



# MICMT Complex Care Management Course – Self Study Module

## Care Management in the Patient Centered Medical Home

# Learning Objectives

- Describe care manager functions
- Explain common goals of a care management program



# Key Points

- Introduction to care management programs that build on PCMH
  - Care management program goals
- How to be a successful care manager
- Introduction to the care manager functions and building a case load



# INTRODUCTION TO CARE MANAGEMENT PROGRAMS



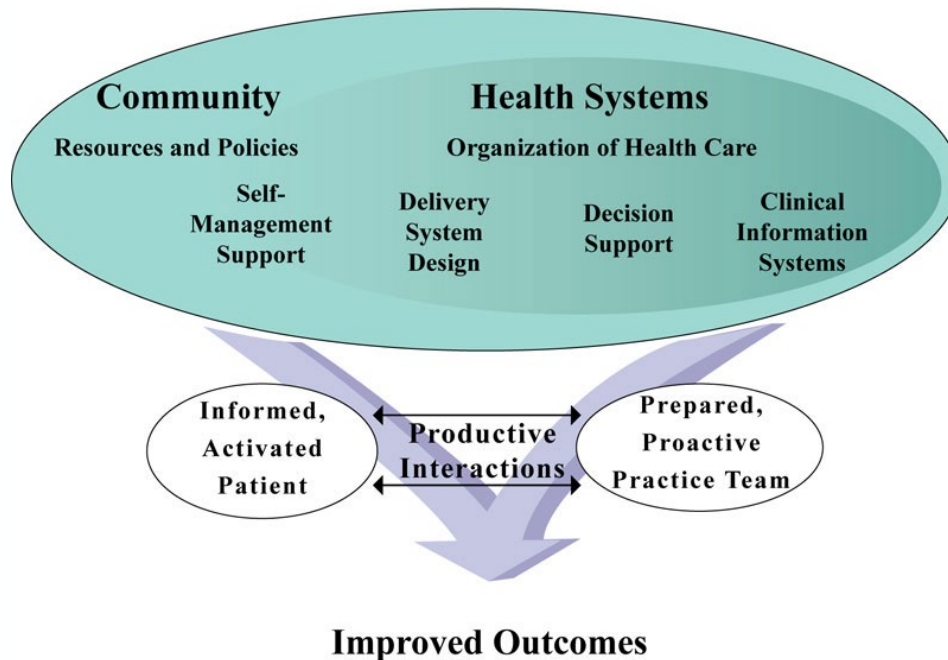
# Care Management as “Advanced PCMH”

- Primary care offices in Michigan have been working on PCMH since the early 2000s.
- Developing capabilities of ***team-based care*** or ***care management*** takes the PCMH model to the next level.



# PCMH Foundation = the Chronic Care Model

The Chronic Care Model



Developed by The MacColl Institute  
© ACP-ASIM Journals and Books

- Care managers enhance the ability of PCP team to be **prepared and proactive**
- Care Managers support the patient to be **informed and activated**
- Care managers coordinate ***across locations of care***, within the community and within health care sites.



# Michigan Care Management (CM) Programs

In Michigan there are several incentive programs that support team based care and care management:

- [BCBSM Provider Delivered Care Management \(PDCM\)](#); [High Intensity Care Model \(HICM\)](#)
- [Priority Health Care Management](#)
- [Michigan State Innovation Model](#) (SIM)
- [Comprehensive Primary Care Plus](#) (CPC+)



# Aligned Program Goals

- While the details of each program vary, they have significant commonality:
  1. Each program has an outreach target
  2. Each program has outcomes goals:
    - **A1c, BP, ED Utilization, and In Patient Utilization**





In which programs  
does your practice  
participate?

What are your  
specific outreach  
goals for each  
payer program?

Which outcomes  
are most important  
to your office and  
Physician  
Organization?



# HOW TO BE A SUCCESSFUL CARE MANAGER



# Care Manager Role

- Philosophic shift from traditional role of a clinician to patient advocate

<https://www.youtube.com/watch?v=0z65EppMfHk>



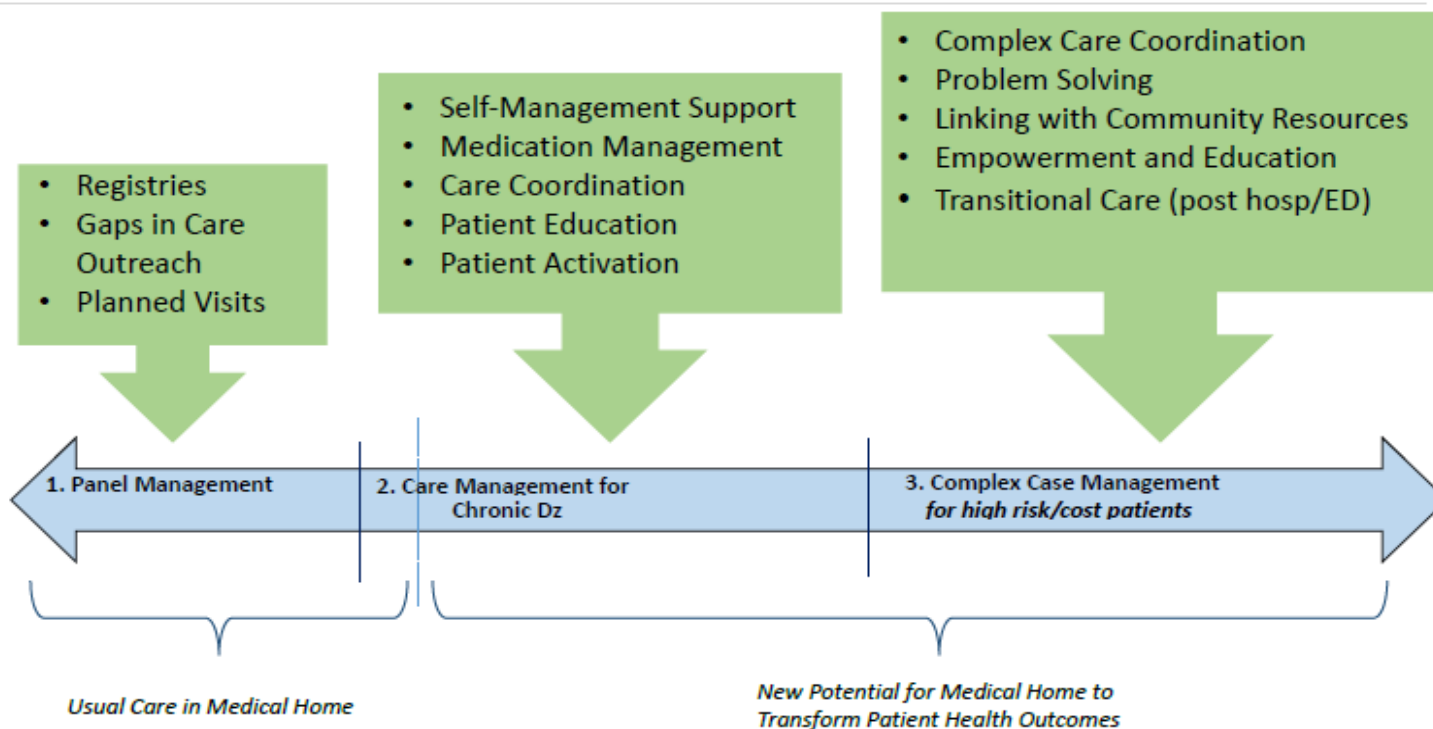
# Care Management Key Elements

- 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
- Pick the right population of patients
  - Target patients at high risk for hospitalization or ED use
  - Target patients in the disease of focus for your office.
  - Make sure your selected population will help improve the quality and utilization metrics selected at your office.



# Care Management Continuum:

## Primary Care Population Health Strategies



*Adapted from: Ramsey, Rebecca (2011). Implementing Effective Clinical Care Management; Building Care Management Capacity within a Transforming*



# 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





# 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

# 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



# Michigan Care Management Resource Center Website

[micmrc.org](http://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](http://www.micmrc.org)





Available Now

## BCBSM 2019 PDCM Online Billing Course

Visit the [Care Management Billing Resources](#) page to view the new webinar. A Certificate of Completion is available after viewing.

### Programs MiCMRC Supports

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

[BCBSM Provider-Delivered Care Management](#)

[BCBSM PDCM-Specialists](#)

[SIM - PCMH Initiative](#)

[Comprehensive Primary Care Plus \(CPC+\)](#)

[High Intensity Care Model](#)

### 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 activities...](#)

### MiCMRC Complex Care Management Course

The MiCMRC Complex Care Management course is designed to prepare the healthcare professional for the role of Complex Care Manager. [Read More](#)

### MiCMRC Approved Self-Management Support Courses and Resources

For a detailed summary of MiCMRC approved Self-Management Support Courses [click to view or download the PDF file](#)

### Care Management Connection Newsletter

Keep up with the latest care management news from MiCMRC. [Click for the latest or past issues ...](#)

### Care Management Billing Resources

MiCMRC maintains this handy page with links to billing resources for specific care management programs. [Click to view...](#)

### Contact MiCMRC

Submit questions, website feedback, resource suggestions and more. [Click here to get started...](#)

### Upcoming Webinars

#### SIM PCMH Initiative Peds Office Hours

**Tuesday, April 23, 2019 - 11:00am**

WEBINAR

PEDIATRICS

#### ADHD Medication Education

Presented by  
Tiffany Munzer, MD

Fellow in Developmental Behavioral Pediatrics

University of Michigan

[Webinar Registration](#)

#### SIM PCMH Initiative Peds Office Hours

**Wednesday, June 26, 2019 - 2:00pm**

Presented by  
Tisa Vorce, MA, RRT

Michigan Department of Health and Human Services

Asthma Program

[Webinar Registration](#)



# 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](mailto:micmrc-requests@med.umich.edu)

