NATIONAL ASSOCIATION OF
Community Health Centers®

HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

CARE MANAGEMENT LEADING TRAINING,
POWERED BY

CARE MANAGEMENT LEADING: LIVE SESSION 2
SEPTEMBER 20, 2023
3:00 – 5:00 PM ET

Care Management (103) Leading
Session 2

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Session #1 Recap

- Leadership Characteristics
- Key team components
  - Defined Goals
  - Defined Roles & Responsibilities
  - Communication
  - Measure for Success
- Population Data provides insight into goals
- Sources of Data
  - EHR/PM
  - Population Registry
  - Payer sources
  - Health Information Exchange

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Session #1 Activity

- Identify available data

	TYPES OF DATA	SOURCE	REPORT OWNER	NOTES / COMMENTS
	Practice Management			
	Demographics (Age, Gender, Preferred Language, Race, Ethnicity)	PM Face		
	Payor	PM Face		Are payor options/dropdown specific- for example Medicare vs Medicare Advantage (MA) and each specific MA plan
	Primary Care Provider	PM Face		
	Care Manager or Behavioral Health Staff	PM Face		Some PM will pull this into the face sheet to allow access for all team members
	Frequency of visits/touches with PCP	Billing		
	Frequency of visits/touches with Care Manager	Billing		Dependent upon submitting a billing code or dummy code
	Chronic disease distribution	Coding		
	Social determinants	Coding		
	Risk status distribution	PM Face		
	EHR			
	Care Manager or Behavioral Health Staff	Discrete		Typically this is pulled from a CM module
	Risk status distribution	Discrete		May be in EHR clinical summary
	Chronic disease distribution	Problem		Some reports may limit what they pull, clarify this
	Social determinants screen	Discrete		
	Social determinants positive responses	Discrete		Clarify if pulls all positive or a limited number
	Medications – number	Med list		Clarify that it pulls only Routine Rx – not PRN
	Medication – High Risk	Med list		This can be pulled from coding
	Substance abuse screening	Discrete		Define parameters – rolling 12 mos vs calender year
	Substance abuse screen positive	Discrete		Define field for results
	Depression screening	Discrete		Define specific screen PHQ 2 vs PHQ 9
	Depression screen score	Discrete		
	Test completion – lab, mammogram, colonoscopy, xray	Discrete		Confirm workflow to enter completion from external sources into discrete field
	Test results	Discrete		
	Quality measure data	Various		Identify specific measure and where data pulls from

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Course 2
Program and Role Development Part II

Module 1
Defining Goals: Analyzing Population Data to Define Care Management Priorities

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Objectives

- Discuss the value of a data-informed approach to care management
- Develop care management goals based on population data
- Align a patient-centered approach with organizational priorities

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Key Considerations: Data-Informed Approach to Care Management Goals

How do I best document the Return on Investment (ROI) for the Care Management Program?

- Review clinic/systems Mission Statement
- Review clinic/systems priorities - community needs, quality, cost
- Revenue stream alignment - payers, grants, others
- Population needs - data informed priorities/goals
- Engage the team - understand drivers of change & opportunities

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Key Considerations: Data-Informed Approach to Care Management Goals

Payor Data

- Identify majority payers – top 3-5; look for payer groups that include 60+% of population
  - Medicaid
    - Example: 68% of the population has Medicaid
      - Managed Care Models - national data shows that 85% of Medicaid members are under some version of managed care payment
      - Review State/Region Medicaid models – identify key processes or quality measures with opportunities for improvement
      - Attribution is important – understand how this occurs – Assignment; PCP visits; CCM care; Medicare - AWV
  - Medicare
      - Medicare Advantage – Attribution; Annual Wellness Visit (AWV) completion; Quality Measures; ED/Hospital utilization
      - Alternative Payment Models (APM) - payment for value not volume
      - Accountable Care Organizations (ACO) - ACO REACH - Attribution, AWV completion, Quality Measures; ED/Hospital utilization
      - Primary Care First (PCF) / Making Care Primary – Medicare Centers for Innovation – APM
  - Commercial
      - Fee for Service; ACO; CM Per member per month; Performance Incentives

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Key Considerations: Data-Informed Approach to Care Management Goals

Payment Model Basics for the Care Management Team

- Fee for Service - Billing for Care Management services – CCM, TCM, screenings
- Managed Care – Attribution; Quality measures; ED/Hospital use
- Medicare Advantage – Attribution; Annual Wellness Visit (AWV)completion; Quality measures; ED/Hospital use
- Alternative Payment Models (APM)
  - Accountable Care Organizations – Attribution; AWV completion; Quality measures; ED/Hospital use
  - CMMI Innovation Models – Attribution; AWV completion; Quality measures; ED/Hospital use

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Key Considerations: Data-Informed Approach to Care Management Goals

Attribution

- AWV completion rate
- PCP visits & complete Px
- CCM visits – billed

Quality Measures (Process & Outcome)

- Patient Experience
- Hypertension control (O)
- Diabetes poor control (O)
- Asthma Rx compliance (P)
- Depression management & follow-up
- Influenza vaccination rate (P)
- Colon CA screening (P)
- Breast CA screening (P)
- Well child visits (P)
- Chlamydia screening (P)
- Fall Screening (P)

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Key Considerations in a Data-Informed Approach to Care Management

Team Priorities

- Efficiencies
  - Medication reconciliation that is accurate
  - Coordination – ER/Hospital/Specialty
- Quality
  - Quality measures that resonate for the team

Baseline Data Review

- Measures that impact revenue not captured
- Current state of quality data

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Care Management Goals Discussion

Example #1:

- Clinic Population with the following characteristics:
  - 29% over the age of 65
  - 35% of population with CAD
  - 22% of population with COPD and/or asthma
  - ED Utilization rate of 52 / 1,000 / month (*national average is 32/1,000**)

Example Care Management Goal:

- Annual Wellness Visit (AWV) completion of 75% for patients ≥ 65 and enrolled in CM by _____(date)
- Asthma / COPD Rx compliance of 60% for patients with COPD/Asthma and enrolled in CM by ____ (date)
- 80% of patients with ED discharge and enrolled in CM, will have a CM F/u contact within 3 days of ED visit
- Medication Reconciliation completed on 100% of patients seen by CM by _______ (date)

https://www.kff.org/other/state-indicator/emergency-room-visits-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

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Care Management Goals Discussion

Example #2

- Clinic Population with the following characteristics
  - 24% uninsured or underinsured
  - Regional data >40% obesity rate (defined as BMI >40)
  - Regional data 72% below poverty level

Example Care Management Goals

- 75% of patients enrolled with CM will have SDOH screen completion by ________(date)
- 75% of patients seen for 3 or more CM contacts will have a patient-identified goal by _______(date)
- 80% of patients with a CM contact will have a documented BMI by _______(date)

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Care Management Goals Discussion

Example #3

- Clinic Population with the following characteristics
  - 62% Medicaid
  - 18% uninsured or underinsured
  - Age – Birth to 96
  - 35% Asthma or COPD
  - 22% Depression / Anxiety
  - 17% Substance abuse
  - 38% No social support
  - 15% No dependable transportation
  - ED Utilization rate 48/1,000 / month (National average 32/1,000/month)

https://www.kff.org/other/state-indicator/emergency-room-visits-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

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Small Group Discussion - Care Management Goals

Time: 15 minutes

Lead: : Identify 1 person to take notes and report out to larger group

TOPICS:

- Discuss your current Care Management Goal/Goals
  - IF no current CM Goal – what would be a possible goal?
  - How do these goals align with system or team goals?
- What data impacts your Care Management Goals? *Consider anecdotal as well as structured data*
- Do you feel you have adequate data to develop CM Goals?
  - IF yes, what is that data?
  - If no, what data would you like?

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Achieving Success with Care Management Goals

- Establish SMART GOALS
- DEVELOP a Quality Improvement PLAN
- DEFINE ROLES & RESPONSIBILITIES
- MEASURE FOR SUCCESS & Celebrate or Adapt

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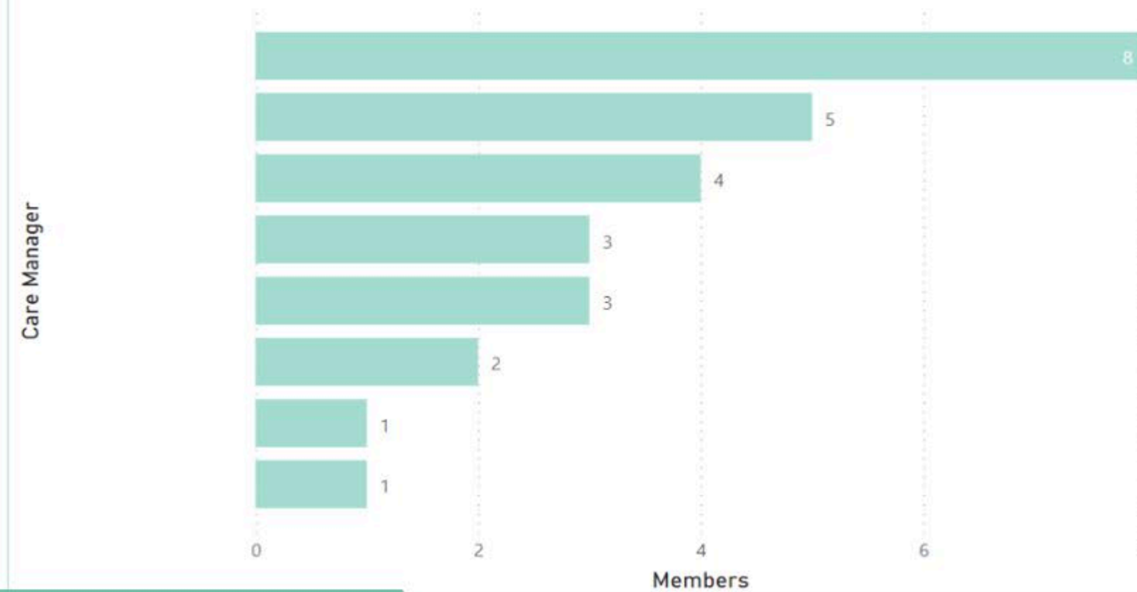
Care Management Scorecard

Care Management Summary

27	18	12
Enrolled in CM	Elligible for CM	Declined CM

Care Manager Caseload

Status Enrolled



Completed Appts

Care Manager	Appts	Unique Members	Avg Appts Per Member
	34	10	3.40
	14	7	2.00
	7	3	2.33
	6	3	2.00
	6	4	1.50
	3	1	3.00
	2	2	1.00
	2	1	2.00
	1	1	1.00
	1	1	1.00
Total	**76**	**33**	**2.30**

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Care Management Scorecard

Care Management Leading Metrics

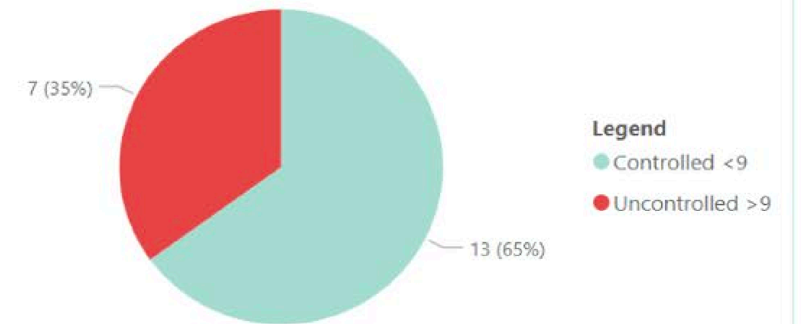
48.15%	4.32	62.96%	15.00%	2.35
PHQ9 Screening Compliance (Quarterly)	Avg # of PHQ-9s in Past 12 Months	SDOH Screening Compliance Rate (Yearly)	HbA1c Lab Count Compliance (Quarterly)	Avg # of HbA1cs in Past 12 Months

CM Enrolled Members Most Recent PHQ-9

13

Members with SDOH Needs

HbA1c Control for Diabetic Members Enrolled in CM



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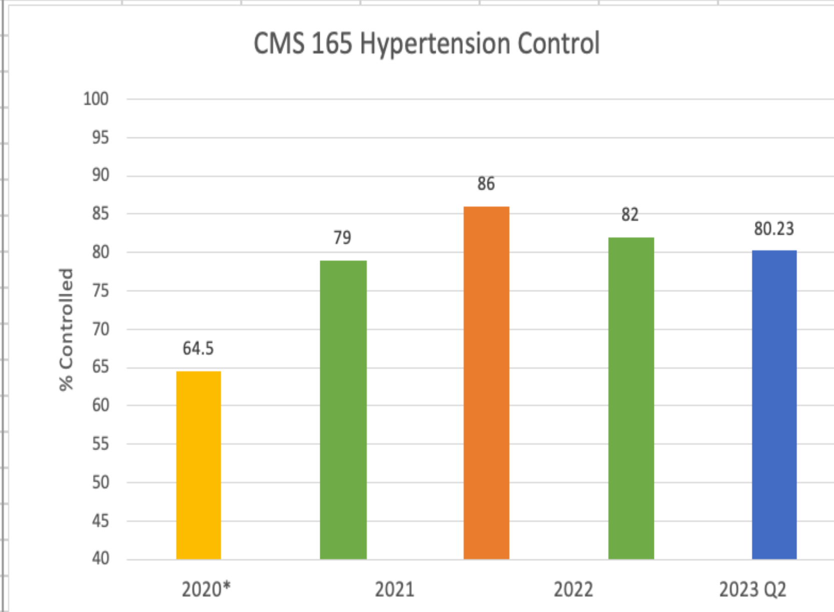
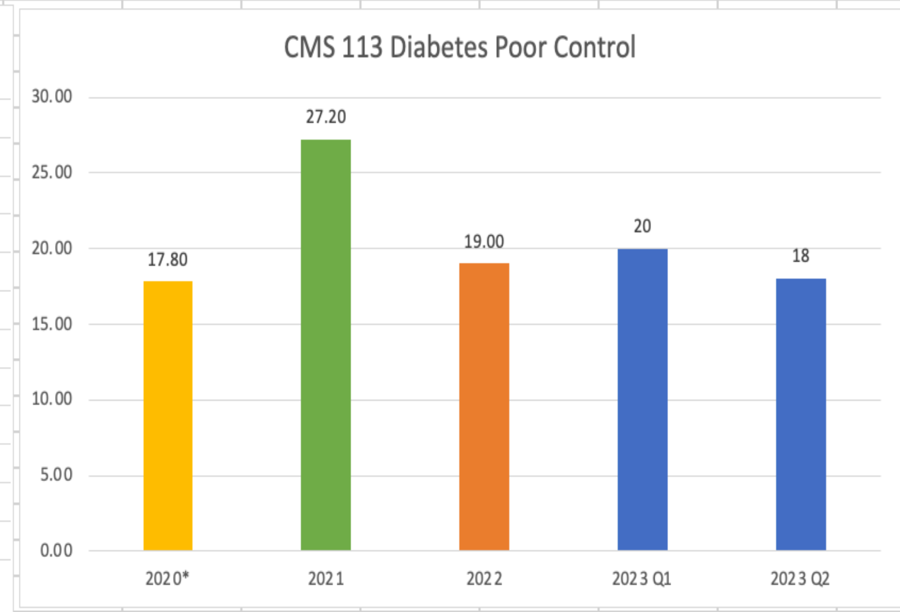
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
				CMS 165 Hypertension Control					CMS 122 Diabetes Poor Control					SDOH Screen		
Program	DATE	PEC 2021	PEC 2022	2020*	2021	2022	2023.Q1	2023.Q2	2020*	2021	2022	2023 Q1	2023 Q2	2021	2022	2023 Q2
Care Mgmt	7.3.2023	82.57	76.75	64.5	79	86	82	80.23	17.80	27.20	19.00	20	18	5.00	65.23	58.19
											18.60					
					goal	80%				goal	<14.0%			goal	44%	
PCF National Benchmark 30%		79.22	77.61		43.05	57.08		56.81	99.45	99.45	69.42		70.00	2.59	27.52	33.33
Quality is based on MIPS pop - 30%																
AHU is based on:																
Gateway - PCF National																
PBA Adjustment PCF Regional																
Quality metric source: NG HQM																
* CPC+ data																





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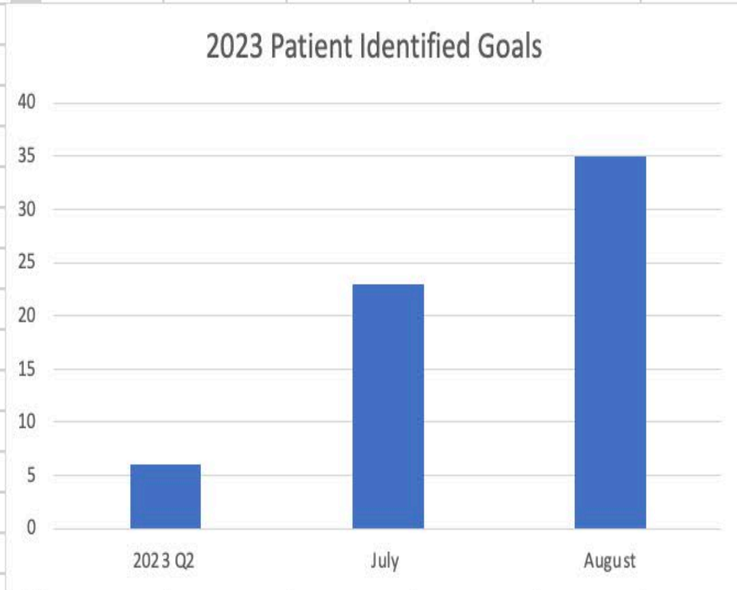
	A	B	C	D	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE
1					Pt Identified Goals				Acute Hospital Utilization (AHU)							CM Enrolle	CM Eligible	
2	Program	DATE	PEC 2021	PEC 2022	2023 Q2	July	August	September	2018*	2019*	2020*	2021	2022	2023 Q2	AWV Completion	2023 Q2	2023 Q2	Average Risk Score
3	Care Mgmt	7.3.2023	82.57	76.75	6	23	35.00		1.36	0.71	0.68	0.85	**0.95**	0.91	79%	223	370	3.8
4															Aug-23			
5				gcl .											Rolling 12 mos.			
6																		
7	PCF National Benchmark 30%		79.22	77.61	4.08	3.85		3.42				1.16	0.97				CM	
8	Quality is based on MIPS pop - 30%												0.85 (70-79 percentile)				1	92
9	AHU is based on:												0.78 (80-89 percentile)				2	103
10	Gateway - PCF National												≤ .67 (90th percentile)				3	68
11	PBA Adjustment PCF Regional																	
12													PBA* 4.23	6.5				
13	Quality metric source: NG HQM																	
14																		
15	* CPC+ data																	



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LET'S TALK

Questions and Discussion

Course 2
Program and Role Development Part II

Module 2
Defining Roles for a Care Management Team

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Objectives

- Discuss a data-informed approach to building an effective care management team.
- Understand key steps of care management team development.
- Discuss the key components of a Care Manager job description that integrate into practice job description policies.
- Apply findings from population analysis to develop a job description that can be immediately implemented.
- Develop strategies for reporting structure options for care management roles that follow practice or organization standards.

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Case Example: Aligning Role/Licensure with Population Needs

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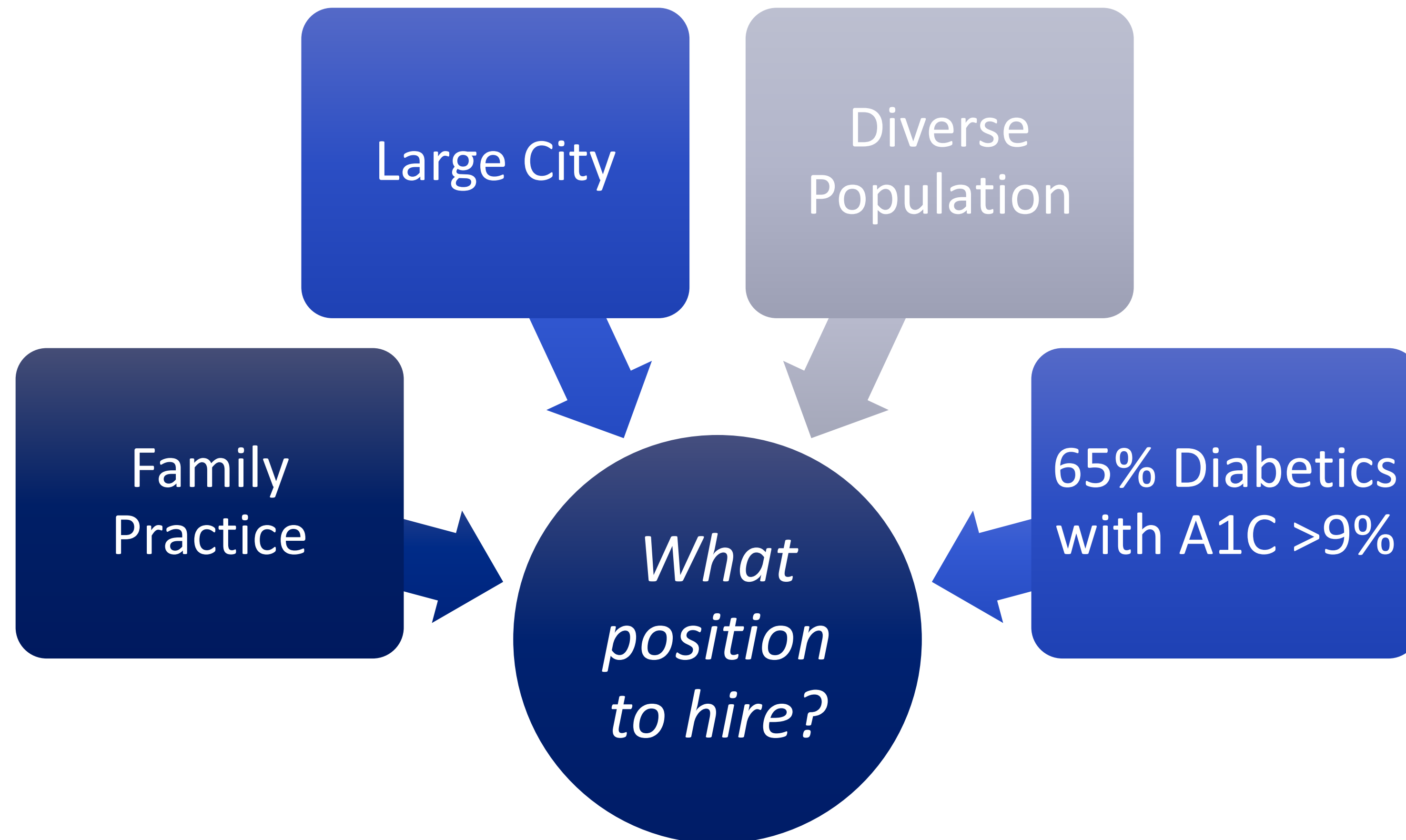
Case Example: Aligning Role/Licensure with Population Needs



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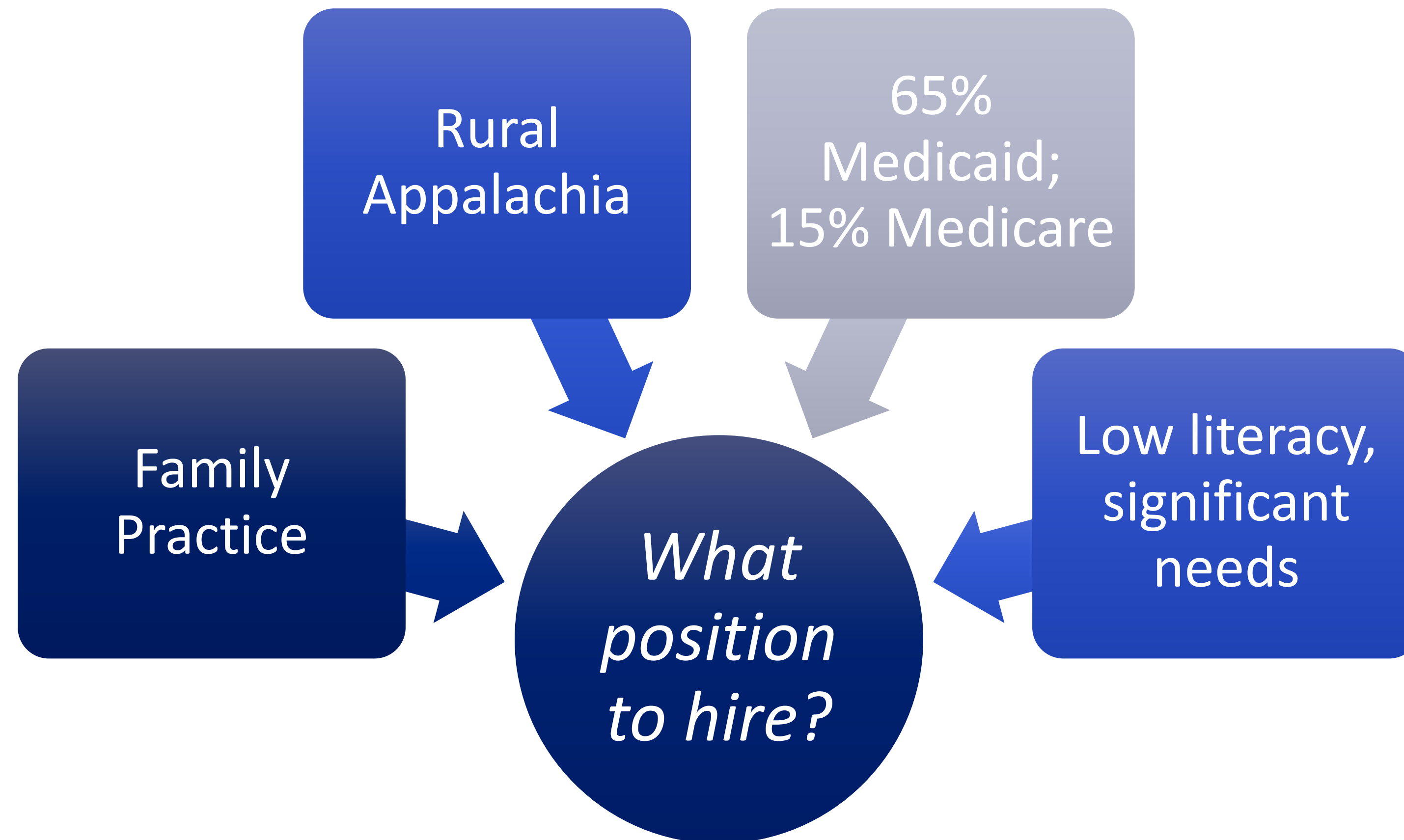
Case Example: Aligning Role/Licensure with Population Needs



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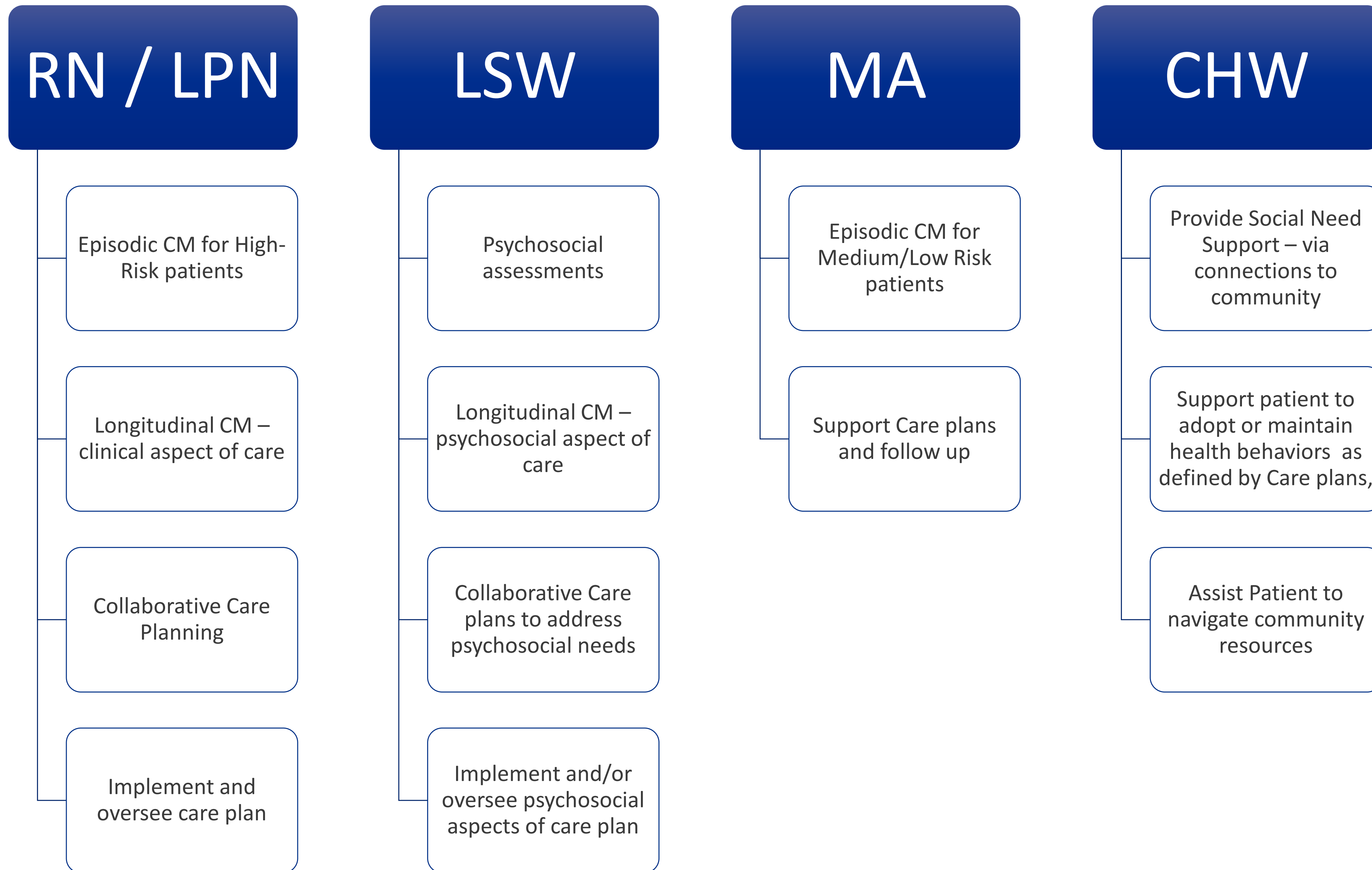
Develop a Care Management Team



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Care Management Team Models Discussion

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One size never fits all.
One size fits one.
Period.

Tom Peters
Author, Business & Leadership Expert

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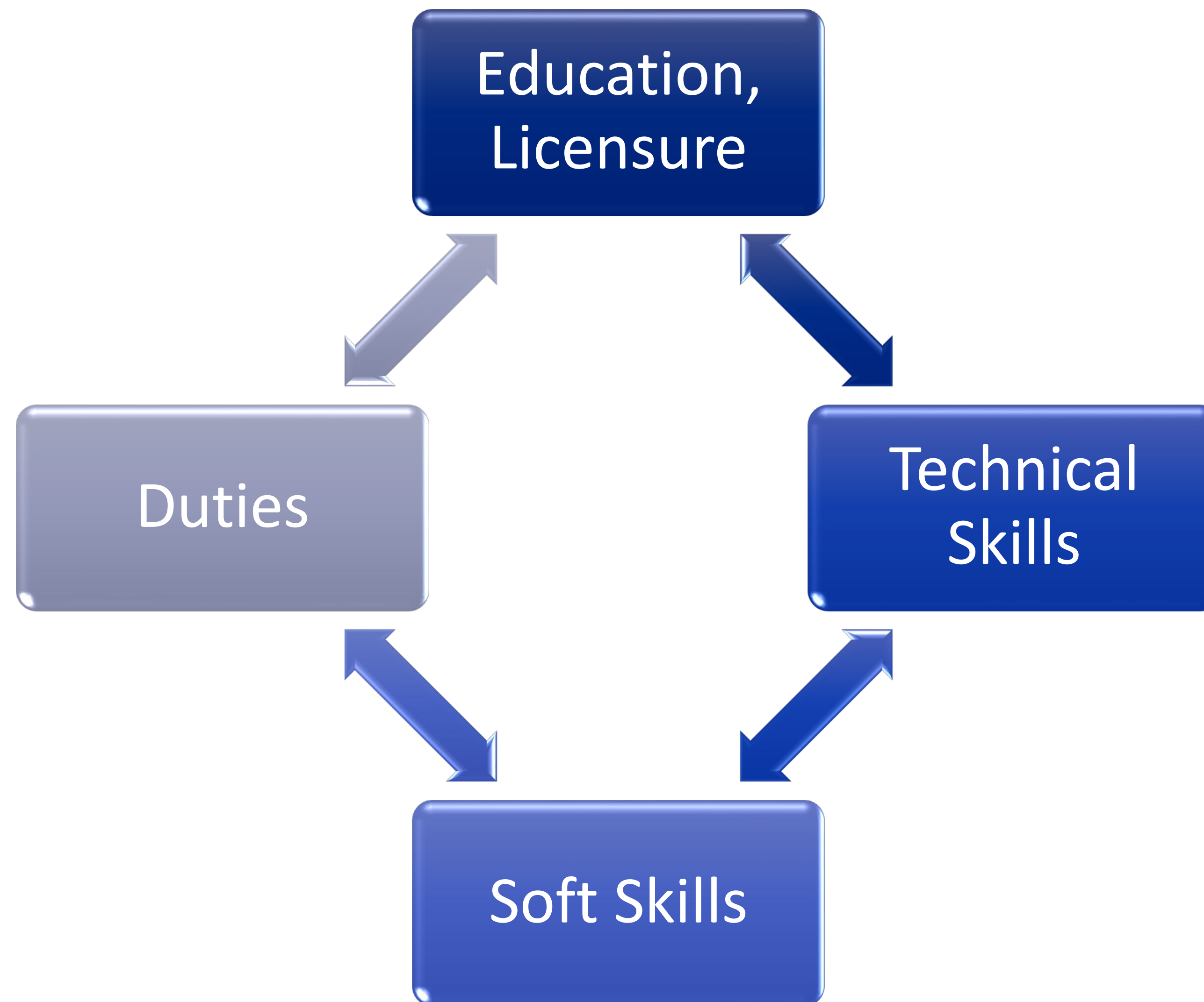
Key Components of a Care Management Job Description



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Application of Population Analysis to Job Description Development

What level of licensure or certification is needed?	*What kind of technical skills are required?*	*What soft skills are needed?*
• RN • LSW • Certified Counselor • CDE • LPN • CHW	• Clinical skills? • Motivational interviewing?	• Emotional intelligence • Adaptive • Problem solving

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Example Job Description

Job Description

Position Title: RN Care Manager

Position Summary: The RN Care Manager is a practice-based RN who directly supports highest risk patients. In collaboration with other members of the healthcare team, the RN Care Manager is responsible for organizing, coordinating, and providing care coordination and care management services to patients within the practice who are most at risk for health deterioration, sentinel events, and/or poor outcomes.

The RN Care Manager communicates with patients to assess their needs and then consults with health professionals to decide on which services to provide. Responsibilities include planning, organizing, and informing patients regarding general preventative care practices as well as individualized care plans. Work involves using health information technology to keep track of patients' records, especially electronic records, and must keep current with computer technology, software, security measures, and legislation regarding patient privacy and other issues.

Work in a manner that supports the mission and purpose of the health center and performs in accordance with system-wide competencies and behaviors, utilizing both the Patient Centered Medical Home model and the Accountable Care Organization measures.

Primary Responsibilities:

Care Management Systems:

1. Manage high-risk patient registry
   a) Oversee systems for identifying high risk patients through EMR, referrals, registries from health insurance payers
   b) Ensure validity of registry; collaborate with Information Technology on registry functionality.
2. Develop a tracking system for patient care coordination and care management across the continuum, including care transitions, Primary and Specialty care.
3. Act as clinical liaison for Payer Based Care Management programs, including ACO, commercial payors, Medicare advantage, managed care and Medicaid as indicated.
4. Conduct data reporting to identify gaps in care or services and conducts patient outreach to facilitate follow-up care or services.
5. Visit, educate, and serve as a resource to providers on patients with chronic and/or high-risk conditions that could benefit from extra services to provide coordination and linkage to general medical services.

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Reporting Structures for Care Management

- Regional Operations Leader
- Population Health Leader
- Care Management Leader
- Practice Manager
- Clinical Manager
- Other

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Considerations for Solo Practice Sites

- Role in the practice with greatest capacity to provide oversight?
- Which leadership role has the greatest ability to 'protect' the role of the CM?
- Does the manager need to have the same license as the Care Manager?

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Questions and Discussion

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Module 3
Defining Responsibilities for the Care Management Team

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Objectives

- Discuss the value of defining responsibilities for the care manager roles
- Examine and translate literature results regarding average Care Manager panel sizes into a strategy for determining the ideal panel size for a practice.
- Discuss the importance of weighing care management responsibilities as described in a job description when determining panel sizes.
- Using two examples, develop strategies for Care Managers to use to ramp up panel sizes in a manner that is appropriate for the practice.

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Literature Results: CM Panel Sizes

1 CM:20-30 pts

American Association of Managed Care Nurses

1 CM:50-60 pts

Guided Care Nursing - Johns Hopkins

1 CM:200 pts

California Healthcare Foundation

1 CM: 50-200 depending on population needs

Michigan Care Management Resource Center

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Factors that Impact Panel Sizes for Care Managers

- Complexity and acuity of population served
- Payer Mix
- CM responsibilities
- Relative experience of the CM
- Size and scope of CM team (Social Worker, Community Health Worker)
- Ancillary care services available in the practice (CMM, BHI)

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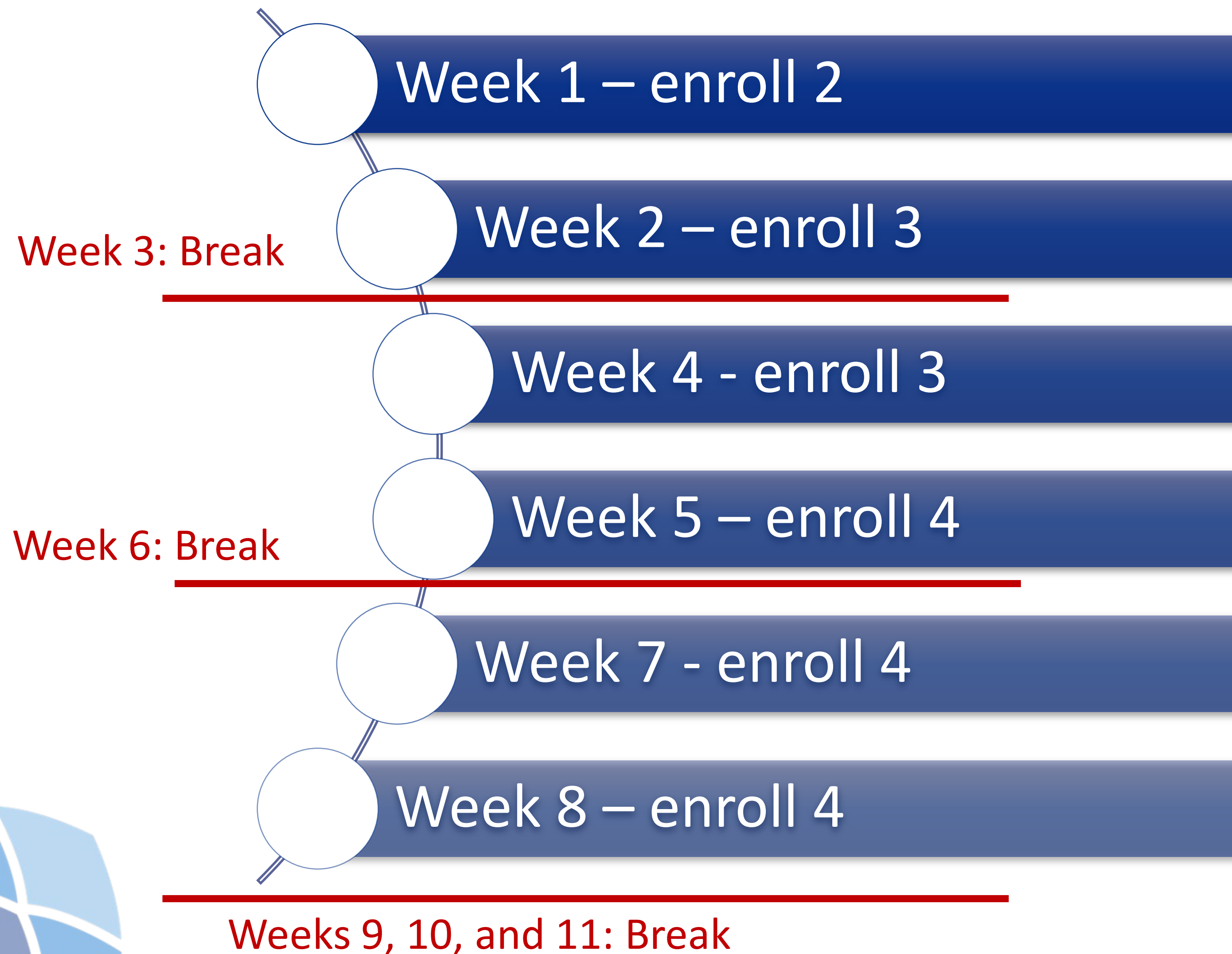
Panel Size ‘Ramp Up’ for a Brand-New CM



- By Week 8, the case load is 20 patients
- Break for 3 weeks; allow time to acclimate
- Once acuity is manageable, repeat the same process
- Repeat this cycle until panel capacity reached

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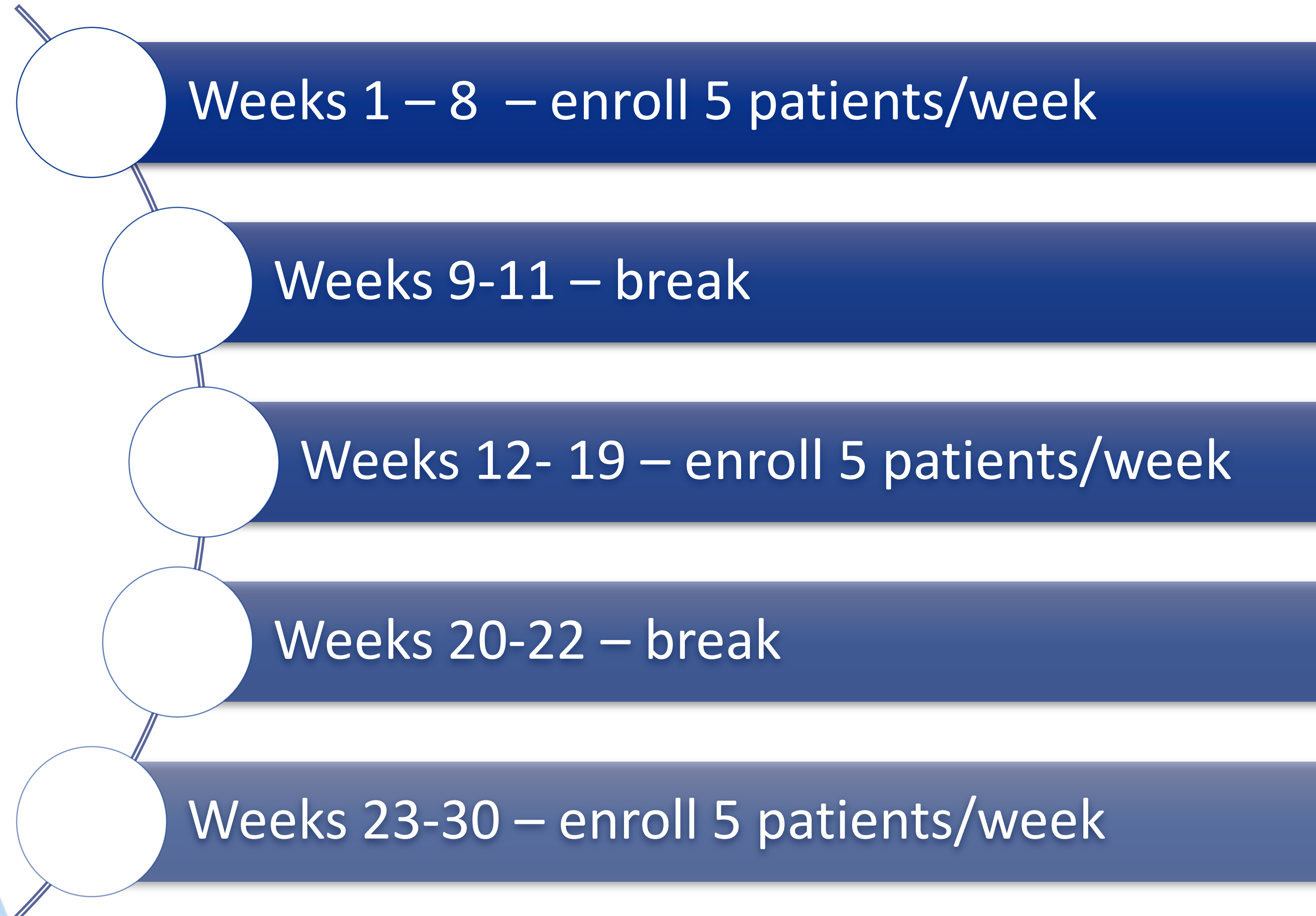
Panel Size ‘Ramp Up’ for a Seasoned CM



- By week 8, 40 patients are enrolled
- Recommended breaks for 3 weeks, to allow the acuity of the panel to settle
- Less time needed to ramp up the panel for an experienced CM

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Care Management Workflows

Creating a Workflow

- Identify a best practice based on team criteria
- Document the steps
- Review ‘DRAFT’ with all to document all variations
- Create DRAFT #2
- Review DRAFT #2 and add any additional variations
- Team review to define and approve Workflow
- Identify task accountability measure
- Educate team on workflow and accountability

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Workflow Example

WORKFLOW The purpose of this SOP is to define the process for an encounter with an established care management patient.

ACTION:

1. Perform Pre-visit Chart prep prior to encounter:
    - You can prepare and update all sections of the encounter except for vitals which is within the review section
        - If you use the Pre-visit Prep Note remember that is intended to help you recall information during the encounter but is not retained once the encounter is closed
    - Review chart using the process outlined in Outreach SOP

    NOTE: If encounter is cancelled or moved all pre-visit chart prep entries will be lost. To retain chart prep the encounter must be rescheduled.

2. Conduct encounter with patient in person or by phone following the flow of the CM Assessment Checklist for and established patient.
3. At the conclusion of the visit, summarize this interaction for patient and co-plan the next care management visit
4. Schedule next encounter using the appropriate visit type:
    - CM Established, Brief – 15, Long – 30, Medium – 45 or Extended – 60
5. Summarize visit conversation using Teach Back Technique.
6. Co-plan for next CM contact.
7. Schedule the next Appointment.
8. NOTE: If the patient does not want to schedule currently update the existing CM Referral Order- by putting a future date for follow-up in the Perform Date field and updating the notes.
9. Update relevant QuickView Additional Information.

CHECKING-OUT

1. Click Ready for Checkout from the Close drop-down in the Sign-off section.

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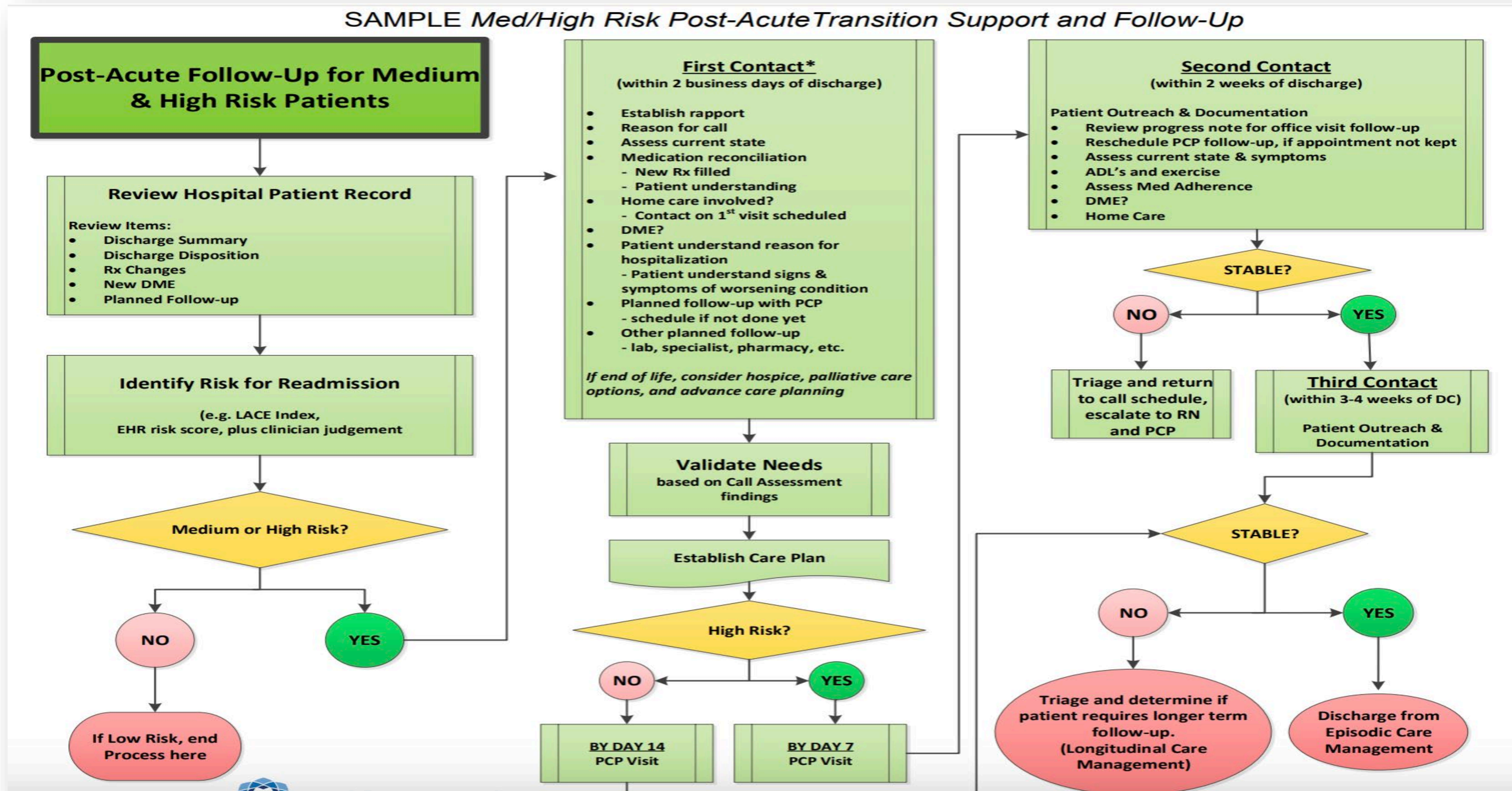
Workflow Example *(continued)*

10. Open Vitals tab (left side of screen), check when last screenings were completed, input screenings that are due in screening drop down such as PHQ, GAD and Audit-C
11. Open History tab (left side of screen) to see when the social history was last completed
12. Input data from chart prep review/risk strat in HPI under Care Management Eligibility

13. Add additional CM templates as appropriate for pt dx(s)

Workflow Diagram



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Questions and Discussion

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Module 3
Communicating the Importance of Addressing Social Needs

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Objectives

- Discuss the impact of social needs on health/clinical outcomes
- Recognize how Maslow's Hierarchy of Needs play a crucial role in understanding patient's needs.
- Identify strategies to demonstrate the ROI for addressing social determinants of health.

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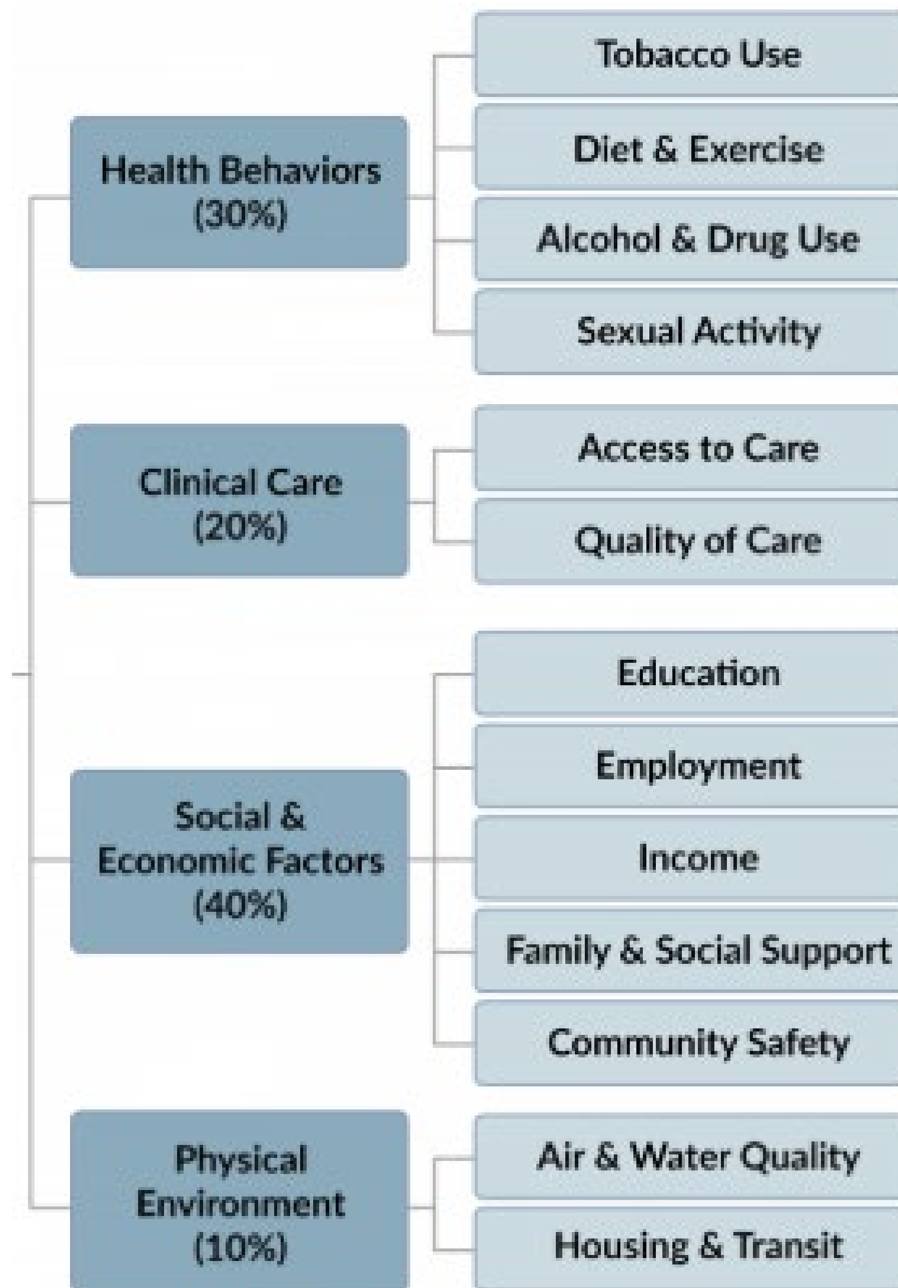
- **20%** of health outcomes are influenced by clinical care
- **80%** are related to factors that take place outside of the clinic



RWJF County Health Rankings model

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Clinical Self-Actualization

Health and Wellbeing Continuum

Level	Needs
Self-Actualization	Morality, creativity, spontaneity, acceptance, experience purpose, meaning and inner potential
Self Esteem	Confidence, achievement, respect of others, the need to be a unique individual
Love & Belonging	Friendship, family, intimacy, sense of connection
Safety & Security	Health, employment, property, family & social stability
Physiological Needs	Breathing, food, water, shelter, clothing, sleep

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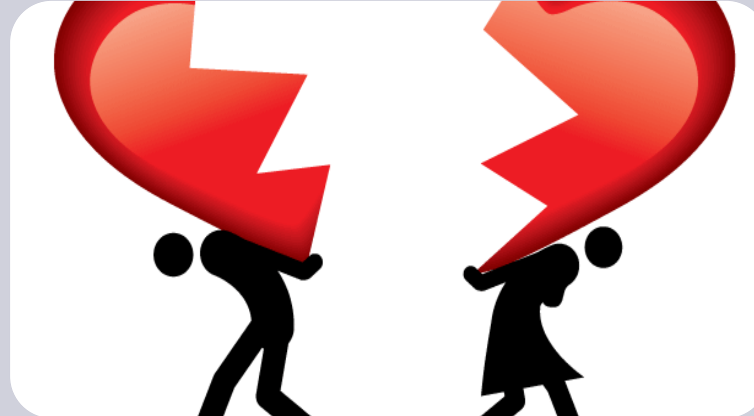
Case Examples



Single mom

Works 2 minimum wage jobs

Received eviction notice (failure to pay rent)

Youngest child has Cystic Fibrosis; unable to afford medications

Man, age 42, just divorced

Lost his home & health insurance d/t divorce

Experiencing chest pain, but unwilling to go to the ED

Successful business woman

Mugged in parking garage while leaving work last week

Experiencing severe PTSD & anxiety

Will not leave her house – thus, can't get to office visit for evaluation & treatment

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Case Examples *(continued)*

- Young child
- Severe asthma
- Family lives in subsidized housing with pest infestation
- Repeat ED & inpatient admissions for asthma exacerbations

- Grandparent
- Living on fixed income
- Has custody of grandchildren
- Multiple chronic conditions
- Cannot afford high monthly out of pocket cost for medications

- Family that lives in suburbs
- Car needs repair and can't be driven; family can't afford the repairs
- Mom recently diagnosed with osteomyelitis – needs daily IV antibiotics at infusion center *(insurance won't pay for home care)*

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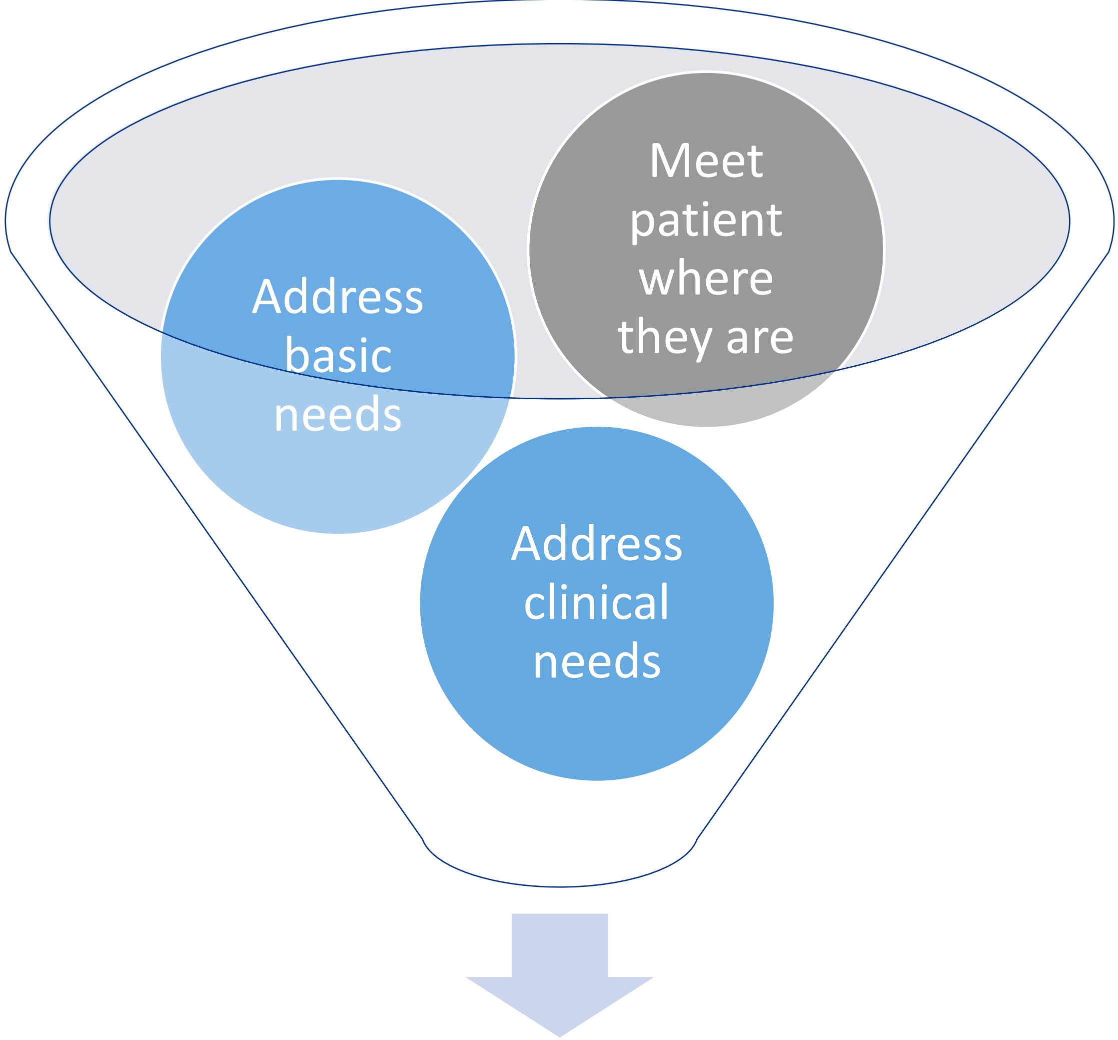
The Value of Addressing SDoH



Clinical Self Actualization + Financial ROI

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Small Group Discussion - Care Management Goals

Time: 10 minutes
Lead: Identify 1 person to take notes and report out to larger group

TOPICS

- Does your current CM team members and skill set reflect the needs of your population?
- Why or Why not?

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LET'S TALK

Questions and Discussion

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Connect With HealthTeamWorks

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Care Management Leading Training: Course Timeline

Pre-Work

Course: September 13, 2023 – October 18, 2023

- ✓ Register for Elevate
- ✓ Block calendar for sessions

Sep 13th
Kick-Off Session

Sept 20th
Live Session 2

Sep 27th
Live Session 3

Oct 4th
Live Session 4

Oct 11th
Live Session 5

Oct 18th
Closing Session

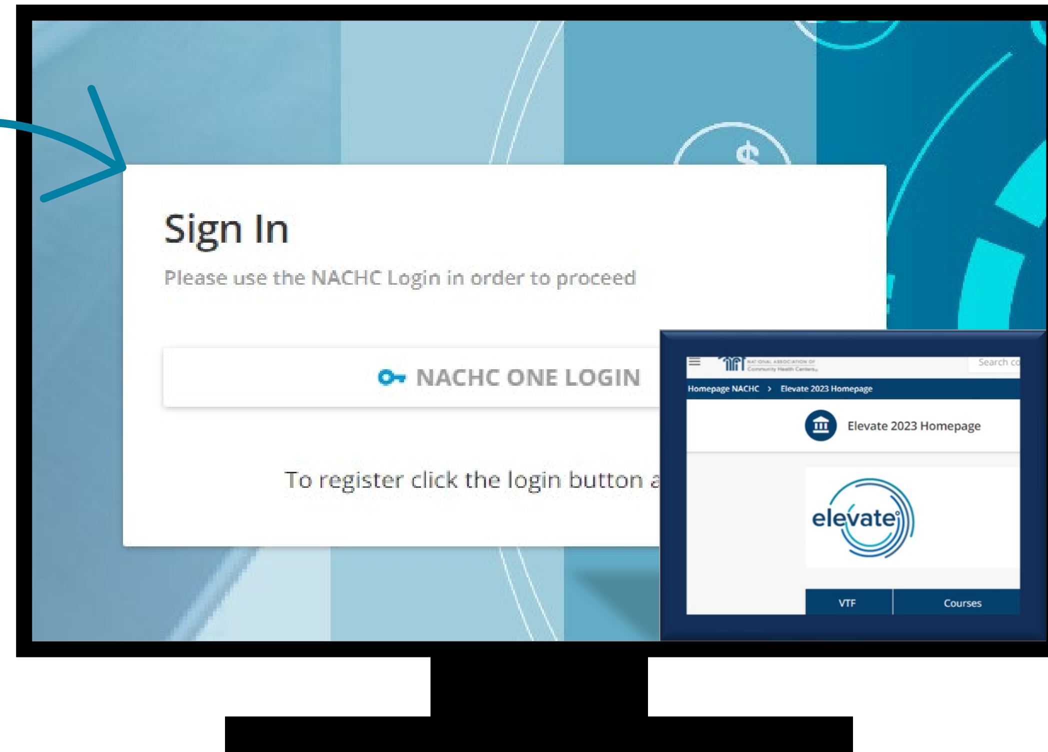
You are here! Congratulations, you have completed the Pre-Work and Session 2! Next steps:

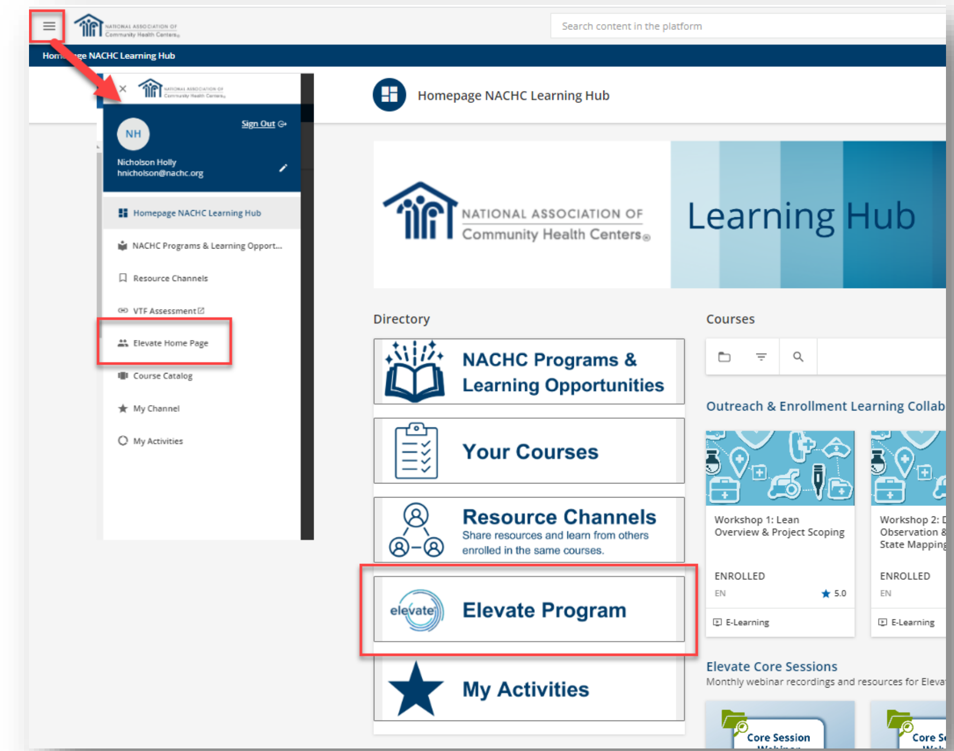
- ✓ Access online course content
- ✓ Complete VTF Assessment
- ✓ Attend remaining courses

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

Health Center Professional Development Program

(content available to registered participants only)

CLICK HERE TO ACCESS

Health Center Professional Development Program

Please select your approved program below to view assigned resources.

Care Management 101: Essentials

(content available to registered participants only)

CLICK HERE TO ACCESS

Care Management 102: Intermediate

(content available to registered participants only)

CLICK HERE TO ACCESS

Care Management 103: Leading

(additional text can go here if needed)

CLICK HERE TO ACCESS

Community Health Worker: 101

(content available to registered participants only)

CLICK HERE TO ACCESS

Community Health Worker: Supervisor

(content available to registered participants only)

CLICK HERE TO ACCESS

QI Professionals

(content available to registered participants only)

CLICK HERE TO ACCESS

Select your course!

Contact Us!

The NACHC Quality Center team is here to help!

Questions on how to access online content? VTF Assessment?

Contact **QualityCenter@NACHC.org**

SESSION #3

Live Session #3	Course 3 Building your Team
September 27 3-5 PM ET	Module 1 Developing Skills for Ambulatory Care Management Roles • Identify the basic clinical and professional skills every Care Manager must have. • Defend the advanced skills and competencies that contribute to the Care Manager's success. • Develop a list of key character traits that are critical for success in the Care Manager role
	Module 2 Assessing for Skills during the Interview Process • Describe value of testing for skills during an interview for a Care Manager. • Propose strategies for testing Care Manager interviewees. • Distinguish methods for a multi-step interviewing process.
	Module 3 Effective Professional and Skill Development for Care Managers • Define opportunities to support Care Manager professional and skill development. • Develop a method for supporting care manager success that adheres to clinic/system policies and procedures

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Time for a Poll!

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Thank You!

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