MI-CCSI
Partnering to Better Care

ATTENDEE HANDOUT

TEAM BASED CARE

MI-CCSI
Center for Clinical Systems Improvement

CONTENTS

AGENDA

TEAM-BASED CARE TRAINING

Optimizing the Impact of the Roles of Care Managers & Coordinators

Arrival ..... 7:45 - 7:50 am

Welcome ..... 7:50 - 8:00 am

Care Team Models and Team Roles ..... 8:00 - 10:00 am

Break (10 minutes)

Care Management Process Overview .....10:10 - 12:00 pm

Lunch (30 minutes)

Care Management Process Overview [CONTINUED] .....12:30 - 1:00 pm

Outcomes; Triple AIM ..... 1:00 - 1:30 pm

Break (5 minutes)

Billing and Coding..... 1:35 - 2:50 pm

Success Strategies ..... 2:50 - 3:35 pm

Evaluations and Wrap up ..... 3:35 - 4:00 pm

Share the Care: Assessment of Team Roles and Task Distribution

This is an example of a planning tool, to assess who is currently doing what tasks in your practice and then who should be doing each task, based on how we learned that LEAP sites define clear roles and responsibilities. There is no "right answer"; task distribution will vary from practice to practice, based on contextual and internal factors. The tool is in the discussion about roles that this worksheet can stimulate. Your practice may be able to redistribute the tasks in a way that better fits your workforce and patients.

Instructions:

1. Modify the worksheet so that the columns reflect all care team roles and the rows contain the most important tasks in your practice. (Note: we use the term "lay person" to mean someone without medical background, so this may include lay caregivers such as Community Health Workers or administrative staff members such as Front Desk staff).

2. Gather a group of staff members who are engaged in redesigning care roles, representing all the roles on the care team.

3. Assess your practice at the current time, for each task. The tasks are organized by categories, such as "communications with patients, outside of the patient office visit." Check boxes to indicate "**Who does it now?**"

4. Next, use the worksheet to think about "**Who Should Do It?**" Discuss which roles are capable of doing each task and how well the work is distributed across roles. Use a different color to check boxes where you think that tasks can be redistributed for improvements to everyone's workload.

	MA	RN	Lay person	PharmD	BH specialist	No one	Other
Communication with patients, outside of patient office visit							
Answer phones, triage calls							
Help manage/triage provider electronic inbox							
Serve as primary point of contact for patients							
Conduct patient outreach for outstanding labs, etc.							
Follow-up by phone or email after visits to make sure that patient understood instructions							
Follow-up with patients after hospital discharge							
Follow-up with patients after Emergency Department visit							
Respond to patient calls requiring clinical assessment and decision-making							
Community-based efforts to connect new patients to the practice							
Notify patients about normal lab results							
Notify patients about abnormal lab results							
Preparation for patient visits and proactive population management							
Pre-visit planning/chart scrubbing							
Conduct patient outreach for outstanding labs, etc.							
Independent visit to prepare patients for a provider visit							
Participate in care team huddles to review the plan for the day							
Participate in regular meetings to review outcomes for patients who have not yet reached chronic disease-related clinical goals							
Participate in regular meetings to review outcomes for patients who have not yet reached chronic mental health-related clinical goals							
Patient visit tasks							
Perform injections							
Reconcile medications							
Scribe for providers							
EKGs							
Spirometry							

	MA	RN	Lay person	PharmD	BH specialist	No one	Other
Assist with basic procedures							
Conduct well visits (with provider oversight)							
Conduct preventive care visits (with provider oversight)							
Patient education, coaching, and care management							
Perform "teach-back" with patient at end of visit							
Orient new patients to the practice							
Develop care plans with patient							
Help address barriers to patient goals							
Health coaching and motivational interviewing							
Patient health education							
Conduct group visits							
Conduct home visits							
Complex care management							
Medication titration, by protocol							
Run patient support groups							
Meet with patients about concerns or resistance with taking medications							
Conduct thorough medication reviews with patients							
Provide self-management support to patients							
Screen patients for depression and other chronic mental health disorders							
Screen patients for substance use disorders							
Administrative and Quality Improvement							
Participate in quality improvement and practice improvement activities							
Lead quality and practice improvement activities							
Coordinate/track outgoing referrals							
Close the loop on referrals (consult notes from the specialist have been received and added to our EHR)							
Administrative tasks around medication refills, labs, imaging							
Pre-authorizations							

	MA	RN	Lay person	PharmD	BH specialist	No one	Other
Check patients in							
Check patients out							
Generate exception reports or registries in order to conduct population management/outreach							
Generate team-level QI reports							
Supervise and support MAs							
Lead the care team							
Other services							
Run specialized care services, such as programs for obstetric patients or Coumadin patients							
Connect patients to resources in the community							
Help patients navigate the health care system							
Consult providers and clinical staff on medication use and dosing							
Provide brief or short-term counseling for patients coping with an episodic behavioral health concern							
Consult with providers on evidence-based treatment for depression, anxiety, or bi-polar disorders							
Other tasks:							
Other tasks:							
Other tasks:							
Other tasks:							
Other tasks:							

Agency for Healthcare Research and Quality

SBAR, which stands for Situation, Background, Assessment, and Recommendation (or Request), is a structured communication framework that can help teams share information about the condition of a patient or team member or about another issue your team needs to address.

In phrasing a conversation with another team member, consider the following:

SITUATION

What is going on with the patient?

"Dr. Lu, this is Alex, a nurse from your 5th Street office. I am calling about your patient, Mr. Webb. He reports being in substantial discomfort and that there is not much urine in his catheter bag."

BACKGROUND

What is the clinical background or context?

"Mr. Webb is an 83-year-old patient that has a catheter in place during his recovery from bladder cancer treatment."

ASSESSMENT

What do I think the problem is?

"He also reports a temperature of 100.4 and that the urine in his bag is cloudy and slightly red. I am concerned he may have an infection and that his catheter may be clogged."

RECOMMENDATION OR REQUEST

What would I do to correct it?

"I would like him to come into the office this morning for you to see him. When he arrives, would you like us to get labs, including blood cultures, to check for infection?"

SBAR is one of the most widely used TeamSTEPPS tools for many reasons:

- Structured communication tools such as SBAR can enhance communication between members of the healthcare team.
- SBAR provides a vehicle for individuals to speak up and express concern in a concise manner.
- SBAR is useful for framing any conversation, especially critical ones requiring a team's immediate attention and action, such as when a patient's condition is rapidly deteriorating. It may also be useful with providers who are not part of the core team, such as remote consultants or mental health providers.

Using SBAR effectively requires careful attention to each step:

- **Situation** states what is currently happening with the patient. It usually begins with the identity of the person communicating the SBAR, patient identifiers such as age and gender, and a brief statement of the current problem or situation.
- **Background** covers clinical background such as patient history related to the current situation, signs and symptoms of the presenting complaint, and any test results, such as lab or imaging reports.
- **Assessment** reports what the person communicating the SBAR thinks the problem is. It states what the nurse or other provider has assessed based on the background information, patient history, and observations. Assessment asks what else it can be, provides sense making, considers sources of other information to provide clarity, and relates actions to consequences. Assessment can also include objective data such as vital signs.
- **Repeat-Back Recommendations and Requests** states an initial recommendation, what is needed and when, and repeats back the stated response from the other provider or patient to ensure accuracy.

Additional notes on using SBAR include:

- Do not forget to introduce yourself—you should not assume that everyone knows who you are.
- SBAR is adaptable. Think of it as a menu: the parts you choose to use and the order in which they are used depend on your team's unique needs. Determine which parts of SBAR are relevant to your team's needs and use those when communicating critical information among your team members.
- SBAR can be modified for use by the patient or family caregivers to communicate with the care team. For example, your facility could provide patients with a summary of SBAR to enable them to share information about their own situation, background, assessment, and recommendations or to ask the care team about their care.
- Consider saying the actual words to keep yourself on track: "The situation is..., The background is..., My assessment is..., I recommend..."

The table shows other practical examples of SBAR.

Step	Desired Message	Starter Phrases
Situation	Confirming understanding of the symptoms.	*"I am glad you came to the clinic. I want to confirm my understanding of your symptoms…[list symptoms]. Is there something I missed?"*
Background	Acknowledge the impact of the symptoms.	*"From what you have explained, your symptoms are impacting you…[describe how symptoms are impacting the patient]. Is there anything else I should know?"*
Assessment	State your initial thinking about the working diagnosis.	*"My initial thinking is that your symptoms are consistent with XXX [name the diagnosis]."*
	Share any uncertainty about the diagnosis.	*"I believe that something is going on, but I do not yet know what it is." "You have some symptoms that are not typical of this diagnosis, and we need to follow them up."*
	Invite patient's concerns.	*"What is most concerning for you about the initial diagnosis?"*
Recommendations and Request	What should the patient do next?	*"I would like you to have some additional tests." "I would like to have you seen by [consulting clinician] to help us get to the bottom of this."*
	How will doing this next step impact the diagnosis?	*"This test/consult will allow us to start to pinpoint the cause of your symptoms and help us achieve the diagnosis."*
	What should the patient expect from any treatment or test?	*"I would like you to have the test/start this treatment." "You should complete the test within 2 weeks and come back to see me so we can talk about the results and any next steps."*
	When should the patient follow up?	*"If you experience X or Y new symptoms, please come back in or call the office."*

To expand your understanding of and ability to use SBAR, choose from the options below:

Reflect on a patient story involving the use of SBAR. After watching the video, consider:

- Why is SBAR particularly helpful in situations where rapid and accurate decisions are essential?
- How do trust and positive working relationships between team members affect the use of SBAR?

Reflect on a video scenario involving the transfer of information using SBAR. After watching the video, consider:

- How did the SBAR technique improve communication between the nurse and physician?
  - The nurse identified herself and the reason she was calling.
  - The physician was quickly made aware of Mrs. Everett's deteriorating situation.
  - The nurse provided the background of the deep vein thrombosis (DVT) diagnosis and all current labs.
  - The recent assessment of the patient has led the nurse to call the physician with her concerns.
  - The recommendation was initiated by the nurse for additional labs, and a plan was discussed for future care.
- How would SBAR help you in similar encounters within your healthcare context?

Reflect on your own experience with SBAR.

- Have you used SBAR in your institution? If so, how was it used? What was the result of its use?
- What were the challenges to implementing SBAR and how were these challenges overcome?

https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/sbar.html
Page last reviewed November 2019 (Page originally created November 2019)

SBAR (ACTIVITY)

PREWORK

READ THE SBAR ARTICLE: "Using SBAR Communications in Efforts to Prevent Patient Rehospitalizations"

REAL PLAY

WORK IN YOUR GROUP

- Using the Mr. B. case study below, develop an SBAR communication
- Real play with your partner
- Share experiences as the person reporting off the information
- Share experiences as the person listening to the SBAR

MR. B

- Age 83
- Increasing symptoms of fatigue, weakness, shortness of breath
- Hospitalized 3 months ago for exacerbation of his Heart Failure
- History of hypertension, coronary artery disease, Myocardial infarction
- Temporarily living with his daughter
- Unsure about his medications
    - Specifically, in the hospital they held his hydrochlorothiazide and on discharge did not give any directions on what to do about that
- States feeling "low"
- Not following the low sodium diet – can't stand the food without seasoning
- Worried about his living arrangements
- Wants to go back home but his daughter is concerned about that
    - He has fallen once – no injuries other than bruises on his forehead
- He's having trouble sleeping
- He is unable to complete his own activities of daily living without some assistance
    - Tires easily and needs help dressing
    - He can do his own personal hygiene
- He completed the SDOH screening
    - Needs assistance with transportation to medical appointments
    - Has housing needs (based on wanting to return home)

SITUATION:

BACKGROUND:

ASSESSMENT:

RECOMMENDATIONS:

ACTIVITY

CROSSWALK "Using SBAR Communications in Efforts to Prevent Patient Rehospitalizations" this to PDCM starting with the example provided in the article.

Meaning of Letter	Information	Data to Include	Crosswalk Example
S Situation	What is going on?	Patient name Current problem	Dr. Jones, I'd like 5 minutes of your time for a situation that has come up for Mr. B, and really should be addressed before the end of the day
B Background	What is the context and background	• Patient's age, gender • Diagnosis • Other pertinent information, as appropriate to the problem • Recent history • Medications, allergies • Etc.	
A Assessment	What physical, behavior and social assessment data will the provider want to know? What do you think the problem is?	Pertinent assessment findings. Perform a comprehensive assessment to identify the barriers and assets before contacting the provider. Name the problem.	
R Recommendation	What do you think will correct the problem?	Suggestions to resolve the problem to avoid untoward events such as hospitalizations and ER visits	

SUMMARY:

- Effective teamwork is critical to achieving the goals of patient care
- Teams have a common focus and shared values – the patient's health and wellbeing
- There are multiple opportunities to establish effective working relationships with the office providers and staff
- Effective teamwork evolves over time; it is enhanced by conscious effort and social skills

SIMULATION PREPARATION

You are a new member of the Primary Care Team. The team includes several physicians, three advanced practice providers (APPs), a care manager, a social worker, pharmacist, a dietician, 2 medical assistants for each provider and registration staff.

ROLES: THIS CARE TEAM

MEDICAL ASSISTANT (MA)

Rotating days. Each MA FTE is assigned to a provider pod 4 days a week. Responsibilities include rooming the patient to prepare for the provider visit. This involves preparing the chart, rooming the patient, and preparing for the provider examination, conducting screenings to include social barriers with the SDOH questionnaire, depression screening with the PHQ2, anxiety screening with the GAD 7 and conducting a medication history. One day a week the MA is dedicated to population health management. This involves reviewing the registry list for "gaps in care/health maintenance needs" and for patients with a gap in care, addressing the gap in care at the time of a visit, and/or telephonically outreaching to the patients on the list to remind them of overdue tests, and if needed, schedule them for an office visit.

RN CARE MANAGER (RNCM)

In the organization, the RN Care Managers are assigned to high-risk patients. High Risk patients are identified as having one or more uncontrolled chronic diseases with one or more out-of-scope measurement for the conditions of diabetes (A1C>9, elevated LDL, elevated BP, missed eye exam, missed foot exam), Hypertension (B/P> 140/90) and Heart Failure (> 1 inpatient admission or ED visit in past 6 months). The RN Care Manager also conducts post-discharge calls for patients admitted with a chronic condition complication or an elective admission that may result in complications of a chronic condition. The RN Care Manager works with the patients on resolving high risk issues, on self-management action plan development, care coordination, and where knowledge deficits are identified, provision of education.

BEHAVIORAL HEALTH SPECIALIST/LMSW (BHS/SW)

The LMSWs are assigned to patients identified as having moderate to severe depression or anxiety and those that screen positive on the Social Determinants for behavioral or safety issues. Screening results for the SODOH, PHQ9 and GAD7 are entered into the EMR by the MA. The provider confirms diagnosis and determines if a referral to the LMSW is needed. Patients referred to the LMSW will have a comprehensive assessment to further evaluate the condition(s) and determine the need for enrollment into depression/anxiety collaborative care (if available), care management for the depression/anxiety, education, brief treatment, or referral to specialist/practitioners outside the practice.

PHARMACIST(PHARMD)

The pharmacist in the organization is assigned to complete a comprehensive medication review (CMR) for all patients on high-risk medications, with a complicated medication regimen, or when multiple chronic conditions are present. The pharmacist is also consulted when medication-related problems are identified or suspected (e.g., access issues related to cost or lack of insurance coverage, patient non-adherence, medication administration counseling, drug-drug interactions, etc.) and when the team needs guidance related to treatment options.

CASE STUDY FACTS

GROUP BREAKOUT: OUTREACHING TO THE PATIENT BREAKOUT

THE PATIENT

Judy Toody is a 65-year-old white woman with a BMI of 42 and a history of heart failure, diabetes, hypertension, and dyslipidemia. She was diagnosed with Heart Failure (HF) about 1 and 1/2 years (18 months) ago. Up until about 6 months ago, her symptoms of HF were well-controlled, and her BP was within the appropriate range (128/76). She has a history of depression. Her last PHQ9 (6 months ago) was 10, of which the provider prescribed Paxil CR 25 mg. per day.

POPULATION HEALTH; PATIENT IDENTIFICATION

- 7 Days ago, the MA reviewed the gap in care registry
- Judy Toody is identified as having needed follow-up. She is overdue for her planned care diabetes visit and A1C test.
- In review of the medical record, the MA identifies Judy "no showed" for her last 2 appointments. This is unusual for Judy.

PATIENT IDENTIFICATION; POPULATION HEALTH PRE-VISIT PLANNING

- To address the gaps in care, the MA places a call to Judy to schedule an appointment. Demonstrating care and concern, the MA brings up the missed appointments. Judy admits she has not been "very on top of things" since her husband died 6 months ago. In addition, her car has been acting up and he always fixed it in the past. It is not currently running but her sister is willing to take her shopping and to appointments. The MA expresses empathy and inquires if Judy's sister would be available and willing to bring her into a doctor office visit. Judy says she would if it is on a Thursday before 3. The appointment is scheduled. The call took 20 minutes **(98967-BCBS, PH no code)**.

INFORMATION ON THE PATIENT REPRESENTING A PLANNED VISIT

DAY OF VISIT - MA VISIT PREPARATION

- The MA reviews Judy's chart (Doorway Fact Sheet)
- MA preps Judy's chart.
    - Notes Judy is overdue for an A1C.
    - Completes a Point of Care (POC) A1C. (The office's Health Maintenance protocol has standing orders that allow the MA to do a Point of Care A1C prior to the patient seeing the provider).
    - MA starts the visit with the patient
        - Obtains the patient's vital signs (BMI, B.P., and has Judy remove her socks and shoes for the monofilament foot exam)
        - Judy's B/P is 165/90
        - POC A1C- today it is 10.7
        - PHQ9 screening score is 12 (#9 suicide question is 0).

GROUP BREAKOUT: INTRODUCING TBC CONCEPTS TO THE PATIENT BREAKOUT

PROVIDER VISIT

- The Primary care physician conducts the diabetes planned care visit. During the visit, Judy reports she stopped the Paxil on her own related to side effects of feeling restless and not being able to sleep. The provider reviews the elevated BP and A1C findings with Judy and inquires on what her thoughts are on this - what might be the reasons for the changes? Judy shares she has not been able to concentrate and has been missing medication dosages. This has been since her husband died, she's been struggling emotionally, pulling away from friends and family. She hasn't gotten out much.
- Based on the findings the provider creates the medical plan of care:
    - Restart Paxil at 10 mg in the morning 5 mg in the evening and tapering up to 10 mg 2X a day in 2 weeks. Referral to the LMSW for depression management
    - Have the referral coordinator follow-up on the transportation issues (calls GoBus-possibly 99497 depends on time end of month)
    - Referral to Pharmacist and BHS in next 3-5 days to conduct the CMR
    - Add Judy to the Team conference Roster scheduled in 1 week – notify extended team of plans to review her case – be prepared to share their findings.(G9007 or G9008 Priority Health-depends on who is there and if G9008 was previously done).

PROVIDER TREATMENT PLAN NOTES

REFERRAL FOLLOW-UP

- A note is sent to the extended team (RNCM, Pharmacist, and LMSW)
    - Dr Jones is finishing up with Judy Toody in room #2. He is asking to have the RNCM come into the room today for a warm handoff. Are you available to come in 5"? He'd like to introduce you. Referral reason is to work with her on her high A1C and B/P. She is here for an overdue diabetes check. She is having trouble remembering her meds and seems confused about them since her husband died. She stopped her metformin when we started her on Lantus and not sure she wants to restart it. She also stopped the Paxil soon after she started it due to restlessness and trouble sleeping. (RN visit G9002 or G9001 if comprehensive – pending how your system manages this with multi-disciplinarians)
    - Referring her to the pharmacist to complete a CMR within the next week. Please outreach to Judy, she can be reached on her cell phone anytime between 9 a.m. and 9 p.m. Doctor reviewed this with Judy and she is anticipating a call. (Pharmacist phone call that took 25 minutes-98968)
    - He's referring to the LMSW for depression management. Please outreach to Judy for the depression management. Dr. reviewed the importance, and she is expecting a call. BHCM calls patient to set up visit. (BHCM Telehealth visit-G9002 or G9001 if comprehensive. Reminder: BCBSM- allows multiple use of G9001).

GROUP BREAKOUT: ESTABLISHING PATIENT KNOWLEDGE AND DESIRE

REFERRAL TO THE CARE MANAGER

- Warm handover today to the RN CM to address chronic disease management needs, medication adherence concerns, and self-management
- Care manager review with the patient her understanding of why she was referred and what area(s) the patient would like to begin addressing
- Care manager (assuming it is diabetes), assist the patient in identifying where she would like to start.

POST-TRAINING (CREDIT REQUIREMENTS)

Please read carefully to ensure you complete all post-training requirements.

1. For this training, Continuing Education (CE/CME) are provided through Mi-CCSI.
   a. After the training, the link to the evaluation at https://www.surveymonkey.com/r/TBC-2024.
      i. Click on the link and complete the evaluation.
      ii. After submitting the evaluation, you will be directed to the certificate for your license/role.
      iii. The certificate for your license/role will allow you to enter your name and training date and save or print your certificate.
         1. There are CE for Social Worker.
         2. There are CME for providers and nursing.
         3. CMA's, CNA's can use the general certificate and agenda for submission to your professional certification program.
   b. Keep a copy of your certificate for your license renewal and proof of training completion.
   c. Questions regarding the training or CE/CME – contact Amy Wales at amy.wales@miccsi.org
2. For **BCBSM PDCM training requirements**, post-training posttest and evaluation must be completed in the MICMT portal to meet the BCBSM Longitudinal Learning Credits.
   a. Within 24 hours, (for those attending this training to meet the BCBSM PDCM Program requirements), your names and emails will be submitted to MICMT.
      i. You will receive an email with a link to the MICMT evaluation and post-test.
      ii. As a reminder, completion of the MICMT evaluation and posttest is **required** to meet the BCBSM PDCM training requirements.
         1. A score of 80% or greater is required to meet the expectations.
         2. If you do not receive an 80%, you can retake the posttest.
         3. The evaluation and posttest must be completed within **5 business days** of attending the training.
         4. Upon completion, you will receive a certificate of completion. This is proof of successful completion of the training and will be used to confirm that you have met the training requirements for the BCBSM PDCM program.
         5. The continuing education (CE/CME) information is on the certificate from Mi-CCSI.
   b. Questions regarding the post-training requirements for the BCBSM PDCM Program – contact MICMT at micmt-requests@med.umich.edu.
   c. Refer to the MICMT screenshots and instructions on the following pages to complete your posttest & evaluation.

MICMT APPROVED TRAININGS:

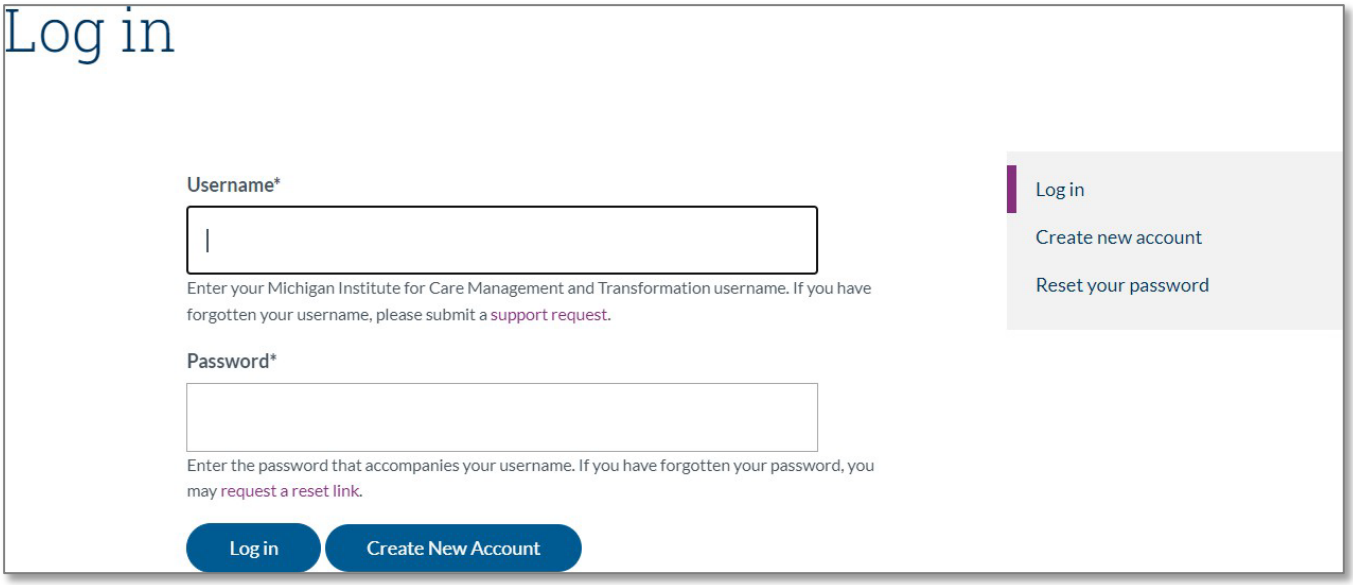
Completing the Evaluation and Post-Test

In order to receive credit (BCBSM PDCM Learning Credits) and training reimbursement dollars for eligible MICMT trainings, a learner **must complete** both the evaluation and test. If the learner does not complete both, credit and reimbursements cannot be provided.

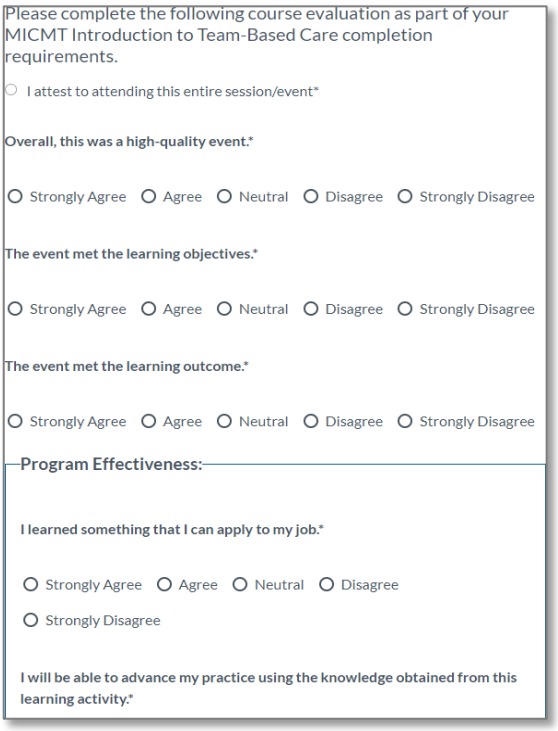
There are two ways to complete the evaluation and post-test following the completion of the course:

1) Learner will receive a link within 24 hours following the training. Please be sure to check junk and spam folders. Click **Link** located in the e-mail.

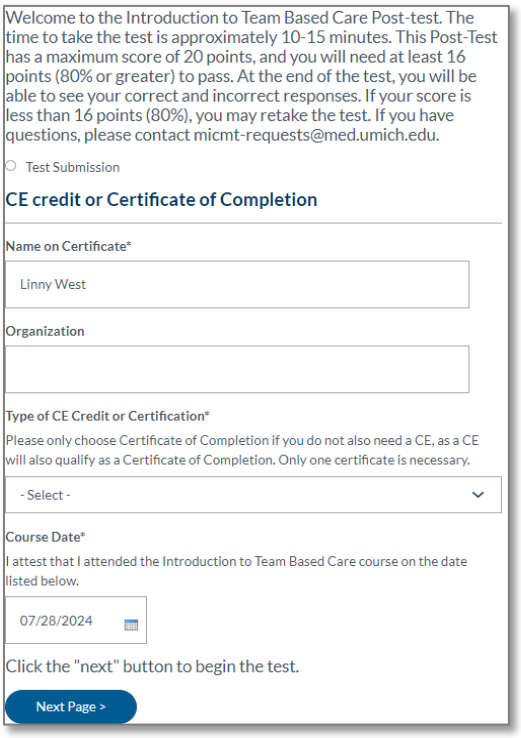
2) Learner will be redirected to the **Evaluation**. If the learner is **not logged in,** they will be required to login:

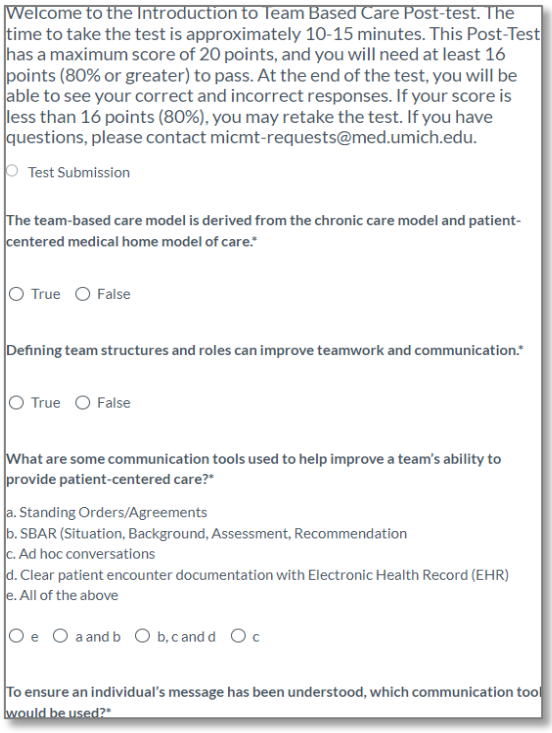


3) If the learner is **logged in**/once logged in, they will complete the **Evaluation**. At the end of the evaluation, there will be a prompt to submit responses.

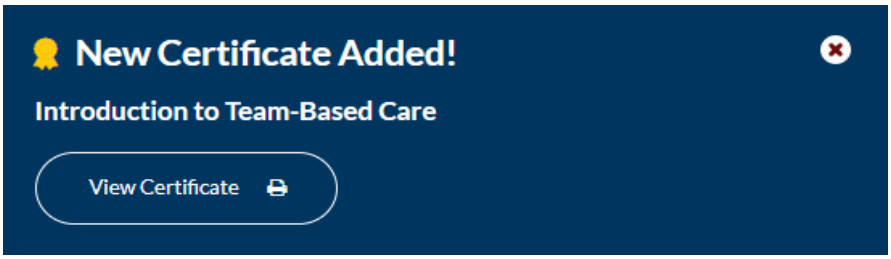


4) After responses have been submitted, learners will be required to select their **CE Credit or Certificate of Completion**, following by the **Test.**



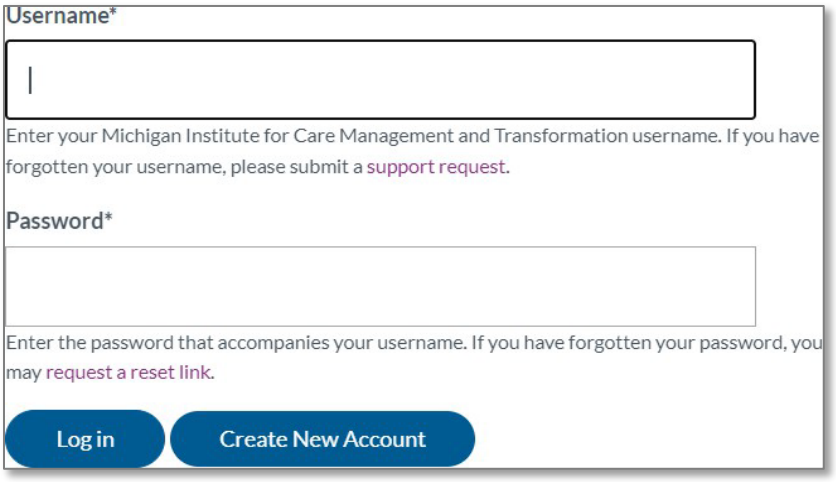


5) After successful completion of both **Evaluation** and **Test,** the learner will have a certificate populate on their dashboard. If a certificate does not populate, the learner did not successfully complete the evaluation and/or test.

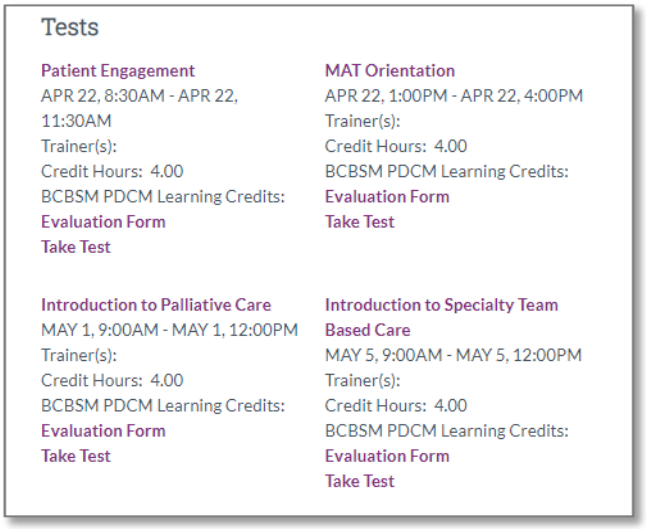


The other way to access the **Evaluation** and **Test** is directly from the dashboard:

1) Login https://micmt-cares.org/user/login



2) Under Tests, locate the training. Complete **Evaluation** first, followed by **Test**

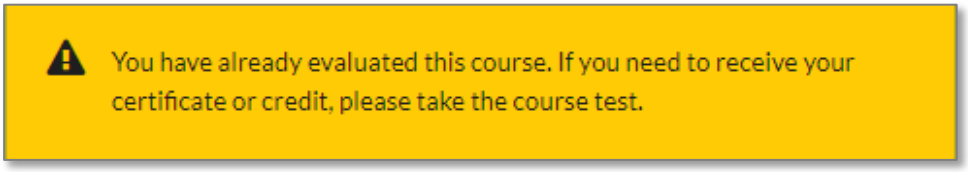


Tips and Tricks:

1) The links aren't working. What should I do?
    a. Make sure you're using Google Chrome or Firefox; Internet Explorer is not compatible to the website.
    b. Contact micmt-requests@med.umich.edu

2) I am getting an "Accessed Denied" message when trying to complete the test.
    a. You will need to complete the **evaluation first**. If you try to take the test first, it will not allow you to.
    b. Make sure you are logged into your account when you attempt to access the evaluation and test.

3) How do I know if I already completed the evaluation or test?
    a. You will receive the following message if you try to retake the evaluation. You can retake the test multiple times.



4) How do I know if I successfully completed both?
    a. You will be able to see a certificate on your dashboard.

5) I've never logged into the website before. What should I do?
    a. Contact micmt-requests@med.umich.edu

6) Any questions or technical issues?
    a. Contact micmt-requests@med.umich.edu

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