SIM Case Presentation*

SIM Participant: 60-year-old male, residing in Ypsilanti

Care team lead: Michigan Medicine Complex Care Management Program (MM CCMP)

Care team members: Home of New Vision, IHA (as primary care provider), community health worker (CHW)

Other service providers (PCP, MH, SA, etc): Participant was previously at Michigan Medicine's Ypsilanti Health Center, but established with IHA (Neighborhood Family Health Center) in April 2018, & IHA Pain Management

Underlying conditions:

A. **Medical conditions:** hypertension (high blood pressure), hepatitis C, chronic obstructive pulmonary disease (COPD), chronic pain, Atrial Tachycardia, History of Bilateral blood clots, and alcohol induced cardiomyopathy
B. **Major psychiatric conditions:** Depression
C. **Substance Use Disorder:** Polysubstance abuse to include: alcohol, heroin, and cocaine.

History:

At the time the SIM referral was entered by the original case study author, the participant had been identified by one of MM CCMP's Care Manager Assistants through the daily ED discharge triage. The participant had been seen in the ED for a fall, which was preceded by an inpatient stay for a fall, which led to findings of bilateral blood clots (started on anti-coagulation medication). Chart notes indicated concerns around a lack of follow through and engagement in his care (participant had recently fired Home Care and was refusing to have repeat lab work completed), as well as self-reported active substance use, including heroin and cocaine.

After further review the care manager discovered that the participant had been previously connected with Home of New Vison and also had some utilization at St. Joseph Mercy Health System. The care manager then submitted a SIM referral.

Barriers:

Engagement was initially a challenge, as the participant only has a government minute phone with limited monthly minutes. After failed attempts to reach him by phone, the care manager submitted a Community Health Worker (CHW) Referral. The CHW and care manager initially completed 2 home visits without success. On the third attempt, the care manager and CHW were able to make contact and obtain consents and get the participant fully enrolled. The participant expressed great appreciation for our outreach and persistence.

**Case presentation from June, 2018 SIM Work Group meeting. Edited to increase anonymity and reduce medical terminology.*

Social supports/Environmental challenges (include strengths and weaknesses of social support system, key contacts, living conditions, access to transportation, phone service, caregiver stress):
The participant has limited social supports. He has 2 siblings that live nearby, but they have their own biopsychosocial barriers and are limited in the amount of support they can provide.

Housing Status:
The participant is housed in Ypsilanti with a Section 8 Voucher, obtained through his former Home of New Vision care manager.

Household income source *(include non-traditional)*:
No formal income, has worked odd cash jobs for several years. Currently unable to work, due to falls and risk (was working at a car wash for the last couple years).

What are the individual's monthly financial obligations? Utilities bills

Participant Strengths:

- Willingness to engage
- Openness and insight into how his substance use was impacting his health care

Care Plan Goals Identified and achieved *(w/care manager, CHW, and Home of New Vision assistance):*
MM CCMP assisted in connecting the participant with a new primary care provider and the IHA Pain Clinic. By establishing with the IHA Pain Clinic, the participant was able to begin Suboxone maintenance therapy in June to better address his substance use and pain. The care manager assisted in connecting the participant with Orthopedic surgery at Michigan Medicine to rule out a meniscus tear in his knee. As a result, the participant was released to begin physical therapy, with hopes of achieving another one of his self-identified goals to return to work. MM CCMP also assisted in obtaining medical equipment for the participant. In addition, the community health worker was instrumental in assisting with scheduling transportation, providing additional community resource information, assisting with obtaining new furniture, following a recent bed bugs infestation, and, per the participant's self-report, it has been extremely beneficial to have someone to check in on him in the community.

If it wasn't for the clinical–community care coordination model that SIM offers, it's possible this participant would have been lost to care and not able to achieve many of these goals.