



NATIONAL ASSOCIATION OF  
Community Health Centers®

# HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

CARE MANAGEMENT ESSENTIALS, POWERED BY



**OFFICE HOURS #2**  
NOVEMBER 1, 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.





# 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

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

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

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

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

**Modules 1- 8, Self-Paced**  
(30 min each)

**Modules 9 – 15, Self-Paced**  
(30 min each)

# Course Content



**HealthTeamWorks**<sup>®</sup>  
Health. Equity. Resilience.

Course Schedule	2023 Dates	Time
<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>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 #3</b>	December 6	11:00 – 11:45 am ET
<b>Live Closing Session</b>	December 13	11:00 – 11:45 am ET



# Care Management Resources



## 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 develop achievable 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

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).

## PAYMENT Reimbursement Tips:

### FQHC Requirements for Medicare Transitional Care Management (TCM)

*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 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
- Hospital 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 skilled nursing (i.e., acute, psychiatric, long-term care, community setting, rehabilitation, or observation status) to a community setting (i.e., home, rest home, assisted living, 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) and 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 condition warrants medical decision making (MDM) of high complexity during the service period (99496) must be seen within seven days of discharge while one whose condition warrants moderately complex 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.

[Care Management Action Guide](#)

[Chronic Care Management Reimbursement Tips](#)

[Transitional Care Management Reimbursement Tips](#)

# ...and MORE!



# Care Management (101) Essentials Office Hour #2



# Care Management Essentials Course Outline

## 15 self-paced, online courses

1. Defining Care Management
2. Identifying Candidates for Care Management
3. Managing the Health of the Population
4. The Role of Maslow's Hierarchy in Care Management
5. Identifying Patients for Episodic Care Management
6. Exchanging Data with Target Facilities
7. Patient Assessment and Documentation for Episodic Care Management
8. Introduction to Processes and Workflows
9. Identifying Patients for Longitudinal Care Management
10. Enrollment, Assessment, and Documentation for Longitudinal Care Management
11. Longitudinal Care Management Processes and Workflows
12. Balancing Panel Size
13. Establishing the Patient Relationship
14. An Introduction to Teach-Back and Motivational Interviewing
15. Collaborative Care Plan Development





# Care Management Essentials: Course Timeline

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Office Hours #3

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

**CM Modules 1-4**  
(approx. 30 min each)

**CM Modules 5-9**

**CM Modules 10-15**



# Essentials of Care Management Discussion

## Opportunity:

- Questions
- Clarifications
- What is working/what is not
- Impact on day-to-day work



# Office Hours Objectives

- Provide the opportunity to ask questions / clarify the Care Management Essentials content
- Facilitate discussion on how to ‘Make it Real’ – taking the CM content and applying it in your day-to-day work
- Engage the group to network and share what has worked & what has not in their Care Manager role



What  
have  
you  
learned?

# Module 1 – 4

## Essentials of Care Management

### Office Hours #1 Discussion

Module 1: Defining Care Management

Module 2: Identifying Candidates for Care Management

Module 3: Managing the Health of the Population

Module 4: Is it *non-compliance* or Maslow's?



# Module 5: Identifying Patients for Episodic Care Management

- Transitions of Care Management – Care Coordination
- Otherwise stable – acute exacerbation
- 4-6 weeks of additional team support
- Defining Episodic Care Management for your population





LET'S TALK



## Questions and Discussion: Identifying Patients for Episodic Care Management?

# Module 6: Exchanging Data with Target Facilities

- Where do your patients go – what are your most frequently used facilities?
  - ER – Hospital – Skilled Nursing
- How is the information shared with your clinic / with care management team?
  - Message with links
  - Log in to a facility-based document/resource
  - Integrated data sharing
  - Health information exchange log-in
  - *FAX*
- Who owns reviewing/acting on discharge notification?

# Value of Care Coordination/Care Transition Management



# Value of Care Coordination/Care Transition Management







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## Questions and Discussion: Exchanging Data with Target Facilities?

# Module 7: Patient Assessment for Episodic Care Management

- Timing of follow-up – 24-48 hrs is recommended; TCM – 2 business days
  - Consider the urgency of their need
- Assess ED/Hospital/SNF stay
  - Reason they went
  - Admission/Discharge Dx -- Key occurrences – Discharge recommendations
  - Medications
  - Social needs / Vulnerabilities
- Outreach
  - Document attempts
  - Connect – Patients view of current health status
  - Pertinent brief assessments
  - Plan of Action
  - Follow-up PCP visit
- Document - Communicate





LET'S TALK



## Questions and Discussion: Patient Assessment for Episodic Care Management?

# Module 8: Introduction to Processes and Workflows

- Understand what resources are available now
- Review who uses them currently – why or why not
- Create the value statement for documenting work
- Identify and engage all that touch the work
- Define the steps
- Review the options
- Define the best practice – sell the why
- PDSA –Plan-Do-Study-Act





LET'S TALK

## Questions and Discussion: Introduction to Processes and Workflows?

# NEXT STEPS: Course Schedule

<b>Course Schedule</b>	<b>2023 Dates</b>	<b>Time</b>
<b>Asynchronous modules 1-3</b>	September 13 – October 3	On your own time - Consider 1-2 modules / week
<b>Office Hours #1</b>	October 4	11:00 – 11:45 am ET
<b>Asynchronous modules 5- 9</b>	October 5 – October 31	On your own
<b>Office Hours #2</b>	November 1	11:00 – 11:45 am ET
<b>Asynchronous modules 10 - 15</b>	November 2 – December 5	On your own
<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



# Connect With Us

**Diane Cardwell**

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# HOW to provide care management?



**STEP 1** Identify or hire a care manager

**STEP 2** Identify high risk patients

**STEP 3** Define care manager-care team interface

**STEP 4** Define services provided as part of care management

**STEP 5** Enroll patients in care management

**STEP 6** Create individualized care plans

**STEP 7** Enhance and expand partnerships

**STEP 8** Document and bill for chronic care management

**STEP 9** Graduate patients from care management

**STEP 10** Measure outcomes





# Step 1: Identify or Hire a Care Manager

Identify staff to serve as the central point of contact for a panel of high-risk patients. These professionals provide one-on-one services to individuals with complex health and often social needs.

An RN often serves in the lead role but other members of the care team (MA, CHW, etc.) can perform many of the care management services within state/license requirements.

When determining the number of care managers needed and which care teams to add them to, consider the volume and care needs of the patient population:

- Empanelment
- Risk Stratification

## Tools & Resources



[Sample Care Manager Job Description](#)



Provide care managers with training on care management and patient self-management. Review national or state training programs available.



## *Step 2:* Identify High Risk Patients

For Chronic Care Management Programs, consider eligibility criteria:

### CCM

Multiple **(two or more) chronic conditions** expected to last at least 12 months or until the patient dies, or places the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.

### CCCM

Multiple **(two or more) complex chronic conditions** expected to last at least 12 months or until the patient dies, or places the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.  
**Complex CCM patient is at a moderate or high medical decision making.**

### PCM

**A qualifying condition** that is expected to last at least 3 months and places the patient at **significant risk of hospitalization**, acute exacerbation/ decompensation, functional decline or death. **PCM patient is at a moderate or high medical decision making.**



## Step 2: Identify High Risk Patients

Pull condition count reports by payor from your EHR or Population Health Management system using conditions included in UDS Table 6A.

Assess whether the patients on the reports have had a qualifying Initiating Visit, including:

- Initial Preventive Physical Examination (IPPE)
- Annual Wellness Visit (AWV)
- Evaluation and Management service (E/M)
- The face-to-face visit included in Transitional Care Management (TCM)

Review lists of identified patients with other care team members and the Primary Care Provider (PCP) to confirm eligibility and the level of medical decision making required.

Diagnostic Category	Applicable ICD-10-CM Code
Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-
Chronic lower respiratory diseases	J40 (count only when code U07.1 is not present), J41- through J44-, J47-
Asthma	J45-
Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)
Hypertension	I10- through I16-, O10-, O11-
Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)



## Step 2: Identify High Risk Patients

The target caseload for an RN care manager varies depending on several factors and is likely to be in the range of **50-150** high-risk patients.

Factors affecting caseload size and complexity include:

- Health center environment
- The care manager's experience
- The clinical and social complexity of patients
- Available social supports
- Target care management outcomes

Evaluate caseload size and manageability on an ongoing basis.

### Tools & Resources



[NACHC Risk Stratification Action Guide](#)



[NACHC Models of Care Action Guide](#)



## *Step 3:* Define Care Manager-Care Team Interface

In addition to the care manager, each patient is assigned to a care team. This includes a designated provider (PCP) who works with the care manager and patient to carry out the patient's individualized care plan.

Determine how, and in what ways, the care manager and care team will work together. Including:

- How often they meet to discuss patient care details
- How they communicate in between face-to-face meetings
- Documentation expectations
- Follow up

### Tools & Resources



[NACHC Care Teams Action Guide](#)



[Checklist, Integrated Care Management](#)



## **Step 4:** **Define Services Provided as Part of Care Management**

A care management program for high-risk patients should ensure comprehensive care plans support chronic disease and prevention needs, as well as mental, social, and environmental factors.

CCM, CCCM, and PCM services focus on the time and resources used to manage patients' health between face-to-face visits

Documentation requirements 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

### **Tools & Resources**



[Care Management Protocol for High-Risk Patients](#)



## Step 5: Enroll Patients in Care Management

Consider enrolling eligible patients in Chronic Care Management, through any of the following methods:

- Warm handoffs from the PCP (or other designated care team member) to the care manager
- The care manager can call, email, or mail a letter indicating that their provider has recommended them for chronic care management.

Consent is obtained during or after the initiating visit and before care management services are provided. Consent can be written or verbal but must be documented in the medical record and:

- Include the availability of care coordination services and applicable cost-sharing.
- Inform the patient that only one practitioner can furnish and be paid for care coordination services during a calendar month.
- Communicate the patient's right to stop care coordination services at any time (effective at the end of the calendar month).
- Provide the patient with permission to consult with relevant specialists.

Track enrolled patients, and their assigned care manager, in the EHR where other care team members can view it

### Tools & Resources



[Sample Internal Referral to CM Form](#)



[Sample Consent Form](#)



# NACHC's Online Learning Hub

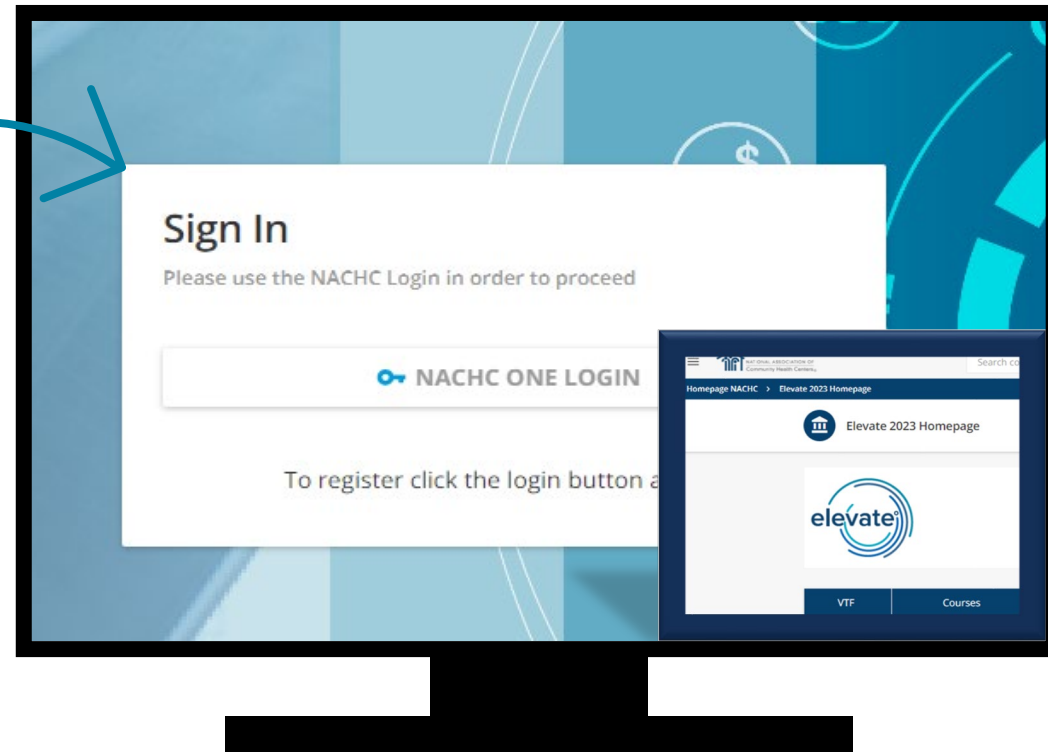
Home page of the Elevate Learning Hub. It features a central 'WELCOME TO THE ELEVATE HOME PAGE' section with a circular diagram showing five steps: ENGAGE, ASSESS, PLAN, TRANSFORM, and REASSESS. Below this, there are several content blocks: 'STEP 1 - ENGAGE' with a 'REGISTER FOR ELEVATE' button; 'STEP 2 - ASSESS' with a 'TAKE THE ASSESSMENT' button; 'Tools and Resources - Quality Center eDirectory'; 'Elevate Forum Series' with a 'CLICK HERE TO REGISTER' button; 'Supplemental Sessions' with a 'CLICK HERE TO REGISTER' button; and 'Health Center Professional Development Program' (highlighted with a red box) with a 'CLICK HERE TO ACCESS' button. A 'Learning Collaborative' section is also visible at the bottom.

A detailed view of the 'Health Center Professional Development Program' card. The card is blue and white, with a red border. It contains the following text: 'Join Elevate's FREE online learning forums' with a 'CLICK HERE TO REGISTER' button; 'Supplemental Sessions' with a 'CLICK HERE TO REGISTER' button; 'Health Center Professional Development Program (content available to registered participants only)' with a 'CLICK HERE TO ACCESS' button; and 'Learning Collaborative' with a 'CLICK HERE TO ACCESS' button. To the right, there are 'Getting Started in Elevate' cards for 'The VTF and Your Transformation Journey' and 'Introduction to the Value Transformation Framework (VTF)'. Below these are 'Tools and Resources' cards for 'Quality Center Resource eDirectory' and 'Tools and Resources'.





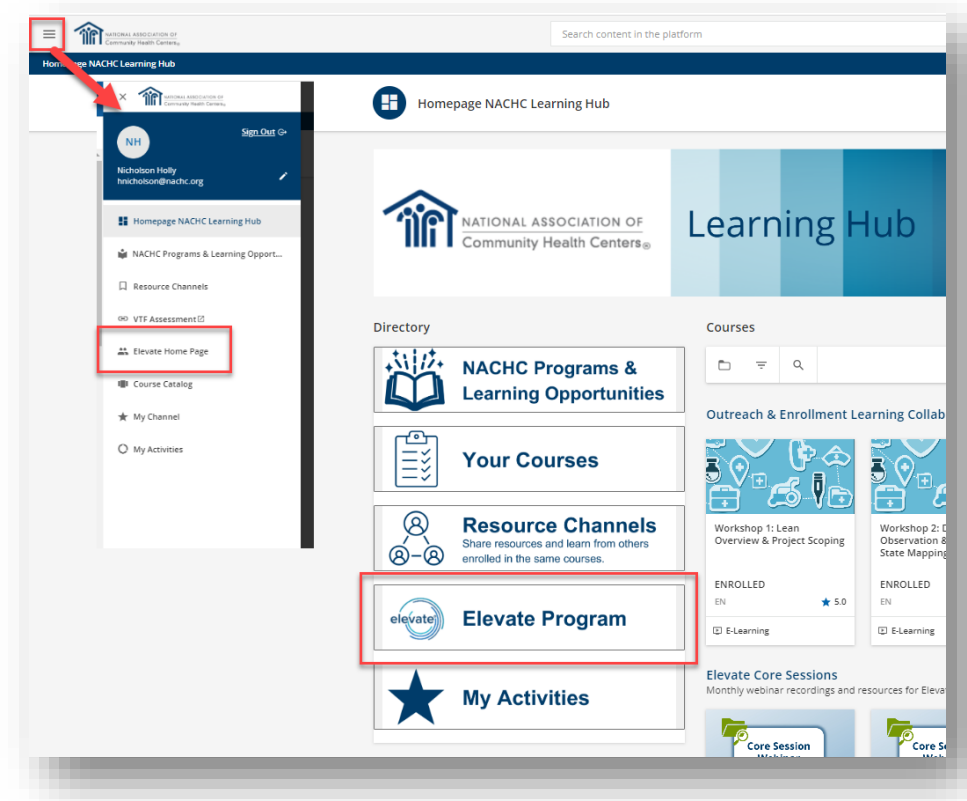
# NACHC's Online Learning Hub



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>





# 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!



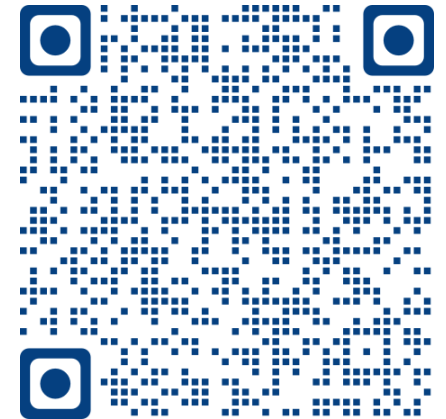
For more information on the VTF Assessment, review the [Action Brief: Assess Transformation Progress](#)

# Additional Support



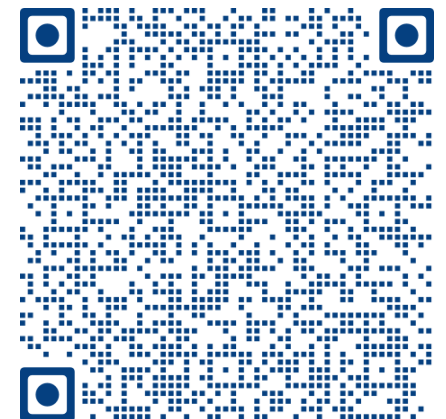
## Solutions Center

- 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)





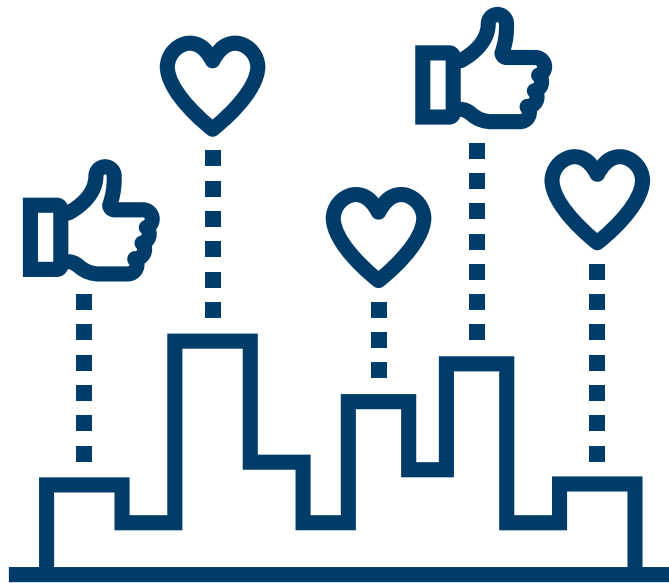
# Wrap-Up

***Thank you!***

Office Hours are available on **Wednesday, December 6<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)



# Provide Us Feedback



# Contact Us!

## The NACHC Quality Center team is here to help!

Questions on how to access online content? VTF Assessment?

Contact [QualityCenter@NACHC.org](mailto:QualityCenter@NACHC.org)



# Thank You!

