Care Manager Meeting Highlights 08/27/20

Handouts from presentations attached to email and on website (handouts and highlights under Care Manager User Group, handouts also under Care Manager Resources). This was strictly a virtual meeting due to COVID-19 from 3:00-5:00pm

Lisa Nicolaou, MSNI, NPO Project Manager: Advanced Care Planning (ACP) Follow-up from 6.25.20 Meeting

- Care Strategies
  - Advancing the conversation beyond does the patient have an ACP document on file. The ACP document itself shows to be less valuable than an ongoing conversation
  - What do you do for a healthy adult?
    - Start the conversation with, "What's important to you?" Then Utilize the ACP video from the ACP Decisions website:
      - On the ACP homepage go to the Healthy Adults section on the left-hand Colum
        - On the right-hand column, pick the video, "What's Important to you- Advanced Care Planning for General Audience": 5min 3s
        - *Last week we spoke of the video Values and Beliefs. If you have access to the ACP website, please watch both videos from the ACP website as we were unable to watch during the presentation due to technical difficulties. If you would like access please contact Lisa Nicolaou @lnicolauo@npoinc.org. Also view the code below.*
          - A prescription can be sent to the patient for them to view at home.
            - Please see attachment *Video Code "What's Important to you-Advance Care Planning for General Audience.* This allows you not only to watch the video but view from the patient's perspective what happens when a code is prescribed.
          - If prescribed by the practice you can see how many are being used/ watched by patients and compare to how many are being prescribed.
  - Videos that can be used for specific needs. PDF attached and available on website: *ACP Decisions Video Category Chart*
    - Training and implementation
    - Video Categories handout
    - Provides videos for disease specific in different stages: Early, advanced, Before surgery, Generally healthy, seriously ill etc.
  - How to prescribe a video?
    - Simply saying go home and watch this isn't best practice
    - Show the video while the patient is in the practice, prescribe and allow them to go home watch again and possibly share with family and or friends
      - For telehealth can the patient view your screen? Nationally, this practice shows to be more effective than the office setting.
    - Click on green RX button
    - Scroll to top and see "Your Order"
    - Under Your Order, click "Complete Order"
    - It brings you to a screen to print directions, or copy link and send to portal for the patient to receive instructions.
- The directions give the patient a site to the MyACPdecsions .org and provides a code to watch the video. The patient clicks agree and understand. The code automatically populates and the video shows ready to start. Just as the example provides with the *Video code attachment* above.

Heidi Leupnitz, NHA, Medilodge of GTC Administrator & Melissa Slepicka, BBA, Medilodge or GTC, Leelanau and TC Admissions Director: Direct Admits

Please Review the Attached Admissions from home PowerPoint with the highlights for majority of presentation information

- Patients get 100 days of rehabilitation services. After the 100 days a 60-day gap is required before the patient qualifies again.
  - Simply call the Admission Director or Administrator at Medilodge and they will help with this qualification information.
- If a patient has Medicaid and they are over in assets. The patient will have a spend down. For example, if you are over 3,000 you need to spend that down before you qualify. Medilodge can assist in helping with ways to spend that money. For instance, if funeral planning has not been done, that money could be spent on funeral expenses for the future.
- Medical care 5 days a week and a 24/7 on-call provider

- Regarding 3877 and 3878 forms and exemption can only occur from the hospital setting. Sometimes you will get a recommendation for the patient to go to the ER so the ER can do their assessment and hospital exempt. However, try to avoid this unless it really is in the patient's best interest
    - The only exemption that would relate to Care Management would be dementia.
- Medilodge has hospice contracts with all available hospice in the area. Typically, Medicare pays for the hospice service and Medilodge works on a separate payer for room and board. This provides extra care to the person. For instance, Medilodge staff provides shower 3 days a week, hospice can provide the off days.

Other Attachments: *Admit From Home Check*

Rachael Smart, MSN, MHS, NPO Quality Support Specialist: SNF Update and Scenario Share with: Kate Marek, Karrie Martin, Echo Dean: *This information may or may not affect the Care Manager. However, if you are a Care Manager who is not notified of SNF ADT you may want to talk to someone at the practice to be notified especially if it is a Care Management patient. If it is not a Care Management patient this may increase opportunity for enrollment in TOC. If the patient agrees, do a once a week follow up for 4 weeks including the TOC. This can help decrease ER Visits, readmissions, and find needs before they become a bigger issue.*

- The NPO Evidence Based Committee, a subcommittee of the NPO Quality Committee worked with the SNFs to determine:
    - PCP Practices do want an admission notice, in addition to the discharge notice, from the SNF Admission
        - The notice should include plan of care including expected therapies and projected time of stay
    - Discharge
        - The simpler the better: It is ideal to receive this information in a general summary containing easy to understand terms
            - Which SNF is discharging the patient
            - Concise, accurate medication list that reflects changes and what is current
            - What therapies occurred including what was accomplished and what is still being worked on, especially regarding PT/OT and DME
            - Any therapies that are still being received
            - A problem list form is ideal
    - How to send to PCP practice
        - Admission and Discharge notices should be faxed and addressed to the practice, rather than a specific person.
        - After discharge PCP visit scheduling:
            - Each practice is unique. Some prefer to work directly with the patient and schedule follow-up with them. Others prefer the SNF to call the practice and schedule the FU appointment giving the practice a heads up that discharge is nearing and they can start preparing to contact the patient. Contacting the practice to determine how to handle this is desired. Details of the appointment scheduling should be included on the discharge notice.
    - This list was shared with all SNFs as the expectations of NPO PCP practices

Difficult Scenario 1: Kate Marek, GTCC

A 4-month-old baby transferred from Devos due to an aborted SIDS event. Had seizures and hypoxic brain injury. Needed follow up with several different specialties. CPS involved from Devos and a nurse at Devos who called to give a report, stating mom was very overwhelmed and needed a lot of help with coordination of care and if she no showed to any appointments it would be appropriate to file a CPS report.

At the new patient appointment, the care manager went in and spoke with mom about upcoming Devos appointments and role of care management in helping mom. Potential risk factors identified at that time where: caregiver stress, potential transportation difficulties, difficulty with care coordination and facilitation.

3 weeks later I called 5 different specialty offices in Devos to see if mom had made it to the scheduled appointments. Mom no showed to 3, one had to be rescheduled due to COVID, and one wasn't made yet. Tried to call mom 4 times that month, she never called me back. Spoke with a social worker at Devos who was also trying to get a hold
of mom.

I met with mom face to face when she came in for a physical. Mom becomes very defensive saying she never missed an appointment. Explained to mom that I had called and spoken to each specialty office and was told she no showed to 3 different specialties. Then mom starts making excuses- she was sick, couldn't get her telehealth to work and it wasn't her fault. Explained to mom that in the future if stuff like that happens, she just needs to make sure she is contacting the offices to let them know and get the appointments rescheduled. I ask mom if she needs the phone numbers to call and reschedule appointments, mom states she has them and she will call and make appointments. Ask mom if she needs any help getting to appointments, mom states she does not. Mom seems very reluctant asking for help. Mom explains she is in the middle of a court case to get custody of her other two kids back and has a lot of health issues and appointments for herself. Again, explain the role of care management and how I can help mom.

I called Devos 2 weeks later to see if mom had rescheduled any of the appointments. Only one appointment out of 3 was rescheduled. Tried to reach mom and she didn't answer her phone or return my calls, so this time I mailed a letter with all upcoming appointments and phone numbers if mom needed to reschedule, including phone numbers for the specialties she still needed to make appointments for. I included my number for any questions.

A month later called Devos to see if mom had made the final two appointments, she had not and the referrals had been closed out. Tried to get a hold of mom again and she never returned my calls.

3 weeks later mom calls me back asking for a referral for ENT in TC since Devos wouldn't see her anymore. Explained to mom about the no shows and that we could certainly do a referral to an ENT in Traverse City if that would be easier for her.

Discussion/ Suggestions:

- Mom does not seem very engaged and there is not much background on why CPS was involved in the first place. This situation is very difficult for the Care Manager, being put into a "cop" like situation. Could the mom be viewing the Care Manager in this way? It's a very tough place to start for relationship building. It appears mom needs support. It was found not many Motivational Interviewing skills had been utilized for different reasons. Building the relationship can be one of the most important things especially when the patient is not engaged or in this situation where the mom may have less trust because of the "cop" like situation. Perhaps questions such as, "Can you tell me how you are doing with all of this, please elaborate a little? How does this situation make you feel, please elaborate a little? What is important to you? What do you think is keeping you from making these appointments? How do you think we better this situation together? Besides dad, do you have any family or friend support? What would you feel comfortable asking these supports with? Trying the reflection technique may also be a way to get mom to open-up. Kate hopes to try some of these techniques in the future.

Difficult Scenario 2: Karrie Martin, West Front Primary

Patient X had their spouse present for their initial Care Management Meeting The patient was not receptive or open to education. The patient stated that he is unmotivated and likely will not change his eating habits or increase his activity. His eating habits were due to pickiness and was blamed on his wife. "She does the cooking; I eat what she makes." They bickered back and forth the whole time and were not interested in any of the educational material I had to provide. He blamed his lack of activity on Covid-19 despite having land and woods he could explore. I have a follow up phone call with him today; it has been over a month since our initial meeting. It is doubtful he will continue with care management despite my best efforts.

Discussion/ Suggestions:

- It was found that this patient was referred by his PCP with the understanding that he could try one visit and go from there. It was clear the patient did not want to be there and was appeasing his one visit. A good tool in this situation is reflection and recognizing what they patient is putting out. His resistance may be coming from the fact that the Care Manager is going to tell him how to live, most people do not like being told what to do. Try saying something like, "You seem to be pretty happy with the way you are or the way things are? I'm not going to make you change because I can't make you change." This may cause the patient to say something like, "well things could be better…" Leading into, "well what do you mean by that etc." From there you may be learning what is important to the patient, does he have any hobbies? With patients who are resistant to change, start slow. It was mentioned the practice has created a nutrition 101, if the patient is resistant, they will tune right out when trying to go over education materials. First start by building the relationship and planting the seed. Other suggestions included had the patient been screen for anxiety or depression and did this occur before and or after COVID? The patient has been screened both times but was not admitting to any signs or symptoms. However, using the techniques just mentioned, may open the door to issues in this area. The patient has ignored the next Care Management attempts through phone. It was suggested to pop in on his next appointment,

perhaps that's all it will be with him for a while and try some of the new techniques. Perhaps he won't take the bait soon, however a relationship can start to build, a seed can be planted and the patient may start to consider trying and become less resistance to change.

Success Scenario 1: Echo Dean, West Front Primary

Client: 52-year-old male, diagnosed with anxiety and adult ADHD

Low self-esteem, feeling hopeless and unworthy, comes from a highly intelligent but very dysfunctional family, was the scapegoat in the family dynamic, started but never finished college, married once for a few years but divorced, no children, has lived with elderly parents for several years to help them but is seen by siblings as a failure

I have seen him for about 1-1/2 years. He just finished his degree in Journalism from MSU and is currently looking for work in his field. He has had a well-paying job for about the past 6 months (not related to his field of interest but is something he can keep and still work in his field). He is going to be leaving his parent's home in the next few months to a place of his own, not because his parents don't still require help but because he has come to realize how toxic this environment is for him. He is off all medication except for his ADHD meds and now sees himself as an intelligent, worthwhile person who deserves to be respected and treated accordingly.

Discussion/Questions

- This was a journey with lots of bumps in the road and many times where the patient wanted to give up because making changes is hard. Echo kept up on constant encouragement, helping him realize his worth, and provided lots of support especially during times when he was struggling. The turning point seems to be when he truly began to believe in himself. His feelings were often normalized making him know that it is ok to feel for instance frustrated at times. Echo mentioned being humbled to part of this experience.

Success Scenario 2: Dawn Maccgir, Northern Pines shared by Rachael Smart

62-year-old male who has been a patient to this practice since 2012. He has been a heavy smoker since the age of 10. Comes from a poor background, illiterate, 8th grade education which has made things a little more difficult.

He would never discuss quitting. He started CM about 3 years ago. The Care Manager has gained a relationship with him over these three years. Each visit she would say something like, "I'd like to talk about your smoking whenever and if ever you are ready". This felt awkward to The CM at times because she figured he would never want to talk about it- what was the point? She continued to gently plant the seed.

About a month ago he said something like, "well, if you tell me I quit that I will breathe better we can discuss this. I understand it may not fix everything such as my oxygen levels etc. but that's ok". He started with a patch. He has not yet completely quit but has cut down. Since he started attempting quitting, he has mentioned feeling better- little more energy and time! He likes to work in the woods, and on his truck. The truck can be a trigger so he goes to the woods more. It depends on the day but he was at 1.5-2 packs now he is at .75 - .5 pack!!

Discussion

- This can tie back to Karrie's Scenario where the patient isn't interested in talking, perhaps popping in the room and having simple normal as possible conversation with MI techniques while planting the seed, "what and if you are ready to talk about X I am here, I know you don't like to hear that but unfortunately for you that is my job." Eventually the patient may agree to change but I can take a long time; time can be needed to create space for change and changing resistance to change. When this happens, it can be very rewarding. One Care Manager commented that building the relationship in this situation may have been the foundation for this patient.

Please watch the following video that is similar to Dawn Macgirr's scenario but can be applied to all the scenarios discussed and portrays the importance of building relationships, the use and power of Motivational Interviewing techniques, and the time it can take to make change.

https://www.youtube.com/watch?v=0z65EppMfHk

Next Meetings: 2020

- October 29th – Virtual Community Support Groups Present
- December 10th – Motivational Interviewing with Kevin DeBruyn