NATIONAL ASSOCIATION OF Community Health Centers®


# Applying the VTF to Your Work

*Care Teams & Care Management*

March 14, 2023

# 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.


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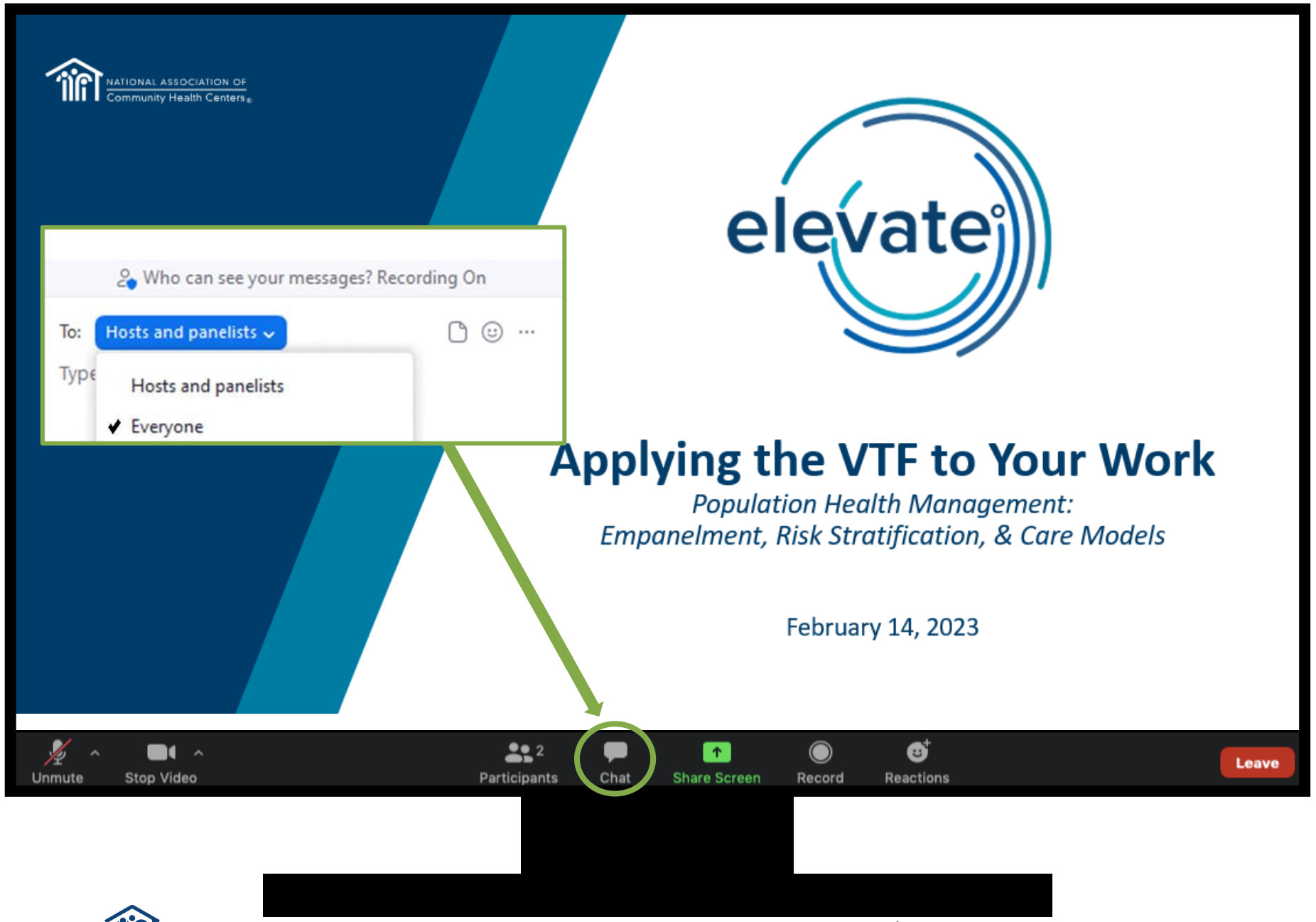


## During today's session:

- **Questions:** Throughout the webinar, type your questions in the chat feature. Be sure to select "Everyone"! There will be Q&A and discussion at the end.
- **Resources:** If you have a tool or resource to share, let us know in the chat!

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

*Bringing science, knowledge, and innovation to practice*


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# Agenda:

- **Value Transformation Framework**
  - Organize Transformation Efforts Using the VTF
  - Enhance Application of the VTF Through Elevate
- **Elevate 2023**
  - Elevate Year-At-A-Glance
  - Elevate *'University'* Offerings and Tracks
  - Health Center Elevate Pathway
  - Use the VTF Assessment 2.0 to Drive Transformation
  - Elevate Online Platform
- **Care Teams & Care Management**
  - Optimizing Care Teams
  - Providing Care Management
  - Measuring Care Management Panel Data
- **Next Steps**

# Value Transformation Framework

The Value Transformation Framework (VTF) is ***an organizing framework*** to guide health center systems change

- ***Supports change*** in many parts of the health center simultaneously
- ***Organizes and distills evidence-based interventions*** for discrete parts of the systems called 'Change Areas'
- ***Incorporates evidence, knowledge, tools and resources*** relevant for action within different parts of the system, or Change Areas
- ***Links health center performance to the Quintuple Aim***

# Enhance VTF Application Through Elevate

**Register** https://bit.ly/2023Elevate

**Assess** https://reglantern.com/vtf
Ideally 3+ staff

**Monthly Forum** Invites are sent to registered participants
2nd Tuesday 1-2pm ET

**Online Resources** https://nachc.docebosaas.com/learn/signin

Opportunity for a 6-month **FREE** trial to RegLantern continuous compliance tool!

**Join us on 3/22 3-4pm ET for more info**

elevate

**National Learning Forum: Guided application of the VTF**

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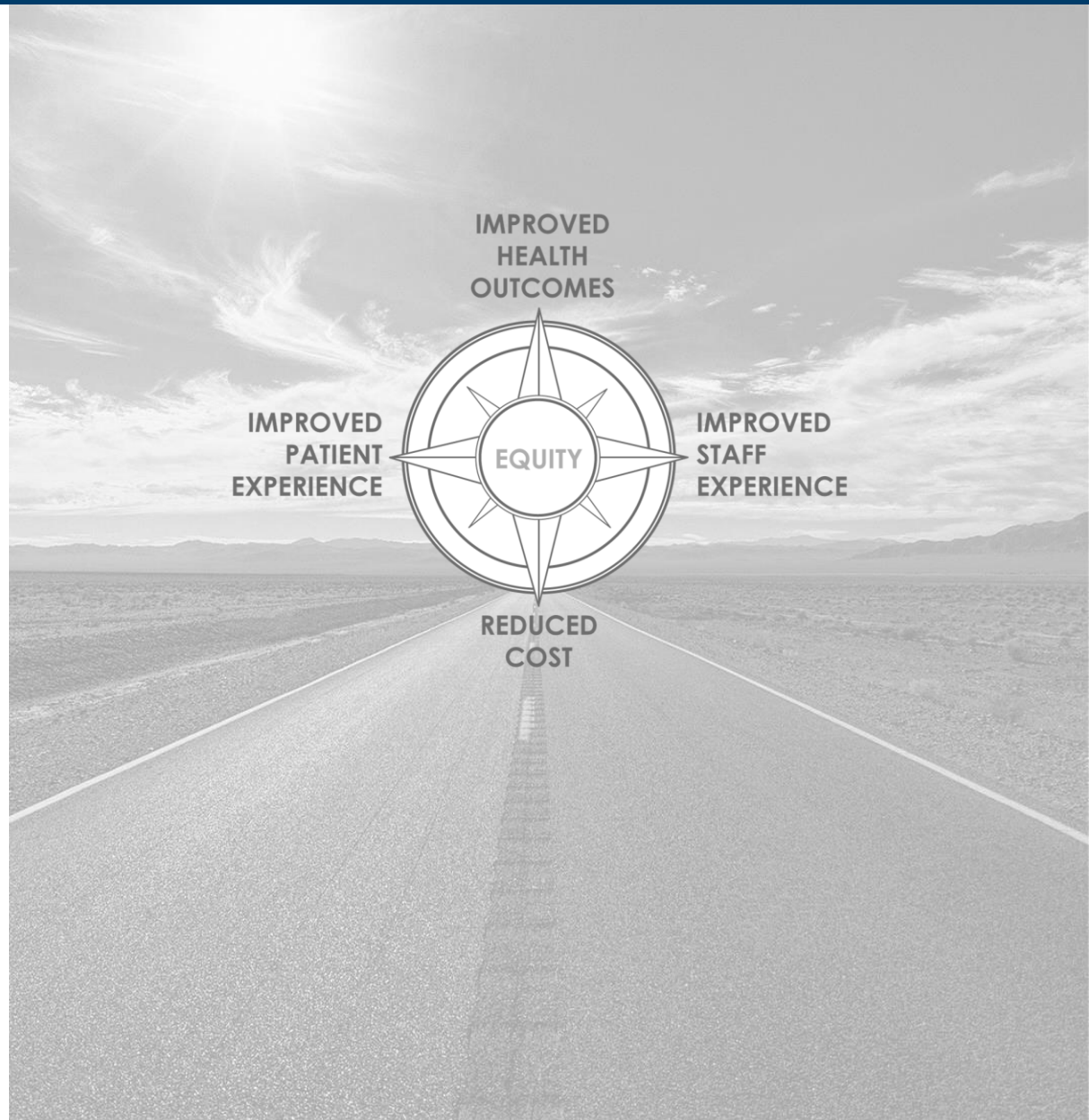
# Elevate 2023: Year-at-a-Glance


**The VTF's systems approach weaves discussion of all 15 Change Areas continuously throughout the year**

- Leadership
- Cost
- Population Health
- Care Teams
- Workforce
- Care Management
- Payment
- Policy
- Evidence-Based Care
- Improvement Strategy
- Patient-Centered Medical Home
- Social Drivers of Health (SDOH)
- Health Information Technology
- Patients
- Partnerships

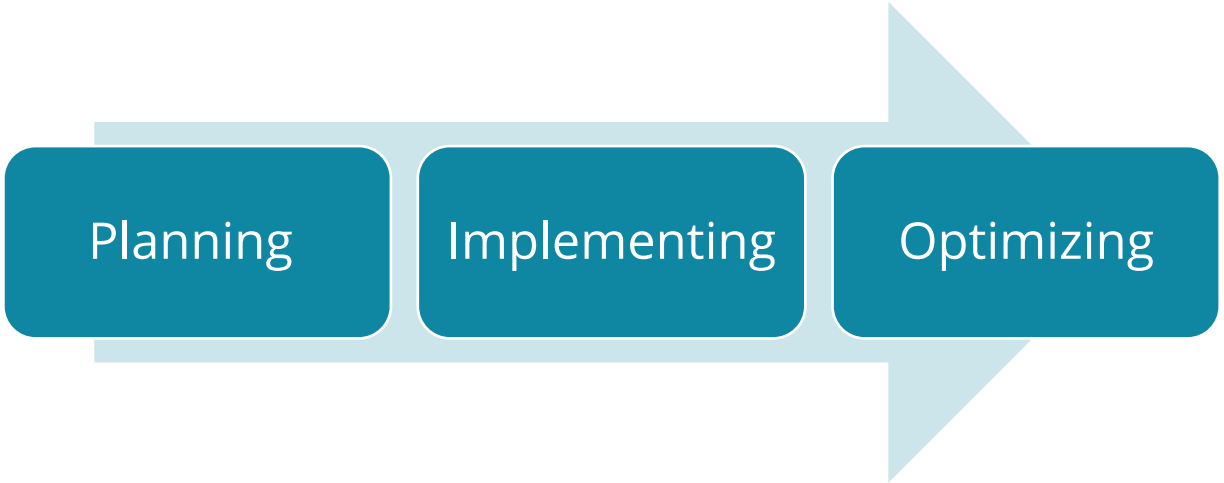


# Elevate *'University'* Offerings

| | |
|---|---|
| **Learning Forums** | Education, training, and peer exchange in areas of health center systems change. |
| **Action Guides** | Step-by-step, evidence-based instructions that break complex topics into manageable action steps. |
| **Reimbursement Tips** | FQHC-specific guidance on billing and coding requirements for Medicare care management and other services. |
| **eLearning** | Self-paced, online learning opportunities to enhance VTF applications, introduce new materials, and support existing practices. |
| **Microlearning** | Concise (< 10 min) learning segments that offer focused learning materials for framework applications. |

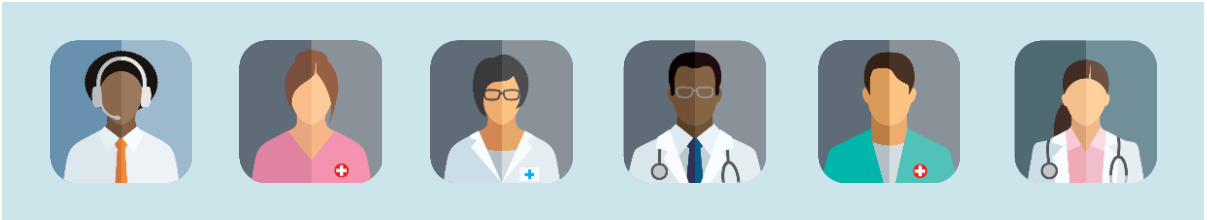
# Elevate *'University'* Tracks

**Content tailored to health center *transformation readiness***



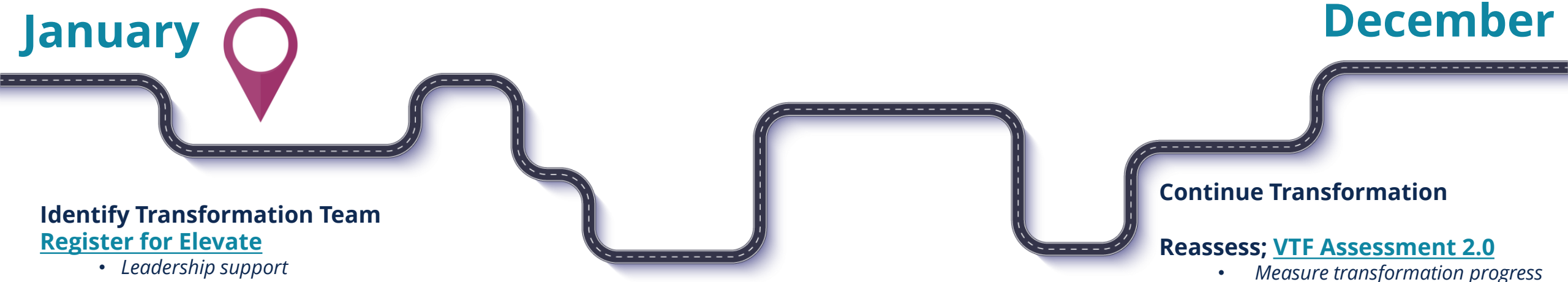

**Content tailored to health center *roles***

*Care Management*
*Outreach & Enrollment*
*Community Health Workers*
*Leadership*



# Elevate 2023: Health Center Pathway

## January



### Identify Transformation Team
### Register for Elevate

- *Leadership support*
- *Interdisciplinary (QI, clinical, finance, HIT)*
- *Care team member engagement*

### Complete the VTF Assessment 2.0

- *Assess progress on transformation continuum*
- *Identify areas for focused improvement*

### Set Goals Based on VTF Assessment Results
### Incorporate into Health Center QI Plan

- *Which Change Areas are most in need of improvement?*
- *Opportunities to leverage other health center initiatives?*

### Leverage the VTF

- *Organize transformation efforts using VTF*

### Access Elevate Resources

- *Attend monthly Elevate learning forums*
- *Apply evidence-based Action Guides*
- *Access eLearning modules & microlearnings*
- *Engage with peers nationally*

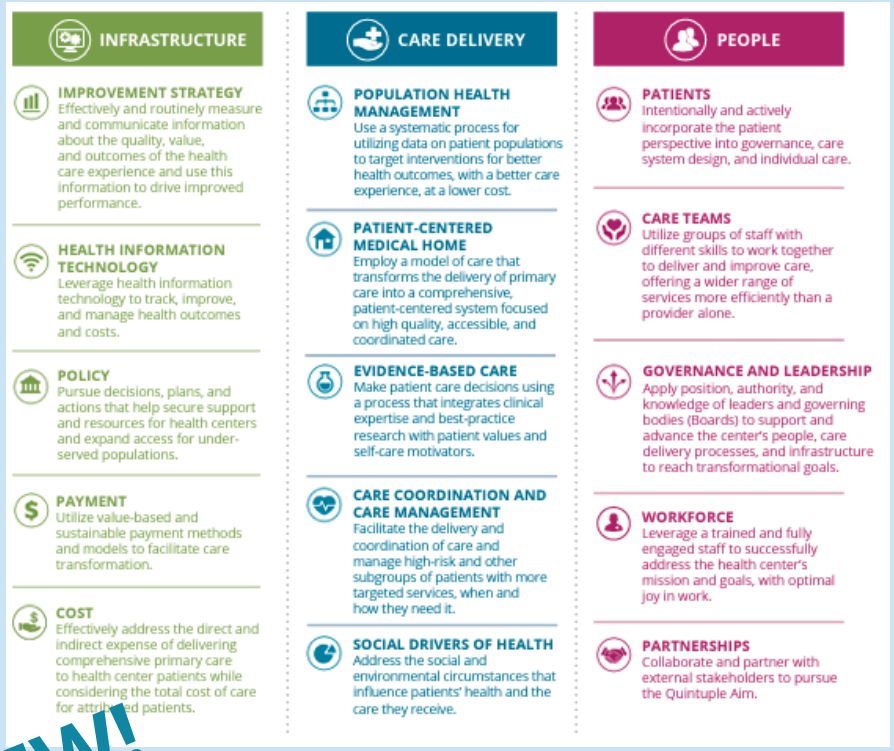
## December

### Continue Transformation

### Reassess; VTF Assessment 2.0

- *Measure transformation progress*
- *Identify areas for focused improvement*

# VTF Assessment: Use To Drive Transformation



**INFRASTRUCTURE**

**IMPROVEMENT STRATEGY**
Effectively and routinely measure and communicate information about the quality, value, and outcomes of the health care experience and use this information to drive improved performance.

**HEALTH INFORMATION TECHNOLOGY**
Leverage health information technology to track, improve, and manage health outcomes and costs.

**POLICY**
Pursue decisions, plans, and actions that help secure support and resources for health centers and expand access for under-served populations.

**PAYMENT**
Utilize value-based and sustainable payment methods and models to facilitate care transformation.

**COST**
Effectively address the direct and indirect expense of delivering comprehensive primary care to health center patients while considering the total cost of care for attributed patients.

**CARE DELIVERY**

**POPULATION HEALTH MANAGEMENT**
Use a systematic process for utilizing data on patient populations to target interventions for better health outcomes, with a better care experience, at a lower cost.

**PATIENT-CENTERED MEDICAL HOME**
Employ a model of care that transforms the delivery of primary care into a comprehensive, patient-centered system focused on high quality, accessible, and coordinated care.

**EVIDENCE-BASED CARE**
Make patient care decisions using a process that integrates clinical expertise and best-practice research with patient values and self-care motivators.

**CARE COORDINATION AND 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.

**SOCIAL DRIVERS OF HEALTH**
Address the social and environmental circumstances that influence patients' health and the care they receive.

**PEOPLE**

**PATIENTS**
Intentionally and actively incorporate the patient perspective into governance, care system design, and individual care.

**CARE TEAMS**
Utilize groups of staff with different skills to work together to deliver and improve care, offering a wider range of services more efficiently than a provider alone.

**GOVERNANCE AND LEADERSHIP**
Apply position, authority, and knowledge of leaders and governing bodies (Boards) to support and advance the center's people, care delivery processes, and infrastructure to reach transformational goals.

**WORKFORCE**
Leverage a trained and fully engaged staff to successfully address the health center's mission and goals, with optimal joy in work.

**PARTNERSHIPS**
Collaborate and partner with external stakeholders to pursue the Quintuple Aim.

NEW!

## VTF Assessment 2.0

- ✓ Still only 15 questions – 1 for each Change Area
- ✓ Refreshed to reflect current state of value-based care


reglantern.com/vtf

- ✓ Assess organizational progress in 15 areas of systems change important to value transformation.
- ✓ Recommended that 3 or more health center staff complete the assessment to get a balanced perspective of organizational progress in areas of systems change

# Complete VTF Assessments ➡ Access FREE Resources

## Complete 3+ VTF Assessments:

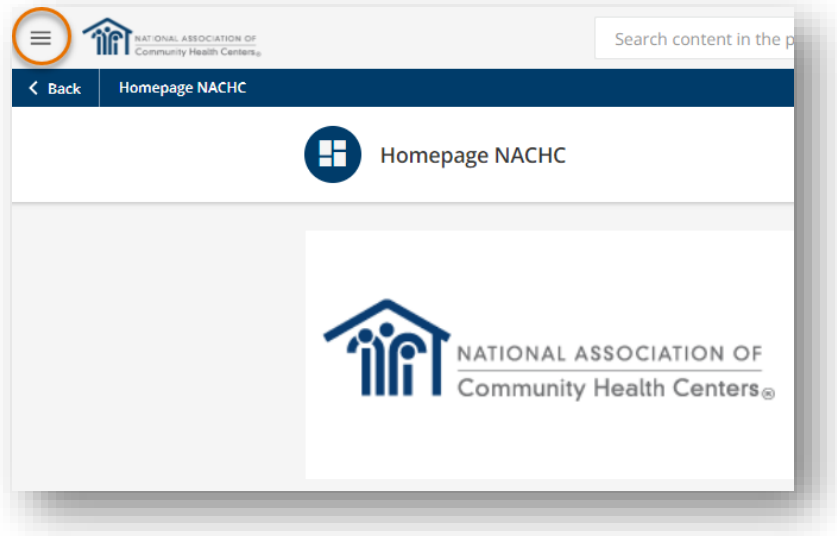
- ✓ Health center receives 5 scholarships, each offering 45-day enrollment in the Institute for Healthcare Improvement (IHI) Open School
- ✓ Health center is eligible for a 6-month trial membership to an online document management platform to support health center OSV preparation and ongoing compliance.

**Save the Date: Thursday, March 22, 2023, 3-4 pm ET**
RegLantern Orientation Call for Health Center Compliance Tool trial subscription
Register Here

**RegLantern Continuous Compliance Tool**

- Cloud-based platform that helps health centers move toward continuous HRSA compliance
- Allows health centers to compile and organize all documents demonstrating compliance in one place
- Embedded with checklists, alerts, and reminders
- Allows a health center to share documents with on-site reviewers during Operational Site Visit (OSV)
- Access to exclusive discounts for health centers interested in continuing subscription after trial period.

# NACHC's Learning Hub: Sign in to Learn More!


Access NACHC's Learning Hub at
https://nachc.docebosaas.com/learn/signin

# VTF & Elevate Resources

## DOMAINS

**INFRASTRUCTURE**
- Improvement Strategy
- Health Information Technology (HIT)
- Policy
- Payment
- Cost

**CARE DELIVERY**
- Population Health Management
- Patient-Centered Medical Home
- Evidence-Based Care
- Care Coordination And Care Management
- Social Drivers Of Health

**PEOPLE**
- Patients
- Care Teams
- Governance And Leadership
- Workforce
- Partnerships

## CHANGE AREAS

**CARE TEAMS**
Utilize groups of staff with different skills to work together to deliver and improve care, offering a wider range of services more efficiently than a provider alone.

## RESOURCES

# Care Teams & Care Management


# Care Teams & Care Management

## WHAT?

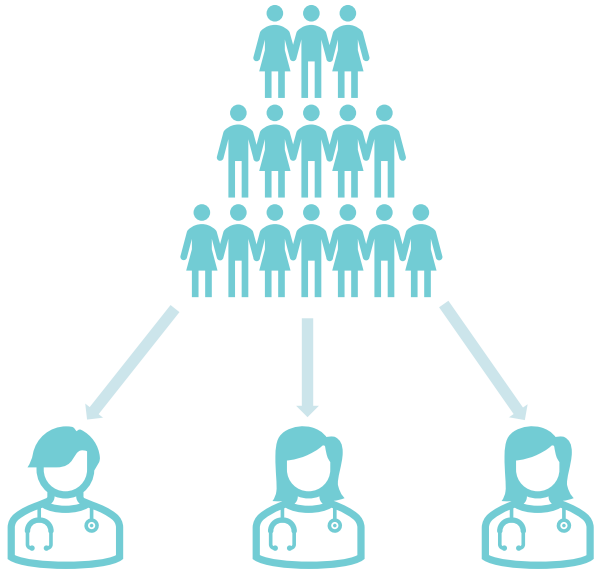
## WHY?

## HOW?

# WHAT role do care teams have in population health management?

## Empanelment → Risk Stratification → Models of Care

The process of matching every patient to a primary care provider and care team.



Segmenting patients into distinct groups of similar complexity and care needs to better target care and services.

- Low Risk
- Rising Risk
- High Risk
- Highly Complex

Designing care models based on risk allows patients to be paired with more appropriate care team members and services.

- *Focus is keeping patients engaged in the health care system without use of unnecessary services.*
- *Focus is on managing risk factors more than disease conditions.*
- *Requires structured care management and one-on-one support.*
- *Requires intensive, pro-active care management.*

# WHAT role do care teams have in population health management?

## Care Teams

Care teams and the tasks that team members are assigned are developed, based on the needs of the patient population (care models) and the availability of personnel, services, and other resources.

## Care Management

A component of care models for high risk and highly complex patients. Care team members provide intensive, one-on-one services to individuals with complex health and social needs.

# **WHAT** role do care teams have in population health management?

Strategies for optimizing care teams and providing care management services can be utilized by health centers at any level – **Planning, Implementing, Optimizing** – with consideration to available resources and attention to staffing challenges.

# Care Teams & Care Management

WHAT?

WHY?

HOW?

# WHY should health centers optimize care teams and provide care management?

## Transitioning to value-based care requires a shift in the way care is delivered:

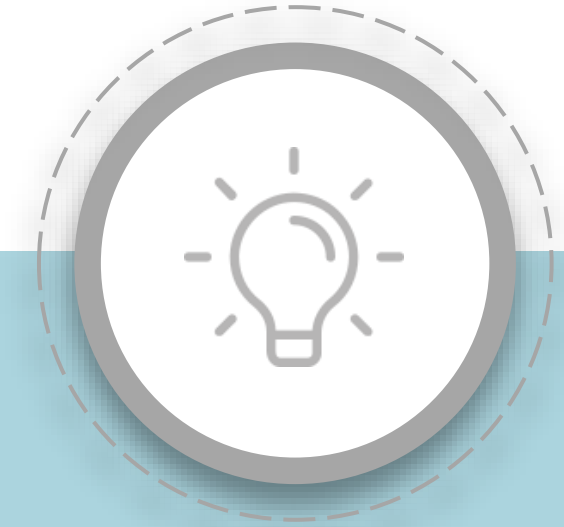
- Increase capacity for the number of patients served
- *'Share the Care'*[+] - provide care as a team with varying staff roles providing care to a panel of patients together
- Reallocate tasks and responsibilities so all team members contribute meaningfully and to full capacity
- Leverage opportunities to capture revenue outside of PPS

**... All while balancing staffing challenges and limited resources!**

**Optimizing care teams has been demonstrated to improve the experience and outcomes of primary care for patients, providers, and staff.**

+Ghorob, A. Bodenheimer, T. (2012). Sharing the Care to Improve Access to Primary Care. New England Journal of Medicine. 366, 1955-1957.

# Care Teams & Care Management

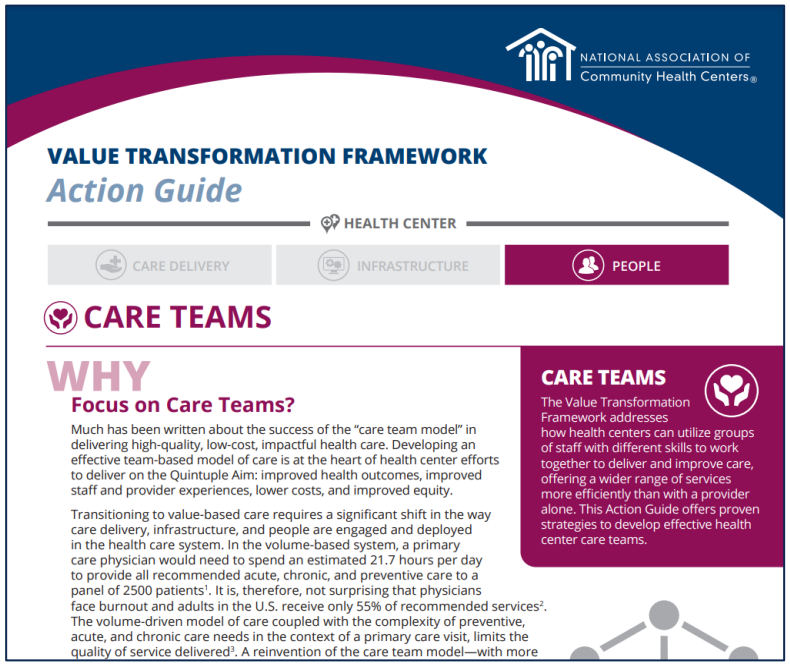


WHAT?

WHY?

HOW?

# Care Teams & Care Management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VALUE TRANSFORMATION FRAMEWORK

*Action Guide*

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

## CARE TEAMS

### WHY

**Focus on Care Teams?**

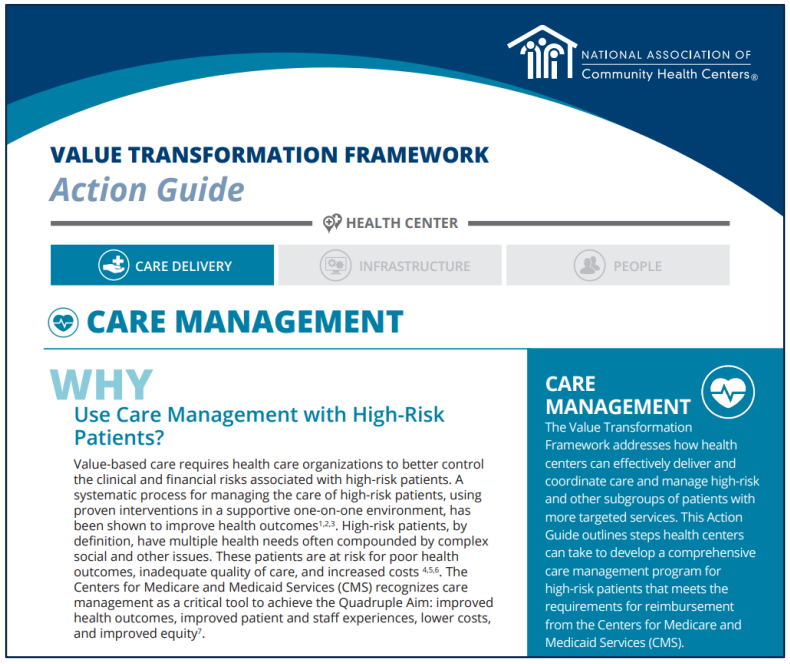
Much has been written about the success of the "care team model" in delivering high-quality, low-cost, impactful health care. Developing an effective team-based model of care is at the heart of health center efforts to deliver on the Quintuple Aim: improved health outcomes, improved staff and provider experiences, lower costs, and improved equity.

Transitioning to value-based care requires a significant shift in the way care delivery, infrastructure, and people are engaged and deployed in the health care system. In the volume-based system, a primary care physician would need to spend an estimated 21.7 hours per day to provide all recommended acute, chronic, and preventive care to a panel of 2500 patients[1]. It is, therefore, not surprising that physicians face burnout and adults in the U.S. receive only 55% of recommended services[2]. The volume-driven model of care coupled with the complexity of preventive, acute, and chronic care needs in the context of a primary care visit, limits the quality of service delivered[3]. A reinvention of the care team model—with more

**CARE TEAMS**

The Value Transformation Framework addresses how health centers can utilize groups of staff with different skills to work together to deliver and improve care, offering a wider range of services more efficiently than with a provider alone. This Action Guide offers proven strategies to develop effective health center care teams.

[NACHC Care Teams Action Guide]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VALUE TRANSFORMATION FRAMEWORK

*Action Guide*

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

## CARE MANAGEMENT

### WHY

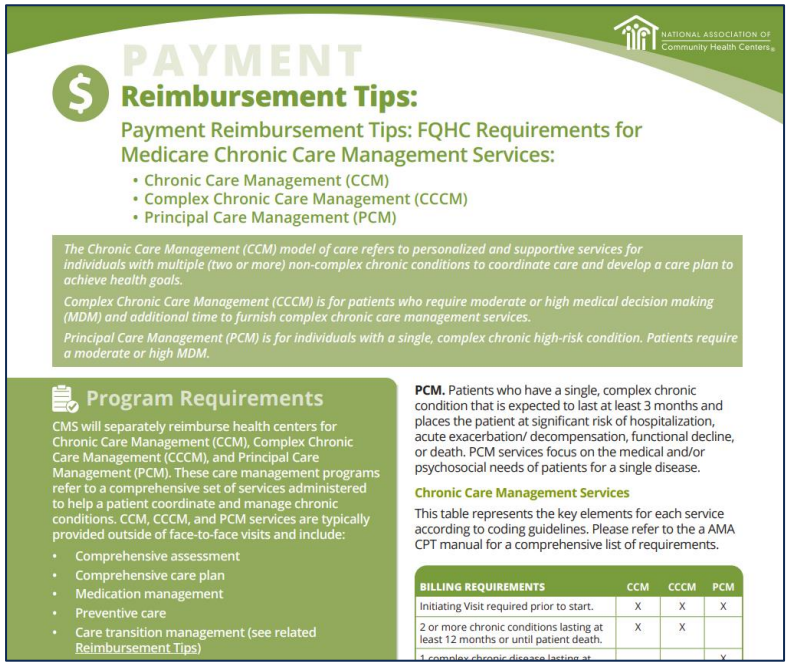
**Use Care Management with High-Risk Patients?**

Value-based care requires health care organizations to better control the clinical and financial risks associated with high-risk patients. A systematic process for managing the care of high-risk patients, using proven interventions in a supportive one-on-one environment, has been shown to improve health outcomes[1,2,3]. High-risk patients, by definition, have multiple health needs often compounded by complex social and other issues. These patients are at risk for poor health outcomes, inadequate quality of care, and increased costs [4,5,6]. The Centers for Medicare and Medicaid Services (CMS) recognizes care management as a critical tool to achieve the Quadruple Aim: improved health outcomes, improved patient and staff experiences, lower costs, and improved equity[7].

**CARE MANAGEMENT**

The Value Transformation Framework addresses how health centers can effectively deliver and coordinate care and manage high-risk and other subgroups of patients with more targeted services. This Action Guide outlines steps health centers can take to develop a comprehensive care management program for high-risk patients that meets the requirements for reimbursement from the Centers for Medicare and Medicaid Services (CMS).

[NACHC Care Management Action Guide]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PAYMENT

## Reimbursement Tips:

Payment Reimbursement Tips: FQHC Requirements for Medicare Chronic Care Management Services:

- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)
- Principal Care Management (PCM)

*The Chronic Care Management (CCM) model of care refers to personalized and supportive services for individuals with multiple (two or more) non-complex chronic conditions to coordinate care and develop a care plan to achieve health goals.*

*Complex Chronic Care Management (CCCM) is for patients who require moderate or high medical decision making (MDM) and additional time to furnish complex chronic care management services.*

*Principal Care Management (PCM) is for individuals with a single, complex chronic high-risk condition. Patients require a moderate or high MDM.*

### Program Requirements

CMS will separately reimburse health centers for Chronic Care Management (CCM), Complex Chronic Care Management (CCCM), and Principal Care Management (PCM). These care management programs refer to a comprehensive set of services administered to help a patient coordinate and manage chronic conditions. CCM, CCCM, and PCM services are typically provided outside of face-to-face visits and include:

- Comprehensive assessment
- Comprehensive care plan
- Medication management
- Preventive care
- Care transition management (see related Reimbursement Tips)

**PCM.** Patients who have a single, complex chronic condition that is expected to last at least 3 months and places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death. PCM services focus on the medical and/or psychosocial needs of patients for a single disease.

**Chronic Care Management Services**

This table represents the key elements for each service according to coding guidelines. Please refer to the a AMA CPT manual for a comprehensive list of requirements.

| BILLING REQUIREMENTS | CCM | CCCM | PCM |
|---|---|---|---|
| Initiating Visit required prior to start. | X | X | X |
| 2 or more chronic conditions lasting at least 12 months or until patient death. | X | X | |
| 1 complex chronic disease lasting at | | | X |

[NACHC CCM Reimbursement Tip Sheet]

# HOW to optimize care teams?

**STEP 1** Define care standards

**STEP 2** Distribute tasks to meet standards and document workflow

**STEP 3** Update job descriptions

**STEP 4** Train staff

**STEP 5** Monitor task performance in dashboards

**STEP 6** Hardwire accountability into personnel systems and performance reviews

**STEP 7** Educate patients on redesigned care team

# KEY STEP: *DEFINE CARE STANDARDS*

**Identify the minimum set of care and services to be provided to patients by age and risk group.**

For example, which clinical guidelines will your health center consider:

- U.S. Preventive Services Task Force (USPSTF)?
- Healthcare Effective Data and Information Set (HEDIS)?
- Uniform Data Systems (UDS)?

Essentially, how is a 'care gap' defined by your health center?

**Cancer Screenings** (breast, cervical, colorectal)

**Immunizations**

**Behavioral Health Measures**

**Chronic Condition Measures** (A1c, BP)

# KEY STEP: *DEFINE CARE STANDARDS*

**LOW RISK**

**RISING RISK**

**HIGH RISK**

**HIGHLY COMPLEX**

- Care management support

- Care gap closure
- Open referral and outstanding lab follow up
- ED and hospitalization follow up

- SDOH support
- Prescriptions/refills
- Triage

**Frequency and Intensity of Support**

# KEY STEP: *DISTRIBUTE TASKS TO MEET CARE STANDARDS*

Once a health center has agreed to a minimum set of care standards for each target group, the tasks necessary to accomplish these standards can be assigned to specific care team member roles.

Ensure staff members are tasked with work that enables them to perform at the top of their licensure.

Implement standing orders to empower support staff to order or provide labs, referrals, and other services.

## Optimize HIT!

Consider which tasks can be delegated to technology. For example, use systems to send automated reminders and schedule services for care gaps so staff members can spend less time manually calling patients.

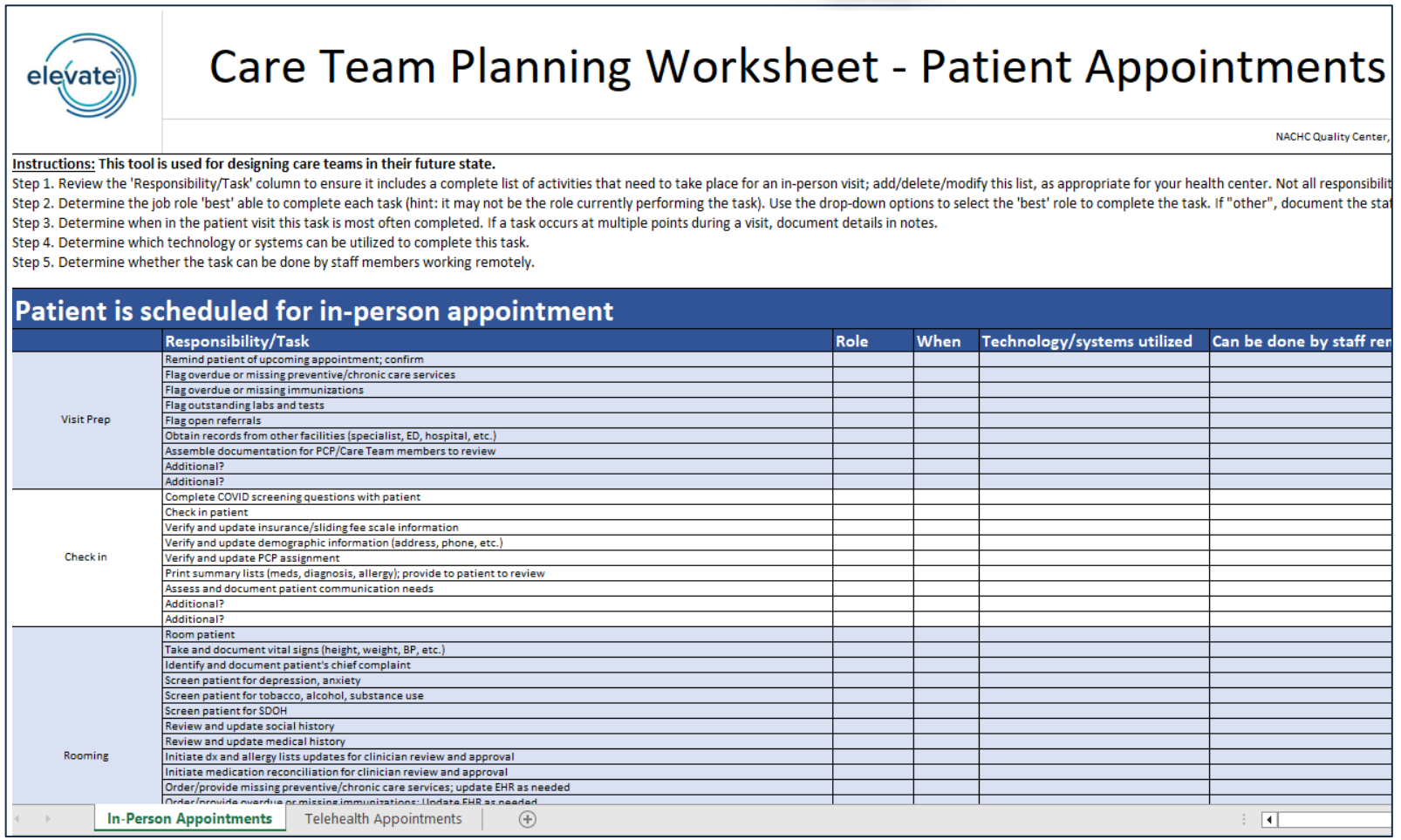
Determine which tasks can be completed remotely and which require staff to be at the health center in-person. Create policies and provide remote access for staff to connect to the EHR and work from home on designated tasks.

# KEY STEP: *DISTRIBUTE TASKS TO MEET CARE STANDARDS*

## Distribute Tasks

Consider using or creating a tool to aid in the process of distributing tasks.

- Start by identifying the responsibility or task that needs to be completed.
- Determine the job role 'best' able to complete that task.
- Also consider:
  - Technology
  - In-person vs remote
  - Primary vs back-up



elevate

### Care Team Planning Worksheet - Patient Appointments

NACHC Quality Center,

**Instructions:** **This tool is used for designing care teams in their future state.**
Step 1. Review the 'Responsibility/Task' column to ensure it includes a complete list of activities that need to take place for an in-person visit; add/delete/modify this list, as appropriate for your health center. Not all responsibilit
Step 2. Determine the job role 'best' able to complete each task (hint: it may not be the role currently performing the task). Use the drop-down options to select the 'best' role to complete the task. If "other", document the stat
Step 3. Determine when in the patient visit this task is most often completed. If a task occurs at multiple points during a visit, document details in notes.
Step 4. Determine which technology or systems can be utilized to complete this task.
Step 5. Determine whether the task can be done by staff members working remotely.

**Patient is scheduled for in-person appointment**

| | Responsibility/Task | Role | When | Technology/systems utilized | Can be done by staff rer |
|---|---|---|---|---|---|
| Visit Prep | Remind patient of upcoming appointment; confirm | | | | |
| | Flag overdue or missing preventive/chronic care services | | | | |
| | Flag overdue or missing immunizations | | | | |
| | Flag outstanding labs and tests | | | | |
| | Flag open referrals | | | | |
| | Obtain records from other facilities (specialist, ED, hospital, etc.) | | | | |
| | Assemble documentation for PCP/Care Team members to review | | | | |
| | Additional? | | | | |
| | Additional? | | | | |
| Check in | Complete COVID screening questions with patient | | | | |
| | Check in patient | | | | |
| | Verify and update insurance/sliding fee scale information | | | | |
| | Verify and update demographic information (address, phone, etc.) | | | | |
| | Verify and update PCP assignment | | | | |
| | Print summary lists (meds, diagnosis, allergy); provide to patient to review | | | | |
| | Assess and document patient communication needs | | | | |
| | Additional? | | | | |
| | Additional? | | | | |
| Rooming | Room patient | | | | |
| | Take and document vital signs (height, weight, BP, etc.) | | | | |
| | Identify and document patient's chief complaint | | | | |
| | Screen patient for depression, anxiety | | | | |
| | Screen patient for tobacco, alcohol, substance use | | | | |
| | Screen patient for SDOH | | | | |
| | Review and update social history | | | | |
| | Review and update medical history | | | | |
| | Initiate dx and allergy lists updates for clinician review and approval | | | | |
| | Initiate medication reconciliation for clinician review and approval | | | | |
| | Order/provide missing preventive/chronic care services; update EHR as needed | | | | |
| | Order/provide overdue or missing immunizations; Update EHR as needed | | | | |

In-Person Appointments | Telehealth Appointments

[NACHC Care Team Planning Worksheet - Patient Appointments]

# HOW to optimize care teams?

## Planning

- Begin by assessing your current state:
  - What are the tasks that are being completed?
  - Who is completing each task?
- Start with just one provider & care team rather than organization-wide.

## Implementing

- Redistribute tasks to more appropriate roles, enabling staff to work to the top of their skill level.
- Leverage HIT systems already in place.
- Expand to additional providers & care teams as staff begins to feel comfortable with the process.

## Optimizing

- Incorporate new, innovative HIT and staff roles to further optimize care team processes and patient care:
  - Integrated services
  - Remote patient monitoring
  - Telehealth

# HOW to provide care management?

**STEP 1** Identify or hire a care manager

**STEP 2** Identify high risk patients

**STEP 3** Define care manager-care team interface

**STEP 4** Define services provided as part of care management

**STEP 5** Enroll patients in care management

**STEP 6** Create individualized care plans

**STEP 7** Enhance and expand partnerships

**STEP 8** Document and bill for chronic care management

**STEP 9** Graduate patients from care management

**STEP 10** Measure outcomes

# KEY STEP: *IDENTIFY OR HIRE A CARE MANAGER*

Identify staff to provide one-on-one services to high risk and highly complex patients.

An RN often serves in this role, but other members of the care team (MA, CHW, etc.) can perform many care management services within state/license requirements.

Use **empanelment data** to help determine which care teams to add care managers to, and **risk stratification data** to help determine the number of care managers needed to meet the needs of the patient population.

If your health center does not have the staffing or resources to hire/identify full-time care managers, consider formalizing care management responsibilities within current care team members' roles to provide services to a smaller number of patients.

**Tools & Resources:** Sample Care Manager Job Description

# KEY STEP: *IDENTIFY HIGH RISK PATIENTS*

## Identify high risk patients based on:

- Risk stratification data
- CCM eligibility criteria

The target caseload for a full-time care manager varies depending on several factors and is likely to be in the range of **50-150** patients. Factors affecting caseload size include:

- Health center procedures and resources
- The care manager's experience
- The clinical and social complexity of patients
- Available social supports
- Target care management outcomes

Evaluate caseload size and manageability on an ongoing basis.

# KEY STEP:

## *DEFINE SERVICES PROVIDED AS PART OF CARE MANAGEMENT*

Ensure comprehensive care plans support chronic disease and prevention needs, as well as mental, social, and environmental factors.

CCM services include:

- Comprehensive assessment of medical, functional, and psychosocial needs
- Preventive care
- Medication management
- Comprehensive care plan
- Continuity of care
- Coordination with home-health and community-based providers
- 24/7 access to providers or clinical staff

Also consider incorporating Transitional Care Management (TCM) services.

**Tools & Resources:**
Care Management Protocol for High-Risk Patients
NACHC TCM Reimbursement Tip Sheet

# KEY STEP: *ENROLL PATIENTS IN CARE MANAGEMENT*

## Consider enrolling eligible patients through:

- Warm handoffs from the primary care provider (or other designated care team member) to the care manager.
- The care manager can call, email, or mail a letter indicating that their provider has recommended them for care management.
- Discuss with patients after a change in health status such as a new diagnosis, transition in care, etc.

- For CCM, provider must have a discussion with patient about CCM prior to enrollment (must be documented!).
- Obtain and document patient consent.
- Track enrolled patients and their assigned care manager in the EHR where other care team members can view.

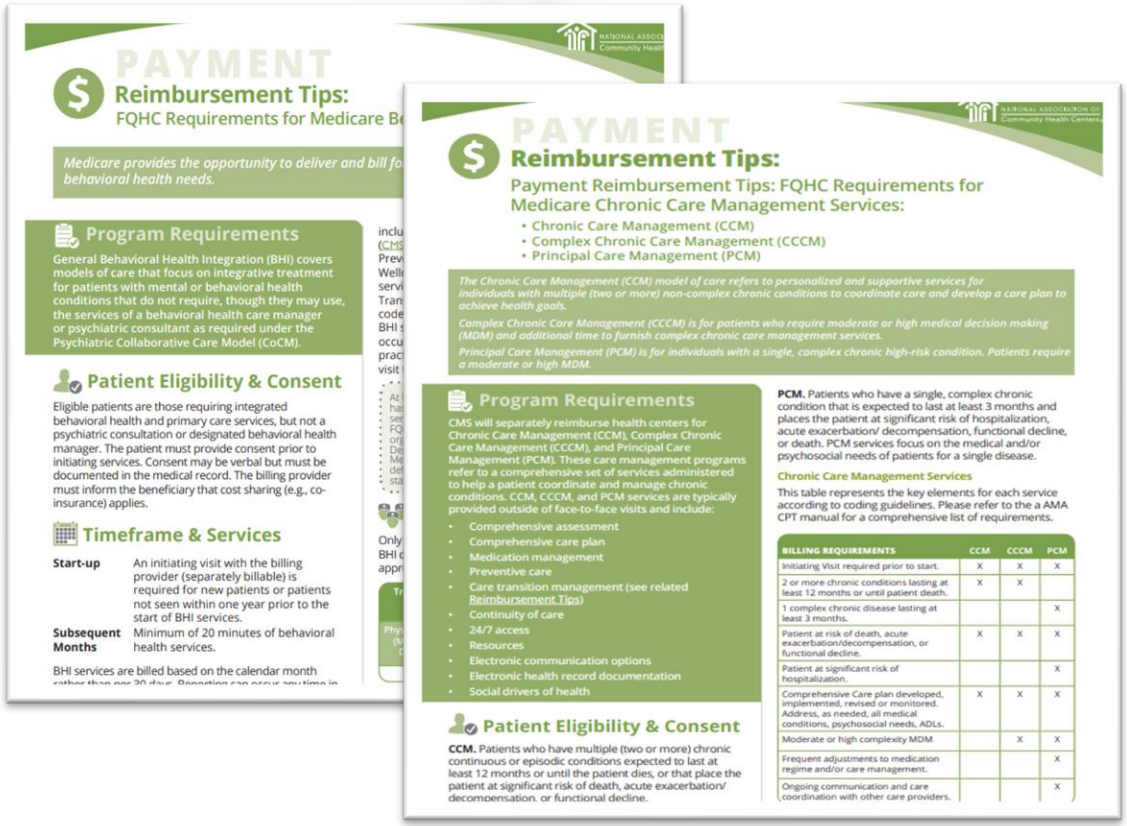
**Tools & Resources:**
Sample Consent Form
Sample Internal Referral to CM Form

# KEY STEP:

## *DOCUMENT & BILL FOR CARE MANAGEMENT SERVICES*

| CMS Care Management Services | Reimbursement Potential |
|---|---|
| Chronic Care Management (CCM),<br>Complex Chronic Care Management (CCCM)<br>Principal Care Management (PCM) | $77.94 |
| Transitional Care Management (TCM) | $187.19 |
| Psychiatric Collaborative Care Model (CoCM) | $147.07 |
| General Behavioral Health Integration (BHI) | $77.94 |

FQHC Reimbursement Tip Sheets for CMS/Medicare Care Management Services are available free of charge on NACHC's Elevate platform.




**Tools & Resources:**
NACHC CCM Reimbursement Tip Sheet

# HOW to provide care management?

## Planning

- Start small! If your health center is not able to hire full-time care managers, formalize care management responsibilities within current care team members' roles to provide services to a smaller number of patients.

## Implementing

- Enroll patients and build care management patient panels. **This takes time!**

## Optimizing

- Incorporate care management services and goals into value-based care contracts and optimize reimbursement opportunities.
- Leverage care management data and outcomes to expand services to a larger portion of the patient population.

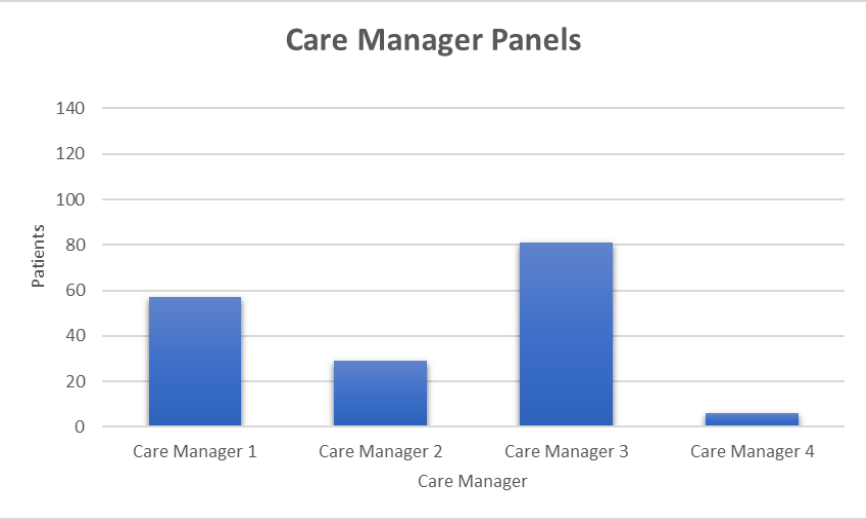
# KEY STEP: *MEASURE OUTCOMES*

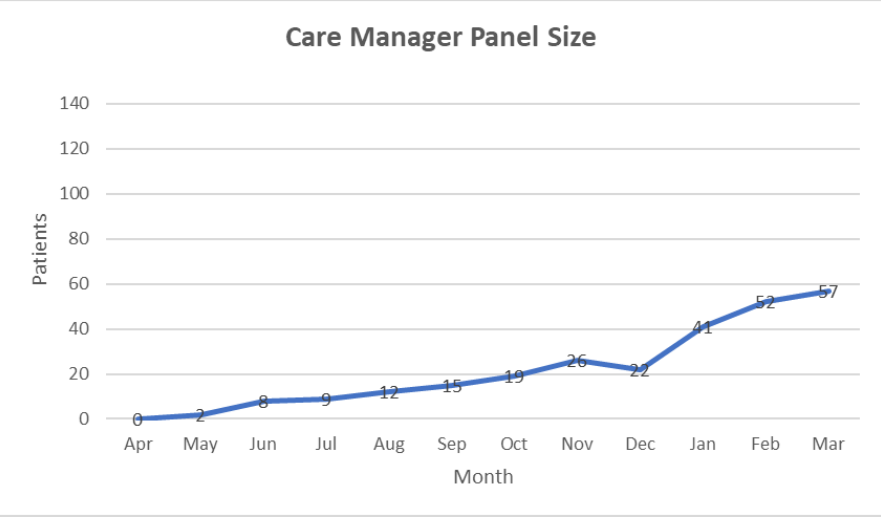
Use care management panel data to scale your care management program, to meet the needs of your patient population while balancing staffing needs and care team responsibilities.

***How? …***

# Measuring Care Management Panel Data

- Measure the number of patients in each care manager's panel to help assess workload and balance with other care team responsibilities.
- Measure each care manager's panel size over time to view 'net' changes.

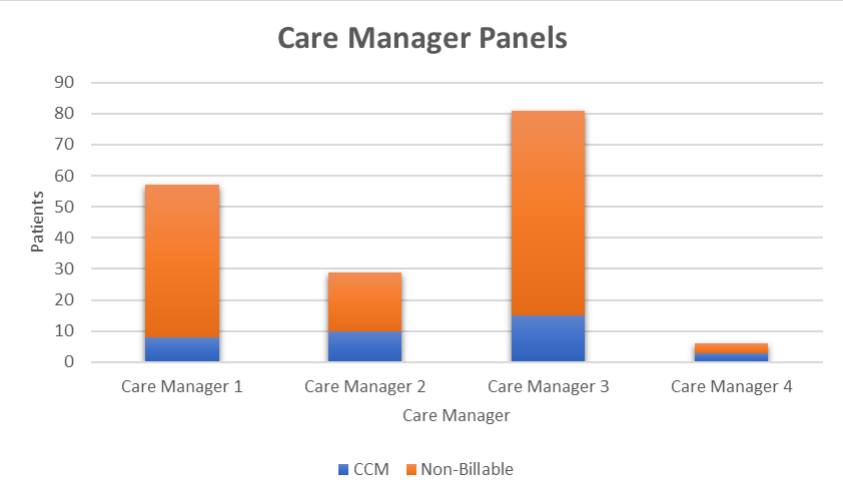


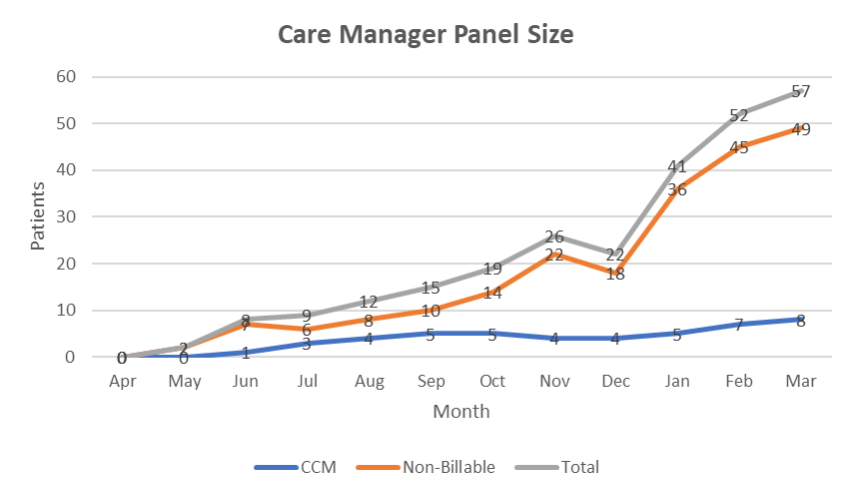




Keep in mind when setting goals or calculating potential revenue for care management, it takes time to build a patient panel.

# Measuring Care Management Panel Data

- If you have more than one care management program, measure panel size by program (or by payor if you have multiple value-based contracts).
- Measure each care manager's panel size by program over time to view 'net' changes.

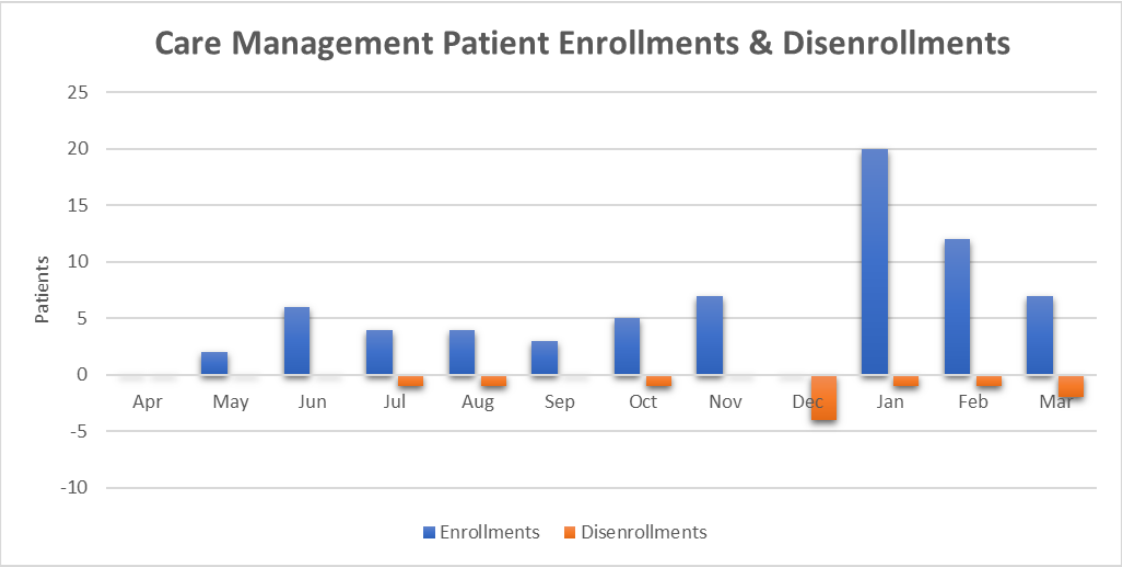


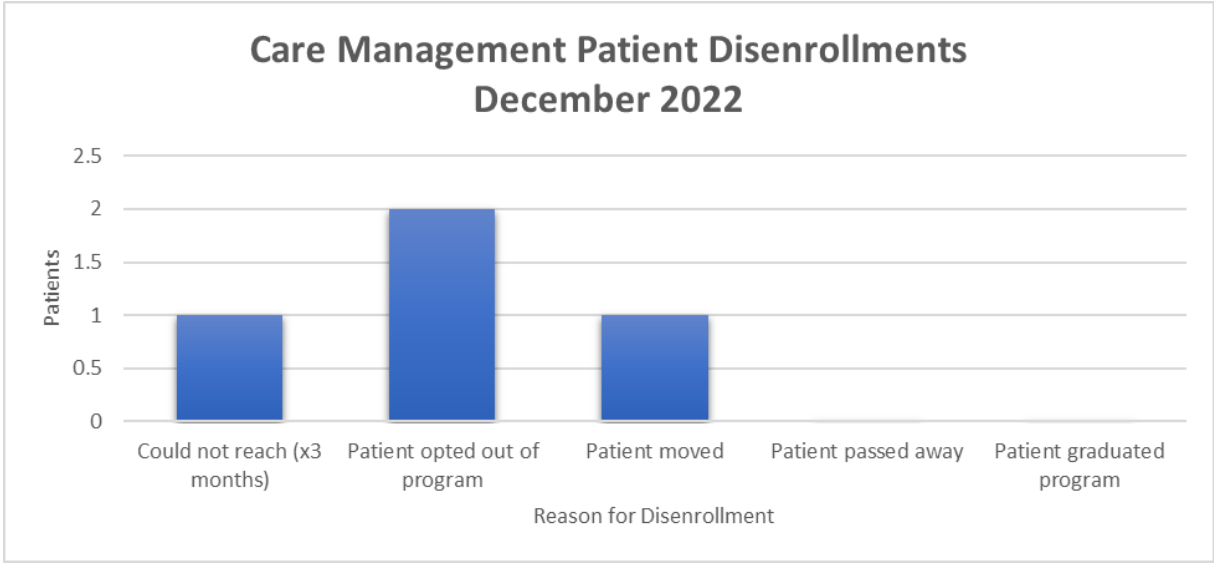




For CCM, this data can be used to set goals and predict potential program revenue.

# Measuring Care Management Panel Data

- Measure patient enrollments and disenrollments by month.
- Measure patient disenrollments by reason.



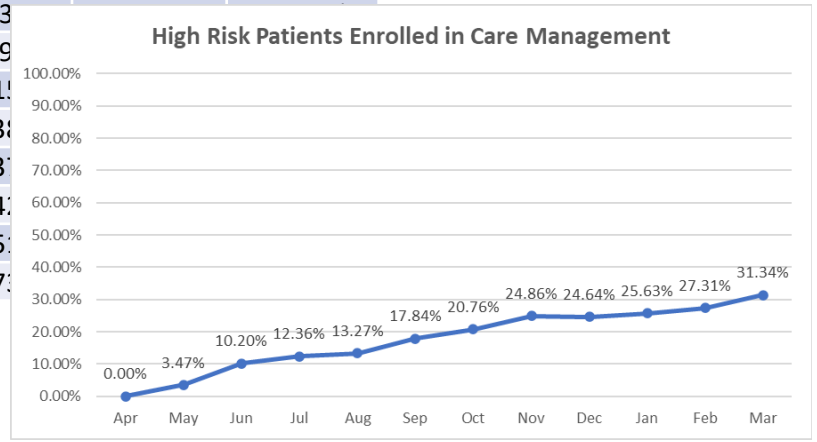




This perspective gives a higher level of insight into how a care manager is building and retaining their panel.

# Measuring Care Management Panel Data

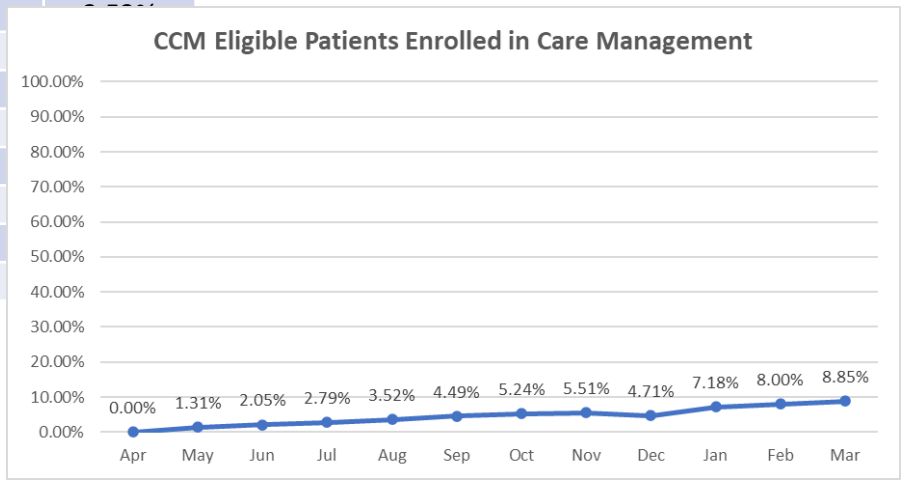
- Measure the number of high-risk patients enrolled in care management.

| Month | Enrolled | High Risk | Rate |
|---|---|---|---|
| Apr | 0 | 549 | 0.00% |
| May | 19 | 547 | 3.47% |
| Jun | 56 | 549 | 10.20% |
| Jul | 68 | 550 | 12.36% |
| Aug | 73 | | |
| Sep | 99 | | |
| Oct | 11 | | |
| Nov | 13 | | |
| Dec | 13 | | |
| Jan | 14 | | |
| Feb | 15 | | |
| Mar | 17 | | |




- Measure the number of CCM eligible patients enrolled in care management.

| Month | Enrolled | Eligible | Rate |
|---|---|---|---|
| Apr | 0 | 380 | 0.00% |
| May | 5 | 382 | 1.31% |
| Jun | 8 | 390 | 2.05% |
| Jul | 11 | 394 | 2.79% |
| Aug | 14 | 398 | |
| Sep | 18 | 401 | |
| Oct | 21 | 401 | |
| Nov | 22 | 399 | |
| Dec | 19 | 403 | |
| Jan | 29 | 404 | |
| Feb | 32 | 400 | |
| Mar | 36 | 407 | |

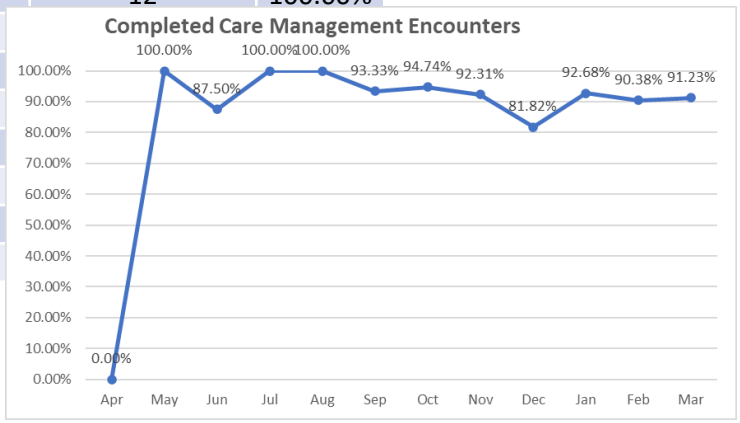



This data can be used to figure out how many care managers are needed to care for a patient population.

# Measuring Care Management Panel Data

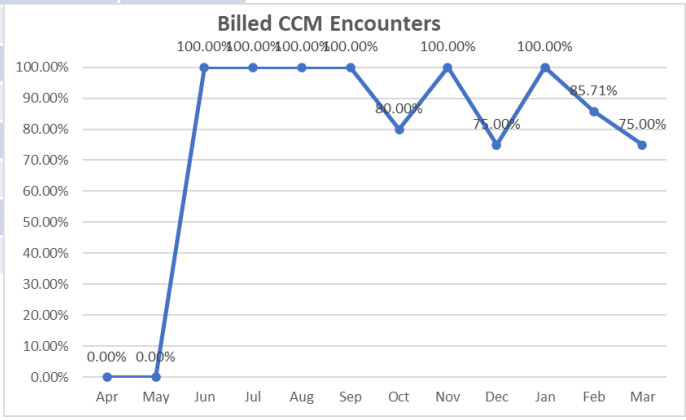
- Measure the number of completed Care Management encounters.

| Month | Panel Size | CM Encounters | Rate |
|---|---|---|---|
| Apr | 0 | 0 | 0.00% |
| May | 2 | 2 | 100.00% |
| Jun | 8 | 7 | 87.50% |
| Jul | 9 | 9 | 100.00% |
| Aug | 12 | 12 | 100.00% |
| Sep | 15 | | |
| Oct | 19 | | |
| Nov | 26 | | |
| Dec | 22 | | |
| Jan | 41 | | |
| Feb | 52 | | |
| Mar | 57 | | |




- Measure the number of billed CCM encounters.

| Month | Enrolled CCM Patients | Billed G0511 | Rate |
|---|---|---|---|
| Apr | 0 | 0 | 0.00% |
| May | 0 | 0 | 0.00% |
| Jun | 1 | 1 | 100.00% |
| Jul | 3 | 3 | 100.00% |
| Aug | 4 | 4 | 100.00% |
| Sep | 5 | | |
| Oct | 5 | | |
| Nov | 4 | | |
| Dec | 4 | | |
| Jan | 5 | | |
| Feb | 7 | | |
| Mar | 8 | | |




This data can be used to ensure care managers have enough 'protected' time to complete care management responsibilities. (Patient engagement is also a factor.)

# Measuring Care Management Panel Data

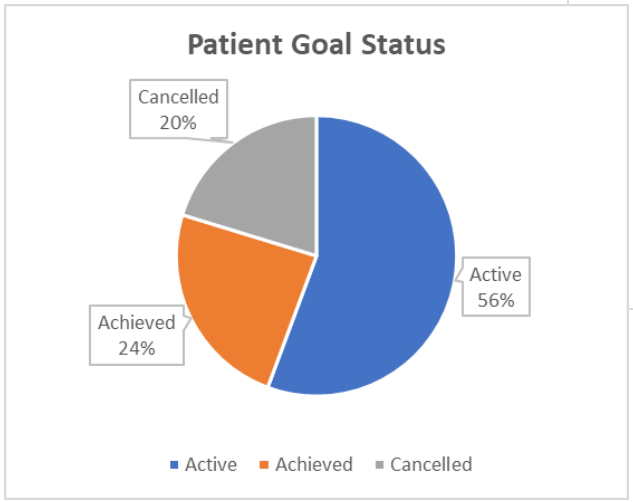
- Measure the impact on quality measures.

| UDS Measure | All Health Center Patients | Care Management Patients (>1yr) |
|---|---|---|
| Colorectal Cancer Screening | 71% | 81% |
| Diabetes A1C Control | 32% | 21% |
| Hypertension Control | 68% | 77% |

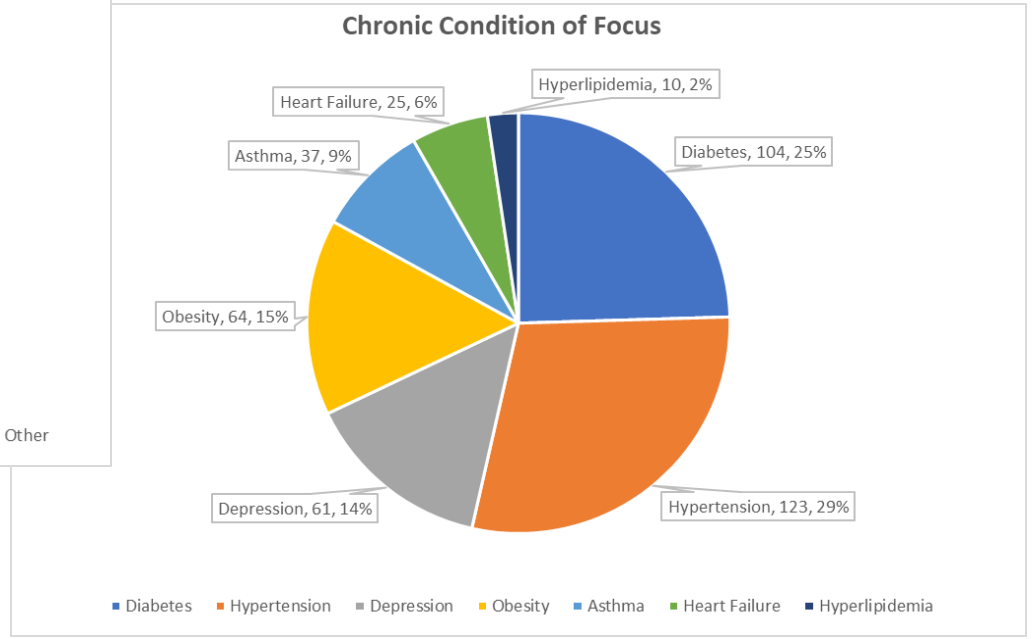
Filter to include care management patients who have been enrolled in care management for >6 months or >1 year, and patients who have graduated from a care management program.

# Measuring Care Management Panel Data

- Consider building structured data fields into documentation workflows, for the ability to measure progress on patient care management goals.








Measure the impact of different care plans and interventions.

# Measuring Care Management Panel Data

## Planning

- Determine the structured data fields you will build into your care management workflows.
  - How will the care manager be identified within the patient's chart?
  - How will encounters be documented?
  - How will goals/progress toward goals be documented?

## Implementing

- Determine which panel data measures you will review and how often you will review them.
- Consider starting with panel size, enrollments & disenrollments, and completed encounters.

## Optimizing

- Expand to review additional panel data measures.
- Focus on outcomes of the care management program.
  - Care management goals
  - Clinical quality measures

Community Health Center Association of Connecticut

# The PCA Experience:

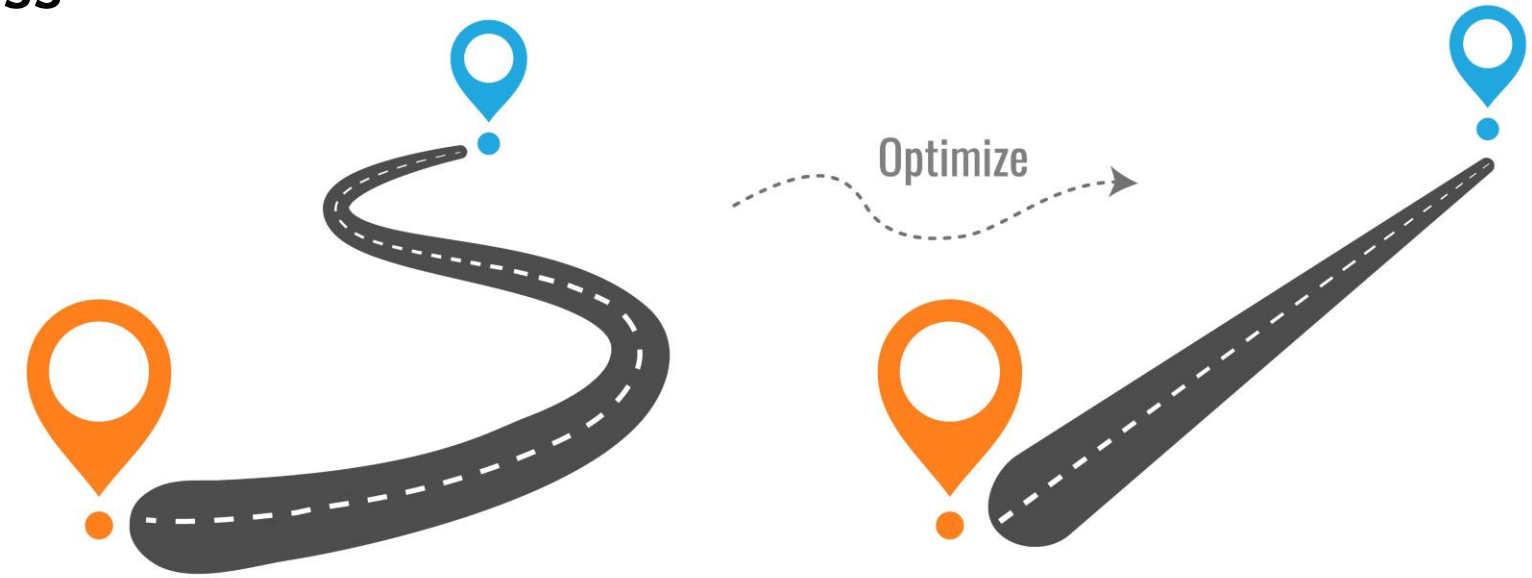
## Optimizing Care Team Roles & Responsibilities

Heather Adams
Director of Training & Education

Colleen Rankine
VP, Operations

# CHCACT & The PCA Experience

- Investment in the process
  - Leadership
  - Time
  - Commitment to improvement
- Understanding
  - Current state/process
  - Future state/process



# Swimlane Process Map

- Approach to systematic change
- Owned by the participants
- Empowering the opportunity to change
- Involving participants doing the work in making the changes

# Health Center Experience


East Hartford Connecticut

Community Health Center Association of Connecticut

# Discussion

# *Extended Care Team: Enabling Services*

**Ted Henson**
Director, Health Center Growth & Development
Training & Technical Assistance
National Association of Community Health Centers

NATIONAL ASSOCIATION OF Community Health Centers

# Enabling Services: Vital Workforce

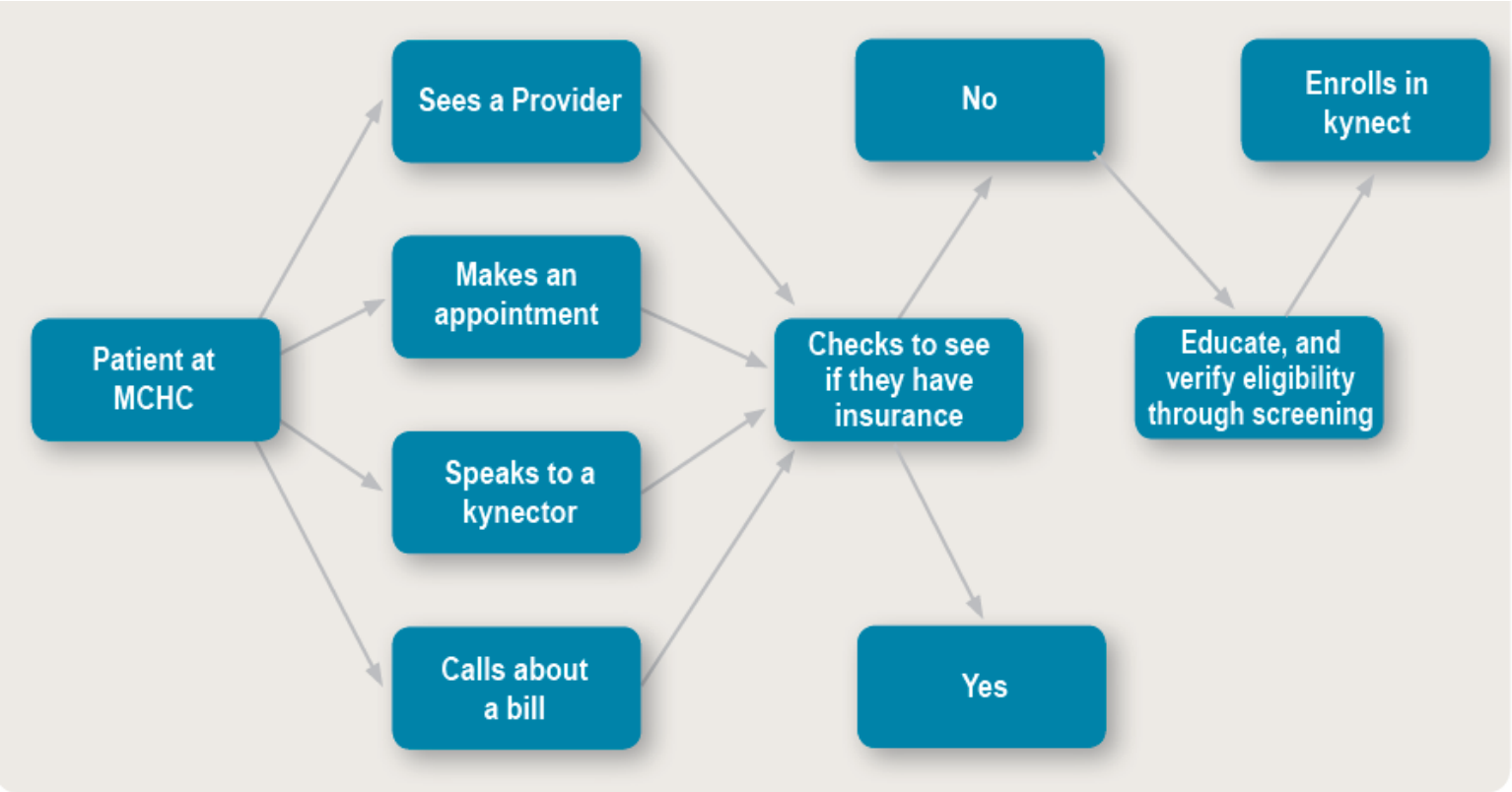
CARE TEAMS

Described in Section 330(b)(1)(A)(iv) of the Public Health Service Act as “non-clinical services that aim to increase access to healthcare, and to improve health outcomes.”

- 25,000+ strong!
  - Case Managers (11,327)
  - Eligibility Workers (4,347)
  - Outreach Workers (2,774)
  - Patient Specialists (2,579)
  - Community Health Workers (1,900)
  - Interpretation (1,213)
  - Transportation
  - Other.
- Potential return on investment (ROI) for enabling services

# Sample Workflow: Enrollment Assistance

CARE TEAMS



# Upcoming Learning Opportunity:

## National Diabetes Prevention Program Basics for Health Centers

Join NACHC and experts from the Association of Diabetes Care & Education Specialists (ADCES) for the opportunity to learn how health centers can implement the CDC-recognized lifestyle change program, focused on healthy eating and physical activity, that has been shown to reduce participants' risk of developing type 2 diabetes.

This webinar will also highlight findings from NACHC's ***Healthy Together*** project which optimizes technology and takes a whole-person approach, including use of self-care tools, for individuals at risk for diabetes as well as living with diabetes.

**Thursday, April 6th 12-1pm ET**

**Registration is required! Register here.**

ADCES

NATIONAL ASSOCIATION OF Community Health Centers®

# Upcoming Learning Opportunity:
## Brain Health 3-Part Webinar Series

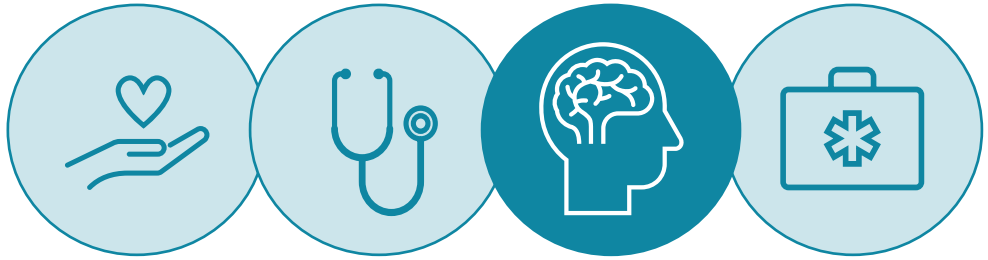
Join NACHC and experts from the field for this 3-part series focused on leveraging health center workflows to care for patients at risk for or diagnosed with dementia.

**Wednesday, May 3rd 1-2pm ET**
Early Detection of Dementia & Reducing Risk Factors

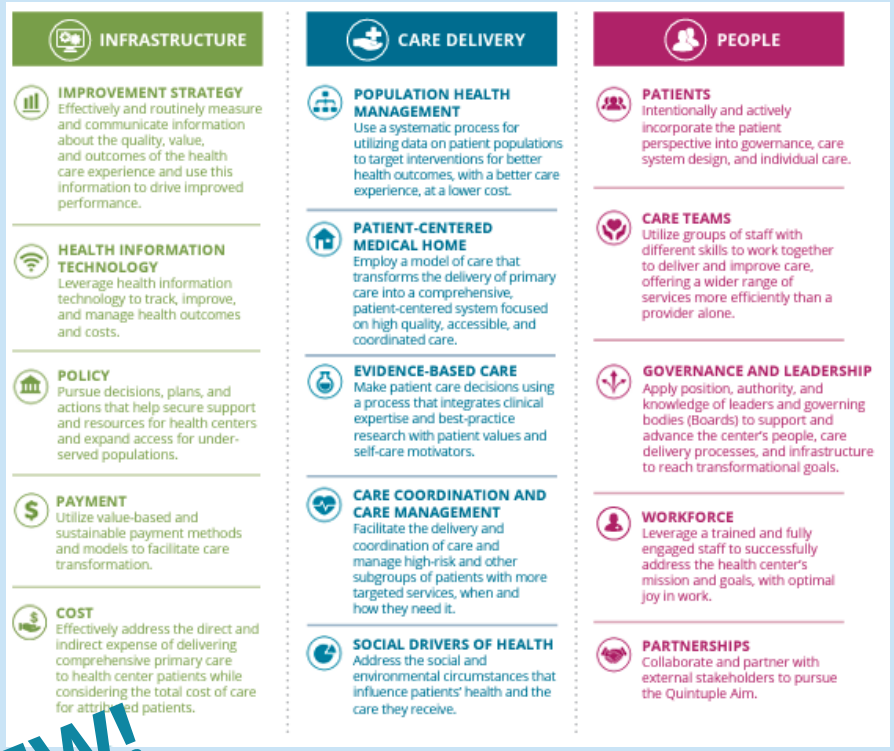
**Wednesday, May 17th 1-2pm ET**
Care Management for Patients with Dementia & Leveraging Reimbursement Opportunities

**Wednesday, May 31st 1-2pm ET**
Health Center Partnerships & Community Linkages to care for Patients with Dementia

**Registration is required! Register** here



# COMPLETE the VTF Assessment



**INFRASTRUCTURE**

**IMPROVEMENT STRATEGY**
Effectively and routinely measure and communicate information about the quality, value, and outcomes of the health care experience and use this information to drive improved performance.

**HEALTH INFORMATION TECHNOLOGY**
Leverage health information technology to track, improve, and manage health outcomes and costs.

**POLICY**
Pursue decisions, plans, and actions that help secure support and resources for health centers and expand access for under-served populations.

**PAYMENT**
Utilize value-based and sustainable payment methods and models to facilitate care transformation.

**COST**
Effectively address the direct and indirect expense of delivering comprehensive primary care to health center patients while considering the total cost of care for attributed patients.

**CARE DELIVERY**

**POPULATION HEALTH MANAGEMENT**
Use a systematic process for utilizing data on patient populations to target interventions for better health outcomes, with a better care experience, at a lower cost.

**PATIENT-CENTERED MEDICAL HOME**
Employ a model of care that transforms the delivery of primary care into a comprehensive, patient-centered system focused on high quality, accessible, and coordinated care.

**EVIDENCE-BASED CARE**
Make patient care decisions using a process that integrates clinical expertise and best-practice research with patient values and self-care motivators.

**CARE COORDINATION AND 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.

**SOCIAL DRIVERS OF HEALTH**
Address the social and environmental circumstances that influence patients' health and the care they receive.

**PEOPLE**

**PATIENTS**
Intentionally and actively incorporate the patient perspective into governance, care system design, and individual care.

**CARE TEAMS**
Utilize groups of staff with different skills to work together to deliver and improve care, offering a wider range of services more efficiently than a provider alone.

**GOVERNANCE AND LEADERSHIP**
Apply position, authority, and knowledge of leaders and governing bodies (Boards) to support and advance the center's people, care delivery processes, and infrastructure to reach transformational goals.

**WORKFORCE**
Leverage a trained and fully engaged staff to successfully address the health center's mission and goals, with optimal joy in work.

**PARTNERSHIPS**
Collaborate and partner with external stakeholders to pursue the Quintuple Aim.

NEW!

## VTF Assessment 2.0

- ✓ Still only 15 questions – 1 for each Change Area
- ✓ Refreshed to reflect current state of value-based care


reglantern.com/vtf

- ✓ Assess organizational progress in 15 areas of systems change important to value transformation.
- ✓ Recommended that 3 or more health center staff complete the assessment to get a balanced perspective of organizational progress in areas of systems change

# 2023 Elevate Calls

SAVE THE DATES!

## Monthly Forums: 2nd Tuesday of the month, 1-2 pm ET

**January** 10th

**February** 14th

**March** 14th

**April** 11th

**May** 9th

**June** 13th

**July** 11th

**August**: Summer break, no Elevate call this month

**September** 12th

**October** 10th

**November** 14th

**December** 12th: Year in Review

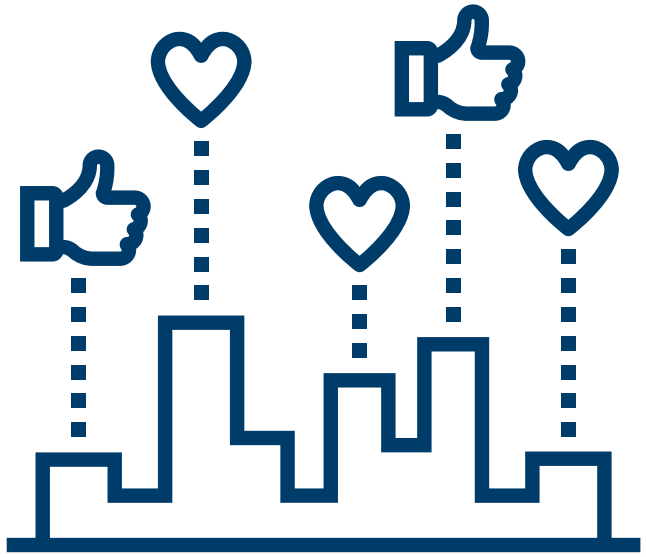
## Supplemental Sessions

**Online Compliance Tool Trial Offer**
March 22nd 3-4 pm ET. **Register** here

**Outreach & Enrollment Learning Community**
6-part series, March – June (filled)

**National Diabetes Prevention Program & NACHC's Healthy Together Project**
April 6th, 12-1 pm ET. **Register** here.

**Brain Health**
3- part series: May 3rd, 17th, 31st, 1-2 pm ET. **Register** here



# Provide Us Feedback

## FOR MORE INFORMATION CONTACT:

qualitycenter@nachc.org

**Cheryl Modica**
**Director, Quality Center**
National Association of Community Health Centers
cmodica@nachc.org
301.310.2250

**SHARE YOUR FEEDBACK**

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

# Next Monthly Forum Call:

April 11, 2023
1:00 – 2:00 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

elevate°

# Together, our voices elevate° all.

**The Quality Center Team**

*Cheryl Modica, Cassie Lindholm, Holly Nicholson, & Addison Gwinner*

qualitycenter@nachc.org