Care Management Connection

A publication of the Michigan Care Management Resource Center

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New 2016 Medication Reconciliation HEDIS Measure

An inconsistency on the drug list is found in two-thirds of discharge summaries[1], which contributes to nearly one in five Medicare patients being readmitted to the hospital within 30 days.[2] One approach to resolving this is to reconcile medication lists with the patient shortly after discharge, which is why the National Committee for Quality Assurance Healthcare Effectiveness Data and Information set includes a quality improvement measure[3] aimed at ensuring that all patients receive a medication reconciliation within 30 days of any discharge. To satisfy the measure, the medication reconciliation must be recorded in the outpatient medical record.

Medication reconciliation can be defined as a comparison of a patient's current medications against what they were taking in a previous setting of care, to identify any discrepancies or medication-related issues[4]. Here are tips for performing a high-quality medication reconciliation, and improving transitions of care:

- Ask the patient to bring discharge instructions, medication bottles and lists, including non-prescription products (over-the-counter, vitamins, supplements).
- Review medication bottles, and match them to the discharge instructions, including any new prescriptions.
- Address all potentially clinically significant drug therapy problems, such as therapy duplication or drug interactions, with the prescriber(s).
- After reconciling medications, create a new list of all medications the patient should be on.
- Go through the new list with the patient, and make sure there is one copy for the patient and another copy in the patient's medical record.
- Talk to your patients about the importance of maintaining an accurate and up-to-date record of all active medications. Medications can often change between settings and the list of medications can be inaccurate or outdated.
- Encourage your patients to keep a copy of the updated medication list and bring it to all appointments. A comprehensive list of medications should include all prescription medications, herbal supplements, vitamins, nutritional supplements, over-the-counter drugs, vaccines, diagnostic and contrast agents, radioactive medications, parenteral nutrition, blood derivatives and intravenous solutions.
- Explain to your patients that this reconciliation is done to avoid medication errors as they relate to such matters as duplications, omissions, dose, timing and adverse drug interactions.
- Establish a process asking patients to bring their medication bottles, including all over-the-counter preparations, to every health care encounter.
- A computer order entry system should be used when possible. It reduces errors and confusion caused by illegible handwriting.
- The updated hospital medication list and discharge instructions are printed for education and review with the patient before he or she leaves the hospital. Request the medication list to better assist in your review and update of the chart during post-discharge medication reconciliation.
- Always include medication reconciliation in your post-discharge visit note, whether you see your patient during an outpatient visit or you review medications over the phone with your patient.

VIEW OUR UPCOMING COURSES

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

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 for new Complex Care Managers (CCMs).

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

Register for all MiCMRC/MiPCT CCM Courses Here

For MiCMRC/MiPCT CCM Course details Click 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 "Care Management Resource Center Approved Self-Management Support Training Programs"

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.

Continued from front page

New Medicare star ratings measure: Medication reconciliation post-discharge

About the measure

The measure assesses patients age 18 and older who were discharged from an acute or non-acute inpatient stay between Jan. 1 and Dec. 1 of the measurement year. It looks at patients whose medications were reconciled from the date of discharge through 30 days after discharge (31 days total).

Medical record documentation requirements

Health care providers must meet certain criteria when documenting evidence of medication reconciliation in Medicare patients' medical records for the reconciliation to count toward this measure. Documentation in the medical record must include evidence of medication reconciliation and the date it was performed. Any of the following meets documentation criteria:

- A note from the provider that current and discharge medications were reconciled.
- The current medication list with a notation that references the discharge medications (for example, no changes in medication since discharge, same medications at discharge, discontinue all discharge medications).
- Current medication list with a notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
- Notation that no medications were prescribed or ordered upon discharge.

Only documentation in the outpatient chart meets the intent of the measure; an outpatient visit isn't required. Medication reconciliation can also be done by phone.

How to receive BCBSM reimbursement for medication reconciliation post-discharge

When Medicare Advantage PPO members are discharged after a hospital stay, schedule a post-discharge office visit as soon as possible and perform medication reconciliation during the visit.

- The outpatient medical record must state that the "current and discharge medications were reconciled."
- Bill $10 for *1111F with the post-discharge office visit claim within 30 days of the discharge.
- Medication reconciliation should be performed after every inpatient discharge.
- CPT 2 code *1111F states, "Discharge medications reconciled with the current medication list in outpatient medical record."
- In addition to the office visit, Blue Cross will reimburse providers an additional $10 for billing 1111F within 30 days of a patient's discharge.

Description	Codes
• Discharge medications reconciled with the current medication list in the outpatient medical record	• *1111F
• Transitional care management services: • Communication (direct contact, telephone or electronic) with the patient or caregiver within two business days of discharge. • Medical decision-making of at least **moderate complexity** during the service period. • Face-to-face visit within **14 calendar days** of discharge.	• *99495
• Transitional care management services: • Communication (direct contact, telephone or electronic) with the patient or caregiver within two business days of discharge. • Medical decision-making of at least **high complexity** during the service period. • Face-to-face visit within **seven calendar days** of discharge.	• *99496

Reimbursement for codes 99495 or 99496 include medication reconciliation and therefore 1111F should not be billed with transitional of care codes.

There is no member cost share for 1111F.

On 7/11/16 or after, if a provider has conducted medication reconciliation post-discharge within 30 days but did not bill 1111F, a claim for 1111F can be submitted (alone.) Make sure the date of service was within 30 days of the hospital discharge to home.

Providers who have billed 1111F after 7/11/16, but with a charge of $0.01 instead of $10, providers may rebill with a $10 charge.

share your story

Submitted by Care Manager Jane Ruhl of Oaklawn Medical Group

In September of 2015 Ms. Sandler was referred for care management services due to multiple ED visits and per the request of the hospital case manager. The patient was identified as being at risk secondary to high ED utilization. The care manager met with the Ms. Sandler to conduct an initial assessment which revealed numerous psychosocial needs, educational needs and a need for self-management support.

Ms. Sandler had multiple ambulatory care sensitive ED visits in 2015, primarily related to abdominal pain. Ms. Sandler had multiple needs for community referrals as well as referrals to specialists, something the ED was not providing effectively. It was clear that Ms. Sandler would benefit from care management services to assist with community referrals, care coordination as well as education and support. Current active diagnoses include: Crohn's disease, peptic ulcer, bipolar disorder and chronic back pain. The patient had recently moved to the area and had a limited support system. Her current support is her husband who works part-time, and she has been receiving SSI assistance. They have a transportation barrier secondary to having no vehicle. In addition, Ms. Sandler struggles with bipolar disorder and when initially assessed was dealing with severe depression. The patient sees a psychiatrist every three months however due to the current transportation issue has not being seeing a therapist and therefore has difficulty accessing behavioral health resources.

The overall goal was to reduce the ED utilization and provide appropriate access to care in the primary care setting. Ms. Sandler, the care manager and the physician developed an action plan by which the patient would call the care manager if she had concerns, the care manager would then assess the situation and provide education/ support or if needed coordinate a same day appointment with the provider for further evaluation. If the physician is not available, the care manager will see the patient that day. This plan was also discussed with the patient's gastroenterologist and health plan case manager.

Referrals were made to behavioral health and community service agencies regarding transportation assistance. With the ability to now access behavioral health services, Ms. Sandler is seeing a therapist every two weeks. There has been great improvement in her depressive symptoms and she has set a goal to do one household chore daily which she is now able to take part in. In addition, she is planning to volunteer at the local animal shelter which has been made possible by the transportation services.

Since the introduction of care management Ms. Sandler's, ED use has decreased 50%. In addition, the ability to access behavioral health and community services has positively impacted her depressive symptoms and her ability to self-manage. Ms. Sandler states she is very proud of the progress she has made and feels good about her ability to volunteer in the community. She states "she has finally found her way." Furthermore, her primary care physician, health plan case manager and gastroenterologist have stated that they are pleased with her progress.

Cultural Competency

Reducing Disparities in Health Care

We live in a complex multicultural society in which there are many disparities, however, nowhere are they more clearly documented than in health care (Sutton, 2000). This complexity can also lead to health care disparities in the primary care setting. Health care professionals including, physicians, nurses, social work, as well as others that may have interaction with the patient need to have an understanding of the differences that exist and how those differences impact an individual's view of the health care system. Many patients face obstacles which may include limited English proficiency, low health literacy, fears or mistrust in the healthcare system or a lack of knowledge of understanding their own health or management of their health (Paez, et. al., 2008).

Culture refers to the integrated patterns of human behavior that includes, language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups (Office of Minority Health, 2000). Cultural competency speaks to a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals that allow them to work effectively in a cross-cultural situation (Paez, et. al. 2008). Cultural competence starts with addressing the strengths and weaknesses with an organization and its staff, as well as the unique needs of the population being served.

Understanding a patients' diverse cultures is not just political correctness but is integral to eliminating health care disparities and providing high-quality care. Health care professional need to work to understand culturally influenced health behaviors. Several things can be done at the practice level to help cultivate cultural competence. These may include:

- Value diversity. Do not merely tolerate people of differing backgrounds but consider their differences as strengths.
- Cultural self-assessment. Click Here to view an example of a cultural competence self-test.
- Diversity can cause conflict. Be aware of the dynamics when people of different cultures interact.
- Institutionalize cultural knowledge. It must start at the top, and be evident in policies and practices
- Adapt service delivery to reflect and understanding of cultural diversity (Sutton, 2001).

In addition, the National Standards for Culturally and Appropriate Linguistic Services in Health and Health Care (National CLAS Standards) are designed to advance health equity, improve quality and help eliminate health care disparities by providing a blueprint for individuals and organizations to implement culturally and linguistically appropriate services (National Institute of Health, 2016). Some of the standards presented include offering language assistance with limited English proficiency. Informing all individuals, the availability of these language services verbally and in writing. Provide easy to understand print and multimedia materials, including signage in the languages commonly used by the populations in the service area. In addition, establish culturally and linguistically appropriate goals, policies, and management accountability (National Institute of Health, 2016). For a complete list of the standards Click Here.

The need for cultural competence is critical for addressing the disparities in health care today. You can do your part by having an understanding of the diverse populations being served within your practice and taking the time to identify the gaps that may exist.

National Institute of Health. n.d. Cultural Respect. Retrieved from https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/cultural-respect

Carillo, E.J., MD., Green, A.R., MD., & Betancourt, J.R., MD. (1999). Cross-cultural primary care: A patient-based approach. *American College of Physicians* retrieved from http://annals.org/

Paez, K.A., Allen, J.K., Carson, K.A., & Cooper, L.A. (2008). Provider and clinical cultural competence in a primary care setting. *Journal of Science and Social Medicine*. 66:1204-1216.

Sutton, M. (2000). Improving patient care: Cultural Competence. Journal of Family Practice Management. 7(9):58-60.

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Recorded Webinars Available for CE Credit

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- **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

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

MiPCT
Michigan Primary Care Transformation

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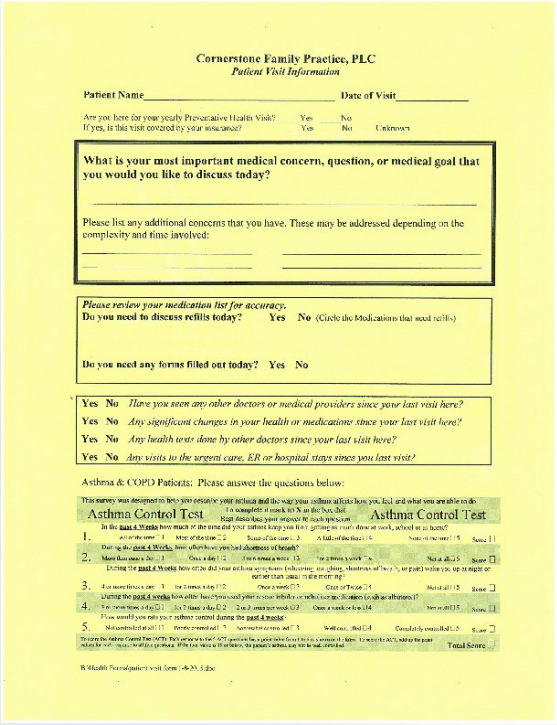
Best Practice Spotlight

Highlighting Best Practices Across the State

Cornerstone Family Practice Learns that it Takes a Trusting Relationship with the Patient and the Family

Situation: Cornerstone Family Practice was selected as a Best Practice site based on high HEDIS scores in preventative measures. The practice achieved this by finding ways to establish a trusting relationship with patients and families and the care team. This was accomplished through development of shared tools. Cornerstone Family Practice's tag line is "Your Foundation for Good Health".

Strategy: Cindy Denk, PA and Care Manager in the practice states that patients and their families are actively engaged in improving their health and receiving quality care (HEDIS measures) over many touch points in the practice. The practice started with creating the **Welcome Patient Information Brochure**. This introduction to the practice lays the foundation for a trusting partnership between Cornerstone Family Practice and the patient/family. The brochure provides patients and families with key information regarding what is a medical home, scope of their practice, practice responsibilities, patient responsibilities, communication methods, open access and preferred urgent care facilities. To take this a step further the practice provides each patient, each visit with a **Patient Visit Information form** to fill out and utilize during their visit to help document their needs, describe chronic condition control and work on an action plan to improve their health. From the front office to the back patient room clinical area, all staff members are aware of and working with the patient on goals and closing gaps in care. They use standard chart preparation, chart flags, standing orders and a referral coordinator who works to schedule tests and appointments with the patient and family. In addition the practice has developed **specific responsibilities** for the MAs to create standard work and reminders.



Cornerstone Family Practice, PLC

Patient Visit Information

Patient Name_____ Date of Visit_____

Are you here for your yearly Preventative Health Visit? Yes No

If yes, is this visit covered by your insurance? Yes No Unknown

What is your most important medical concern, question, or medical goal that you would you like to discuss today?

Please list any additional concerns that you have. These may be addressed depending on the complexity and time involved:

Please review your medication list for accuracy.

Do you need to discuss refills today? Yes No (Circle the Medications that need refills)

Do you need any forms filled out today? Yes No

Yes No *Have you seen any other doctors or medical providers since your last visit here?*

Yes No *Any significant changes in your health or medications since your last visit here?*

Yes No *Any health tests done by other doctors since your last visit here?*

Yes No *Any visits to the urgent care, ER or hospital stays since you last visit?*

Asthma & COPD Patients: Please answer the questions below:

Asthma Control Test

Asthma Control Test

Total Score

The practice uses monthly staff meetings as the opportunity to review data and reasons for missed gaps in care. The meeting is centered on how the team may improve their process and care for the patient.

Cindy states "We achieved these results because everyone including the patient is actively involved and on the same page in improving care both in the office and in the medical neighborhood."

For more information regarding this story please contact Cindy Denk @ denksa1@yahoo.com