NATIONAL ASSOCIATION OF Community Health Centers®

HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

CARE MANAGEMENT (103) LEADING TRAINING, POWERED BY

HealthTeamWorks®
Health. Equity. Resilience.

SESSION #6
OCTOBER 18, 2023
3 PM ET

You are part of a national community of leaders who supervise care managers and staff 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.

21 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

elevate

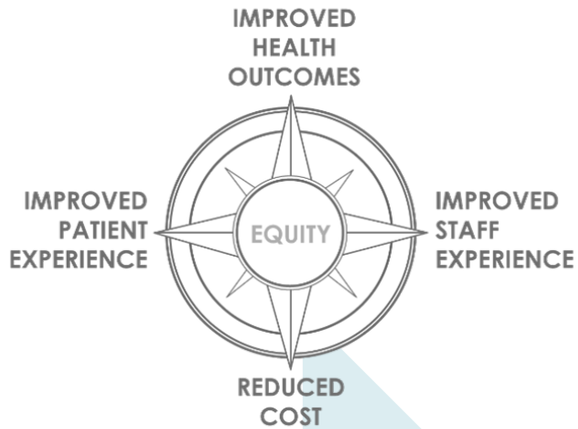
Operationalized through the

Elevate National Learning Forum

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

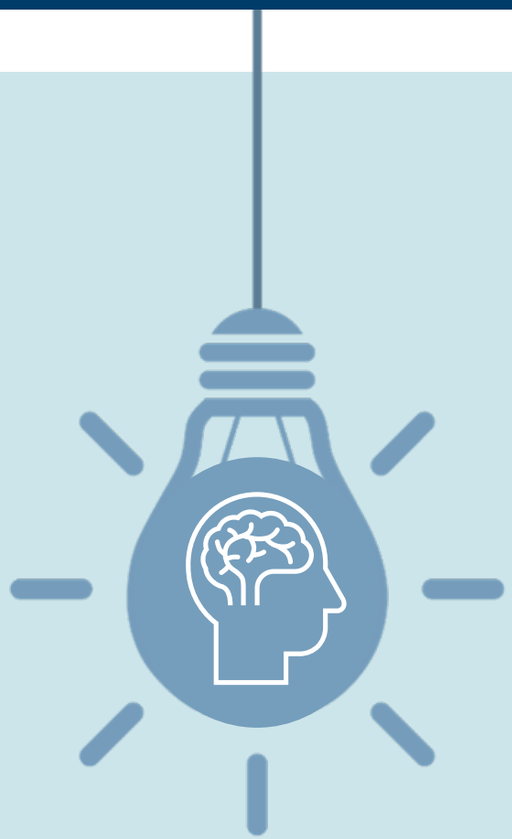
Offered to staff supporting Brain Health

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

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

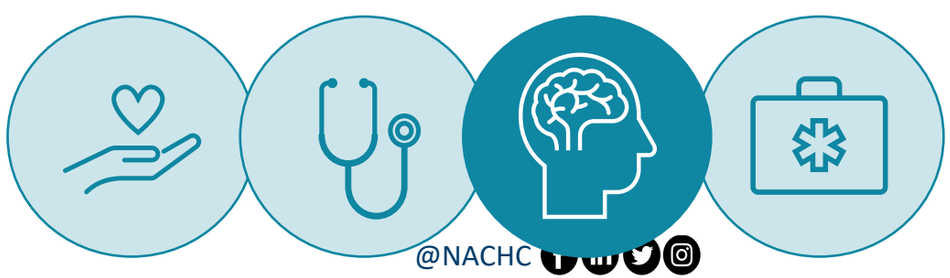
Sample QI Workplan Activity:

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.

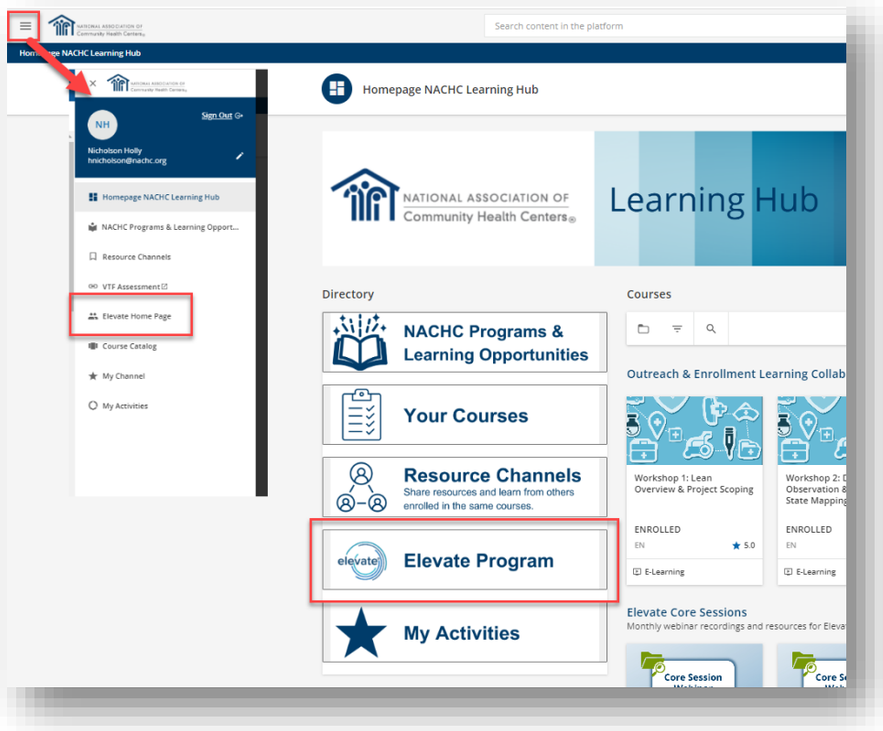
Care management and staff engagement/professional development opportunities are both important components!

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 (103) Leading
Session 6

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Session #5 Recap

- Effective Care manager/Primary clinical team integration
- Discussed what the ideal integration looks like – all see others as integral team members, all working towards a goal
- Value of clearly defined goals
- Challenges of role creep
- Value of clearly defining the problem
- Value of clearly defined goals to support CM task priorities

Case Study Breakout Topics

Select 2 Topics that you would like to participate in the Group Breakouts
Enter the corresponding numbers in the chat.

1. Effective Integration: Promoting the value of care managers/care management to the primary clinical team
2. CM Measures of Success: Identifying effective Care Management goals
3. Setting Boundaries for CM: Care manager task prioritization

Course 5

Supporting Care Team Integration, Part II

Module 3

Monitoring & Mitigating Care Manager Burnout

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Objectives

- Distinguish the impact burnout can have on the Care Manager, care team, and patients
- Identify tools to assess burnout
- Through utilization of assessment tools, identify common contributors that can alert to current or future Care Manager burnout.
- Develop effective strategies to mitigate Care Manager burnout

Recognizing Burnout on Care Team Members

- Depression, fatigue
- Appetite changes
- Job dissatisfaction
- Turnover
- Lack of clearly defined self-care activities
- Reduced productivity
- Turnover
- Other – self-care

Tools to Assess for Burnout

- Measures: Emotional exhaustion, depersonalization, & personal accomplishment
- Validated with US health and human services workers
- Cost associated per individual or group

Maslach Burnout Inventory – Human Services Survey

- Geared toward physicians
- Benchmark data not available
- No cost – free to the public (AMA Steps Forward)

Mini-Z

What Contributes to CM Burnout?

- Lack of role clarity
- Understaffing, and having to “fill in” for other staff
- Poor understanding of CM role: Inappropriate referrals
- Heavy workload and little support from leadership
- Ineffective or lack of self care

Strategies to Mitigate CM Burnout

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Promoting Wellness

Course 6

Evaluating Success

Module 1

Developing Metrics to Monitor Success

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Objectives

- Define the three major categories of measurement for a care management program.
- Describe data sources that are available in a practice for each category of measurement.
- Identify when and how to apply each category of measurement in a practice.

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

Lack of Clarity or Defined Goals

Data Types

Quantitative

Lead – Process – Task

- CM panel
- Care plan completion rate
- TCM completion rate
- PCP visits and /or CM touches
- Breast CA or Colon CA screening completion
- HgbA1c test completion
- SDOH screening completion

Lag – Outcome

- Total cost of care
- Clinical outcomes (e.g., B/P control; A1c poor control)
- Health related social needs met
- Depression remission at 12-months
- Changes in risk status or score over time

Qualitative

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

Data Sources

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

Data Sources

EHR (Clinical)

HIE

Payer (Claims)

Patient-Reported

EXCEL - Do it Yourself

Applying Data

Patient Engagement Improvement

- PCP visit completion
- CM visit completion
- % of patients in CM with Patient identified goals
- Movement on patient-identified goals – ie. Act on identified action steps
- Medication refill/compliance

Quality measure improvement

- PCP visit/CM visit completion
- AWV completion rates (ACO)
- Medication refill/compliance
- Patient identified goals
- SDOH needs met

ED/Hospital/Readmission discharge rates

- TCM completion rates
- PCP or CM visits for priority discharge diagnosis (or reason for visit)
- SDOH needs met

Questions and Discussion

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Course 6

Evaluating Success

Module 2

Qualitative Measurement of a Care Management Program

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Objectives

- Define qualitative data.
- Describe methods to collect qualitative data that anyone can use.
- Develop strategies to collect qualitative data that can be immediately implemented in the practice.

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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Value of Qualitative Data

- Tells the story
- Identifies areas to develop quantitative data point
- Resonates to reflect quality of life improvement
- Provides an opportunity to correlate to other quantitative measures – Patient Experience – Provider/Staff Experience

Questions and Discussion

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Course 6

Evaluating Success

Module 3

Outcomes Reporting

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Objectives

- Describe methods of sharing data with various stakeholders in the organization based on their role.
- Develop tactics to demonstrate ROI for care management program that can be easily implemented into the practice.

Data Sharing

Understand the Value statement for team/person you are talking to

- Practice Leaders/C-Suite – Care Management impact on Revenue
  - Billing revenue - CCM, TCM, Educational services
  - Quality measures that impact high-cost areas – ED/Hospital
- Site leads – providers/clinical team: What is important to them
  - Impact on quality measures
  - Patients engage in their care – complete PCP visits, reduce No Shows, Med compliance
  - Efficiencies
- Care Management team: What is important to them?
  - Qualitative data – the stories that show impact on lives
  - Patient-identified goals
  - Quality measures
  - Screening measures

Data Sharing

- Regular data review
- Consider graphing data for those who prefer visual
- Post data in common space in clinic
- Review definitions and how data is captured
- Help them to understand how CM impacts the data and what their role is
- Share best practice examples of the tasks done by CM that lead to data improvement (or change)
- Share data unblinded by Care Manager if feasible – model best practices

Questions and Discussion

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Course 6

Evaluating Success

Module 4

Coaching for Performance

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Objectives

- Identify possible causes of poor ROI in a care management program.
- Develop strategies for interventions and solutions when ROI is not as expected.

Potential causes of poor ROI (performance)

- Lack of clearly defined goals
- Unclear or outdated workflows, roles/responsibilities
- No clear direction to guide task priorities
- Poor integration with the Primary team

Process for Problem Solving

- Define the problem
  - Contributing factors
  - Measure for Baseline
    - What is happening now with data
- Brainstorm for solution (goal)
  - Engage those who do the work
- Develop optional action steps
- Implement action steps
  - Consider PDSA
- Review progress and celebrate or adapt

Course 6
Bringing It All Together for Effective Care Management

Module 5
Group Case Study Discussions

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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:

- Discuss the case study.
- Identify any additional data that would help clarify (if applicable).
- Based on the information provided develop 2-3 action steps that could lead to a solution for this case study.
- If possible, identify course content that guided your discussion – action step planning.

Group Discussion

Case Study #1: Effective Integration: Value of Care Managers / Care Management

Case Study #2: Defining meaningful Care Management Goals

Case Study #3: Care Manager Task Prioritization

CASE STUDY # 1

EFFECTIVE INTEGRATION: Promoting the Value of Care Managers & Care Management

General: This is a large network (>6 locations) with 2-9 providers at each location; There is also a behavioral health center to serve the population.
Care Management: There is no CM on site currently but are in the process of moving from contracted CCM and ACO CM services to having CM on site – either centralized or dispersed at each location. Currently providers do not value CM services as they do not see a value and feel the outsources services have created more work for them. We will strive to provide CM to all patients (not just the ACO patients). The outsourced CCM has interacted with approximately 3% of the primary care population.

Our current physician leader (CMO) does not have a clear understanding of Care Management and does not see a strong value in care management. The physician leader is somewhat ineffective and not well respected by the provider team. There is no formal leader at each clinic location.
We are concerned with developing a CM program on site without strong support from the primary clinical team.

ACTION STEPS:

1. Educate the CMO – CM/CMO meeting with qualitative stores from CM and data; including CM contacts (at 100%); Data that supports patient support as well as revenue
2. Engage with CEO
3. Promote the value of CM at each location – huddles, nurse meetings (tell stories);
4. Consider building a provider lead at each location;
5. Share your vision – Offering every patient Care Management

CASE STUDY # 2

CM Measures of Success: DEFINING MEANINGFUL CARE MANAGEMENT GOALS

General: This is a 5 location FQHC network with medical, dental, mental health and community resources at each location.
There are 2-5 medical providers at each location, .5-2 mental health providers and 1-2 CM members (including some BH CM) at each location.

Payor: We are a part of an ACO network (ACO REACH) and are struggling with how we define appropriate measures of success for our care management team.

Measures: The CM Leader is struggling to identify clearly defined measures across the Care Management team (including BH) and a measure specific to each location.
The ACO has identified the following measures for us to focus on:

- AWV completion
- Reduce ED / Hospital use

We have worked to improve our AWV completion, but patients seem to no show or refuse to schedule following an AWV outreach initiative. No providers see a value in AWV completion so do not promote it.
We know that depression & anxiety contribute to inappropriate ED use and delay in chronic disease care resulting in avoidable hospitalizations.

ACTION STEPS:

1. Identify baseline data – ED/Hospital utilization –clearly define the source of this data
2. Identify patients with high utilization with a focus on patients with medical and BH problems
3. Review data by each location – to identify site specific priority
4. Understand how data comes into each location
5. Confirm when patients are identified & define how they are assigned to a CM
6. Define resources for patients identified.
7. Set goal for AWV completion – value of this to identify contributing factors early
8. Site-specific

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CASE STUDY # 3

Setting Boundaries for CM: Care manager task prioritization

General: We are a 4 location Community Health Center network located in the Midwest. There are 1-3 providers at each location.

Care Management: We have 1 care manager to support all locations. There are more patients than she can effectively manage but at this time we have no funding to expand the CM team. We are primarily Medicaid and grant funded.

Quality Measures: Our Medicaid measures include:

- Depression screening completion
- Breast & Colon CA screen completion
- Hypertension control rates
- Diabetes poor control rates

We do have an opportunity for bonus if we can reduce our ED utilization rate.

How do I guide my CM to prioritize tasks for the population she works with.

ACTION STEPS:

1. Confirm **risk stratification** for higher risk patients – prioritize patients with ≥ 3 ED visits in 6 mos (or 1 yr)
2. Establish an appropriate **CM case load** –
3. Define referral workflow for patients with additional needs – SDOH – community; BH needs – Mental Health
4. Confirm clinical guidelines to empower other team member to complete routine screening

Take Away's & ACTION Steps

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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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Thank You!

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