



NATIONAL ASSOCIATION OF  
Community Health Centers®

# HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

CARE MANAGEMENT ESSENTIALS, POWERED BY



**KICK-OFF WEBINAR**  
SEPTEMBER 13, 2023  
11:00 – 11:45 AM ET



# 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.





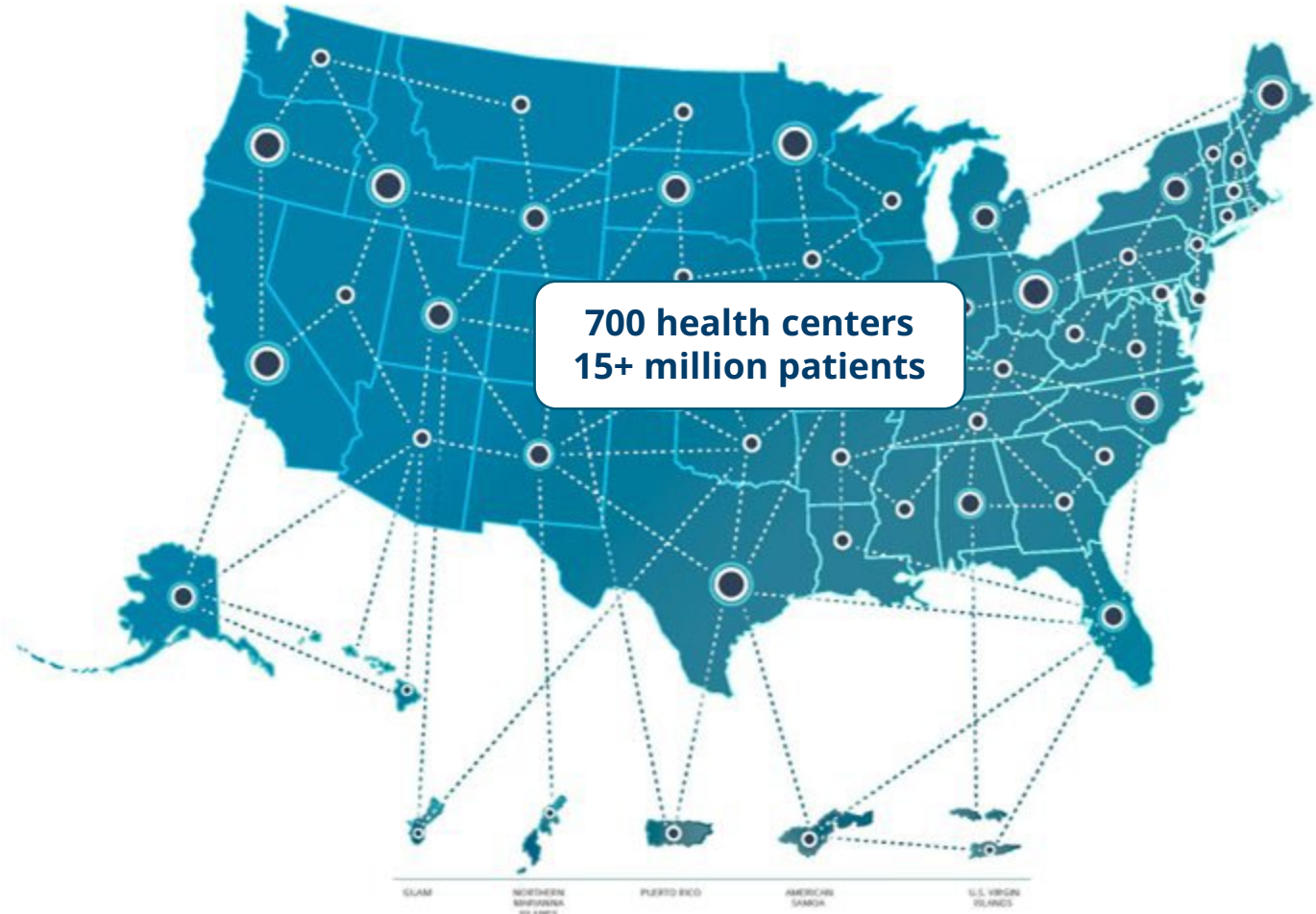
**Welcome!**

**You are part of a national community of health center care managers working to provide care and support to the health center patients who need it most.**

**An exciting opportunity to learn, share, and grow in your role.**

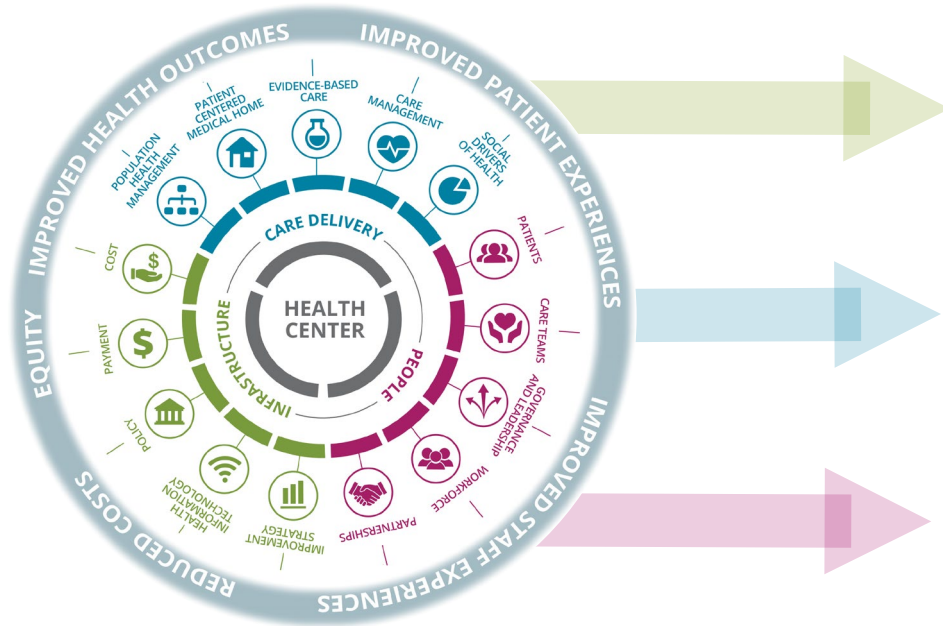
***50 health center staff participants strong!***

# This Professional Development Course is a NEW offering through NACHC's Elevate National Learning Forum





# NACHC's Elevate National Learning Forum



- ✓ Monthly webinars
- ✓ Supplemental sessions
- ✓ Evidence-Based Action Guides
- ✓ Action Briefs
- ✓ eLearning modules
- ✓ Tools & Resources
- ✓ [Online Learning Platform](#)
- ✓ NEW Professional Development Courses, including **Care Management Essentials**

**Provides guided application of the Value Transformation Framework**

For more information on how to leverage the VTF and Elevate for systems transformation, review the [Action Brief: How to Use the VTF and Elevate](#)



# Care Management Resources

**VALUE TRANSFORMATION FRAMEWORK Action Guide**

HEALTH CENTER CARE DELIVERY INFRASTRUCTURE

**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, has been shown to improve health outcomes<sup>1,2,3</sup>. 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<sup>4,5</sup>. 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 cost and improved equity<sup>6</sup>.

This Action Guide provides the steps to start a health center care management program for high-risk patients. The outlined recommendations meet the requirements of Chronic Care Management (CCM) services defined by CMS and, therefore, are eligible for reimbursement.

**WHAT**  
Does a High-Risk Care Management Model Look Like?

High-risk care management involves intensive, one-on-one service by a nurse or other health worker, to individuals with complex health needs. The formal design of a health center care management program is a standardized approach to managing high-risk patients by a nurse. The formal design of a health center care management program is a standardized approach to managing high-risk patients by a nurse. The formal design of a health center care management program is a standardized approach to managing high-risk patients by a nurse. The formal design of a health center care management program is a standardized approach to managing high-risk patients by a nurse.

© 2019 National Association of Community Health Centers. All rights reserved. | QualityCenter@nachc.org | December 2021

**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 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 that requires moderate or high medical decision making.

**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)
- Continuity of care
- 24/7 access
- Resources
- Electronic communication options
- Electronic health record documentation
- Social drivers of health

**Patient Eligibility & Consent**

**CCM.** Patients who have multiple (two or more) chronic conditions or episodic conditions expected to last at least 12 months or until the patient dies, or that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

**CCCM.** Patient must be at moderate or high complexity medical decision making (MDM) and require a longer threshold of time than for CCM patients (see Coding & Billing below).

**PCM.** Patients who have a single, complex chronic high-risk condition that is expected to last at least 12 months or until the patient dies, or that places the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

**Chronic Care Management**

This table represents the requirements for CCM, CCCM, and PCM according to coding guidelines in the CPT manual for a comprehensive assessment.

BILLING REQUIREMENTS
Initiating Visit required
2 or more chronic conditions (at least 12 months or until death)
1 complex chronic condition (at least 3 months)
Patient at risk of death, acute exacerbation/decompensation, or functional decline
Patient at significant risk of hospitalization
Comprehensive Care Plan implemented, revised, or updated, as needed
Moderate or high medical decision making
Frequent adjustment of care
Ongoing care coordination

© 2021 National Association of Community Health Centers. All rights reserved. | QualityCenter@nachc.org | May 2023

**PAYMENT Reimbursement Tips:**

Transitional Care Management (TCM) supports the transition and coordination of services from an inpatient/acute care setting to a community setting by establishing a coordinated plan with the patient's primary care provider(s).

**Program Requirements**

Transitional Care Management (TCM) refers to the coordination of a Medicare patient's transition to a community setting after discharge from an acute care setting. As part of TCM, a practitioner provides or oversees the management and/or coordination of a patient's medical, psychological, and daily living needs following discharge from one of the following:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long-Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a Community Mental Health Center

**Patient Eligibility & Consent**

Eligible patients are those transitioning from an inpatient hospital setting (i.e., acute, psychiatric, long-term care, community setting (i.e., home, rest home, assisted living, including temporary or short-term settings such as hotel, hostel, or homeless shelter). A practitioner must obtain consent before furnishing or billing for TCM. Consent may be verbal or written but must be documented in the medical record.

**Timeframe & Services**

TCM services may be offered within the 30-day period starting on the date when the beneficiary is discharged from inpatient care, continuing for the next 29 days. The three TCM components include:

- Interactive Contact
- Face-to-Face Visit
- Non-Face-to-Face Services

**Interactive Contact**

Within two (2) business days of discharge date, the physician, qualified health professional (QHP), or clinical staff have direct and interactive communication with the patient (i.e., phone, in person, electronic). Contact must be more than simply scheduling a follow-up appointment and it would typically address the type(s) of services the patient had during admission, what the discharge diagnosis was, and what follow-up services they may need.

If two or more reasonable but unsuccessful attempts are made to reach the patient within two days after discharge, and all other TCM criteria are met, the service may be reported (billed). Document all contact attempts. Continue attempts to communicate until successful.

**Face-to-Face Visit**

Within either seven (7) or fourteen (14) days following discharge, a face-to-face visit is required. A patient whose high complexity medical decision making (MDM) of condition warrants moderate complexity decision making (99495) must be seen within seven days of discharge while one whose moderate complexity decision making (99495) must be seen within fourteen days. Medication reconciliation must occur no later than the date of the face-to-face visit. Refer to the 2023 MDM table for more information about medical decision making scoring.

During the COVID-19 Public Health Emergency (PHE), CMS allows TCM to be provided as an audio-visual telehealth service to a new or established patient. As it is on the CMS list of telehealth services, it would be billed for using G2025 for the duration of the PHE when provided as an audio-visual telehealth service. Health centers must capture the actual CPT service code (e.g., 99495) for tracking purposes. The PHE telehealth flexibilities for TCM will continue through December 31, 2024 after the PHE expires on May 11, 2023.

**Non-Face-to-Face Services**

Throughout the 30-day post-discharge time period, non-face-to-face services refer to the provider's activity to assess and inform the patient, other providers, caregivers and involved community services about the patient's health, care coordination needs, and education needs. Non-face-to-face services must be provided unless determined not medically indicated or needed.

© 2020 National Association of Community Health Centers. All rights reserved. | QualityCenter@nachc.org | May 2023

[Care Management Action Guide](#)

[Chronic Care Management Reimbursement Tips](#)

[Transitional Care Management Reimbursement Tips](#)

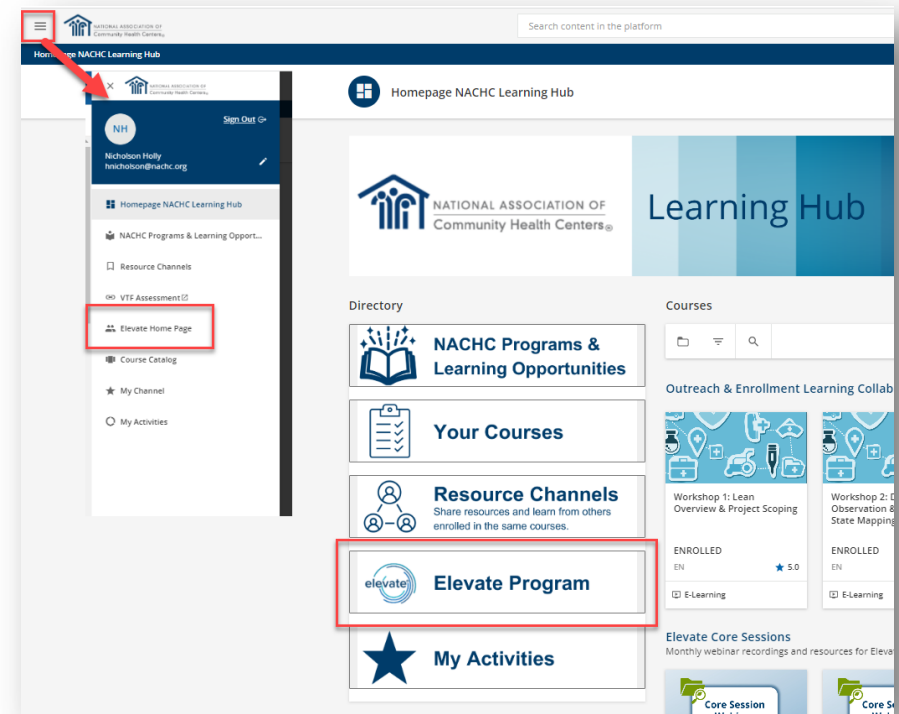
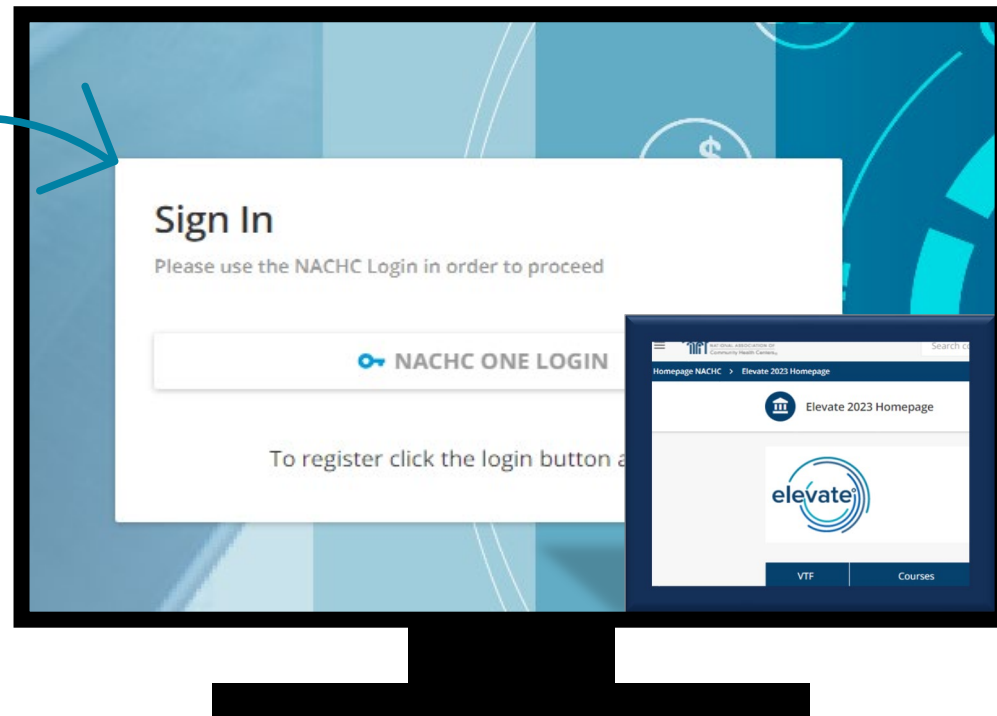
...and MORE!



# NACHC's Online Learning Hub

*If you already have a 'NACHC One' login  
(the login used for NACHC conferences),  
use this to sign in.*

*If you do not yet have a 'NACHC One'  
login, **register for free!***



Access NACHC's Learning Hub at  
<https://nachc.docebosaaS.com/learn/signin>



# NACHC's Online Learning Hub

The screenshot shows the Elevate Home Page with a navigation bar at the top. A large banner at the top center features a circular diagram with five steps: STEP 1 ENGAGE, STEP 2 ASSESS, STEP 3 PLAN, STEP 4 TRANSFORM, and STEP 5 REASSESS. Below the banner are several content blocks: 'STEP 1 - ENGAGE', 'STEP 2 - ASSESS', 'Tools and Resources - Quality Center eDirectory', 'Elevate Forum Series', 'Supplemental Sessions', 'Health Center Professional Development Program' (highlighted with a red box), and 'Learning Collaborative'. A blue arrow points from the highlighted box on the left to a larger, zoomed-in view of the same box on the right.

This is a zoomed-in view of the 'Health Center Professional Development Program' box. The box has a blue background and white text. It contains the following information: 'Join Elevate's FREE online learning forums' with a 'CLICK HERE TO REGISTER' button; 'Supplemental Sessions' with the subtext 'Register for supplemental learning opportunities' and another 'CLICK HERE TO REGISTER' button; and the main title 'Health Center Professional Development Program' with the subtext '(content available to registered participants only)' and a 'CLICK HERE TO ACCESS' button. The entire box is enclosed in a red border.





# Care Management Essentials: Course Timeline

## Pre-Work

- ✓ Register for Elevate (completed)
- ✓ **Complete VTF Assessment**
- ✓ Block calendar for sessions

## Course: September 13, 2023 – December 13, 2023

**Sep 13<sup>th</sup>**  
Kick-Off Session

**8 Self-Paced Modules**  
(30 min each)

**Oct 4<sup>th</sup>**  
Office Hours 1

**7 Self-Paced Modules**  
(30 min each)

**Nov 1<sup>st</sup>**  
Office Hours 2

**Dec 6<sup>th</sup>**  
Office Hours 3

**Dec 13<sup>th</sup>**  
Closing Session



# Complete the **VTF Assessment**

**Health centers are required to complete the VTF Assessment for course participation... WHY?**

The VTF Assessment enables health centers to measure progress in areas important to value transformation.

Care management and staff engagement/professional development opportunities are both important components!





# Complete the VTF Assessment

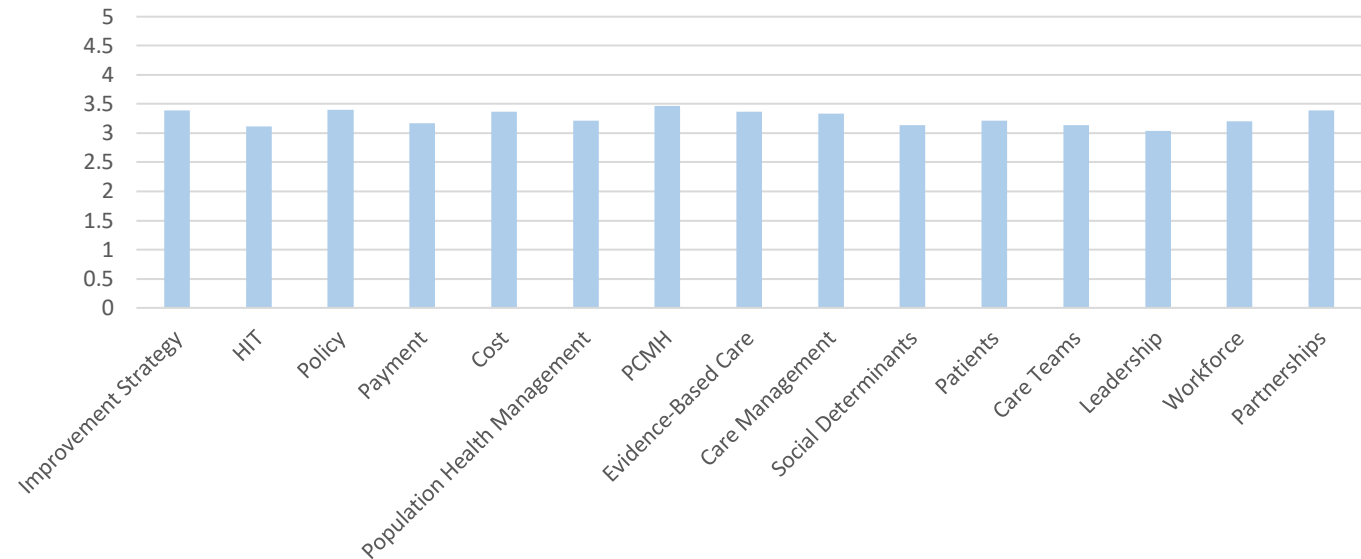
**NOTE: The tool assesses organizational progress.**

**The individual participating in the training does NOT have to be the person who completes the Assessment.**

**While it is encouraged that multiple staff across an organization complete the tool, with results shared and discussed, only one individual from each participating health center needs to complete an assessment.**

*The VTF Assessment is best completed by health center staff who have knowledge of a wide range of health center systems (e.g., leadership, finance, clinical care, etc.).*

## CM Essentials Participants: Average Score by VTF Change Area



# Meet The Trainers!



**Diane Cardwell, MPA, NP, PA**  
*Trainer*



**Angie Schindler-Berg, MS, LMPH**  
*Trainer*



**Cecilia L. Saffold, MBA, PMP**  
*Chief Executive Officer*



**Hanna Moffett**  
*Program Manager*



**HealthTeamWorks®**

Health. Equity. Resilience.

# Course Content



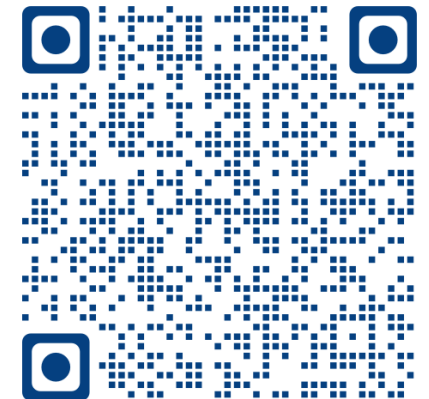
Course Schedule	2023 Dates	Time
<b>Live Kick-off Session</b>	September 13	11:00 – 11:45 am ET
<b>Asynchronous Modules 1-8</b> <ul style="list-style-type: none"><li>• Defining Care Management</li><li>• Identifying Candidates for Care Management</li><li>• Managing the Health of the Population</li><li>• The Role of Maslow's Hierarchy in Care Management</li><li>• Identifying Patients for Episodic Care Management</li><li>• Exchanging Data with Target Facilities</li><li>• Patient Assessment and Documentation for Episodic Care Management</li><li>• Introduction to Processes and Workflows</li></ul>	September 13 – November 1	On your own
<b>Office Hours #1</b>	October 4	11:00 – 11:45 am ET
<b>Asynchronous Modules 9-15</b> <ul style="list-style-type: none"><li>• Identifying Patients for Longitudinal Care Management</li><li>• Enrollment, Assessment, and Documentation for Longitudinal Care Management</li><li>• Longitudinal Care Management Processes and Workflows</li><li>• Balancing Panel Size</li><li>• Establishing the Patient Relationship</li><li>• An Introduction to Teach-Back and Motivational Interviewing</li><li>• Collaborative Care Plan Development</li></ul>	November 1 – December 13	On your own
<b>Office Hours #2</b>	November 1	11:00 – 11:45 am ET
<b>Office Hours #3</b>	December 6	11:00 – 11:45 am ET
<b>Live Closing Session</b>	December 13	11:00 – 11:45 am ET

# Additional Support



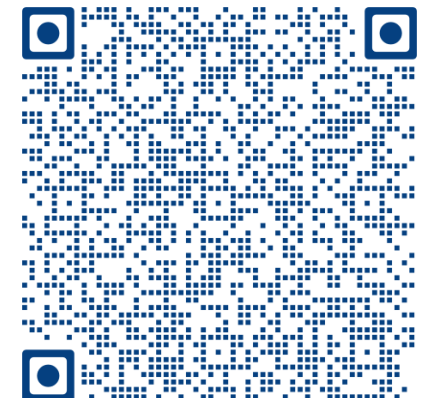
## Solutions Center

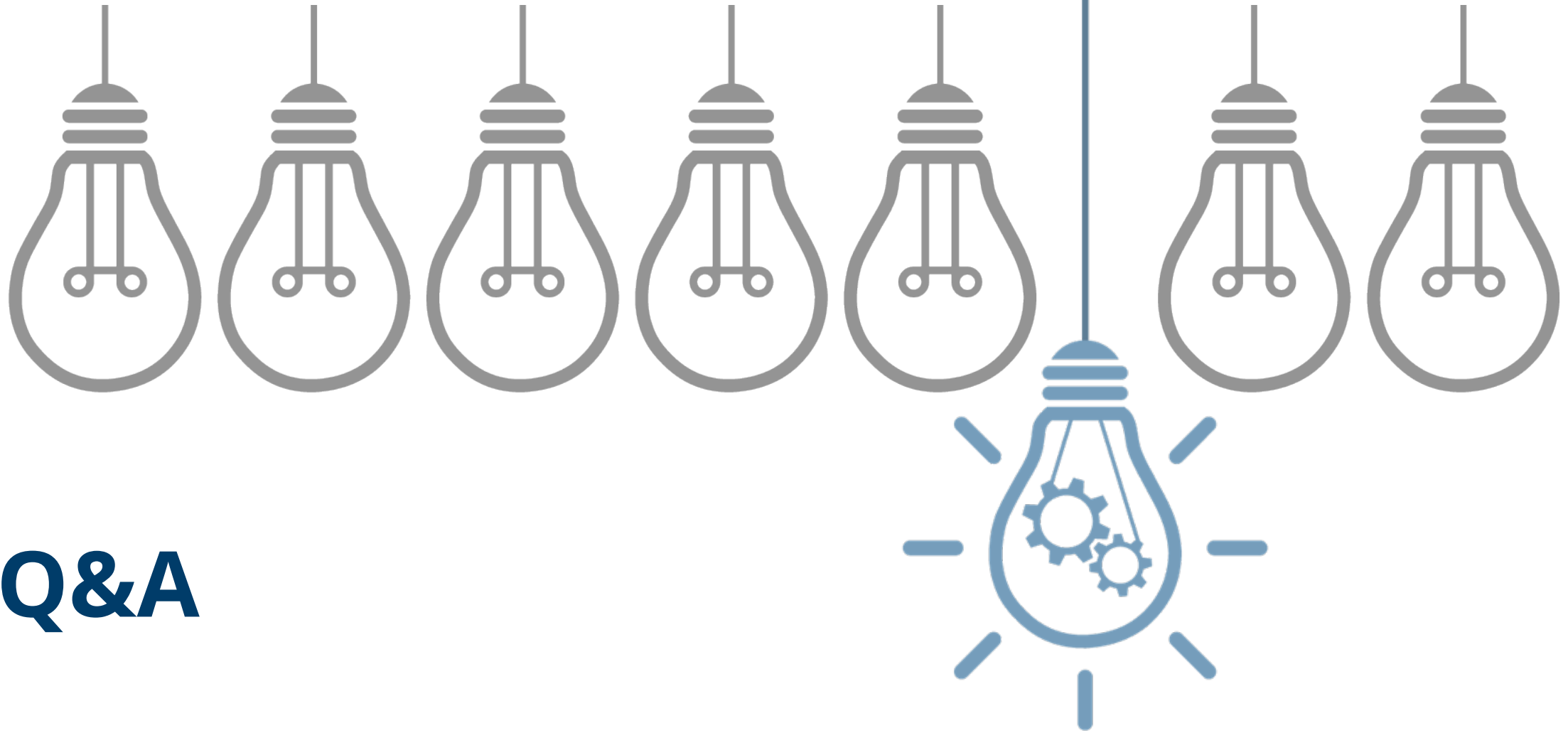
- Included in this course is 12-month access to HealthTeamWorks Solutions for tools, templates, and Solution Center resources
- To access Solutions Center, please register via the following link:  
<https://www.healthteamworks.org/user/register>



## Contact Us

- For questions and support about the Care Manager Essentials Course, please reach out to: [caremanagement\\_nachc@healthteamworks.org](mailto:caremanagement_nachc@healthteamworks.org)





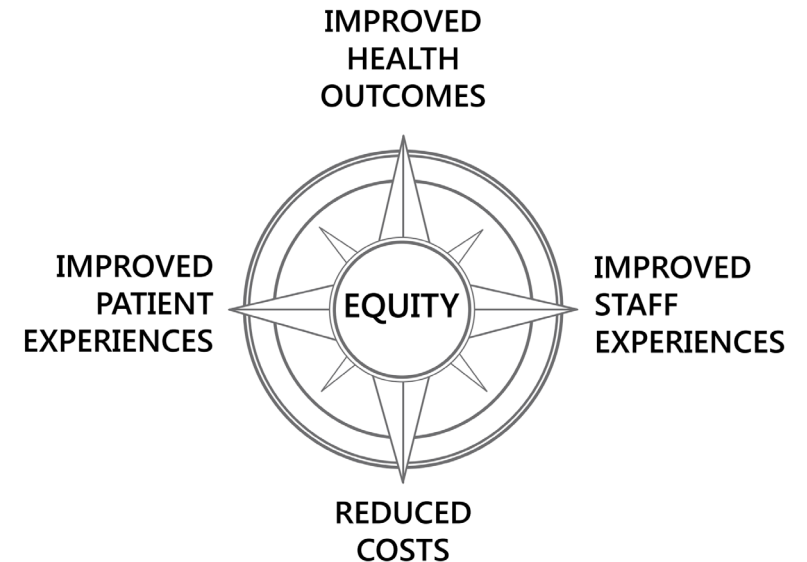
# Q&A



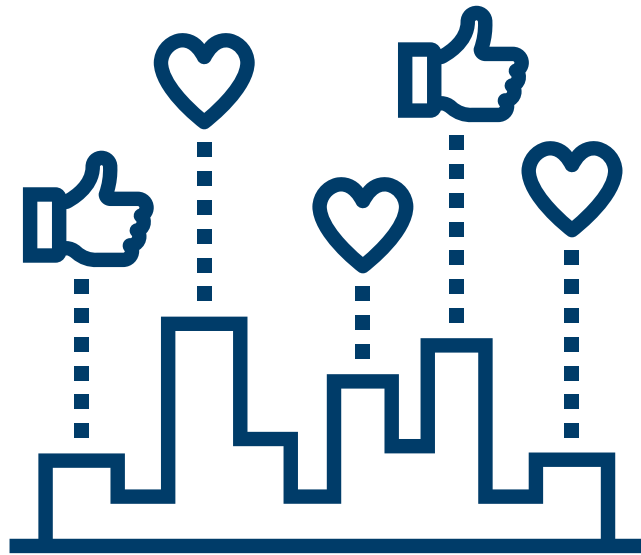
# Quintuple Aim Goals

- The NACHC Quality Center recognizes the critical importance of providing access to training opportunities for health center professionals to build skills, develop competencies, and advance careers while driving improved patient care and health outcomes.
- These trainings support health centers to achieve the Quintuple Aim

**Improved Health Center  
Performance  
through  
Systems Transformation**







# Provide Us Feedback



# Wrap-Up

***Thank you!***

Office Hours are available on **Wednesday, October 4<sup>th</sup> 11:00 am – 11:45 am ET**

Questions regarding course content? Contact [caremanagement\\_nachc@healthteamworks.org](mailto:caremanagement_nachc@healthteamworks.org)

Questions on how to access course modules on NACHC's learning forum? VTF Assessment? Contact [QualityCenter@NACHC.com](mailto:QualityCenter@NACHC.com)