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

Course: September 13, 2023 – December 13, 2023

- ✓ Register for Elevate (completed)
- ✓ **Complete VTF Assessment**
- ✓ Block calendar for sessions

Sep 13th
Kick-Off Session

Oct 4th
Office Hours 1

Nov 1st
Office Hours 2

Dec 6th
Office Hours 3

Dec 13th
Closing Session

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

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

Course Content

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Health. Equity. Resilience.

Course Schedule	2023 Dates	Time
Asynchronous Modules 1-8 • Defining Care Management • Identifying Candidates for Care Management • Managing the Health of the Population • The Role of Maslow's Hierarchy in Care Management • Identifying Patients for Episodic Care Management • Exchanging Data with Target Facilities • Patient Assessment and Documentation for Episodic Care Management • Introduction to Processes and Workflows	September 13 – November 1	On your own
Asynchronous Modules 9-15 • Identifying Patients for Longitudinal Care Management • Enrollment, Assessment, and Documentation for Longitudinal Care Management • Longitudinal Care Management Processes and Workflows • Balancing Panel Size • Establishing the Patient Relationship • An Introduction to Teach-Back and Motivational Interviewing • Collaborative Care Plan Development	November 1 – December 13	On your own
Office Hours #3	December 6	11:00 – 11:45 am ET
Live Closing Session	December 13	11:00 – 11:45 am ET

Care Management Resources

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY

INFRASTRUCTURE

CARE MANAGEMENT

WHY Use Care Management with High-Risk Patients?

WHAT Does a High-Risk Care Management

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)

Program Requirements

Patient Eligibility & Consent

PAYMENT Reimbursement Tips:

FQHC Requirements for Medicare Transitional Care Management (TCM)

Program Requirements

Patient Eligibility & Consent

Timeframe & Services

Care Management Action Guide

Chronic Care Management Reimbursement Tips

Transitional Care Management Reimbursement Tips

...and MORE!

Care Management (101) Essentials
Office Hour #2

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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

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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 13th
Kick-Off Session

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

Oct 4th
Office Hours #1

CM Modules 5-9

Nov 1st
Office Hours #2

CM Modules 10–15

Dec 6th
Office Hours #3

Dec 13th
Closing Session

Essentials of Care Management Discussion

Opportunity:

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

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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

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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?

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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

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Questions and Discussion: Identifying Patients for Episodic Care Management?

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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?

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Value of Care Coordination/Care Transition Management

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Value of Care Coordination/Care Transition Management

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Questions and Discussion: Exchanging Data with Target Facilitities?

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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

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Questions and Discussion: Patient Assessment for Episodic Care Management?

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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

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Questions and Discussion: Introduction to Processes and Workflows?

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NEXT STEPS: Course Schedule

Course Schedule	2023 Dates	Time
Asynchronous modules 1-3	September 13 – October 3	On your own time - Consider 1-2 modules / week
Office Hours #1	October 4	11:00 – 11:45 am ET
Asynchronous modules 5- 9	October 5 – October 31	On your own
Office Hours #2	November 1	11:00 – 11:45 am ET
Asynchronous modules 10 - 15	November 2 – December 5	On your own
Office Hours #3	December 6	11:00 – 11:45 am ET
Live Closing Session	December 13	11:00 – 11:45 am ET

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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

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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

www.nachc.org

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NACHC's Online Learning Hub

WELCOME TO THE ELEVATE HOME PAGE

STEP 1 - ENGAGE
Participate in the health center learning community
REGISTER FOR ELEVATE

STEP 2 - ASSESS
Transformation progress using the VTF Assessment
TAKE THE ASSESSMENT

Tools and Resources - Quality Center eDirectory
Included Resources: Action Guides, Action Briefs, Reimbursement Tip Sheets, Fact Sheets and more!
CLICK HERE TO ACCESS

Elevate Forum Series
Join Elevate's FREE online learning forums
CLICK HERE TO REGISTER

Supplemental Sessions
Register for supplemental learning opportunities
CLICK HERE TO REGISTER

Health Center Professional Development Program
(content available to registered participants only)
CLICK HERE TO ACCESS

Learning Collaborative
Health Center Outreach and Enrollment Staff (Private Group)
CLICK HERE TO ACCESS

Getting Started in Elevate
Introductory courses for Elevate Participants - Value Transformation Framework (VTF) and Elevate

- The VTF and Your Transformation Journey — ENROLLED — EN | 10m 00s — E-Learning
- Introduction to the Value Transformation Framework (VTF) — ENROLLED — EN | 10h 00m — E-Learning

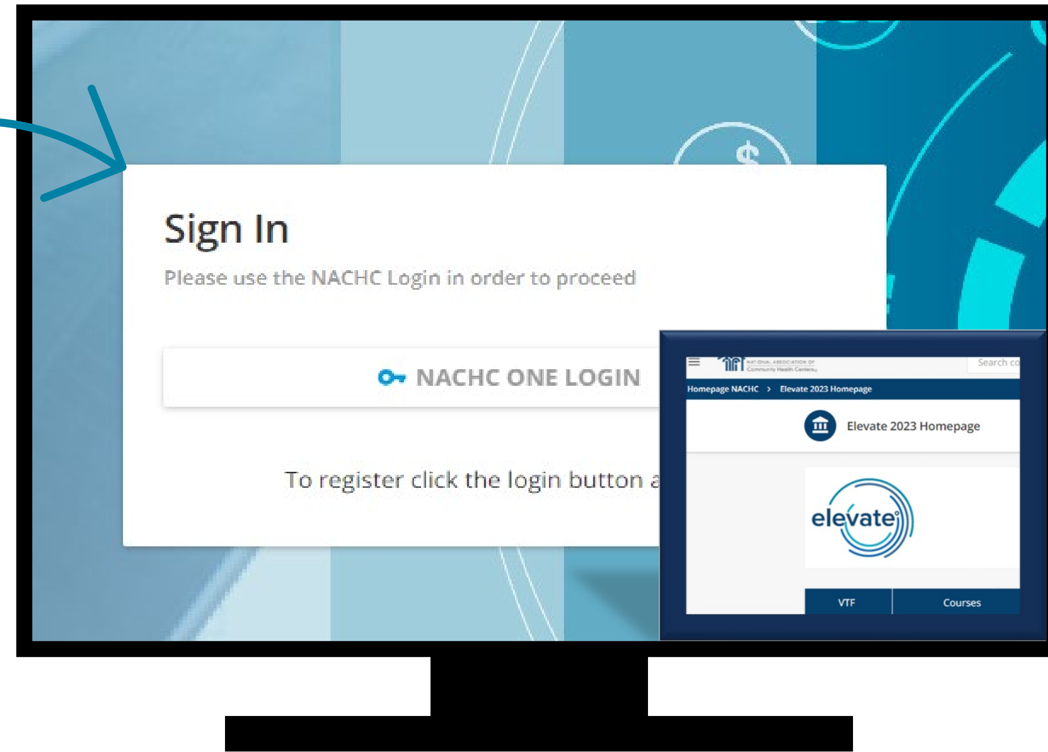
Tools and Resources
Resources for Elevate participants - Action Guides, Reimbursement Guides, etc.

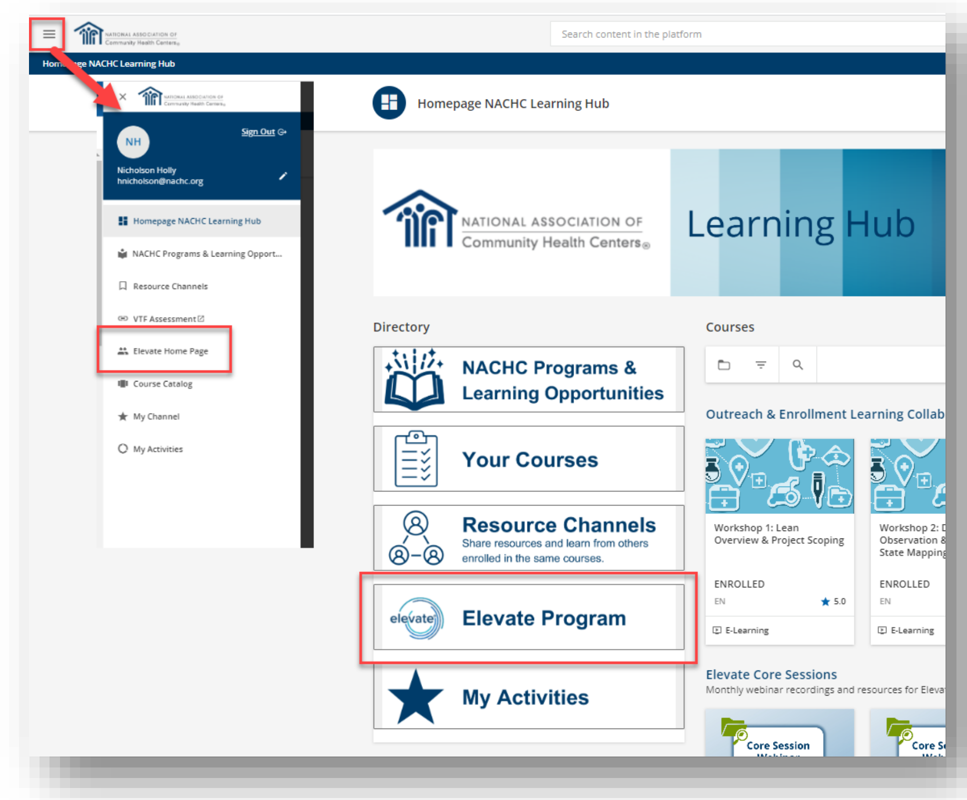
- Quality Center Resource eDirectory - Collection of resources that support... — ENROLLED — EN — E-Learning

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

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Complete the VTF Assessment

Health centers are required to complete the VTF Assessment for course participation… WHY?

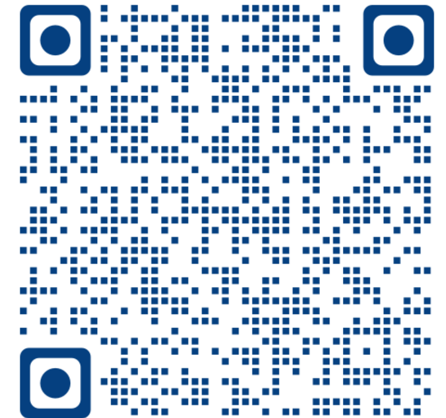
The VTF Assessment enables health centers to measure progress in areas important to value transformation.

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

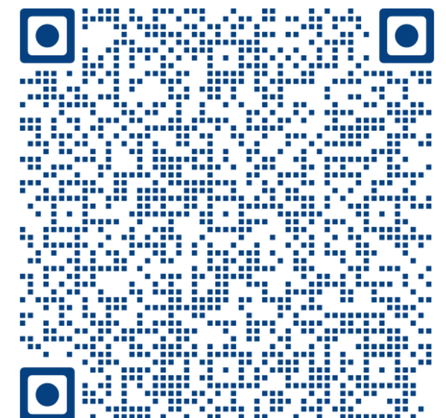
Additional Support

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

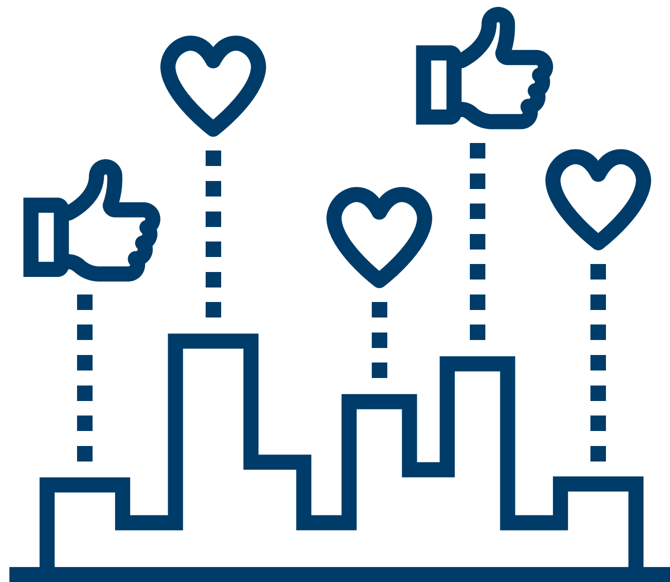
Wrap-Up

Thank you!

Office Hours are available on **Wednesday, December 6th 11:00 am – 11:45 am ET**

Questions regarding course content? Contact caremanagement_nachc@healthteamworks.org

Questions on how to access course modules on NACHC's learning forum? VTF Assessment? Contact **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**

Thank You!

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