MiCMRC Self Study Module

Care Management in the Patient Centered Medical Home

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Objectives

- Describe the goals of care management
- Identify elements of a successful care management programs
- Recognize the care manager functions and 5 step process

What is a Care Management Program?

"Care management programs apply systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively."

reference: http://www.chcs.org/media/Care_Management_Framework.pdf

Goals of Care Management Programs

- Achieve optimal level of wellness for patients
- Improve coordination of care
- Minimize fragmentation of care
- Provide cost effective, non-duplication services

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Elements of Successful Care Management Models

- Close collaboration between care manager and Primary Care Physician (PCP)
- High level of "in-person" contact between care manager and patient
- Close attention to transitions of care
  - "Handoffs" are where many errors occur
  - Need timely information on hospital/SNF discharges
- Medication reconciliation is regularly performed
  - Need access to patient record/EHR
  - Assess adherence to medication regimens
- Target patients at high risk for hospitalization or ED use

http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/aug/1764_hong_caring_for_high_need_high_cost_patients_ccm_ib.pdf

Elements of an Effective Care Management Model

- CCM programs must be tailored to their particular context.
  - Contextual factors include practice size, location in an urban or rural area, and program sponsorship and governance.
- In selecting patients, CCM programs aim to identify individuals who are at the highest risk for poor outcomes and who would benefit from the planned care management interventions.
  - This requires alignment between selected populations, interventions, and desired outcomes, and a combined quantitative and qualitative approach appears to work best.
- The composition of the CCM team must be tailored to the target population and constructed to effectively deliver the desired outcomes.

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http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/aug/1764_hong_caring_for_high_need_high_cost_patients_ccm_ib.pdf

Elements of an Effective Care Management Model

- The needs of the patients being served and the CCM team composition determine the appropriate caseload as well as the frequency and location of interactions.
  - Caseloads for the primary care manager or CCM team unit ranged from 25 to 500 patients
  - Care managers typically interact with their patients weekly to monthly, although crisis can drive daily interactions.
- The key task for the CCM team is to build trusting relationships with patients/families as well as with primary care providers and their staff.

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http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/aug/1764_hong_caring_for_high_need_high_cost_patients_ccm_ib.pdf

Elements of an Effective Care Management Model

- CCM teams must ensure all providers share information, secure smooth referrals, and help patients find needed resources in health systems and in communities.
  - Medication reconciliation, Action plans, TOC, End of life services

http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/aug/1764_hong_caring_for_high_need_high_cost_patients_ccm_ib.pdf

Essential Activities of Care Management Models

- Identifying and engaging patients who are at high risk for poor outcomes and unnecessary utilization.
- Performing comprehensive health assessments to identify problems that, if addressed through effective interventions, will improve care and reduce the need for expensive services.
- Working closely with patients and their caregivers as well primary care, specialty, behavioral health, and social service providers.
- Rapidly and effectively responding to changes in patients' conditions to avoid use of unnecessary services, particularly emergency department visits or hospitalizations.

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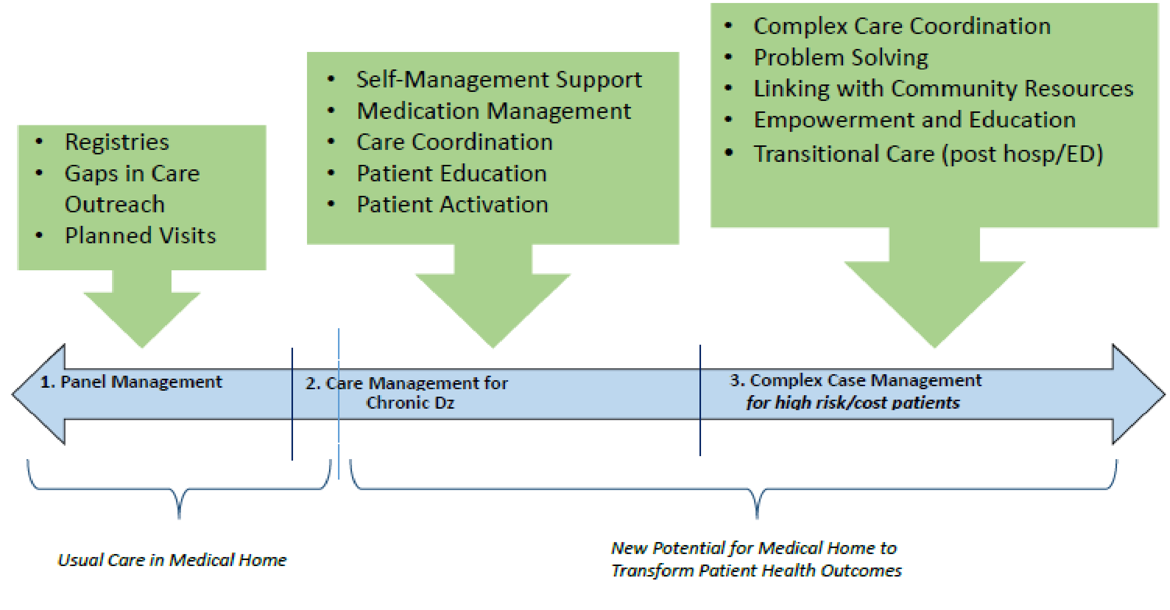
http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/aug/1764_hong_caring_for_high_need_high_cost_patients_ccm_ib.pdf

Care Management Continuum:



Care Management Delivery
Team Based Care

In Michigan there are several demonstration programs which include team based care and care management

Examples of Programs in Michigan currently:

- BCBSM Provider Delivered Care Management
- Priority Health Care Management
- Michigan State Innovation Model
- Comprehensive Care Management Plus
- High Intensity Care Management

Each program specifies the licensure types to fill the role of the Care Manager

Care Management Process

"A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocating for options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes. "

Care Management Society of America definition of care management

Case Management Society of America Guiding Principles

Care Management Principles

- Patient-centric, collaborative partnership approach
- Facilitates self-determination and self-care
- Comprehensive, holistic approach
- Practices cultural competence
- Use of evidence-based care
- Promotes optimal patient safety
- Promotes integration of behavioral change science and principles
- Links with community resources
- Assists with navigating the health care system

Care Manager Functions

- Partners with primary care practice leadership to integrate care management into the practice
- Assists with patient transitions of care between settings
- Performs comprehensive assessment, assessing healthcare, educational, and psychosocial needs of patient/family
- Creates, maintains and follows up on individualized plan of care
- Develops a longitudinal relationship
- Provides self management support, empowering patient/family to manage chronic conditions
- Provides patient family education, including teach back
- Implements evidence based care, close gaps in care, addresses prevention and health promotion
- Assists with advanced care planning

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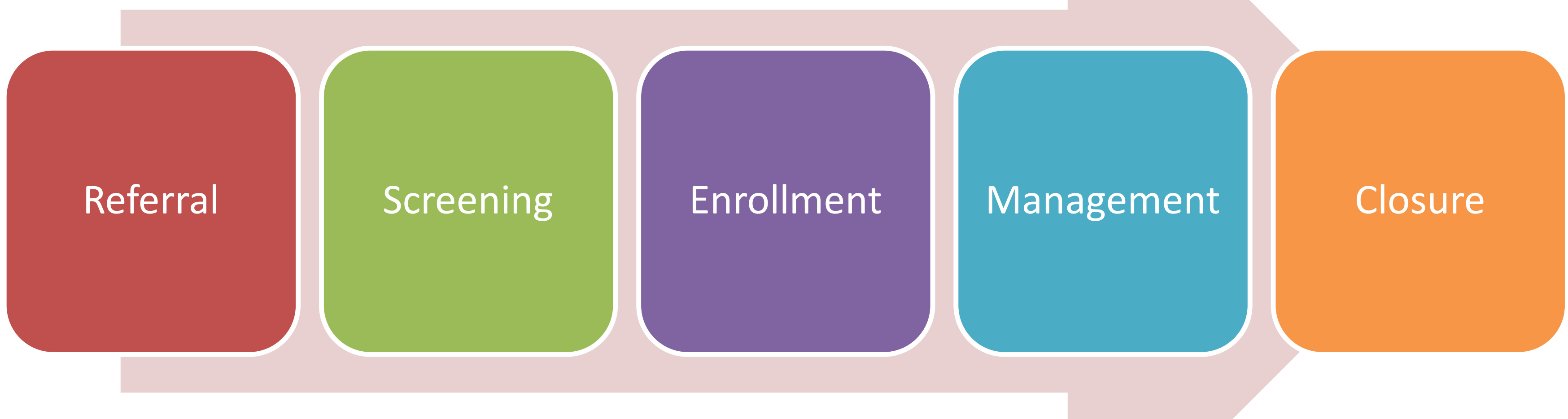
Care Manager – Evidence Based Interventions

- Relationship-based communication
- Transitions of care across settings
- Behavior change, motivational interviewing, brief action planning
- Self-management
- Chronic Disease Management, protocols, & health promotion

Care Management Process

Five Steps:



Referral

- Physician input
- Transition of Care
- Gaps in Care – uncontrolled chronic condition(s)
- Targeted chronic conditions

Screening

- Review the medical record
  - Chronic conditions
  - Psychosocial
- Utilization
  - Emergency room visits
  - Hospital admissions
  - Underutilization
- Claims data
- Condition specific
  - CHF
  - COPD
  - Children with complex needs

Enrollment / Patient Engagement

- Obtain patient consent
- Complete initial comprehensive assessment

- Lessons Learned
  - PCP in person introduction of the care manager to patient/caregiver
  - Helpful tools include*
    - Flyer physician may use to explain the care management program
    - Care Manager phone script

*Note access tools here: http://micmrc.org/care-management-101/step-1-care-management-introduction

Management - **Interventions**

- Establish an individualized care plan and identify goals
  - Identify any critical care plan needs and initiate action
  - Set short and long term goals
- Make sure patients/care givers are a part of the plan of care
- Reinforce patient self-care and self-management
- Establish on going follow up
  - monitor /adjust care plan

Case Closure

Examples to consider for case closure:

- Improved ability to self manage
- Transfer to hospice care
- Disenrollment - patient no longer interested in participating in care management

➢ An important step - Collaboration and Communication
Discuss with PCP prior to closing case

Building & Managing a Patient Case Load

- Design Workflow and Processes to address:
  - Admission Discharge Transfer alerts (ADTs)
  - Referrals to the care manager from PCP and office team members aware of criteria for patients who may benefit from care management
- Multidisciplinary team in the physician office
  - Ability to view the care managers patient schedule
  - Ability to view the individualized patient care plan
    - identify, review and update patient goals
- Tracking and Monitoring - Data Reports
  - Billing the care manager visits
  - Quality metrics – ex.
  - Care manager activity process metrics

The Right Care Manager/Patient Ratio?

- Will evolve over time
- Will vary based on your patient population and acuity
- Based on the needs of your population's top chronic conditions

A common complex care programs ratio

- One care manager per 200 commercial patients
- One care manager per 50-60 highest-acuity patients

California Quality Collaborative Complex Care Management Toolkit, http://www.calquality.org/resources/toolkits

Michigan Care Management Resource Center Website micmrc.org

Care Management 101 is a web based self study opportunity

- a suggested road map of staged content for the new Care Manager
- may be utilized to create customized curriculum for self-study based on the CM's self-assessment
  - Care managers may identify their areas of strengths and gaps
  - Review CM 101 content to select recorded webinars, tools, resources

Access Care Management 101: www.micmrc.org

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Michigan Care Management Resource Center

Search...

Home | Programs MiCMRC Supports | Care Management 101 | Topics | Resources | Webinars | Best Practices

Programs MiCMRC Supports

MiCMRC provides training and support for the following statewide Care Management initiatives:

Continuing Education

Select MiCMRC activities offer the opportunity to obtain free CE credits in Nursing or Social Work suitable for Michigan professional licensing requirements. Click here for more information regarding CE webinars...

MiCMRC/MiPCT Complex Care Management Course

The MiCMRC/MiPCT Complex Care Management course is designed to prepare the healthcare professional for the role of Complex Care Manager. Course Content is applicable to all care managers in the ambulatory care setting working with complex patients.

Best Practices

MiCMRC spotlights the innovative care management strategies, techniques and tools being developed by practices throughout Michigan. Read more...

Share Your Success Story

MiCMRC wants to hear about and share success stories in care management, team-based care and high intensity care management (HICM). Click here to share yours...

Upcoming Webinars

MiCMRC/MiPCT Educational Webinar

Wednesday, June 22, 2016 - 2:00pm — BEHAVIORAL HEALTH

Nonpharmacological Approaches for Depression

Presented by Linda Keilman, DNP, GNP-BC

For information regarding CE credits Click Here

Webinar Registration

MiCMRC/MiPCT Educational Webinar

Wednesday, July 13, 2016 - 2:00pm — PAIN MANAGEMENT

Nonpharmacological Approaches for Pain Management

Presented by Linda Keilman, DNP, GNP-BC

For information regarding CE credits Click Here.

Webinar Registration

Access your specific program information

View CE approved Webinars

Share your success as a care manager and practice team

View best practice stories and tools

View multiple webinars on various clinical topics

Michigan Care Management Resource Center Website micmrc.org

Topics for Care Managers Include:

- Advance Care Planning
- Palliative Care
- Pediatrics
- Medication Management
- Transitions of Care
- Patient Centered Medical Home & Team Based Care
- Chronic Conditions
- Quality and Population Health Management
- Elderly Population
- Behavioral Health

Thank You!

- Questions?
  - micmrc-requests@med.umich.edu