Care Management Connection

A publication of the Michigan Care Management Resource Center

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Elements of a Shared Care Plan

A shared care plan is a patient-centered health record designed to facilitate communication among members of the care team, including the patient and providers. Rather than relying on separate medical and behavioral health care (treatment) plans, a shared plan of care combines both aspects to encourage a team approach to care. (https://integrationacademy.ahrq.gov/playbook/develop-shared-care-plan)

Engaging patients to participate in developing their shared care plan and gaining an understanding of their preferences leads to an increase in shared decision making between patients and providers. Engaging patients in the development of their plan requires participation of multiple members of the care team. Depending on the concerns, goals and needs of the patient many team members may work with the patient and family member(s) to identify the health goals. Development of a shared care plan occurs over time and requires multiple interactions with the patient and team. (reference: J. Van Dongen, et al. 2016)

Four elements of a shared care plan include:

- Current state
- Goals and concerns
- Actions and interventions
- Evaluation

Current State: Current state relates to the individual's situation. Current state includes the patients background, demographics, functioning, use of medication and usual treatment. The current state element may be continuously adjusted by the health care team.

Goals and Concerns: This involves the patient's goals and concerns and includes information related to the care requirements and goals identified by the patient and the professionals. These goals are in line with the individual's preferences, values, needs and expectations, which is the central focus of the plan.

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UPCOMING EVENTS

VIEW OUR UPCOMING COURSES

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

December 4-7, 2017, Lansing

January 22-25, 2018, Lansing

MiCMRC CARE MANAGEMENT EDUCATIONAL WEBINAR

Date and Time: Wednesday November 29th, 2-3 pm

Title: How CM's Can Prepare Patients to Have the Most Successful DSME Appointment

Presenter: Tara Rybicki, MS, RD, CDE; Amanda Woods, MPH

Register HERE

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 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

New Easy e-Asthma Action Plans

You know it's important for your patients with asthma to have an action plan – it's how they know what to do to stay in control, and what to do when asthma symptoms start. Does your practice struggle to find one plan all of the clinicians will like and use? **Check out the Asthma Initiative of Michigan's new e-AAPs**!
Three National Heart Lung and Blood Institution guidelines-based versions are available: adult, student (5 to 18 years old), and ages 0-4 years old. These easy-to-use fillable PDF plans can be customized to your clinic and added to EHRs. Each plan features age -appropriate medications and doses in drop down menus for asthma, GERD and allergy medications, and includes a triggers section. The 0-4 year old version includes a place for parental permission to administer meds at school or daycare. The student version includes places for permission to self-carry and administer inhalers at school, and to share the AAP with others who need it.

Try them out today, and contact **Tisa Vorce** (517-335-9463) with any questions about their development or use.

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.**

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:

December 4- 7 | Lansing, MI |**REGISTER HERE** | Registration deadline: November 30th, 2017

January 22-25 | Lansing, MI |**REGISTER HERE** | Registration deadline: January 18th, 2018

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**

BCBSM Revised Provider Delivered Care Management Training Requirements

BCBSM has revised the BCBSM Provider Delivered Care Management training requirements for Care Managers (CM) and Qualified Health Professionals (QHP). To learn more about the revised BCBSM training requirements, please contact the staff person responsible for coordinating care management services at your practice's Physician Organization (your practice manager should be able to give you contact information for the Physician Organization). Also, at a glance training information is available here: **http://micmrc.org/training/supported-programs/pdcm**

NEW - Blue Cross Blue Shield of Michigan
Online Provider Delivered Care Management Billing Training course

The Blue Cross Blue Shield of Michigan (BCBSM) Provider Delivered Care Management (PDCM), Blue Distinction Total Care (BDTC) and High Intensity Care Model (HICM) Billing Online Course is now offered via web-based training. The PDCM/ BDTC/HICM Billing Course is available for viewing at your convenience.

To access the Blue Cross PDCM/BDTC/HICM Billing Online Course **click here.**

NEW - Blue Cross PDCM/BDTC/HICM Webinar Offered Monthly

On a monthly basis, Blue Cross will conduct a question and answer session via WebEx relating to questions you may have after you've completed the online PDCM/BDTC/HICM Billing Online course regarding these programs. They are scheduled for the first Thursday of each month from 12:00 noon – 1:00 p.m. for the remainder of 2017. Dates and WebEx information:

- November 2, 2017
- December 7, 2017

To join this meeting (Now from mobile devices!)

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1. Go to https://bcbsm.webex.com/bcbsm/j.php?MTID=m9e19c18ee71d2a4203d6087055092b77
2. If requested, enter your name and email address.
3. If a password is required, enter the meeting password: pgip
4. Click "Join".
5. Follow the instructions that appear on your screen.

Teleconference information

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1. Please call one of the following numbers:

Toll-Free: 1-800-4625837

Local: 1-313-2254000

2. Follow the instructions that you hear on the phone.

Your Cisco Unified MeetingPlace meeting ID: 734 134 932

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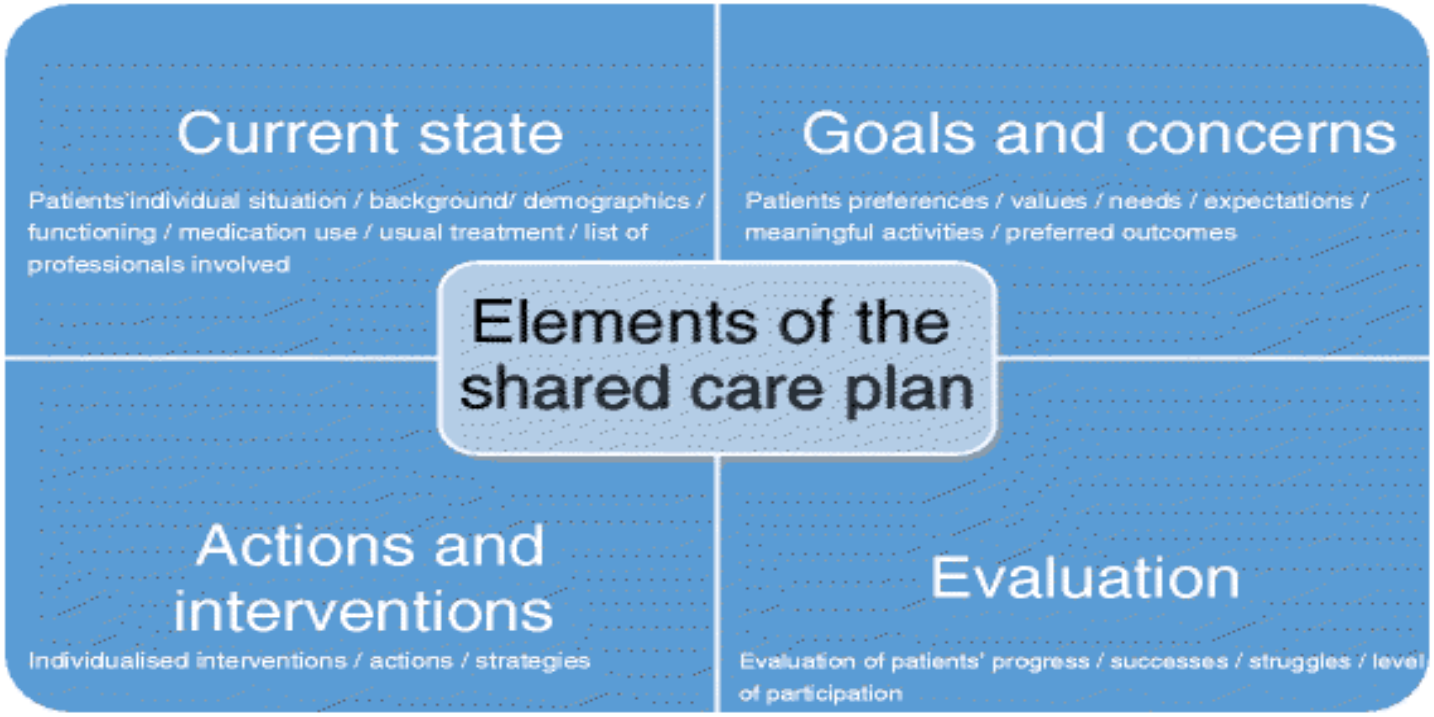

Von Dongen et al. BMC Family Practice (2016) 17:137

Actions and Interventions: The actions and interventions are based on the established goals and concerns. The interventions are individualized and tailored per the patient's perspective. Additionally, the plan needs to be kept up to date, ideally is documented using lay terms, and includes aspects to support the patient's emotional social and physical needs. Redundancy can be minimized if the interventions are specific, time based, and relate to one of the health care professionals involved.

Evaluation: Evaluation includes the professional documenting a patient's progress to include successes and struggles and level of participation in goal setting. This also involves revising the plan of care based on the patient's response and current status. The plan should be up to date and address the patients emotional, physical and social needs.

In addition, there are factors that influence the interprofessional development of the shared care plan. Some of these factors are related to interactions between care managers and other team members, as well as competencies of individual team members and communication. Maintaining a level of trust and respect between team members and the appreciation for other's roles is key. Finally, it is important for the team to designate an individual to be the coordinator of the plan. Frequently, the care manager is the coordinator of the shared care plan.

The shared care plan is a living document utilized by members of the care team and includes updates which reflect the patient's current goals and preferences. To read more about developing a shared care plan using and electronic health record, engaging patients in their care plan, and to view examples of shared care plans **click here**

Van Dongen et al. (2016). Developing interprofessional care plans in chronic care: a scoping view. BMC Family Practice 17:137. Retrieved from **https://bmcfampract.biomedcentral.com/articles/10.1186/s12875-016-0535-7**

The Academy. Integrating behavioral Health and Primary Care. Retrieved from **https://integrationacademy.ahrq.gov/playbook/develop-shared-care-plan**

Michigan Care Management Resource Center Website

www.micmrc.org

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COMPLEX CARE MANAGER COURSE*	**CARE MANAGEMENT 101**	**ELEARNING COURSES***	**SELF MANAGEMENT SUPPORT COURSES**	**WEBINARS LIVE & RECORDED***
Online and in person class to prepare Care Managers new to their role Designed to prepare the healthcare professional for the role of Complex Care Manager	Road map offers self guided development for Care Managers new to their role Quick start tools, and resources for daily work	A series of brief 15-30 minute interactive online modules ideal for the busy learner Examples: •CM 5 step process •Role of the Care Manager •Medication Management	MiCMRC approved course list, with details, objectives, location, cost and more Includes access to self management support tools and resources	Monthly live webinars in addition to a library of recorded webinars presented by national and local subject-matter-experts Examples: •Palliative Care •Team Based Care •Social Determinants of Health

*Continuing Education Contact hours for RN and SW for selected programs and webinars, at no cost

"The Michigan Care Management Resource Center provides evidence based foundational and longitudinal curriculum, tools and resources to support care management and population health management delivery initiatives across the state."

For questions and suggestions contact us at micmrc-requests@med.umich.edu

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www.micmrc.org

CHRONIC CONDITION PAGES

Provides a framework aimed at Care Management interventions, resources, education, and tools for patients with chronic conditions

Examples:

- HF
- Asthma
- Diabetes

TOPIC PAGES

Provides webinars and websites of interest pertaining to various patient care topics

Examples:

- Pediatrics
- Social Determinants of Health
- Team Based Care

CARE MANAGEMENT BILLING RESOURCES

Resources related to specific programs and CMS initiatives

PROGRAMS MICMRC SUPPORTS

Training, requirements and details on statewide Care Management initiatives

Examples:

- Blue Cross Blue Shield of Michigan Provider Delivered Care Management
- State Innovation Model
- High Intensity Care Model

NEWSLETTER

Current & past publications of the Care Management Connection

Newsletter includes articles, upcoming educational offerings, and updates

micmrc

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