Care Management Connection

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Effectively Utilizing Strength-Based Communication Strategies

Linda Keilman, DNP, GNP - BC

"The basic building block of good communications is the feeling

that every human being is unique and of value"

(Author Unknown)

Communication is a dynamic process occurring between individuals and is composed of verbal (7%), nonverbal (58%), and tone of voice (35%) components. As health care professionals (HCPs) working with unique individuals in a variety of care settings, we know that communication is the foundation for establishing positive collaborative relationships. Effective communication utilizes authenticity, sensitivity, compassion, and empathy (Barnard & Ganca, 2011). According to a 2012 Institute of Medicine Report, communication that is consistent and effective has been associated with improved patient satisfaction and safety, better health outcomes, and lower health care costs – all of which are goals of care management. Ensuring that communication is therapeutic, effective, and accurate at the same time requires a refined and directed set of skills. This skill set is especially important when working with frail older adults in their home environment and starts from the first moment of contact – over the telephone or in person.

The first and most crucial step is envisioning frail older adults from a strength-based perspective rather than the traditional problem-oriented view point. Getting to know the patient as an individual is paramount! While the patients enrolled in care management are living with multiple co-morbid conditions, emphasis should be placed on potential rather than deficits or what the older adult is lacking. Every human being has a unique past filled with experience and gained knowledge. While aging brings many changes and chronic health concerns, focusing on well-being, education, facilitation, engagement, and application of supportive affirmation helps to build the working relationship which leads to optimal goal attainment and care plan adherence. Seeing the patient as a person, versus a disease, is a huge goal to work toward! Discovering what the older adult knows (existing competencies), their available resources, concerns they may have, and ability to problem-solve and learn new skills gives the HCP the information needed to create a solid collaborative foundation. Strengths can be used as care plan building blocks and older adults *can* change, learn, and grow – with appropriate information, resources and support. To determine strengths, think about asking some of the following questions or develop your own questions and share them with the rest of the team:

•What are your hopes, goals and dreams?

•What matters most to you in your life right now?

•Considering your life, what are you most proud of?

•What experiences do you want to have? Feel? See? Hear? Touch? Taste?

•What have you always wanted to do but have not yet accomplished?

•Are there any special moments or experiences you want to do/see in the future?

How do you want to be remembered?

Positivity, optimism, intentionality, and hospitality are a few of the professional characteristics the HCP can incorporate into their practice style. This style of interaction can lead to mutual trust and respect where health maintenance and healing begin to emerge. A strength based approach assumes that people and environments interact and change each other in the process (Hirst et al., 2011). Remembering that every human being has a name, a history, a past, a present, and a future – just like you do – helps give clear vision to the uniqueness of the individual and ways you might be able to help. Genuine

Continued on Page 5

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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

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MiCMRC/MiPCT Care Manager recorded webinars:

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

http://micmrc.org/programs/micmrc-mipct-complex-care-management-course/registration

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 http://micmrc.org/contact-us

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.

Protecting Adults: Are You Meeting the Standards for Adult Immunization Practice?

Jacklyn Chandler, M.S., Outreach Coordinator, MDHHS Division of Immunization

Making sure your adult patients are up-to-date on vaccines recommended by the Centers for Disease Control and Prevention (CDC) and the Michigan Department of Health and Human Services (MDHHS) gives them the best protection available from several serious diseases and related complications. The National Vaccine Advisory Committee (NVAC) recently revised and updated the Standards for Adult Immunization Practice to reflect the important role that **all** healthcare professionals play in ensuring adults are getting the vaccines they need.

These new standards were drafted by the National Adult Immunization and Influenza Summit (NAIIS) of over 200 partners, including medical associations, state and local health departments, pharmacists associations, federal agencies, and other immunization stakeholders[1]. What makes adult immunization a priority for leaders in medicine and public health?

Every year, tens of thousands of adult Americans suffer serious health problems, are hospitalized, and even die from diseases that could be prevented by vaccines[2]. These diseases include shingles, influenza, pneumococcal disease, hepatitis A, hepatitis B-related chronic liver disease and liver cancer, HPV-related cancers and genital warts, pertussis ("whooping cough"), tetanus and more. Adult vaccination rates are extremely low. For example, coverage rates for Tdap and zoster vaccination are less than 30% for adults who are recommended to receive them[3]. In Michigan, even high risk groups are not getting the vaccines they need – only 30.6% of adults younger than 65 years old who are high risk for complications from pneumococcal disease are vaccinated[4].

Make it clear to your patients that vaccination is important because it not only protects the person receiving the vaccine, but also helps prevent the spread of certain diseases, especially to those that are most vulnerable to serious complications, such as infants and young children, elderly, and those with weakened immune systems. Immunizing adults creates healthier communities and protects the places in which we live, work, and play.

Adults trust their healthcare provider to advise them about important preventive measures. Most health insurance plans provide coverage for recommended adult vaccines. Furthermore, research indicates that most patients are willing to get vaccinated if recommended by their provider[5, 6]. However, many patients report their healthcare providers are not talking with them about vaccines, missing critical opportunities to immunize[7].

MDHHS is calling on **all** healthcare professionals to make adult immunizations a standard of routine patient care in their practice by integrating four key steps[8]:

ASSESS immunization status of all your patients at every clinical encounter. This involves staying informed about the latest CDC recommendations for immunization of adults and implementing protocols to ensure that patients' vaccination needs are routinely reviewed.

Strongly RECOMMEND vaccines that patients need. Key components of this include tailoring the recommendation for the patient, explaining the benefits of vaccination and potential costs of getting the diseases they protect against, and addressing patient questions and concerns in clear and understandable language.

ADMINISTER needed vaccines or REFER your patients to a provider who can immunize them. It may not be possible to stock all vaccines in your office, so refer your patients to other known immunization providers in the area to ensure that they get the vaccines they need to protect their health. Coordinating a strong immunization referral network will reduce a substantial burden on your adult patients and your practice. If your adult patients do not have insurance, or if their insurance does not cover any of the cost of an immunization, check with your local health department to see if your patient qualifies for the following public vaccines: Td, Tdap, MMR, HPV9, PCV13, PPSV23, Hep A, Hep B or Zoster.

DOCUMENT vaccines received by your patients. Help your office, your patients, and your patients' other providers know which vaccines they have had by documenting in the Michigan Care Improvement Registry (MCIR). And for the vaccines you do not stock, follow up to confirm that patients received recommended vaccines.

Want to learn more? MDHHS hosts a continuing education opportunity entitled *Adult Immunization in Michigan: Using the Standards to Increase Coverage*. This presentation is offered in-person or via live webinar. For more information, please contact Jackie Chandler at ChandlerJ3@michigan.gov.

Informational brochures about immunization topics are available free of charge from MDHHS. A variety of materials is available, and can be ordered online at www.healthymichigan.com – click "Enter Site" and "Immunizations" to begin adding resources to your cart. In spring 2016, the "AIM Packet – Adult" was added: the contents focus on adults and include the immunization schedule, brochures, posters, and other educational flyers and resources for your practice.

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West Front Primary Care Utilizes Motivational Interviewing to Assist Patient with Weight Management

Submitted by CM Lauren Fine, West Front Primary Care

Mrs. X, a 58 year old female saw her Primary Care Provider (PCP) at West Front Primary Care in Traverse City Michigan, where she expressed interest in meeting with a nutritionist regarding weight management. The PCP discussed the patient's motivations and concerns for wanting to see a nutritionist and together they decided to first try working with the practice's embedded care managers. A referral was made to Lauren Fine, RN, CCM, who has been with the practice for one year as a MiPCT Care Manager. Outreach was made to the patient and a care management initial evaluation appointment was set. Prior to the initial evaluation appointment, Lauren met with the PCP and reviewed the patient's past medical history, medications and known history with weight loss efforts which included bariatric surgery. Her previous bariatric surgery experience initially resulted in weight loss, however she believed that the program did not teach her skills to maintain the weight and as a result her old habits came back, causing her to regain the lost weight.

During the initial evaluation the patient talked about her current physical limitations which have limited her ability to exercise. She also discussed how she has historically used her current health issues as an excuse to not move forward in healthier lifestyle choices. Those health issues included joint disease, fatigue related to Lyme's disease, fibromyalgia and sciatic nerve pain in her feet. In addition to these issues Mrs. X has controlled asthma and depression which is managed by her PCP. During the evaluation, the patient identified portion control, stress eating (over eating and unhealthy food choices) and cravings for sweets as barriers to losing weight. In further analyzing the patient's nutritional intake, Lauren and Mrs. X noted that there was a deficit in whole food intake of fruits and vegetables. Mrs. X self-identified the long term goals of losing 80lbs over the course of 2 years or 3lb/month. Working with the care manager the patient's short term goals were identified as:

1. Do stretches every day for at least 5 minutes for one week. (Establishing habits)

2. Review mindful eating (patient education handout) and utilize this theory at least daily, especially with snacking

3. Eat at least 2 whole fruits a day for one week

Five months into their work, Mrs. X continues to establish very reasonable goals and is able to accurately identify her barriers and plans to overcome them. She not only understands, but also values, that weight loss is related to lifestyle change. Mrs. X admits to feeling safe in sharing personal health information which has been key to the success of her efforts. The ability to be honest about her struggles and status without fear of judgment is unique and critical to her ability to continue for the long term. She still has occasions when her fatigue or chronic pain prohibits her from staying on track yet she finds a way to actively engage in her goals. For example, if Mrs. X is not able to use her recumbent bicycle, she finds another activity like "Workout to Go" which focuses on gentler stretches, flexibility and strengthening exercises. If she has a busy schedule that week, she uses cut-up vegetables and other healthy grab and go foods to help stay on track. Additionally, she has begun preplanning events and times when she must eat out, so that her efforts are not sabotaged. During those times when life takes over and she cannot be as controlled in her planning, she has gained the ability to look at the long term and self-evaluate rather than criticize herself. In the past, this negative self-thinking may have led to even greater relapses. One of the mottos that Lauren believes in and uses with patients is that "actions take us either towards our goals or away from our goals". She believes that, far too often, patients and caregivers phrase outcomes as either good or bad. Lauren states "When we take the time to reframe our thoughts in terms of goals, our motivation to change behavior is remarkably different".

Lauren advised that she was in contact with Mrs. X every week for the first few months, alternating between face to face and telephone outreach. This has tapered off to where they now meet once per month face to face, with a telephone call in between. In reflecting on her work with Mrs. X, Lauren felt that the most important tool she had was the Motivational Interviewing skills that are the basis for developing patient centric treatment plans. The frequency of touch points with the patient and the ability to listen to the patient's perspective helped her to assist the patient to reframe barriers into solutions. Mrs. X notes that in addition to the obvious successes of having lost 29.6 pounds to date, she is able to use less pain medication to treat her physical symptoms, has more energy, and fewer symptom flare-ups than before she started with care management. When she does have occasional symptom flare-ups, she seems to recover quicker and the symptoms are not as severe. Lauren also noted that because of the frequency of contact with the patient there have been at least 2 specific situations where other clinical problems (chest pain and urinary tract infection symptoms) were detected and managed more effectively thereby avoiding potential Emergency Department visits. Mrs. X now looks forward to the future and is committed to "enjoying the journey" as well as the results. She has found care management services very supportive and expresses much gratitude. "I am eating and shopping thoughtfully and this is now becoming a habit. You keep me on track and it makes a difference. I can't thank you enough."

Continued from Front page

interest in who the patient is as a unique human being can add value, worth, meaning and purpose to their existence – it can give them hope for their future. Helping the older adult to feel comfortable, safe, and secure in their environment can become a sustainable goal. Remember that your presence (therapeutic use of self) and support are essential in gaining sustained engagement and trust. It's not just *what* you do – it's *how* you make the person feel. Attentive listening and therapeutic silence are also strategies to convey respect for the older adult's story. Maintaining these individuals within their home environment is the primary intervention to promote quality of life, eliminate unnecessary care transitions, and decrease health care costs for individuals and healthcare systems.

So, what are some positive interventions you can utilize to engage your patients and their family members? The following are some basic strength-based communication strategies that are the cornerstone of mutual relationship building and engagement.

If you are going to be making a home visit, remember that you are a guest. Before you take off your coat or sit down, ask the older adult where they would like you to sit, where you can place your coat, etc.

Ask the individual how they would like to be addressed and then document the response so all team members can comply with the request.

You have a name and a role – always introduce yourself and your role; tell the individual who you are representing – their primary care provider. Use the physician's name – this courtesy establishes legitimacy for the contact.

If culturally appropriate, shake hands and make eye contact while you are introducing yourself.

Acknowledge and greet other individuals and pets in the home. Find out the names and relationships and document the information.

Remind the patient why you are there (or calling). Tying in all of the above bullet points sets the tone for the conversation or assessment.

Inform the patient approximately how long your stay will be at the very beginning of the visit (duration). Generally, 45 – 75 minutes is the maximum amount of time a frail older adult will be able to be engaged in one sitting. Timing depends on the number and types of co-morbid conditions and level of cognition. The HCP should formulate visits based on patient need first and map out how additional information can be collected over time.

- Explain what is going to happen in a verbal summary so the individual knows what to expect.
- Write down questions or information that you need to follow-up on after you end the visit. Remember no one knows everything; we don't have all the answers. You can offer to find out; ask someone - refer! But whatever you do, give enough of a timeline to the patient for an answer so you have time to research the information and have someone in the practice get back with them. Unkept promises can lead to patient disengagement.
- Mutually agree upon the plan of care or next steps. If the older adult does not buy in to your suggestions or treatment plan, no change will occur.

Sincerely thank the individual at the end of the visit or phone call for sharing their valuable time with you. Summarize what was accomplished, what needs to be done in the future, and the next time you will be contacting them. Be sure you document this information so you can maintain the timeline and keep the engagement rolling!

If you carefully think about your approach before your initial contact, this strategy can promote positive engagement. There is no right or wrong way to approach older adults and practice makes perfect! There is no recipe or cookbook formula that you can memorize and use on every patient! Everyone's time is valuable so preparation, knowing some strength-based information about the patient and their health history prior to any contact will help promote your attempt to gain access to the frail older adult. Utilizing the physician's name with every contact plants the seed of familiarity in the person's mind and may lead to gaining appointment time. Being the best you can be – mentally, physically, and spiritually – will help in you being motivated, positive, optimistic and engaged. As a member of the care management team – you are an invaluable resource! Thank you for what you do!

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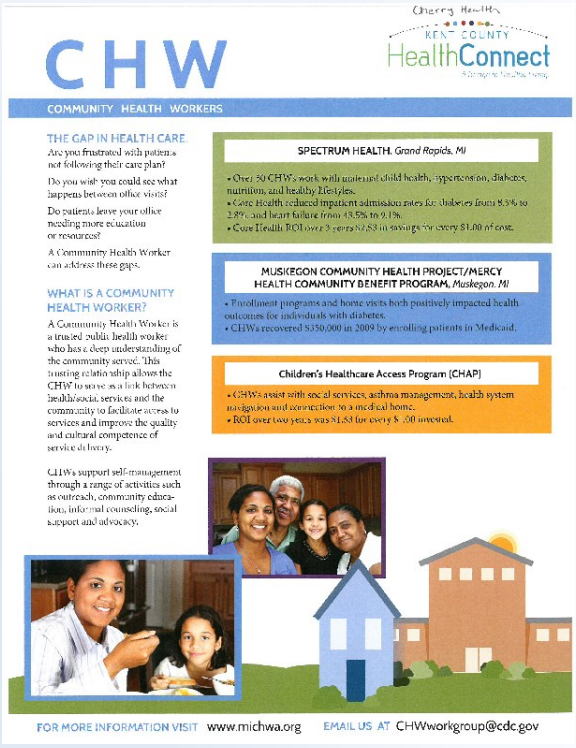
Best Practice Spotlight

Highlighting Best Practices Across the State

Cherry Health Westside Ensures that Reviewing and Improving Quality Care is a Priority

Situation: Cherry Health Westside recognizes the importance of integrating HEDIS measures into patient care.

Strategy: Each Morning the Cherry Health Westside practice starts their day with a team huddle. Per Nancy Pagan, Westside site manager, "I see the staff hurrying to make huddle each day because of the value it provides to the team and the patients." The huddles purpose: to coordinate care and share knowledge to ensure patient satisfaction and outcomes. The huddle consists of the Primary Care Physician Dr. Perez; the RN Care Managers Colleen McGuire and Lexie Bryce; as well as the Medical Assistant working with the physician that day; as well as the lead MA Gabriella Medina. The huddle also includes a Community Health Worker (CHW) Maria Sanchez; as well as Joanne Rapp the Front Desk Supervisor. During this time Dr. Perez and the team utilizes the **day before appointment chart prep**, to review gaps in care that will need to be addressed with the upcoming patients during their visit. This chart prep covers the eleven steps the MA completes the day before the appointment to ensure care needs are being met.



During the patient visit, the team utilizes workflows specific to the patients' chronic condition, (**hypertension** and **diabetes**) with swim lanes. Each lane is designated by the team member role: provider, MA, CHW, CM and their corresponding responsibilities in the delivery of patient care. The workflow also identifies referrals needed either internally, i.e. diabetic educator, externally to community resources. Most recently a new addition to the team was made by way of a Community Health Worker. The CHW has a deep understanding of the community and available resources. Being a part of the community the CHW has the ability to visit patients in their homes, help them access needed community resources and help support their self-management goals. The practice has been advertising this new team member by way of a **community health worker flyer**.

Dr. Perez has seen the success of team-based care in the practice. Dr. Perez states that he did not learn about team-based care during his residency, but here in the practice. He went on to say, "Without the care team approach, we would not be achieving our outcomes. We learn together and build trust in team and with the patients. We work on closing gaps in care. Our results show A1C now in control, decreased use of the ED, increased physician visits for chronic condition control, and increased time with the physician. The Care Manager has helped by having patients call her when they feel sick or have issues, or have a gap in understanding how to manage medication. Now they bring meds to appointments, and have their advance directive documents completed."

For more information regarding the information in this article please contact Lexi Bryce @ AlexandriaBryce@cherryhealth.com