



## Curriculum

Funded by The John A. Hartford Foundation

Audience: Registered Nurses who have a background in primary care settings

Length: 2 Day Seminar, 8 Core Modules with Supplemental Information

### Introduction

Care management provides a system of treatment across the health care continuum for people with a particular condition or combination of conditions. It weaves together efforts between multiple points of care, supports therapeutic relationships, protects the quality of patient care, and decreases health care costs for defined populations. Quality care management gives patients and families seamless transitions—transitions that move them to the needed services and providers at the appropriate time.

The Care Management Plus model, which includes key elements of the Chronic Care Model (CCM), uses a primary care team approach with the patient at the center. The generalist care managers are located within multi-payer primary care clinics, where they collaborate with physicians, patients, families, and community resources to improve patient outcomes for a variety of conditions.

A critical model element is the use of an electronic health record that allows flexible access to clinical data, individualized decision support, and communication between providers. The individualized decision support encourages best practices for patients with a variety of both primary and secondary conditions. This care management model encourages patient self-management, creates core health care organizational goals, and improves the providers' and patients' connections to community resources.

### Curriculum Description

This in-person and online curriculum is devoted to essential topics in care management. Its underlying assumptions are that knowledge is constructed from experience and that learning is an active, collaborative process. Conceptually, the curriculum moves the learner from the acquisition of facts about the role of care managers to the synthesis and application of evidenced-based information in a clinical, care manager situation. It is constructed to ensure that learners not only stay motivated and engaged, but that they also successfully interact and collaborate in an online learning environment.

The curriculum begins in the more traditional instructor-student/deliverer-receiver roles with the instructor leading the first in-person seminars and setting the initial class tone. Participants of the in-person seminar will get to know instructors and members of the course and become familiar with the online classroom. With knowledge about the care manager's role established, and basic online course competencies acquired, module 1 introduces the first online content-based, engaged activities. The remaining modules' interactive elements progress through case-focused, learner-driven critical thinking activities, collaborative problem solving exercises, and a final case synthesis focused on management of the frail elderly.

The actual curriculum content explains the role and functions of the care manager and highlights critical issues in the physical and emotional management of chronic illness for both individuals and their families. By using this curriculum, care managers will improve their overall knowledge of common chronic illnesses, the physiologic changes associated with the conditions, co-morbid assessment and treatment considerations, and the evolving self-management needs of patients and their families.

They will also increase their knowledge of, and comfort with, discussions of palliative care. The curricular threads in each unit include: case studies, condition-specific barriers to care, cultural diversity in self-management approaches, health literacy issues, health promotion, and strategies for accessing local and web-based community resources for professionals, patients, and families.

### Curriculum Goal

In collaboration with patients, families, health care providers, and community resources, care managers will facilitate meeting the complex needs of patients through quality, effective and resource-efficient interventions and referrals.

### Curriculum Objectives

Care Managers who successfully complete the Care Management Plus curriculum will gain skills to:

1. Teach patients with multiple chronic diseases to organize, prioritize, and implement suggested self-management strategies
2. Identify barriers to care and intervene to overcome or eliminate these when possible
3. Coordinate resources to ensure that necessary services are provided at the most appropriate level of care and at the appropriate time
4. Identify patient situations at-risk for destabilization and intervene to eliminate the risk when possible
5. Gather, interpret, and use data to identify problems and trends and to demonstrate outcomes and cost-effectiveness

### Curriculum Format

In-person seminars; online modules

### Teaching Methods

Lectures, online discussions, self-directed learning, case studies, online exercises

### Course Requirements

Weekly module completion which includes website reviews, readings, online discussions, and related assignments

### Evaluation Strategies

Final case study syntheses, reflective journals; online discussions; expert phone discussions, and assessments

## Course Completion

A certificate of completion will be awarded when the curriculum deadlines and requirements are met

## Required Texts

Required readings are linked in PDF format in each module

## Core Curriculum Topics

Module	Title
In-person	Chronic Disease Management & Outcomes of Care Management Plus
In-person	Roles and Responsibilities of Care Managers
In-person	Motivational Interviewing
In-person	Patient/Family Assessment & Caregiver Support
In-person	Tools for Assessing Patients
In-person	Care Management in the Medical Home
In-person	Implementation of CM+: Strategies, Success Metrics & Quality Measures
In-person	Orientation to Care Management Tracking Software
Online 1	Pain
Online 2	Palliative Care
Online 3	Advance Directives
Online 4	Sleep Disturbances
Online 5	Hypertension, Diabetes, Depression
Online 6	Asthma & COPD
Online 7	Dizziness, Falls & Safety Evaluation
Online 8	Management of the Frail Elderly

## Supplemental Information

Supplemental Information	Title
A	Diabetes
B	Heart Failure
C	The Older Driver
D	Constipation in the Elderly
E	Age-Related Incontinence and Bladder Problems in Women
F	Preventive Health in Older Adults
G	Pediatric Bronchiolitis & Asthma
H	Nutrition and Exercise Patient Information
I	Challenging Populations

