Care Manager Meeting Highlights 8/31/17

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

Melissa Fournier, Michael's Place

Michael's Place has been in Traverse City for 16 years; Melissa serves as program director. Initially, Michael's Place was started as a grief support for children, but has expanded to include grief support for all regardless of age. Michaels Place is specifically designed for grief after a death of a loved one, but will provide referrals for those suffering from grief for other reasons such as divorce. Melissa described the various programs available.

The support group is focused on a family night, with a meal prepared by volunteers. This supplies those that may be feeling alone and isolated with social support. After the dinner, the large group breaks into smaller groups based on age and looking at where the members of the group are emotionally. The groups are run by facilitators trained by Michael's Place. Michael's Place is not a counseling or therapist office, they are a grief support center based on peer to peer support model. The children support groups are for all kinds of loss of a loved one. The adult support groups are broken down into a group for bereaved parents, a group for those that loss their loved one to suicide, general grief support, a women's group. There are also support groups that go beyond regular support for those who want to access their grief through other means, such as a writing group, a yoga group, etc. If there is not a group that seems to fit an individual person, Michael's Place does offer single sessions, but those are limited.

There is a program called Robins Nest started by the widow of a Navy pilot whose son really missed talking to his dad about flying etc., and a volunteer took her and her children on a helicopter ride, and her daughter said the experience was the "best day ever". The mom got involved with Michael's Place and started the program to give grieving children their "best day ever". The program is set up for groups of children to be together, they take place once a month and are promoted on their website and to the support groups. The idea is to have a great day and have fun even though they are grieving.

Michael's Place does a lot of work with area schools, having grief support groups, teacher trainings etc. so that schools are prepared if there is a death of a student or faculty member. Michael's Place helps schools to have a plan in place and have a way for school faculty to respond effectively.

Michael's Place also offers compassionate workplace support groups. They work with employers to come up with individual support plans, knowing that two days off is not enough to grieve. They help employers to explain to other employees about grief and the grieving process.

Every service that Michael's Place provides is free to the people that receive them. They rely on donations and grants to fund their programs. Michael's Place also provides services such as talks etc. to community groups. Michael's Place has about 300 volunteers per year. The staff of Michael's Place consists of 2 part time and 4 full time employees, the rest is volunteers.

Michael's Place most likely will receive a referral or phone call directly from a family, within a few days of the death. They will then set up an appointment with the family to discuss what Michael's Place offers and how they can help the family.

Kevin asked Melissa to share her best story. She told of a family that lost someone to suicide who was a young woman, and her grandfather would come in to group, and clip his nails the entire time. And when he finally shared, it was a photo of the granddaughter's casket that he built in his garage. People grieve in different ways and even if they don't actively participate may still benefit from group support.

Mary Douglas, GTI

Mary Douglas discussed a program that her practice has been implementing.

- To improve the referral of diabetics/prediabetics to Care Management, one physician's nurse wrote a letter to send to patients on behalf of the physician – very mushy!
    - The patient, instead of just seeing the physician every six months, would come in every three months and meet with Mary to specifically discuss diabetes, no other health problems. When they see the physician at the 6-month times, that is when they would discuss other health problems.
    - There is a very good response to this letter, it is mailed to the patient or given to the patient at their appointment. Many have called and signed up for this program.
- The other thing that the practice is working on is ED utilization.
    - The practice has found that the patients don't know they can call the office on the weekends or after hours and talk to someone. So, it is a patient education piece.
    - There is a big push at the office to reiterate at appointments that the patient CAN call the office before going to the ED, that they may still get sent to the ED, but to call office first.

<u>Open Discussion</u>

Kris asked the group if they felt they were getting enough referrals from their physicians for Care Management.

- Some in the group do not feel they are getting enough referrals, so the group gave ideas for getting more referrals sent to Care Management:
    - The doctors seem uncomfortable or are uncomfortable talking to their patients about Care Management.
    - Kevin wrote a script for a physician a while ago for a physician to begin to talk to their patient about Care Management. There are many different approaches that one can use to broach the subject of referral for chronic illness management. Perhaps the easiest and most direct would follow the lines of "We have been adjusting your medications and working on trying to get your illness to a point where it will minimally affect your future health. The best way in which you can manage your long-term health is to look at some lifestyle changes. I want you to go see someone who can help you make those changes."
    - Leave a note in the chart for the physician saying the patient may be a good candidate for Care Management.
    - Share success stories with the physicians who are not referring.
    - Set specific protocols for certain diagnoses, for example a new diagnosis of ADHD always has an appt. with the Care Manager etc. and communicate to the patients this expectation.
    - Enlist the help of the physician's nurse or MA in getting referrals for those new diagnoses and those patients that would benefit.

There was a question asked about what others are doing with Chronic Care Management (code 99490).

- Kevin responded that there is one practice where his staff is that is actively using CCM, and other practices that are at various stages.
- Some physicians are asking the Care managers to do "cold calls" to their patients to get them enrolled in CCM.
    - This could be awkward when you have not met the patient before, and some are finding when they call the patient they are "fishing" for something to talk about.
    - There is a struggle to find patients who will really get something from the calls
    - It seems to be taking more than the 20 minutes, at least for the first call, need to review chart, usually will have to explain CCM, then have conversation, then do documentation.
- Kevin responded that there is a lot of different interpretations of what is necessary in a CCM call.
    - Here is how he looks at it:
        - What is important?
        - Letting the patient know with the first call what to expect. Explain program, will be calling every month, these are the things we are going to talk about and this is what we hope comes of it.
        - What do you talk about for 20 minutes?
            - Has there been any changes?
            - Try to be proactive, let patient know that if something comes up, give you a call first.
            - Mix of medical and social
            - You will have to make many calls to many patients that feel like they may not be doing any good, but you might make a difference for one patient.
            - With all the reach out, it makes the patients feel like the office really cares.

- Kris stated that CMS is really pushing CCM for their patients, and have been sending out tips, Kris will forward these on to the group.
- Kevin gave the following example of a call – you only have 20 minutes:
    - Hello Mrs. Smith, I noticed that the doctor adjusted your insulin, were you able to get your prescription? Are you taking the new dosage? Are you having side effects?
    - This is where you will find out if they went to the pharmacy and it cost $500 so no she did not get meds. Speak to someone (the physician) to find out if there is an alternative, or if there are side effects… you can let the provider know.
- Are there specific charting requirements for Medicare CCM patients?
    - The amount of time
    - Brief description of what was discussed.
- Some patients want to come into the office for a face-to-face visit, not a phone call. Can this be billed as CCM?
    - Yes, it does not have to be a phone call, just 20 minutes per month in contact with the patient. It is about routine contact.
- Kevin stated that usually those patients who are high risk usually have multiple specialists etc. The CCM codes cover physician to physician calls, chart review etc. for those patients who are enrolled in CCM.

Next Meeting – all meetings from 3P – 5P:

- 2017 meetings (Thursdays, 3-5P)
    - 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.**