Care Management Connection

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Care Management Success Story
Bronson Family Medicine

Submitted by:
Susan Nason, RN Practice Clinical Care Coordinator

Brenda is a 60-year-old with uncontrolled diabetes. Brenda was recently hospitalized for diabetic ketoacidosis. The first encounter with the patient regarding care management took place during the transition of care call which revealed her non-adherent behavior, low health literacy, and her lack of motivation to address her health. Her current diabetes regimen included injectable insulin daily and an oral agent twice daily. The PCP was made aware that this patient may benefit from care management services. A follow up appointment was made to meet with the PCP post-discharge. At the time of hospitalization her A1C average glucose levels were elevated.

During the follow up appointment the patient agreed to care management services. At the time of the visit the patient was in a crisis mode with blood sugars in the very high range. The care manager worked with the patient on diabetes survivor skills, provided educational handouts, inquired about diabetes education classes and contacted the clinical pharmacist to assist with medication management. Goals developed with the patient included measuring blood sugars twice daily, attending diabetes education classes, and going to the gym twice a week. The care manager, team pharmacist, and patient partnered to address these identified goals. They wanted to avoid unnecessary hospitalizations and adverse health effects.

A few days later the pharmacist contacted the patient to review blood sugars and medication. Blood sugars were still running in the high range. Her daily insulin dose was increased. The pharmacist also spent some time reviewing carbs and their impact on her diabetes. The following week the patient came in to meet with the pharmacist. Blood sugars were improving, but still with higher readings in the afternoon. Insulin increased again. Discussion began about the My Plate method and how to begin counting her carbs. The pharmacist made a follow up call a week later to the patient which revealed blood sugar readings improving in the mornings and afternoons. During the conversation, the patient mentioned that her Medicaid spenddown was $1000 per month and she was going to have difficulty obtaining her insulin and testing supplies. The pharmacist contacted a pharmaceutical representative regarding their assistance program and switched her testing supplies over to am affordable, lower cost brand.

Three months later, the patient was approved for financial assistance through the pharmaceutical company and her insulin was now free of charge. While the patient was slow to start, she began attending the diabetes education classes as well as going to the gym twice a week. Four months after initiating care management services, the patient was now connecting her blood sugars to what she was eating and making long term health goals. She now has a much better understanding of her diabetes and is ready to start self-managing her illness. At her 6 month PCP appointment her A1C was normal and the pharmacist is considering putting her on a glucagon-like peptide-1 receptor agonist (GLP-1 RA).

By working together as a team, the pharmacist and care manager were able to work with Brenda to help meet her needs. Without the intervention of care management, the patient may have continued to utilize the ED for crisis intervention. Instead the patient over time realized the importance of self-management and the improvement in her quality of life.

UPCOMING EVENTS

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

January 14-17, 2019 Dimondale

February 4-7, 2019 Lansing

MiCMRC CARE MANAGEMENT EDUCATIONAL WEBINAR

Title: Depression and Primary Care
Date and Time: Wednesday, December 12th 2-3 pm
Presenter: Sarah Fraley, LMSW MiCMRC Project Manager
Register HERE

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

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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 the Michigan Care Management Resource Center is provided by Blue Cross® Blue Shield® of Michigan as part of the BlueCross Value Partnerships program. Michigan Care Management Resource Center is not affiliated with or related to Blue Cross Blue Shield of Michigan nor Blue Cross Blue Shield Association .

Nursing, Social Work, and CCMC continuing education opportunities. 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

MiCMRC Complex Care Management Course Registration

The MiCMRC Complex Care Management (CCM) 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. For CCM Course details **click here**

Upcoming CCM course dates and course registration:

January 14-17, 2019 | Dimondale | **REGISTER HERE** | Registration deadline: January 10, 2019

February 4-7, 2019 | Lansing | **REGISTER HERE** | Registration deadline: January 31, 2019

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**

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MiCMRC Approved Self-Management Support Courses and Resources Update

To access the list of the MiCMRC approved Self-Management Support courses, **click here**. The list of MiCMRC approved Self-Management Support Courses provides a detailed summary of each course, with associated objectives, location, cost and more.

Additionally, MiCMRC has collected resources for Self-Management Support including: websites of interest, publications, tools, videos, and even patient materials. MiCMRC's "Self-Management Support Tools and Resources" document offers an at a glance list and summary of these resources, along with descriptions and website links for quick access. For "Self-Management Support Tools and Resources" **click here.**

Both of these documents can also be accessed on the MiCMRC website home page **http://micmrc.org/**

New - Care Manager Orientation Resources!

The Michigan Care Management Resource Center would like to invite you to access the new "**Care Manager Orientation**" web based tools, resources and recorded webinars. These resources, tools and recorded webinars may be used to enhance an existing care manager orientation program, assist with building an effective care manager orientation, and to address onboarding for new care managers. Successful care manager orientation and onboarding programs assist practices in producing outcomes which improve quality and decrease cost.

Care Manager Orientation Cornerstones

There are three cornerstones of an effective Care Manager orientation:

1. Orientation to the care manager role and responsibilities
2. Orientation to the practice environment, the people and the work
3. Orientation to the population of patients seen by the practice

To access the recorded webinars and associated materials:

"Cornerstones of a Care Manager Orientation" **click here**

"Best Practice Sharing: Care Manager Orientation" **click here**

If you or your organization has Care Manager Orientation tools and resources you would like to share send them to **micmrc-requests@med.umich.edu.** To learn more about tools and resources available, visit **http://micmrc.org/topics/care-manager-orientation**