MiCMRC Complex Care Management Course

The MiCMRC Complex Care Management Course: is designed to prepare the healthcare professional for the role of a 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 care management role, foundational elements of integration into the ambulatory care setting, and development of care management skills to meet the needs of complex patients.

The MiCMRC CCM Course is built upon the Care Management Society of America (CMSA) Standards of Practice for Case Management and Geisinger ProvenHealth Navigator Case Management. The MiCMRC Complex Care Management Course instructors have extensive backgrounds in care management implementation.

Opportunity for Ongoing Education: MiCMRC CCM Course attendees receive invitations to live webinars hosted monthly by the Michigan Care Management Resource Center. Additionally, course attendees may access the MiCMRC library of recorded webinars which focus on delivery of care management in the primary care setting, foundational knowledge for new care managers, and care manager skill-building. Opportunities to earn Nursing and Social Work Contact Hours via webinar completion will be provided periodically.

Continuing Education:

Nursing and Social Work CE Contact Hours: 13

This continuing nursing education activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91)

"Michigan Care Management Resource Center is an approved provider with the Michigan Social Work Continuing Education Collaborative". Approved Provider Number: MICEC 110216

For course dates & registration contact:

http://micmrc.org/training/micmrc-complex-care-management-course

The CCM Course Content

Care Management Introduction

- The Chronic Care model
- Successful Care Management models

Medication Reconciliation

- Steps to complete medication reconciliation
- Barriers influencing medication adherence

Transitions of Care

- Coordination of care
- Key elements for successful transitions of care

Medical Neighborhood

- Goals of a high-functioning medical neighborhood

Patient-Centered Medical Home

- Core principles of PCMH
- Care Manager role in the PCMH

The 5-Step Care Management Process

- Care Manager work flow
- Risk stratification

Comprehensive Assessment and Care Plan

- Elements of a comprehensive assessment

Evidence-Based Care

- Population health management
- Care Management interventions for the complex patient

Team Based Care

- Team members in the Primary Care Setting

Social Determinants of Health

- Assessment and Management

Clinical-Community Linkages

- Community Mapping

Course Schedule:

DAY 1 Introduction, Live one hour logistics webinar

DAY 2 Self-study, recorded webinars, post-tests, 6 hours

DAYS 3&4 In-person training, 8 hours each day