Care Management Connection

A publication of the Michigan Care Management Resource Center

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Care Giver Awareness Month!

This month we celebrate caregiver awareness month. Everyday millions of people take part in providing unpaid care to friends and loved ones. Those that are caregivers go through a tremendous amount of stress and emotional strain, which many times goes unnoticed. As care managers we need to assess the needs of the caregiver just as we assess the needs of the patient. Family caregiver's play an intricate role in providing care for their loved one. It is important to assess caregiver's stress and offer resources and support.

Caregiver Stress: Supporting the Caregiver

The term family caregiver and/or informal care giver refers to an unpaid family member, friend, or neighbor who provides care to an individual suffering a chronic condition and needs assistance with various activities such as bathing, eating, dressing or taking medications. When caring for older adults or those with chronic disabilities of all ages, this "informal care" can be substantial in scope, intensity, and duration. Sometimes caregivers are referred to as secondary patients who also need attention and guidance.

A recent 2015 survey conducted by AARP regarding caregiving in the U.S. showed that approximately 43.5 million adults had provided unpaid care to an adult or child in a twelve -month period. In addition, 60% of caregivers were female, whereas males accounted for 40%. Furthermore, in 2013 it was estimated that caregivers in the U.S. provided 37 billion hours of unpaid care at an estimated cost of 470 billion dollars. On average an informal caregiver devotes 4.3 years to this work. In most cases the care being provided is that of activities of daily living (ADL) or instrumental activities of daily living (IADL). However, this does not always paint a clear picture of unforeseen challenges of providing assistance with such activities, i.e. patients who may have dementia, are

resistant to care or have complex medication management.

Most family members feel unprepared to take on the caregiver role, with many having a lack of knowledge of how to deliver appropriate care and receive little guidance from health care professionals. Many are unaware of when community resources may be needed and therefore may not know how to access those resources. Caregivers are patients themselves, with many dealing with physical and mental health issues from their physically and emotionally demanding role as a caregiver. For example, elderly spouses who experience stressful caregiving situations have a 63 percent higher mortality rate. Caregivers have additional risk for fatigue and sleep disturbances, increased blood pressure, lower immune functioning and an increased risk for cardiovascular disease.

In addition to the increased health risks, caregivers have a difficult time balancing caregiving with other activities such as work or family leisure time, which can lead to increased distress from not being able to participate in those activities. More than half of adult children caring for a parent are employed. They report missed days, interruptions of their work, and reduced productivity. Moreover, those who are unemployed or have lower incomes may experience more distress due to fewer resources to meet the demands.

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Click on the links below to register for the MiCMRC/ MiPCT Complex Care Management Course

November 7th - 10th, Lansing

December 5th - 8th, Lansing

Click Here for additional course dates

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 Michigan Primary Transformation demonstration project, High Intensity Care Management, BCBSM Provider Directed Care Management (PDCM) Phase III and BCBSM PDCM Oncology program.

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

In case you missed it

Continuing Education Opportunity

MiCMRC/MiPCT Care Manager recorded webinars:

- "Non-pharmacological Approaches for Behavioral and Psychological Symptoms of Dementia"
- "Non-pharmacological Approaches to Depression"
- "Non-pharmacological Approaches to pain"

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/MiPCT Complex Care Management Course

The 2016 MICMRC/MIPCT Complex Care Management (CCM) Course is provided in a blended learning activity format. The MiCMRC/MiPCT CCM course is designed to prepare the healthcare professional for the role of Complex Care Manager (CCM).

Completion of the MiCMRC/MiPCT CCM Course occurs over a 4 day period. The course consists of:

- Live Webinar on day 1 - introduction of MiCMRC/MiPCT CCM course
- Self-study modules and post- tests which are completed prior to the in-person training (total expected time to complete the self-study and post tests is six hours)
- In person training days 3 and 4

For MiCMRC/MiPCT CCM Course details visit www.micmrc.org

Register for all MiCMRC/MiPCT CCM Courses Here

Note: 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-requests@med.umich.edu

Please submit questions regarding the MiCMRC/MiPCT CCM course to: ***micmrc-requests@med.umich.edu***.

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 MiCMRC-Approved Self-Management Support Program Summary

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. PDCM III and PDCM Oncology Care Managers are required to complete a MiCMRC-approved self-management course. For questions please submit to: micmrc-requests@med.umich.edu

Submitting Your Success Story Just Got Easier

The Michigan Care Management Resource Center now features a new single web based Success Story Template located on the micmr.org web site. The new web based template link is designed for submission of your care manager, practice and PO success stories. To submit your story Click Here

Also, The Michigan Care Management Resource Center (CMRC) is proud to announce a new Team Based Best Practice web page http://micmrc.org/best-practices

This page is dedicated to the great work that is happening across the state by Practice Teams. In addition, you will able to access the tools and/or resources that have been shared by the practice.

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The Care Manger's Role

Professional advocacy, including nurses and social workers can be instrumental in raising awareness of caregiver stress. The care manager plays an important role in supporting the caregiver at risk for physical and emotional harm. Interventions should serve two purposes. First, support the caregiver as a client. In this approach the caregiver is the primary recipient of the education and training which then benefits the patient secondarily. Second, utilizing interventions to help the caregiver increase competency and confidence, will lead to providing safe and effective care to the patient, indirectly reducing stress. Research has found that multicomponent interventions rather than single interventions like support groups or education greatly reduce burden.

In some cases, those caring for stroke survivors or patients with dementia found counseling to improve quality of life and reduce depression. Furthermore, many caregivers felt a reduction in burden or distress when receiving socially-supported phone calls that provided some respite from caregiving. Also, home visits and enhanced social support including assistance with respite/day care interventions reduced depression and increased well-being. In addition, a prescriptive program based on research on problem-solving and therapy was developed to empower family members to moderate caregiver stress through the Prepared Caregiver Model which is summarized in the acronym COPE (Creativity, Optimism, Planning, and expert information). This model teaches caregivers how to design and carry out a plan that focuses on medical and psychosocial issues and are coordinated with care plans of health care professionals.

Caregivers require the knowledge, skills and judgement to carry out the needed tasks of caregiving and having those things help them feel more prepared to deliver care. When providing care one needs to take into account the following dimensions:

- Nature of the task
- Frequency of the tasks
- Hours of care provided each day
- Skills, knowledge and ability
- Extent to which tasks can be routine, incorporate into daily schedules
- Support of other family members.

At a minimum, care managers can recognize and respect a caregiver's efforts, assess their needs, provide concrete instructions on the specific care they are giving and refer them to other community resources to provide on-going help. This assessment should take place in addition to the patient assessment. Listening skills and the ability to interpret body language and verbal communication are essential competencies when meeting with patients and their family members. Linking caregivers throughout the disease trajectory is critical because many times they are unaware of the support services available

Houts, P. S., Nezu, A. M., Nezu, C. M., & Bucher, J. A. (1996). The prepared family caregiver: a problem-solving approach to family caregiver education. *Patient education and counseling*, *27*(1), 63-73.

Schulz, R. PhD, & Sherwood, P.R. PhD, RN, CNRN. (2008). Physical and mental health effects of family caregiving. American Journal of Nursing. 108(9 Suppl): 23-27.

Care Giving in the U.S. Final Report. (June 2015). AARP. Retrieved from http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Final-Report-June-4_WEB.pdf

Family Caregivers Provide Staggering $470 Billion in Unpaid Care According to AARP Study. (July 2015). Retrieved from http://www.aarp.org/about-aarp/press-center/info-07-2015/family-caregivers-provide-470-billion-in-unpaid-care-aarp-study.html

Reinhard SC, Given B, Petlick NH, et al. Supporting Family Caregivers in Providing Care. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 14. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK2665/

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share your story

Laurisa Cummings, Care Manger

Children's Medical Group of Saginaw Bay

Laurisa Cummings, LMSW is a care manager at Children's Medical Group of Saginaw Bay. She recently had the opportunity to begin working with Bailey, a 5 year old very energetic, happy child. Bailey is the youngest of three children, who reside with their parents in a small community. The parents brought their daughter to the PCP following multiple contacts from 'Bailey's' teacher who stated Bailey was exhibiting behavioral difficulties throughout her academic day. 'Bailey required multiple interventions throughout the day to maintain her focus and attend to her academic tasks. The parents shared with the PCP Bailey's academic challenges as well as behavioral concerns noted at home. They identified 'Bailey' having hyperactive behaviors, always "being on the go", and not being able to complete two or three step commands. They also noted Bailey's difficulty with transitions and changes. 'Bailey' was also described by her parents as having repetitive hand flapping movements, a decline in her language skills, and "mimicking speech" in which she would repeat exactly what is said to her.

PCP evaluated her for ADD/ADHD through the process of Vanderbilt rating scales and found her to have a positive diagnosis for ADHD. PCP initiated treatment for ADHD, prescribing a standard stimulant. PCP also discussed care management services available through the practice. The parents were very happy to receive help and scheduled an initial visit with Laurisa.

During the initial evaluation, Laurisa noted not only behaviors and symptoms of ADHD, but also those that could be related to a sensory or developmental delay such as Autism. Laurisa completed an assessment based on ADHD, reviewing Bailey's acceptance, tolerance, and adherence to the new medication. It was noted Bailey's focus and attention at school had improved, increasing her academic achievement scores. However, parents were told Bailey was often found off on her own, rarely playing with her classmates. When she did interact with her peers, she often engaged in physical altercations after becoming upset because her peers would not play as she believed they should. She was also having difficulty managing transitions throughout the day when asked to change activities, which lead to angry outbursts. Parents noted she was becoming more particular in food choices, refusing to try new foods, and eating mostly "soft" foods or skipping meals. Bailey refused hot lunches, requiring her preferred foods to be packed for her daily. Parents also shared Bailey's adversity to many clothing textures, having her hair brushed or even touched, refusing to be bathed, and a recurrent need to "chew and suck" on items. Laurisa discussed symptom sets, identifying and differentiating between ADHD and sensory symptoms. Bailey's parents disclosed they had wondered if she had Autism, although Bailey had passed all developmental assessments previously provided.

Laurisa suggested the next step would be to complete the AQ-10 Child Assessment Scale, which Bailey's parents agreed to do. Bailey scored 8 out of 10, indicating a positive score and suggesting need for further testing for Autism. Laurisa completed a referral request to PCP, which was approved, and an order for testing was submitted to the referral department at Children's Medical Group of Saginaw Bay.

Denise from the referral department worked with Bailey's parents, discussing options for testing, identifying the most timely and appropriate center for Bailey.

While waiting for her testing date, Laurisa identified the need to begin working with Bailey's school. A release to exchange information between the school and Children's Medical Group of Saginaw Bay was signed by Bailey's parents. Laurisa contacted Bailey's teacher, exchanging observations and concerns with Bailey's symptoms, behaviors, strengths, and academic concerns. Based on this discussion, it was determined the teacher would request 'Bailey' be evaluated for Autism and other special education needs.

While waiting for both assessments to be completed, Laurisa continued to work with Bailey and her parents weekly. Laurisa was also able to work with Bailey's sibling as well, as the two often had significant disputes at home. Behavioral management, symptom management, and parenting techniques were addressed, with goals to reduce outbursts and resistance to necessary care being at the forefront of the care plan.

Bailey continued to experience significant behavioral outbursts at times, and her current ADHD treatment plan was not sufficiently managing her symptoms. Laurisa scheduled a team conference with PCP and a determination was made to refer Bailey to a Psychiatrist. Parents were in agreement and Laurisa worked with them to schedule an initial consultation. Bailey was seen by the Psychiatrist and an antidepressant was initiated. Following the addition of this medication, Bailey's behaviors stabilized and improved.

Bailey was diagnosed with Autism at the certified Autism testing center. She was also diagnosed with Autism through the school system. A meeting was scheduled at the school in which behavioral and academic plans with appropriate interventions were developed. The meeting included Bailey's parents, principal, assistant principal, her teacher, school social worker, speech therapist, occupational therapist, physical therapist, Autism behavioral specialist and Laurisa. A collaborative care plan with individualized behavioral interventions were developed and a subsequent meeting was scheduled to monitor Bailey's progress and response to the plan. During the academic evaluation, it was identified she would benefit from OT, PT, and ST, which was also initiated. Baileyt met the criteria for special education services and an Individual Education Plan (IEP) was established.

Since the plan was put in place, Bailey continues to work with Laurisa, although the frequency has decreased from weekly to monthly. 'Bailey' is accomplishing her academic goals and is responding very well to the interventions. Her parents also report behaviors have improved at home. Laurisa worked with Bailey's parents to identify an agency from which to receive Applied Behavioral Analysis (ABA) services, which are being provided in the home 20 hours per week. The PCP continues to oversee and manage ADHD medication and treatment plan and the Psychiatrist continues to oversee and manage psychotropic medication.

Social Determinants of Health: Closing Gaps in Overall Health

The term social determinants of health are often referred to broadly as any nonmedical factors influencing health, including health literacy, attitudes, beliefs or behaviors. They are conditions in the environment in which people are born, live, work, play, worship, and age that effects a wide range of health, functioning, quality of life outcomes, and risks (Healthy People 2020).

Over the past two decades, there has been an increased international interest refocusing on the nonmedical and nonbehavioral precursors of health and illness. This approach has been well developed in many European countries while in the United States it has been subordinate to traditional medical models (Raphael, 2006).

In the United States, it is becoming clear that medical care alone is not adequate to improve overall health or reduce the disparities without addressing where and how people live (Braveman, et. al. 2011). Health starts in our homes, schools, workplace, neighborhoods and communities. Eating healthy, staying active, not smoking, receiving the recommended immunizations and seeing the physician when we are sick all influence our health. However, our health is also influenced by access to social and economic opportunities, resources and supports available in the home and community, quality of schooling, cleanliness of food, water and air as well as the nature of social interactions and relationships.

Resources that improve quality of life can have a large impact on population health outcomes. Some examples of these resources include safe and affordable housing, public safety, access to healthy foods, and emergency/health services (Healthy People 2020). The Patient Centered Medical Home offers an opportunity to promote population health by systematically addressing the social determinants of health. Although primary screenings have been developed for specific psychosocial issues such as substance abuse, there is increasing evidence that screening for basic unmet material needs (i.e. food, employment, education, transportation) can help increase patient contact with community resources, especially for the vulnerable elderly population (Garg, et al, 2013). There is a need to broaden the availability of community-based resources (i.e. housing programs, food pantries, transportation services) especially for primary care practices serving low income populations (Garg, et al., 2013).

Social determinants should be a component of the patient's care plan. In many cases, when faced with social determinants of health, patients will be reluctant to proceed with any plan until basic needs are met. For example, if a patient is financially unable to put food on the table or is unable to afford their prescription copays then they may not be concerned their diabetes management. In many ways we can relate social determinates of health with Maslow's Hierarchy of Needs. Unless certain physiological needs are met there is the inability to reach additional needs such as safety, love and belonging, esteem and self-actualization.

Care managers play a critical role in coordinating services to help meet the social needs of patients. This is done in part by working closely with team members who have linkages in the community. In addition, care managers as well as other members of the primary care team need to build solid working relationships with community organizations to ensure resources are provided efficiently and meet the needs of the patient. This can be a challenge especially for smaller practices working in rural areas who may not have access to certain services.

Recently there has been a growing recognition of the importance of social determinants and the impact on health. A growing number of initiatives have been surfacing to address these broader determinants of health and develop integrated solutions within the context of the health care delivery system. This has been seen through many Medicaid delivery and payment initiatives (Heiman & Artiga, 2015).

Braveman, P., Egerter, S., & Williams, D.R. (2011). The social determinants of health: Coming of age. Annual Review of Public Health. 32. 381-98.

Garg, A. MD, MPH., Jack, B. MD, & Zuckerman, B. MD. (2013). Addressing the social determinants of health within the patient-centered medical home. *Journal of the American Medical Association.*

Healthy People 2020. United States Department of Health and Human Services. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinats-of-health

Heiman, H.J., & Artiga, S. (2015). Beyond health care: the role of social determinants in promoting health and health equality. *The Kaiser Commission on Medicaid and the Uninsured.*

Raphael, D. (2006). Social determinants of health: Present status, unanswered questions, and future directions. *International Journal of Health Services*. 36(4). 651-677.

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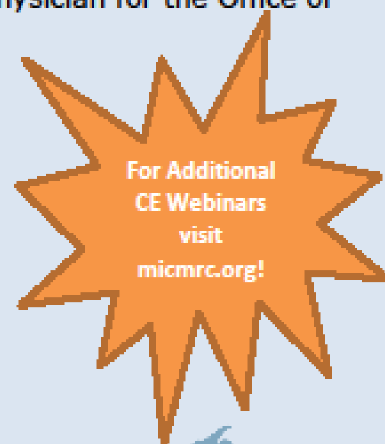
    *CE credit available until June 7, 2017
- **Understanding the Complexities of Cognition**
  - Presented by Linda Keilman, DNP, GNP-BC
    *CE credit available until April 27, 2017
- **2015 Updated BEERS Criteria**
  - Presented by Kim Moon PharmD
    *CE credit available until February 10, 2017



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Best Practice Spotlight

Highlighting Best Practices Across the State

Cereal City Pediatric and Moazami Practice: Patient Engagement is the Key

Situation: The practice uses multiple ways to engage our community, families and patients. Recently the practice started using ***Facebook*** to get information out to both current and potential families in our area on important health information, seasonal concerns and news about the practice.

Strategy: The ***Website*** tag line- WELCOME TO CEREAL CITY PEDIATRICS - ***we'll be there as they grow....*** States from very first newborn checkup in the hospital to the unique health concerns of adolescents and every childhood illness in between, our caring providers have the expertise to help you safely navigate the sometimes confusing waters of children's health care. The website also has added many helpful pages: office hours, seasonal issues/ concerns, is your Child Sick search, medication dosages, links to educational resources, scheduling, provider information, appointment guidance. The practices have access 6 days a week in the summer and 7 in the winter with extended office hours 7:30am – 6:30pm M-F and on Saturday and Sunday 7:30am – 12 noon. Patient hours our 8:00am – 6:00pm M-F with daily open slots for sick visits only from 4:30pm to 6:00pm M-F and on Saturday and Sunday 8 am to 11:30am to meet family needs. Patient/family can schedule a get acquainted visit to the practice. During their first visit as a patient they receive a Welcome to Cereal City practice folder which they are encouraged to bring to each visit. It contains:

- Information about office practice, providers, office hours, making appointments
- Calling the office after hours and weekends
- Immunization schedule
- Fever treatment
- Feeding
- Joining portal, how to create account
- Information practice needs

Their patient ***portal*** is used by families to access visit information, stores copies of forms, medical summery of all visits, or records needed for school or sports. It also provides frequently requested information like medication dosing. It also facilitates communication between provider, CM and family.

One week before a planned 9mo, 18mo or 2yr well visit families receive an age appropriate Ages and Stages questionnaire to fill out and bring back with them to the visit. They also can access SMART Healthy Behaviors Goal sheet with 5 questions help patient/ families develop action plan based on their goals and needs. During their office visit there are given educational materials specific to visit type; this information is also forwarded to patient portal for families to have access later. Parents are educated on immunization, choices and consequences. AIM Toolkit from the Alliance for Immunizations in Michigan is used (aimtoolkit.org). If the patient has an urgent care, emergency room or hospital visit a TOC call is done (based on criteria) to follow up. First question is "How are you and your child doing now?"

Triage nurses from the practice are on call at night and on weekends to answer question and direct care. If family visits emergency room without calling the office first an opportunity is taken to educate the family to call office 1st. Diane Thomas, Office Manager, stated each contact with our families is an opportunity to support care from "first hello to last good bye". "Providing this level of care does not work unless everyone is on board. Everyone has a role and everyone touches the patient. Staff know what they do matters. Every visit is an opportunity to discuss and close care gaps." "All staff have training and understands process and roles to identify and close gaps in care. " Catching gaps in care starts with the front desk staff, they generate a gap in care report from the registry, and health plan. They place flags and tasks in the EMR to alert staff of what is needed. They also place this information on a pink encounter form, which follows the patient/family through the visit from the hello to check out. They know why the patient and family are there. During any visit the MA checks pink encounter form, MICR and EMR for HEDIS care gaps and closes according to protocols.

The provider reinforces care, referral and next follow-up visit. At checkout, the next visit is scheduled from the pink encounter form. Education and materials are provided throughout the visit and attached to the portal. Office scanner makes sure referrals and reports get into chart. Amy Goff, Care Manager, focuses on both moderate and complex care management. She has an introduction letter for patients who may benefit from care management along with follow up contact letters for patients. She looks for every opportunity to help staff to understand care for each CM patient and be part of cheering them on when they are meeting their goals.

Asthma patients receive a ***Red Folder*** with educational fliers and symptom log to help document symptom, track treatment and impact. There is consistent ongoing education and teach back patient demonstration on use of inhaler and spacers at each visit.

Dee Dailey, Practice Coach, is viewed as part of the team keeping them aware of the data and assisting with opportunities for improvement. She presents at quarterly staff meetings the Quality Data Board with updated reports, raw data and specific cases for gaps not met. She helps staff see the impact of improvements and that what they do matters.

For more information on the great work Cereal City has been doing please contact Wendy Hanson @ wendy@cereal.pcc.com