



Michigan Institute for Care Management & Transformation

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

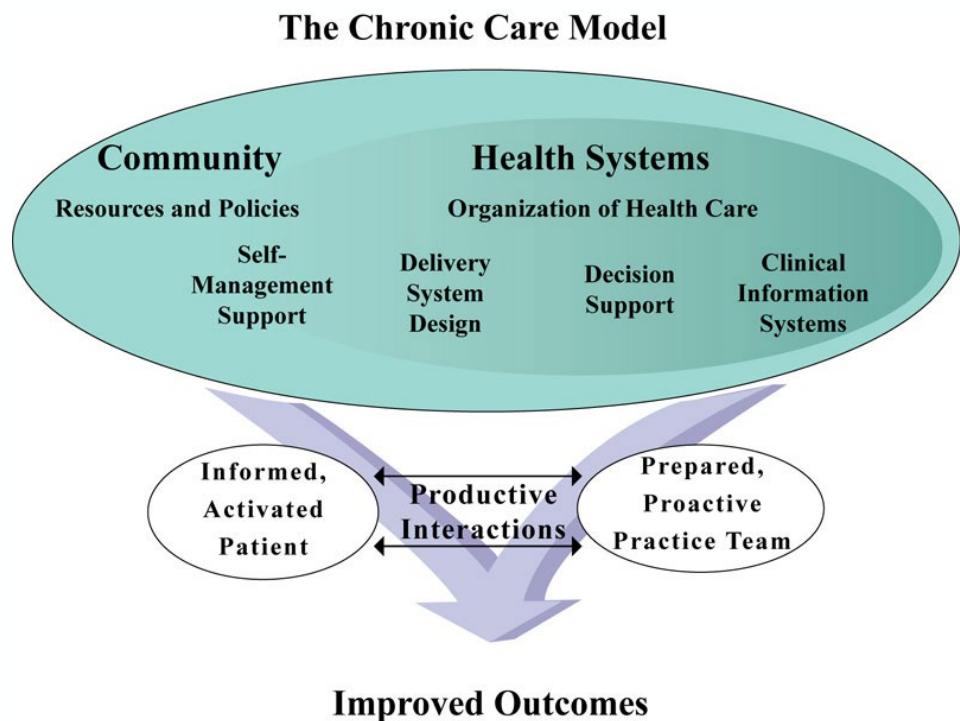


Care Management as “Advanced PCMH”

- 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



- 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.

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



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>



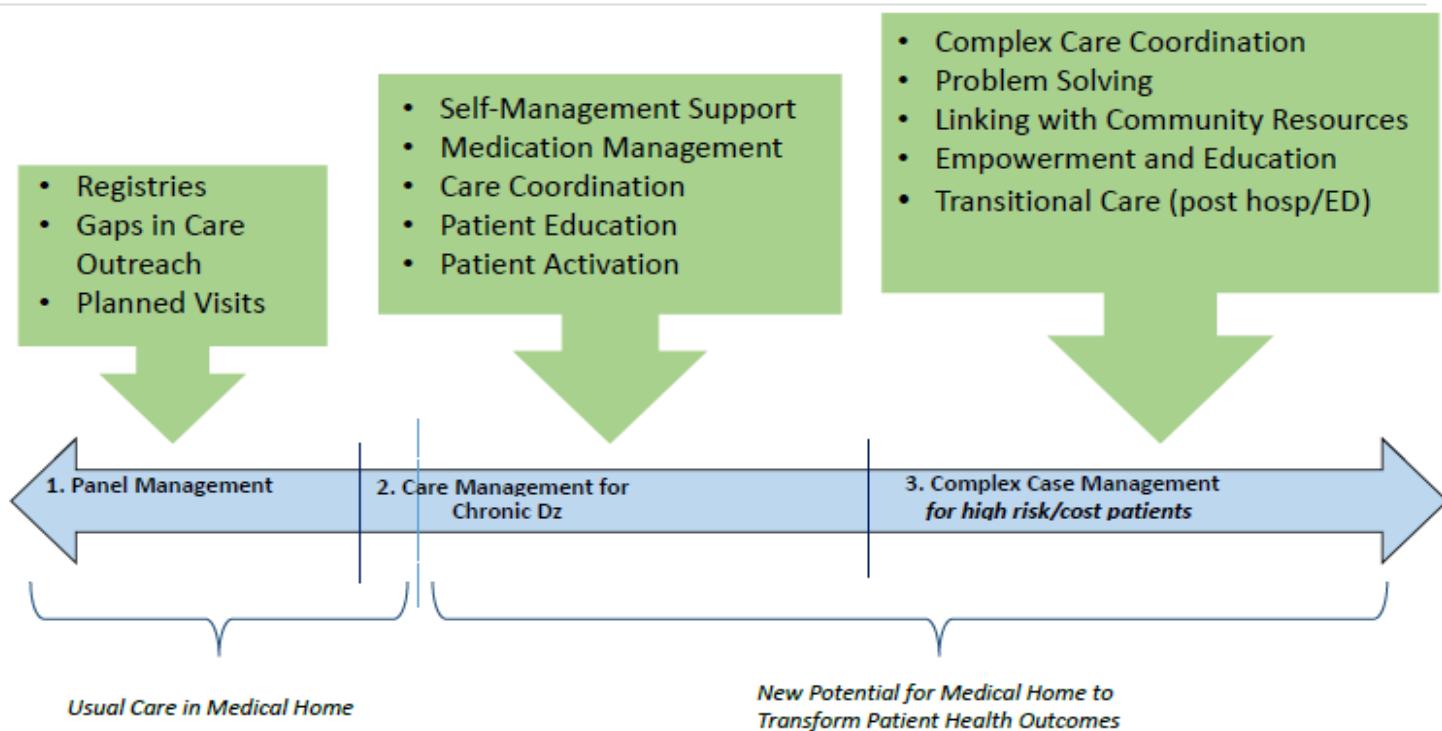
Care Management Key Elements

- 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

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





Available Now

BCBSM 2019 PDCM Online Billing Course

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...](#)

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

Upcoming Webinars

SIM PCMH Initiative Peds Office Hours

Tuesday, April 23, 2019 -

WEBINAR

11:00am

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

Pediatric Asthma

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



The screenshot shows the homepage of the Michigan Care Management Resource Center (MiCMRC). The header features the MiCMRC logo with a stylized map of Michigan and the text "Michigan Care Management Resource Center". A search bar is located in the top right corner. The main navigation menu includes Home, MiCMRC Courses, Care Management 101, Topics, and Resources. A sidebar on the left is titled "TOPICS" and lists various topics with corresponding images: Advance Care Planning (Durable Power of Attorney for Health Care Decisions), Palliative Care (two people in a medical setting), Pediatrics (two children painting), Medication Management (a hand holding a prescription bottle), Transitions of Care (a hand holding a prescription bottle), and Patient Centered Medical Home and Team-Based Care (a group of healthcare professionals).



Thank You!

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

