MiPCT Complex and Moderate Care Management Orientation Reference Guide (ver 1.1)

PCMH Care Management Pertinent Hyperlinks	Progression of PCMH/MiPCT - Michigan's PCMH Care Management Development Guideline		Status	Comments
https://www.pcpcc.org/about/medical-home	PCMH			
http://www.improvingchroniccare.org/index.php?p=the_chronic_care_model&s=2		Review the Patient Centered Primary Care Collaborative Definition of PCMH		
		Review the Chronic Care Model of Care Delivery		
BCBSM PGIP PCMH				
http://www.bcbsm.com/providers/value-partnerships/physician-group-incentive-prog/models-of-care.html	PGIP			
		Review the PGIP PCMH Guidelines (paying close attention to the initiatives on):		
		Individual Care Management		
		Linkage to Community Services		
		Coordination of Care		
		Specialist Referral Process		
		Self Management Support		
MiPCT				
http://mipctdemo.wordpress.com/	MiPCT			
		Review the MiPCT Project Model		
		Review Care Management Resources - MiPCT Implementation Guide		
		Identify your organization MiPCT champion and review the org objectives		
		Review the MiPCT job description for Moderate Care Management		
		Review the MiPCT job description for Complex Care Management		
		Review the MiPCT job description for Hybrid Care Management		
		Review the MiPCT patient eligibility data dictionary, patient eligiblity reports, and billing guidelines for health plans participating in MiPCT (BCBSM commercial, BCBSM Medicare Advantage, Medicaid Managed Care, Medicare		
www.micmrc.org	MiCMRC	Review the Michigan Care Management Resource Center website (micmrc) - Care Manager tools, guidelines, share best practice, submit questions. MiPCT care manager resources, recorded Webinars and presentations are located on the password protected section of micmrc.org		
CMSA				
http://www.cmsa.org/Individual/MemberResources/StandardsofPracticeforCaseManagement/tabid/69/Default.aspx	CMSA			
		Review the Case Management Society of America Standards of Practice		
		Review CMSA crosswalk with PGIP PCMH Initiatives		
		Compare the CMSA Standards of Practice with the MiPCT Clinical Model		
		Identify how the CM role parallels into the PCMH Model of Care		

Care Manager Clinical Knowledge: Geisinger Practice Assessment - MiPCT Requirements - Self Management - Clinical				
	CM Clinical Knowledge	Individual CM needs assessment		
		Completed Training on Patient Self-management support		
		Completed Training for behavioral activation (motivational interviewing)		
		Chronic Disease Management Training using evidence-based care guideline ongoing year 1		
Guideline Resources				
	Guideline Resources	Identify the evidence-based guidelines this practice/organization uses for:		
http://mqic.org/guidelines.htm		Diabetes		
http://www.qualityforum.org/QPS/QPSTool.		COPD/ Pneumonia		
http://www.mqic.org/pdf/MQIC_2015_heart_failure_guideline_update_alert.pdf		Heart Failure		
http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm		**Pediatrics:** Cardiovascular Health and Risk Reduction Guidelines		
http://www.nhlbi.nih.gov/guidelines/current.htm		Asthma		
http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm		**Pediatrics:** Asthma (Guidelines for ages 0-4 yrs, 5-11 years, and 12 to adulthood)		
http://www.aafa.org/display.cfm?id=8&sub=16&cont=41		**Pediatrics:** Asthma in Infants		
http://www.goldcopd.org/guidelines-pocket-guide-to-copd-diagnosis.html		Chronic Kidney Disease		
http://care.diabetesjournals.org/content/35/Supplement_1/S11.full		Renal Failure		
		Depression		
http://www.psychiatry24x7.com/bgdisplay.jhtml?itemname=adhd_toolkit_		**Pediatrics:** ADHD		
		Morbid Obesity/Obesity		
http://www.mqic.org/pdf/mqic_prevention_and_identification_of_childhood_overweight_and_obesity_cpg.pdf		**Pediatrics:** Obesity		
http://www.cdc.gov/growthcharts/who_charts.htm		**Pediatrics:** Growth Charts		
http://www.mqic.org/pdf/mqic_prevention_and_identification_of_childhood_overweight_and_obesity_cpg.pdf		**Pediatrics:** Weight Management Guidelines & f/u recommendations		
http://www.nichq.org/		**Pediatrics:** ***National Initiative for Children's Healthcare Quality (NICHQ)*** Guidelines and Information for specific focus areas		
http://www.cdc.gov/vaccines/schedules/index.html		Age Specific Preventive Measures		
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthyAssessmentQuestionnaires.aspx		Gender Specific Preventive Measures		
http://www.ahrq.gov/research/findings/evidence-based-reports/index.html		Age Specific risk and safety assessment tool		
		Gender Specific risk and safety assessment tool		
		Depression Specific risk and safety assessment tool		
http://www.mqic.org/pdf/mqic_2015_routine_preventive_services_for_infants_and_children_birth_to_24_months_cpg.pdf and http://www.mqic.org/pdf/mqic_routine_preventive_services_for_children_and_adolescents_ages_2_to_21_cpg.pdf		**Pediatrics:** Screening Guidelines		
http://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_44443-157836--,00.html		**Pediatrics/Adults:** Michigan Penal Code (Mandatory Reporting Law)		
http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/adolescent-health/guidelines-adolescent-preventive-services/screening-health-guidance-suicide-depression.page		**Pediatrics:** Screening & Health Guidance for Suicide & Depression		

Clinical Pathway Samples				
Clinical Pathway Samples		Identify Clinical Pathways in place at the practice/organization for:		
		Understands definition of a critical path.		
http://www.universityhealthsystem.com/files/03-Diuresis%20Algorithm.pdf		Diabetes		
http://www.universityhealthsystem.com/clinical-pathways-and-guidelines/		COPD/Pneumonia		
		Heart Failure		
		Asthma		
		Chronic Kidney Disease		
		Renal Failure		
		Depression		
http://psychology.case.edu/documents/feeny_tads.pdf		**Pediatrics:** Depression Medication Algorithym		
http://pediatrics.aappublications.org/content/108/4/1033.full.pdf+html		**Pediatrics:** ADHD		
http://www.ncbi.nlm.nih.gov/pubmed/17513980		**Pediatrics:** ADHD Medication Algorithym		
		Morbid Obesity/Obesity		
		Age Specific Preventive Measures		
		Depression specific risk and safety assessment tool		
		Anti-coagulation Management		
		Identify documentation requirements/preferences for:		
www.micmrc.org		MiPCT G-codes - see password protected side micmrc.org, tools tab. Also www.mipctdemo.org		
		HIPAA Ambulatory Care documentation guidelines - Organization Policy		
		Electronic Medical Record (EMR) Meaningful Use measures applicable at the organization		
		Identify and delineate standard EMR or paper documentation req. for all components of CM		
		The team/organization has an established flag/marker to identify when a CM is assigned to a case/patient		
		The practice/organization has a process/guideline for closing cases to CM		
		Case Identification/Risk Stratification:		
		Process in place to identify patients included in the MiPCT Demonstration		
		Process in place to determine which cases will be managed by each role/staff member across the care team involved in CM		
		The CM is familiar with the registry or EMR with registry components		
		The CM has access to a gaps in care report for patients assigned to them		
		The CM can timely access information and identify patients hospitalized		
		The CM can timely access information and identify patients using the ER		
		The CM can timely access information and identify all patients re-admitted		
		The CM can timely access information and identify patients admitted to Home Health Care		
		The CM can timely access information and identify patients admitted to Skilled Nursing		
		The CM can timely access information and identify patients admitted to LTAC		

PCMH Care Management Pertinent Hyperlinks	**an's PCMH Care Management Development Guideline**			
Transitions of Care				
			status	**Comments**
http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/06Boost/03_Assessment.cfm	Transitions of Care	Communication and processes that facilitate effective care transitions		
		The PCP CM has a process in place to contact and communicate with the Acute Care in-patient CM'er(s)		
		The PCP CM has a process in place to contact and communicate with ER/ER CM'er(s)		
		The PCP CM and in-patient CM'er(s) have a shared trigger for patients are risk for re-admission		
		The PCP		
		The PCP		
		The PCP CM has established a communication process with regional LTAC Facilities/CM'er(s)		
		The PCP CM has established a communication process with payer CM'er(s)		
Med Reconciliation				
http://psnet.ahrq.gov/primer.aspx?primerID=1	Medication Reconciliation	Medication Reconciliation		
http://www.ahrq.gov/qual/match/match.pdf		The CM reviewed the Meaningful Use Criteria for Medication Reconciliation		
http://www.ahrq.gov/about/annualconf09/dewalt2.htm		The Care Manager has reviewed the Concepts of Teach-back		
http://www.chcs.org/resource/health-literacy-fact-sheets/		The Care Manager has reviewed the Definition and concepts of Health Care Literacy		
http://www.youtube.com/watch?v=cGtTZ_vxjyA		The PCP CM has established a process to complete Medication Reconciliation at each patient transition		
http://www.youtube.com/watch?v=BgTuD7l7LG8&feature=related		Acute to Home		
http://www.youtube.com/watch?v=IKxjmpD7vfY&feature=related		Acute to Home Health Care		
		Acute to Skilled Nursing Care		
		Acute to Long Term Acute Care		
		Acute to Long Term Care		
		Any Inpatient Setting to Home		
		Any Inpatient Setting to Home Health Care		
		The Care Manager has identified the documentation expectations/requirements for Med. Rec.		

		The Care Manager has identified the documentation expectations/requirements for Med. Rec.		

Care Transitions				
	Transitions of Care	- Post Discharge Follow-up		
http://caretransitions.org/tools-and-resources/		Assess the current practice policy/procedure on discharge follow-up? What is it?		
		Assesses the current practice policy on care transitions. What is it?		
http://www.caretransitions.org/documents/manual.pdf		The Practice/Care Manager has a process for completing a follow-up call with the Pt. within 2 days of discharge		
		The Practice/Care Manager has a process for scheduling a follow-up visit with the PCP for the Pt. post discharge		
		The Practice/CM has a template/location for documentation for the Post Discharge Call (PDC)		
		The practice/organization knows where to locate the documentation on the PDC		
		The CM has a process in place to identify and follow up on patients being seen for a Post Discharge Visit		
		The Practice Management System has a visit type specific to a Post Discharge Visit		
		The CM has a template for documenting the follow-up visit/call that meets billing requirements		
		The practice/CM has a process/protocol for following up on issues requiring immediate/urgent attention from the PCP		
The Medical Neighborhood				
		The internal practice/organization neighborhood		
		CM has identified and introduced themself to the practice team within the office		
		The CM has met with the physician(s) in the practice and inquired about the criteria recommended to be used to determine patients eligible for care management services and the role of the CM		
		The PCP and practice team have developed a process to refer eligible patients to the CM		
		The practice/organization has developed a script for the team/staff on how to communicate the CM services and introduce the CM to the patient		
		The eligibility criteria for CM services have been determined and clearly communicated to the practice/staff		
		Complete a practice readiness assessment - see sample from Geisinger		
Medical Neighborhood	Medical Neighborhood	Community Services		
http://www.bcbsm.com/provider/value_partnerships/pgip/pcmh-and-osc.shtml		The practice/organization has a Community Service referral policy and the CM has reviewed it		
		The practice has a system in place to review community resources on a regular basis: ex. every 6 months		
(Review Guideline section on Community Services)		The practice/organization has a place to track high risk community service referrals for follow-up		
		The Practice/organization has a Community Service Directory in place and the CM has access to it		
		Assesses if the practice/organization participates in a regional initiative to assist patients with access and services to community and social services		

http://www.bcbsm.com/provider/value_partnerships/pgip/pcmh-and-osc.shtml		Specialist			
Review Guideline section on Specialist Referral			The practice/organization has a policy/procedure on completing specialist referrals		
			The practice/organization documents and tracks specialist referrals for follow-up		
			There is a defined communication process between the PCP and the Specialist on who will complete recommended tests/services and complete ongoing communication to the patient		
		Services outside of the Medical Home			
			The CM has established relationships with regional HHC agencies to communicate the role of the PCP CM and establish expectations		
			The CM has established relationships with regional SNF agencies to communicate the role of the PCP CM and establish expectations		
			The CM has established relationships with regional Hospitals to communicate the role of the PCP CM and establish expectations		
			The CM has established relationships with regional LTAC to communicate the role of the PCP CM and establish expectations		
			The CM has established relationships with regional Rehabilitation facilities to communicate the role of the PCP CM and establish expectations		
			The CM has established relationships with participating payer providers to communicate the role of the PCP CM and establish expectations		
Daily Documentation - Tools, PCMH Team Communication					
		Process to identify patient workload and schedule for the day.			
		The CM has reviewed with the PCP key components to document in the Medical Record/EMR			
		The CM/Practice/Organization has a documentation template for			
		Initial Assessment			
		Follow up Note			
		Readmission Note			
		Telephonic follow up			
		Med Reconciliation			
		Medical Neighborhood Communications			
		Progress goals/self management goals			
		Transition notes			
		Patient education materials			
		Patient letter templates			
		Identify the Health Information Technology used by the practice: Electronic Health Record, Registry, Care Management Software			
		Physician and practice leader introduces care manager to health care team members.			
		Identify team members and their roles and responsibilities			
		Conduct staff meeting to review role of the Care Manager and discuss integration into work flow and office practice, include how role is "value added" for the physicians			

Depression Management					
	Depression Mgt.	The practice/organization has a tool to assess patients at risk for depression (such as PHQ 2 and PHQ9)			
Depression		The practice/organization has a process to integrate patients with positive depression screening into the CM caseload.			
http://www.uspreventiveservicestaskforce.org/uspstf/uspsaddepr.htm		The practice/organization has established relationships with behavioral health providers			
http://www.aafp.org/online/en/home/clinical/exam/depression.html		The practice/organization has a tracking process to monitor the patients response to depression treatment			