Care Manager Meeting Highlights 3/2/17

Handouts from presentations are attached to email and on website (handouts and highlights under Care Manager User Group, handouts also under Care Manager Resources)

Welcome

Kevin DeBruyn welcomed everyone.

Kevin shared a Care Management story for everyone to think about:

- A Care Management patient had for some time, an A1C of 14, which was not moving. Patient was giving up on making changes, and was getting discouraged. Then, the patient's latest A1C was 10. The care manager called the patient to let her know and to congratulate her. The patient had already known the result from her physician, and let the care manager know that she went out to celebrate with a PIZZA and CANDY BAR.
    - This story speaks to the potential frustration in the job of care manager and that society is entrenched in celebrating with food. This type of situation often happens around holidays, too. So, be prepared to handle these "slips" or "celebrations" with strategies for your patients (acknowledge the good is one strategy) and ensure that you don't get discouraged.

Case Presentation

Echo Dean, LMSW presented a case and asked for suggestions with helping this patient.

- Background:
    - Working with this morbidly obese patient for close to 1 year
    - Drives, reads, is personable and has a good sense of humor.
    - Patient has cognitive deficits which come into play when trying to explain cause and effect such as how what she eats impacts her body.
- What has been done so far – experimenting to find what works:
    - Writing things down so the patient has something to refer to
    - Explaining in detail, but in the simplest terms, hoping she understands and retains
    - Had the patient write down everything she ate for one week so they could discuss in detail
        - Found that patient was eating 3-4 carb servings per meal for every meal
        - Discussed with patient: lowering carb intake, don't go to the grocery store hungry, make a grocery list, don't buy or keep things in the house that you know you cannot resist.
- Echo feels like she is making some progress with the patient, as she is maintaining weight, but is asking for suggestions because for the patient's health, needs to move the mark, it is getting harder for her to walk. It is also hard to pinpoint the cognitive deficit.
- Questions from Group:
    - Does the patient exercise?
        - Some – she tries to walk 10-15 minutes a day, but her feet start to hurt after 10 minutes
        - On days she cannot get out, she tries to ride a stationary bike (located in gym that is at her home)
    - Does she have financial resources?
        - No, not much.
        - Family/friends take her out to dinner often.
            - Suggested asking for a box prior to ordering
            - Know what she is going to order before she does not have to look at the menu.
    - Do you think portion control is a problem?
        - Yes, and have given her visual references, but not sure if she is using.
    - Does she cook?

        - Not really, was giving her recipes, but she does not use.
        - Mostly buys prepared meals, and have tried to discuss "healthy" prepared foods with her.
    - Does she like and/or drink water?
        - She likes to drink lemonade and peach iced tea, just discussed amount of sugar in those drinks which led to a discussion about label reading.
- Suggestions from the Group:
    - Fruit/Vegetable water she can make and pick a container/pitcher that is appealing to her.
    - A color-coded portion (for protein/veggie/carb) "children's plate"
    - Chair exercises – will help get strength up to do more exercises
    - MMC Community Health Library has "bags" you can check out with books for specific disease management
    - Farmers market on Mondays at the Commons in the summer has demonstrations on how to prepare fresh veggies and fruits and have recipes to take with you.
    - Oryana has classes and demonstrations
    - Websites for resources:
        - www.michigan.gov/mdhhs
        - http://micmrc.org/resources
        - www.cdc.gov
        - www.diabetes.org
        - www.choosemyplate.gov
- Kevin noted that the goal is to help change the mindset, focus on what the patient CAN do. Patients tend to focus on what they CANNOT do.

CHF Tools

Cherie Bostwick, RN Care Manager for Munson Family Practice shared her CHF patient teach-back tool.

- Cherie has the tool in a binder.
    - Care Manager: explains what heart failure is, and the "words you need to know"
        - Question for patient: Based on what we talked about, tell me in your own words what heart failure is.
    - Care Manager: asks patient how they feel, review common symptoms of heart failure.
        - Question for patient: What were your symptoms when first diagnosed? What are your symptoms now? Let the patient know if they feel new symptoms, or symptoms have changed, heart failure is NOT under control
    - Care Manager: makes sure patient knows his/her baseline
        - With the patient, write down baselines for example:
            - I can walk _____ before I experience SOB
            - I can take _____ stairs before I experience SOB
            - My belt buckle fits at the _____hole.
        - Reinforce how they felt when they were first diagnosed.
    - Care Manager: Tell patient to watch for changes, and what to do if something changes
        - Question for patient: What would you do if you felt changes?
    - Care Manager: Discuss with patient weight gain and what happens if they gain weight. Emphasize weighing at the same time every day. Emphasize that when they do gain weight, when do they call their physician? If in the hospital/dr. office, tell them to weigh themselves as soon as they get home on their own scale to get a baseline since scales can differ.
        - Questions for the patient: Do you have a scale? How often will you weigh yourself?
    - Care Manager: Discuss with patient the importance of a low sodium diet. Review high sodium foods, review nutrition label reading, possibly a referral to a dietician.
        - Ask the patient to tell you examples of some high sodium foods.
        - *Note: AFCs are required to provide physician prescribed diets such as low-sodium.*
    - Care Manager: Discuss fluid intake, give examples of 2 liters, and remind patients that everything that is a liquid at room temperature is a fluid – including soup and ice cream!
    - Self-Management questions for the patient:
        - Who does the shopping in your house? What would you tell them is important?
        - Who does the cooking in your house? What would you tell them is important?
        - What would you tell someone about limiting fluids? Why is it important? How can you keep track?

- Have an action plan for the patient.
  - Do you have a pill box? If not, can you get one?
  - Is your med list current? How would you explain your med list to someone?
  - Symptom chart/action plan
  - A way to log meals and sodium intake.

NPO asked for suggestions on how CMs can get a referral from their physicians immediately upon a chronic diagnosis such as CHF or diabetes.

- Have to have "buy in" from physicians
- If physicians have a choice between RN care manager and MSW care manager, they usually go to the RN for medical dx and the MSW for behavioral health dx. The RNs find that they are sometimes going back to the physician to request the MSW care manager, as many times the medical dx is only part of the issue.
- NPO stated: if you think it would be helpful the NPO Medical Directors could talk to your physicians about Care Management, let NPO know to set up a visit.
  - Dr. Gail Gwizdala – Traverse City
  - Dr. Melanie Manary – Petoskey area
  - Dr. Joel Anhalt – Manistee area

NPO Updates

Marie Hooper – Executive Director, NPO, NMHN and Trillium Health

- Background:
  - NPO invited Dr. Christine Nefcy and Dr. Kevin Omilusik from Munson to a Quality Committee meeting and a Skilled Nursing Facility Meeting to talk about reducing readmissions.
  - Munson, as part of efforts to reduce readmissions is asking for processes and contact information for Practice Care Managers.
- Would it be ok to give a list of practices and their Care Managers to the MMC discharge care managers? It would be expected that you receive a list of their Care Managers also.
  - Lots of discussion about how the process could work
- Next Steps: Marie to schedule a meeting between Munson CM and this group. Cherie offered her practice's conference room.
  - **MEETING scheduled for 4/3/17 from noon – 1P.**

<u>Next Meeting – all meetings from 3P – 5P:</u>

- <u>5/11 Thursday</u> - Kathleen Brown, NPO Pharmacist – OTC, Drug interactions and other agenda items TBD

- <u>2017 meetings (Thursdays, 3-5P)</u>
  - 6/22
  - 8/31
  - 10/19
  - 11/30

***PLEASE NOTE: If you plan to attend the next meeting either in-person or telephonically, please either email kelliott@npoinc.org or call NPO at 231-421-8505 to RSVP. After we* receive your RSVP, we send you an Outlook appointment. Please bring in parking garage tickets for validation. NPO has moved to 125 Park Street, Suite 300. You can still park in the parking garage; the building entrance is across from Sorellina Restaurant.**