Care Management Connection

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Care Management Success Story
Mercy Health Physician Partner

Submitted by:
Jessica Neuman RN, CM

Jessica has been working as a care manager with Mercy Health Physician Partners for two and a half years. She received a new referral and met with Mr. and Mrs. Jones. At the time of the referral Mr. Jones had a history of COPD, HF, PVD, chronic pain and tobacco use. Mr. Jones had been visiting the ED at least every other week due to exacerbations and other medical needs. At the time of the care management referral Mr. Jones met criteria for hospice services but he was not ready. It was also known that Mr. Jones was not adherent to his medication regimen. Mrs. Jones had a history of cognitive impairment, PVD and stage four kidney disease and was burdened by the care of her spouse. Self-management goals included Mr. Jones taking his medication as prescribed and to contact the office prior to seeking treatment in the ED.

The care manager met with the care team which included Mr. Jones's PCP, nurse practitioner, and medical assistants. Mr. and Mrs. Jones were known by the members of the care team. During the team meeting the patient's goals were discussed along with the plan of care. Mr. Jones's plan of care focused on controlling symptoms, decreasing ED utilization, and finding support for his wife. Jessica initially set up a safety and needs assessment in the home and found that there were in fact many needs at home as well as limited family support. The care manager worked behind the scenes to ensure the couple's needs were met by connecting them with community resources, which included Senior Resources, Meal on Wheels, and Let's Stay Home programs.

A few months later, Mr. Jones was hospitalized for an exacerbation of his COPD. During this hospitalization hospice care was discussed and he did accept initiating hospice care. Jessica coordinated with the inpatient case management team to initiate a hospice consult. Mr. Jones was in agreement and he was discharged to home with hospice care.

Mr. Jones continued on hospice for over a year. During that time Mr. Jones stayed out of the hospital and remained at home with his spouse and family. Shortly thereafter Mrs. Jones' health started to decline. She was no longer able to care for herself. Jessica coordinated care with Senior Resources to help get Medicaid in place and assistance in the home for Mrs. Jones.

Jessica continued to work with Mrs. Jones and her family. Together they explored long-term care options for Mrs. Jones. With the help of Jessica and the PCP team they were able to advocate for Mrs. Jones and she was placed in a long-term care facility where she would receive the care she needed. The work completed by Jessica in helping the patient and family navigate the vast health care system resulted in safe transitions for both Mr. and Mrs. Jones. Jessica's strength as a nurse and care manager enabled her to partner with internal team members and community organizations to address the needs of her patients. As a result, there was a reduction in cost related to reduced ED visits and hospitalizations, improved communication and a positive patient experience. Coordination of care is crucial as we strive to improve the health of our patients and communities.

Interested in reading additional success stories? **Click Here**. Be a part of our growing community by sharing your success story **Click Here**

UPCOMING EVENTS

VIEW OUR UPCOMING COURSES

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

December 10-13, 2018, Lansing

January 14-17, 2019, Dimondale

MiCMRC CARE MANAGEMENT EDUCATIONAL WEBINARS

Title: Conversations for Michigan Physician Orders for Scope of Treatment (MI-POST)
Date and Time: Wednesday, October 31st 2-3 pm
Presenter: Kate LeBeau, RN Advance Care Planning Program Manager, Upper Peninsula Health Plan
Register **HERE**

Title: Depression and Primary Care
Date and Time: Wednesday, December 12th 2-3 pm
Presenter: Sarah Fraley, LMSW, MiCMRC Project Manager
Register **HERE**

Nursing, Social Work, and CCMC continuing education opportunities. 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

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 10-13 | Lansing | **REGISTER HERE** | Registration deadline: December 6, 2018
January 14-17 | Dimondale | **REGISTER HERE** | Registration deadline: January 10, 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**

MiCMRC 2018 CARE MANAGEMENT EDUCATIONAL WEBINARS

Title: Conversations for Michigan Physician Orders for Scope of Treatment (MI-POST)
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Presenter: Kate LeBeau, RN
Advance Care Planning Program Manager, Upper Peninsula Health Plan

"This continuing nursing education activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91)"

"Michigan Care Management Resource Center is an approved provider with the Michigan Social Work Continuing Education Collaborative". Approved Provider Number: MICEC 110216

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for 1 CE contact hour(s). Activity code: I00032995 Approval Number: 180002679
To claim these CEs, log into your CCMC Dashboard at **www.ccmcertification.org**
Register **HERE**

Title: Depression and Primary Care
Date and Time: Wednesday, December 12th 2-3 pm
Presenter: Sarah Fraley, LMSW
MiCMRC Project Manager
Register **HERE**

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

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.**

Both of these documents can also be accessed on the MiCMRC website home page **http://micmrc.org/**

Michigan Physician Orders for Scope of Treatment (MI-POST) - Educational Opportunities

According to www.acpmich.org website, "Public Act 154 was signed by Michigan's Governor in November 2017. This law establishes the use of Physician Orders for Scope of Treatment in Michigan."

MI-POST

A medical order designed to improve end-of-life care by converting patients' treatment decisions into medical orders that are transferable throughout the healthcare system.

- Is a standard of care for communicating the scope of treatment decisions
- For frail elders or others whose death in the next 12 months would not be surprising.
- Is always voluntary
- Form follows the patient

MI-POST Goals:

- To create a specific written plan to document medical treatment decisions and ensure they are honored by healthcare providers throughout the continuum of care.
- Discussions are focused on assisting the individual, or the designated Patient Representative, in making the following healthcare decisions:
  - CPR
  - goals of care for cardiopulmonary failure, including hospitalization
  - artificial nutrition and hydration
  - comfort care options
  - other types of treatment desired

MI-POST and Advance Directives:

MI-POST and Advance Directives serve different purposes. According to the newly established law, an appropriately executed MI-POST form, as a medical order, stands over the hypothetical advance directive document when it comes to medical treatment decisions. The purpose of an advance directive is to:

- Name a Patient Advocate, to communicate the individual's treatment decisions in the event he/she cannot. This is the legal portion of the document, called the Designation of Patient Advocate form.
- Communicate to the Patient Advocate wishes for future healthcare and other related wishes, in a non-legally binding portion referred to as a living will portion.
- An activated Patient Advocate, as a legal decision-maker, can communicate medical decisions that result in the completion of a MI-POST or changes to an existing MI-POST.

The Michigan Department of Health and Human Services is currently working with an advisory committee to finalize the MI-POST form and recommended rules to its use. The form is not yet readily available across the state.

Resources to learn about MI-POST:

The Michigan Care Management Resource Center (MiCMRC) hosted an educational webinar on June 13, 2018 titled "Michigan Physicians for Order Scope of Treatment (MI-POST) 101". To view the recorded webinar, click here: http://micmrc.org/webinars

Upcoming Webinar: "Conversations for MI-POST", October 31, 2018 2pm-3pm

Presenter: Kate LeBeau, RN, Advance Care Planning Program Manager, Upper Peninsula Health Plan

Registration: http://micmrc.org/webinars

For further information on MI-POST refer to www.acpmich.org

Provider Delivered Care Management (PDCM)
Blue Distinction Total Care (BDTC)
High Intensity Care Model (HICM)

Monthly Billing Q & A Sessions

On a monthly basis, Blue Cross Blue Shield of Michigan will conduct a question and answer session via WebEx relating to questions you may have after you've completed the online Billing/Coding course regarding these programs. They are scheduled for the first Thursday of each month from 12:00 – 1:00 for 2018. Below is the 2018 scheduled question and answer sessions.
Please do not ask specific questions about claims. If you have an issue, you should contact your provider consultant for assistance or you can submit an inquiry to valuepartnerships@bcbsm.com. For additional billing resources visit http://micmrc.org/training/care-management-billing-resources

Below are the dates and WebEx information to join the conference call.

Barbara Brady invites you to an online meeting using WebEx.

To join this meeting (Now from mobile devices!)
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1. Go to https://bcbsm.webex.com/bcbsm/j.php?MTID=m4b96f6a21bf31261e0162488e206e731
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: 735 921 157

To join this meeting from bcbsm.webex.com

Meeting Number: 735 921 157
Meeting Password: pgip
https://www.webex.com

November 1st
December 6th