Care Spectrum Plus
COORDINATED CARE FOR ALL

Population Health Management Training Outline

Facilitated by: Quality First Healthcare Consulting, Inc.

Training Description: The purpose of the Population Health Training is to give participants an understanding of the systems and tools necessary to work successfully with population health models, processes, staffing, training, patient engagement, and reporting. This new model of care will require health center personnel acquire the knowledge and skills necessary to move from an episodic orientation to a population health model. This training is designed around the essential elements in population health management: managing transitions of care, managing high-risk complex populations, engaging patients in self-care, and measuring performance. Skills required to achieve these goals include but are not limited to cultural change, coaching, empowerment, motivating behavior change, advocacy, and mastering continuous quality improvement principles.

Who Should Attend: Those who are interested in developing a greater understanding of the field and working successfully in population health management and care coordination.

Learning Objectives:

In this training session participants will develop a better understanding of:

- Developing an actionable definition for Population Health Management
- The value in managing populations in a value-based system
- Key components of Population Health Management (care coordination, care management, patient engagement, etc.)
- Different population health models
- Essential tools and resources needed to effectively and efficiently identify and manage patient populations
- How to analyze specific interventions for effectiveness in targeted patient populations.
- Methods and strategies for managing clinical outcomes in diverse patient populations.

I. Population Health Management: Background and Overview

Learning Objectives:

- To present the history and principles of the Patient-Centered Medical Home model of care.
- To understand key drivers, Why Population Health?
- To understand the importance of redesigning population health to bridge clinical and non-medical services – Social Determinants

II. Care Coordination: Principles and Practice

Learning Objectives

To develop a better understanding of:

- The definition, principles, and aims of care coordination and transitions.
- The value of investing in Care Coordination.
- Steps to Consider in assessing your care coordination activities and making improvements.
- Critical success factor to consider when implementing a care coordination management model.
- Care Coordination models and resources available.
- Performance Measurement/Management

III. Care Management: Principles and Practice

Learning Objectives:

To develop a better understanding of:

- The definition, principles, and aims of care management
- Population identification, referral, and intake processes
- Different care management models
- Care planning and management
- Performance Measurement/Management

IV. Motivational Interviewing

Learning Objectives:

- Define Motivational Interviewing
- Identify the 6 general principles
- Determine best strategies for implementing MI within the practice

V. Self-Management, Self-Efficacy, and Behavior Change

Learning Objective

To develop a better understanding of:

- Definition of Self-Management
- Elements of Self-Management Support
- Process for enhancing patients' motivation, confidence, and capacity to self-manage and follow-through with treatment plans Principles of Motivational Interviewing and Behavior Change
- Core Clinical Competencies for Self-Management support
- Action Planning
- Self-Management Support Cycle
- Strategies for Efficiently Integrating Self- Management within the Practice

VI. Health Literacy

Learning Objectives:

To develop a better understanding of:

- Definition of Health Literacy
- Why is health literacy important?
- Who is at Risk and "Red Flags"
- What can we do?
- Teach Back Method