NATIONAL ASSOCIATION OF Community Health Centers®

HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

CARE MANAGEMENT ESSENTIALS, POWERED BY HealthTeamWorks® Health. Equity. Resilience.

OFFICE HOURS #3
DECEMBER 6, 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.

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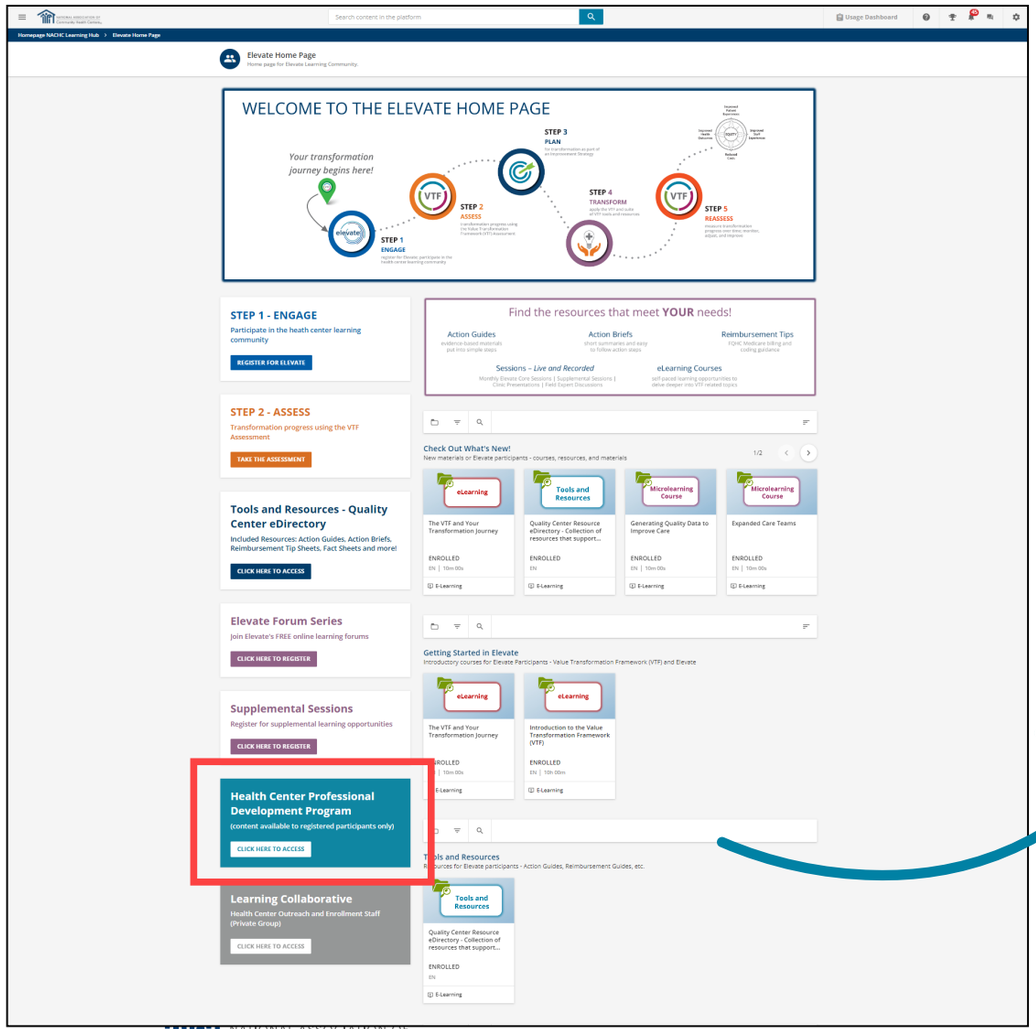
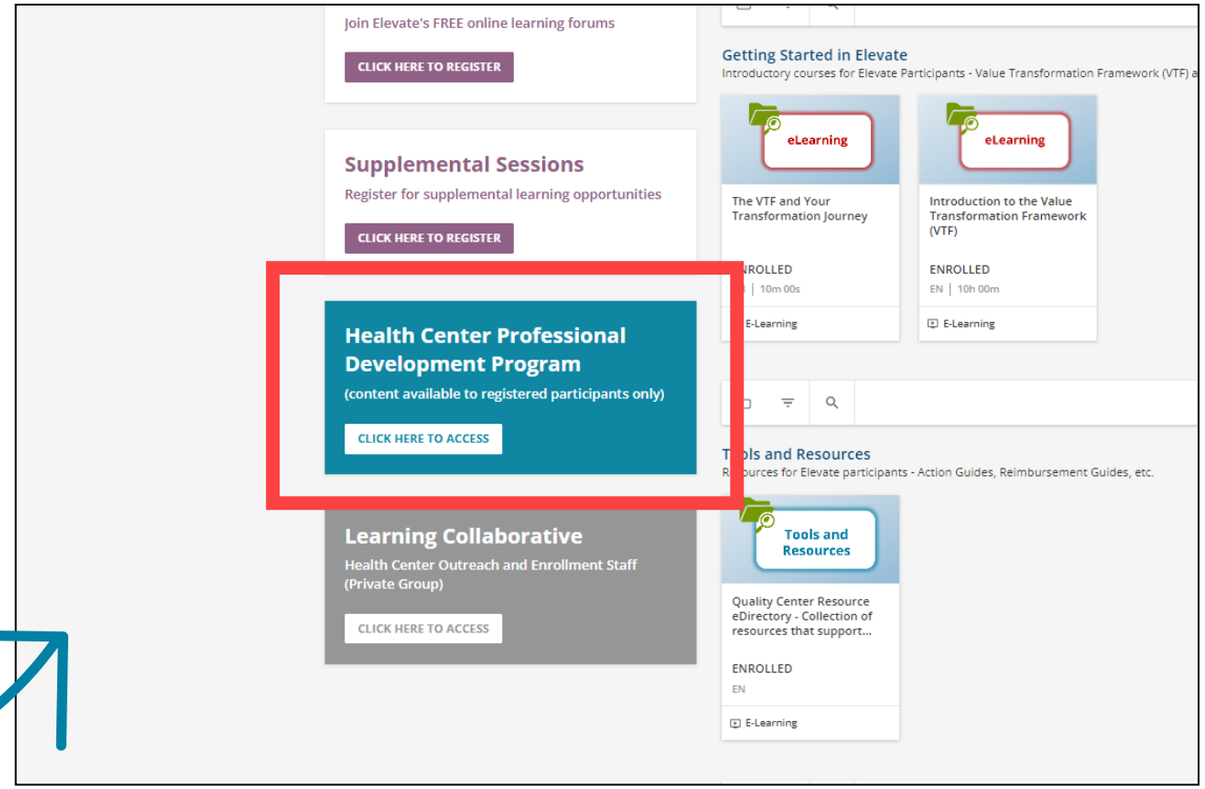
NACHC's Online Learning Hub





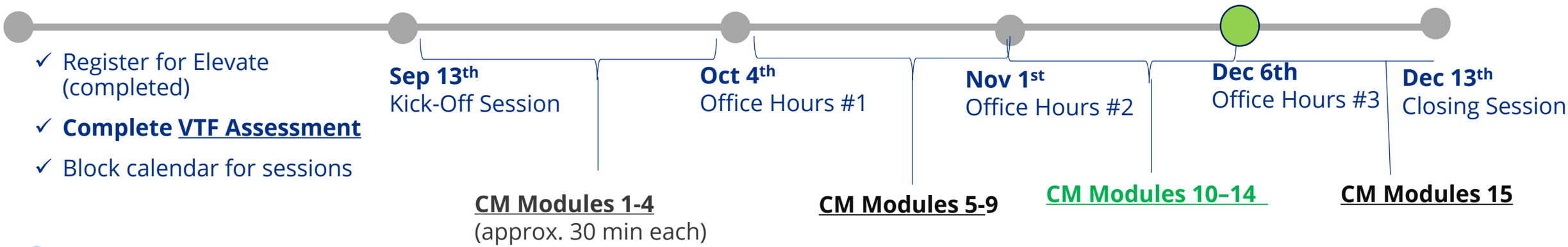
Care Management (101) Essentials
Office Hour #3

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



Care Management Essentials Course Content

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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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

Office Hours #1

Modules 1 – 4 Essentials of Care Management

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?

Office Hours #2

Modules 5 – 9 Essentials of Care Management

Module 5: Identifying Patients for Episodic Care Management

Module 6: Exchanging Data with Target Facilities

Module 7: Patient Assessment and Documentation for Episodic Care Management

Module 8: Introduction to Processes and Workflows

Module 9: Identifying Patients for Longitudinal Care Management

Module 10
Enrollment, Assessment & Documentation for Longitudinal Care Management

- Initial Outreach:
  - Chart Review
    - ✓ Develop a preliminary priority for the patient
  - Value statement for patient
    - ✓ Health status 0-10
    - ✓ What would improve the status score
- Enrollment:
  - Define the process – confirm how CM is documented across the team, consider panel data capture
  - Communication:
    - ✓ Patient
    - ✓ Team

Module 10
Enrollment, Assessment & Documentation for Longitudinal Care Management

- Assessment:
  - Clearly define priority assessments
  - Define documentation – ensure communication across the team
- Documentation:
  - Ensure consistent documentation fields/ format
  - Define priority data for communication across team
  - Define priority data to capture and ensure documentation in discrete fields

Questions and Discussion: Enrollment, Assessment & Documentation for Longitudinal Care Management?

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Module 11
Processes & Workflows for Longitudinal Care Management

- Define the work / core expectations for Care Management
  - Identifying patients
  - Outreach to patients
  - Chart review
  - Assessment
  - Care plan
  - Documentation

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PROCESS PURPOSE:

The purpose of this PROCESS is to outline the steps taken to identify patients for care management.

IDENTIFYING PATIENT ELIGIBLE FOR CARE MANAGEMENT

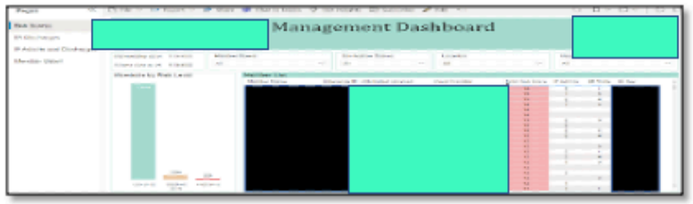
1. Refer to the Care Management Patient Identification decision table below:

If....	Then....
CM reviews CM Risk Stratification Power BI Dashboard	Patients with risk scores of 8 and above can be engaged in CM per standing order. Proceed to **"CM Identifying Patients Eligible for Care Management Based on Standing Order Criteria"** Step 1.
CM identifies a patient who does not meet risk score criteria, but CM believes they would benefit from CM	Proceed to **"CM Identifying Patients Eligible for Care Management Based on Standing Order Criteria"** Step 4.
Provider identifies a patient who does not meet risk score criteria, but provider believes they would benefit from CM	Provider enters CM Referral order for CM to engage patient in CM. Proceed to **"Patients Identified for Care Management Based on Provider Referral"**
Other Care Team members (BHC, HC, CDE, CGA, etc.) identifies a patient they believe would benefit from CM	Team member initiates conversation with CM in weekly CM Huddle, or Team member creates Patient Case. Proceed to **"~~CM~~ Identifying Patients Eligible for Care Management Based on Standing Order Criteria "** Step 4.

CM IDENTIFYING PATIENTS ELIGIBLE FOR CARE MANAGEMENT BASED ON STANDING ORDER CRITERIA

1. Open Power BI and review the Risk Scores page within the Risk Stratification Dashboard to identify patients eligible for Care Management.

   NOTE: The Risk Stratification Dashboard refreshes nightly so the most up-to-date information will be in the list obtained from Power BI directly.



2. Identify the patients with a risk score of 8 and above on the Risk Stratification Dashboard.

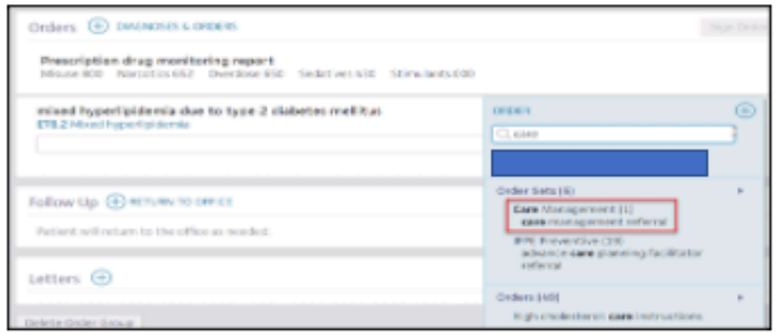
   NOTE: From time to time, the upper and lower Risk Scores to determine patient eligibility for Care Management may be adjusted based on Spira Care patient population needs, public health events, staffing, and other factors. Regularly confirm the Risk Score range in use.

3. Review each eligible member's risk score information to understand the factors contributing to the score. This will inform the outreach you may perform to attempt to enroll the patient in Care Management.
4. Access patient chart in Athena.
5. Perform Plan Coverage Eligibility Check. (See *Checking Member Eligibility SOP*)
   a. If active, continue.
   b. If inactive, no further action needed, you have completed the steps of this SOP.

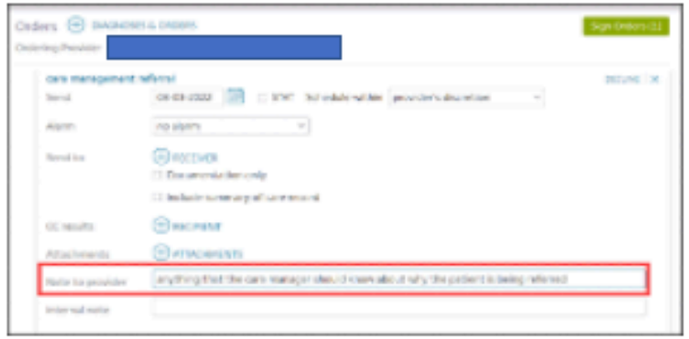
6. Enter a Referral to Care Management from within the Assessment and Plan (A/P) under Orders.
7. Select any diagnosis from patient problem list.

   NOTE: Upon selecting a diagnosis, related resources will automatically appear, delete any diagnosis related resources that are not applicable at this time.

8. Add order under diagnosis by typing in "care" under the appropriate diagnosis.
9. The order set for "Care Management Referral" will appear.
10. Select the "Care Management Referral" order set.



11. In the Note to Provider field add any key additional information regarding CM eligibility.



NOTE: The care manager will have access to the patient chart and provider notes but providing additional context in the referral is helpful.

12. Sign the order.

Questions and Discussion:
Processes & Workflows for Longitudinal Care Management

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Module 12
Balancing Panel Size

- Define priorities
- Consider utilization and payment opportunities
- Consider non – CM expectations
- Experienced CM vs New to role

Discussion Points That Impact CM Panel

- Care Management GOALS
- Complex patients that impact Alternative Payment Model Success
- Complexity of patient population
- Understanding the work that you do

Questions and Discussion: Balancing Panel Size

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Module 13
Establishing the Patient Relationship

- Building rapport with patient
- Engaging the patient
- Patient activation – meeting them where they are at
- Impact of Maslow's hierarchy of needs
- Patient driven care management

Building Rapport

- What is going on in your life?
- What is important to the patient?
  - How do you view your health status on a scale of 1-10?
  - What would improve the health status – from a 4 to a 5?
  - What do they feel they can do to improve their health?
- Take the time to know their story and what is important to them.

Questions and Discussion: Establishing the Patient Relationship

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Module 14
Intro to Teach Back and Motivational Interviewing

- Teach back technique / Reflective listening
- Open Ended Questions
- MI – Assist the patient with their ability to change
  - ✓ Change Talk – Skills – Principles – Spirit
  - ✓ **R**esist the Righting Reflex
  - ✓ **U**nderstand their motivation
  - ✓ **L**isten to the patient
  - ✓ **E**mpower the patient

Questions and Discussion:
Intro to Teach Back and Motivational Interviewing

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Module 15: Collaborative Care Planning

- Engage the patient
- Understand the priorities and abilities
- Uncover the obstacles
- Use SMART Goals
- Measure for success

Questions and Discussion: Collaborative Care Planning

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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

Connect With Us

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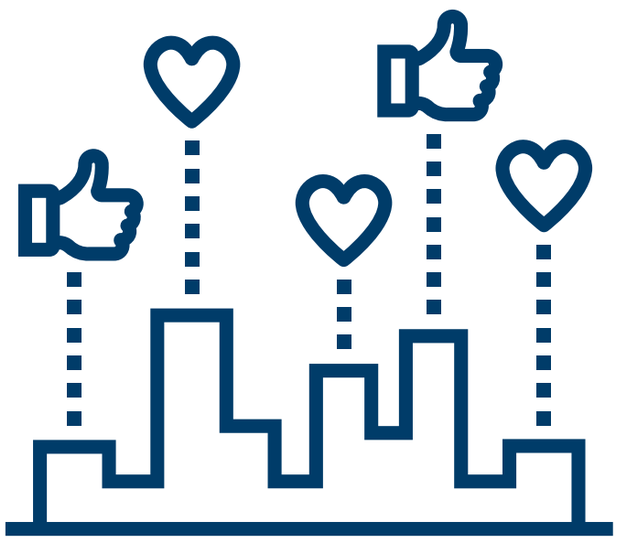

Provide Us Feedback

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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