NATIONAL ASSOCIATION OF
Community Health Centers®

HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

CARE MANAGEMENT (102) INTERMEDIATE TRAINING, POWERED BY

SESSION #5
OCTOBER 11, 2023
12:30 PM ET

Care Management (102) Intermediate
Session 5

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Session # 4 Recap

- The value of healthy boundaries
- Established priorities to support boundaries and saying no
- Task inventory as a tool to understand workload and validate a need for boundaries
- BURNOUT – symptoms, impact
- Defined process for identifying community resources & community partners
- Approaches & resources to building community relationships
- Defining roles via a Collaborative Care Agreement

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Promoting Wellness

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Course 4

Demonstrating the Value of the Care Management Program

Module 1

Data Sources to Assess the Effectiveness of the CM Program

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Learning Objectives

- Discuss the importance of strategic alignment for Care Management Program
- Review data types and how they relate to measures of success for care management
- Identify key data sources

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Vision for Care Management:

Every system is perfectly designed to get the results it gets

- If you want to increase your success – define success
- Clearly defined goals increase potential for achieving them
- Provides clarity for all

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Lack of Clarity or Defined Goals

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Strategic Alignment

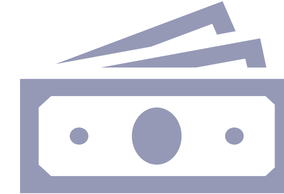
ORGANIZATIONAL GOALS

Prescription Narcotic Use
Tobacco Use / Cessation
Colon CA Screening
Maternal / Child Health

POPULATION GOALS/NEEDS

Adolescent/Pediatric
Depression screening & management

STD screening & management



PAYMENT MODELS & INCENTIVES

Managed Care
Medicare Advantage
Alternative Payment
Grant deliverables

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Poll: Do you as a Care Manager have clearly defined goals or measures of success? (select all that apply)

- ❑ Yes, we have Care Management goal or goals
- ❑ Yes, we have goals that align with the primary care team
- ❑ Yes, I have individual care manager goals
- ❑ No, we do not have Care Management goals
- ❑ Yes, I receive data to review on identified goals (if applicable)

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Group Discussion: Defined Goals

- What is most important for you to accomplish?
- How do you measure success?
- How do measures of success guide your priorities?

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Data Types

Quantitative

Lead

- CM caseload
- Collaborative care plan
- Utilization (e.g., ED, imaging, admissions, readmissions)
- Process (e.g., A1c testing)

Lag

- Total cost of care
- Clinical outcomes (e.g., A1c control)
- Health-related social needs met
- Depression remission at 12-months
- Changes in risk over time

Qualitative

- ED and/or admission diversion
- Engagement and activation
- Patient experience
- Provider and staff experience

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Qualitative Data

Qualitative Data - Stories from the Field			
Date	Care Manager	Theme *(drop down function to sort)*	Narrative
4/5/22	Care Manager name	ED Diversion	*Enter description here - document examples from each CM/Care Guide-RN during weekly teaming meetings. Results gathered over time can be sorted by theme.*
4/14/22	Care Manager name	Avoided Admission	
4/27/22	Care Manager name	Avoided Readmission	
5/10/22	Care Manager name	Improved Quality Metrics	
5/23/22	Care Manager name	Re-Engaged	
5/13/22	Care Manager name	Other	
5/31/22	Care Manager name	Avoided Readmission	
6/23/22	Care Manager name	ED Diversion	
6/19/22	Care Manager name		

ED Diversion
Avoided Admission
Avoided Readmission
Improved Quality Metrics
Re-Engaged
Other

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Data Sources

- EHR (Clinical)
- HIE
- Payer (Claims)
- Patient-Reported
- Social Referral Platforms

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Steps to Defining CM Goals

- ✓Identify key System or Clinic goals – KPI's – mission statement
- ✓Identify key revenue drivers
  - Payment models
    - Performance payment
- ✓Program deliverables
  - Million Hearts
  - Substance abuse – chronic pain management
- ✓Grant deliverables
- ✓Measures that influence provider income
- ✓Population needs/priorities
- ✓Clinical team priorities

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Validate CM Goals

- ✓Review goals with the direct report
  - ✓CM leadership
  - ✓Practice manager
  - ✓Lead provider
- ✓Review goals with the provider team
- ✓Review goals with clinical team
- ✓Engage all to support priorities to ensure success with CM Goals

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Questions and Discussion

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Course 4
Demonstrating the Value of the Care Management Program

Module 2
Methods to Assess the Effectiveness of the CM Program

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Introduction & Learning Objectives

- Identify different methods to analyze CM impact
- Identify when each methodology is appropriate to use
  - Lead (Process and Interventions)
  - Lag (Outcomes)

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Methods of Assessing a CM Program

- Lead Measures
  - Caseload – enrolled patients
  - Task completion
  - Process measures
    - Screenings
    - Tests
  - TCM / CCM Billed or Visits/Touches
  - Depression screen & management
  - PCP engagement measure
- Lag Measures
  - Diabetes Control
  - ED utilization
  - Hospital utilization

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Questions and Discussion

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Module 3

Communicating Program Success

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Introduction & Learning Objectives

- Outline a CM Communication Plan and strategies for communicating to various audiences
- Discuss opportunities to promote the value of Care Management
- Identify quantitative and qualitative measures of success to review with leaders

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CM Communication Plan: Telling Your Story

CM Supervisor/Leader:

Providers & Clinical Team: Qualitative data - examples

CM Team: Options to team with other Care Managers to share best practices

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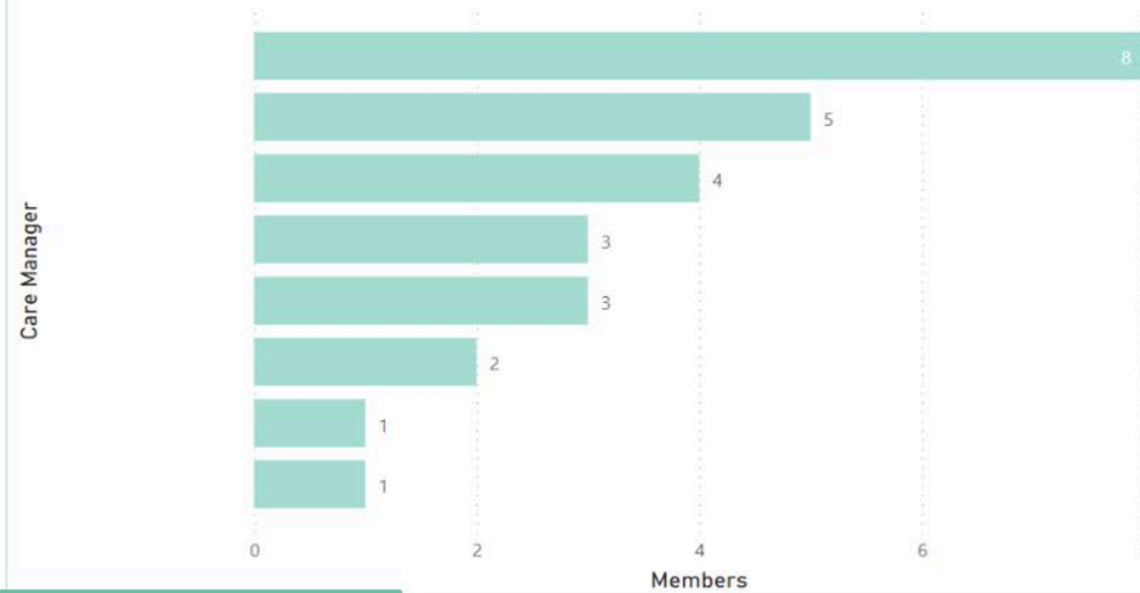
Care Management Scorecard

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

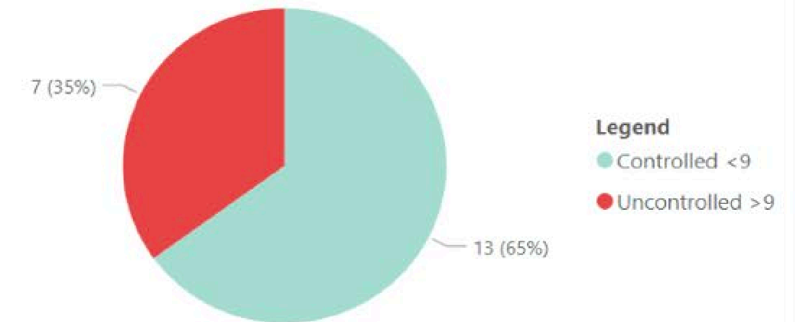
Care Management Leading Metrics

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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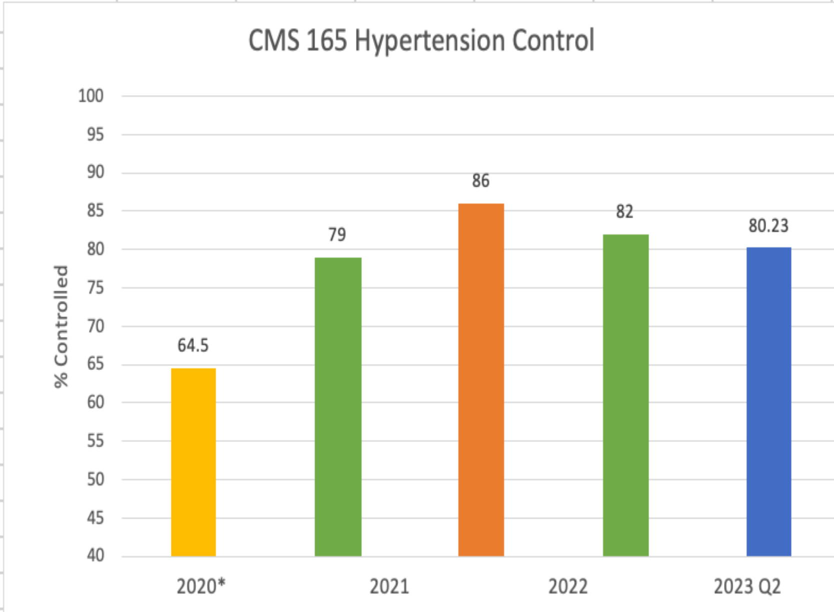
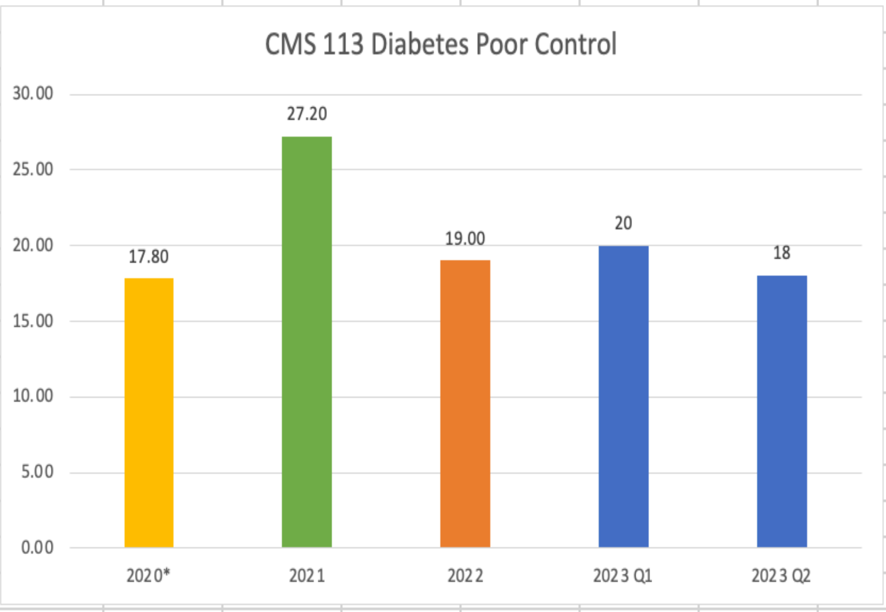
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
				CMS 165 Hypertension Control					CMS 122 Diabetes Poor Control					SDOH Screen		
Program	DATE	PEC 2021	PEC 2022	2020*	2021	2022	2023.Q1	2023.Q2	2020*	2021	2022	2023 Q1	2023 Q2	2021	2022	2023 Q2
Care Mgmt	7.3.2023	82.57	76.75	64.5	79	86	82	80.23	17.80	27.20	19.00	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																





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Small Group Discussion

- Small groups of 4-5 individuals
- Identify/confirm leader – someone who will take notes and report back

- Discuss the following:
  - ➢ What would be a feasible measure of success for Care Management (or you as a Care Manager)
  - ➢ Why do you feel this is a good measure of success
  - ➢ How would you promote the value of Care Management (or your role as Care Manager) using this measure of success?

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GROUP DISCUSSION: CARE MANAGEMENT GOALS

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WRAP UP – Key Take Aways

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Session #6

Course 5. Bringing It All Together for Effective Care Management
October 18, 12:30 – 2:30 PM EST

Module 1. Review Key Characteristics of an Effective Care Management Program

- Review the process to understand your population
- Discuss the value of defining your priorities and setting goals
- Share options to measure for success

Module 2. Group Case Study Discussion

- Discuss case study examples and apply concepts discussed during the CM intermediate course
- Identify opportunities to apply CM concepts in ongoing Care Management work

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ASSIGNMENT – SESSION #6

In preparation for Session #6:

- Identify 1-2 areas where you would like to take knowledge from this course and set a goal.
  - Examples
    - A specific patient that does not engage with care management (no HPI, just general characteristics)
    - I struggle with the primary team knowing what I do and how I bring value so need a goal that will resonate for the team. (share team challenges, clinic goals, etc.)
- Email your potential areas of interest to Diane and Angie by the end of day Monday, October 16th.
- NACHC will send a reminder email to all on Friday.

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Connect with Us

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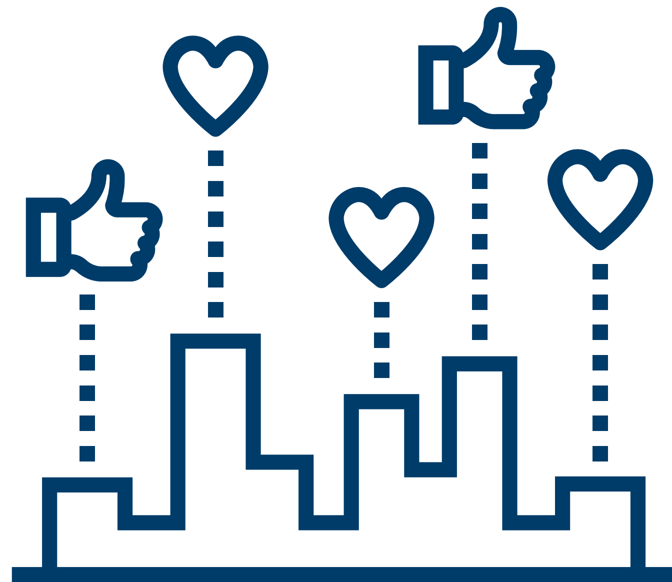

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The NACHC Quality Center team is here to help!

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Contact QualityCenter@NACHC.org

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THANK YOU!

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