Care Management Connection

A publication of the Michigan Care Management Resource Center

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MiCMRC Complex Care Management Course Registration – 2017 Updates

New in 2017 The MiCMRC Complex Care Management (CCM) course:

- **Open to all care managers!**
- **Has been updated to include new content!**
- **No course fee!**
- **Provides Social Work and Nursing CE's!**

The MiCMRC Complex Care Management course is designed to prepare the healthcare professional for the role of Complex Care Manager. Course content is applicable to all Care Managers in the ambulatory care setting, working with complex patients. The MiCMRC Complex Care Management Course (CCM) curriculum provides the framework for the complex care management role, foundational elements of integration into the ambulatory care setting, and development of complex care management skills.

NEW FOR 2017: No fee for the MiCMRC CCM Course. **Also, due to the numerous care management programs in 2017, MiCMRC is now *re-quiring* the PO leader, practice manager or attendee's direct manager to register the care manager for the Complex Care Management Course.** This will facilitate accuracy of completion of the course registration fields and access to longitudinal resources for your staff.

The training format for MiCMRC CCM course consists of: a one-hour introductory live webinar, two days for recorded webinar self-study (approximately 6 hours' self-study) and two days of in person classroom instruction.

****For High Intensity Care Model Managers (HICM) ONLY- *New*** for 2017, HICM now integrates with the CCM course. HICM participants are required to complete the MiCMRC CCM course and two subsequent HICM self-study modules that provide the additional specific information for the HICM program.

NOTES: If you have 15 or more Care Managers in your area and would like the MiCMRC team to provide a regional training at your location please submit your request to: **micmrc-ccm-course@med.umich.edu**

For questions please contact : **mailto:micmrc-ccm-course@med.umich.edu**

Upcoming course dates and course registration:

January 23-26, 2017. Introductory Webinar January 23rd, 2017. Total six-hour self-study modules and post-tests January 23-24th, 2017. In person training January 25-26th, 2017. NOTE: Registration available. Please visit micmrc.org.

January 30- February 2nd, 2017. Introductory Webinar January 30th, 2017. Total six-hour self-study modules and post-tests January 30-January 31st, 2017. In person training February 1-2, 2017. NOTE: Registration available. Please visit micmrc.org for registration links.

Click on the dates below to register:

January 23-26, 2017, Lansing

January 30-February 2, 2017 Lansing

Share Your Success Stories

Submitting your success story is as easy as clicking on the following link:

Share Your Success Story

For help submitting your success story contact us at http://micmrc.org/contact-us

MICHIGAN CARE MANAGEMENT RESOURCE CENTER

The Michigan Care Management Resource Center is funded by Blue Cross Blue Shield of Michigan and aligns with BCBSM Value Partnerships, Physician Group Incentive Program. The goal of the resource center is to assist and support Michigan primary care practices as they continue to build upon their current Patient Centered Medical Home capabilities. MiCMRC provides clinical support for the Michigan Primary Transformation demonstration project, High Intensity Care Management, BCBSM Provider Directed Care Management (PDCM) Phase III and BCBSM PDCM Oncology program.

Support for The Michigan Care Management resource Center is provided by Blue Cross and Blue Shield of Michigan as part of the BCBSM Value Partnerships program

Nursing and Social Work continuing education opportunity. For more information visit www.micmrc.org/continuing-ed

MiCMRC Questions?

For questions please Contact Us

Questions about billing?

For questions about billing regarding your program send an email to:

ValuePartnerships@bcbsm.com

MiCMRC CARE MANAGER WEBINARS

NEW 2017 MiCMRC CARE MANAGER EDUCATIONAL WEBINARS

Wednesday January 18th 2017 2-3pm
Title: Family Caregiver Health
Presenter: Donna Yadrich, MPA

To register for this webinar: **http://micmrc.org/webinars**

Michigan Care Management Resource Center Approved Self-Management Support Training Programs – Update

For information about MiCMRC approved self-management programs please see the document titled "Care Management Resource Center Approved Self-Management Support Training Programs" at **http://micmrc.org/system/files/Copy%20of%20micmrc-approved-self-management-support-mcm-program-summary-v16a.pdf**
This document includes details for each MiCMRC approved self-management program: location, objectives, modality, resources, course date/criteria to schedule, trainer qualifications, certification/CEs, and cost.
MiPCT Moderate, Complex and Hybrid Care Managers are required to complete a MiCMRC-approved self-management course. For questions please submit to: **micmrc-requests@med.umich.edu**

BCBSM Pharmacy Resources Now Available, May be Helpful for PDCM Practices

New pharmacy resources are available on the PGIP Collaboration site that MiPCT/PDCM care managers may find helpful when working with chronic condition patients.

Resources include an online toolkit published by the U.S. Department of Health and Human Services to educate providers and patients about safe pain management, called **www.turnthetiderx.org**; as well as the new *Toolkits and Fliers* section on the left side of the Pharmacy Initiative page, which includes information for physician organizations, patients and providers. Topics include saving money by using generic drugs, the dangers of antibiotic overuse, engaging providers in Collaborative Quality Initiatives, and safely managing patient pain, among others.

To access this information and share it with MiPCT/PDCM care managers, visit the Pharmacy Initiative page on the collaboration site under "Initiatives/Projects/Workgroups."

HIV Consultation Program

As a result of the Affordable Care Act and Medicaid expansion, more Michiganders have health coverage than ever before and are seeking out primary care services. As a result, health care professionals in primary care are more likely to encounter patients diagnosed with HIV (or at risk of contracting the virus), than ever before. According to the **2015 Annual Michigan HIV Surveillance Report**, there are just over 15,000 individuals living with HIV in Michigan. Many providers may have questions about addressing the health care needs of such individuals. A new consultation program established by the Michigan Department of Health and Human Services, in partnership with Henry Ford Health System, can address questions and help support health care providers in caring for patients living with or at risk for HIV.

The Michigan HIV Consultation Program offers Michigan health care professionals information and guidance regarding:

☐ HIV Occupational and Non-Occupational Post-Exposure Prophylaxis (PEP/nPEP)

☐ HIV Pre-Exposure Prophylaxis (PrEP)

☐ HIV Disease Management

☐ HIV Drug Interactions

☐ Perinatal HIV treatment

Non-urgent questions can be submitted to www.henryford.com/hiv-consult-program-request and will receive a response in 24-48 hours. For urgent questions, health care professionals should call the 24-hour consultation line at (313) 575-0332. Consultations are provided by a team of knowledgeable doctors and mid-level providers.
Please visit www.michigan.gov/hivstd for information about the State of Michigan's activities related to prevention, control and surveillance of the human immunodeficiency virus (commonly called HIV), sexually transmitted diseases (also known as STDs), and viral hepatitis (types A, B and C).
You can always find more public health information and resources, including an order form for education-al materials for use in primary care, at **www.michigan.gov/primarycare**.

Social Determinants of Health Resources

When caring for your patients it is important to include screening for social determinants of health to assess for basic needs. This is a critical time to ensure that resources are made available.

The state of Michigan has many programs to assist families, the elderly and those that may be struggling to make ends meet. Listed are the various programs available with links to the information.

Resources available through the Michigan Department of Health and Human Services:

- **Food assistance through MI Bridges** - Food assistance program
- **Michigan Coordinated Access to Food for the Elderly (MiCAFE)** - Assists those 60 and over to apply for the Bridge Card
- **Michigan Community Action Agency** - Provides free programs and services to help low-incoome individuals and families achieve higher levels of economic self-sufficiency and stability
- **Step Forward Michigan** - Assisting unemployed and underemployed residents to assist homeowners who are at high risk for default or foreclosure with federal funds
- **Veterans Affairs Michigan** - Directory of information to assist veterans
- **Low income Home Energy Assistance** - Income eligibility guidelines

MiCMRC Recorded Webinars - Earn FREE CE Credit!

- **What:** MiCMRC recorded webinars offering continuing education contact hours are available for CE credit at no cost.
- **Who:** CE Credit is available to both Nurses and Social Workers. Webinars are open to all.
- **When:** Recorded webinars available on demand.
- **Where:** To view all available recorded webinars and apply for CE Credit

http://micmrc.org/continuing-ed

Recorded Webinars Available for CE Credit

- **Nonpharmacological Approaches for Depression**
  - Presented by Linda Keilman, DNP, GNP-BC
    *CE credit available until June 22, 2017
- **Overview of Current Opioid Use in Michigan**
  - Presented by Catherine Reid, MD Consulting Physician for the Office of Medical Affairs, MDHHS
    *CE credit available until June 7, 2017
- **Understanding the Complexities of Cognition**
  - Presented by Linda Keilman, DNP, GNP-BC
    *CE credit available until April 27, 2017
- **2015 Updated BEERS Criteria**
  - Presented by Kim Moon PharmD
    *CE credit available until February 10, 2017

Additional CE Webinars Coming SOON!

For questions, please submit to micmrc-requests@med.umich.edu

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share your story

Care Manager Success Story

Submitted by Colleen Jergenson, Otsego Memorial Hospital Medical Group

Dee, a 20-year-old special needs female was referred to care manager Colleen via her primary care physician for uncontrolled diabetes, inconsistently updating her diabetes log, and missing numerous appointments. Dee was currently residing with her father who was responsible for updating her diabetes long, however, her mother had taken on the responsibility of getting Dee to her appointments. During Colleen's first phone contact with Dee's mother there were multiple social barriers that came to light: neither parent had a personal vehicle for transportation, Dee's mother was homeless and unaware of any available assistance, furthermore when not in school, Dee would remain at home alone while her father went to work. During that time her food intake and blood sugars were not being monitored.

As a short-term goal Dee's father would provide an updated blood sugar log to the provider prior to the appointment. A long-term goal, after Dee's mother had voiced her concerns over her daughters wellbeing, was the possibility of Dee moving into an adult foster care where she would be provided better care but still be able to be in contact with her parents. Dee was brought to the next appointment with the help of transportation facilitated by Colleen, however, her father failed to provide the blood sugar log as requested by her physician. Colleen made several attempts to contact Dee's father but was unsuccessful.

At the end of the appointment Colleen discussed with Dee and her mother the opportunity to attend a special needs camp that Colleen would be volunteering as a camp nurse. Dee was excited at the opportunity to attend the camp. Colleen assisted with getting the application filled out and sent it to Community Mental Health for assistance with funding. In addition, Colleen notified the CMH Family Support coordinator, introduced herself as Dee's care manager, and stated her willingness to work with the support coordinator regarding Dee's care.

Dee arrived at camp with much enthusiasm. However in light of her excitement, there were numerous challenges. First, Dee was found to have head lice and needed to be treated prior to activities. Second, it was discovered that her current insulin bottle had been expired four years prior and her testing strips had expired five years prior. Dee's father was unaware of this and gave permission for Colleen to work with her physician to get new Insulin and testing strips. At the advisement of the camp staff as well as Dee's primary care provider, Adult Protective Services along with her CMH support worker were contacted.

Following the events at camp, Dee's current situation was investigated by APS and permanent guardianship was approved with placement into an adult foster care home. Colleen reached out to Dee's new guardian and caregiver to introduce herself as her care manager, to provide contact information, and schedule a follow up appointment with Dee. Diabetic education was provided to Dee and her new caregiver. Since Dee has been appointed a new guardian, she has attended all scheduled appointments. In addition, Dee's caregiver has been very proactive in her care and eager to learn on how she can better serve Dee.

At her next appointment, Dee's physician asked how her new home was. Her first response was she loved taking hot showers, having clean clothes every day and was excited to show off her new haircut. In the two weeks since Dee had been in her new home her blood sugars have decreased from 246-355 to 84-192 due to consistency of her diet and checking her blood sugar. Although it was unfortunate Dee had to be removed from her current home environment, it was through the work of Colleen her care manager and the collaboration of others that Dee was able to get back on track with her diabetes management and have a renewed sense of happiness in her life.

Although Blue Cross Blue Shield of Michigan and The Michigan Care Management Resource Center work collaboratively, the opinions, beliefs and viewpoints expressed by the author do not necessarily reflect the opinions, beliefs and viewpoints of BCBSM or any of its employees.

Best Practice Spotlight

Highlighting Best Practices Across the State

Cereal City Pediatric and Moazami Practice: Patient Engagement is the Key

Situation: The practice uses multiple ways to engage our community, families and patients. Recently the practice started using ***Facebook*** to get information out to both current and potential families in the area on important health information, seasonal concerns, and news about the practice.

Strategy: The ***Website*** tag line- **WELCOME TO CEREAL CITY PEDIATRICS** - ***we'll be there as they grow....*** states "From very first newborn checkup in the hospital, to the unique health concerns of adolescents and every childhood illness in between, our caring providers have the expertise to help you safely navigate the sometimes confusing waters of children's health care." The website has also added many helpful pages: office hours, seasonal issues/ concerns, is your Child Sick search, medication dosages, links to educational resources, scheduling, provider information, appointment guidance. The practices have access 6 days a week in the summer and 7 in the winter with extended office hours 7:30am – 6:30pm M-F and on Saturday and Sunday 7:30am – 12 noon. Patient hours are 8:00am – 6:00pm M-F with daily open slots for sick visits only from 4:30pm to 6:00pm M-F and on Saturday and Sunday 8 am to 11:30am to meet family needs. Patient/family can schedule a get acquainted visit to the practice. During their first visit, patient's receive a Welcome to Cereal City practice folder which they are encouraged to bring to each visit. It contains:

- Information about office practice, providers, office hours, making appointments
- **Calling the office after hours and weekends**
- Immunization schedule
- Fever treatment
- Feeding
- Joining portal, how to create account
- Information practice needs

Their patient ***portal*** is used by families to access visit information, stores copies of forms, medical summery of all visits, or records needed for school or sports. It provides frequently requested information such as medication dosing and facilitates communication between provider, CM and family.

One week before a planned 9mo, 18mo or 2yr well visit, families receive an age appropriate Ages and Stages Questionnaire to fill out and bring back with them to the visit. They are also able to access a SMART Healthy Behaviors Goal sheet with 5 questions help patient/families develop action plan based on their goals and needs. During the office visit, patients and family members are given educational materials specific to the visit type; this information is forwarded to patient portal for families to access after the visit as well.. Parents are educated on pros and cons of immunization.

AIM Toolkit from the Alliance for Immunizations in Michigan is used in this process (aimtoolkit.org). If the patient has an urgent care, emergency room or hospital visit a TOC call is done (based on criteria) to follow up. The First question asked is "How are you and your child doing now?"

Triage nurses from the practice are on call nights and weekends to answer question and direct care. If a family visits the emergency room without calling the office first, an opportunity is taken to educate the family to call the office. Diane Thomas, office manager, stated "each contact with our families is an opportunity to support care from 'first hello to last good bye'. Providing this level of care does not work unless everyone is on board. Everyone has a role and everyone touches the patient. Staff know what they do matters. Every visit is an opportunity to discuss and close care gaps. All staff have training and understand the process and roles to identify and close gaps in care. Catching gaps in care starts with the front desk staff, they generate a gap in care report from the registry, and health plan. They place flags and tasks in the EMR to alert staff of what is needed. They also place this information on a pink encounter form, which follows the patient/family through the visit from the hello to check out. They know why the patient and family are there."

During any visit the MA checks pink encounter form, MICR and EMR for HEDIS care gaps and closes according to protocols. The provider reinforces care, referrals and follow-up visits. At checkout, the next visit is scheduled from the pink encounter form. Education and materials are provided throughout the visit and attached to the portal. The office scanner makes sure referrals and reports are placed into chart. Amy Goff, care manager, focuses on both moderate and complex care management. She has an introduction letter for patients who may benefit from care management along with follow up contact letters for patients. She looks for every opportunity to help staff understand care for each patient and be part of cheering them on when they are meeting their goals.

Asthma patients receive a ***Red Folder*** with educational fliers and symptom log to help document symptom, track treatment and impact. There is consistent ongoing education and teach back patient demonstration on use of inhaler and spacers at each visit.

Dee Dailey, practice coach, is viewed as part of the team keeping them aware of data and assisting with opportunities for improvement. She presents at quarterly staff meetings a Quality Data Board with updated reports, raw data and specific cases for gaps not met. She helps staff see the impact of improvements and that what they do matters.

For more information on the great work Cereal City has been doing please contact Wendy Hanson @ **wendy@cereal.pcc.com**