Cornerstones for Developing a Care Manager Orientation

STATE INNOVATION MODEL PATIENT CENTERED MEDICAL HOME INITIATIVE OFFICE HOURS

6.20.18

Team Members

Laura Kilfoyle, SIM Care Delivery Coordinator

Susan Stephan – Senior Business Systems Analyst, Michigan Data Collaborative

Marie Beisel - Senior Project Manager, MiCMRC

Cindy Stevens – Administrative Assistant, MiCMRC

Scott Johnson – Project Manager, MiCMRC

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

Open and close your control panel

Join audio:

- Choose **Mic & Speakers** to use VoIP
- Choose **Telephone** and dial using the information provided

Submit questions and comments via the Questions panel

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

micmrc

micmrc

SIM MDHHS State Innovation Model

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).

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.

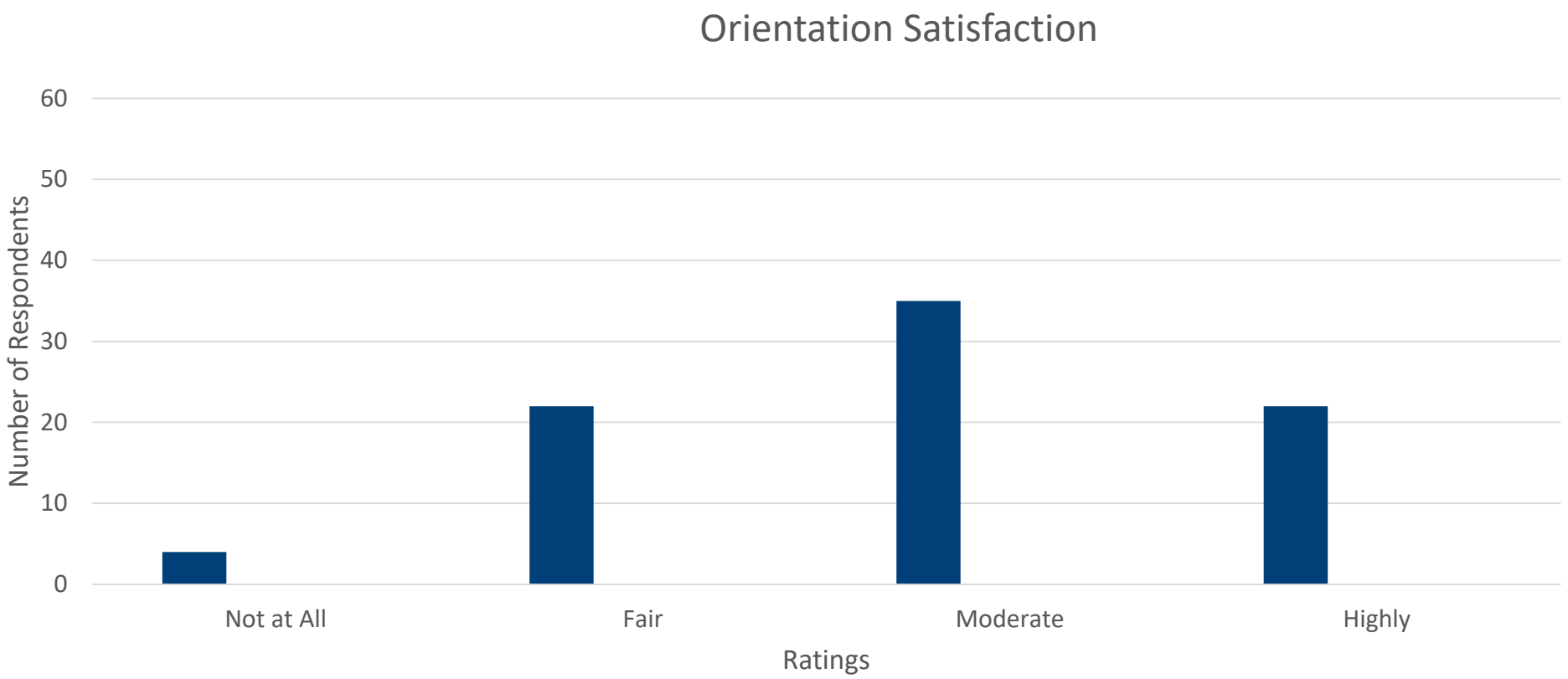
Sims, Gloria(2018). Orientation vs Onboarding, The Insperity Guide to Employee Engagement, Issue 1

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

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
• 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	• Determine who should provide CM services given population needs and practice context
• 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	• Identify needed skills, appropriate training, and licensure requirements
		• 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”

SIM
MDHHS State Innovation Model

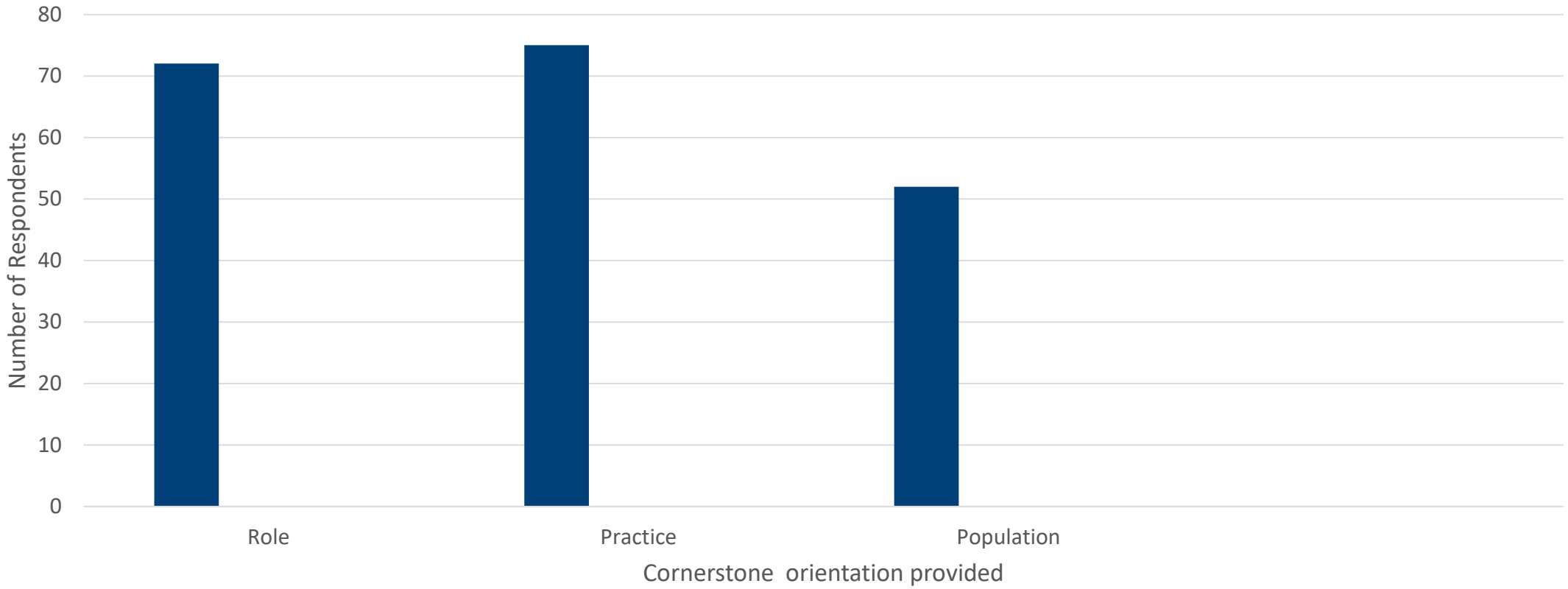
The 3 Cornerstones

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:	Resources:
Is there a script and a flyer to introduce care management Services?	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
How does the Care Manager receive referrals? Areas of focus? • Assessment, management, case closure	Care Management – 5 step process: http://micmrc.org/e-learning/five-step-process
How do you identify a patient for episodic vs. longitudinal care management services?	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:	Resources:
What are the roles and responsibilities of the care manager? What does a comprehensive assessment look like?	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
How do you develop an accurate, appropriate Individualized Care Plan? (using SMART goals, follow up and consistent revamping)	MiCMRC E-Learning Self Study Modules http://micmrc.org/e-learning
What patient educational materials are available in my practice?	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

micmrc

SIM MDHHS State Innovation Model

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

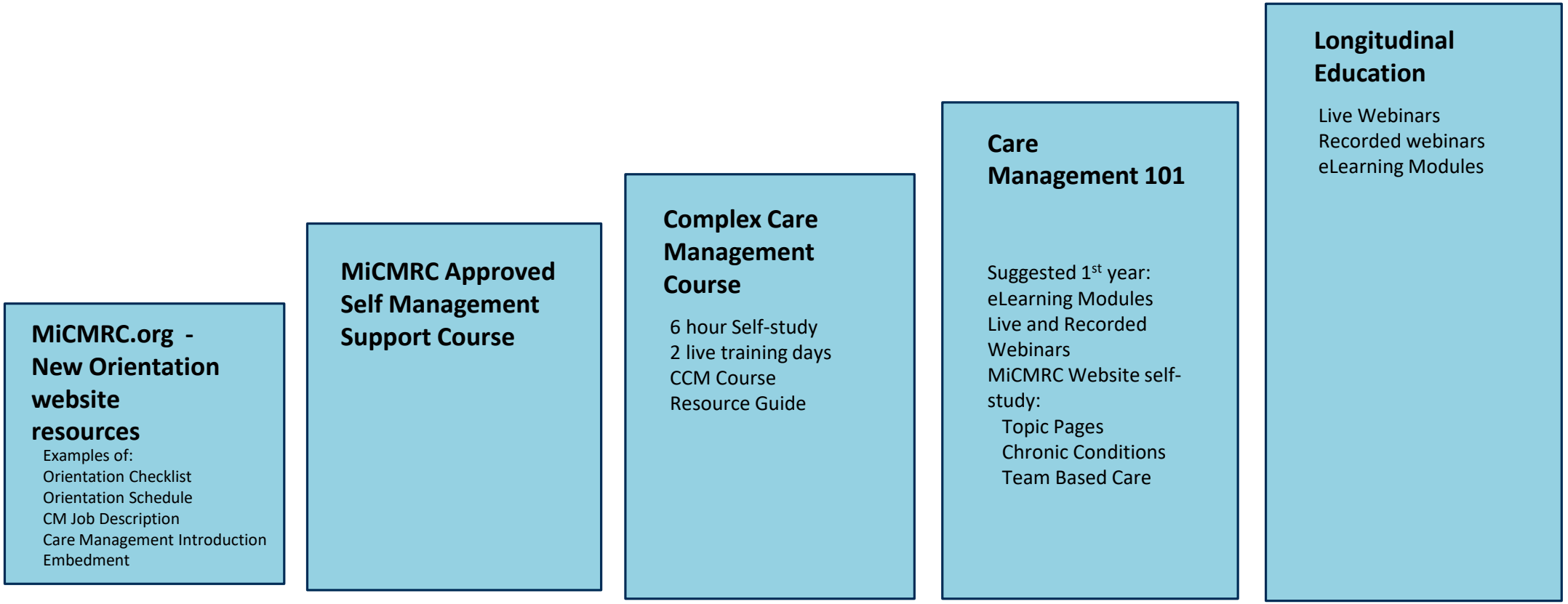
Identifying Patients for Care Management

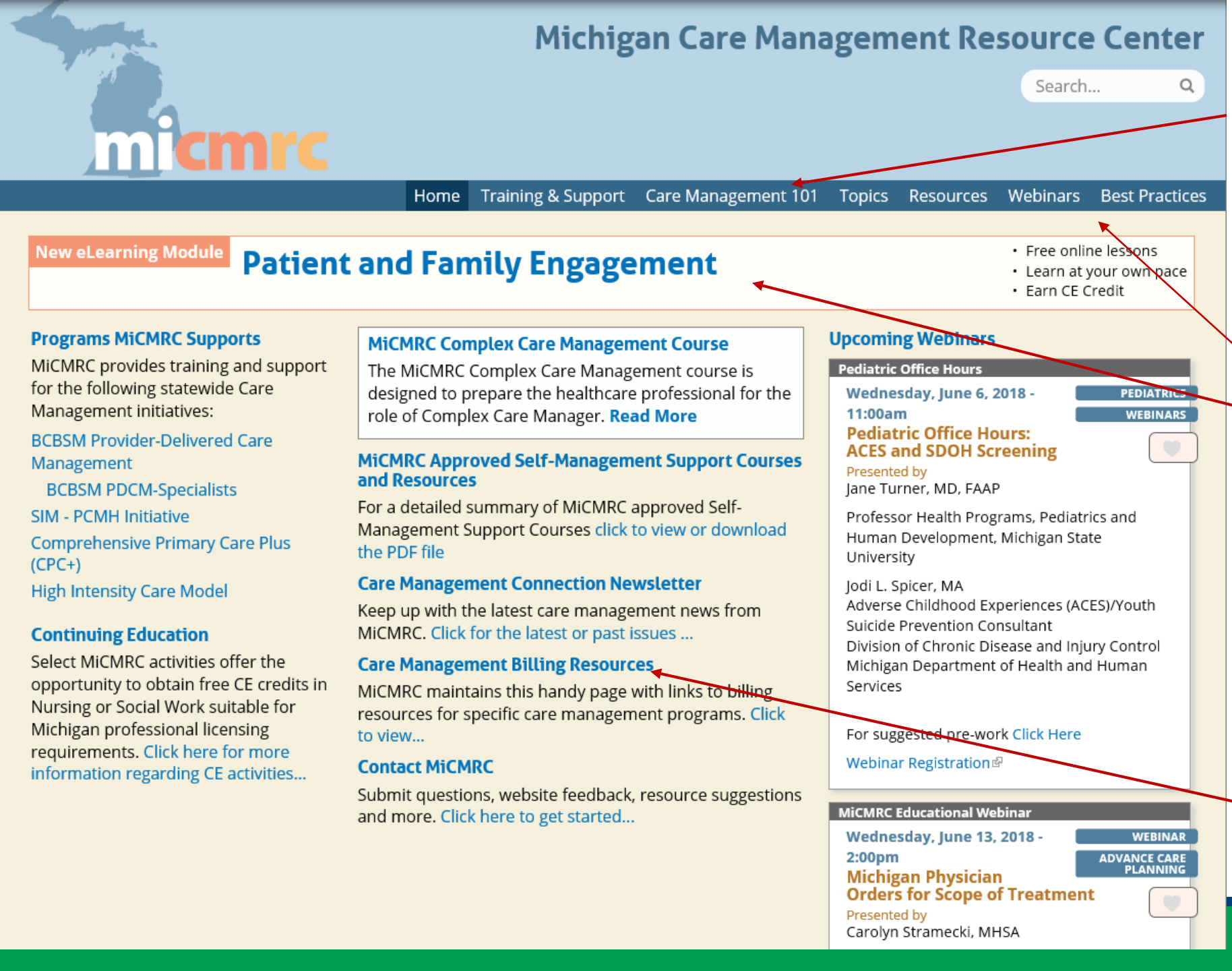
Monthly list review can uncover patients for care management

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





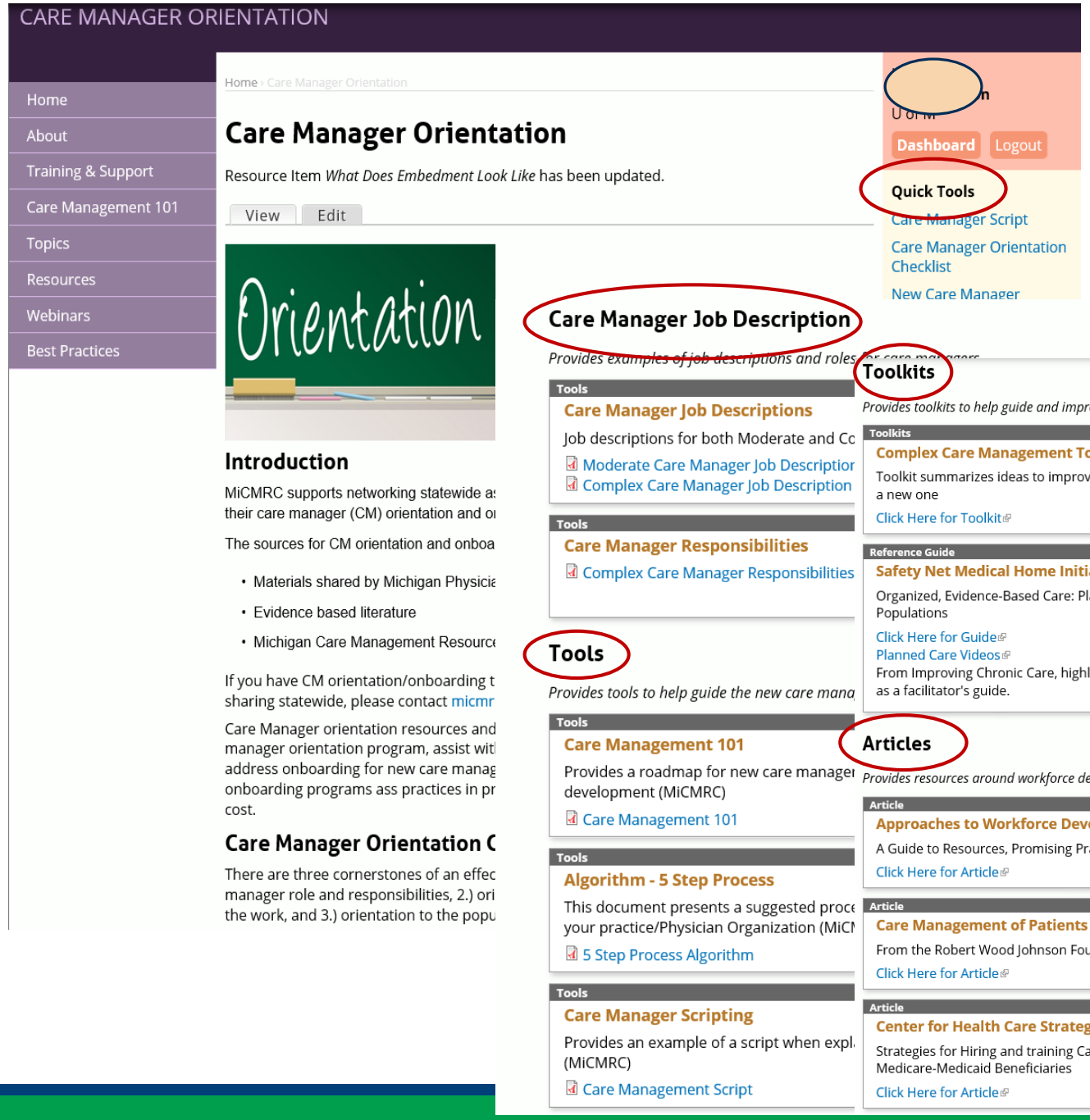
www.micmrc.org

Care Management 101

Longitudinal learning
- Webinars
- eLearning

Orientation to coding and tracking resources

SIM MDHHS State Innovation Model



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

SIM
MDHHS State Innovation Model

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: ▪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

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