

PrimePartners

for Case Managers

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Best Practice Care Coordination Learning Day Is September 29

County case managers who work with members of PrimeWest Senior Health Complete (HMO SNP), Minnesota Senior Care Plus (MSC+), Special Needs BasicCare (SNBC), and Prime Health Complete (HMO SNP) are invited to attend the Best Practice Care Coordination Learning Day on Thursday, September 29, 2016, from 8:30 a.m. to 4:30 p.m. at the Radisson Blu Mall of America.

This learning day is presented by the Minnesota Department of Human Services (DHS), Blue Plus, HealthPartners, Itasca Medical Care (IMCare), Medica, Metropolitan Health Plan (MHP), PrimeWest Health, South Country Health Alliance (SCHA), and UCare. Registration is free; lunch will be on your own.

More information can be found on the [DHS website](#) under the “What’s New” heading. 

Skilled Nursing Facility (SNF) Comprehensive Assessment Tool

Kristi Shamp, RN, BSN, CPHM, SNP Senior Care/UM Care Coordinator

PrimeWest Health is excited to announce the launch of the newly revised *Skilled Nursing Facility (SNF) Comprehensive Assessment Tool*. As of May 16, this is the tool county case managers will use for members of PrimeWest Senior Health Complete (HMO SNP), Minnesota Senior Care Plus (MSC+), Prime Health Complete (HMO SNP), and Special Needs BasicCare (SNBC) who have been admitted to and reside in an SNF. The tool must be updated at least annually and each time there is a change in member care, status, or need.

Benefits of the tool

- This one-part tool combines and replaces the previous two-part SNF tool.
- The tool is a working document. This means that once you create the original assessment, you will make updates to this *same* assessment. You do not need to recreate a new assessment each time you make an update.

You can access the tool directly at www.primewest.org/forms/snf-assessment. You will be prompted to enter a user ID and password. Use the same log in information you use for the electronic care plan.

If you have questions, please send an email to seniorcare@primewest.org. 

July 2016 Formulary Changes

Ann Ehlert, PharmD, Pharmacy Manager

PrimeWest Health’s Medicaid formulary is updated at the beginning of each year and quarterly thereafter. The following changes will become effective July 2016 for the Medicaid formulary.

The following drugs will be removed from the formularies, but an alternative will be available:

- Pataday® 0.2% drops will be removed. They are now available as generic olopatadine 0.2% drops.
- Suboxone® film and buprenorphine/naloxone tablets and film will be removed. Formulary alternatives will be Bunavail® film and Zubsolv® tablets.

Many generic drugs will be added to the formularies along with the following brand name drugs:

- Alecensa®
- Bunavail®
- Strensiq®
- Zubsolv®

In addition to the changes to our covered formulary drugs, the following is a list of recently released drugs that have been classified as non-formulary. This list may help you answer member questions about coverage and denials.

- Allzital®
- benzoyl peroxide wash and topical cleanser: 3%, 7%, and 9%
- cyclopentolate HCL 0.5% ophthalmic drops
- Enstilar®
- ephedrine sulfate – 0.9% NaCl/PF 50 mg/10 mL intravenous syringe
- FreeStyle Precision Neo™ blood glucose meters and strips
- FORA® D40/G31
- FORA® and OneTouch® Delica® lancets
- metformin ER 500 mg and 1,000 mg (Glumetza®)
- morphine sulfate – 0.9% NaCl/PF 50 mg/25 mL PCA intravenous syringe
- naftifine 2% topical cream
- norethindrone-e.estradiol-iron (Microgestin® 24 FE) 1 mg-20 (24) tablet
- norgestimate-ethinyl estradiol 7DAYSX3 LO tablet
- OneTouch Verio®
- Pradaxa® 110 mg capsule
- QuilliChew ER™
- Safe-Clip™
- Tagrisso™
- tretinoin microspheres (Retin-A Micro®) 0.1% topical gel
- Viberzi™
- Vraylar™
- Zepatier™

You can review the [formulary](#) and [pharmaceutical management procedures and criteria](#) on our website. If you have questions or would like to request a printed copy, call our Provider Contact Center at **1-866-431-0802** (toll free). 

Talk with Members and Their Parents about Summer Camps

If you know a child or teen who would benefit from attending an asthma, diabetes, or weight management summer camp, let us know! PrimeWest Health encourages all eligible members to attend qualified camps. We think this is a great way for youth to learn more about their conditions and to form friendships with other kids who have similar issues. Because of this, PrimeWest Health pays all registration fees for qualified camps for children who are PrimeWest Health members when camp begins.

Qualified camps are listed below. We encourage you to tell members about these camps and to refer those who qualify. Camps start soon, but there is still time to register!

Qualified asthma camps

- **Camp Superkids** – An overnight camp for youth ages 7 – 15. It's held June 26 – July 1 in Loretto, MN.
- **Camp We-No-Wheeze** – An overnight camp for youth ages 7 – 13 who use daily preventive asthma medication. It's held August 13 – 15 in Annandale, MN.

Qualified diabetes camps

- **Camp Daypoint** – A day camp for kids ages 5 – 9. It's held August 15 – 19 from 9 a.m. to 3:30 p.m. each day. The camp is located in Hudson, WI. Buses pick up and return campers to Minneapolis and St. Paul locations.
- **Camp Needlepoint** – An overnight camp for youth ages 8 – 16. It's held August 14 – 20 or August 21 – 27 in Hudson, WI. 16-year-olds can participate in the Leadership Development program, which runs from August 14 – 27.
- **Camp Sioux** – An overnight camp for youth ages 8 – 17. It's held June 12 – 17 or June 19 – 24 in Park River, ND. There is also a "camp sampler" program for kids ages 8 – 10 held June 12 – 15.
- **Camp Sweet Life** – A day camp for kids ages 5 – 7 and an overnight camp for youth ages 8 – 15. It's held August 14 – 18 in Madison Lake, MN.

Qualified weight management camp

- **Camp Healthy U** – An overnight camp for youth ages 10 – 15. It's held July 5 – 8 in Loretto, MN. This camp is specifically for youth who have a body mass index (BMI) higher than the 85th percentile for their age and gender. Camp Healthy U can help determine if a child falls into this category. You can call them at **1-866-937-9622** (toll free).

If you would like more information or want to refer a member to one of these camps, please contact **Jennifer Bundy** or **Ann Challes**. 

Substance Abuse in Older Adults: Why It Often Goes Undetected

Chelsey Wildman, BES, LADC, ADC-MN, Chemical Dependency Care Coordinator

Addiction does not discriminate based on culture, gender, sexual orientation, financial status, or age. Yet, when we think of addiction, we often have a picture of a certain “type” of person in mind—and that person is usually young. We don't often think of an older person as the “type” who struggles with substance abuse.

But the reality is that “substance abuse, particularly of alcohol and prescription drugs, among adults 60 and older is one of the fast growing health problems facing the country.” Up to 17 percent of adults 60 and over have been identified as misusing alcohol and prescription drugs. As Americans continue to live longer, not addressing substance abuse issues in the older population robs seniors—and their families—of valuable time and can cause unnecessary health complications (Center for Substance Abuse Treatment 1998).

Older adults are uniquely vulnerable to substance abuse for the following reasons:

- Drugs (prescription or illicit) often have a stronger effect on older adults compared to younger adults. This is mainly due to biological changes that occur with age (Perkinson 2012, 186).
- The number of research and clinical trials of medications that have been conducted using older adults are limited, leading to a lack of knowledge about how many medications affect this population (Center for Substance Abuse Treatment 1998).
- Older people “tend to take a variety of medications without proper medical supervision” (Perkinson 2012, 186).
- The loss of family and friends that comes with age, possibly coupled with retirement, can lead to “a depressive state where substances are used to ease the pain” (Perkinson 2012, 186).

However, evidence shows that treatment of older adults with substance abuse issues is effective and worthwhile. Studies have shown that, “compared with younger patients, older adults are more likely to complete treatment . . . and have outcomes that are just as good or better than those of younger adults” (Center for Substance Abuse Treatment 1998). But there are still many barriers to treatment. Understanding these barriers and why they exist is important.

Barriers

- **Ageism.** When people reach a certain age, there is a tendency to “explain away their problems as a function of being old rather than looking for specific medical, social, or psychological causes.” This tendency, known as ageism, is one reason substance abuse is often overlooked in older adults. Assumptions are made that, because someone is older, she isn't in need of education, intervention, or treatment. Another common misconception is that older people won't have a very good quality of life regardless of whether they get treated for substance abuse, or that they are not likely to live long enough to justify treatment (Center for Substance Abuse Treatment 1998).
- **Stigma.** Many older adults see substance abuse as a “moral failing” and do not feel that it is a real disease. If they do, they may feel the “stigma associated with psychiatric disorders” such as substance abuse very acutely. Children of older adults often feel this same stigma and are ashamed that their parent is experiencing substance abuse issues. This often leads to avoidance and denial, which only continues the cycle of abuse and

physical and mental deterioration (Center for Substance Abuse Treatment 1998).

- **Lack of detection.** When providers see a patient, their attention is directed at evaluating the symptoms that brought the patient into the care setting.

Substance abuse often ends up at the bottom of the list or is not considered at all when a patient presents with many medical or personal problems. Providers, older patients, and family members typically place higher priority on physical conditions such as heart problems and renal failure than on alcohol abuse (Center for Substance Abuse Treatment 1998).

This often leads to substance abuse going undetected or being blamed on another illness or old age (Perkinson 2012, 187).

As county case managers, you can make a difference by being an advocate for members. Consider doing the following:

- Start a discussion with the member.
 - Talk about alcohol, its effects, and how those effects change with age. Also talk about how much the member drinks and how much could be too much.
 - Talk about the importance of taking medications as prescribed.
 - Talk about the dangers of using alcohol or other substances in combination with prescribed medications or over-the-counter drugs.
 - Talk about resources the member has and who she can contact with questions or concerns.
- Get the member's primary care provider involved.
 - Help the member prepare for health care appointments. Go through a practice scenario with the member so she will be more comfortable and able to express herself during the actual appointment.
 - Attend the appointment with her.
 - Talk with the member's primary care provider about conducting a Screening Brief Intervention and Referral to Treatment (SBIRT) to determine the need for further assessment.
- Help schedule a Rule 25 assessment with the member's county Social/Human/Family Service department to explore the need for outpatient or residential treatment.

You can be the difference in breaking the silence. Help members be healthier and value their later years. Hope and the opportunity to live a healthier life should not go away simply because a member gets older.

Sources: Center for Substance Abuse Treatment, "Substance Abuse among Older Adults: An Invisible Epidemic," in *Substance Abuse among Older Adults*, Treatment Improvement Protocol (TIP) Series, 26 (Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998), www.ncbi.nlm.nih.gov/books/NBK64422.

Perkinson, Robert R., *Chemical Dependency Counseling: A Practical Guide*. 4th ed. (Los Angeles: SAGE, 2012), 186 – 187. 

Helping Members Cope with Anxiety Disorders

Lourie Kavanagh, SNBC Care Coordinator

Just about everyone experiences anxiety in some way, shape, or form in their everyday lives. Under certain circumstances, anxiety can be useful. According to Jerilyn Ross, MA, LICSW, "Anxiety is a natural reaction . . . that reaction helps motivate us, prepares us for things we have to face, and sometimes give us energy to take action when we need" (quoted in Davis 2005).

However, for people with an anxiety disorder, the anxiety does not go away and can get worse with time. This type of anxiety involves more than temporary worry or fear: it is excessive, hard to control, and interferes with relationships and daily activities such as work and school. According to the Substance Abuse and Mental Health

Services Administration (SAMHSA), “Evidence suggests that many anxiety disorders may be caused by a combination of genetics, biology, and environmental factors,” and they are not rare. “National prevalence data indicate that nearly 40 million people in the United States (18%) experience an anxiety disorder in any given year” (SAMHSA 2015).

If you work with a member who has high anxiety, encourage him to contact his primary care provider for an assessment. The primary care provider may recommend the following:

- Various forms of counseling, including cognitive behavioral therapy, psychotherapy, relaxation training, or a combination thereof. Counseling/therapy can help address the underlying reason a person suffers with anxiety.
- Medication
- A combination of medication and counseling/therapy

You can also share the following basic tips from the Anxiety and Depression Association of America (ADAA) with members to help them cope with and work through anxiety:

- Limit alcohol and caffeine
- Get enough sleep
- Exercise daily
- Focus on deep breathing
- Don’t try to be a perfectionist—do your best and accept that you can’t control everything
- Try to maintain a positive attitude
- Try to learn what triggers your anxiety. Keeping a journal can help.
- Tell someone how you are feeling. Positive support from family and friends helps reinforce treatment.

Anxiety disorders can greatly interfere with a person’s life. Make sure members know that they are not alone and that help is available.

Sources: Davis, Jeanie Lerche, “Coping with Anxiety,” WebMD, 2005, www.webmd.com/anxiety-panic/guide/coping-with-anxiety.

SAMHSA, “Mental Disorders,” last updated October 27, 2015, www.samhsa.gov/disorders/mental.

“Tips to Manage Anxiety and Stress,” ADAA, 2016, www.adaa.org/tips-manage-anxiety-and-stress. 

Tools for Person-Centered Thinking: Part 3 of 7

Ann Tesch, RN, BSN, PHN, CCP, Complex Care Coordinator

This is the third in a series of articles about tools to help county case managers develop a skill set focused on person-centered thinking, a concept that emphasizes empowerment, personal rights, choice, and inclusivity when working with members. This article focuses on the concept of relationship mapping.

A relationship map is a tool that you and a member can develop together. It can be used to do the following:

- Identify the important people in a member’s life
- Help identify potential issues with specific relationships and determine if the relationships are positive or negative
- Determine how important each person is to the member and if the member wants the person involved in his care planning and treatment team
- Identify people who might be able to provide additional insight into the member’s needs and wants
- Identify potential relationships where the member has support, but may not have thought of it that way.

Examples include unpaid support personnel, such as family members, neighbors, and friends.

The people identified on a relationship map should include family members, friends, paid and unpaid support

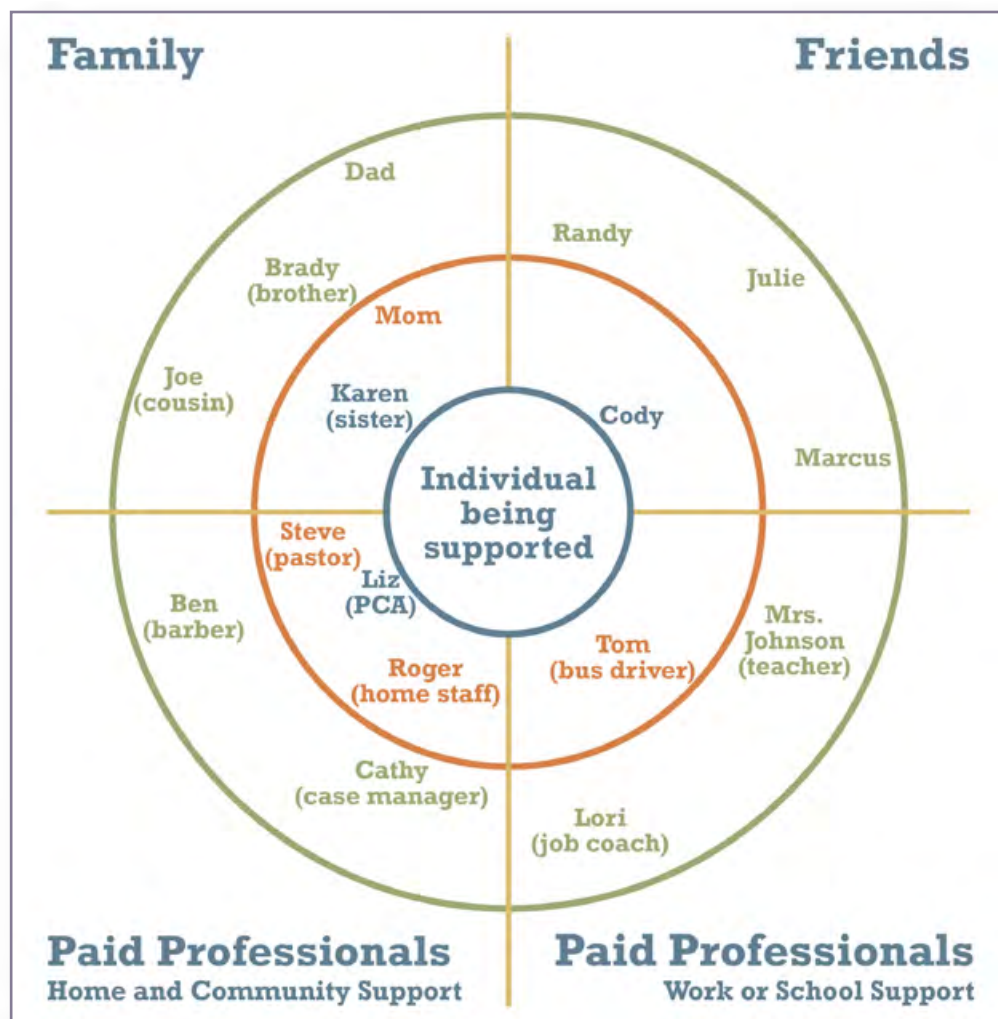
personnel, and coworkers, as applicable. A relationship map is typically drawn as a circle divided into quadrants with the name of the member placed in the center of the circle. Quadrants are labeled “family,” “friends,” “paid professionals – home and community support” and “paid professionals – work or school support.”

Talk with the member to identify and place people on the relationship map based on the kind of support they provide and how close or important they are to the member. The level of closeness or importance is indicated by placement on the relationship map. The farther out from the center a person is placed, the less of a support that person is.

A relationship map is a simple tool to use, and it is a great way to help members make the best use of their community by identifying relationships that are important to and for them and where potential supports may be missing. **However, it may be best not to use relationship mapping if the member you are working with is experiencing depression or suicidal ideation.** It can potentially increase depression by identifying a member’s lack of support or relationships. Relationship mapping is best utilized after the member is stabilized and actively working on integrating himself back into the community.

A sample relationship template is shown below. As you can see, it is simple to use and offers a visual representation of the member’s important relationships.

For more information, please see the [Learning Community for Person Centered Practices](#) website or contact **Ann Tesch**. 



Important Dates

✓ County supervisor meeting

Meetings are held on the third Thursday of the month, 10 a.m. – 3 p.m., at PrimeWest Health in Alexandria, unless otherwise noted.

June 16	October 20
July 21	November 17
August 18	December 15
September 15	

✓ County case management educational training

Trainings are held on the fourth Wednesday of the month via webinar from 10 a.m. – noon, unless otherwise noted.

May 25	September 28
June 22	October 26
July 27	November 23
August 24	December 28

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