for providing care still being worked out
- Team based care
- Measuring what you do
- Managing the transition from what we used to do to what we are trying to do

# Best Practices:
# Running your Care Coordination Program

# Care Coordinator Program Activity Assessment

# Time for a break!

# Running Your Care Coordination Program

# Care Coordination Program Design

- The devil is in the **details**
- Though care coordination programs need to be tailored to the communities they serve, some emerging design elements that are showing success across contexts.
- **Customize** your approach to your local context and caseload

- The Promise of Care Coordination: Transforming Health Care Delivery, Families USA, April 2013

# Target high need, high risk individuals

- Programs able to identify and engage high-need, high-risk individuals are more likely to improve health outcomes
- Do you have a system in place? How well does that system work?
- Successful programs use both **quantitative and qualitative data** to identify individuals in need of services


- The Promise of Care Coordination: Transforming Health Care Delivery, Families USA, April 2013
- Randall Brown, The promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illness (Princeton: National Coalition on Care Coordination, 2009)

# Feature frequent, in-person interactions with patients

- **In-person** leads to more successful care coordination programs
- Successful Medicare Coordinated Care Demonstration programs averaged **one in-person contact per month** for the first year of patients participation in the program
- **"Warm-hand offs"** between patients and providers results in better patient engagement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# Have a strategy for transitional care

- What are the **systems and processes** that are set up for you to get **information on hospital and ER use** of the individuals you care for?
- What processes are in place to **coordinate with other providers** including behavioral health and primary care?
- Randomized controlled studies have shown the **effectiveness of care coordination** programs on reducing hospitalizations


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# Think about your staffing model

- Program at an academic medical center in St. Louis had *increased* costs for telephone care management
- Net savings after **reconfiguring** its program through:
  - More **in-person contacts** by local care coordinators
  - Supervised use of **CC assistants** for patients at lower risk levels that allowed nurse care managers to focus greater attention on higher risk patients
- Other staffing models that have shown success:
  - **Nurse-social work dyad** with MD support at Cambridge Health Alliance showed 40% fewer hospital days for patients and 30% lower cost
  - **Social work led care/case management teams** with focus on homeless patients and linkages to housing entitlements, primary care and mental health

- D. McCarthy, J. Ryan and S. Klein, Models of Care for High-Need, High Cost Patients: An Evidence Synthesis, The Commonwealth Fund, October 2015

# Recruiting and retaining staff

- Consider **all types of staff** for care coordinator roles: Nurses, social workers, case managers, CHWs, medical assistants, navigators
- Consider having **non-licensed staff** handle some administrative tasks like making appointments to free up licensed staff time
- **Regular meeting time** for staff to discuss cases with each other and with you or other supervisory staff
- **"Champion"** their work and build relationships and collaborative agreements with other organizations and providers
- These jobs are hard, your staff needs **support**/appreciation (as do you)

- D. McCarthy, J. Ryan and S. Klein, Models of Care for High-Need, High Cost Patients: An Evidence Synthesis, The Commonwealth Fund, October 2015

# Have training and staff engagement strategy

- Orientation: enrollment in program, conducting an intake and assessment, care planning,
- Motivational Interviewing
- Care transitions training
- 1:1 support in the first three months, case review
- Promote face to face interaction between members of the care team
  - multidisciplinary case conferences
  - Introductory meetings with doctors and other care team members

# Caseloads

- There is **no "correct" caseload number**, effective programs customize their approach
- Match team composition and interventions to **needs of the population** you serve
- A **mix of low, moderate and high-need individuals** can allow a care coordinator to manage more individuals
- **Reassess** the risk level of individuals on an ongoing basis
  - Stages of disease, psychosocial evaluations, assessment of functional status
- Job satisfaction of care coordinator improves with a more**balanced caseload mix**


- Complex Care Management Toolkit, California Quality Collaborative, April 2012
- Care Coordination Case Study Preliminary Findings Center for Health Workforce Studies April 2014
- D. McCarthy, J. Ryan and S. Klein, Models of Care for High-Need, High Cost Patients: An Evidence Synthesis, The Commonwealth Fund, October 2015

# Develop a clear job description

- Set expectations by having a clear job description that details out:
  - Tasks that the Care Coordinator is responsible for
  - The dual role of managing and coordinating care for the individual and maintaining contact and collaboration with the primary care or other providers

- Complex Care Management Toolkit, California Quality Collaborative, April 2012

# Build rapport with doctors

- Meet **face to face** with them and come **prepared** with talking points
- **Educate** on program, what the goals are, and how to contact staff
- Discuss **how your work can help them**, how care coordination has worked elsewhere
- Try to discuss an **actual patient** of theirs as an example of what the work your staff does looks like
- Providers engage in different ways: for some 1:1 will work best, for other group discussion will be more helpful
- **Never assume** they know what you and your staff do
- **Keep them updated** on what you have done with their patients

- Complex Care Management Toolkit, California Quality Collaborative, April 2012

# Engage in quality improvement and use data

- Running a care coordination program requires continuous quality improvement (CQI)
- Do not take on too much!
- Start small, analyze a problem or workflow and test out solutions, reconvene, and then roll out successful changes (PDSA)
- Bring together all levels of the organization to analyze a problem and get input from multiple perspectives
- Do not just dive into making a change, first decide how you will measure improvement and stay focused on those measures


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# Activity:
# Visioning Where You Want Your Care Coordination Program to Go
# and
# Designing Measures That Will Help You

# Transformation Takes Time (and letting go)

- The primary goal of care coordination is to improve health and decrease suffering for the individuals we care for
- If done well and if our payment system changes, it can also reduce costs
- Moving from “volume” to “value” requires an enormous culture shift
- Radically different way of thinking about how care is delivered for most stakeholders including doctors, other healthcare staff and patients
- To let something new come in, there must be an acknowledgement of a letting go of the old way, even when the new way is better
- Bridges, W. *Managing Transitions: Making the Most of Change*

# LUNCH

BNI for Supervisors tool & practice

# INDIVIDUAL MI SUPERVISION

# Assessment Conversation

- How are you & your teams using MI now?
- How comfortable are you with these concepts & practicing them?
- What are your pressing questions about MI supervision?

- Our Belief: Care Coordinators will learn best by your example. If you want them to use MI well with their patients, use MI in the way you supervise them & it will carry over.

# Quick MI Teach back

- What are the OARSs & why do we like them?
- How does MI help care coordinators work with clients around health behavior change?
- What are the Stages of Change and how can we use them?
- Name 2-3 key aspects of Harm Reduction.

# 3 Approaches to Supervision Demo

- What do you like about each?
- What doesn't work as well?
- How does MI fit in?

# Feedback & You

- How do you like to hear feedback?
- What bugs you in getting feedback?
- What's important about giving it?
- Any examples to share?
- Look over Feedback Circle for Supervisors handout together

# Effective Feedback

- Start with the positive & give generously
- Be specific!
- Limit critical feedback to a few things
- Always be respectful & empathetic
- Present it as your perspective not the “Truth”
- If you’re emotional/heated, wait until later to share
- Give feedback privately & in a moment staff will be more able to hear it nondefensively

# Giving Feedback Activity

- Trainer will read mini-scenarios of troubling staff behavior.
- 3 people will role play how they would give clear, supportive feedback in that situation.
- Everyone is encouraged to participate, but you can pass.

- Debrief questions:
  - For you, what is easy or hard about giving feedback?
  - To your peers/supervisors/supervisees?

# Burn-Out Prevention

***What strategies do you use to help staff feel supported?**

- Empathy
- Acknowledge systemic & structural factors
- Use affirmations & focus on successes
- Support ongoing staff professional development
- Be as flexible & respectful as possible
- Model healthy boundaries
- Proactively build team with strong relationships

- Activity: Group Affinity Brainstorm on burnout prevention using Team Brainstorming Tools worksheet

# BREAK

# Supervisor's BNI

Two versions

- For issues related to Patient Care
- For issues related to Staff Behavior

BNI=:

- Collaborative
- Focused on finding & strengthening person's internal motivation
- Strengths-based
- Structured & practical
- Ends with SMART goal setting

# BNI Demo & Role Play Activity

- Trainer Demo of BNI tool
- Pairs– use a real case with "Patient Care" BNI:
  - Break into pairs and one person plays the supervisor & goes through BNI steps & other plays your real supervisee struggling with how to approach a tricky patient

# Relay Role Play

- Trainer will be a supervisee with several problematic work behaviors.
- 6 Trainees will volunteer to rotate in to use “Staff Behavior” BNI for 2 minutes in your own style.
- It’s fine to read from the Cheat Sheet & “phone a friend” if you get stuck.
- When bell rings, a new supervisor rotates in and picks up where the previous person left off.
- Debrief:
  - What did they supervisors so well?
  - Where did they struggles & how else might we approach that?
  - Lingering questions?

# Wrap-Up

- Pairs: MI Goal setting
- Reading & handout: Dr. Rachel Naomi Remen
- Check-out: take - aways
- Evaluations