CHAPTER 5

Middle Managers and Connected Care

CHAPTER OBJECTIVES

After completing this chapter readers will be able to:

- Understand the clinical manager role in achieving connected care
- Describe healthcare middle manager connected care competencies and skills
- List managerial effectiveness measures
- Explain mindset changes necessary to achieve connected care
- Describe managerial tools and techniques for achieving connected care
- Identify obstacles to achieving connected care and describe how to overcome them

Introduction

The challenge of achieving quadruple aim and connected care goals ultimately falls to front line clinicians and middle managers, often clinicians themselves, who support them. In this chapter we will examine the vital, and all too frequently discounted, role of the healthcare middle manager. Middle managers must translate senior management's vision and strategic plan for clinical culture change to front line employees, who then coordinate care and manage communication and care transitions for patients. This complex work cannot be done well without clear goals, adequate skills, resources, teamwork structures, technical tools, cooperation from other departments, external resources, personal support, and time to do the job. Providing this web of support is the essential role of middle managers.

This chapter will also focus on the middle manager's role as a "change buffer." As health care evolves from a volume to a value-based system, staff at all levels are distracted by a barrage of almost continuous change. It is at this intersection between change, the daily work of patient care, and the business of health care that middle managers implement connected care. For this implementation to be done well, managers must attempt to filter, and at least

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partially control, the onslaught of constant change to give clinicians time and space to focus on patients.

For clinicians, the generic term used to describe the practice of connected care is "care coordination." This term encompasses a variety of complex care techniques such as incorporating patient goals into care plans, utilizing cross-functional teamwork to achieve better outcomes, enabling seamless care transitions, maintaining constant patient and family communication, and ensuring that all patient support activities are completed without "falling through the cracks."

To achieve effective care coordination, middle managers must support clinicians in sophisticated ways by communicating performance measures, involving clinicians in the design of improved clinical processes, embedding evidence-based best practices into daily work, providing needed resources, and helping to problem solve and advocate for front line clinicians' needs and interests. A constant dialogue between clinicians and middle managers is necessary to create and maintain both technical and human systems that support connected care. Middle managers should also build internal relationships that facilitate smooth information handoffs to and from senior management. They should also ensure good communication between clinicians and support staff, such as medical secretaries, and with staff departments such as human resources (HR), quality assurance (QA), and information technology (IT) systems.

In this chapter, we will explore the roles of middle managers in achieving connected care. We will review competency statements and measures of middle manager effectiveness. The chapter will also contain information about the mindset and skillset transformation that is necessary to achieve connected care in the middle layer of the organization. We will describe managerial techniques for facilitating change such as impact analysis, strategic communication, process improvement, and performance management. We will list obstacles and issues in achieving connected care at the front lines and will discuss potential solutions.

Connected Care at Every Level

Connected care requires consistent, goal-directed efforts, coordination, and integration from all levels of the organization as illustrated in **FIGURE 5-1**.

Senior managers are responsible for organizational-level connected care. Middle managers are accountable for connected care at the work unit or team level. Clinicians are responsible for the actual delivery of connected care to patients. This model assumes that managers are responsible for achieving good outcomes for two populations (groups of people who have some like characteristics): patients and employees. Interventions at both the individual patient/employee and population or group level are necessary to achieve connected care. For example, a clinical manager should develop connected care strategies for all patients who receive care from her team or unit (the patient population). To do this, the manager would analyze the demographics and clinical characteristics of the clinical unit patient population. The manager would then work with unit staff to tailor organizational connected care processes

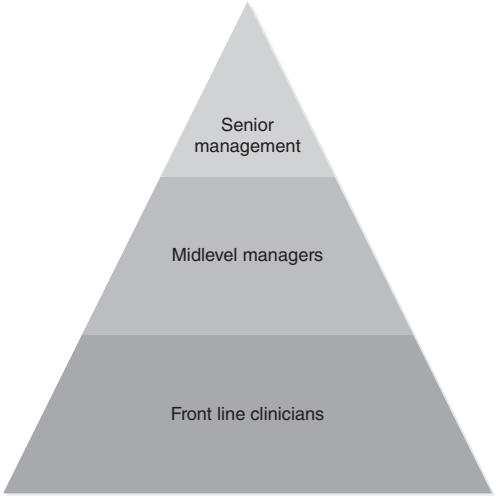

FIGURE 5-1 Who's Responsible for Connected Care?

such as admissions and care transitions to the specific needs of the unit's patient population.

For example, a clinical team that provides care to a patient population with health literacy challenges might have to simplify the standard organizational script for explaining clinical services to better meet the needs of their patient population.

The manager should consider the characteristics and performance of her own team (the employee population) in improving connected care. For example, a manager working with a team of less experienced clinicians might need to do more training in basic health coaching. The manager can analyze work unit employee group performance on connected care measures such as readmissions or effective medication reconciliation and tailor managerial interventions to improve performance. If the manager identified, through patient satisfaction survey data from the patients on her unit, that patients do not understand what to expect from the organization, who is responsible for their care, or who to call for help, she might work to coach and train clinicians who are not proficient in communication. She might also create team processes such as admission scripts and checklists, training in active listening, and patient rounds.

In this model, staff members at every level of the organization have both specific and flexible connected care roles. Senior managers are the direction setters, structure builders, and resource providers. Middle managers are the translators, integrators, process designers, facilitators, and trouble shooters. Front line staff, with support and resources from senior and middle managers, are the executors who work within an interdisciplinary team to provide care, coordinate care, offer emotional support to patients, and solve clinical problems. In effective organizations, innovation, communication, problem solving, teamwork, and continuous improvement occur at all organizational levels. Connected care is an integrating element for the organizational culture that can tie all staff together in the service of patient-centered care and achievement of the quadruple aim.

CASE STUDY

Everford Management Continuity Team Case Study

The Everford Health System senior management team decides that the key to successful outcomes, good patient experience, and more profitability is a culture that fosters collaboration and connection. To achieve this goal, senior managers charter a continuity team of middle managers, each of whom represents a sector in the Everford Continuum. Members of this group include Mary, the hospital director of care coordination; Doug, the practice manager for one of the largest Everford primary care practices; Tanya, director of nursing for the highest performing skilled nursing facility in the system; and Theresa, vice president for clinical affairs for the largest and highest performing home healthcare agency. The goal of the team is to develop methods to help system middle managers in implementing patient-centered, connected care.

The continuity team establishes a team charter, some broad measures, and boundaries. They decide that they will focus on the pillars of connected care for their work and will engage other groups or managers in other aspects of the culture change. After a meeting with the system CEO and the CEOs of each of their own organizations, the group decides to adopt a series of goals and measures that will form the basis for management connected care action. This list of goals and measures is described in **TABLE 5-1**.

The rest of the chapter will explore the various competencies that Everford middle managers will need to achieve the goals, the issues that the team will face, and managerial tools and techniques that can help achieve connected care in the Everford Health System.

The Middle Manager Role—Essential and Ambiguous

Healthcare middle managers are defined as "the first line of leadership with direct contact

TABLE 5-1 The Everford Continuity Team Connected Care Goals and Measures

Patient centeredness	■ The patient's medical record will document what is important to the patient and key patient goals for the episode of care. ■ Each chart note will demonstrate that the clinician asked the patient to describe an agenda, and concerns for that encounter.
Communication with patients and staff	■ Each system organization will meet state benchmarks for scores on patient experience survey questions about communication effectiveness. ■ Employee surveys will demonstrate a high level of satisfaction with organizational and managerial communication. ■ There will be no evidence of complaints or medical errors due to miscommunication between staff and between staff and patients.
Transitions	■ There will be a very low rate of transfers to inpatient within 48 hours of discharge from one setting to the next. ■ Chart reviews will show that risk scores and key elements of the patient's story were communicated to the organization receiving the patient in the transition. ■ Patients will receive an orientation to the next step in care and potential issues in transition to that step will be identified. ■ Discharge medication lists will be accurately transmitted to the next step in the continuum of care.
Care coordination	■ There is evidence that medication reconciliation is properly completed on admission and discharge. ■ Patient experience surveys will demonstrate scores equal to state benchmarks for questions relating to patients receiving explanations about their care and what to do after discharge. ■ Quality assurance reviews demonstrate evidence of consistent care task follow-up and do **not** find a significant incidence of missed handoffs in care that results in patient harm.
Teamwork	■ The medical record will demonstrate that there is regular interdisciplinary communication among members of the patient's care team. ■ There is medical record evidence that each profession is referring to other disciplines when appropriate. ■ For high-risk patients there will be evidence of care "huddles" or complex case conferences. Patients and families will be included in case conferences. ■ Managers periodically assess team function and review teamwork scores on employee satisfaction surveys.
Collaboration	■ Employee surveys demonstrate positive working relationships between clinical management and support departments such as IT, HR, QA, Billing, and Admissions. ■ Human Resources does **not** spend significant time mediating disputes between departments and professions. ■ The system has information on community resources and can identify individuals in each major resource to call on behalf of patients.

and supervision of frontline employees, who exercise administrative responsibilities without a clinical role" (Zjadewicz, White, Raffin Bouchal, & Reilly, 2016). The Bureau of Labor Statistics indicates that middle managers make up about 7.6% of the workforce. About 330,000 middle managers (a significant part of healthcare human resource costs) work in health care. The number of healthcare middle managers is expected to grow by 24% from 2012–2024, which is much faster than the average for all occupations (Bureau of Labor Statistics, 2016).

The literature on the role of middle managers in achieving the quadruple aim and making the volume-to-value shift is sparse. Most studies of middle managers focus on their role in innovation, quality, patient safety, and change management. First and foremost, middle managers are seen as two-way communicators who translate senior management's vision and strategies into understandable and actionable goals and activities for front line staff and then inform senior management of employees' response to proposed change. As one CEO noted in an interview: "Middle managers are the sailors in the crow's nest—sometimes they can see the icebergs and we need to rely on them to warn us and help redirect the ship through troubled waters" (Pappas, Flaherty, & Wooldridge, 2004). Middle managers "diffuse and synthesize information related to operations including the feasibility of project implementation, impact on current operations and workload" (Zjadewicz et al., 2016, p. 3). Middle managers are also "design reality testers" who transform the senior management vision into the processes, structures, training, and communications that help the organization achieve its strategic goals.

In more progressive organizations, middle managers are invited to use their knowledge of organizational culture and information from their internal social networks to participate in designing and culture change (Goldstein, 2015). In an older, but classic, 6-year study of middle managers, consultant Quy Nguyen Huy found that middle managers played four key roles in organizational change.

Entrepreneur

Middle managers are best able to restructure work to accommodate change because they are both close to the reality of the front lines and far enough away to see the "big picture." They are also close enough to patients/customers to have direct interactions with them and to understand their perspectives and issues. They are a more diverse group than senior managers and bring a broader array of perspectives and experience to the change effort. This "nuts and bolts" understanding of the work and of the proposed change allows them to recast some of the high-level, theoretical ideas of senior management into practical strategies that will work to achieve the desired goals.

Communicator

Middle managers are nexus points in communication to and from employees, patients, and external organizational partners. Middle managers use their broad and deep social networks to spread the word and get people on board. Managers may use nontraditional means of communication such as engaging employees one on one in social settings. Other managers cultivate trusted employee opinion leaders as ambassadors who can gain the support of more skeptical staff members.

Middle managers may have other methods of "selling" change that include explaining the rationale for the change, linking the change to employee benefit, and making adaptations to the change that help make it more palatable to employees.

Therapist

Since change, by its very nature, evokes anxiety and stress, middle managers have no choice but to support employees through it. They do this by providing a psychological safe space for employees, allowing them to express their concerns, providing encouragement, and giving people the tools to do the job. Managers must work through their own reservations and role

model positive attitudes toward change even if they don't fully support it.

Since change brings out the best and worst in people, middle managers must encourage altruistic, supportive behavior among employees and should defuse and redirect resistance and negativity before it becomes toxic and infectious. Advocacy for employee concerns links the therapist and communicator roles. If the manager uncovers change stressors that are truly threats to employee ability to care for patients and manage their own well-being, they must communicate this back to senior management and propose more effective alternatives. One of the key stressors for employees during periods of change is a perceived lack of resources. The middle manager should assess the reality of these perceptions and lobby senior management to close legitimate resource gaps or help employees find ways to reduce waste in work and "work smarter."

Tightrope Walker

Balancing daily work and change is the essence of the healthcare manager's job. During the change process, the manager has to maintain a delicate balance between keeping the work of daily patient care going while gradually testing and implementing changes in work structures, processes, training, and technology. The manager's challenge is to hold on to core values and cultural norms while simultaneously changing how the work gets done. In essence, the manager's job is constant triage of effort, resources, and emotional energy (Huy, 2001; Zjadewicz et al., 2016).

The Negativity Perception—A Formidable Barrier to Middle Management Success

While integral to the transformation of American health care, and absolutely essential to the support of front line clinicians, middle managers are often seen in a less than favorable light. While some articles describe middle managers as "heroic," others label them as "bureaucrats," "resistant to change," or even as "corporate concrete."

Embertson (2006) suggests that the turbulent conditions of the 1990s—which included mergers, acquisitions, cost cutting, and reengineering—contributed to negative perceptions of middle managers: "Since this trend of restructuring and reengineering, an understanding of the value of middle managers has been misplaced. Their importance in strategic formulation and implementation has largely been overlooked. They have been perceived as intermediaries that slow organizational efficiency without adding much measurable value" (p. 223).

These negative perceptions have been a barrier to achieving the full potential of middle managers in achieving connected care. Placed in ambiguous positions with limited power and support, and squeezed between senior management demands, the rigors of managing daily clinical work, constant change, and clinical staff who need structure, support, and advocacy, many middle managers find themselves becoming stressed and dissatisfied with their work. Some experts describe this situation as being "both victims and agents of change" (Braf, 2011). While managers often suffer from a lack of respect and support, actual studies of their influence prove that they are an essential element in organizational success. The challenge for many healthcare organizations is to recognize the problem and then empower and support these middle managers so they can play an essential role in achieving the quadruple aim.

ASK YOURSELF

- How are middle managers perceived in your organization?
- What key roles do middle managers play in achieving quadruple aim goals?
- How does your organization support middle managers in achieving organizational goals?
- What barriers do middle managers face?

Healthcare Middle Manager Competencies

Effective management for connected care requires a complex set of competencies, many of which are evolving in response to the radical change occurring in the healthcare system. An international consortium of 18 healthcare management organizations has created a consensus framework for health services managers under the auspices of the International Hospital Federation. This framework is illustrated in **FIGURE 5-2**.

This framework lists five competency areas for managers:

- **Communication and relationship management**—The ability to establish relationships and communicate clearly and constructively with those both inside and outside the organization
- **Leadership**—The ability to create a unified vision, to inspire organizational excellence, and to manage change to achieve organizational goals
- **Professionalism**—Aligning personal conduct with ethical and professional standards and a commitment to patients and lifelong learning

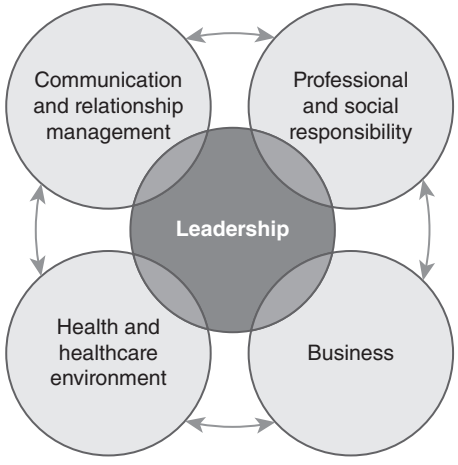

FIGURE 5-2 Leadership Competencies for Health Services Managers

International Hospital Federation. (2015). *Leadership competencies for health services managers*. Bernex, Switzerland: Author, p. 4.

- **Knowledge of the healthcare environment**—Understanding the healthcare system and environment in which the manager and the organization must function
- **Business skills and knowledge**—These competencies encompass the traditional functions of management such as financial, human resources, strategic planning, marketing, use of technology, risk management, and quality improvement (modified from International Hospital Federation, 2015, pp. 363–364)

The American Organization of Nurse Executives has created a similar framework for nurse managers. This model is divided into a three-part framework:

- **The Science**—Managing the Business
- **The Leader Within**—Creating the Leader in Yourself
- **The Art**—Leading the People

In this model, the "science" competency mirrors that of the international consensus document and lists similar skills. It does list an additional competency area, "clinical practice knowledge," which is not part of the international consensus document. The nursing management competency document emphasizes personal development, accountability, and career planning as important competency areas.

The "art" section of the nurse manager competency document emphasizes skills that are essential to achieving connected care, including human resource leadership, relationship management, influencing others, diversity, and shared decision making (American Organization of Nurse Executives, 2015).

These two frameworks encompass the whole gamut of management skills, including those key competencies necessary to achieve connected care: communication skills, change management, use of technology, systems thinking, personal competency, professionalism, and leadership. In the rest of this chapter we will explore these competencies further and give examples of how they manifest themselves in real clinical management practice.

CASE STUDY

A Nurse Manager's Connected Care Journey

Elena Mastriano, RN, MSN, has worked in various parts of the healthcare industry for 15 years. She has been in middle management positions for 10 of these 15 years. As she has progressed in her career she has evolved as a clinician and manager and has adopted the mindset and many of the skills necessary to support connected care.

Elena started her career in hospital nursing. She worked mostly on surgical floors and performed her nursing duties in a task-oriented way. Her mental paradigm in those days was: "get the work done as fast as possible so it doesn't eat you alive." She also gravitated to units where highly technical medical procedures were performed and patient stays were short. She got her job satisfaction from being part of an elite team and performing high-risk, high-tech tasks very expertly. Her interest in her patients as people was secondary. Elena was promoted to a managerial position on her unit and as she became accountable for the behavior of her staff as well as clinical outcomes, and patient experience, her view broadened and she began to think more in terms of working with systems and populations of patients and employees.

Elena eventually went back to school and got a master's degree in nursing. While in school, Elena oriented with a local home care agency and worked there as a home healthcare nurse. This experience further developed her managerial thinking as she saw how all the disconnected, task-oriented care that was delivered in various parts of the healthcare system created stress and less optimal clinical outcomes for patients and family caregivers. During this period, Elena was certified in the use of patient self-management support techniques. She became expert in health coaching and in helping patients self-manage their health in creative ways. Because of her enthusiasm and expertise she was made a preceptor for new staff.

When Elena graduated from her master's program she was promoted to nursing team manager and eventually to director of nursing at her agency. Elena had become expert in new skills such as the use of data to drive decisions, population health, the use of technology in patient care, lean process improvement, advanced communication skills, and the use of performance management and employee empowerment techniques.

Elena worked with her nurse manager team to involve staff in the redesign of care processes. She developed complex case conferences with staff nurses and involved families and primary care physicians. She created a visible measurement system so clinicians could see how they were doing on key metrics. Elena developed the habit of using data to drive decisions and she typically went beyond superficial problem solving to uncover root causes of clinical and service problems. She worked with the marketing team to develop a clinical liaison program in skilled nursing facilities and to improve care transitions. At Elena's direction, agency education staff implemented extensive training in active listening, Status Background Assessment Recommendation (SBAR), and motivational interviewing for clinical staff. Elena spent a significant portion of her time going on visits with staff, calling patients, and trying to overcome barriers to care experienced by both groups.

Partially as a result of Elena's efforts her agency received a Medicare Compare 5 star rating, the agency became the local employer of choice, and it built a reputation as an effective, patient-centered care organization. Elena currently has a very high level of job satisfaction and she has become a leader who is always learning and improving and is very well respected by patients, staff, and senior management.

Measuring Healthcare Middle Manager Effectiveness

Measurement of management effectiveness in achieving connected care is currently more of an art than a science. Measures of effectiveness occur at three levels.

Achievement of Connected Care Outcomes

Middle managers are expected to help their clinical team improve its scores on quadruple aim outcome measures such as: 30-day readmissions, accurate medication reconciliation, and patient perceptions of care as measured by one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) assessment tools. Measures of adverse events, complaints, and process accuracy measures also reflect the competence of the clinical unit manager. Team or unit level measures will be most closely aligned with middle manager effectiveness. Other generic measures of management effectiveness are measures like staff turnover, achievement of unit financial goals, and successful implementation of strategic change efforts.

Organizational Assessment of Middle Manager Effectiveness

All healthcare organizations have some type of performance appraisal system that describes expectations for managers and measures how well they achieve these expectations. Middle managers typically get feedback on their performance when a higher level manager or executive conducts an annual performance appraisal and gives the manager a rating or a score. Performance appraisals usually assess how well managers have performed the skills specified in their job description, whether they have achieved specific goals that have been previously set, and their performance on organization core values. While subjective, these scores are used to drive recognition, reward, and performance development plans for middle managers. A less common, but more comprehensive approach is the use of 360-degree feedback tools in which the manager is assessed not only by his or her manager but by employees and peers. Employee surveys that ask specific questions about management support and communication are another method of assessing management effectiveness.

Personal Self-Assessment

Healthcare managers can foster their own self-development by completing a self-assessment tool and using it as a springboard for designing a personal education and development plan. One such tool, the American College of Healthcare Executives (ACHE) Competency Assessment (2017), is geared toward senior managers, although it has good assessment questions on connected care competencies such as communication, relationship building, and leadership.

The New Healthcare Management

There is no clear road map for middle managers who hope to achieve connected care for their patients and employees. Senior managers are distracted by the struggle to keep their organizations moving forward through a period of political turmoil and the volume-to-value shift, in what is possibly the most tumultuous period of change for the healthcare industry in modern history. For the highest level of the organization, developing strategies that can guarantee long-term organizational survival and achievement of financial and clinical goals is paramount. This senior management distraction may mean that less time and fewer resources are spent on developing and supporting middle managers. Middle managers are also grappling with the highly stressful new reality of an unstable

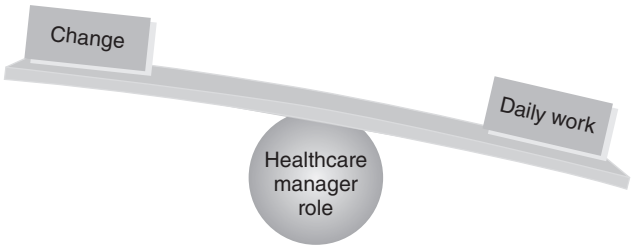

FIGURE 5-3 The Healthcare Manager Balancing Act—Daily Work and Change

healthcare regulatory and business landscape. While in previous eras managers could expect the need for change to be occasional and small scale, it is now huge and continuous. Their role in the turmoil is to keep the business going while balancing and incorporating constant change into daily work (**FIGURE 5-3**).

All levels of the organization must grapple with two types of continuous change, both of which have profound significance for reducing fragmentation and connecting the dots for patients (**TABLE 5-2**).

The first, sweeping changes in healthcare systems norms are pervasive and require organizational clinical culture change. The second, more local or limited regulatory or internal changes necessitate a planned quick response that allows the change to be assessed and absorbed and then allows the clinical team to move on. The challenge is to allocate time, space, and resources for long-term clinical culture change while dealing with the constant distraction of frequent small-scale changes that continually disrupt daily operations.

Another area of concern for middle managers is the stress of change. For clinicians in all areas of health care, the stress of change has a huge impact as they struggle to adapt to a world of higher acuity patient care, shorter periods of patient contact, and a shift from "doing for" patients to "doing with" patients. These changes may require clinicians to relinquish deeply held beliefs and familiar ways of delivering care—something many are loathe to do. Middle managers who are themselves coping with the impact of these changes should not only transform their

TABLE 5-2 Two Types of Healthcare Change

The Really Big Thing (Sweeping and deep—requires culture change)	**Industry Specific and Local** (Absorb into daily work and move on)
■ Political turmoil surrounding health care	■ State regulatory demands
■ Population health	■ State healthcare model redesign
■ New care models	■ Rate cuts
■ Value-based payment	■ New authorization limits
■ Industry consolidation	■ Insurer changes and demands
■ Health consumerism	■ Industry-specific CMS regulation changes
■ Technology revolution	■ Local market forces
■ Population demographic shifts	■ Referral source changing requirements
■ Large employer demands	■ Local workforce issues

own mindsets, but also help clinical staff reframe their attitudes and the way they do their daily work.

What Managers Need to Accomplish—High Level

Connected care is an integral part of the volume-to-value shift and achievement of the quadruple aim. The quadruple aim (Bodenheimer & Sinsky, 2014), which adds the vital ingredient of clinician satisfaction to the triple aim formulation, is rapidly gaining ground at a time when clinician stress and burnout are serious limiting factors for healthcare organizations seeking to be successful in the volume-to-value shift. For middle managers, achieving employee satisfaction has always been part of the job, but the emergence of the quadruple aim concept gives it new strategic significance and possibly more senior management support.

Achieving the quadruple aim and with it, connected care, requires middle managers to embark on a program of capability building both for themselves and for their operation. Middle managers must build their own personal capability and a work operation that can withstand the impact of constant change. One way to think of this is to imagine your department as an earthquake-proof building. If it is strong and flexible enough, it will sway with change and keep everyone safe as "the next new thing" buffets and rocks the healthcare world.

Although there is no clear roadmap for the transformation of the healthcare system, there is considerable research being done, with many innovative clinical experiments, and with collaborations of the best minds working together to find the best way forward. The job of the middle manager is to search out these cutting-edge experiments and ideas and to gain energy and ideas from industry leaders and innovators (**FIGURE 5-4**).

Building Personal Capability

The new world of health care requires managers to make a radical departure from the fee-for-service paradigm of organizational silos, task-oriented work, a hyperfocus on your own profession's issues, and a patient compliance

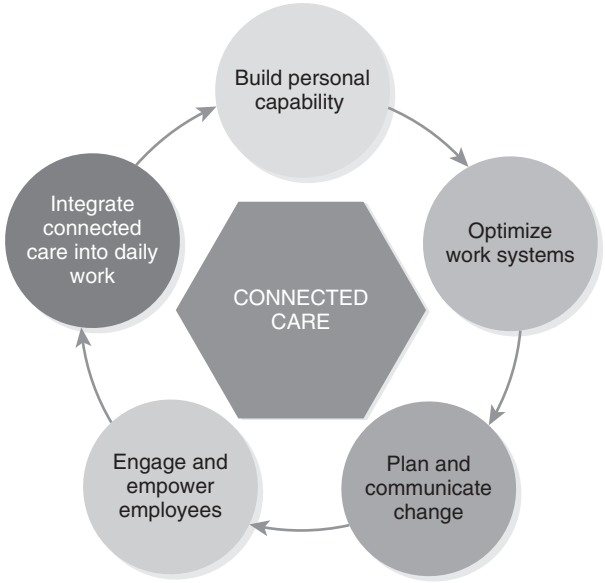

FIGURE 5-4 What Health Care Middle Managers Need to Accomplish—High Level

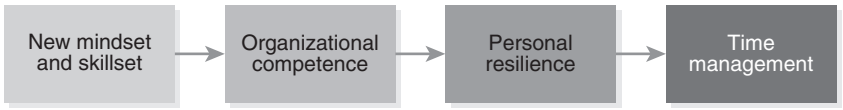

FIGURE 5-5 Four Steps to Capability and Empowerment for Healthcare Middle Managers

attitude. As a first step toward achieving connected care and quadruple aim goals, managers should try to achieve a rapid and radical improvement in capability and personal empowerment. This transformation is accomplished in the four steps illustrated in **FIGURE 5-5**.

Developing a New Mindset

Middle managers who hope to survive and thrive through the volume-to-value shift may need to change their mental paradigm. Such change is not easy, but extreme pressure from the external world and from senior management's urgency to ensure long-term organizational survival will naturally precipitate some of these changes. The more managers work with senior management on change initiatives, the more likely it is that they will develop a new, more connected care mindset.

The Institute for Healthcare Improvement, in a recent white paper on leadership, identified four mental models that are necessary for high impact healthcare leadership:

1. Individuals and families are partners in their care
2. Compete on value, with continuous reduction in operating cost
3. Reorganize services to align with new payment systems
4. Everyone is an improver (Swensen, Pugh, McMullan, & Kabcenell, 2013)

While formulated for senior leadership, these mental models are integral to middle manager success in achieving connected care. Each concept has profound implications for middle manager goals, activities, and time management.

TABLE 5-3 The New Healthcare Manager Mindset

Old	New
Task oriented	Systems oriented
Think only about the present situation	Conduct contingency planning
Make decisions with intuition and experience	Add data to the decision mix
Reactive thinking	Critical thinking
If it isn't broken don't fix it	Continuous improvement
My clinical discipline rules	It takes a cross-functional team
I am just a cog in a machine	I can take power and be accountable
Authoritarian management	Collaborative management

Once internalized, these concepts will help managers prioritize daily work and will help them triage competing change management initiatives. Middle managers can also use this list as components of culture change communications to staff. **TABLE 5-3** describes the necessary

managerial mindset shift in more ordinary terms. While no manager is entirely represented by the "old mindset," most of us, if we are honest, find ourselves in a reactive, task-oriented thinking mode more often than we would like, simply from the pressures of daily demands.

Personal aspects of mindset change involve lowering personal defensiveness, being willing to accept feedback, and being open to reexamining habitual thinking patterns. One way to accomplish this is to discuss some of the ideas in this chapter with your colleagues.

Another activity that can help with mindset change is spending time with people from other healthcare disciplines or other settings in the care continuum and hearing different points of view. Reading outside your own field in the wider world of health care, scientific discovery, human resources, business literature, and other areas that are more peripherally related to your work can also help you to create the new mindset. A powerful mindset expanding activity is to ask patients and their family members how they see things. A simple question like "What has it been like to get care from our organization?" can get the conversation started. Seeing your world through the patient's eyes might be just the thing to help a manager question old assumptions and readjust mental habits.

Building the New Skillset

Connected care requires a whole new skillset for managers. **FIGURE 5-6** lists some of the essential skills that managers will need to successfully navigate the volume-to-value shift and implement connected care.

For many healthcare managers who have risen through the ranks, management training has been achieved through experience, coaching from more senior managers, and short, intermittent educational events. University programs that educate health professionals are slowly catching up to the healthcare system transformation and are creating training in areas such as population health. However, practical, nondegree educational opportunities to help middle managers who are already in the field gain the skills necessary to achieve connected care and the volume-to-value shift are scarce.

An article about building the essential skills that middle managers need to create a patient

FIGURE 5-6 The New Healthcare Management Skillset

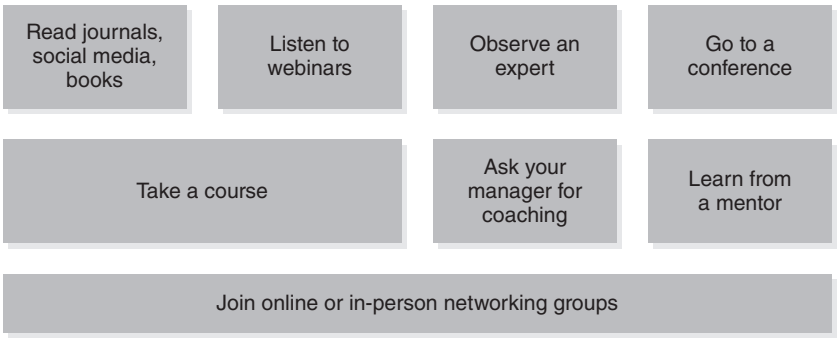

FIGURE 5-7 Methods for Developing New Skills

safety culture offers some practical suggestions for managers who need to gain higher level skills:

- Lead an improvement team with a mentor.
- Lead a project that is part of a national or regional improvement collaborative.
- Attend seminars and conferences on safety and quality improvement.
- Join an internal quality improvement group.
- Attend an in-house training program for managers.
- Use self-study or e-learning to build new skills. (Federico & Bonacum, 2010)

FIGURE 5-7 depicts some other methods that managers can use to create a self-development program for new skills.

Absent formal educational opportunities, acquiring these new skills may require managers to use persistent and assertive self-learning. In this regard, senior managers are good role models because they are also "figuring it out as they go along" on the rollercoaster ride of healthcare change.

ASK YOURSELF

- Which of the skills listed do you think are most important for achieving connected care in your organization?
- Which skills do you currently possess?
- Which skills do you need to build?
- What steps can you take to build these skills?

CASE STUDY

The Everford Continuity Team Identifies a Management Skill Gap

The Continuity Team studies the new mindset and competency standards for middle managers and concludes that many, who were promoted through the ranks without formal management training, do not have the necessary skills. Even some recent graduates of master's level population health programs have theoretical knowledge but not practical knowledge of how to apply the new tools and techniques. The team decides that improving managerial skills is outside its mission and boundaries so they enlist the aid of Human Resources, Senior Leadership, and the Clinical Management Council. A new team of individuals from these groups creates a revised list of management competencies and a performance appraisal document and works with a consulting firm to adapt its value-based payment leadership course to Everford's needs. While the Continuity Team works on the pillars of connected care, the new team is busy building middle management capability and, in some cases, replacing managers who are not interested in, or capable of meeting, the new standards.

Middle Manager Organizational Effectiveness

To achieve connected care, middle managers must be effective at getting things done within their own organizations. Middle managers who are organizationally effective are typically those who have strong internal social networks. These networks of relationships with other managers and employees allow them to obtain information, find resources, get help with solving problems, and build an informal organizational support team.

Some managers who are content in their own department silos should make a deliberate effort to reach out and develop strong internal, collegial relationships. A good relationship with support departments like human resources, information systems, finance, and quality assurance is essential to achieving the kind of transformative change that creates connected care for patients. This network building occurs partially as a result of personal relationships, but also through deliberate actions like having conversations about what each department needs from the other, carefully reading communications from other departments, following other departments' procedures, not making unreasonable demands, negotiating interdepartmental conflicts, helping colleagues achieve their goals, and helping other managers overcome barriers and obstacles to their work.

A key element of connected care is smooth handoffs. Managers should look carefully at what happens in the "white space" between departments. This is where patient handoffs often occur and where communication and patient care tasks tend to fall through the cracks. Having a good relationship with the managers of the departments before and after yours in the clinical process flow is essential to smooth transitions for patients and for effective information transfer. Managers who "run a tight ship" are more likely to be organizationally effective, as senior managers, colleagues, and employees know that they can count on these managers to get the work done accurately and to communicate about it clearly.

Managers are organizationally effective when they get clarity from their own manager about their goals and accountabilities and when they triage their time and energy to achieve these goals. Communicating and "selling up" is another hallmark of organizational effectiveness. Managers who find that strategic goals are unrealistic as envisioned by senior managers, who have hit roadblocks, or who are underresourced must advocate for their staff to get work plans modified in a more realistic way and to obtain needed resources. The use of data and a calculation of "return on investment" can help with this.

ASK YOURSELF A VERY HARD QUESTION

If someone was to ask your colleagues and your employees how effective you are at running your department, collaborating with other departments, and getting things done ("running a tight ship"), what would they say?

Building Resilience

The pace and impact of change in our current healthcare system is enormous and relentless. Managers sit in the epicenter of this change as they try to balance building a new clinical culture, keeping the business going, caring for patients, and supporting employees. Thriving in such an environment requires enormous resilience. Those managers who do not develop this resilience will soon find themselves on a short road to burnout. Building resilience involves two things: using stress management techniques and developing a sense of personal empowerment. The latter is especially important in our current tumultuous environment where both

employees and managers feel "unmoored" from the safe and the familiar. Personal empowerment grows as managers build their new mindset, but it also involves resourcefulness and reframing.

This means reframing problems in terms of what you can do, not what you can't do. It also involves finding internal and external resources to help with the challenges you face on a daily basis. Middle managers in health care should also find resources to help them deal with overwhelming and emotionally draining clinical situations. Managers who must help staff cope with noncompliance, dying patients, patient and family discord, behavioral outbursts, and conflicts between staff need support and help themselves.

Sometimes managers need to seek out this help from their own senior manager, from quality or human resources staff, from social work or behavioral health colleagues, from their own internal collegial network, or from family, friends, or counseling professionals.

Stress Management

As the pressure mounts, it is essential for managers to evaluate and modify their current stress management routine to allow them to absorb and manage the stress of change. Classic stress management techniques such as exercise, distraction with pleasant activities, humor, and meditation are always helpful. Both at home and in the workplace it is essential to set boundaries and negotiate or delegate activities to other family members or employees. This not only helps the manager, but also others build their personal empowerment and self-esteem.

Managing Time

How managers spend their time at work is a reflection of multiple complex factors. **FIGURE 5-8** illustrates some of the factors that compose management time.

Managers who are constantly "firefighting" and battling crises are probably dealing with either personal disorganization or some type of underlying organizational dysfunction, lack of coordination with other departments, work process failures, or staff performance deficiencies.

Use Data to Analyze Where Your Time Goes

Managers can start to gain control over their time by using data analysis. There are two methods for doing this:

1. **Use the quality improvement approach.** Review data on department performance and identify performance gaps. Localize these problems with data (staff, patients, time, type of equipment, diagnosis, type of staff, etc.). This helps you identify work systems or human problems that are

FIGURE 5-8 Take Back Your Time

consuming time in problem solving. Once you know where and when the problems are occurring, you can start to look for and eliminate root causes.

2. **Use the direct time analysis approach (the yellow sticky technique).** Set a time frame for your study. Two weeks is best. Every time you are asked to solve a problem, write it down on a sticky note. Be sure to include problems that you, yourself, have generated, such as time searching for something you can't find. Pile the notes up and at the end of the 2 weeks, sort them into piles by category. Count the number of items in each category to determine what factors are driving the time that you spend solving problems.

Once you have identified sources of problems and crises, you can put action plans into place to correct them. Some key steps in managing time are:

- Monitor the environment for upcoming changes and prepare in advance.
- Stay focused by considering how each action and task will impact achieving your key goals.
- Set small, achievable goals at the beginning of every day.
- Avoid meetings and appointments that don't have a clear purpose or focus.
- Pay extra attention to change at critical points (start up, rising resistance, maintaining change).
- Plan ahead for predictable crises (particularly scheduling issues that tend to be seasonal).
- Put staff capability building on your calendar.
- Avoiding common time management mistakes such as excessive multitasking, social media addiction, and being easily distracted.

Optimizing Work Systems

Connected care, by definition, requires smoothly flowing and effective work processes that can connect activities, tasks, and communications into a seamless whole. Given the pace of change and the complexity of healthcare systems, this is an endless and very challenging task for managers. The core skills for managers in optimizing work systems are quality improvement and work simplification tools and techniques. In more sophisticated organizations, managers may be trained to use more complex techniques such as Six Sigma or Lean management systems. Some generic techniques for optimizing work include:

1. Build staff capability, skills, confidence.
2. Engage staff in improvement.
3. Use data to localize and eliminate errors and problems.
4. Simplify work by reducing unnecessary complexity, too much checking, too many handoffs, and too much variation and inconsistency.
5. Cluster tasks and the tools and information needed to perform a task to avoid unnecessary walking or searching.
6. Work the "white space" by improving communication between disciplines, departments, and other organizations (this is where many problems and errors occur).
7. Skill up, delegate down—that is, train clinical staff to "work to the top of their license" and delegate tasks that can be performed by support staff.

Managing employees who are not performing effectively is essential to optimizing work. One common healthcare management mistake is to tolerate poor performance simply to keep a position filled for fear it will not be possible to find a replacement. Such an approach not only creates a barrier to good department performance but also demoralizes other employees who are performing well.

Integrating Connected Care into Daily Work

Managers can use a variety of concrete techniques to integrate connected care into daily work. **FIGURE 5-9** lists the key steps in this process.

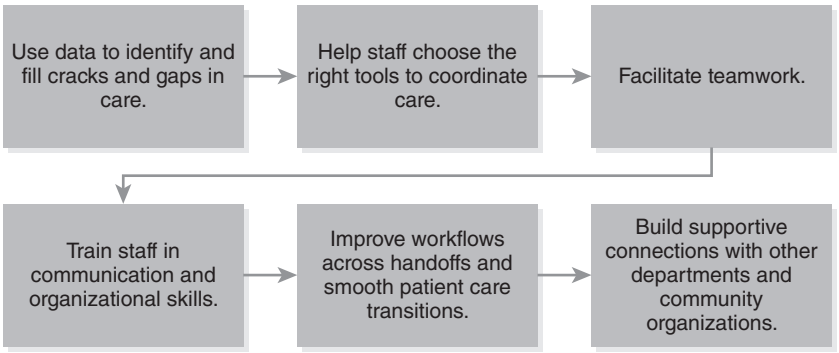

FIGURE 5-9 Integrating Connected Care into Daily Work—What Managers Need to Accomplish

Use Data to Identify and Fill Cracks and Gaps in Care

The manager should use data to monitor his or her operation and identify process problems that create fragmented, disconnected care for patients. Some of these process problems include staff inconsistency, scheduling problems, transition problem patterns, lack of interdisciplinary communication, patterns of poor follow-up, and external problems such as a pattern of patient readmissions from certain hospitals.

Much of this data can be obtained from the electronic medical record or from quality assurance data collection and studies. The key is to use data to find the gaps and then apply work simplification or clinical best practices to close them.

Help Staff Use the Right Tools to Coordinate Care

Without coaching, employees will develop their own methods for managing care and may not use the most optimal tools and techniques. The manager can help with this by coaching staff to use tools and techniques such as SBAR, when reporting to an MD, point-of-service charting, electronic medical record (EMR) tools such as sending tasks to other disciplines, online calendar tools, and organizational reference manuals or databases.

Train Staff in Communication and Organization

First, the manager herself must be an expert in communication and organization skills and should model these skills for staff. The most basic communication skills for staff are active listening, explaining, giving feedback, and reporting to other professionals. Providing some sample scripts for employees to use in common situations can be helpful in improving communication. Training clinicians who are disorganized often requires very concrete coaching and tools, such as a pre- and post-visit checklist, helping staff with more efficient charting methods, and getting help from information systems to optimize computers, smartphones, and other technical tools. It can be very helpful to observe less organized employees as they give care, so the manager can offer practical tips and tricks immediately after an issue is observed. The manager can also pair the less organized employee with one who is more efficient for some peer counseling and observational learning.

Improve Workflows Across Handoff Points

Another aspect of the clinical manager's job is to ensure that information flows smoothly between departments, disciplines, and other organizations.

For example, there should be a smooth process for the handoff between admissions/intake and the clinical work unit. This means the manager should talk to other departments about what they need and then should explain what his or her team needs from that department. If the two views of roles and responsibilities are at odds, the managers must negotiate to an acceptable compromise or miscommunication and animosity between the staff of the two departments will certainly ensue.

Monitor Common Disconnect Situations

Certain situations and processes are more prone to producing care fragmentation than others. It pays to focus attention in these areas to prevent disconnected care. Some common examples of high-risk disconnect situations are:

- Combining a high-risk patient with a low-performing clinician
- Admissions or start of care when things are busy and rushed and important tasks are missed
- Reporting and responding to patient changes in conditions when many staff members or different work shifts are involved in patient care
- During the implementation of new procedures when processes and accountabilities are not entirely clear
- When a patient is being moved from one location to another
- Uncontrolled variation in which each staff person performs a clinical process differently, thus creating fuzzy expectations, accountability, and communication
- When a group of clinicians is caring for a patient, but no one is in charge and the "team" is not communicating

Debriefing the root causes of clinical errors due to disconnects or miscommunications will often uncover one of the situations listed as a root cause.

INTERVIEW WITH ALEXANDRA CHIN, GENESIS HEALTH CARE

Ms. Chin has been the director of nursing at a rehabilitation and long-term care skilled nursing facility for 2 years. She oversees all nursing staff, certified nursing assistants, and medical records staff. Ms. Chin had worked in a hospital and had been a floor nurse and a unit manager prior to her current position. Each floor of the facility is staffed with a charge nurse who oversees resident care plans and administers medications and treatments. Certified nursing assistants provide personal care to residents and help them with activities of daily living.

Ms. Chin describes the long-term side of the building as the resident's home. The care is very personalized and coordinated and the facility provides recreation, social work, psychologist services for those with psychiatric diagnoses, as well as physical, occupational, and speech therapy. The nursing staff takes time to talk with residents at length, understand what matters to them, and create a very individualized care plan which is updated at least quarterly.

In this setting; staff, family members, and patients become "members of a family." Residents are given as much choice as possible, such as the ability to choose food from a restaurant-like menu. The facility is very patient centered and tries to foster resident decision making. There is a resident council. Members of the council are very involved and often have strong opinions. The facility tries to accommodate council decisions. Families are an important part of integrating care for facility residents. They are very involved in care planning and are invited to care planning meetings. Families are always called when a resident experiences a change in condition.

(continues)

INTERVIEW WITH ALEXANDRA CHIN, GENESIS HEALTH CARE *(continued)*

The facility uses a number of strategies to create a positive and connected experience for each resident. The facility team works together to create a customized care plan and schedule that incorporates patient preferences. The recreation department assesses resident preference for things like the type of bathing that the resident wants and asks the resident how late he or she wants to sleep. The facility also tries to create a cohesive experience for residents through periodic interdisciplinary team meetings which involve both the patient and family. Nurses are highly involved in these meetings.

On the short-term unit, home care agencies that will follow the patient after discharge come to discharge planning meetings to facilitate more coordinated discharges. The facility liaison goes into the hospital and meets patients who have been referred to the facility prior to discharge to help them understand what to expect and to facilitate discharge and transition communication.

Ms. Chin believes that teamwork is an important part of avoiding fragmented care for residents. The organizational culture fosters a teamwork mentality. Each employee, no matter what their rank or status, is expected to pitch in and help residents as needed. Ms. Chin coaches aides to help each other with resident personal care tasks and not to "go it alone." If a patient light is on, each and every staff member knows that they are responsible for answering it, even administrative staff. All staff also help with meals and with passing out trays. A member of the staff who is certified in the Heimlich maneuver is always on duty during meals. Someone must be with the residents at all times when they are eating, so even office staff take their turns at covering the dining room.

Ms. Chin's facility works hard to help the certified nursing assistants (CNAs) understand that they are very important and that they see situations with residents that no one else sees. The facility uses INTERACT communication tools such as the STOP and WATCH tool (a one-page tool that helps CNAs know when to report a resident change) to identify resident changes in condition. The form is printed in hot pink so it catches staff attention.

All clinical staff are also instructed to use the SBAR method of reporting for a resident condition change. The facility uses the INTERACT template for reporting when a patient is transitioned to an inpatient facility.

A section of the EMR is used to monitor unplanned patient transfers. Ms. Chin regularly meets with the medical director to review unplanned admissions. She then educates the staff about root causes and talks with individual clinicians who were involved in the patient transfer. Ms. Chin tries to call the hospital when a patient is transferred, but does not always find that hospital staff are interested in transition reporting.

The facility uses standardized, commercially printed teaching materials. The nurses have access to this material online. Facility nurses also teach patients and families self-care using a "stoplight" tool, which labels various symptoms as "red," "yellow," or "green" to signify the level of symptom severity. Nurses use teach-back, asking the patient to repeat what was taught.

The facility has been able to reduce care fragmentation due to patient hospital transfers by improving its medical capabilities. Staff are now IV certified, and can do procedures such as peritoneal dialysis, total parenteral nutrition (TPN), and wound vacs. They can provide IV push Lasix to avoid transfers for congestive heart failure (CHF) patients who are retaining fluid.

Ms. Chin summarizes by saying that there are many misconceptions about skilled nursing facilities. Many people think of them as mini-hospitals. In the skilled nursing facility, there is access to a team but not as many medical resources as in a hospital. "You have to be a better nurse in this setting and use quick critical thinking." Working in this setting has given Ms. Chin a newfound respect for skilled nursing facility nurses.

Applying the Pillars of Connected Care in Middle Management

As mentioned previously, the core elements of connected care are called "pillars." These pillars are the key characteristics of a culture of connected care. The foundation of connected care is patient-centered care. The pillars are teamwork, transitions, coordination, communication, and collaboration. To achieve connected care, each level of the organization must play its part. Senior managers incorporate the pillars of connected care into the organizational vision and strategic plan. **Middle managers create the structures and processes that support performance**. Frontline clinical staff apply connected care principles, tools, and techniques to actual patient care. Professionals in staff positions support managers in achieving culture change, particularly in the areas of quality improvement projects, team building, and data management. In the rest of this chapter, we will examine specific managerial tactics that can be used to build the pillars of a connected care system.

Implementing connected care requires a mindset shift from task-oriented to patient-centered care, an improved skillset, and the constant application of critical thinking to patient care.

To help employees evolve and make this transformation, managers must employ more sophisticated training and coaching techniques than are usually used in health care. Most of all, the connected care transformation requires managers to put aside sometimes pressing tasks to provide the meaningful engagement and coaching that employees need to transform their practice.

Middle Managers and Patient-Centered Care

Patient centeredness is THE core element of a connected care culture. The manager's job in developing patient centeredness is to focus, direct, and support clinicians to put patient needs ahead of their own. To accomplish connected care, professionals need their own level of support, but in a patient-centered culture the patient's needs come before all others.

Making Connected Care Matter to Clinicians

Clinical staff, especially those steeped in a compliance mentality, may not be inclined to adopt a patient-centered attitude and behavior unless the organization makes it matter. The organization can get clinicians' attention on the issue of connected care by embedding it into job descriptions, through clinical coaching, and in the performance appraisal process. Employees should also be offered training on practical techniques for collaborative patient care such as patient self-management support tools and techniques.

The new Medicare Conditions of Participation (COPS) for Home Health Care and Skilled Nursing Facilities contains provisions that mandate more patient-centered care and care delivery through teamwork. These new regulatory requirements can be used as leverage to get employees to accept connected care. The organization should integrate connected care competency testing into new clinician orientation and the annual clinician competency assessment process. An example may be to role-play a patient situation and to see if the nurse uses active listening techniques. Another approach may be to have the nurse read a patient case study and create a patient-centered care plan. Managers should consistently monitor clinical employee's use of patient-centered behaviors during case reviews, huddles, and case conferences and provide on-the-spot coaching to turn behavior in a more patient-centered direction.

Those employees who do not consistently demonstrate collaborative patient care attitudes and action will require clinical coaching, possibly combined with motivational interviewing techniques by the manager. Ultimately, clinicians and support

staff should be evaluated on their patient-centered care attitudes and actions. This occurs both during coaching and performance appraisal and should be tied to annual salary increases.

Connecting Patient-Centered Care to Health Professional Job Satisfaction

Paradoxically, a focus on patient needs can only be accomplished if staff feel valued and supported. The Institute for Healthcare Improvement in a paper on "Joy in Work" describes this aspect of the middle manager role: "Primary responsibilities of core leaders are utilizing participative management; developing camaraderie and teamwork; leading and encouraging daily improvement, including real-time measurement; and promoting wellness and resiliency through attention to daily practices. Core leaders have the pivotal role of improving joy in work every day at the point of service. They work with their teams through the process of identifying what matters, addressing impediments through performance improvement in daily work. They analyze what is and is not working well, developing strategies, co-creating solutions with team members, advancing system-wide issues to senior executive champions, and working across departments or sites for joint solutions. This practice of participative management combined with collaborative process improvement makes it possible to meet fundamental human needs." (Perlo et al., 2017, p. 20).

Techniques for Building a Patient Centered Care Culture

The balance between staff and patient needs is no easy task, as managers are confronted with clinician needs on a minute-by-minute basis, while they may be somewhat more distant from interactions with patients. Helping clinicians shed the compliance mindset for a patient collaboration mindset requires the manager to first examine his or her own feelings about "compliance" issues and clearly articulate a vision of what patient-centered care looks like. The stark reality is that patient nonadherence to medical recommendations creates discomfort, lower outcome scores, and considerable inconvenience and frustration for staff. The other stark reality is that try as we might, we cannot control patients and their caregivers to achieve the results we want.

We can only help patients find their own motivation to change or set limits through approaches such as risk contracting that specify the actions health professionals will take as a consequence of patient and family choices. Spending more time asking patients what is important to them and asking how well your clinical team is doing on providing these important elements of care is a good way to continually adjust personal clinician attitudes.

Another way to revise attitudes about patient-centered care is to ask clinicians to visualize themselves being lectured by a health professional about the need to change behavior "for your own good" and then being scolded if they don't change. Maybe you have had such an experience and can bring it to mind when you are tempted to reinforce a heavy-handed clinician approach to achieving compliance. Shedding the compliance mindset also requires managers to coach clinicians about the limits of their power to "fix patient's lives" and to accept that adults who are mentally competent have the right to make "bad decisions" (or at least decisions we as health professionals do not agree with). Helping staff spend more time talking to patients about their lives and the challenges they face may also help with this issue. Encouraging clinicians who are more expert in patient-centered care to share success stories is another way to help other staff visualize what patient-centered care looks like in daily practices.

One good way to help staff stay in touch with the patient viewpoint is to encourage them to visit the Patient's View Institute (2018) website (gopvi.org) and read some of the stories that patients have told about what has worked both well and poorly in their experiences with the healthcare system and health professionals. The manager can then facilitate a discussion about

some of these stories at staff meetings. As the stories illustrate,the more acute the setting, and the more compromised the patients, the more important it is to make an extraordinary effort to treat patients with respect and to give them what little control they are able to use.

Another method for fostering patient centeredness is to encourage the use of patient-centered language and ban the use of derogatory labels such as "train wreck." Modeling respectful discussion about patients, after acknowledging staff concerns, helps to counteract negative feelings that clinicians may have about difficult patients. "I know that this has been a difficult case for you to manage. Mrs. Jones seems to have a very challenging life situation without much support. It must be very difficult for someone with her personality to not be in control of her life and her health. How could we look at it from her point of view?"

Managerial Tools for Developing Patient-Centered Staff Behavior

While managers may be tempted to become defensive and automatically take the side of staff in misunderstandings with patients, it is essential that the manager remain balanced and look at the problem from both the staff and patient points of view. Luckily, while the challenge of achieving patient centeredness is great, the tools to achieve it are many. Some tools that managers can employ include:

- **Expectation setting.** If senior management has aligned the organizational culture around patient-centered connected care, middle managers, when they interpret organizational vision and goals, must turn the senior management message into clear actions and accountabilities. Before creating this communication, the manager should clearly visualize what a good job would look like and how she would know it if she saw it.

  The manager must fight the urge to communicate expectations in platitudes and generalities, neither of which is effective in changing employee behavior.

  For example, "We as an organization are committed to better care transitions and care coordination. This means that each individual clinician is responsible for not allowing any tasks, information, or follow-up to fall through the cracks. It is the job of support staff to help clinicians in dealing with the follow-up details such as ordering supplies."
- **Adopt a patient-centered filter for management decisions.** This technique is a matter of awareness. To do it, ask yourself: "Who will this decision benefit and how will it impact patients?" If you decide to change scheduling practices, will it result in more clinician continuity for patients or more fragmentation?
- **Motivational interviewing.** This is an advanced communication technique that builds on active listening skills and can be used to help people find their own motivation to change. It works well as a tool to help staff in changing their attitudes toward patient care. We will discuss this technique more in the section on communication.
- **Clinical coaching.** Managers help to embed patient centeredness into the clinician's day-to-day work by reviewing cases with clinicians, asking questions about the patient's goals and the use of self-management support strategies, acknowledging frustration with adherence issues but focusing on constructive problem solving. Managers should try to elicit suggestions from staff themselves and use active listening, but offer resources or ideas if none are forthcoming.
- **Involving patients in staff teaching and in clinical conferences.** Hearing directly from patients is the best way to achieve patient centeredness. If the clinical unit does complex patient conferences or daily huddles, invite patients and their families to participate.

  If you are doing training on care coordination, communication, or patient teaching, ask a patient to attend and to

play a part or to give feedback. Creating a patient/family advisory committee and heeding their recommendations is also a powerful way to demonstrate commitment to patient-centered care.

- **Share patient comments from CAHPS surveys, complaints, and compliments.** Patients often provide both positive and negative comments about their experiences of care when they answer surveys or when they write letters to the organization. Reading from these comments at each staff meeting is another way to bring the patient voice into the world of clinicians.
- **Support staff in providing patient-centered care.** As mentioned, providing patient-centered care, especially when patients are very ill or nonadherent, can be stressful and frustrating for staff. Sometimes the manager should intervene and become the buffer between clinical staff and patients/family members who are particularly hostile or who have overwhelming problems. The healthcare manager can help staff deal with stress through techniques such as active listening, acknowledging frustration, finding community resources, advocacy on behalf of staff, problem solving and simple nurturing through creating a lower stress environment, giving praise, and thanking staff for their efforts. Even bringing in a plate of cookies occasionally can go a long way to nurturing in a highly stressful clinical environment. If staff are particularly frustrated with certain situations or if morale is very low, it may be time to seek help from a senior manager or from human resources staff.

BOX 5-1 describes an exercise that can be used to encourage clinician patient-centered care thinking and actions.

INTERVIEW WITH KRISTIN LAGANA, RN

Kristin Lagana, RN, is a clinical quality specialist with Genesis Health Care, a holding company with subsidiaries that operate skilled nursing facilities. Kristin provides consultation services to directors of nursing in the 10 rehabilitation centers that she supports. These 10 centers primarily provide long-term care, but some provide more intensive services such as caring for patients with left ventricular assist devices (LVADs) and serious cardiac disease. Kristin has an online calendar that centers can access and request assistance as needed.

Kristin helps facility administrators and directors of nursing "build a team and supports everyone working to the top of their license." She acts as a role model and coach. Kristin helps centers develop quality assurance/quality improvement (QAPI) programs. Kristin monitors facility quality through environmental rounds, infection control monitoring, chart reviews, an assessment of best practices use, survey preparedness, and an analysis of reportable events. Kristin assists the center leadership in identifying trends in quality indicator data, which generate improvement projects. She checks to ensure that action plans have been initiated for quality issues.

In addition to helping centers identify trends in quality data, she helps teams investigate and test improvements. Kristin says, "People feel they are alone in dealing with some of these problems. I provide them with help." Kristin feels that an important part of improving care is her role modeling behavior for staff. She tries to create a no-blame atmosphere in which center staff can ask for help more than once. They can develop and implement a plan and then come back for help.

Kristin consults with line staff, nurse managers, clinical liaison, and sometimes families. She is most likely to interact with families in times of difficult situations or poor outcomes and the family "needs

(continues)

to hear from someone else. People see me as an outside regional person." Often, people just need to feel that there is someone who cares and with whom they can establish a relationship. Kristin may get involved with complaints. She spends a lot of time listening and is able to prevent situations from escalating.

Kristin helps provide more connected care for patients by facilitating monthly regional meetings in which nurse executives can share ideas for improving care. Connected care in Kristin's view is "all about communication." Another area important to connected care is medication reconciliation when a patient is admitted to the facility after a hospital discharge. Providing consistent staff, especially certified nursing assistants, to each patient is another important aspect of "connecting the dots" for patients. Finances for the patient and the patient's family are an area of stress and sometimes create fragmented care for patients. Within a few days of admission, center staff meet with the patient and/or patient's representative regarding financial planning for the admission with the hope to put their minds at ease and give them the information they may need.

The patient care plan is another aspect of connected care in Kristin's view. The care plan is intended to be personalized to the patient and includes attention to diagnoses, behavior, and quality of life. Patient preferences are an integral part of the care plan.

BOX 5-1 Acknowledge Team Blind Spots

Katie Owens, vice president of Healthstream Engagement Institute, describes an exercise that managers can conduct at staff meetings to help their team renew their commitment to patient-centered care excellence:

1. "Perform a fill-in-the-blank exercise with your team to identify the following:
   - It is hard to feel empathy for patients who_____
   - It is easy to feel empathy for patients who_____
   - It is hard to prioritize patients when_____
2. Discuss your answers frankly and purposefully.
3. Acknowledge some of your common stereotypes or labels.
4. Address common vulnerabilities that can trip you up when attempting to eradicate patient labeling.
5. Communicate openly with the understanding that a nonnegotiable expectation is that you will practice patient-centered behaviors with every single patient, every interaction.
6. Get help and support from your senior leadership team and others who are stakeholders and champions of the culture you are trying to create" (Owens, 2017, p. 5).

The Planetree organization (Planetree.org, 2016) provides managers with a simple self-assessment tool called Person-Centered Leadership Self Reflection Questions. The quiz is available to download at https://planetree.org/wp-content/uploads/2017/04/20.-Person-Centered-Leadership-Self-Reflection-Questions.pdf.

Communication

Communication is possibly the most essential pillar of connected care. Consider the huge amount of harm that occurs when two-way communication about patient information is not communicated across the continuum. Managers have a

vital role to play in ensuring that all members of the team receive accurate and updated information both about organizational issues and about the care of their current patients. They must also ensure that patients receive clear, accurate, and constantly updated information about their condition and the care they are receiving.

Effective communication in health care is a risk management tool, as many incidents relating to patient harm and subsequent malpractice suits result from miscommunication. In a 2015 study, Crico Strategies, a risk management firm, evaluated 7,100 malpractice cases in which miscommunication was a key root cause of patient harm, much of it serious. The study found that 57% of cases involved poor provider-to-provider communication and 55% involved provider-to-patient communication with a 12% overlap (Ruoff, 2015).

Common problems included miscommunication about the patient's condition, poor documentation, not reading the medical record, inadequate informed consent, and an unsympathetic response to patient complaints. Every single one of these disconnection issues can be addressed by focusing management attention on clinical culture change for better communication. Managers accomplish this by using a set of core principles that are illustrated in **FIGURE 5-10**.

FIGURE 5-10 Communication Key Principles for Managers

Key Communication Principles for Middle Managers

- **Drive out fear.** In health care this is necessary because of the often painful and difficult information that must be conveyed and because of the power differentials and status differences between patients and professionals and within professional hierarchies that can create fear and blame. Creating an open, blame-free environment has been an important element in the patient safety culture movement. Managers drive out fear by not reacting negatively or defensively to hearing messages from staff and patients that may not be welcome. They also advocate for staff who tell the truth about difficult clinical situations and buffer employees from powerful clinicians or managers who may prefer that they stay silent. Managers should also lower the threat level for patients by ensuring that they have time, privacy, and a sympathetic person to whom they can tell their story.
- **The next step is the customer.** In the concept of "throw it over the wall" transitions there is one-way communication without feedback. This is diametrically opposed to what should happen in a connected care environment. In connected care, each profession and department has a basic understanding of what the next person or function in the workflow needs to know to care for the patient. The "supplier" department or worker provides that information in a form that is usable and complete. By treating the next step in the continuum as the customer, staff ensure that the right information gets to the right person at the right time. Managers implement this principle by monitoring communication, identifying root causes of miscommunication, and coaching staff to think about internal customer service when doing care planning.
- **Close the loop.** In closed loop communication, information is sent to a listener or

receiver who then verifies receipt of it. In high-risk situations such as when orders are transmitted in an emergency, the receiver may repeat back what he or she heard: "The order is for 50 milligrams of Benadryl." In other situations, the receiver simply replies to indicate that the information was received: "Got it."

Managers foster closed loop communication by modeling it. One way they do this is to acknowledge and return phone calls and emails from staff and peers. The second step in closing the loop is taking time to read, understand, and respond to the message that has been delivered. Another way to foster closed loop communication is to immediately address situations in which staff used only one-way communication, such as leaving a message about a patient's condition change but not ensuring that the clinician at the other end received it.

- **Remember the ripple effect.** Every organizational action, decision, or change affects multiple staff and their patients. However, communication is often incomplete or misses some of the people who need the change information. Managers can ensure that they get important information to key people by using strategic communication tools and techniques and by not forgetting people who work per diem, part time, or in lower level support jobs. Every major managerial communication should be preceded by the question, "Who needs to know?" One failure in communication is leaving out part-time, per diem, remote, or off-shift employees. Managers should be vigilant about ensuring that these employees are included in important communications.

How Managers Facilitate Communication

- **Modeling.** Managers also achieve effective communication by modeling the key interpersonal communication techniques such as active listening, negotiation, motivational interviewing and assertiveness, and training and coaching staff to use them as well.
- **Using strategic communication** to ensure that information about organizational issues gets to the right people in a form that they can understand and use. One way to facilitate strategic communication is to create a simple list or spreadsheet that identifies who is impacted by a decision or change and how best to communicate with them. The strategic communication grid in Chapter 4 can be used for this purpose. This is a formal tool for answering the key question, "Who needs to know?"
- **Providing access to formal communication skills training.** Organizations such as the Institute for Healthcare Communications (http://healthcarecomm.org) provide intensive in-person courses. Other programs are available from the Academy for Communication in Healthcare (http://www.achonline.org).
- **Providing accessible and understandable information** about policies, procedures, and organizational changes through email, written communication, or formal presentations.
- **Implementing training, processes, and tools that foster the use of evidence-based clinical communication techniques** such as SBAR reporting or structured care communications about changes in condition such as the STOP and Watch Tool from the Interact Program (Pathway Health, 2017).
- **Creating processes that support effective communication** to patients and between members of the clinical team. An example is implementing standards and specific mechanisms for interdisciplinary communication exchanges, and monitoring to ensure that this communication occurs. An example from home care would be to set a standard that interdisciplinary conferencing must occur every 2 weeks and working with staff to develop a template that can be used for communication between nursing, therapy, and social work.

- **Providing support in the use of communication technologies** such as email, secure mail, texting, use of specialized software, portals, and patient tracking systems.
- **Giving constructive feedback** to employees, peers, and in certain circumstances, senior managers when a problem arises.

Practical Communication Improvement Practices

A white paper from the company Healthstream identifies 10 best practices that managers can apply to improve communication in the healthcare workplace. This paper provides a series of step-by-step guidelines for improving both employee communication skills with patients and managerial communication. One technique suggested in this paper is "Words that Work" (SM). This approach helps healthcare professionals analyze a typical patient experience situation and brainstorm a list of words or phrases that can be used to communicate a consistent message to patients in a friendly way. Another term for this approach is "scripting." See an example of this technique in **BOX 5-2**.

The paper suggests that managers embed the Words that Work (SM) concept into daily work by including staff in the development of the scripts, posting the key words in a prominent place where staff can see them, recognizing and rewarding staff who use the scripts, coaching staff who are struggling to use the "words at work concept," and continuing to develop and refine scripts at staff meetings. The paper recommends a series of managerial communication support techniques, including teaching step-by-step formulas for patient communication, regular rounding (meeting) with both patients and employees to get feedback on how things are going and to identify potential problems, creating department communication boards with data about department performance, and relaying compliments and information about new procedures (Healthstream, 2017).

BOX 5-2 Words That Work (SM) Example

Issue Addressed: **Staff Responsiveness** (use this during admission rounding)
Example: "Let me explain how to use your call button. Our team responds to the call button immediately at the nurses' station. It may take x (determine call light response time) minutes before your nurse can be with you in your room; however, we will treat your request with urgency" (Healthstream, 2017, p. 6).

CASE STUDY

Clinical Managers Tackle Communication Challenges

A group of home healthcare clinical managers from the Everford Health System decided to develop a process improvement team to improve employee and patient communication. This project was launched because employee surveys identified concerns about fragmented communication, and patient experience scores showed that clinician communication with patients was less than ideal.

Based on data from focus groups and individual interviews with both staff and patients, the team decided to adopt a set of management communication best practices that included closed loop communication between clinicians, managing out-of-office voicemails and email messages, reducing email overload for clinicians, and ensuring that anyone affected by a clinical issue gets notified.

The managers also decided to create a system of "radical transparency" in which they would help employees to better understand the agency's business environment, goals, and strategies for achieving

(continues)

the quadruple aim. The group created a weekly email newsletter update that included agency procedure changes, compliments, key metrics, and new programs of interest to clinicians. They also instituted a "letters to the management" section so employees could communicate back with ideas and issues. The managers reduced the amount of employee email overload by using a set of standardized subject headings in emails so staff could triage those emails that needed to be opened first. They reinstated regular staff meetings and dedicated a period of time for employee suggestions and input into workflow changes, procedures, or other issues. The managers adopted a standard form for strategic communications that cued them to think through the issue of "who needs to know." Working with employees, they then devised an agency-wide process for interdisciplinary communication that incorporated the idea of "closing the loop" or always responding to patient-related communication.

The clinical managers asked the organization to provide them with some intensive interactive training in clinical interviewing and motivational interviewing. They then restated communication expectations for staff, instituted a series of education programs on communication, made communication skills part of the annual competency evaluation, and incorporated more stringent communication requirements into performance appraisals.

Managers modeled communication skills, went on visits to observe employees, and coached employees to improve these skills. The team also worked with clinical employees to develop scripts for specific steps in the care process such as the start of care and discharge. After 6 months of intensive work on communication, a second employee survey revealed significant improvement. The agency's next HCAHPS (CMS publicly reported survey, Home Health Consumer Assessment of Healthcare Providers and Systems) survey also showed improvement in outcome scores.

Anecdotal data suggested that complaints and care transition problems had dropped significantly as a result of better communication. Eventually the Everford Continuity Team adopted the communication best practices developed by the home health agency for all entities in the system.

Middle Managers and Care Coordination

Care coordination, one of the most essential of the pillars of connected care, requires special clinical skills and expertise and considerable support from management to achieve the best outcomes for patients. Within the care coordination function, nurses or other clinicians organize the elements of information, health services, and resources that patients need for recovery and self-care and transition to the next step in the care continuum.

Managers support the complex process of care coordination through employee selection, training, assembling resources, and helping clinicians with organization and complex patient problem solving.

In specialized care coordination departments, the manager him or herself will be an experienced care coordinator who is responsible not only for supervising and managing care coordinators but for overseeing and managing care coordination policy, processes and structures. In other settings, such as in ambulatory care or home health care, care coordination may be only a part of the clinician's and manager's jobs. Several methods that can help the manager support clinicians who perform care coordination functions are:

- Review and analysis of clinician caseload data and tracking of the highest risk patients with clinicians.
- Clinical coaching to help clinicians manage the more challenging patients in their caseload.
- Debriefing of the root causes of faulty care coordination such as transitions that resulted in transfers to inpatient, emergency room, or a higher level of care.
- Facilitating interdisciplinary meetings, such as complex case conferences, to help

support clinicians in coordinating care for complex patients.
- Providing education and training in new care coordination techniques and resources.
- Acting as an advocate and intermediary with other employees such as the organization compliance officer for clinicians who are dealing with risk management situations or when external agencies such as a protective services agency is involved.
- Providing advice, support, and community resources or higher level medical resources in cases in which the clinician and/or the team doesn't have all the skills or knowledge to deal with a high-risk/high-need patient.

PROVIDING CONNECTED CARE IN A LONG-TERM ACUTE CARE HOSPITAL

Interview with Kathy Reilly, RN, Director of Care Management, Gaylord Hospital; Deb Kaye, RN, Care Manager, Gaylord Hospital

Gaylord Hospital is a long-term acute care hospital (LTACH). This type of facility provides hospital level care for complex patients. Patients usually have a longer length of stay (3–4 weeks) than inpatients in acute care hospitals. Typical patients who are admitted to this setting include those who have complex wounds, must be weaned off ventilators, have respiratory failure, or have traumatic brain or spinal cord injuries. Gaylord also provides a rehabilitation component for patients with problems such as strokes who also have other severe comorbidities or unstable medical conditions. Patients in this setting are typically admitted from an acute care hospital.

Case management is an integral part of the services provided by the LTACH. These services begin with a regional clinical liaison nurse who visits potential patients in acute care hospitals. The liaison nurse conducts a thorough clinical assessment, reviews the medical record, and visits the patient and family. The liaison decides whether the patient meets the criteria for LTACH admission and whether LTACH is the appropriate level of care.

If Gaylord agrees to admit the patient, the liaison explains the services to the patient and family and describes what to expect. Ms. Reilly notes that a referral to an LTACH is usually quite acceptable to patients as they feel safe in an environment that provides a hospital level of care and in which they are seen by a doctor every day. The LTACH setting also provides much more intensive levels of nursing care than a skilled nursing facility with nurse-to-patient ratios of one RN to six to eight patients. A big issue for the facility is that patients do not want to leave when it is time for discharge. The LTACH goal is not to completely return patients to full function but to help them transition to the next and most appropriate level of care, which may be a discharge home or a skilled nursing facility.

Every patient admitted to Gaylord is assigned to a nurse case manager. The case manager starts to plan the patient discharge from the admission. Starting with information provided by the hospital liaison nurse, the case manager assesses patient clinical needs, finances, insurance coverage, family support, psychosocial issues, and patient goals and wants. While direct care clinical staff mostly coordinate care when the patient is an inpatient, the case manager may intervene to ensure the services essential to the discharge plan, such as occupational therapy, are brought into the patient's case.

Gaylord has weekly interdisciplinary team rounds in which case managers participate. These are "walking around" rounds in which the team goes to the patient's room to discuss care, family members are included, and the plan and target dates for discharge are discussed. If the patient or family members cannot attend the team meeting, the case manager will share the team's discussion with them later.

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The case manager will work with the inpatient nursing staff to prepare the patient and family for discharge. For example, if the patient has a complex wound or needs a technical procedure to be done at home, the case manager will create a communication sheet that outlines necessary patient teaching.

Gaylord sees postacute and medical equipment providers as colleagues and has an open-door policy that allows these agencies to send in a clinical liaison to meet the patient, evaluate the case, and possibly create a teaching plan that can be started on the Gaylord inpatient unit. For example, a company that provides enteral nutrition may develop a patient teaching plan for the inpatient nurse unit staff.

Case managers do a thorough assessment of potential barriers to discharge—for example, considering how to arrange the home for a patient who has had a leg amputation but who lives on the second floor. Case managers also consider the patient's caregiving support network and may refer to community agencies to close the gaps. In recent years, case managers have found housing to be a big barrier for lower income patients. While case managers do not actually arrange for housing they will try to find a social services agency in the community that can help.

Care management staff continue to follow patients after discharge from Gaylord by calling the patient 3 to 5 days after the discharge to clarify medication orders, ensure that supplies and equipment have arrived, and check on the status of medical follow-up appointments, postacute services, and problems. For those patients who are discharged without services, the case manager will schedule a postdischarge appointment with the patient's primary care doctor.

Creating discharge plans for patients with highly complex and resource intensive needs is a constant challenge for Gaylord case managers. For example, few skilled nursing facilities want to accept ventilator-dependent patients. Finding resources for patients who need long-term, complex wound care or daily physical occupational or speech therapy can be very difficult. In many cases, these patients may need to be placed in facilities far from their homes, sometimes in another state.

Another challenge is finding a primary care physician who will accept these complex patients. Regulations surrounding reimbursement are other issues for LTACH case managers.

Ms. Reilly and Ms. Kaye state that as highly challenging as this work is, it is rewarding in the same measure. In some ways it is a pure form of nursing where there is intense engagement with patients and families and the satisfaction of knowing that front line clinical staff and case managers make a big difference in patient's lives.

When asked about the case they are most proud of, both case managers tell about a man who was a patient at Gaylord. He had had a cardiac arrest and was revived, but suffered anoxic brain damage. He had a tracheostomy, a feeding tube, and was ventilator dependent. He was also on renal dialysis. Through intensive research the case manager was able to find a company that would do home renal dialysis. The wife, who had been an emergency medical technician (EMT) at one time, was so desperate to take her husband home that she agreed to learn all the complex high-tech procedures that he would need. The dialysis company also helped to train the wife in their procedures. After 9 months as an inpatient, the patient went home. Ms. Kaye says "there wasn't a dry eye in the hospital when they left." Unfortunately, the home stay was short lived as the patient contracted a respiratory infection and subsequently died. The wife was so grateful for the time she had at home with her husband that she continues to return to the hospital for visits and to express her gratitude for the extraordinary efforts that the Gaylord team made.

Employee Selection and Training for Care Coordination

Managers who hire clinicians for jobs that contain a care coordination component should expect candidates to have excellent basic clinical skills in assessment, patient teaching, and the performance of clinical procedures. Managers should also assess job applicants for highly developed organizational skills and advanced communication, negotiation, and health coaching skills.

A 2013 article in the journal *Nursing Economics* describes the range of competencies necessary to effectively perform care coordination (Haas, Swan, & Haynes, 2013). Because care coordination usually involves coordinating multiple resources for patients, potential employees should be well versed in the role of other health professions and in the use of community resources. One method for assessing potential care coordination capability is to provide candidates with some typical patient case studies and ask them to describe how they would approach care coordination for this patient.

Use of Data and Population Health Tactics

Care coordination is by nature a population health effort. The clinician manages a caseload or population of patients, each of whom is at a different level of risk for decompensation or a return to acute care. The manager in turn oversees the caseloads of the whole team or unit. More sophisticated organizations apply evidence-based best practices to patient populations at different levels of risk. The manager should understand how to use data to identify the levels of risk and to apply these best practices. For example, a home care agency may apply frailty best practices to patients who are in the medium risk category.

The manager must support clinicians in constantly triaging their patient population using clinical assessment and caseload data. **FIGURE 5-11** provides an example of a "commonsense" risk triage system for nurse case managers.

In a primary care medical home setting, the manager may assess population risk by automatically receiving risk scores from the practice electronic medical record or from information received on referral. The manager must help clinicians stay focused on high-risk situations within their caseload such as a patient newly returned home after an acute care transfer.

Helping Employees Prioritize Care Coordination Tasks

Using data, the manager can help employees prioritize care coordination tasks and determine the level of care intensity needed by specific patients. Often this involves discussion with clinicians about the use of time and scheduling. For

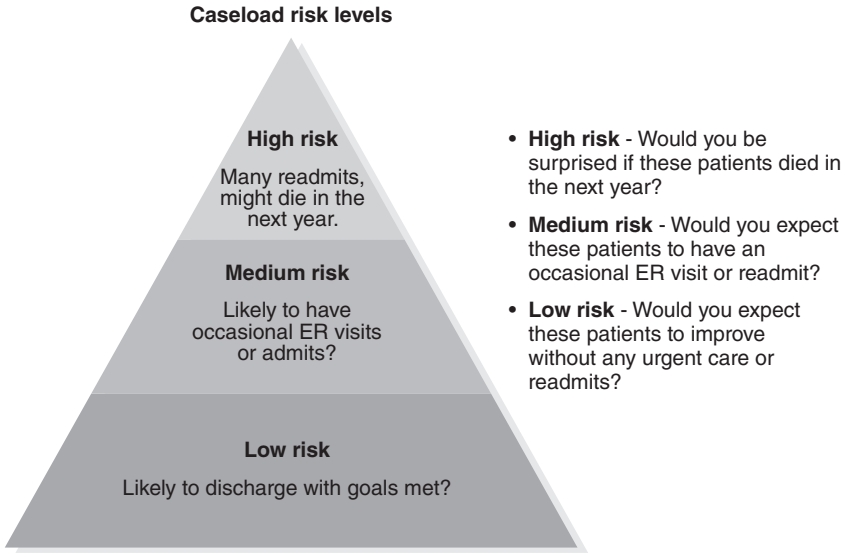

FIGURE 5-11 Case Manager Population Risk Assessment Guide

example, in the early stages of a home health-care episode, care is "frontloaded" for high-risk patients (such as a patient recently discharged from the hospital after an exacerbation of heart failure), meaning that the employee must have time to make extra visits and phone calls. The manager should help keep caseloads balanced, so no one clinician is overloaded with the highest risk, most intense cases. The manager can help coach and train employees in time management and efficiency techniques such as point-of-service charting using the nurse's laptop computer in the patient's home.

Facilitating Referrals and Case Sharing

High-risk, high-need patients with many issues related to the social determinants of health will need help from community resources.

The middle manager should ensure that clinical staff does not simply work in isolation, focusing on their own professional responsibilities while ignoring factors such as food, transportation, mental illness, or substance abuse that might completely derail any medical care plan.

To help staff utilize community resources, the manager may need to work with the organization's community outreach, social work, or marketing department to create resource guides or listings for community resources, and other community care coordination resources programs, such as those in medical offices and insurance plans. Through reading and networking, the manager should get to know other managers in local community organizations, learn what these resources are capable of providing, and encourage staff to make good referrals and sometimes to coordinate care with these other entities. In more complex cases when multiple agencies are involved, or in cases in which the care coordinator goes into a residential facility to provide services (such as a home care nurse seeing patients in an assisted living facility), there may need to be case sharing or some type of formal agreements about clinician roles and responsibilities.

CASE STUDY

Hanna, a regional clinical care director for the local Everford skilled nursing facilities that specialize in short-term rehabilitation, found that many patients were being discharged without adequate care support at home and often without referrals to home health care. These patients were being readmitted to the hospital at a high rate. Hanna contacted Tanya, the skilled nursing facility representative to the continuity team, to help her with this problem. Together they researched insurance company and Medicaid care coordination programs and developed relationships with these care coordinators so social workers could refer high-risk patients to them on discharge.

Tanya and Hanna also worked with the Everford Continuity Team to develop a clinical liaison and referral program with the system home health agencies. Hanna created a resource directory of community organizations that could help patients with social determinants of health and Tanya researched the availability of MSW services from within the health system.

Using these resources, both nursing and social work staff were able to create much better transitions for patients and subsequently a lower readmission rate for Hanna's facilities.

Care Coordination Helping and Hindering Forces

A study reported in the *Journal of the American Board of Family Medicine* looked at the factors that both help and hinder good care coordination (Friedman et al., 2016). The results of the study can guide middle managers in their efforts to build both human and technical systems for good care coordination. The study used an online social learning collaborative with 25 care coordinators in primary care medical homes to identify the factors that facilitate and hinder their effectiveness.

The study found that facilitating and hindering forces for care coordination fell into three categories: organizational/system, interpersonal, and individual. Specific factors are discussed next.

Providing Resources for Care Coordination Effectiveness

Caseload and Workload. Coordinators stated that having too many patients on their caseload (one person had 300 patients) diluted the bond between patient and coordinator, making a workable relationship difficult. Patients who had many problems with mental health and socioeconomic issues required a greater time commitment from the care coordinator but these factors were not always taken into account when assigning work. Another issue was the requirement that coordinators both deliver care coordination and conduct patient tracking activities, functions that the care coordinators felt were incompatible with success.

Time and volume of work is a resource-related factor that is controlled by managers. The manager may determine how many new patients the unit or the team can take, how many patients should be on a caseload, and how many care transitions or care coordination activities each staff person can reasonably handle. Managers should assign tasks and workload by truly understanding the care coordination tasks that their employees are performing, the intensity of the work, and the characteristics of the patient population.

Providing Good Quality Clinical Information Technology

Clinical technology that is not functional for care coordination purposes was a big complaint of study participants. In particular, the inability to run reports by patient population was a frustration. Coordinators reported running multiple reports and then cobbling them together manually. Another frustration was lack of interoperability between hospitals, specialists, and the practice. Some coordinators created work arounds by developing relationships with other facilities and having information faxed to them. This an area where a manager with good organizational effectiveness skills can make a difference. Since many managers do not have the skill or the knowledge to address these issues directly, good relationships with internal departments such as information systems, quality assurance, or marketing/community outreach can be leveraged to get employees the help they need. By working with their information systems department to create integrated reports, by advocating for the purchase of interoperable systems (which allow outside agencies to look at hospital electronic records), and by building information exchange relationships with partner organizations in the care continuum, managers help employees better perform care coordination.

The Availability of Community Resources

Care coordinators found searching for community resources to address issues such as transportation, medication delivery, mental health services, and low-cost dental care to be essential to their success. Coordinators indicated that having a good community resource directory was invaluable in creating better patient care plans. Managers can help with this problem by finding community resource directories, advocating for their organization to develop their own directory, and inviting representatives of community agencies to come into their facility to explain how their agencies can help patients.

Interactions with Clinicians and Other Health Care Facilities

Coordinators in the study who practiced in primary care medical homes report that getting "buy-in" for care coordination and collaboration from physicians and other care team members was a big obstacle to success. Likewise, some

coordinators complained of the difficulty of getting cooperation from other healthcare organizations, while still others found relationships with health professionals in hospitals or other practices to be invaluable. For managers, working with senior managers, physicians, and other managers to understand and support the care coordination role can be a key success factor for employees.

The manager should be able to explain the benefits of the care coordination function, be able to back up any claims with data, and act as an advocate for those who are performing the difficult task of coordinating care for high-risk patients.

Interactions with Patients

Coordinators often found patient's lack of health literacy, unwillingness to engage in self-care, and distrust of the care coordinator to be barriers to working effectively. One solution that worked for some coordinators was to become an expert at motivational interviewing even to the point of creating an "MI club" where coordinators met monthly to discuss strategies for dealing with patients who are struggling with effective self-care. As noted in the section on communication, managers can impact this problem by role modeling excellent communication skills, spending time with very demanding or angry patients to relieve staff of stress, teach and coach communication skills, and provide scripts for common situations.

The Coordinator's Own Self-Care Practices

Many care coordinators struggled with high stress levels and in some cases difficulties setting boundaries with patients. Without support from managers in the form of coaching, respite breaks, forums for expressing concerns, and coaching about self-care, employees who perform care coordination functions are vulnerable to burnout (Friedman et al., 2016).

Creating Structures and Processes for Better Care Coordination

Providing a clinical work structure that produces the best outcomes for patients is a key role for managers. This is particularly important in care coordination, where either a lack of structure or overly rigid organizational or professional structures can result in fragmentation, patient safety issues, and poor outcomes. The key structures and processes for care coordination are those that involve admitting patients, transmitting information, transferring patients, or situations in which staff must work cooperatively for the good of the patient. Some of the processes that are most prone to fragmentation and errors in all settings are:

- Patient admissions or starts of care
- Scheduling multiple services for patients
- Identifying patient changes in condition, reporting, and taking action
- Processes for ordering supplies and equipment for patients
- Patient movement between different organizational entities or to other facilities
- Transmittal of patient information between departments
- Reassessing patients when they have returned from a more acute level of care

Each of these key processes works best when the manager works with staff to create a standardized workflow, applies work simplification techniques, uses consistent forms or computerized templates for transmitting information, schedules staff in a consistent way so there is continuity of care for patients, and develops a system for monitoring whether the process was completed properly.

Middle Managers and Collaboration

Rarely can one clinician provide all the services necessary to care for a patient. The manager

should help clinicians identify internal and external resources for patients and provide coaching on how to use these resources appropriately. Managers must encourage clinicians who are coordinating care to learn about the scope of practice and types of support that other professionals can provide to patients.

They should also monitor internal referrals to ensure that their staff are referring appropriately and frequently enough. For example, nurses may not understand the types of assessment and support that physical, occupational, and speech therapy can offer patients. They may not even truly understand the differences between these professions. It is up to the middle manager to educate nursing staff about how the therapies can help and how they function differently from nursing. Social work is another profession that is often poorly understood by nurses who may perceive it as simply finding benefits and entitlements and not understand the type of emotional support and help with social determinants of health that a social worker can provide. In settings that have pharmacy consultants as members of the team, clinicians should learn how to utilize the pharmacist's special knowledge to help with medication management, drug interactions, and medication reconciliation.

The manager should work with other professional managers to facilitate joint training and dialogue between the professions to build respect and teamwork. Managers must also develop collaborative arrangements with other organizational professionals and departments to support the work of connected care. An example is a nurse manager and physical therapy manager who realized, through feedback from their respective staffs, that there was considerable misunderstanding and even distrust between the professions. Each profession had its own philosophy of patient care with therapy being very goal focused and nursing being focused on patient emotional needs and care tasks.

The managers of the two functions organized a "get to know you" session with a facilitator. After some group icebreakers, the facilitator was able to do a series of exercises that helped the two professions better understand each other.

Middle Managers and Care Transitions

Patient and information transitions are the most crucial aspects of connected care. Care transitions are often invisible and elusive for managers since they involve managing the "white space" between professions, departments, and other providers in the care continuum.

Managers should understand how their department's finished work impacts the next step in care. For example, in acute care facilities and in home care, the next step in the continuum is often a discharge to home and a handoff of information and responsibility to the primary care physician. Managers must have a sense of what the patient, the family, and the physician need to know and need to do to make the transition successful. For example, if the nurse has been managing medications for the patient, what strategies will be used to prepare medications in the home once the professional is out of the picture? To achieve care transition goals, middle managers should pay serious attention to the structures and processes that support transition outcomes. Care transition structural elements include:

- Senior management oversight and attention to care transitions.
- The adoption of evidence-based care transition models.
- Clear functions and roles for managing care transitions such as admission and discharge management responsibilities.
- Resources and time allocated to care transitions.
- Policies and procedures that support effective care transitions.
- Computer information systems and other tools for care transition communication.
- Forms and patient education materials that foster effective care transitions.
- Negotiated relationships, expectations, and contracts with other providers who send patients to the facility or agency. This is particularly important in value-based payment relationships when clinician behavior (i.e., a home care nurse sending all patients with

a decline in condition to the emergency room) can create financial penalties for partner organizations.

Middle Managers and Teamwork

Teamwork in clinical care is highly dependent on management support. Without clear direction, individual clinicians and support staff may perform their work in a way that suits them and does not necessarily contribute to better team outcomes. Managers support teamwork by ensuring that team members know that it is an important expectation for everyone. Managers should provide a clear message about the goals of the team and explain how each employee's job, and performance, contributes to the work of the team. Managers should also clarify expectations about mutual respect between team members, meeting behaviors, supporting other team members and team communications. Data about team outcomes and performance can help keep everyone focused on improving clinical results.

Other managerial actions that support teamwork are giving staff time to do interdisciplinary conferencing, scheduling high-risk case conferences and team huddles, giving staff a voice at meetings, and listening for care coordination, communication, and care transition barriers. Managers should encourage teamwork and mutual staff support outside team meetings.

Performance Management—A Key Tool in Achieving Connected Care

Effective management of employee performance is absolutely essential to achieving connected care. The process of performance management does not start with orientation and end with a yearly performance appraisal. It is a continuous process of setting expectations, providing resources, coaching, giving feedback, and helping employees make course corrections. **TABLE 5-4** describes examples of specific performance management techniques that can be used to achieve connected care.

Clinicians and the Performance Continuum

Managers can apply performance management techniques to support and encourage good employee connected care performance and to improve low performance. Managing lower levels of performance is often a big part of the healthcare middle manager's job, especially in areas where workforce shortages create a smaller pool of well-qualified clinicians.

This focus on lower levels of performance can divert manager attention away from steady and reliable staff and high-performing clinicians who, if nurtured, can become role models, mentors, and champions of connected care innovation and improvement. Reliable and high-performing employees need regular attention. To sustain and encourage these clinicians, managers give specific feedback on what they are doing right, encourage and support attempts at improvement, even if they fail, provide public recognition for good performance and offer opportunities for new skill development or participation on committees or change projects.

Each department has its share (hopefully small) of staff who do not perform up to standards. Chronic low performance produces less than optimal patient care, and often creates complaints, resentment from other staff, and time pulled away from the manager's clinical culture change work. Looking at performance as a systems issue can help managers improve the performance of their whole employee population.

Low performance is not only a matter of employee attitude and commitment. It can often be traced back to system failures in performance management including: rushed or

TABLE 5-4 Performance Management Techniques for Achieving Connected Care

Action	Examples
Set expectations	■ Explain, in very specific ways, what is expected and offer examples. ■ Tell stories that illustrate the expectation. ■ Show videos that provide examples. ■ Share patient comments that illustrate how clinician behaviors affected the patient experience.
Offering training and job aids	■ Provide training in the tools and techniques of patient-centered, connected care. ■ Direct employees to outside webinars, lectures, conferences, and training. ■ Help each employee conduct a self-assessment of skill gaps and create a plan to close the gaps.
Build competence with supervised practice	■ Offer classroom opportunities for practice. ■ Use teach-back and return demonstration to verify learning. ■ Have employees observe and give each other feedback. ■ Provide an opportunity for the employee to work with and observe an expert in action. ■ Test skills at competency fairs. ■ Find and show video models of connected care techniques in action.
Provide the resources to do the job	■ Provide access to needed technology. ■ Give clinicians time to do the job. ■ Provide continuous access to needed supplies and equipment. ■ Provide support staff help as appropriate.
Offer tools to support performance	■ Add scripts, templates in the electronic medical record to cue connected care activities as well as forms, email, and text reminders.
Give feedback and coach for improved performance	■ Tell employees, in very specific ways, how they are doing: "Mrs Jones responded well when you asked her what was really important to her. It might have been helpful to allow her to talk a bit more afterward." ■ Coach employees to identify improved behaviors. ■ Use motivational interviewing techniques to help employees find their own motivation to change.
Praise good work	■ Give positive feedback, naming specific actions that the employee has performed: "Your documentation clearly shows that you have been helping patients set smart goals. Every one of your records achieved the goal."
Incorporate new expectations into workflows	■ Get employee input on how to examine and improve work processes to accommodate new requirements. ■ Ask groups of employees to a meeting to discuss and flowchart a modified patient encounter that uses patient-centered care techniques. ■ Engage employees in patient-centered care process improvement projects.

Data from Mager and Pipe, 1997.

inadequate orientation, lack of clear expectations, inadequate training, no opportunity for practice, not enough time and resources to do the job, limited feedback on performance, and perverse rewards such as getting smaller work assignments because of poor performance. After diagnosing the problem, the manager, sometimes with the help of human resources, should take direct accountability for daily monitoring, coaching, feedback, and counseling or discipline if the poor performance does not resolve itself. Simply tolerating low performance in the vain hope that things will change of their own accord creates both a risk management situation and imposes a less than adequate practitioner on sick patients.

Measuring Front Line Clinician-Connected Care Performance

Managers need methods for evaluating clinician-connected care competence and effectiveness. These methods can include observation of patient care, clinician self-assessments, peer assessments, supervisory performance appraisal, and individual clinician outcome measures. The QSEN Institute website provides a variety of evidence-based tools to assess mastery of the QSEN competencies (QSEN Institute, 2017). These methods could possibly be used in periodic nurse competency testing, although they tend to be laborious to administer and may be more useful in an academic environment.

In organizations that have a quadruple aim key indicator system, and that publish regular performance reports, measurement is easier because goals are clear and managers understand connected care key indicators for their organization and their own team. Visible measurement, in which care teams get frequent updates on their own performance, can be a highly motivating strategy for staff. In some settings, managers can provide clinical staff with data on their own outcome measures, such as readmissions of patients on their caseload, and help them compare their performance to team and organization benchmarks. While each setting will have its own key indicators, core care coordination measures that are key to measuring connected care are:

- Hospital readmission rates
- Patients who received a transition record at the time of discharge
- Medication reconciliation accuracy
- Patient experience of care coordination using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

Another key measure of connected care is adverse events that result from miscommunication and lack of care coordination.

The data are likely to be measured and communicated by the organization quality assurance function. For example, missed visits and adverse events can occur in home care when a nurse case manager goes on vacation and does not adequately report on her patient caseload care needs to her supervisor or to the per diem nurses who will be covering her patients.

Outcome Measures and Individual Accountability

While organizations may be tempted to use outcome measures as a true reflection of clinician effectiveness, this approach must be taken with caution. There should be a careful evaluation of the link between the outcome and the influence that clinician behavior has on achieving it.

For example, effective medication reconciliation is a key outcome measure. Individual clinicians are usually responsible for this process, so it may be an appropriate measure of individual clinician effectiveness. However, other organizational, patient, and external factors may play as much a role in outcomes as individual clinician work. A nurse may report medication discrepancies, but she cannot reconcile them without physician response and involvement. Readmissions, while influenced by clinician behavior, may have a number of other root causes that are outside the control of the

individual clinician. For example, a nurse may identify a weight gain and increased shortness of breath in a patient with heart failure. If she notifies the physician and suggests an additional trial dose of a diuretic, she has reached the limit of her ability to control the situation. It is then up to the physician to concur with the nurse's recommendation or to send the patient to the emergency room. Organizational workflows can also strongly influence individual clinician outcomes. However, a pattern of patient readmissions from a nurse who refuses to use best practices consistently is probably a true performance problem.

Connected Care Self-Auditing

Another type of connected care measurement is self-audit or peer audit. Clinicians periodically review their own work or that of their peers if that is the organizational process. They then become aware of gaps and cracks in their own practice and identify patterns in their work processes that create a fragmented experience for patients. Clinicians can then strive to eliminate these disconnected care habits. For example, a nurse may not regularly check her cell phone voicemail and may miss important calls from patients or colleagues. Self-audits identify situations in which patient care tasks have "fallen through the cracks."

In many cases, these situations do not necessarily result in an adverse event if the clinician or another staff person has quickly "picked up the pieces." For example, a busy nurse is receiving patient care questions from aides or medical assistants and is not responding in a timely fashion. Once the nurse reviews her own work, or gets complaints from the aides or their supervisor, and becomes aware of this problem, she can build in time to communicate with aides and close that particular gap.

Chart Audits and Supervisory Monitoring

These are the most commonly used tools for evaluating clinician connected care competence and effectiveness. As noted earlier, embedding connected care responsibilities and competencies into job descriptions and performance appraisal makes the criteria for performance clear. Quality assurance staff check adherence to these performance standards through focused chart audits on processes such as medication reconciliation, the consistent use of clinical best practices, the quality of patient care transitions, and documented evidence that the clinician has worked with the patient to set goals. Managers should make opportunities to observe employees delivering clinical care.

Discussing cases with clinical staff on a daily basis can help the manager determine whether the tools and techniques of connected care are being used. By monitoring comments and complaints from patients and families, managers can get a sense of whether there are issues with lack of follow-up or miscommunication that originate with clinical employees. Once quality assurance data have been collected, the data can be reviewed with groups of staff to get input on possible root causes and to identify solutions that staff feel they "own."

Monitoring Connected Care by Talking to Patients

One important measure of how well connected care is working on a clinical unit or team is patient and family perceptions of care connection or fragmentation. While formal surveys like CAPHS scores provide semiquantitative measures of the patient experience, the data from these surveys are typically stripped of nuances and emotion. When managers speak with patients about their experiences they get the details and much more information about the impact of staff behaviors and unit work processes on the patient experience. One way to gather data on patient perceptions of unit connected care is to periodically call or visit patients who have experienced a transition—into or out of the clinical unit—or who have had a decline in condition or some intensive care experience.

These conversations can be as simple as "What was it like for you when you were admitted to our service or unit?" The manager can consolidate information from these conversations into themes and anecdotes and bring it to staff meetings for discussion.

Managers and Obstacles to Connected Care

Managers face a variety of hurdles in working with their employees to achieve connected care for patients. Organizational systems with rigid boundaries that discourage teamwork are a barrier to collaboration and smooth transitions. Senior managers who disparage or are not supportive of the work of middle managers can be an insurmountable barrier to the type of fluid and collaborative work needed to achieve connected care.

Another major issue for managers is what some describe as "being the meat in the sandwich," in which the manager is caught between unrealistic demands from both senior management and employees. A large volume of required administrative tasks and paperwork can become a barrier for managers who do not have time to observe, coach, and interact with employees; a situation that allows performance problems and staff discontent to take root

Mergers, acquisitions, downsizings, and reorganizations are fertile breeding grounds for disconnects, fragmented care, and medical errors. These situations are especially problematic if management staff are being moved around, laid off, or put in different positions, thus damaging continuity of support for employees.

Distraction from constant regulatory and business changes, even when there are no major organizational upheavals, keeps both managers and employees off balance as they struggle to perform the daily work of patient care while absorbing new requirements, forms, procedures, and tasks.

If not managed well, these changes not only contribute to fragmented care for patients, but may actually cause medical errors if unfamiliar procedures disrupt routine clinical practice. Finally, manager burnout is a very real obstacle to connected care. If managers are left to juggle too many demands without adequate resources to do the job and without positive reinforcement and support, they become disillusioned, stressed, and ultimately unable to maintain empathy for staff or patients.

The Everford Continuity Team Tackles Connected Care Implementation

The Everford Continuity Team wants to be sure that they are deploying the connected care vision of senior management. To do this, they decide to go back to their mission statement and to review documents developed by senior management to describe their part in the effort. The team finds that senior managers at the beginning of the connected care culture change (about 8 months ago) had planned to implement clinical culture change in several areas:

- Develop the workforce for connected care
- Clearly define connected care coordination roles and responsibilities
- Clinical managers practice connected care
- Work structures support connected care
- Organizational work processes support connected care
- Technology supports connection
- Create systems for engaging patients and families in connected care

In the intervening time, the senior management team had been challenged by a number of market forces, new regulations, and turnover in key positions at the senior management level. While some of the planned activities had been implemented, some were still "on the back burner."

The continuity team decides to convene a focus group of middle managers to get their perceptions of how far connected care clinical culture change has progressed, how they see their roles, and obstacles they face. The focus group reveals that middle managers are not fully clear on what

is expected of them. They have been given some direction on areas that need connected care improvement such as patient transfers between facilities and discharges to home. They have not received training in process improvement or performance improvement as promised. They have become embroiled in managing constant change and feel that senior management has downplayed their concerns and been reluctant to provide resources for the connected care effort. The continuity team relays these issues to senior management and a joint working session between senior management and key middle managers results in an action plan that includes the following:

- Senior managers clarify middle manager expectations and accountabilities.
- Training for managers will occur and will be provided by a local consulting firm.
- There will be regular meetings between the two groups to monitor progress and troubleshoot obstacles.
- Senior management will charter a "Change Management Group" of staff from HR, QA, marketing, and senior leadership who will monitor external changes and do a better job of managing the impact on middle managers and the clinical workforce.
- Senior managers will be more open to recommendations on process improvement and structural changes to support connected care. One senior management meeting per quarter will be devoted to this topic.
- Both groups agree to take a snapshot of quadruple aim measure scores and to use those scores to monitor progress of the connected care effort.

Energized by more support from senior management the middle manager team creates its own action plan around the pillars of connected care:

- Each manager reviews and revises job descriptions to incorporate connected care competencies.
- At the request of the team, HR modifies the performance appraisal system to reflect the importance of connected care accountabilities.
- Middle managers work with QA to identify the elements of patient-centered care and to integrate it into the quality assurance monitoring processes.
- Middle managers start to implement connected care by creating and implementing a patient-centered care communication and training plan for staff. Part of this training focuses on: "What does a good job of patient-centered care look like?" and "How will I know it when I see it?"
- Middle managers conduct an audit of how well the pillars of connected care are being implemented in their own facilities.
- Based on the audit findings, managers institute a series of customer/supplier conversations between front line staff and support departments.
- Managers set up "get to know you" sessions between professional groups such as nursing and social work to talk about differing viewpoints and patient care goals.
- Managers adopt a set of communication best practices including the adoption of closed loop communication for all clinical communications.
- Whenever there is a new staff communication, managers create a "who needs to know" grid and check off each group/individual as they send communication.
- Managers identify "cracks and gaps" in work processes, especially around care transitions and discharges. They ask the senior management team to charter a cross-organizational improvement team to improve these processes.
- Managers study team-building techniques, adopt teamwork tools, and work on getting more employee input and team building within their own departments.
- Each manager agrees to incorporate connected care principles into interdisciplinary team meetings and individual coaching sessions with employees.
- Middle managers meet with the continuity team on a regular basis to discuss progress and to provide mutual support in overcoming obstacles.

BOX 5-3 Manager Connected Care Checklist

- ❑ Managers are clear on their accountability for connected care.
- ❑ Achievement of connected care is part of manager performance appraisal.
- ❑ Managers have been trained and receive coaching in the principles and practices of connected care.
- ❑ Managers create a personal self-development plan that includes both mindset and skillset changes needed to implement connected care.
- ❑ Managers communicate connected care principles and expectations to staff.
- ❑ Managers consistently use the principles of effective communication.
- ❑ Managers foster teamwork and run effective team meetings and interdisciplinary case conferences.
- ❑ Managers foster understanding and cooperation between disciplines.
- ❑ Managers collaborate with other internal departments to clarify customer/supplier requirements and to gain support for their team.
- ❑ Managers provide internal and community resource information to staff.
- ❑ Managers set clear expectations for connected care performance.
- ❑ Managers ensure that staff are trained in patient-centered care, teamwork, communication, collaboration, care coordination, and effective care transitions.
- ❑ Managers audit charts for evidence of connected care activities.
- ❑ Managers monitor work processes for handoff failures and implement improvements.
- ❑ Managers advocate for the resources necessary to implement connected care.
- ❑ Managers assess organizational changes for their potential impact on connected care and try to align change with connected care goals where possible.

Over a 6-month period, the Everford system, while still buffeted by constant change and distraction, had made significant progress on connected care. CAHPS scores had improved and readmissions had declined. An employee satisfaction survey revealed improved satisfaction, although some staff, who were not comfortable with the level of patient centeredness and collaboration, had decided to leave. The middle management team had gained more respect from senior management and was now being included in discussions about innovation and implementation of the new strategic direction.

BOX 5-3 lists expectations for managers, developed by the Everford Continuity Team.

Chapter Summary

Middle managers are the vital link between senior management strategic goals and the front line staff who deliver connected care. Middle managers play the role of translator, facilitator, and therapist for clinical staff. In stressful or problematic situations, middle managers act as the face of the healthcare organization for patients and families and function as buffers between staff and problematic situations. Middle managers walk a tightrope between high-level strategic plans and the realities of implementation in the day-to-day clinical world. Middle managers implement change while keeping their own clinical operations running smoothly.

The middle manager's job is to communicate both to senior managers above and to the front line staff below her. Sometimes this requires middle managers to provide senior management with a "reality check" about the practicality of some strategic level plans. Middle managers are also process engineers who must turn organization policies and procedures into practical workflows and handoffs between individuals and departments.

Managers must assess employee requirements for information, technical tools, administrative support, and time. They must then

provide these resources within existing organizational constraints. In the day-to-day world of care delivery, middle managers must coach and facilitate implementation of the pillars of connected care, particularly communication, teamwork, collaboration, and care transitions. Care transitions, in particular, require the manager's attention because they involve activities that must be coordinated outside the boundaries of the organization. Transitions require managers to foster collaboration with other healthcare organizations, families, and community resources.

Managing through the volume-to-value shift requires middle managers to achieve a higher level of competency in areas such as communication, higher level clinical expertise, driving decisions with data, the use of technology, and process improvement strategies. Clinical middle managers must also make a shift from a task-oriented to a goal-oriented, value-based mindset. Managers require additional and more sophisticated training to function effectively through the volume-to-value shift. Effective training opportunities may be scarce in an environment where education lags behind the realities of a rapidly changing healthcare system. Given the challenges of their role, middle managers should build both organizational effectiveness and personal resilience skills. These skills include time management and the ability to create functional internal support networks of colleagues and support staff.

Organizations assess middle managers on team-level quadruple aim outcomes and through more subjective performance appraisal by a more senior manager. Middle managers do not always get the recognition or support their vital role demands. Many suffer from a misplaced and negative senior management perception about their value and effectiveness. Managers are often perceived as rigid or obstacles to change, and in some cases are seen as readily dispensible. This is an issue that can contribute to burnout and turnover in the middle management ranks.

Middle managers integrate the pillars of connected care into daily work through staff performance management and support. Managers must extricate themselves from firefighting and a mountain of administrative work to set clear expectations, train, coach, monitor, and give feedback to staff. Managers use the key principles of communication to drive out fear, treat the next step in care as a customer, and ensure that everyone affected by a patient care issue or decision uses closed loop communication ensure that patient care messages are acknowledged and managed. Managers use chart audits, peer chart reviews, clinical case conference, and employee coaching sessions to assess levels of care coordination, communication, and teamwork. Middle managers play a vital role in implementing connected care. Building their skills, and supporting and recognizing their efforts, must be essential elements of any connected care organizational implementation.

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