Care Management Connection

A publication of the Michigan Care Management Resource Center

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Volume 2 Issue 1

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 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:

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.

VIEW OUR UPCOMING COURSES

Click on the dates below to register:

January 30-February 2, 2017 Lansing

February 20-23, 2017, Lansing

February 27-March 2, 2017, Grand Rapids

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 SIM - PCMH Initiative, BCBSM's - High Intensity Care Management ,Provider Delivered Care Management (PDCM), and PDCM Specialty programs.

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

2017 MiCMRC CARE MANAGER EDUCATIONAL WEBINAR

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

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**

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

New pharmacy resources are available on the PGIP Collaboration site that 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 PDCM care managers, visit the Pharmacy Initiative page on the collaboration site under "Initiatives/Projects/Workgroups."

CMRC Announces New eLearning—Online "Basic Care Management Program"

The Michigan Care Management Resource Center is proud to announce an interactive online program, focused on building care management skills and 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!

New in 2017, this online learning opportunity is designed for busy care managers and ambulatory care team members. The "Basic Care Management Program" consists of a series of on line, 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 both nursing and social work. Modules that are available beginning February, 2017 include:

Medication Management

Introduction to Advance Care Planning and Palliative Care

Modules are due to be released in February. Stay tuned to our website for more information @ **www.micmrc.org**

CMRC 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.

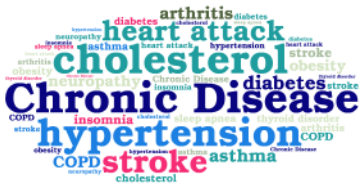
The information contained within these chronic disease pages is designed to:

- 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.**



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

micmrc

share your story

Community Health Worker and Care Manager Provide the Team Work Needed to Manage a Complex Patient

Submitted by Lori Lynn BSN, RN, CCP-Care Manager, Cherry Health

Mr. George was a 65-year-old Hispanic male with a history of HTN, obesity, and poorly controlled type 2 diabetes. Primarily Spanish speaking, Mr. George also had a history of poor follow up with his primary care physician and refills on insulin. In May 2015 Mr. George was hospitalized for a non-healing wound on his great toe, which led to amputation. His A1C was 12.6 upon admission. He was discharged from the hospital 12 days later with a 24-page discharge summary in English. The CM conducted a transitions of care follow up call that lasted one hour due to the multiple specialists involved in Mr. George's care, including: home health, infectious disease, wound care specialist, orthopedic surgeon, and nephrologist for newly diagnosed chronic kidney disease.

Mr. George brought all of his medications to his one-week post discharge follow up with the primary care physician. A complete medication reconciliation revealed patient lack of understanding and poor adherence. Barriers to self-care included: a language barrier, low health literacy, lack of transportation, poor support system, fear of deportation, and marital conflict. The CM discussed his medical history and barriers with Carina, the community health worker, and together we developed a plan to assist the patient in achieving success in managing his chronic disease. Mr. George welcomed our assistance and agreed to actively participate in self-management of his conditions.

One short-term goal was to help the patient better understand his multiple chronic diseases and impact on his health long-term. Another, was to reduce his A1C as evidenced by daily glucose monitoring, meal planning, and appropriate insulin administration. Carina created a patient notebook for Mr. George in Spanish which included a calendar with all of Mr. George's appointments, medication list, and contact information for all of his specialists. Mr. George was referred to Ride-Link for ongoing assistance to keeping medical appointments. As a result of these interventions, continued care coordination assistance and patient education, Mr. George's A1C dropped to 8.9 by late July of 2015.

In August of 2015 Mr. George was hospitalized with a pleural effusion and newly diagnosed congestive heart failure. After discharge from the hospital Mr. George continued to demonstrate adequate self-management of diabetes and an interest in CHF self-management through daily weights, medication, and monitoring leg swelling. Kidney function tests revealed worsening kidney disease however, and Mr. George began showing symptoms of depression and needed a cane to assist with ambulation. Mr. George's kidney disease had progressed to end stage renal disease, but the patient declined dialysis because "it would be going too far", however did not want to complete advance directives forms indicating his treatment preferences during this time.

Mr. George's diabetes was well-controlled, but worsening CHF and kidney disease led to three hospital admissions between November 2015 and April 2016. During the April hospitalization, specialists strongly recommended dialysis and scheduled AV fistula placement, but the patient refused. At his transitions of care follow up visit to the PCP the CM discovered Mr. George held several misperceptions regarding fistula placement and dialysis treatment. He agreed to keep the fistula appointment after further explanation and education. Carina continued weekly calls to Mr. George to see how he was doing, and the patient began receiving dialysis treatment three times per week.

In late July 2016 Mr. George walked in to the clinic asking to see the CM and Carina. He wanted to thank us for the time and attention he received from us during the last year. He said his depression was gone, and he expressed happiness and a renewed sense of hope.

Mr. George has not been hospitalized or in the emergency room for the past 9 months. He is an active participant in managing his health, and now walks without the use of a cane. He is currently waiting to get on a kidney transplant list.

This story shows how powerful a Community Health Worker can be and how they can help support the work of the care manager. Per Lori Lynn, "the support provided by Carina for Mr. George provided her with the ability to provide care management services to more patients. Carina was able to make a connection with Mr. George through a cultural connection which fostered a trusting relationship with positive results.

Diabetes Best Overall

Lifetime Family Care

Lifetime Family Care was the recipient of the best overall diabetes practice winner in 2016. When asked what made the difference they stated it was communication, communication, communication. In addition, the physician champion was the leader of the team. Furthermore, staff collaborated through monthly staff meetings, impromptu meetings, administrative meetings and clinical management meets. Also, daily huddles took for the first 15 minutes of each day with the entire staff, to discuss workflows, and admission discharge and transfers (ADT). The practice has developed a **daily huddle agenda** to help to keep them on task.

This practice is very patient-focused by giving patient surveys and reviewing the results each month. Changes are made accordingly to improve care. In addition, staff takes part in monthly trainings to help strengthen patient and practice team relationships. The emphasis of these trainings is to help patients feel valued. The addition of a pharmacist to the team helped make a difference in terms of medication management and patient support.

The practice maximized its use of technology by using Wellcentive to utilize active data entry, care summaries and alerts. Within the electronic health record they developed shortcuts, reminders, and reports. Patient Ping was utilized to capture their admissions, discharges and transfers. Again, the efforts were to help patients feel valued when they came to the office.

Lifetime family Care has this to offer other practices striving to increase the value of the patient experience:

- Involve everyone on the team in all practice processes
- Always work as a team,
- Develop policies as a team to ensure ownership
- Enforce your policies and don't let them just exist on paper.

For more information regarding this story you may contact Erica Ross @ **eross@mednetone.net**

Lifetime Family Care Huddle

Date: **Start Time:** **Note taker:**

Attendees: Dr. Kue Dr. Palaganas Xee Tammi Kang PK Amanda Pang Yer Others:

Yesterday's Patient Count: *(Actual Patient's only)*
Dr. Kue: Dr. Palaganas:

Yesterday's Problem Areas:

Overnight Changes:

Today's Schedule:

Staff Scheduled for Today:
Dr. Kue: Dr. Palaganas:

XL: TO: KK: PKX: AH: YL: KD: Tia:

Others:

Reminder Calls: Yes No **Patient Charts Prepped:** Yes No

MiPCT Care Summaries: Yes No **Non-MiPCT:** Yes No

Hospital Admissions:

Hospital Transitions:

Meetings This Week:

Reminders-All Staff:

Other Comments:

Next Huddle Date: **Time:**
Initials After Reviewing:

Lifetime Family Care - Daily Huddle Agenda