NATIONAL ASSOCIATION OF Community Health Centers®

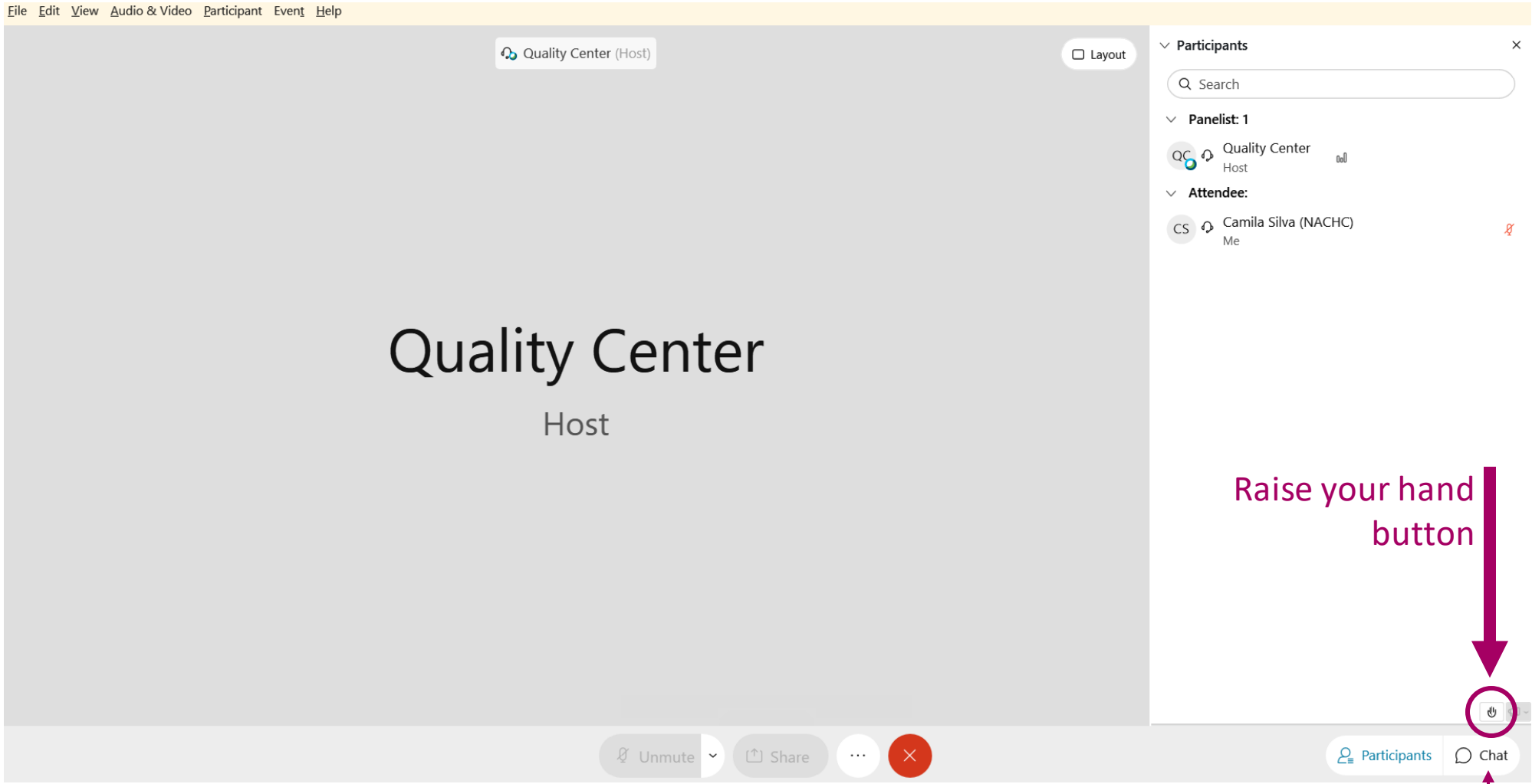
elevate

Together, our voices elevate all.

Care Management & Care Coordination

Elective Series, Part 1 of 2

May 19, 2021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Camila Silva (NACHC)
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Chat
Chat: When using the chat, please send the message to “Everyone”

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

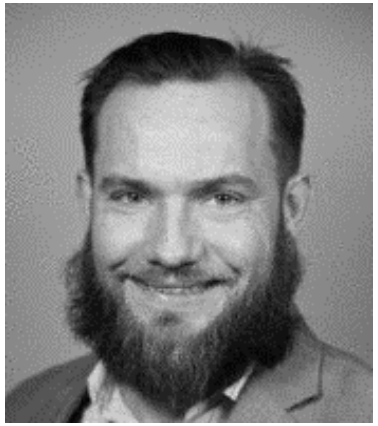
NATIONAL ASSOCIATION OF Community Health Centers®

Packaging and implementing evidence-based transformational strategies for safety-net providers

Bringing science, knowledge, and innovation to practice

Cheryl Modica

Director,
Quality Center



Luke Ertle

Manager,
Quality Center

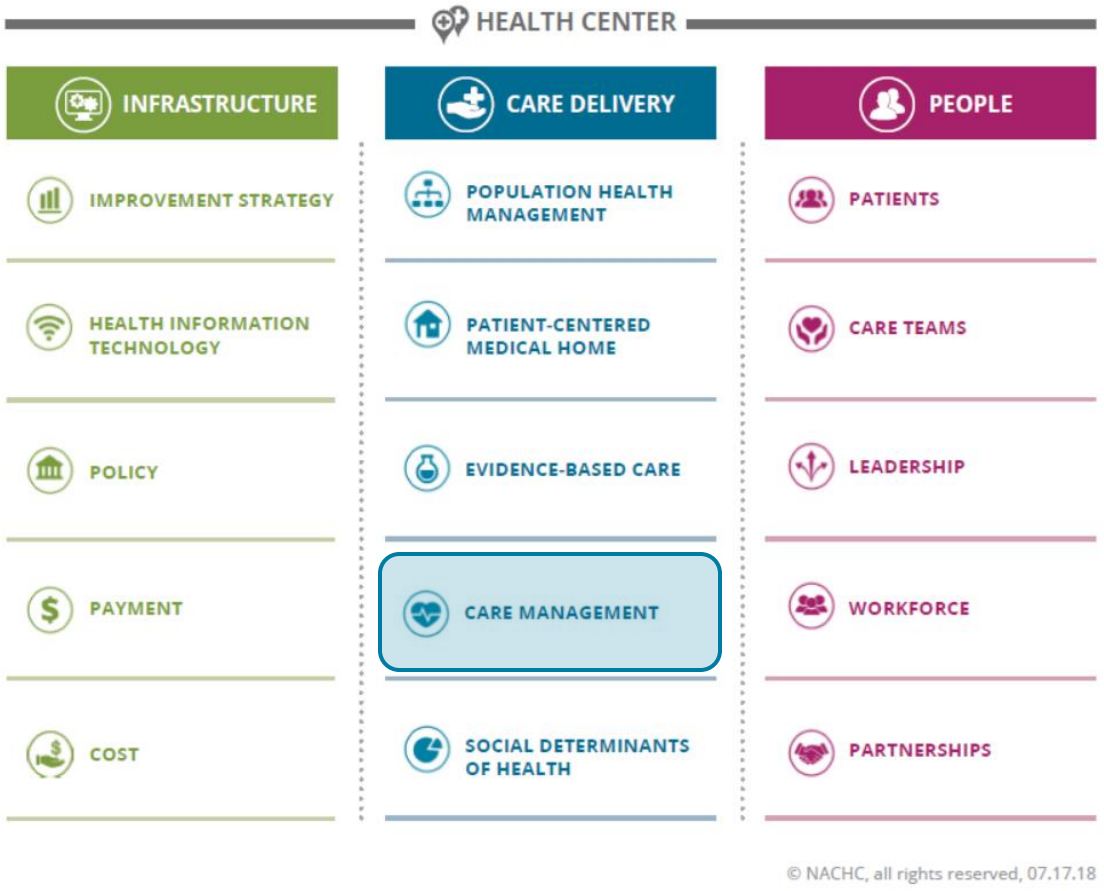
Camila Silva

Manager, Quality Center
Training & Curriculum

Lizzie Utset

Specialist, Quality Center

Value Transformation Framework



https://www.nachc.org/clinical-matters/value-transformation-framework/

CARE MANAGEMENT

Facilitate the delivery and coordination of care and manage high-risk and other subgroups of patients with more targeted services, when and how they need it.

https://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Care-Management-AG_November-2019.pdf

Polling Question

Does your health center have a care management program for high-risk patients?

- Yes
- No

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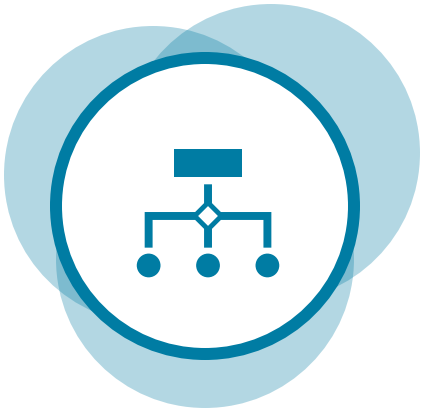
Why Care Management?



Essential population health activity

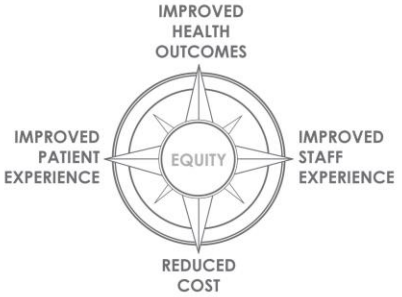
Improve health outcomes

Revenue potential*

*Health centers have the opportunity to obtain revenue above and beyond their federally-qualified all-inclusive flat rate when they offer, document, and bill for allowable care management services. This additional revenue has the potential to help fund systems change as health centers transition from a volume to value-based payment model.

Return on Investment (ROI):

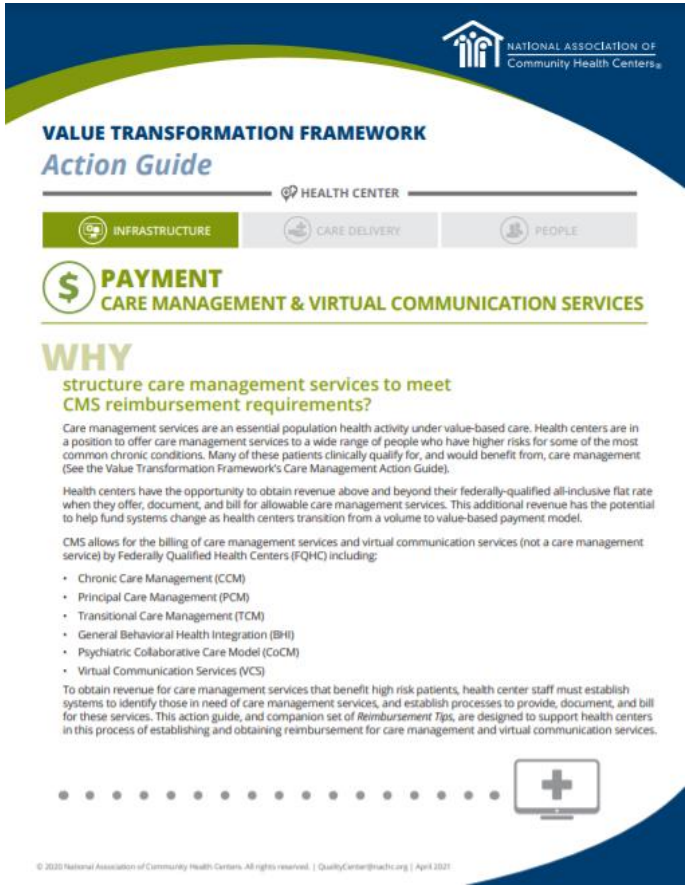
Know the Reimbursement Opportunities



Care Management Services	Reimbursement*
Chronic Care Management (CCM)	$65.25
Principal Care Management (PCM)	$65.25
Transitional Care Management (TCM)	$207.96 (moderate) / $281.59 (high complexity) $99.45 (telehealth)
Psychiatric Collaborative Care Model (CoCM)	$154.23
General Behavioral Health Integration (BHI)	$65.25
Virtual Communication Services	$24.76+

*Above intended to provide a general picture of reimbursement potential using 2021 CMS reimbursement guidance. See Reimbursement Tips for more details.
+For the duration of the COVID-19 public health emergency, will be paid at a rate of $24.76 rather than the 2021 PFS rate of $23 .73.

Payment Action Guide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VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

INFRASTRUCTURE | CARE DELIVERY | PEOPLE

PAYMENT
CARE MANAGEMENT & VIRTUAL COMMUNICATION SERVICES

WHY

structure care management services to meet CMS reimbursement requirements?

Care management services are an essential population health activity under value-based care. Health centers are in a position to offer care management services to a wide range of people who have higher risks for some of the most common chronic conditions. Many of these patients clinically qualify for, and would benefit from, care management (See the Value Transformation Framework's Care Management Action Guide).

Health centers have the opportunity to obtain revenue above and beyond their federally-qualified all-inclusive flat rate when they offer, document, and bill for allowable care management services. This additional revenue has the potential to help fund systems change as health centers transition from a volume to value-based payment model.

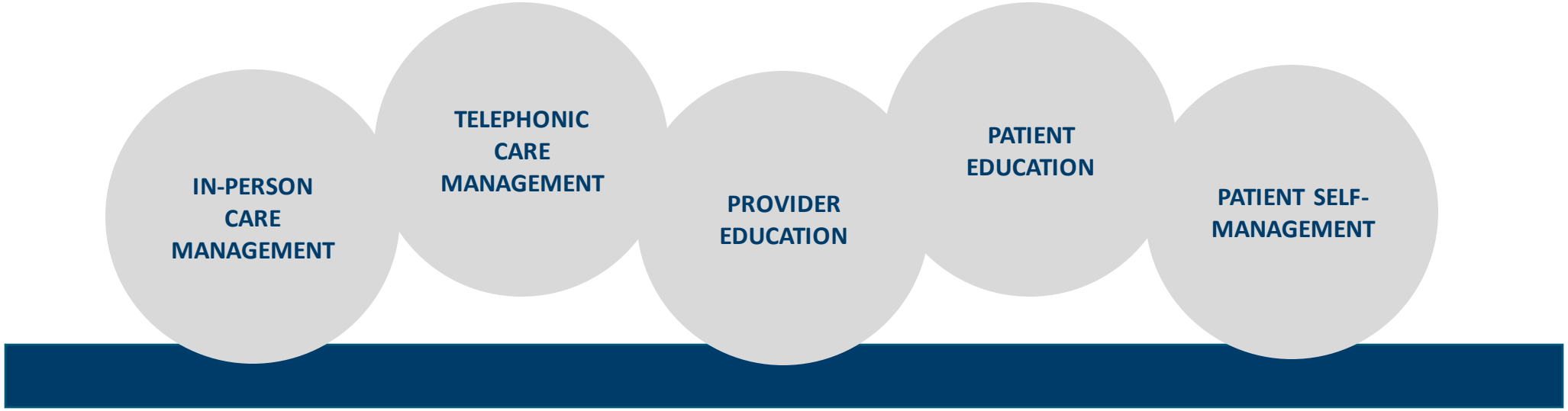
CMS allows for the billing of care management services and virtual communication services (not a care management service) by Federally Qualified Health Centers (FQHC) including:

- Chronic Care Management (CCM)
- Principal Care Management (PCM)
- Transitional Care Management (TCM)
- General Behavioral Health Integration (BHI)
- Psychiatric Collaborative Care Model (CoCM)
- Virtual Communication Services (VCS)

To obtain revenue for care management services that benefit high risk patients, health center staff must establish systems to identify those in need of care management services, and establish processes to provide, document, and bill for these services. This action guide, and companion set of *Reimbursement Tips*, are designed to support health centers in this process of establishing and obtaining reimbursement for care management and virtual communication services.

- Payment Reimbursement Tips: Chronic Care Management
- Payment Reimbursement Tips: Transitional Care Management
- Payment Reimbursement Tips: Behavioral Health Integration
- Payment Reimbursement Tips: Psychiatric Collaborative Care Model
- Payment Reimbursement Tips: Initial Preventive Physical Exam
- Payment Reimbursement Tips: Virtual Communications Services
- Payment Reimbursement Tips: Medicare Telehealth Services during the COVID-19 Public Health Emergency
- Guidance: Sliding Coinsurance for CMS/Medicare Care Management Services

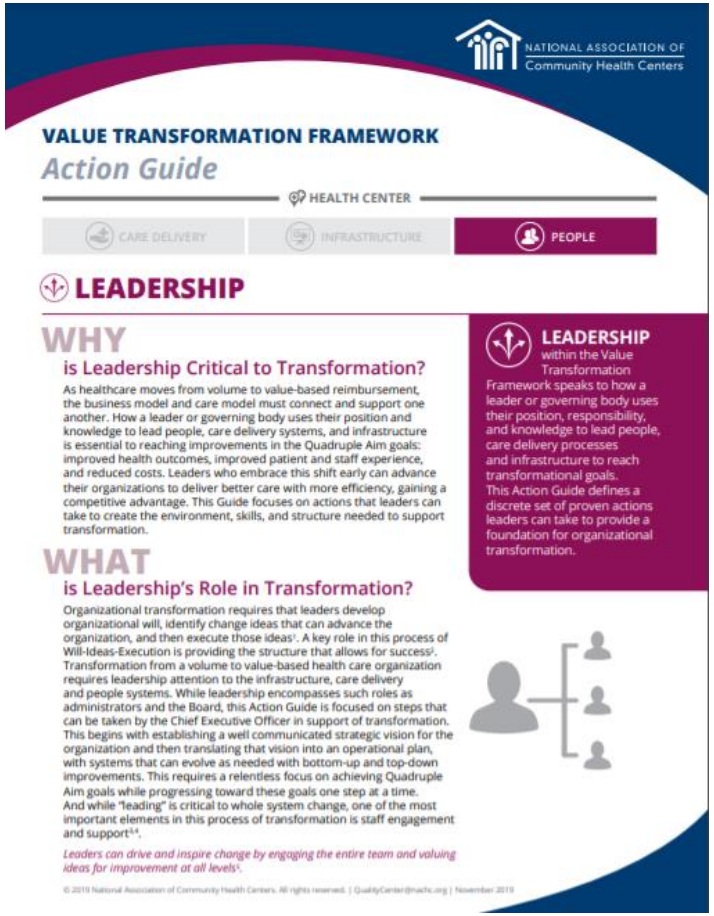
Designing Care Management:
Consider Effectiveness of Different Care Management Interventions



- A review of care management interventions showed **in-person care management** had the strongest impact on clinical outcomes.
- Other effective interventions include telephonic care management, provider education, patient education and patient self-management & monitoring.

https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/medicaidmgmt/mm8.html

Leadership Support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VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

LEADERSHIP

WHY

is Leadership Critical to Transformation?

As healthcare moves from volume to value-based reimbursement, the business model and care model must connect and support one another. How a leader or governing body uses their position and knowledge to lead people, care delivery systems, and infrastructure is essential to reaching improvements in the Quadruple Aim goals: improved health outcomes, improved patient and staff experience, and reduced costs. Leaders who embrace this shift early can advance their organizations to deliver better care with more efficiency, gaining a competitive advantage. This Guide focuses on actions that leaders can take to create the environment, skills, and structure needed to support transformation.

WHAT

is Leadership's Role in Transformation?

Organizational transformation requires that leaders develop organizational will, identify change ideas that can advance the organization, and then execute those ideas[1]. A key role in this process of Will-Ideas-Execution is providing the structure that allows for success[2]. Transformation from a volume to value-based health care organization requires leadership attention to the infrastructure, care delivery and people systems. While leadership encompasses such roles as administrators and the Board, this Action Guide is focused on steps that can be taken by the Chief Executive Officer in support of transformation. This begins with establishing a well communicated strategic vision for the organization and then translating that vision into an operational plan, with systems that can evolve as needed with bottom-up and top-down improvements. This requires a relentless focus on achieving Quadruple Aim goals while progressing toward these goals one step at a time. And while "leading" is critical to whole system change, one of the most important elements in this process of transformation is staff engagement and support[3,4].

Leaders can drive and inspire change by engaging the entire team and valuing ideas for improvement at all levels[5].

LEADERSHIP within the Value Transformation Framework speaks to how a leader or governing body uses their position, responsibility, and knowledge to lead people, care delivery processes and infrastructure to reach transformational goals. This Action Guide defines a discrete set of proven actions leaders can take to provide a foundation for organizational transformation.

Foundational action steps (see Action Guide):

- Create your business imperative
- Institute Structure and Clarity with Psychological Safety
- Invest in QI Training
- Track Quadruple Aim Progress

Additional care management-focused action steps:

- Leadership commitment to a care management program
- Leadership public statement supporting efforts
- Hire/identify care managers/coordinators
- Set goals for care management/coordination program

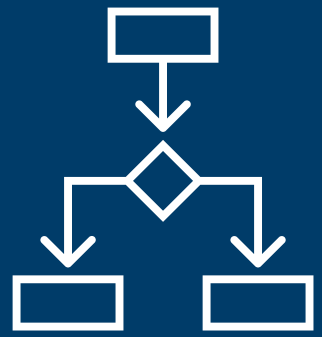
https://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Leadership-AG_November-2019.pdf

Setting Goals & Defining Metrics

1. Goals

Start with the end in mind, what are the major goals you would want to accomplish.

Now break it down into smaller steps that will lead the way to the larger goal.



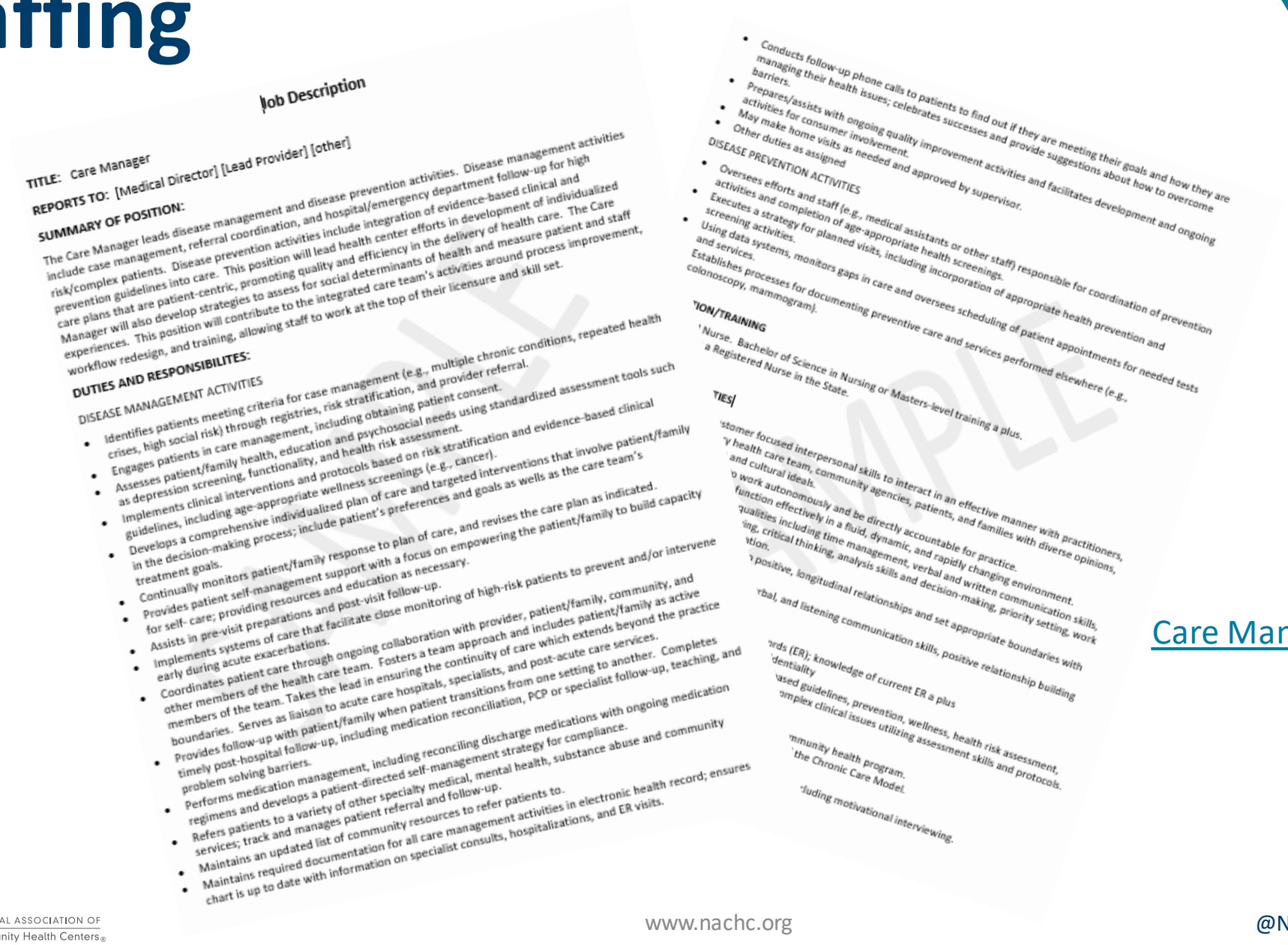
2. Data

Which data do you need to gather throughout the program.

3. Metrics

Which metrics will define success

Staffing



Job Description

TITLE: Care Manager

REPORTS TO: [Medical Director] [Lead Provider] [other]

SUMMARY OF POSITION:

The Care Manager leads disease management and disease prevention activities. Disease management activities include case management, referral coordination, and hospital/emergency department follow-up for high risk/complex patients. Disease prevention activities include integration of evidence-based clinical and prevention guidelines into care. This position will lead health center efforts in development of individualized care plans that are patient-centric, promoting quality and efficiency in the delivery of health care. The Care Manager will also develop strategies to assess for social determinants of health and measure patient and staff experiences. This position will contribute to the integrated care team's activities around process improvement, workflow redesign, and training, allowing staff to work at the top of their licensure and skill set.

DUTIES AND RESPONSIBILITES:

DISEASE MANAGEMENT ACTIVITIES

- Identifies patients meeting criteria for case management (e.g., multiple chronic conditions, repeated health crises, high social risk) through registries, risk stratification, and provider referral.
- Engages patients in care management, including obtaining patient consent.
- Assesses patient/family health, education and psychosocial needs using standardized assessment tools such as depression screening, functionality, and health risk assessment.
- Implements clinical interventions and protocols based on risk stratification and evidence-based clinical guidelines, including age-appropriate wellness screenings (e.g., cancer).
- Develops a comprehensive individualized plan of care and targeted interventions that involve patient/family in the decision-making process; include patient's preferences and goals as wells as the care team's treatment goals.
- Continually monitors patient/family response to plan of care, and revises the care plan as indicated.
- Provides patient self-management support with a focus on empowering the patient/family to build capacity for self- care; providing resources and education as necessary.
- Assists in pre-visit preparations and post-visit follow-up.
- Implements systems of care that facilitate close monitoring of high-risk patients to prevent and/or intervene early during acute exacerbations.
- Coordinates patient care through ongoing collaboration with provider, patient/family, community, and other members of the health care team. Fosters a team approach and includes patient/family as active members of the team. Takes the lead in ensuring the continuity of care which extends beyond the practice boundaries. Serves as liaison to acute care hospitals, specialists, and post-acute care services.
- Provides follow-up with patient/family when patient transitions from one setting to another. Completes timely post-hospital follow-up, including medication reconciliation, PCP or specialist follow-up, teaching, and problem solving barriers.
- Performs medication management, including reconciling discharge medications with ongoing medication regimens and develops a patient-directed self-management strategy for compliance.
- Refers patients to a variety of other specialty medical, mental health, substance abuse and community services; track and manages patient referral and follow-up.
- Maintains an updated list of community resources to refer patients to.
- Maintains required documentation for all care management activities in electronic health record; ensures chart is up to date with information on specialist consults, hospitalizations, and ER visits.
- Conducts follow-up phone calls to patients to find out if they are meeting their goals and how they are managing their health issues; celebrates successes and provide suggestions about how to overcome barriers.
- Prepares/assists with ongoing quality improvement activities and facilitates development and ongoing activities for consumer involvement.
- May make home visits as needed and approved by supervisor.
- Other duties as assigned

DISEASE PREVENTION ACTIVITIES

- Oversees efforts and staff (e.g., medical assistants or other staff) responsible for coordination of prevention activities and completion of age-appropriate health screenings.
- Executes a strategy for planned visits, including incorporation of appropriate health prevention and screening activities.
- Using data systems, monitors gaps in care and oversees scheduling of patient appointments for needed tests and services.
- Establishes processes for documenting preventive care and services performed elsewhere (e.g., colonoscopy, mammogram).

'ION/TRAINING

'Nurse. Bachelor of Science in Nursing or Masters-level training a plus.
a Registered Nurse in the State.

TIES/

'stomer focused interpersonal skills to interact in an effective manner with practitioners,
'y health care team, community agencies, patients, and families with diverse opinions,
and cultural ideals.
o work autonomously and be directly accountable for practice.
function effectively in a fluid, dynamic, and rapidly changing environment.
qualities including time management, verbal and written communication skills,
ing, critical thinking, analysis skills and decision-making, priority setting, work
tion.
positive, longitudinal relationships and set appropriate boundaries with
rbal, and listening communication skills, positive relationship building
rds (ER); knowledge of current ER a plus
'dentiality
ased guidelines, prevention, wellness, health risk assessment,
omplex clinical issues utilizing assessment skills and protocols.
mmunity health program.
the Chronic Care Model.
luding motivational interviewing.

Sample

[Care Manager Job Description]

Staffing:
Integrating with/within Care Team

- Include care manager(s) as part of the care team – or link in a formal way.
- Instruct health center staff on how to refer patients to care management.
- Provide staff with the list of criteria for patient referral to care management.
- Ensure there is a way for all staff to identify in the EHR patients who are enrolled in care management.
- Create a mechanism for the care manager to be notified when a patient has an in-person visit scheduled.

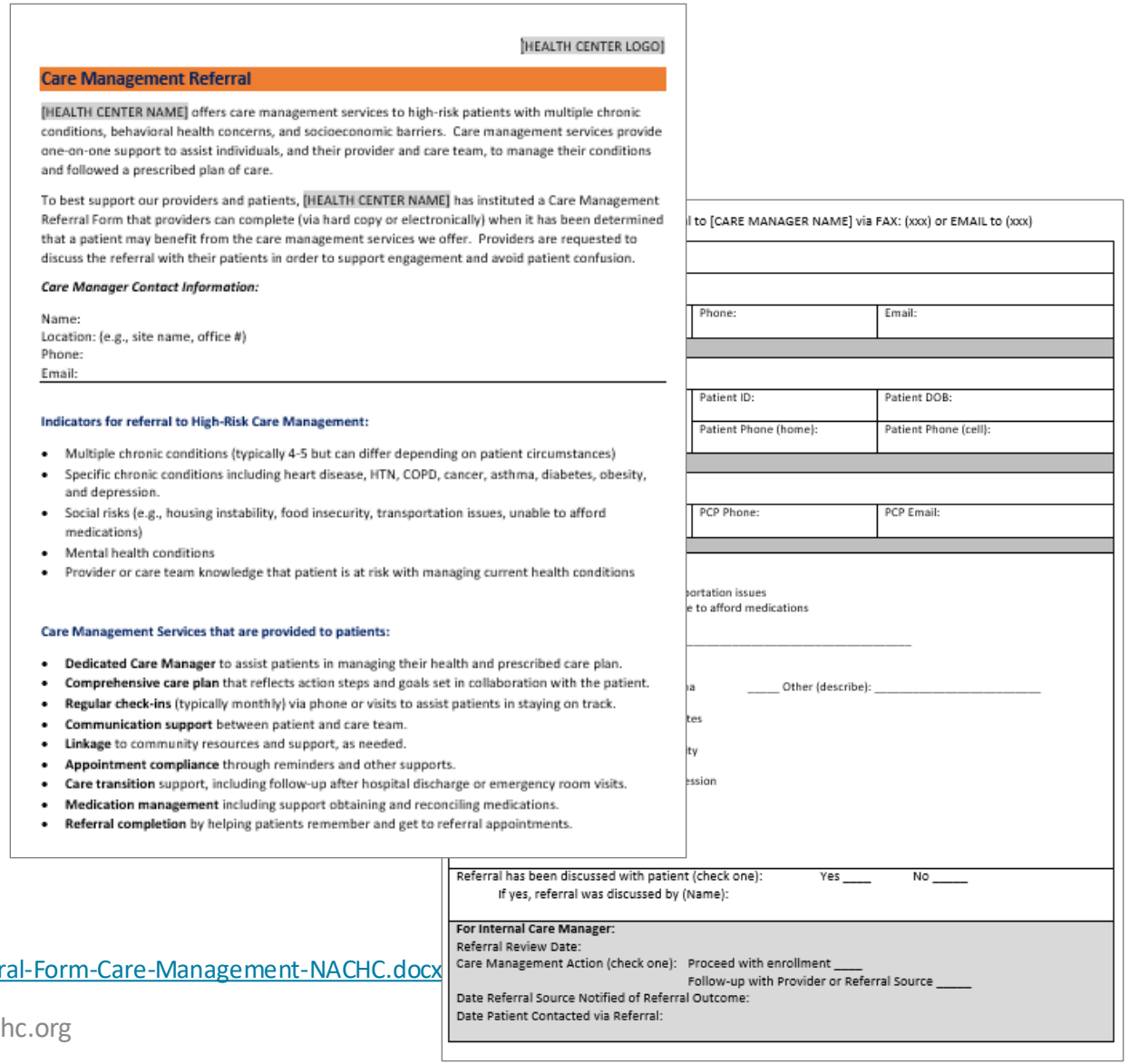
Checklist: Is Your Care Management Program Integrated?

Enroll Patients in Care Management

Referral Form

Includes:

- Sample language of **WHAT** the Referral Form is;
- **WHY** patient is being referred;
- **WHAT** the care management services are;
- **HOW** to refer.



[HEALTH CENTER LOGO]

Care Management Referral

[HEALTH CENTER NAME] offers care management services to high-risk patients with multiple chronic conditions, behavioral health concerns, and socioeconomic barriers. Care management services provide one-on-one support to assist individuals, and their provider and care team, to manage their conditions and followed a prescribed plan of care.

To best support our providers and patients, [HEALTH CENTER NAME] has instituted a Care Management Referral Form that providers can complete (via hard copy or electronically) when it has been determined that a patient may benefit from the care management services we offer. Providers are requested to discuss the referral with their patients in order to support engagement and avoid patient confusion.

Care Manager Contact Information:

Name:
Location: (e.g., site name, office #)
Phone:
Email:

Indicators for referral to High-Risk Care Management:

- Multiple chronic conditions (typically 4-5 but can differ depending on patient circumstances)
- Specific chronic conditions including heart disease, HTN, COPD, cancer, asthma, diabetes, obesity, and depression.
- Social risks (e.g., housing instability, food insecurity, transportation issues, unable to afford medications)
- Mental health conditions
- Provider or care team knowledge that patient is at risk with managing current health conditions

Care Management Services that are provided to patients:

- **Dedicated Care Manager** to assist patients in managing their health and prescribed care plan.
- **Comprehensive care plan** that reflects action steps and goals set in collaboration with the patient.
- **Regular check-ins** (typically monthly) via phone or visits to assist patients in staying on track.
- **Communication support** between patient and care team.
- **Linkage** to community resources and support, as needed.
- **Appointment compliance** through reminders and other supports.
- **Care transition** support, including follow-up after hospital discharge or emergency room visits.
- **Medication management** including support obtaining and reconciling medications.
- **Referral completion** by helping patients remember and get to referral appointments.

l to [CARE MANAGER NAME] via FAX: (xxx) or EMAIL to (xxx)

Phone:	Email:
Patient ID:	Patient DOB:
Patient Phone (home):	Patient Phone (cell):
PCP Phone:	PCP Email:

ortation issues
e to afford medications

_____ Other (describe): _____

tes

ty

ession

Referral has been discussed with patient (check one): Yes ____ No _____
If yes, referral was discussed by (Name):

For Internal Care Manager:
Referral Review Date:
Care Management Action (check one): Proceed with enrollment ____
Follow-up with Provider or Referral Source _____
Date Referral Source Notified of Referral Outcome:
Date Patient Contacted via Referral:

http://www.nachc.org/wp-content/uploads/2018/12/Sample-Referral-Form-Care-Management-NACHC.docx

Building a Care Management Program

Required CMS CCM Service Elements

http://bit.ly/NACHC_CMSBillingChecklist

NATIONAL ASSOCIATION OF Community Health Centers

Cancer Transformation Project

Billing for Care Management Services

Care Coordination Services and Payment for Federally-Qualified Health Centers

Checklist of FQHC Requirements to Bill CMS for Care Management Services	Completed 'Yes'	Missing 'No'
Initiating Visit. An Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse-Midwives (CNM) has occurred no more than one-year prior to commencing care coordination services. This would be billed as an FQHC visit.		
Beneficiary Consent. Has been obtained during or after the initiating visit and before provision of care coordination services by FQHC practitioner or clinical staff; can be written or verbal, must be documented in the medical record and includes information: ▪ On the availability of care coordination services and applicable cost-sharing ▪ That only one practitioner can furnish and be paid for care coordination services during a calendar month ▪ On the right to stop care coordination services at any time (effective at the end of the calendar month) ▪ Permission to consult with relevant specialists.		
Patient Eligibility. Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.		
Care Coordination Services. At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the FQHC physician, NP, PA, or CNM, and b) by an FQHC practitioner, or by clinical personnel under general supervision.		
Electronic Health Record Documentation. Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care		
24/7 Access. 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week.		
Continuity of Care. Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.		
Comprehensive Assessment. Comprehensive care management including systematic assessment of the patient's medical, functional, and psychosocial needs.		
...ill recommended		
...herence and ...ations.		
...tion, revision, ...cognitive, ...hensive care plan ...naged		
...including fax) in a ...the plan of care		
...n and among ...ollow-up after an ..., skilled nursing ...smit continuity of		
...clinical service ...community-based ...s in the patient's medical record		
Electronic Communication Options. Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.		
Coding. Document visit using G code G0511 for General Care Management.		
Billing. CCM services can be billed by adding the general care management G code, G0511, to an FQHC claim, either alone or with other payable services. Payment for G0511 code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period.		

Patient Eligibility

CCM

Chronic Care Management

Multiple **(two or more) chronic conditions** expected to last at least 12 months or until the patient dies, or places the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline

PCM

Principal Care Management

A qualifying condition that is expected to **last between 3 months and 1 year**, or until the death of the patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.

BHI

Behavioral Health Integration

Integrated behavioral health and primary care services that does not require, but may use, services of psychiatric consultation or designated behavioral health manager.

CoCM

Psychiatric Collaborative Care Model

Integrated behavioral health and primary care services but with two additional service components beyond general BHI: **a dedicated care manager and psychiatric consult**.

VCS*

Virtual Communication Services

Communications-based technology or remote evaluation services (e.g., telephone audio/video, secure text messaging, email, portal), including online digital evaluation and management, by a provider within 24 hours of a request by a patient for conditions not related to a visit within the past seven (7) days and that does not result in an appointment in the next 24 hours or next available appointment.

*VCS is not a care management service but can billed in the same month as care management services as long as the requirements of both are met.

Initiating Visit & Consent

INITIATING VISIT

- A comprehensive initiating visit is required for new patients or patients not seen within one year before CCM, PCM, BHI, and CoCM services can be provided.
  - Initiating visits can include Initial Preventive Physical Examination (IPPE), Annual Wellness Visit (AWV), or Evaluation and Management services (E/M).
  - The face-to-face visit included in TCM also qualifies as an initiating visit.
- The initiating visit **is not part of care management** and is **billed separately**.

CONSENT

- Patient consent to care management services **is required**.
- Consent can be **verbal or written** but must be documented in the medical record.
- During the COVID-19 public health emergency, consent may be obtained at the same time services are provided.
- Health center is required to inform patients that **coinsurance applies**.

CMS/Medicare Care Management Services
Can Coinsurance be Slid?

CARE MANAGEMENT PART 2

More information on:

- Payment
- Coding
- Billing

- While health centers are required to impose Medicare coinsurance for CMS/Medicare care management services, **the coinsurance may be "slid" commensurate with the sliding fee discount program (SFDP) policy of the health center**.

- Federal anti-kickback statutes and beneficiary inducement prohibitions include exceptions allowing health centers to discount coinsurance for patients who are eligible for the health center's sliding fee discount program without violating Medicare rules.

- HRSA's guidance (Compliance Manual, Chapter 9, Element K) **allows health centers to discount coinsurance for their SFDP eligible patients** to an amount no more than what the patient would have paid under his/her applicable SFDS payment level.

Guidance per Feldesman Tucker Leifer Fidell LLP, April 2020

Authorized Provider/Staff

See Reimbursement Tips for additional details.

CCM	PCM	BHI	CoCM	VCS*
Chronic Care Management	**Principal Care Management**	**Behavioral Health Integration**	**Psychiatric Collaborative Care Model**	**Virtual Communication Services**
Staff directed by a qualified health professional (QHP): MD, DO, NP, PA, & CNM.	Staff directed by a QHP: MD, DO, NP, PA, & CNM.	QHP or staff under the direct supervision of the billing practitioner ('incident to'): MD, DO, NP, PA, & CNM. Other services by the care management team are permitted under general supervision (under billing practitioner direction and control but physical presence not required).	QHP or staff under the direct supervision of the billing practitioner ('incident to'): MD, DO, NP, PA, & CNM. Other services by the care management team are permitted under general supervision (under billing practitioner direction and control but physical presence not required).	Must be performed personally by a qualified health professional: MD, DO, PA, CNM, CNS, Clinical Psychologists, LCSW.

Timeframe and Services

See Reimbursement Tips for additional details.

CCM	PCM	BHI	CoCM	VCS*
Chronic Care Management	**Principal Care Management**	**Behavioral Health Integration**	**Psychiatric Collaborative Care Model**	**Virtual Communication Services**
Non-complex CCM: Minimum of 20 minutes. 20-minute add-ons up to 60 mins. **Complex CCM**: minimum of 60 minutes of services 30-minute add-ons. **Provider only:** Minimum of 30 mins provided personally by a qualified health professional.	Minimum of 30 minutes.	Minimum of 20 minutes.	**Initial:** Minimum of 70 minutes. **Subsequent:** Minimum of 60 minutes of services. 30-minute add-ons.	Minimum of 5 mins.

Target Population
Complete Risk Stratification; Create Models of Care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Action Guide

HEALTH CENTER

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POPULATION HEALTH MANAGEMENT

MODELS OF CARE

WHY

Design Different Models of Care Based on Risk Level?

Population management is key to successful value-based care. Effective population health management requires that health care organizations group patients based on their needs to direct care and target resources (See *Risk Stratification* Action Guide). Top performing health centers segment patients by risk and design models of care tailored to each subgroup. The purpose is to offer more appropriate and cost effective care to patients who fall into different levels of risk, rather than using a "one size fits all" approach. Identifying unique subgroups of patients, and analyzing each group's health needs, trends, and outcomes, allows health centers to best intervene for improved outcomes.

WHAT

are Care Models Based on Risk?

Designing care models based on risk allows patients to be paired with more appropriate clinical and other services. This Action Guide outlines approaches to building models of care for high, rising and low-risk target populations. Models for highly complex patients are very specialized and not addressed here.

- **High-risk** patients are assigned a care manager who coordinates care across the continuum.
- **Rising-risk** patients are managed within the Patient Centered Medical Home (PCMH) model, with scalable strategies to manage their immediate needs and prevent them from becoming high-risk.
- **Low-risk** patients are managed with more remote, group, and technological solutions. Strategies may include care other than in-person visits, including self-care.

POPULATION HEALTH MANAGEMENT

within the Value Transformation Framework speaks to the systematic process of utilizing data on patient populations to target interventions for better health outcomes at lower cost, with a better care experience. This Action Guide outlines a framework for the design of unique models of care to subgroups of the population identified through risk stratification.

https://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Pop-Health_Models-of-Care-AG_November-2019.pdf

Highly complex. Require intensive, pro-active care management.

→ Care Management Action Guide

High-risk. Engage in care management to provide one-on-one support for medical, social and care coordination needs.

Rising-risk. Manage within PCMH model; support in managing risk factors (e.g., obesity, smoking, blood pressure, cholesterol).

Low-risk. Manage using more remote, group, and technological solutions; focus on keeping patients healthy and engaged.

Developing Care Plans

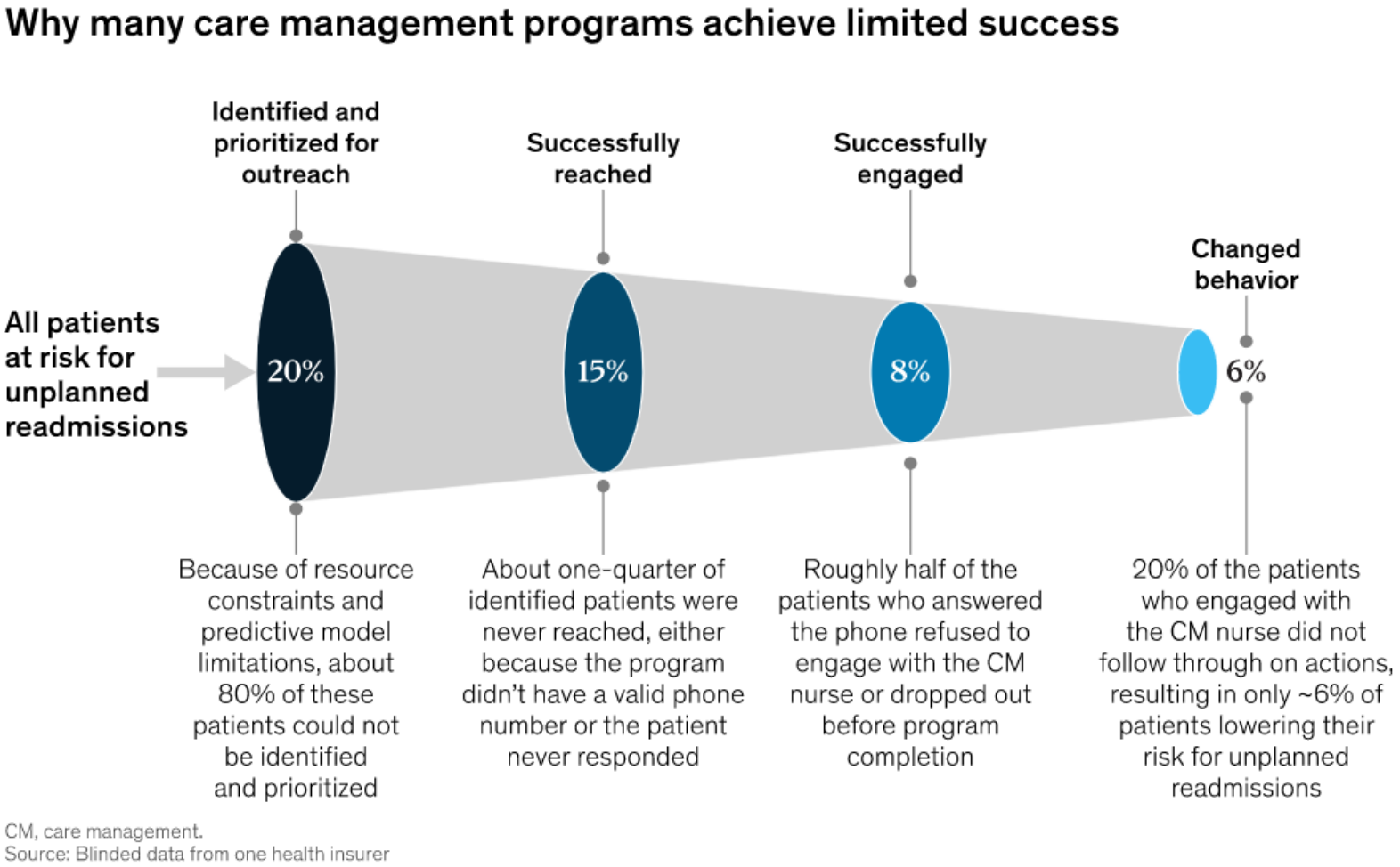
- ✓ Must **document** discussion and **patient's agreement** to the care plan**.**
- ✓ A **copy must be shared** with the patient and patient's provider.
- ✓ Must be documented in a certified **electronic health record (EHR).**
- ✓ Must include: **patient demographics, medical problems, medications, and medication** allergies.
- ✓ A comprehensive care plan includes, but is not limited to, the following elements:

  - Problem list
  - Expected outcome and prognosis
  - Measurable treatment goals
  - Symptom management
  - Planned interventions, including responsible individuals
  - Medication management
  - Community/social services ordered
  - A description of how outside services/agencies are directed/coordinated
  - Schedule for periodic review and, where appropriate, revision of the care plan

Sample Workplan – "My Shared Care Plan"

Michigan Care Management Resource Center

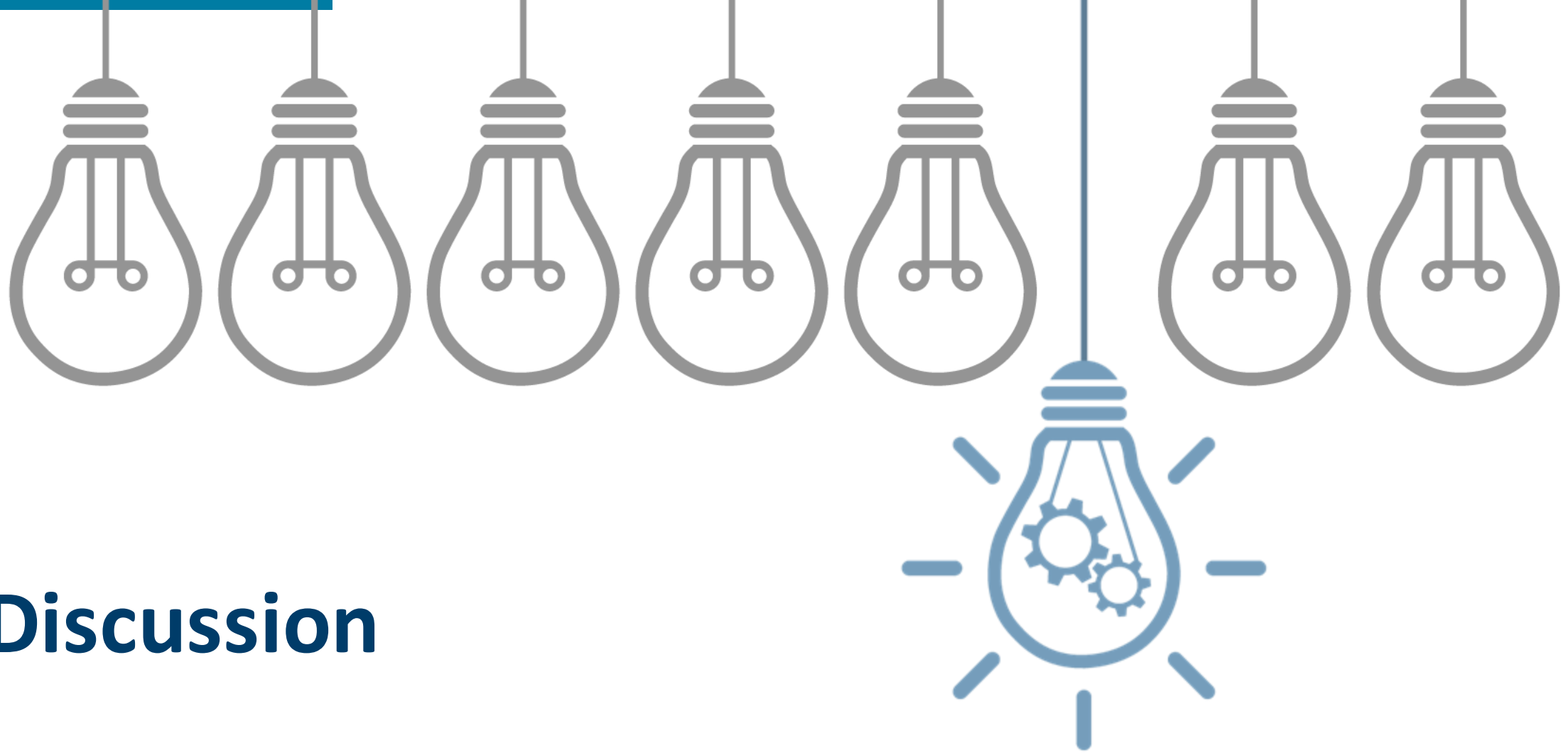
Lessons Learned:



POTENTIAL SOLUTIONS

- **Analytics**
  - Use data to identify patients that will need the highest level of care.
- **Consumer-Centered Approach**
  - Use delivery format that patients are familiar with.
- **Digital Engagement**
  - Technology can be used to increase engagement, either as primary or additional delivery method.

https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/supercharging-the-roi-of-your-care-management-programs



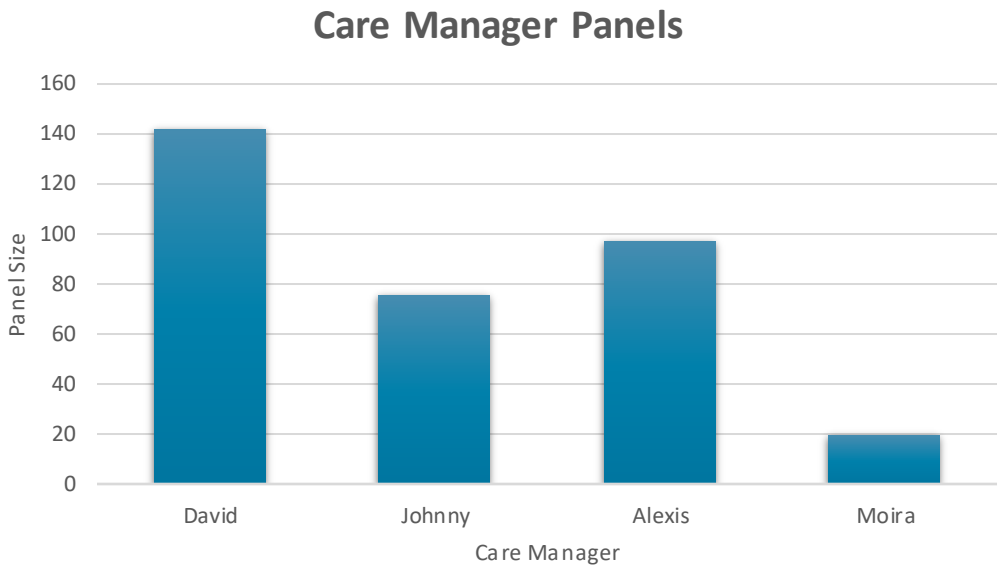
Discussion

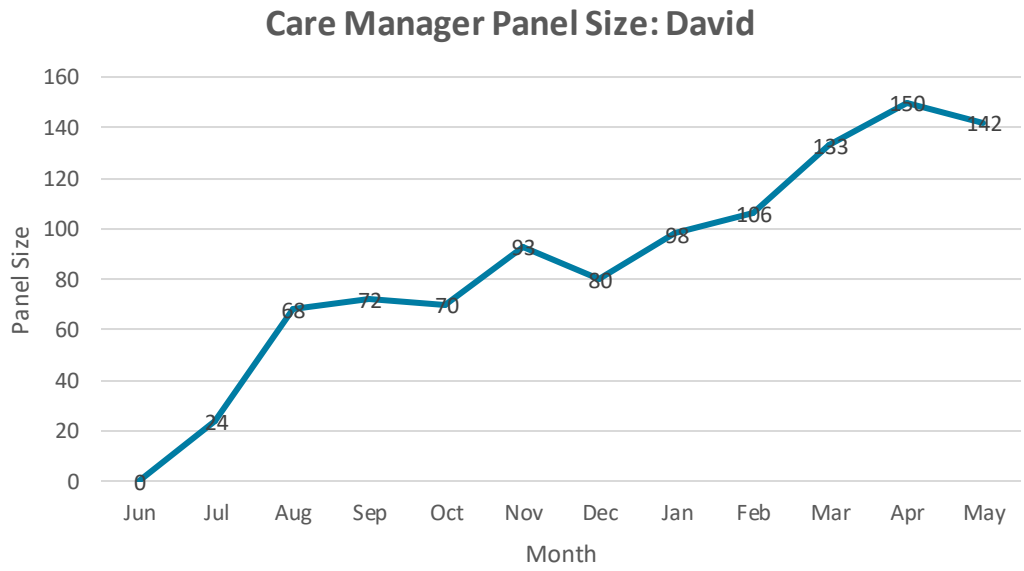
Measurement: Care Management

Cassie Lindholm
Deputy Director, PCA/HCCN Network Relations, NACHC

CASE STUDY
Measuring Care Management Panels

- It can be helpful to measure the number of patients in each care manager's panel or case load.
- Keep in mind when setting goals or calculating your health center’s return on investment for care management, that it takes time to build up a patient panel.

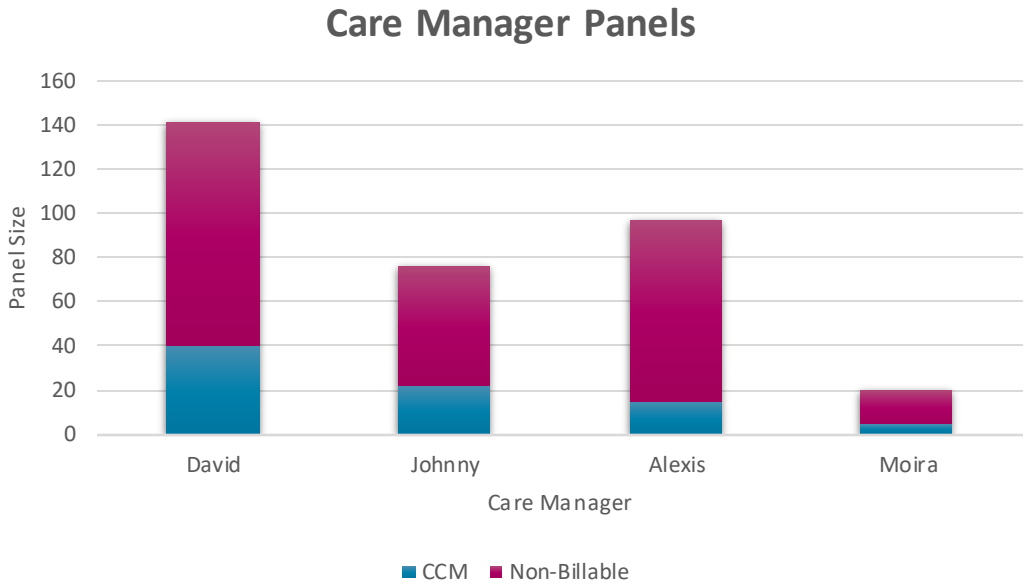


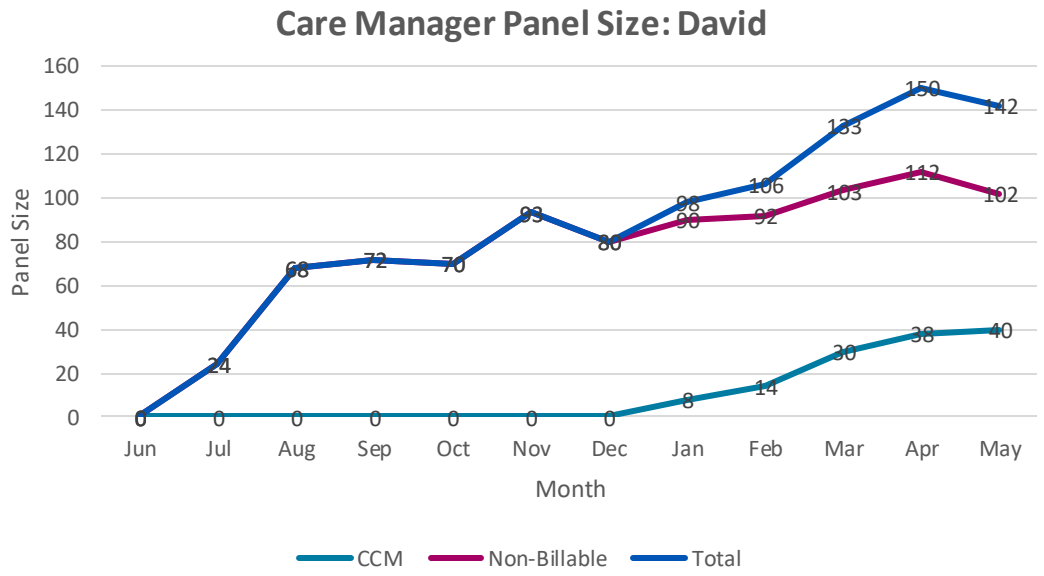


NATIONAL ASSOCIATION OF Community Health Centers®

CASE STUDY
Measuring Care Management Panels by Program

- If you have more than one care management program, track panel size by program.
- For CCM, this can be a helpful data point when measuring revenue for CCM, setting goals, or looking at return on investment.

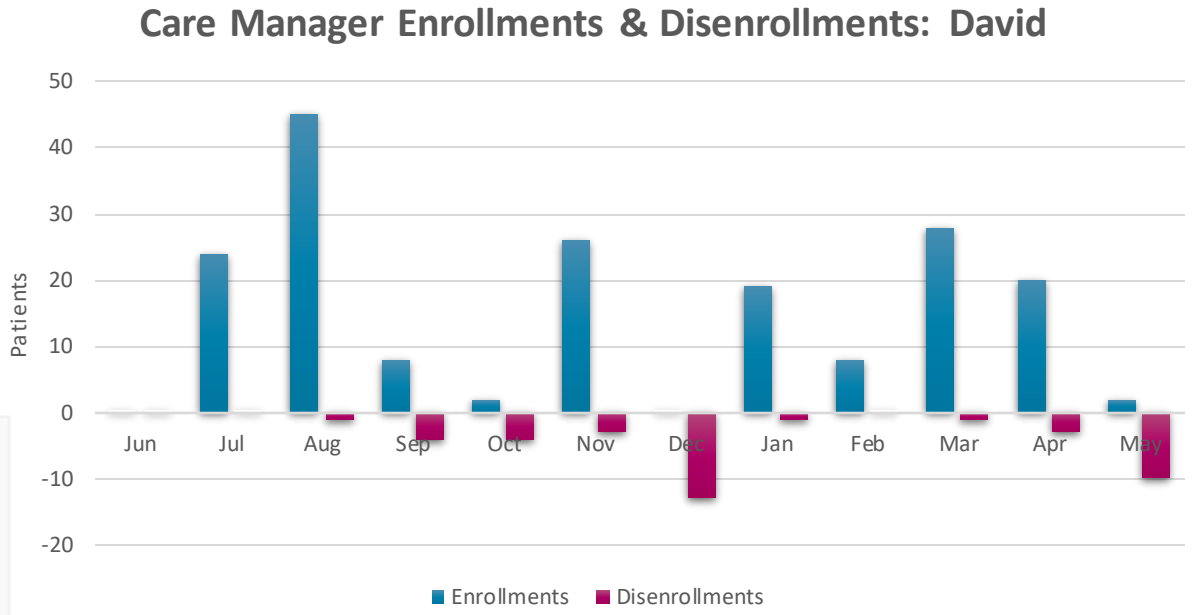


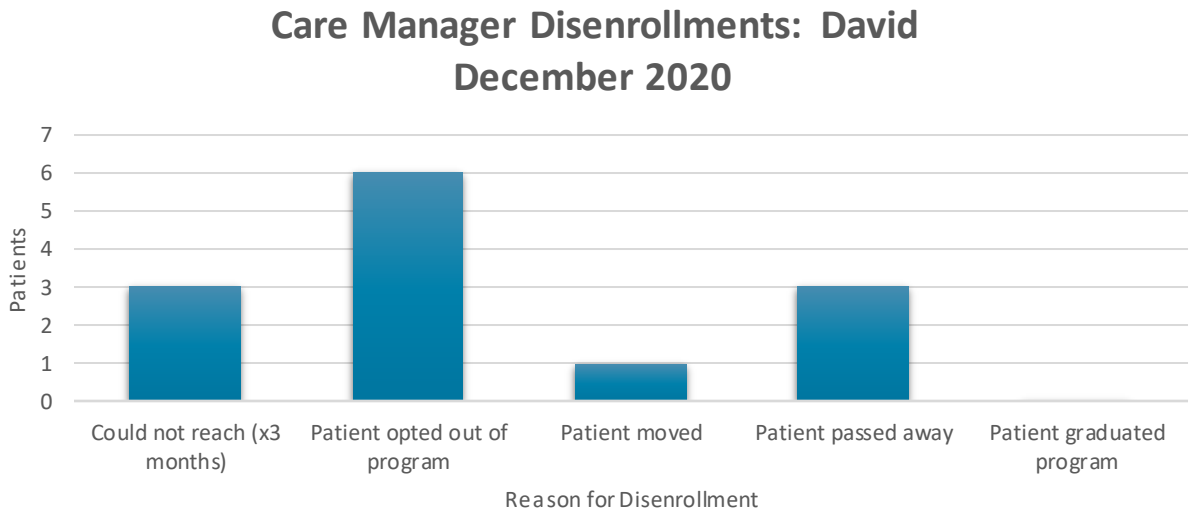


CASE STUDY
Measuring Enrollments and Disenrollments

- Panel growth is not a straight line, there are ups and downs. The graph on the previous slide that displayed panel size by month does not demonstrate all these ups and downs, only the net increase or decrease.

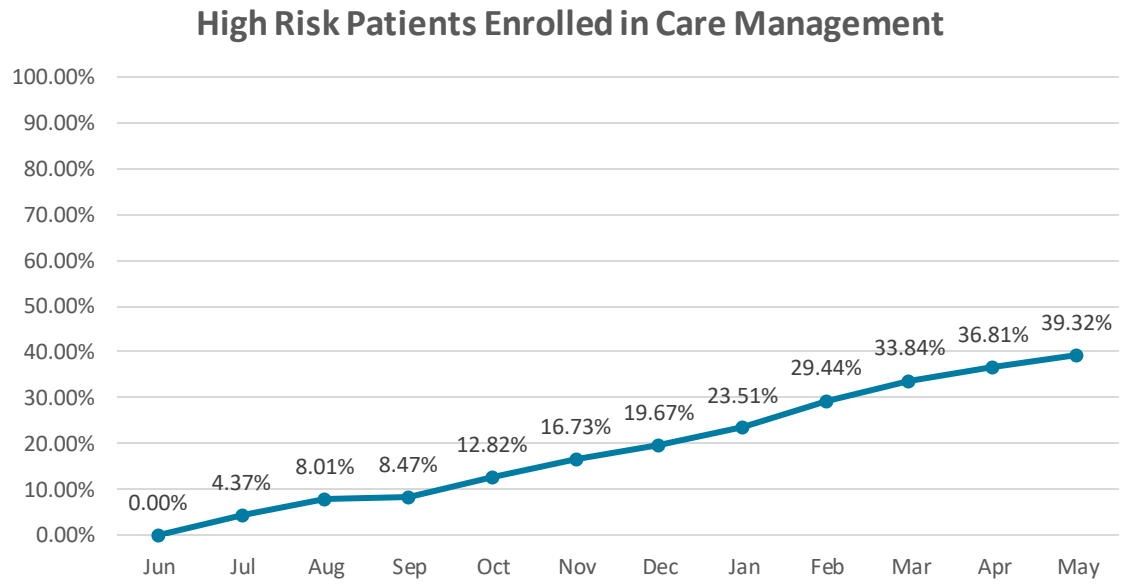
- This is an important perspective because it gives a higher level of insight into how a care manager is building and retaining their panel.





CASE STUDY
Measuring High Risk Patients Enrolled in Care Management

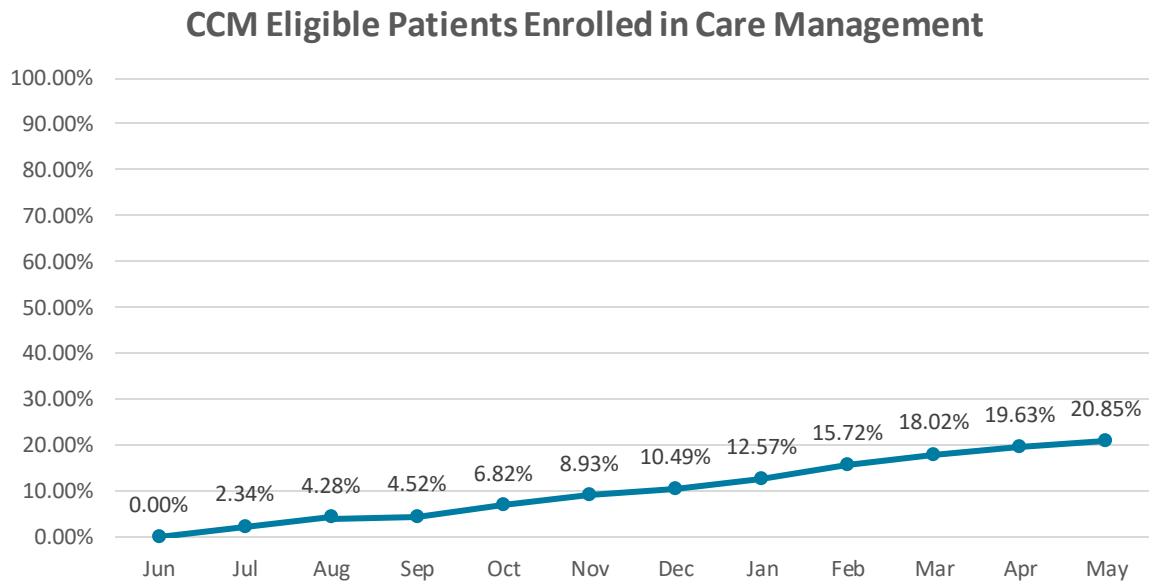
Month	Enrolled	High Risk	Rate
Jun	0	849	0.00%
Jul	37	847	4.37%
Aug	68	849	8.01%
Sep	72	850	8.47%
Oct	109	850	12.82%
Nov	143	855	16.73%
Dec	168	854	19.67%
Jan	201	855	23.51%
Feb	252	856	29.44%
Mar	289	854	33.84%
Apr	314	853	36.81%
May	335	852	39.32%



- How many patients in your high-risk patient population that you are providing care management services to over time
- Can be helpful when figuring out how many care manager FTEs you may need

CASE STUDY
Measuring CCM Eligible Patients Enrolled in Care Management

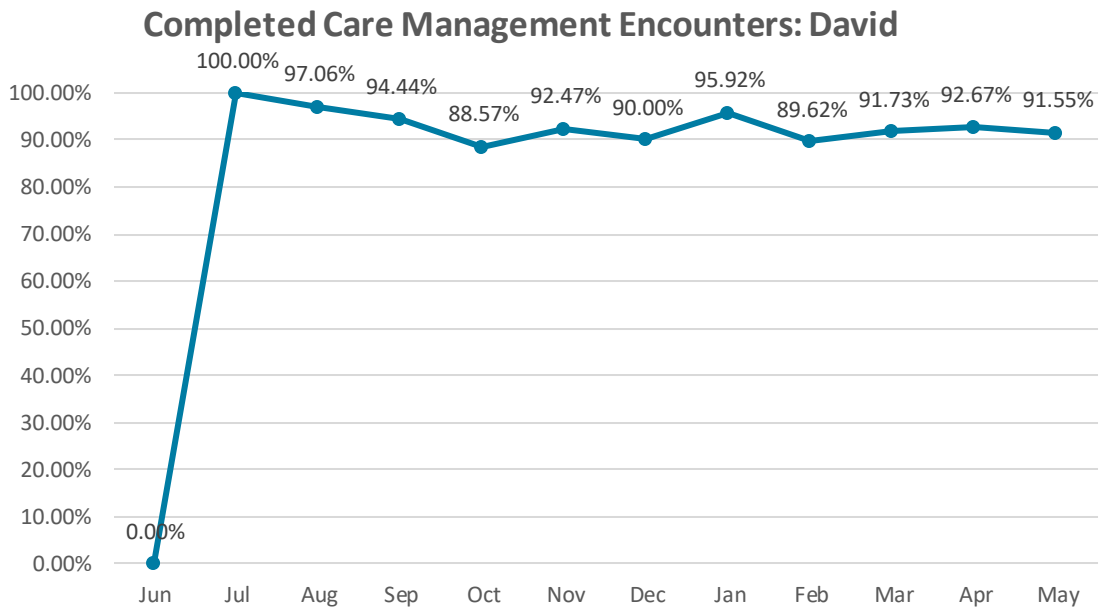
Month	Enrolled	Eligible	Rate
Jun	0	1580	0.00%
Jul	37	1582	2.34%
Aug	68	1590	4.28%
Sep	72	1594	4.52%
Oct	109	1598	6.82%
Nov	143	1601	8.93%
Dec	168	1601	10.49%
Jan	201	1599	12.57%
Feb	252	1603	15.72%
Mar	289	1604	18.02%
Apr	314	1600	19.63%
May	335	1607	20.85%



- How many patients of out CCM eligible patients you are providing care management services to over time

CASE STUDY
Measuring Completed Care Management Encounters

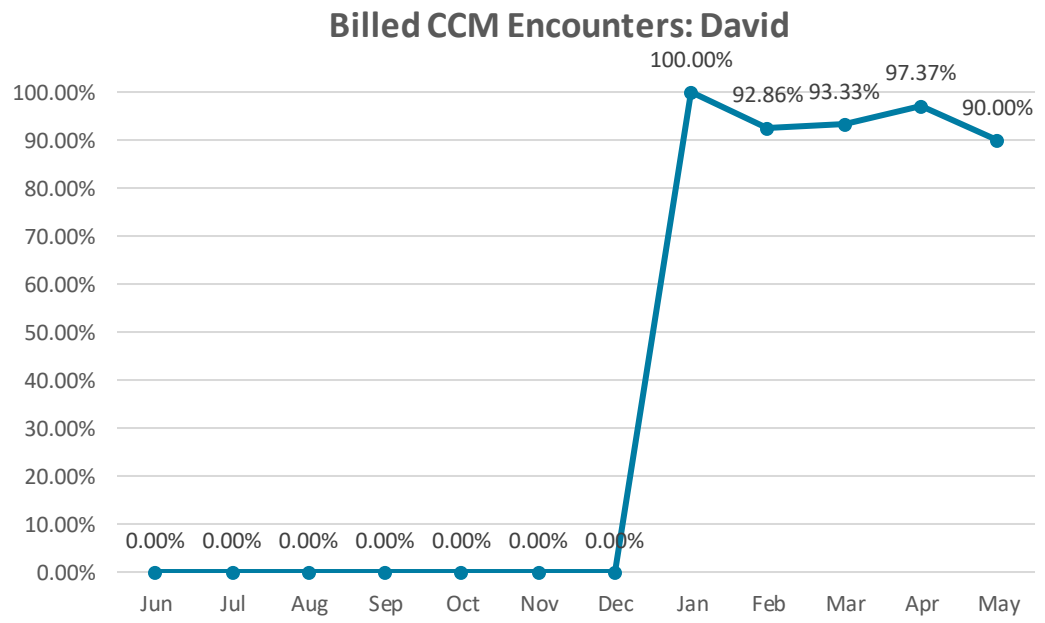
Month	Panel Size	CM Encounters	Rate
Jun	0	0	0.00%
Jul	24	24	100.00%
Aug	68	66	97.06%
Sep	72	68	94.44%
Oct	70	62	88.57%
Nov	93	86	92.47%
Dec	80	72	90.00%
Jan	98	94	95.92%
Feb	106	95	89.62%
Mar	133	122	91.73%
Apr	150	139	92.67%
May	142	130	91.55%



- Measuring completed care management encounters out of the care manager's total panel size
- It is not likely that every care manager will have a successful encounter with every one of their patients every single month

CASE STUDY
Measuring Billed CCM Encounters

Month	Enrolled CCM Patients	Billed G0511	Rate
Jun	0	0	0.00%
Jul	0	0	0.00%
Aug	0	0	0.00%
Sep	0	0	0.00%
Oct	0	0	0.00%
Nov	0	0	0.00%
Dec	0	0	0.00%
Jan	8	8	100.00%
Feb	14	13	92.86%
Mar	30	28	93.33%
Apr	38	37	97.37%
May	40	36	90.00%



- Measuring billed CCM encounters out of the care manager's total panel size
- It is not likely that every care manager will have a successful encounter with every one of their patients every single month
- This is something to take into consideration when setting goals for CCM revenue or ROI

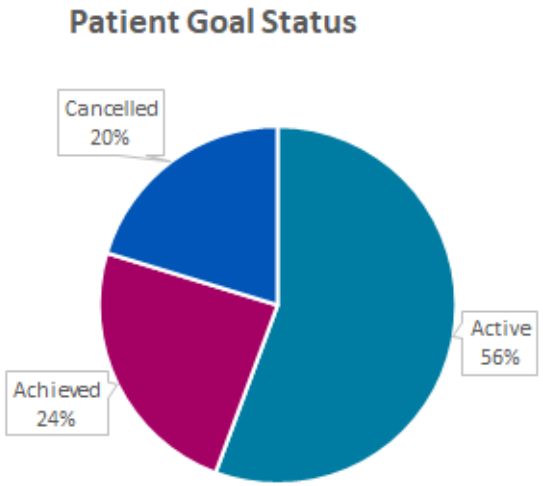
CASE STUDY

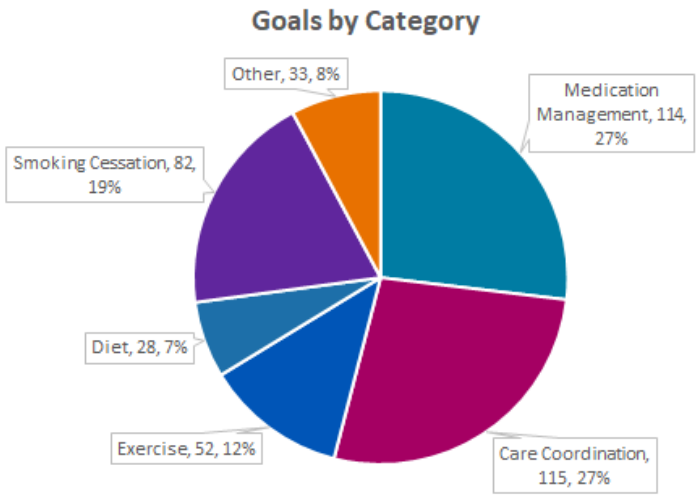
Measuring Quality Outcomes

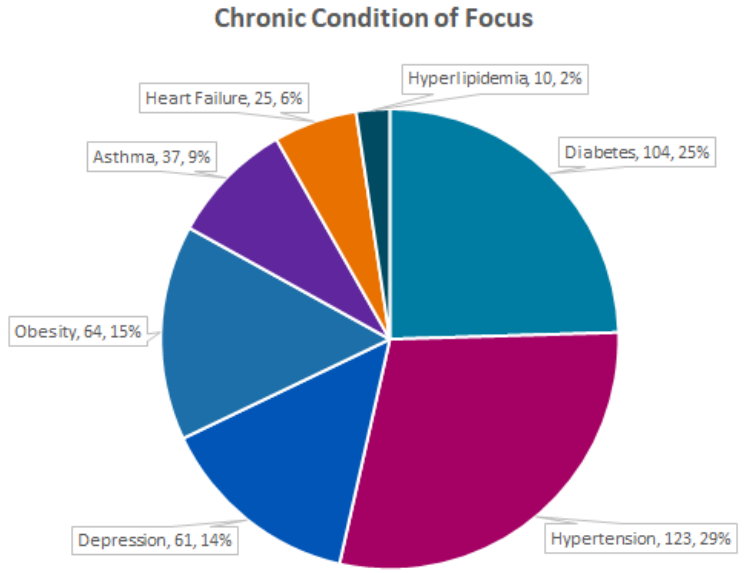
UDS Measure	All Health Center Patients	Care Management Patients (>1yr)
Colorectal Cancer Screening	71%	81%
Diabetes A1C Control	28%	21%
Hypertension Control	73%	79%

- Filter to include care management patients who have been enrolled in care management for a longer period of time (>6 months or > 1 year) and patients who have graduated a program.

CASE STUDY
Measuring Patient Goals

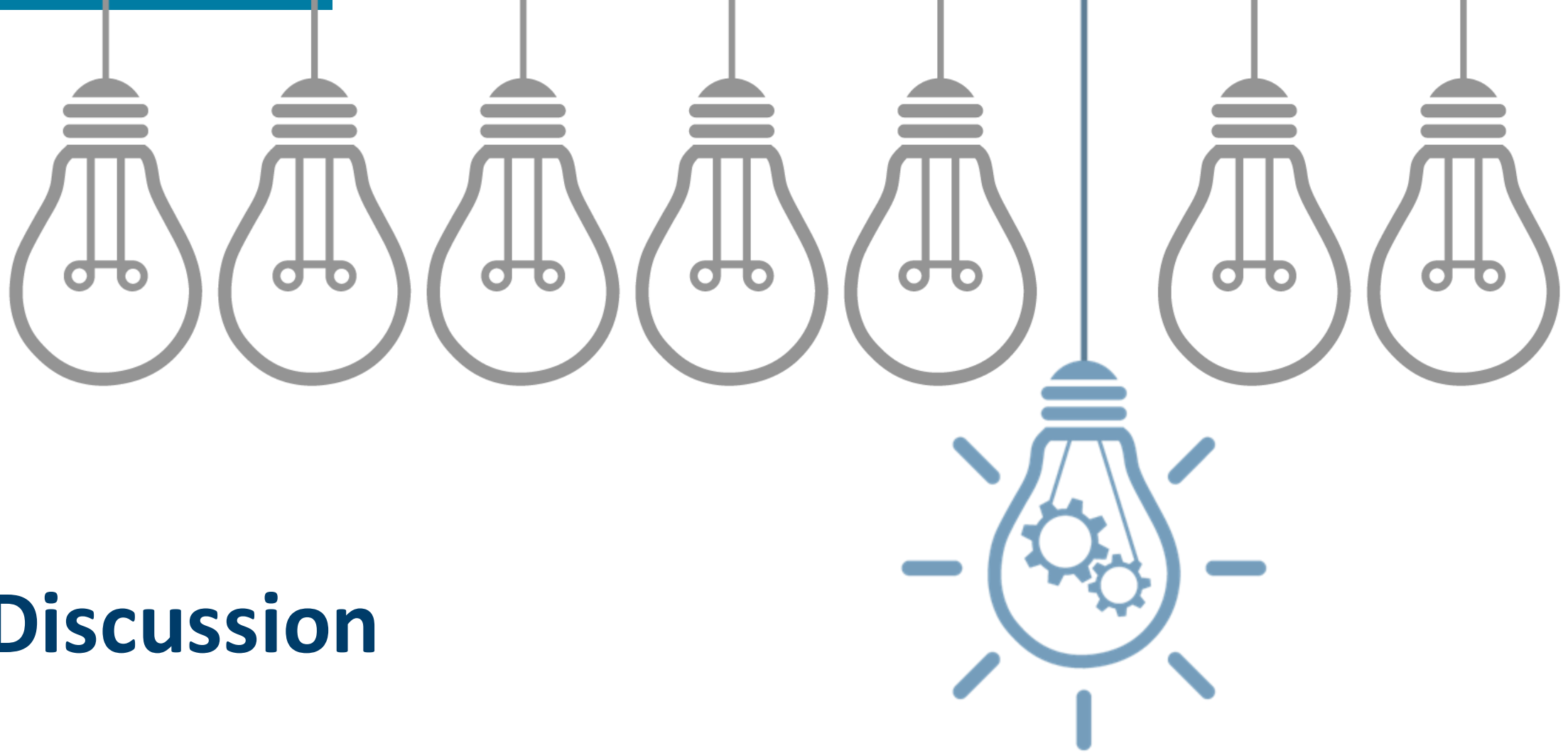




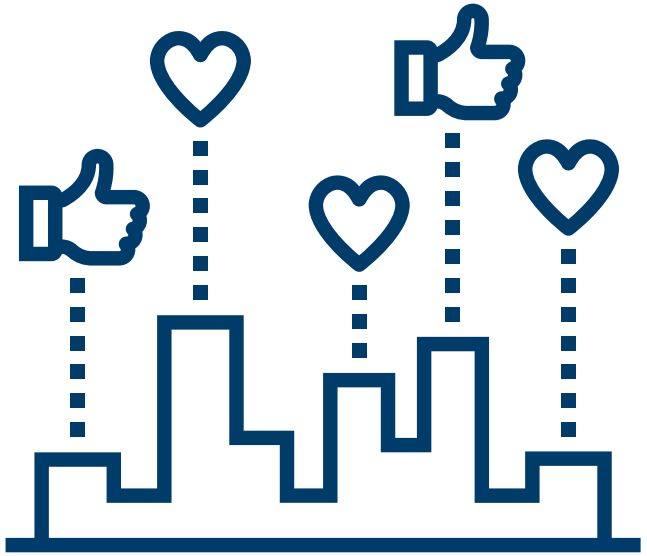


- After pulling quality measures you may be wondering some care management patients met certain quality measures while some did not. It can be helpful to then dive deeper into the care management patient goals.
- Measure "achieved" goals of a specific category against the relevant UDS measure
- Measure the efficacy of different care plans and interventions.

Erin Raftery, Care Manager



Discussion



Provide Us Feedback

FEEDBACK

Don't forget! Let us know what you thought about today's session.

FOR MORE INFORMATION CONTACT:

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Next Monthly Forum Call:

June 8th, 2021
1 -2 pm ET

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Together, our voices elevate all.

The Quality Center Team
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