Care Management Connection

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Social Workers Play a Vital Role in Team-Based Care

March is National Social Worker Month! We would like to recognize and thank all social workers for their commitment, contributions, and dedication in the work they complete to assist individuals, caregivers and families. Social workers have been an instrumental part of the American health care system since the early 1900s by providing psychosocial support, discharge planning assistance and education for patients in acute and ambulatory care settings.

Since the beginning of the profession, social workers have recognized the interconnection of physical, psychological, and social well-being, leading them to adopt a biopsychosocial approach when working with patients. In the past mental and physical health were treated separately, resulting in a fragmented health care system which increased costs and caused many conditions to go unrecognized and untreated. The rationale for social work involvement is straightforward in that, those who seek medical treatment require support beyond the identification and treatment of a medical problem.

Team-based care reinforced by a strong social work component supports the triple Aim: improving patient experiences, improving the health of populations, and reducing care costs. In order to provide appropriate clinical care, physicians not only rely on diagnostic tests but also the verbal communication from patients and caregivers. The social worker plays a crucial role here with their unique skill set of critical thinking, clear communication, detailed assessments, and knowledge of community resources, which is vital for the patient and care team in order to meet patient goals. Because social workers have a deep understanding of the psychosocial influences on a patient and barriers to disease management , their knowledge of community resources places them in a unique position to expand their role to help patients understand and manage the interventions needed. Social workers in the primary care setting act as navigators, educators and grief counselors, often being a mediator between patients and their families as well as members of the health care team.

A longitudinal study was conducted on social workers' management of older adults with chronic conditions near the end of life, and receiving comprehensive care from a community-based program. The study found through use of questionnaires, interviews and focus groups, how social workers supported these patients through illness. Social workers supported the patient in the following ways:

- Ensure basic needs are met
- Provide a meaningful, caring relationship
- Complete organizational tasks
- Help make informed decisions
- Prepare for end-of-life care
- Tackle problems
- Promote patient's independence at home

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UPCOMING EVENTS

VIEW OUR UPCOMING COURSES

Click on the dates below to register for MiCMRC Complex Care Management Courses:

April 24-27, 2017, Lansing

May 15-18, 2017, Lansing

MiCMRC CARE MANAGEMENT EDUCATIONAL WEBINARS

Date and Time: Wednesday April 12th, 2017 2-3pm
Title: Diabetes and Pregnancy
Presenter: Kim Lombard, MDHHS

Click Here to register

Save the Date: Wednesday April 26th, 2017 2-3pm
Title: Diabetes Prevention
Presenter: Tamah Gustafson, MDHHS

Registration coming soon!

The Michigan Care Management Resource Center supports ambulatory practices statewide to implement and build upon Patient-Centered Medical Home (PCMH) and PCMH Neighborhood (PCMH-N) capabilities related to care management, population management, self-management support, and care coordination. MiCMRC provides foundational and longitudinal curriculum, tools and resources to assist practices with developing a sustainable, evidence-based clinical model for care management activities. Support for MiCMRC is provided by Blue Cross Blue Shield of Michigan Value Partnerships program.

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

MiCMRC Questions?

For questions please **Contact Us**

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

Date and Time: Wednesday April 12th 2-3pm
Title: Diabetes and Pregnancy
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REGISTER

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 **www.micmrc.org**

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

AVAILABLE NOW! Michigan Care Management Resource Center Announces eLearning—Online "Basic Care Management Program"

The Michigan Care Management Resource Center "Basic Care Management Program" is an interactive online program, focused on building care management skills. The program features quick tools for daily work.

The online eLearning series is open to all care managers and physician office practice team members at ***no cost***. Learn at your pace and at a time convenient for you!

This online learning opportunity is designed for busy care managers and clinical team members in the primary care and specialty practices. The Basic Care Management Program consists of a series of online, interactive modules. Each module has brief 15-30 minute lessons; ideal for the busy learner.

When you participate in the eLearning modules you are joining care managers and office practice team members across the state from many practices and physician organizations, building core skills and improving the care delivered to their patients.

Each module will offer continuing education contact hours for nursing and social work. Modules **available now** include:

Medication Management
Introduction to Advance Care Planning and Palliative Care
Transition of Care
5 Step Process
Care Planning ***(Coming soon!)***

Access the online program and complete CE contact hour details @ **www.micmrc.org**

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For this group of patients and family members, the social worker was more than just a point of contact, but also a safety net. By establishing a rapport early in the professional relationship, social workers quickly grow close to their patients who in turn rely on them for support. The study also focused on family members' and caregivers' perception of the social worker and identified support in the following ways, in addition to what the patients identified:

Provide intellectual and social stimulation
Address grief and bereavement
Provide emotional support
Facilitate transitions
Facilitate independence
Serve as a central care manager

It is not uncommon for a caregiver to form a close bond with the social worker, more so than any other team member. With regards to social work, forming this bond is essential to the success of the care plan as they customize interventions to meet the needs of patients and their families.

Mann, C., Golden, J., Cronk, N., Gale, J., Hogan, T., & Washington, K.(2016). Social workers as behavioral health consultants in the primary care clinic. Health and Social Work. 41(3):196-200. Retrieved from https://academic.oup.com/hsw/article/41/3/196/1749853/Social-Workers-as-Behavioral-Health-Consultants-in

Conlisk, M. (2016). Delivering the triple aim via the social worker. Annals of Long-Term Care: Clinical Care and Aging. 24(8):31-35 Retrieved from https://www.researchgate.net/publication/308172847_Delivering_the_Triple_Aim_Via_the_Social_Worker

Reckrey, J., Gettenberg, G., Ross, H., Kopke, V., Soriano, T., & Ornstein, K. (2014). The critical role of social workers in home based primary care. Social Work Health Care. 53(4):330-343.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4790723/pdf/nihms763730.pdf

MiCMRC Website Offers New Chronic Condition Pages!

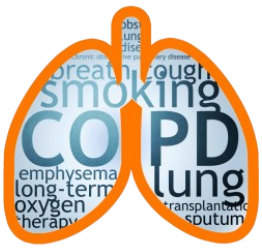
New in 2017 the Michigan Care Management Resource Center in an easy to access format offers chronic condition pages. Care Managers can now access tools and resources specific to asthma, diabetes, heart failure and hypertension, COPD.

The information contained within these chronic disease pages is designed to:

- Help care managers assist patients who face difficulty from specific chronic conditions
- Provide a framework for care management interventions
- Present various resources dedicated to the education of both the care manger and the patient
- Provide quick access to tools used in patient care setting

Each chronic disease page includes the following:

- Disease definition
- Evidenced based guidelines
- Action plan
- Care management interventions
- Patient interventions
- Care management quick tools
- Patient handouts
- Care management learning resources



To learn more about these specific chronic conditions **Click Here**.

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MiCMRC Complex Care Management Course Registration

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 *requiring* 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 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. **For HICM team members who completed the HICM course prior to 1/2017—No additional training is required**

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 : **micmrc-ccm-course@med.umich.edu**

Upcoming course dates and course registration:

NOTE: Registration deadlines

April 24 - 27 | Lansing, MI | **REGISTER HERE** | Registration deadline: April 20th, 2017.

May 15 - 18 | Lansing, MI | **REGISTER HERE** | Registration deadline: May 11th, 2017.

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Team-Based Care and the Primary Care Setting

The delivery of health care through a coordinated team is associated with improved patient outcomes. Patients may reap the benefits of having additional expertise and experience, various bodies of knowledge, and a wider range of skills. The idea of care teams in the primary care setting can seem confusing and has previously been met with some skepticism. However, successful chronic disease management usually involves a coordinated multidisciplinary team.

The most widely accepted definition of team-based care that is consistent with the World Health Organization **principles of primary healthcare** and is inclusive of the **six IOM aims for improvement** is as follows: "The provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals within and across settings to achieve care that is safe, effective, patient-centered, timely, efficient, and equitable."

Health care teams will vary based on what works best for the patient population of each practice. They can be large or small, centralized or dispersed. They may be virtual or face-to-face, while tasks can be focused and brief or broad and lengthy. A driving force for primary care providers to transition from being a soloist to working as a team is the complexity of modern health care. With over 2,700 clinical practice guidelines and 25,000 new clinical trials published each year, no single person has the ability to absorb that amount of information. To deliver comprehensive care for an individual with a chronic condition often involves care coordination amongst the primary care practice, specialists, and community organizations. An effective team is the result of the skill and reliability of the team members and their commitment and agreement to communicate, collaborate and coordinate the care with a focus on delivering optimal patient care.

Mitchell and colleagues, through their team interviews and review of the literature, discovered that five key principles of team based care emerged: shared goals, clear roles, mutual trust, effective communication, and measureable processes and outcomes.

Shared goals means that the team, including the patient, family members or other support persons, works collaboratively to establish shared goals that show respect for the patient and family priorities. These goals can be clearly communicated, are understood by, and have the support of all team members. The foundation for a successful and effective team is the entire team's early adoption of a clearly defined set of shared goals for both the patient's care and the team's work in providing that care. In many cases this does not happen easily or by chance.

Clear roles refer to team members having a clear expectation of each team member's function, accountability, and responsibilities. This enables a team to optimize efficiency and take advantage of divisions of labor, thus accomplishing more than the sum of its parts.

Mutual trust occurs when team members create trust through concrete norms or reciprocity, which thus provides a greater opportunity for shared achievement.

Effective communication is the result of the team prioritizing and continuously honing their communication skills. There are consistent channels for candid and complete communication, which are utilized and accessed by all team members across all settings.

Finally, having measureable processes and outcomes involves the team providing reliable and timely feedback on failures as well as successes with how the team is functioning and achieving its team goals.

While not all teams are at the same level of competency and effectiveness, there are many advantages for patients. These include better access to care and services with a consistent team, improved quality, safety and reliability of care. Patients' and families' satisfaction with their experience tends to improve with a high-functioning team. The specific mix of staff will vary from practice to practice, however the practice needs to understand the services it provides and then decide how the work should be divided among the care team to provide those services. From there all staff members should be working at their highest level of licensure, expertise, and abilities. Other ways to ensure a high functioning team is the use of standard protocols, cross-training staff, and huddles with limited interruptions to improve communication.

Establishing protocols can help move certain work away from the provider. Some examples include lab and radiology standing orders for certain symptoms, advice protocols for home care, or developing protocols when the care manager can take the place of a physician visit. Cross-training provides an additional option to smooth out work-flow and support the providers. Cross-training helps extend the flexibility of the practice to meet periods of high demand or unexpected events. Team **huddles** provide a quick and efficient way to communicate each day with team members.

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share your story

Pediatric Asthma: Care Manager Helps to Identify Asthma Triggers

Submitted by Amanda Post, RN Algers Pediatrics

Amanda Post is an RN care manager in the Alger Pediatrics practice. The practice participates in the Blue Cross Blue Shield of Michigan PDCM program. Recently Amanda had the opportunity to work with a pediatric patient with asthma. She received a referral from the provider, with whom she discussed the patient's history. The patient was being seen at six month intervals in the asthma clinic for evaluation of uncontrolled moderate persistent asthma. During the asthma clinic visit with the mother and patient, the care manager discussed the home environment and possible triggers. The patient had a constant cough with activity, persistent runny nose, and night time cough with some wheezing.

Short term goals included: Healthy Homes visit the patient's home to evaluate for mold as well as any other triggers in the home; and for the patient to be rid of night time cough and wheezing, constant runny nose, and cough with activity.

The care manager made a referral to Healthy Homes. Healthy Homes then contacted the patient's mother to set up a home visit. Healthy homes provided a dehumidifier for the patient, placed vents into the bathroom and gutters on the home's exterior. Dust mite encasings were also provided. After the great experience with Healthy Homes, the patient's mother then started working for the company!

The patient along with the mother, was better able to manage the chronic condition, avoid adverse health effects, and reduce utilization of emergency room visits, with an increase in patient satisfaction. Mom verbalized many times how appreciative she was that the care manager took the time to listen, to discuss the home environment, and to make a referral to Healthy Homes. Mom states that the patient has been much healthier this past year. There have been no unplanned visits to the provider's office for asthma or any respiratory illnesses. The patient's asthma is under control even when experiencing cold symptoms.

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Team huddles, usually short in duration, looks at the day ahead, and may focus on the day's appointments, potential patients for care management, quality updates or process improvement needs, or other practice updates.

Finally, it's important to educate the patient on the team-based approach to care. For some patients having a team involved means less time seeing their physician. Many times this requires a shift in thinking to understand the benefits of a team approach. It should be explained that providing care is definitely a team approach and that the physician will be involved with decision making along with the rest of the team.

To access additional information about "Team Based Care", please access the MiCMRC web site resources by **Clicking Here.**

Hupke, C. (2014). Team Based Care: Optimizing Primary Care for Patients and Providers. Retrieved from: http://www.ihi.org/communities/blogs/_layouts/15/ihi/community/blog/itemview.aspx?List=0f316db6-7f8a-430f-a63a-ed7602d1366a&ID=29

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Wagner, E. (February 28th 200). The role of patient care teams in chronic disease management. British medical Journal. 320:569-72. Retrieved from http://www.bmj.com/content/320/7234/569

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