



Cornerstones for Developing a Care Manager Orientation

STATE INNOVATION MODEL PATIENT CENTERED MEDICAL HOME
INITIATIVE OFFICE HOURS

6.20.18



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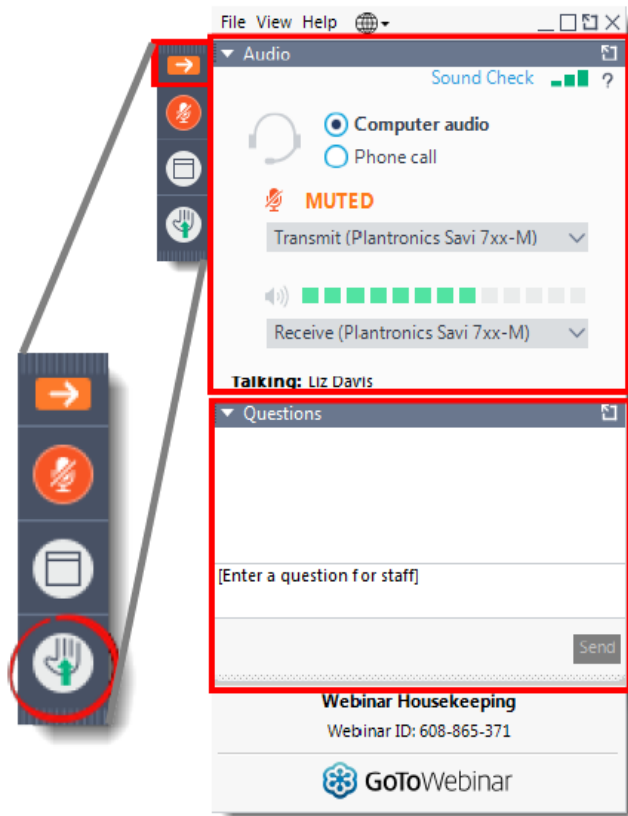
Judy Avie – Project Manager, MiCMRC

Objectives

- Describe the 3 Cornerstones of a Care Manager (CM) orientation
- Identify Michigan Data Collaboration resources
- Identify resources for Care Manager orientation

Housekeeping:

Webinar Toolbar Features



Your Participation

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Note: If time allows, we will unmute participants to ask questions verbally.

- Please raise your hand to be unmuted for verbal questions.

NOTE:

In the event that there is not time to answer questions live, all questions submitted via the Question Function of the GoToWebinar toolbar will be recorded, an FAQ generated and posted to our webpage



Questions for Participants

What are your ***key challenges*** in providing Care Manager orientation?

What are your ***key learnings*** in providing Care Manager orientation?

Definition of Care Management

“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, and mental health conditions more effectively.”

“Care Management Definition and Framework.” Center for Health Care Strategies, 2007 ([www.chcs.org/usf_doc/Care Management Framework. pdf](http://www.chcs.org/usf_doc/Care_Management_Framework.pdf)).

The Care Manager Position

Consider the Care Manager position in an ambulatory care environment.

- What are the *skills and experience* of the newly hired Care Manager?
- What *knowledge and skills are needed* to be successful in the Care Manager role?



Interview – Setting the Expectation

The importance of describing the Care Manager role extensively

- Describe care manager orientation
- Care Manager: Identify performance expectations for the care manager; care manager responsibilities, productivity, tracking and monitoring codes
- Primary care practice: quality and utilization metrics, SIM PCMH Initiative

Orientation vs. Onboarding

Orientation – more administrative in nature and typically involves the completion of new hire paperwork, enrolling in benefit plans and learning the mission, values and vision of the organization.

Onboarding – long term focus aimed at identifying training needs, setting performance goals, providing on-going feedback, and ensuring the new employee is a positive addition to your team

➤ When used together, orientation and onboarding help establish organizational commitment, clarity of job tasks, and job satisfaction.

Sims, Gloria(2018). Orientation vs Onboarding, The Insperity Guide to Employee Engagement, Issue 1

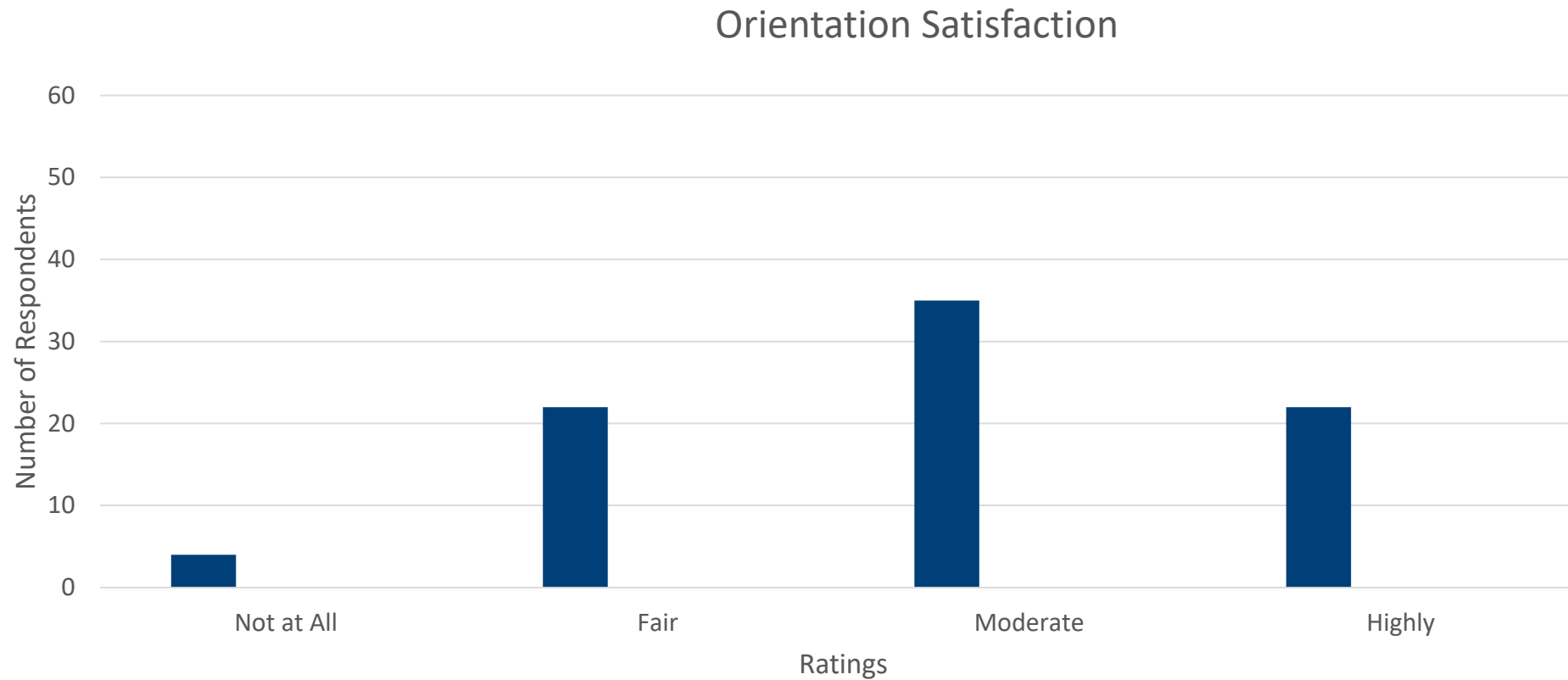
What are the benefits of an effective orientation and onboarding process?

1. Reduces start up costs, helping employees get up to speed more quickly
2. Helps to reduce employee anxiety
3. Improves employee retention
4. Saves time of supervisor
5. Develops realistic job expectations
6. Improves employee satisfaction

IMPORTANT

Sims, Gloria(2018). Orientation vs Onboarding, The Insperity Guide to Employee Engagement, Issue 1

The Results of MiCMRC Complex Care Management Course Poll



Care Management Orientation: SIM PO and Practice Leaders Key Learnings

- Coaching, networking and mentoring
 - CM peer group meetings
 - One to one meetings frequently with CM and preceptor/supervisor
- Shadowing
- Identifying care management patient enrollment criteria
 - “practice staff, providers, and CM all on the same page”
- Sharing care management metrics and data

Care Management Strategies for the Practice

Farrell T, Tomoaia-Cotisel A, Scammon D, Day J, Day R, Magill M. Care Management : Implications for Medical Practice, Health Policy, and Health Services Research. AHRQ Publication. Rockville, MD. February 2015.

Identify Populations with Modifiable Risks	Align CM Services to the Needs of the Population	Identify and Train Personnel Appropriate to the Needed CM Services
<ul style="list-style-type: none">• Use Multiple metrics to identify patients with modifiable risks	Tailor CM services, with input from patients, to meet specific needs of populations with different modifiable risks	<ul style="list-style-type: none">• Determine who should provide CM services given population needs and practice context
<ul style="list-style-type: none">• Develop risk-based approaches to identify patients most in need of CM services	Use EMR to facilitate care coordination and effective communication with patients and outreach to them	<ul style="list-style-type: none">• Identify needed skills, appropriate training, and licensure requirements
		<ul style="list-style-type: none">• Implement interprofessional team-based approaches to care

The 4 phases of onboarding

1. Pre hire preparation – from the time of job acceptance to the first day on the job
2. Introductions – official welcome of your new or transferring employee
3. 1- 90-days; evaluation period
4. 90 days through at least the first year

www.insperity.com/blog/employee-onboarding-vs-orientation-need/

Pre-hire

What should be ready....

1. Develop an orientation checklist specific to your organization
2. Ensure that there is a functional work space ready for the employee
3. Ensure the employee has proper equipment and supplies
4. Provide a welcoming environment



Introductions

- Introduce Care Management to all practice staff; the what, the why, and the how
- Introduce the Care Manager to all practice staff
- Support the Care Manager to introduce care management services at the practice provider meetings, staff meetings
- Introduce the Care Manager to specialists and other referral sources
- Identify a care management “champion”

The 3 Cornerstones

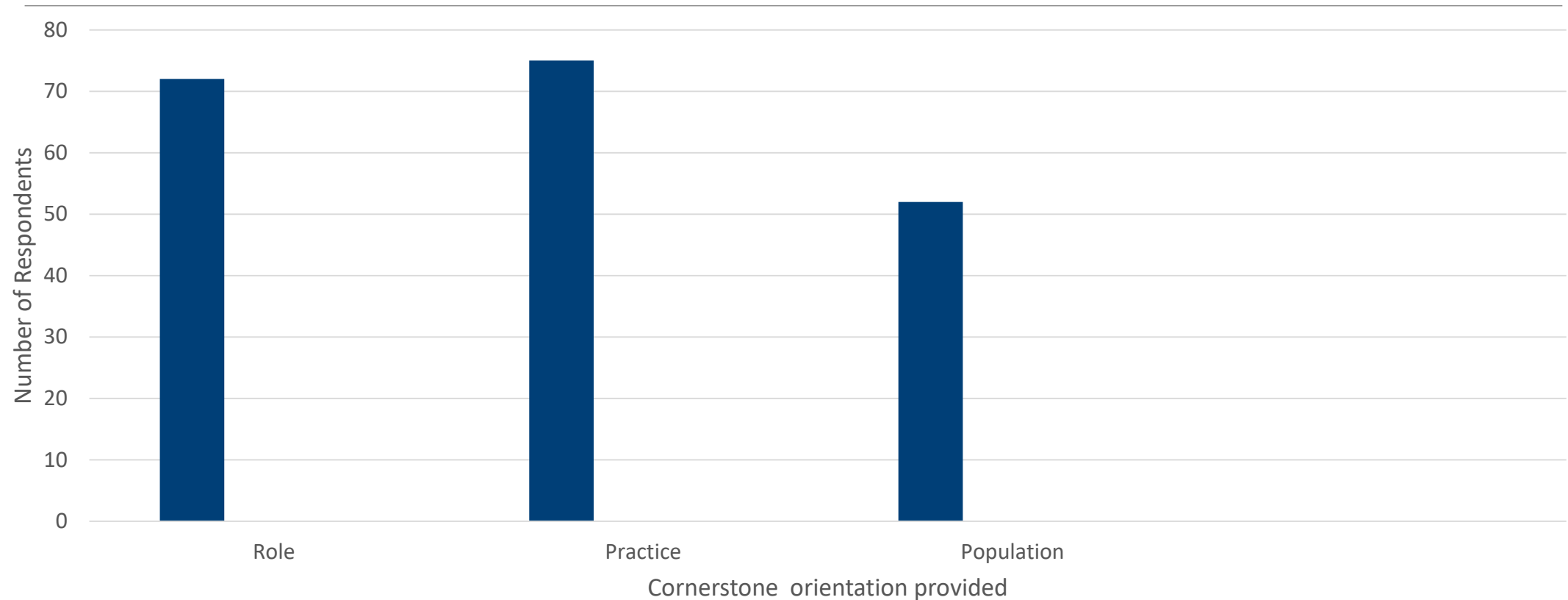
Key Areas of an Effective CM Orientation

1. Care Management Role
2. Practice
3. Population

Cornerstone: is an important quality or feature on which a particular thing depends or is based.



Orientation to 3 Cornerstones



1. CARE MANGER ROLE

CM role and responsibilities in the practice

- Care Manager role and responsibilities in the practice
 - Care Manager responsibilities
 - Care Manager Job description
 - Care Management introduction letter for patients and business cards for care manager
- Care Manager initial training and longitudinal education *
 - Complex Care Manager Course - MiCMRC
 - MiCMRC approved self-management course
 - Longitudinal education
- Care Manager caseload – building and managing
 - Embedment
 - Referral criteria, process and sources
 - Enrollment process and engagement in longitudinal relationships
 - Patient education materials
 - System to schedule enrollment and follow-up visits
 - CM metrics and tracking system
 - Performance feedback for CM – productivity metrics

• Additional information on SIM required CM training can be found in the 2018 PCMH Initiative Participation Guide https://www.michigan.gov/documents/mdhhs/2018_SIM_PCMH_Initiative_Participation_Guide_604730_7.pdf



Additional Ideas:

- Ramp up the responsibilities and caseload of the CM over time
 - Example - CM focuses on the transition of care visits during the initial orientation phase
- Provide opportunities for CM to learn from internal experts and peers through:
 - Shadow content experts in the first 2 weeks after hire, such as disease management leads; diabetes educators
 - Shadow more experienced CMs according to their strengths
 - Meet 1:1 with staff that interface with care management services and discuss collaboration
 - Partner a new CM with a mentor over the course of 3-6 months
 - Meet 1:1 with preceptor or supervisor weekly

CM Role

Care Manager Responsibilities:

Is there a script and a flyer to introduce care management Services?

How does the Care Manager receive referrals?
Areas of focus?

- Assessment, management, case closure

How do you identify a patient for episodic vs. longitudinal care management services?

Resources:

MiCMRC care manager script for introducing services:

<http://micmrc.org/system/files/7.1%20Care%20Manager%20PDCM%20pilot%20script%20V3.pdf>

MiCMRC care manager introduction flyer:

<http://micmrc.org/system/files/7.2%20Care%20Management%20Patient%20Handout%20V2.pdf>

Care Management – 5 step process:

<http://micmrc.org/e-learning/five-step-process>

SIM PCMH Initiative Participation Guide 2018

https://www.michigan.gov/documents/mdhhs/2018_SIM_PCMH_Initiative_Participation_Guide_604730_7.pdf

CM Role

Care Manager Responsibilities:

What are the roles and responsibilities of the care manager?

What does a comprehensive assessment look like?

How do you develop an accurate, appropriate Individualized Care Plan? (using SMART goals, follow up and consistent revamping)

What patient educational materials are available in my practice?

Resources:

MiCMRC responsibilities of the care manager:

<http://micmrc.org/system/files/2.1%20CCM%20responsibilities%201-18-16%20V3.pdf>

MiCMRC Care Management 101, Step One

<http://micmrc.org/care-management-101>

MiCMRC E-Learning Self Study Modules <http://micmrc.org/e-learning>

MDHHS no cost educational materials:

http://micmrc.org/system/files/3.4%20MDCH_Primary_Care_and_Public_Health_Order_Form_475588_7_0.pdf

MiCMRC Chronic Conditions Pages for Heart Failure, COPD, HTN, Asthma, Childhood Obesity, Adult Obesity and Diabetes <http://micmrc.org/topics/chronic-conditions>

2. PRACTICE FRAMEWORK

How things happen in your particular
practice

- Identify a champion for care management
- Role and responsibilities of practice staff members, shadowing experiences
- Health care team communication, documentation systems, and tracking codes
- Practice meetings and other communication methods
- Care Manager meetings – CM peer group meetings
- Performance feedback for CM – productivity metrics
- Baseline practice assessment
- Patient access, communication methods, (portal), and education materials
- Specialists utilized frequently by the practice, collaborative agreements
- SIM PCMH Initiative requirements, PCMH designation areas of focus
- Practice policy, procedures, and protocols and evidenced – based guidelines



Additional Ideas:

Involve Care Manager in practice meetings

- Huddles
- Staff meetings
- Case load reviews
- Provider meetings

Identify how care coordination across all team members occurs in relationship to individual patient, community clinical linkages

- Note in EHR
- Care team conference
- Screening results and care plan available in EHR to all team members

Recognize burn-out and staff fatigue

- Provide support for your staff, just as you provide care to your patients and their caregivers

Practice

Care Manager Responsibilities:

Resources:

What are the SDOH screening tool used by the practice? Practice's SDOH workflow?

SIM Participation Guide 2018

https://www.michigan.gov/documents/mdhhs/2018_SIM_PCMH_Initiative_Participation_Guide_604730_7.pdf

What other practice team members are involved with each patient?

Assessment of Team Roles and Distribution / RWJF Leap tool

<http://micmrc.org/system/files/9.3%20LEAP%20Team-Step3-Share%20the%20Care%20Worksheet-assess%20team%20roles%20and%20tasks.pdf>

What are the community resources? Who are the community organizations and partners?

Community Resources: Michigan 2-1-1 Information Guide (a resource for SIM PCMH Initiative)

https://www.michigan.gov/documents/mdhhs/2-1-1_brochure_Final_619035_7.pdf

SIM PCMH Initiative office hours webinar: Michigan 2-1-1 Basic Concepts and Utilization https://www.michigan.gov/mdhhs/0,5885,7-339-71551_64491_86032_86033-467622--,00.html

3. POPULATION

Who are your patients and what are their needs

- Identifying the population who will potentially benefit from care management services
- Accessing data to target the patients who may benefit from care management services
- Introductions to the community resources and linkages used by the practice, operationalizing the Community Clinical Linkages



Additional Ideas

Proactive population management through:

- Planned visits
- Patient outreach
- Gaps in care reports
- Quality metrics, data reports, and quality improvement activities at the practice
- Introduce population health tools
 - MDC patient lists
 - Registry reports
 - SDOH screening
 - Behavioral health screening

Population

Care Manager Responsibilities:	Resources:
How are community clinical linkages operationalized: practice work flow, partnerships with community organizations, resources?	MiCMRC recorded self study webinar: The Role of Care Coordinators and Care Managers in Developing and Maintaining Community Linkages http://micmrc.org/training/developing-and-maintaining-community-linkages
How does the practice screen for SDOH? Who does the screening and where does the information go?	For Ideas see SIM Participation Guide 2018 https://www.michigan.gov/documents/mdhhs/2018_SIM_PCMH_Initiative_Participation_Guide_604730_7.pdf
Who contacts the patient to address unmet SDOH needs and who does the follow up once a community linkage is made?	For Ideas see SIM Participation Guide 2018 https://www.michigan.gov/documents/mdhhs/2018_SIM_PCMH_Initiative_Participation_Guide_604730_7.pdf

Rising Risk and SDOH

- Healthcare providers are in the forefront of addressing SDOH within the scope of patient centered medical home.
- Rising Risk
 - Rising risk patients often have inadequate access to providers or supportive services, (resources are often centered on high-risk patient management)
 - To effectively interrupt the escalation from rising – to high risk, core drivers should be identified to determine intervention:
 - Chronic condition diagnoses
 - Biopsychosocial risk factors
 - Patient levels of health literacy and engagement

Addressing the Needs of Your Rising-Risk Patients, Executive Summary. 2017 Advisory Board, Population Health Advisor,

Patient Population Tool – Patient List

Susan Stephan – Senior Business Systems Analyst, Michigan Data Collaborative

Polling Question

Do you currently use the SIM Patient list as part of your orientation to understand your SIM Patient Population?

Yes

No

Don't know

Patient List

- Identify patients with chronic conditions
- Identify high utilizers
- Identify patients new to your practice this month
- Identify patients attributed to your practice but not seen in the last 12 months (**New fields as of May 2018!**)
- Combination of chronic conditions, high utilizers, and never seen

Demo of Sample Patient List

Key Fields

of Inpatient Visits in newest Release

of ED Visits

of Readmissions

of Visits to Any PCP in 12 months

Most Recent PCP Visit Date

Chronic Conditions:

- Diabetes
- Asthma
- Hypertension
- Obesity

New Patient PO and PU Flags

High ED Utilizer

Useful Excel Options

Hide columns

Sort

Filter

Identifying Patients for Care Management

Monthly list review can uncover patients for care management

Focus on Key Fields

- Chronic conditions to identify largest volume
- High utilizers that have not had a recent planned visit
- Multiple chronic conditions new patients

MiCMRC Care Management Resources

MiCMRC.org - New Orientation website resources

Examples of:
Orientation Checklist
Orientation Schedule
CM Job Description
Care Management Introduction
Embedment

MiCMRC Approved Self Management Support Course

Complex Care Management Course

6 hour Self-study
2 live training days
CCM Course
Resource Guide

Care Management 101

Suggested 1st year:
eLearning Modules
Live and Recorded
Webinars
MiCMRC Website self-
study:
Topic Pages
Chronic Conditions
Team Based Care

Longitudinal Education

Live Webinars
Recorded webinars
eLearning Modules

New eLearning Module

Patient and Family Engagement

- Free online lessons
- Learn at your own pace
- Earn CE Credit

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

Pediatric Office Hours

Wednesday, June 6, 2018 - 11:00am

Pediatric Office Hours: ACES and SDOH Screening

Presented by

Jane Turner, MD, FAAP

Professor Health Programs, Pediatrics and Human Development, Michigan State University

Jodi L. Spicer, MA
Adverse Childhood Experiences (ACES)/Youth Suicide Prevention Consultant
Division of Chronic Disease and Injury Control
Michigan Department of Health and Human Services

For suggested pre-work [Click Here](#)

[Webinar Registration](#)

MiCMRC Educational Webinar

Wednesday, June 13, 2018 - 2:00pm

Michigan Physician Orders for Scope of Treatment

Presented by

Carolyn Stramecki, MHSA

Longitudinal learning

- Webinars
- eLearning

Orientation to coding and tracking resources

- Home
- About
- Training & Support
- Care Management 101
- Topics
- Resources
- Webinars
- Best Practices

Home > Care Manager Orientation

Care Manager Orientation

Resource Item *What Does Embedment Look Like* has been updated.

View

Edit

Introduction

MiCMRC supports networking statewide as their care manager (CM) orientation and onboarding. The sources for CM orientation and onboarding include:

- Materials shared by Michigan Physicians
- Evidence based literature
- Michigan Care Management Resource Center

If you have CM orientation/onboarding training and would like to share statewide, please contact [micmrc](#)

Care Manager orientation resources and onboarding program, assist with addressing onboarding for new care management programs across practices in the state.

Care Manager Orientation Cornerstones

There are three cornerstones of an effective care manager role and responsibilities, 1.) orientation to the work, and 2.) orientation to the population.

Dashboard

Logout

Quick Tools

Care Manager Script

Care Manager Orientation Checklist

New Care Manager

Care Manager Job Description

Provides examples of job descriptions and roles for care managers

Tools

Care Manager Job Descriptions

Job descriptions for both Moderate and Complex Care Manager Job Descriptions

Moderate Care Manager Job Description

Complex Care Manager Job Description

Tools

Care Manager Responsibilities

Complex Care Manager Responsibilities

Tools

Care Management 101

Provides a roadmap for new care manager development (MiCMRC)

Care Management 101

Tools

Algorithm - 5 Step Process

This document presents a suggested process for your practice/Physician Organization (MiCMRC)

5 Step Process Algorithm

Tools

Care Manager Scripting

Provides an example of a script when explaining the role of a care manager (MiCMRC)

Care Management Script

Toolkits

Provides toolkits to help guide and improve complex care management programs

Toolkits

Complex Care Management Toolkit

Toolkit summarizes ideas to improve an existing complex care program, or implement a new one

Click Here for Toolkit

Reference Guide

Safety Net Medical Home Initiative

Organized, Evidence-Based Care: Planning Care for Individual Patients and Whole Populations

Click Here for Guide

Planned Care Videos

From Improving Chronic Care, highlights Planned Care visits through short videos as well as a facilitator's guide.

Articles

Provides resources around workforce development and training for care management

Article

Approaches to Workforce Development to Support Care Management

A Guide to Resources, Promising Practices, and Tools

Click Here for Article

Article

Care Management of Patients with Complex Health Care Needs

From the Robert Wood Johnson Foundation Synthesis Project

Click Here for Article

Article

Center for Health Care Strategies

Strategies for Hiring and training Care Managers in Integrated Programs Serving Medicare-Medicaid Beneficiaries

Click Here for Article

Michigan Care Management Resource Center
www.micmrc.org

Welcome to our new Care Manager Orientation web page!

If you have questions regarding the page, would like to share a tool or resource or leave feedback about the page contact us at micmrc-requests@med.umich.edu

To access the Care Manager Orientation page [Click Here](#)

Future SIM PCMH Initiative Events

Date	Event	Content	Presenters
July 12, 2018 12 noon – 1:30 pm	SIM PCMH Initiative Quarterly Update	SIM updates, Operationalizing an Effective Care Manager Orientation	Operationalizing CM Orientation: <ul style="list-style-type: none"> ▪ Ruth Clark, Executive Director – Integrated Health Partners ▪ Jodi Buchholz, Manager of Ambulatory Case Management – Henry Ford Health System ▪ Casidhe Kowalczyk RN, BSN Preceptor - IHA
July 18, 2018 12 noon – 1 pm	SIM PCMH Initiative Office Hours	Utilization Measure Changes New Measures in Release 5 Understanding the Care Management Reports	Susan Stephan – Business Systems Analyst Senior, Michigan Data Collaborative

Registration for SIM PCMH Initiative Events: [https: click here](https://www.michigan.gov/sim)

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.



Discussion, Q and A



Contact Us

Michigan Care Management Resource Center:

micmrc-requests@med.umich.edu

Michigan Data Collaborative:

<https://michigandatacollaborative.org/>

MDHHS SIM Care Delivery:

mdhhs-simpcmh@michigan.gov