Michigan Center for Clinical Systems Improvement
Care Management Simulation Training

Simulation training provides the new or the care manager looking for a refresher to apply their knowledge and learnings in an experimental environment.

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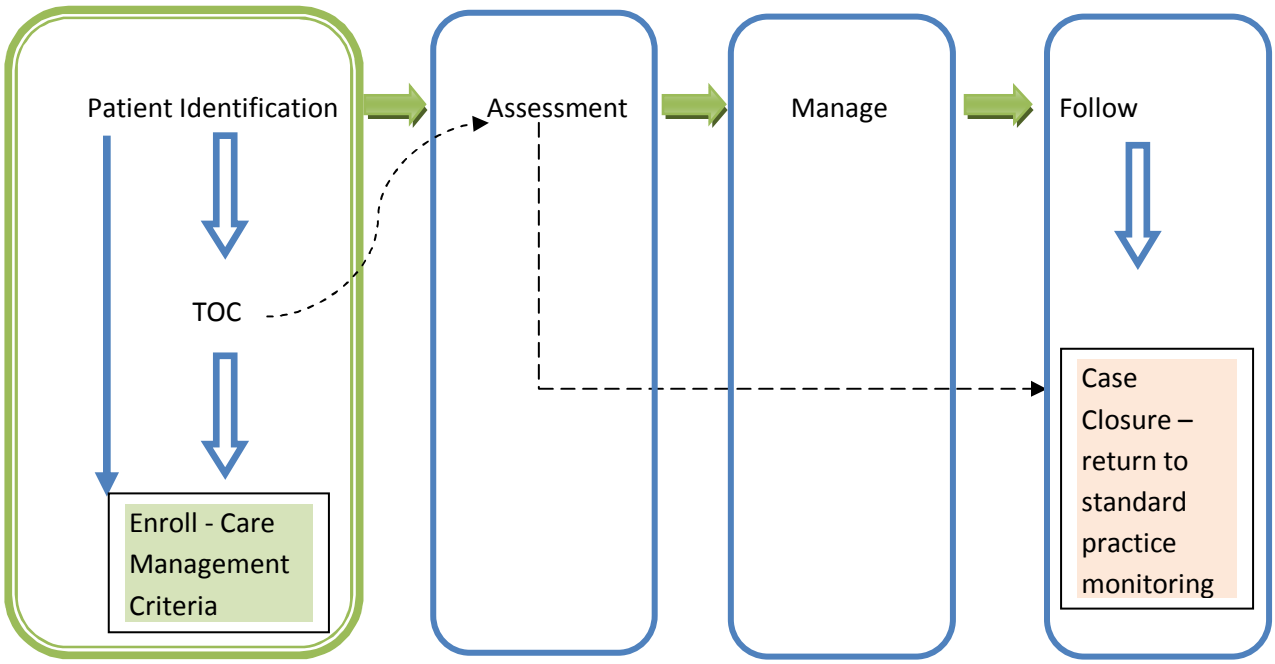
Care Management Process



Care/Case Management Process

A. Identification
    a. TOC
        i. Current Process
            1. CM completes TOC on all patients
            2. CM and clinical team staff share responsibility
            3. Team staff complete TOC – no CM involvement
            4. Other

    b. Complex
        i. Current Process
            1. MiPCT/Payer score/High Risk Stratification
            2. High cost/utilization
            3. Internal predictive modeling score
            4. Physician Identifier(s)
            5. Registry
            6. Other

    c. Moderate
        i. Priority/Focus in the process

    d. Eligibility
        i. Covered service for patients based on the payer(s)/health insurance coverage plan

B. Assessment
    a. Greatest concern of the patient/family (if appropriate)
    b. Greatest risk – TOC/Frail/Social Determinants/Other
    c. Medication management
        i. Adherence
        ii. Knowledge
        iii. Barriers
    d. Review of systems - condition specific
    e. Self-management
        i. Knowledge
        ii. Motivation
        iii. Barriers

C. Manage/Monitoring
    a. Monitor to agreed patient and provider treatment goal(s)
    b. Monitoring to Risk
        i. Frequency – suggested
            1. High risk - Frequent monitoring intervals (minimum of 1-2 weeks)
            2. Moderate high risk - monitoring every 2-4 weeks
            3. Moderate risk - monitoring monthly to quarterly
            4. Low risk - transition to care team monitoring via
                i. Gaps in care/registry reports
                ii. During scheduled and unscheduled appointments
    c. Treat-to-target
        i. Safety factors: minimize risk of admission, re-admission, and untoward event(s)
        ii. Chronic and multiple chronic condition(s)
            1. Determine maximum improvement goal(s)
                a. Patient goal(s)
                b. Clinical plan and goal(s)
            2. Assess progress toward goals at each interval (within reason)
                a. Examples
                    i. Repeat PHQ9
                    ii. BP readings
                    iii. Blood sugar readings and A1C
                    iv. Weights
    d. Prioritize interventions and determine impact of changes to all diagnosed conditions
        i. Example: A patient with diagnosis of diabetes, COPD, and hypertension
            1. Steroid intervention for COPD exacerbation
                a. Anticipate risk and impact of the steroid treatment with the diabetes and hypertension management
    e. Self-management/relapse prevention
        i. Review the self-management/relapse prevention preparation plan
            1. Confirm established goals are yet pertinent or of priority
                a. To plan of care
                b. To patient
            2. Progress with basic knowledge and ability to self- manage
                a. Barriers
                b. Strengths
            3. Readiness
                a. Confidence: Attitudes and beliefs about the importance of the change
                b. Conviction: Attitudes and beliefs about the ability and skills to accomplish the change

c. See Resource tool Conviction & Confidence

D. Follow, Transition to alternate care programs, progress to independent self-management and care team monitoring
    a. Follow up and evaluation of the progress with the plan of care
        i. Review treat-to-target
            1. Progress to treatment goals/plan of care
            2. Barriers or obstacles to reaching goals
            3. Need to re-establish goals/treatment plan
                a. Change in clinical priority
                b. Change in condition
                c. Change in patient priority
        ii. Utilization
            1. Hospitalization(s)
            2. ER visits
            3. Services
                a. HHC
                b. DME
                c. High tech radiology
                d. Other
        iii. Self-management
            1. Maximized improvement
            2. Goals met – new goals identified
            3. Goals met – established maxim improvement - ready for independent self-management
    b. Transition to alternate care programs
        i. Condition end-stage
            1. Consider palliative care or hospice
        ii. Compromised or limited ability to function independently – non-reversible with therapies
            1. PACE Program
            2. Assisted living
            3. Long-term care

Simulation Experience

1. Didactic refresher of basic enhanced care management training course
    a. Chronic Care Model
    b. Clinical workflows within the PCMH
    c. Effective Inter-professional communication – building relationships within the team
    d. Effective communication and health care literacy
    e. Attitudes and self-management
    f. Introduction and basics of motivational interviewing
    g. Case/care management process
2. Overview of the simulation stations – what to expect
    a. 3-4 patient stations simulated to the care management activities and responsibilities
        i. Transitions of care – post hospitalization of a patient with a complex social issue
        ii. Face to face visit with a patient with multiple conditions to include depression
        iii. Face to face visit with a patient referred from the physician – moderate care needs
        iv. Transitions of care – multiple ER visits of a young adult with asthma
    b. Each station will be set-up as a care managers office
        i. Available patient records – based on the case presentation this may include the following:
            1. PCP progress reports
            2. Specialist reports
            3. Lab/x-rays
            4. Care manager documentation notes
        ii. Telephone
        iii. Chair/desk/table for patient visit
        iv. Recording equipment
    c. Role of the "Standard Patient"
        i. Standard patients are individuals who have been trained and apprised of specific characters, medical condition and symptoms, and the process for evaluating the care mangers technique and application of the skills reviewed in the training
        ii. The Standard Patient completes a visit with the care manager as the patient (in character) they have been trained to stay in character and respond to your questions and interviewing techniques
        iii. Based on the care managers application of the care management skills, the standard patient responds as the character outline they were provided
        iv. Subsequent to the "visit", the Standard Patient provides feedback of the experience to the care manager
    d. Care management documentation

i. The care manager will complete the care management process, and document according to the payer expectations and the care management enhanced CM training guidelines

e. Debrief process – this will vary depending on the focus of the simulation
    i. Subsequent to completing each of the 4 Standard Patient workstations, the group will meet and review randomly selected videos of the care manager visit(s)
    ii. Using the "SP Assessment Form," the group will review the selected videos and complete the assessment form
    iii. The group will have discussion on opportunities for development and strengths
f. Self-assessment
    i. Each care manager will be provided a copy of their video(s) or audio conference call for the purpose of self-assessment and continued self-evaluation
g. SP Assessment
    i. Each SP will meet with each care manager individually and provide them with their assessment and feedback
h. Video-taping
    i. Sign consent and release for videoing

3. Evaluation
    a. MiCCSI will aggregate the SP assessments, group assessments and self-assessment results
        i. Results of each will be provided to the care manager
        ii. Results will not be distributed to other care managers in attendance
        iii. Based on prior agreement and understanding: Results will be shared with the care manager's supervisor/manager upon request, and terms of agreement of the organization sponsoring the care manager training. The care manager will be apprised of this, should this be the reason for their attending the simulated exercise.
    b. MiCCSI may aggregate blinded results for reporting, research, and marketing purposes
4. Tools
    a. Billing and coding introduction
    b. Self-assessment evaluation
    c. SP evaluation
    d. Trainer evaluation
    e. Self-learning modules
        i. Care management process - introduction
        ii. Healthcare literacy
        iii. Care plan development (in progress)
        iv. Payer product review and correlation to patient identification
        v. Transitions of care
        vi. Legal terms and application to the care manager role

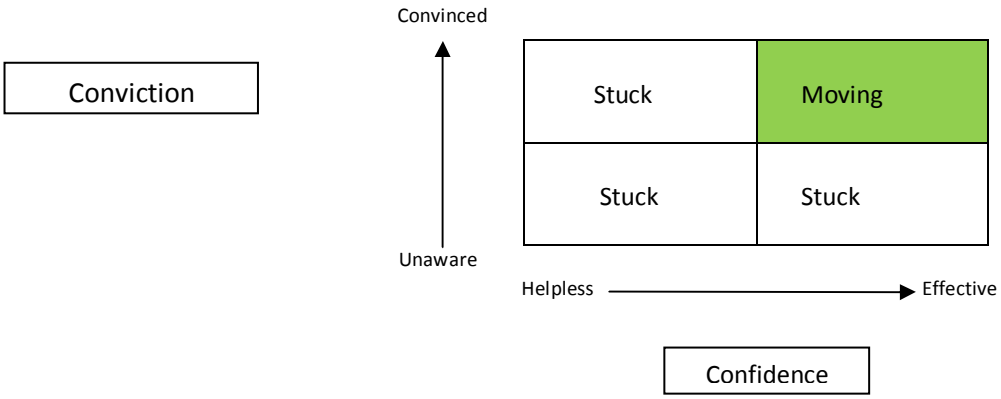
5. Resources
    a. CMSA Standards of practice
    b. Community resource directory
    c. Care plan example
    d. MiCCSI materials via the website at www.miccsi.org

6. References

    a. http://www.nova.edu/ssss/QR/QR15-4/sanford.pdf
    b. http://www.cmsa.org/Individual/MemberToolkit/StandardsofPractice/tabid/69/Default.aspx
    c. The Brown Report; The Promise of Care Coordination Randal Brown Mathematica
    d.

Tools

Conviction and Confidence Resource Tool



Transitions of Care Initial Call Scripting Template for the Nurse Care Manager

Step One: Verify you are speaking with the patient. Do not disclose any personal health information until this step is completed. This is to ensure compliance with HIPPA.
If the patient is not available, leave your name, where you are from and the number to reach you at. Do NOT disclose any personal health information, such as indicating the patient's admission.

Key Components:

- Identify yourself and your relationship to the patient's physician
- Provide a brief description of the call purpose, and ask for permission to continue the call

Draft scripting sample:

- Hello my name is _____. I'm a nurse care manager calling from Dr._____ office.
- The office received notification that you have recently been in the hospital/ER/Urgent Care. Many patients have lots of questions after being discharged from the hospital/ER/Urgent Care and find it helpful to talk with a nurse about their care.
- Do you have a few minutes to talk with me now about your health (or is there someone else you prefer I talk with)? (If asked to speak with someone other than the patient, obtain and document verbal consent, provide a brief explanation of the reason for calling and establish need for HIPPA).

Step Two: Completing the call. Elicit concerns and questions the patient has in response to the admission, his/her understanding of the reason for the admission, his/her understanding of the discharge instructions and follow-up care. Frame the expected outcomes of the call and the approximate time it will take. Provide information that normalizes the discharge to home and follow-up care.

Key Component:

- Permission to continue declined

Draft scripting sample:

- I want to be respectful of your decision, may I ask the reason? Would it be o.k. for me to call at a different time?

- Permission to continue provided

Draft scripting sample:

- Before we get started, what are your concerns or questions? (Either address now – or let the patient know they will be addressed during your conversation at a later point).
- Have you been in the hospital/ER/Urgent care before this recent visit?
    - (If yes) what type of visit(s) and approximately the last date(s)?
- What I would like to do on this call is review with you the medications you are taking and any changes since the hospitalization/ER/Urgent care, the discharge instructions and follow-up care needs and appointments, and warning signs or symptoms that would indicate a need to call the doctor(s), or be seen before your next appointment. Depending on the questions, this should take about 20 to 30 minutes. Before we get started, it would be helpful for us to review the discharge instructions and your medications. Can you locate the discharge instructions and get your medications out so we can reference them during the call?

Step Three: Transitions of Care General Assessment – Initial Contact. The primary focus of this assessment is to establish the patient's level of risk and safety. The goal is to reduce risk and optimize safety to prevent an unnecessary untoward event or readmission.

Key Component:

- **Psychosocial assessment**

Draft scripting/questions:

- What care needs do you have since being discharged from the hospital?
- Do you have someone at home to help you since you've been discharged from the hospital/ER/Urgent Care?
  - Who/relationship
  - How often
- **Financial needs assessment**

Draft scripting/questions:

- Sometimes people have difficulties paying for medications, co-payments, transportation, or other things such as equipment or supplies. Can you describe any issues or concerns you've had?
  - Transportation to doctor or ordered treatment issues?
  - Medication co-payments or inability to fill prescriptions?
  - Paying for recommended equipment
  - Paying for homecare or private duty care
  - Other
- **Medication reconciliation assessment**

Draft scripting/questions:

- At this point I'd like to spend some time reviewing your medications. I'm going to ask that you read to me your list of medications from the discharge instructions. As we go through that list I would like you to see if you have a prescription bottle that matches the name of that medication on the list. If so, I'll have you keep those in a separate area while we're talking.
  - Complete the medication reconciliation process
- Some people have trouble taking their medications at the times and as often as they are prescribed. Can you share with me any issues you've had with this?
  - **Explore potential barriers (may have been addressed during the financial assessment)**
- Do you use more than one pharmacy?

  Education to consider if yes:
  - To make sure everyone has the same information it is recommended you take a list of all medications and your pill bottles to each pharmacy and doctor's appointment you see (some pharmacies have a pharmacist available to assist you with medication questions and issues).
  - After each of your doctor's appointment, ask to have a print out of the medications you should be taking.

- **Self-management – warning signs and assessment**

Draft scripting/questions:

- After an admission/ER/urgent care, it can be confusing to know what is important to report. I'd like to spend some time reviewing this with you.
- What would be some of the signs that your condition is worsening, and you would want to call the doctor about?
    - **Use affirmation for accurate information**
        - You really seem to have a good understanding of the warning signs.
- Would it be o.k. for me to review a couple of things that other patients have said was helpful to them?
    - Explain to the patient reportable warning signs pertinent to their condition(s).
        - Examples are fluid retention or weight gain for CHF
        - Wounds that are warm, or change in drainage
- What would you do if you had any of the warning signs we just reviewed?
- How about in the evening or on the week-ends?
    - Educational Opportunity
        - Review the organizations protocol for after- hours care
            - Urgent care centers or availability
            - When to use the emergency
            - Call center numbers
- **Follow-up care assessment**

Draft scripting/questions:

- After hospitalization/ER/Urgent Care can be a confusing time for patients. It is recommended that patients have a follow-up visit with their primary care doctor.
    - Coordination of care opportunity
        - Review the patient's record to determine if an appointment has been scheduled within the next 7 days-14 days.
    - (If appointment is scheduled) I see you have an appointment scheduled on (date). That's great. If for some reason you are not able to make the appointment, make sure you reschedule it, and let the person know the visit was for a follow-up visit for a recent hospitalization/ER/Urgent care.
    - (If appointment is not scheduled) I don't see where there is an appointment scheduled for you. Would it be o.k. for us to do that now?
- Do you have appointments to see other doctors or for any treatments?
    - Coordination of care opportunity
        - Review the importance of specialist appointments, and if the care is complex, consider contacting the specialist with any concerns or questions.
- We might have covered this before, but I want to make sure we cover this. Will you have problems with transportation to any of the appointments?
    - Coordination of care opportunity
        - Explore options if transportation is an issue
            - If health plan HMO – transportation coordination
            - Go bus
            - Family/friends

Closure:
Draft scripting

- Thank you for taking the time to talk with me. Have we addressed your questions/concerns? Is there anything else I can do for you?
- Before we end the call I would like to set-up a follow up call and provide you with my name and phone number/portal contact information
    - Coordinate the next phone call
    - Provide contact information
- Thank you for taking the time for the call today. I hope you found this helpful, and look forward to our next call on _____ (date), or seeing you at your appointment on _____(date).

Initial Contact for non-clinical staff

Do you have a follow-up physician appointment(s) scheduled? Y/N

- **Yes, member has appointment scheduled**

  "Who are you seeing and when is the appointment?"
  Enter MD name or PCP/specialty
  Appointment date:

  What, if anything, might make it difficult for you to keep this appointment?
  Explore potential barriers.
  If any issues present – follow practice triage/protocol

- **No, member doesn't have appointment scheduled**

  Can I help you schedule this appointment now? Y/N

  - **No, member doesn't wish to schedule**
    Inform the physician to determine next steps