NATIONAL ASSOCIATION OF
Community Health Centers®

HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

CARE MANAGEMENT (102) INTERMEDIATE TRAINING, POWERED BY

SESSION #6
OCTOBER 18, 2023
12:30 PM ET

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

We hope this training provided a rich opportunity to learn, share, and grow in your role.

22 health center staff participants strong!

In Partnership with the CDC

This program is made possible through the partnership and support of the Centers for Disease Control and Prevention (CDC)

NACHC's Fall 2023 training opportunities focus on health center staff who support healthy aging and brain health as part of whole-person care.

Key health center roles in brain health and dementia reduction and early detection:

- Community Health Workers (CHWs) and CHW Supervisors
- Care Managers & Care Manager Supervisors
- Quality Improvement Staff

This national professional development series and peer-to-peer professional network included:

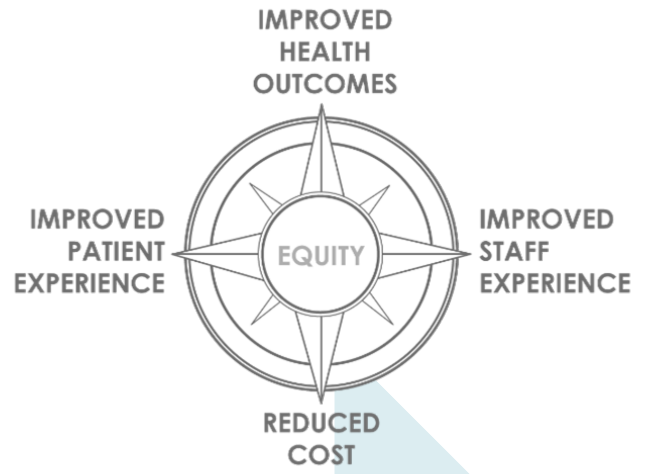
200+ health center staff

150+ health centers

36 states, DC, and Puerto Rico

Driving Health Center Value Transformation

Initiatives and learning opportunities are…



Grounded in the **Value Transformation Framework**

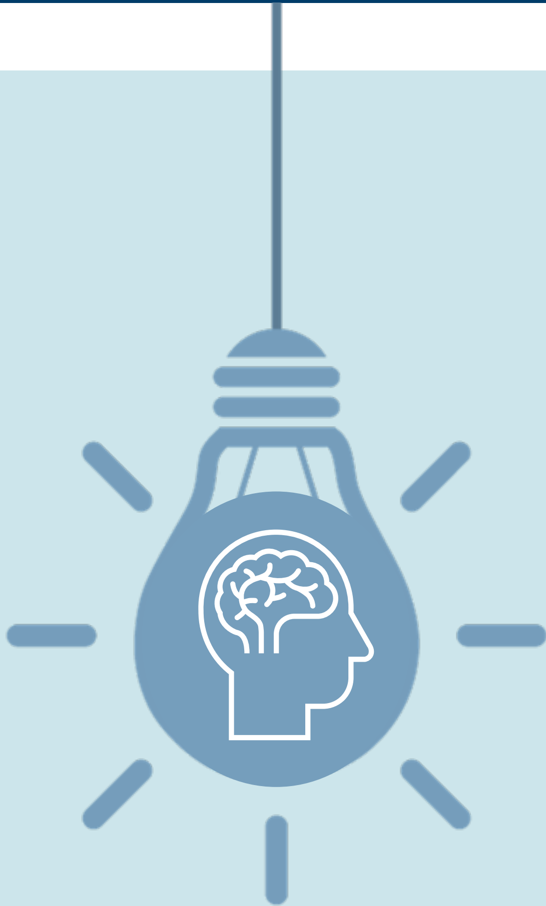
Operationalized through the **Elevate National Learning Forum**

- **700+** Health Centers
- **77** PCAs/HCCNs/NTTAPs
- **6000+** Health Center Peers
- **15,000,000** Patients

Offered to staff supporting Brain Health ***Care Management Training***

Achieving **Quintuple Aim** Goals

The Aging Population: Is Your Health Center Prepared?



65+ years of age fastest growing health center patient population*

36% of health center patients 45+ years of age*

- 11% - 65+ years of age
- 25% - 45-64 years of age

6th leading cause of death in the United States+

Alzheimer's kills more seniors than breast and prostate cancer combined+

Non-Hispanic Black and Hispanic older adults disproportionately more likely than White older adults to have Alzheimer's or other dementias+

* NACHC, Community Health Center Chartbook 2023. https://www.nachc.org/community-health-center-chartbook-2023/
+ Alzheimer's Association. 2023 Alzheimer's Disease Facts and Figures. Alzheimer's Dement., 19: 1598-1695. https://doi.org/10.1002/alz.13016

The Aging Population: Your Health Center is Part of the Solution!

Primary care providers provide 85% of first diagnosis of dementia; provide 80% of care*

Providers and care teams:

- ✓ Can address modifiable risk factors which may slow dementia progression and modify comorbid conditions
- ✓ Address safety and incorporate advanced care planning
- ✓ Achieve cost savings and help reduce rate of hospital admissions in adults 65 years and older (1.78 greater risk of ambulatory care sensitive admissions[+])
- ✓ Generate revenue for care management and other Medicare services: Annual Wellness Visits and Advanced Care Planning

+ Phelan EA, et. al., Association of incident dementia with hospitalizations. JAMA. 2012 Jan 11;307(2):165-72. doi: 10.1001/jama.2011.1964.
*Alzheimer's Association. 2023 Alzheimer's disease facts and figures. Alzheimer's Dement., 19: 1598-1695. https://doi.org/10.1002/alz.13016

Why Focus on Care Management?

Contributes to quality care. Allows care team members to assess and monitor risk factors, *(including risk factors for Dementia/early detection)*, support patients with the management of chronic conditions *(Dementia, Hypertension, Diabetes, etc.)* and promote positive health behaviors *(Dementia risk reduction)*.

Offers reimbursement opportunity driven by extended care team.

Delivers on Quintuple Aim Goals: Improved health outcomes, improved patient experience, improved staff experience, reduced costs, and equity.

Care Management Services

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

VALUE TRANSFORMATION FRAMEWORK
Action Guide

NATIONAL ASSOCIATION OF Community Health Centers®

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].

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.

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).

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

High-risk care management involves intensive, one-on-one services, provided by a nurse or other health worker, to individuals with complex health and social needs. The formal design of a health center care management program can ensure a standardized approach to managing high-risk patients by a care manager. The model discussed in this Action Guide is based on a nurse in the role of care manager. Other staffing models can be employed with some modification. Key components of care management include: identifying and engaging high-risk individuals, providing a comprehensive assessment, creating an individual care plan, engaging in patient education, monitoring clinical conditions, and coordinating needed services[8,9,10].

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Also consider incorporating Transitional Care Management (TCM) services.

Tools & Resources:

- Care Management Protocol for High-Risk Patients
- NACHC TCM Reimbursement Tip Sheet

Care Management Resources

Care Management Action Guide

Chronic Care Management Reimbursement Tips

Transitional Care Management Reimbursement Tips

...and MORE!

The Aging Population: Your Health Center is Part of the Solution!

HOW to apply new skills to Dementia early detection and risk reduction?

- ✓ Review resources to understand signs/symptoms of dementia (early detection) – see next slide
- ✓ Update workflows (care management, annual wellness visits, advanced care planning) to include early detection and risk reduction
- ✓ Develop a systems approach to the management of chronic conditions; use tools to assess cognitive function
- ✓ Enhance and expand partnerships and community linkages to support early detection and risk reduction.
- ✓ Incorporate into your health center Improvement Strategy.

Aging Population: Leverage the VTF and Elevate

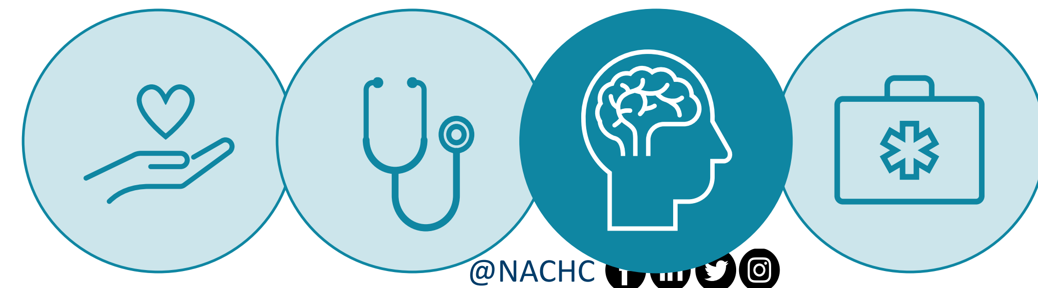
Sample QI Workplan Activity:

1. **Incorporate** the VTF systems approach within your health center QI strategy, as an organizing approach for all age groups, including older adults
2. **Assess** health center progress in 15 areas of systems change using the VTF Assessment. To access the VTF Assessment go to www.reglantern/vtf.
3. **Join** a national learning community (Elevate) for free training and professional development opportunities. Register for Elevate at https://bit.ly/2023Elevate.
4. **Build** capacity to provide services that provide early detection and risk reduction for dementia in combination with attention to chronic conditions and social risk: Chronic Care Management (CCM) services, Annual Wellness Visits (AWV), Advanced Care Planning (ACP)
5. **Bill** code and bill for additional services (CCM, AWV, ACP)
6. **Improve** patient health outcomes and advance toward Quintuple Aim goals

The Aging Population: Your Health Center is Part of the Solution!

For more information, access the NACHC 3-Part Webinar Series

1. Early Detection of Dementia & Reducing Risk Factors
2. Care Management for Patients with Dementia & Leveraging Reimbursement Opportunities
3. Health Center Partnerships & Community Linkages to care for Patients with/at risk for Dementia



Certificate of Completion: VTF Assessment

To receive your Certificate of Completion, be sure you, or someone from your health center, has completed the VTF Assessment.

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

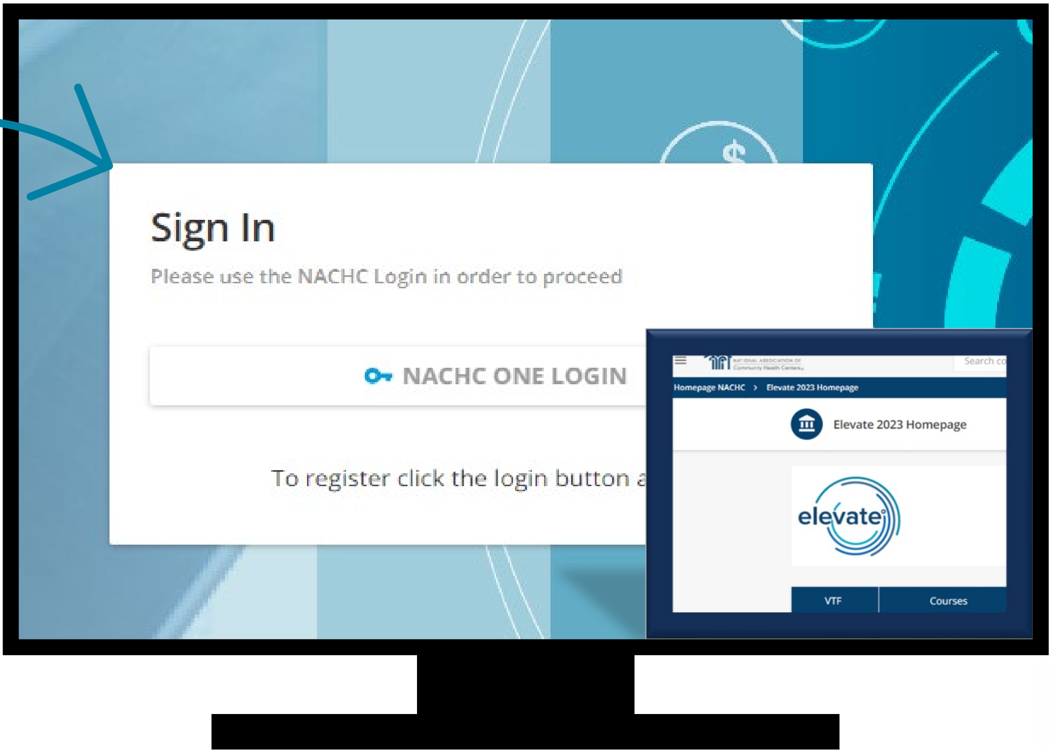
Care management and staff engagement/professional development opportunities are both important components!

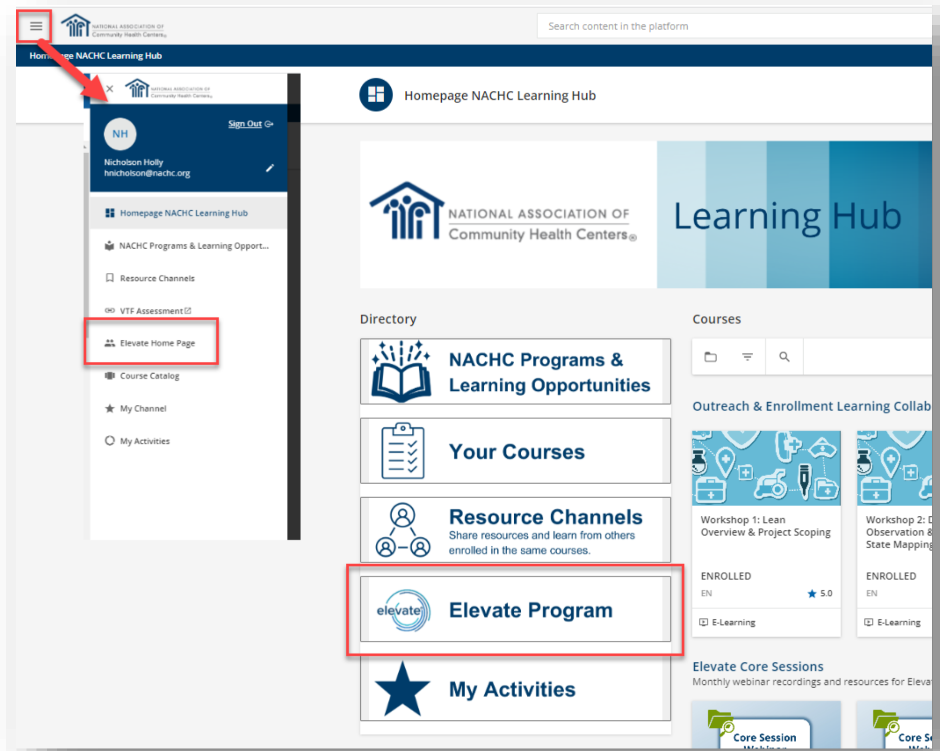
For more information on the VTF Assessment, review the **Action Brief: Assess Transformation Progress**

Access Course Materials & Other Resources

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

Care Management (102) Intermediate
Session 6

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Session # 5 Recap

- Measuring success in Care Management
  - Value of clearly defined goals
  - Data sources for measuring success
- Communicating Care Management Success
  - Impact on effective integration
  - Promoting what you do
- Goal Examples
  - Improving patient self care
  - Quality measure improvement
  - Impact on Patient experience scores

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Case Study Small Group Discussion Topics

Select 2 Topics that you would like to participate in the Group Breakouts

Enter the corresponding numbers in the chat.

1. Setting Boundaries for CM: Care Manager task prioritization
2. Promoting the value of Care Managers/Care Management
3. Engaging patients in their health (Care Management)

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Module 1
Review Key Characteristics of an Effective Care Management Program

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Introduction & Learning Objectives

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

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Understanding Your Population

Household Economics

Age, Gender, Sexual Orientation

Race, Ethnicity

Population Knowledge

Social support

Geography

Medical, Mental & Behavioral Health

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Understanding Your Population

- ❑ Review primary care population that you serve - # of patients by clinic, # of patients by provider
- ❑ Review patient population enrolled in Care Management (CM)
  - Patients enrolled in care management are clearly identified via a discrete field in EHR
- ❑ Patients enrolled in care management are empaneled to a specific member of the care management team (Define how this is done & communicated across the team)
- ❑ Review population data showing chronic disease and mental health condition distribution
- ❑ Review population data (ideal if you can review data on patients enrolled in CM) showing chronic disease and mental health condition status, such as:
  - % of patients with Hypertension and B/P $< 140/90$
  - % of patients with diabetes and HgbA1c ≥ 9
  - % of patients with depression and PHQ-9 of ≥ 10
- ❑ Review population data (ideal if you can review data on patients enrolled in CM) showing utilization, such as:
  - % of patients with ED visits in the previous 3-6 mos
  - % of patients with Hospital discharge in previous 3-6 mos

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Value of Defining Goals

- Provides focus and prioritization for Care Manager tasks
- Provides key data to sell 'What it is we as Care Managers Do'
- Resource to integrate with the primary care team
- Promotes a focus on population needs

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Process for Defining Goals

- Clearly define an area you feel is a challenge or needs improvement
  - PCP Integration or understanding the value of Care Management
  - Patient engagement in their health & healthcare
  - Care Manager task prioritization

Ensure **SMART** goal format

- **S**pecific
- **M**easurable
- **A**chievable
- **R**easonable
- **T**ime Sensitive

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Goals to Consider

- **PCP Integration or promoting the value of Care Management**
  - Identify a goal that the PCP team sees as valuable
  - PCP team quality goal
    - Depression screen completion for patients enrolled in CM will be 100% by _________. (Define frequency of depression screening - monthly/quarterly)
    - 50% of patients with hypertension, poor control and enrolled in CM will see improved Hypertension control by _______.
    - 85 % of eligible patients enrolled in CM will have an AWV completed (ACO measure) by ________.

- **PCP Team Efficiencies**
  - Medication list reconciled & current on all patients in CM
  - ED, Hospital & Specialty notes are readily available and summarized

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Goals to Consider

- **Patient engagement in their health and healthcare**
  - **75%** of patients enrolled in CM will complete recommended PCP visits (confirm what this is – monthly, quarterly) by ___________.
  - **85%** of patients enrolled in CM will have a patient identified goal that is current (reviewed within previous 4 weeks) by __________.
  - **90%** of patients enrolled in CM will have an accurate medication list at their PCP visit by __________.

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Goals to Consider

➢ **Care Manager task prioritization**

- 85% of tasks completed by CM will be CM related tasks by _______.
- Depression screen completion for patients enrolled in CM will be 100% by ________. (define the frequency of depression screening – monthly/quarterly)
  - Prioritize depression screening
- 85% of patients enrolled in CM will have a patient-identified goal that is current (reviewed within previous 4 weeks) by _________.
  - Prioritize patient-identified goals

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Care Management Billing

- Understand your Payor Distribution
  - % of Medicaid
  - % of Commercial Insurance
  - % of uninsured or under insured
  - Grant programs
- Identify a support in your billing department
  - Clarify codes used by each primary payor
  - Understand denial management process & ROI

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Medicare – TCM / CCM

Transitions of Care Management: ‘The process for a provider to “oversee management and coordination of services, as needed, for all medical conditions, psychosocial needs and activity of daily living support.” *

Chronic Care Management: CCM is the provision of care management and care coordination services to patients with two or more chronic conditions. **

*https://www.ruralhealthinfo.org/care-management/transitional-care-management
**https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/connected-hcptoolkit.pdf

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Transitions of Care Management (TCM)

Transition of Care Management (TCM) 30-day period

- Discharge from an approved inpatient setting to a community setting
- Clinical staff under supervision of a physician, NP, PA, CNM, CNN
- Contact with patient within 2 business days of discharge
  - Repeated efforts if unable to reach within 2 business days
- Face to Face visit
  - 99495 – visit within 14 days of discharge
  - 99496 – visit within 7 days of discharge

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TCM Tasks

- Review discharge information
- Review discharge follow-up – tests, medications, treatments
- Coordinate with any referral recommendations – Specialty, PT, OT, etc.
- Educate patient, family, caregiver
- Coordinate community referrals

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Chronic Care Management CCM

- Beginning in 2022 RHC & FQHC can submit CCM billing
- Require a billing provider visit within the previous year (E/M, AWV, IPPE)
- Patient consent – written or documented verbal consent
- Clinic provides 24/7 access to care
- Provides continuity of care
- Provides enhanced opportunities to communicate – phone, portal, secure messaging
- Patients with two or more chronic conditions expected to last a minimum of one year (CCM)
- Patients with single chronic conditions or single high-risk condition (PCM) high-risk

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Chronic Care Management CCM

Care Management requirements:

- Assess/document medical, functional and psychosocial needs
- Recommend timely preventative services
- Review medications and potential interactions
- Oversee medication self-management
- Coordinate home and community-based care
- Manage care transitions
- Create a comprehensive care plan

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Chronic Care Management CCM

Time-only CCM codes:

99491: Billing practitioner time minimum of 30 minutes

99487: Care Manager time Initial 60 minutes

99489: Care Manager time additional 30 minutes

99490: Care Manager time monthly 20 minutes

99439: Care Manager time additional 20 minutes

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Questions and Discussion

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Course 5
Bringing It All Together for Effective Care Management

Module 2
Group Case Study Discussions

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Introduction & Learning Objectives

- 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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Case Study Small Group Discussion

Break Out Discussion Time: 15 minutes
Recognize or identify a leader – takes notes and reports back

Review Case Study:

- Develop 2-3 Action steps that are steps to a solution for this case study

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SMALL GROUP #1

Setting Boundaries: Care Manager Task Prioritization

General: Large 13 location FQHC Network; 3-6 providers at each location

Care Management: CM Nancy is a solo Care Manager responsible for a Clinic Program focused on cardiovascular disease prevention, early detection and management for women aged 40-64. She is struggling with not having enough time to do a good job with the program due to competing demands with the clinical team pulling her into primary clinical work. She gets pulled into cover for the MA to room patients and to provide immunizations. When she does get patients to return her calls, the front desk tells the patient they do not know what they are asking about and should call back at another time. Because of these competing demands she has poor enrollment in the program and is having difficulty showing any improvement in patient engagement and B/P management for those in the program.

ACTION STEPS:

1. Clearly defined goal for Care Management program – 100% of women age 40-64 will have a B/P reading;
2. Alert in chart that notates CM enrolled
3. Educate staff on what CM enrolled or program priorities means – Structured training for all on program; Program agenda item at staff meetings;
4. Request dedicated administrative time – 1-2 days working from home

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SMALL GROUP #2

Promoting the Value of the Care Manager and Care Management
General: This is a 4 clinics network with 5 nurse practitioners.

Care Management: One care manager provides chronic care management for patients from all 4 locations and travels as needed, but primarily located at one location. 3 out of the 5 providers use the CM frequently, 2 providers do not ever refer to CM or see the value of CM. Clinic administration does not really see the value of Care Management and therefore expanding the team has not been an option. The CM has a strong supporter in her manager, but since stopping focus on billing and revenue production with more of a 'care management for all' approach it feels like the value of CM has dropped as there is uncertainty of what CM brings to the table. The CM is uncertain of the value as the CM is no longer able to see that he produces revenue to cover her salary.

ACTION STEPS:

1. Aligning quality measures improvement with what the primary team is prioritizing – Diabetes control; Improves quality of care for patients enrolled in CM. Promoting this with the clinical team
2. Communication and CM documentation to promote the value of CM
3. CM Goals – even if the administration does not have a clearly defined goal
4. Educate team: Confirm that CM is included in regular team meetings; Newsletters

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SMALL GROUP #3

Engaging Patients in their Health (Care Management)

General: This is a solo Community Health Center clinic with 3 providers in a small rural community

Care Management: Solo Care Manager who provides chronic care management. The CM struggles with how to be an effective CM for patients who do not want to engage in their health.

Patient example:

Jane Doe -- 52 yr old female with Hypertension – poorly controlled; Diabetes HgbA1c – 10; Last Mammogram was 5 yrs ago; Colon CA screen – none;

- Reluctant to change
- Repeated NoCancelNoShow
- Misses appointments primarily to lack of reliable transportation
- When in the clinic is distracted/on phone /dealing with traumatic situations – ie fighting with boyfriend in constant fight or flight
- Resource referrals are often not followed up on/medications not picked up/diets not followed / plans not executed

The CM struggles with how to engage with these individuals and feels she has a high number of non-engaged patients.

ACTION STEPS:

1. Using MI skills to identify obstacles: What is important to her – guide her to set smart goals
2. Develop a patient identified goals – help patient find their strength – and areas of success to build on
3. Consider Depression / SDOH screening

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Breakout Room 1-Setting Boundaries: Care Manager Task Prioritization

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Breakout Room 2 Promoting the Value of the Care Manager and Care Management

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Breakout Room 3 Engaging Patients in their Health (Care Management)

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Jane Doe -- 52 yr old female with Hypertension – poorly controlled; Diabetes HgbA1c – 10; Last Mammogram was 5 yrs ago; Colon CA screen – none;

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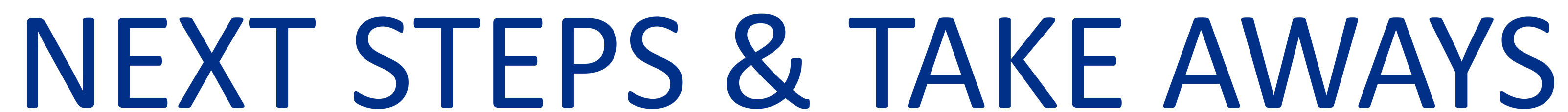

NEXT STEPS & TAKE AWAYS

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The NACHC Quality Center team is here to help!

Questions on how to access online content? VTF Assessment?

Contact **QualityCenter@NACHC.org**

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