Care Management Toolkit for Health Centers

This toolkit is meant to help health center staff develop, improve, and measure the success of their care management programs.

Health Center Association of Nebraska
HCAN

www.hcanebraska.org

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Overview

This toolkit is designed to support your health center in developing and implementing an effective care management program.

The resources included are intended to be customized and scaled to fit unique health center environments.

Follow along with the information in this toolkit to build a sustainable care management program that advances health access, improves quality of care, and reduces avoidable healthcare costs.

Program Development

Care management refers to activities you and your team perform to coordinate patient care across the health care system. Successful care management programs increase patient satisfaction, improve outcomes, and reducing costs to the health care system by avoiding unnecessary hospital and emergency department utilization. This page outlines 10 steps for starting a care management program, adapted from NACHC.

Follow these steps to design or review your care management program. A similar approach can be utilized for case management and care coordination programs.

10 Steps For Starting a Care Management Program

Step 1: Identify or Hire a Care Manager

This staff member will serve as the central point of contact for a panel of patients and will manage the individual care plans of each patient in their panel. See "Who to Hire" on Page 2.

Step 2: Identify Patients

Identify a group of patients within the health center's patient population to enroll in care management services. Risk stratification is used to select a manageable group of pations based on the size of your health center and the number of care managers.

Step 3: Define how your Care Team Works Together

Define how and when a patient's care management and primary care provider collaborate as a team.

Step 4: Define the Services Provided

Create a care management program for patients that is modeled after CMS's reimbursable CCM services. Outline key duties and responsibilities, documentation requirements and processes, and associated workflows for care managers. Consider requirements around patient consent and provider communications.

Step 5: Enroll Patients in Care Management

Establish processes to refer, introduce, and onboard patients into care management.

Step 6: Create Individualized Care Plans

Develop and document personalized care plans by the care manager, in collaboration with the provider and patient.

Step 7: Enhance & Expand Partnerships

Establish relationships with a continuum of providers and other partners in the community for the referral and care of patients' health, social, and related needs.

Step 8: Document & Bill

Utilize the NextGen care management templates, or create another, to document all billable care management services. Use applicable diagnosis codes for billing. (See page 13)

Step 9: Graduate Patients from Care Management

Establish a process for patients to move out of care management as they reach care plan goals and return to routine care and follow-up.

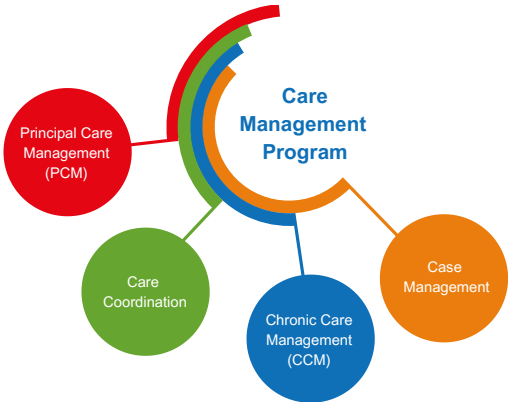
Step 10: Measure Outcomes

Track care management program effectiveness using the measurement tools on Page 15.

Define Your Program

The lines between Care Management, Care Coordination, and Case Management are blurred and confusing. This chart outlines the key differences between each so that you can best plan your health center's care management program.

All of the roles outlined below are key to achieve better patient outcomes, lower costs, improved patient experience, and improved staff satisfaction



Read through the table and consider:

1. How does my CM team match with these roles? Are there any changes we need to make to existing roles?
2. What combination of these roles are needed to build our clinic's ideal CM program? How do we achieve that vision?

Program Title	Principal Care Management (PCM)	Chronic Care Management (CCM)	Care Coordination	Case Management
Who to Hire	RN Recommended	RN Recommended	No requirements, often an RN or other role with supporting protocols such as an MA, CHW, or health navigator	No requirements, often an RN or other role with supporting protocols such as an MA, CHW, or health navigator
Patient Eligibility	For patients with a **single, complex chronic condition**	For patients with **two or more complex chronic conditions**	Any patient identified as needing additional support to manage their care	Any patient identified as needing additional support to manage their care
Tasks might include:	• Assessment & Care Planning • Disease Education • Schedule Appointments, Monitoring & Follow-Up • Coordination and/or Transition of Care • Medication Reconciliation • Support for Self-Management	• Assessment & Care Planning • Disease Education • Schedule Appointments, Monitoring & Follow-Up • Coordination and/or Transition of Care • Medication Reconciliation • Support for Self-Management	• Appointment and Referral Scheduling & Management • Medication Reconciliation Assistance • Results Data Entry • Resource Coordination	• Appointment and Referral Management • Medication Reconciliation Assistance • Patient Advocacy • Review Results & Notify Provider • Patient Outreach for Overdue Screenings
Program Goal	Stabilize the patient's condition and develop a disease-specific care plan	Stabilize the patient's condition and develop a disease-specific care plan	Organize and manage a patient's healthcare activities across multiple providers and settings to ensure safe, effective, and patient-centered care	Improve outcomes, experiences, and value for patients, ensuring they receive necessary support in a coordinated, effective, and efficient manner
Certifications to Consider	N/A	N/A	Certified in Care Coordination and Transition Management (CCCTM)	Certified Case Manager (CCM) Certification
Billing Status	Medicare & Some Private Insurers	Medicare & Some Private Insurers	Not Billable	Not Billable

Identify Your Patients

Risk Stratification

Risk stratification is a strategy that helps divide up the health center's patient population into smaller groups. It is useful to help identify a group of patients to enroll in care management services. Depending on the size of the clinic and the number of care managers, your Care Management program may need to divide patients into a manageable subgroup for initial focus. For example, it may be easier to start with a specific age group or those in need of a certain preventive service. Depending on your patient population, it may be more impactful to focus on patients at a moderate risk level, rather than high. **More information to come on this topic, but feel free to reach out to HCAN for individualized support.**

Download the Risk Stratification Action Guide from NACHC HERE.

Caseload Considerations

The target caseload for a care manager ranges from about 50-150 patients depending on several variables including health center environment, the care manager's experience, the clinical and social complexity of patients, available social supports, and target care management outcomes. Evaluate caseload size and manageability on a monthly basis using the metrics on page 15.

Consent to Treat

If billing, all patients must consent before care management can begin.

- Consent will ensure the patient is engaged and aware of the cost share involved. It only has to be obtained once and it may be verbal or written, but must be documented in the medical record.
- Consent must include:
  - Cost share
  - Explanation that only one practitioner can furnish the service and be paid during a calendar month
  - Explanation that the patient has the right to stop CCM services at any time

Step 1 Provider discusses care management services with a patient during a visit

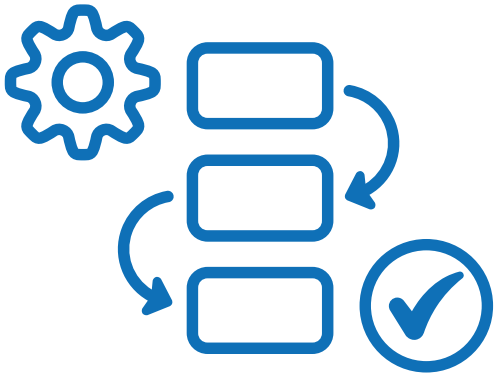
Step 2 Another member of the care team (e.g., nurse, medical assistant, and other staff under direct supervision of the provider) completes the consent process

Step 3 After consenting to the service, any provider (e.g., MD, PA, NP, PharmD., RPh, CSW or qualified support staff with direct supervision from the provider) can provide care management services

Download an example care management consent form from NACHC HERE.

Workflows

The next 5 pages outline several example workflows for different care management scenarios. These workflows can help guide your health center care managers through the various types of support they may need to provide. Read through each of the workflows and consider how they might be utilized in your health center, who would provide the service, and any potential barriers in completing the workflows.



See below for the use case of each sample workflow.

General Care Management Workflow

Use this workflow for patients needing additional support with things like making specialty appointments, resource coordination, or health education. This workflow might be used for patients with a recent diagnosis needing specialty care, patients needing routine preventative screenings, or patients experiencing situations of need.

New Patient PCM & CCM Workflow

Use this workflow for new patients who are eligible for Principal Care Management or Chronic Care Management services.

Existing Patient PCM & CCM Workflow

Use this workflow to progress your existing PCM and CCM patients through the care management program.

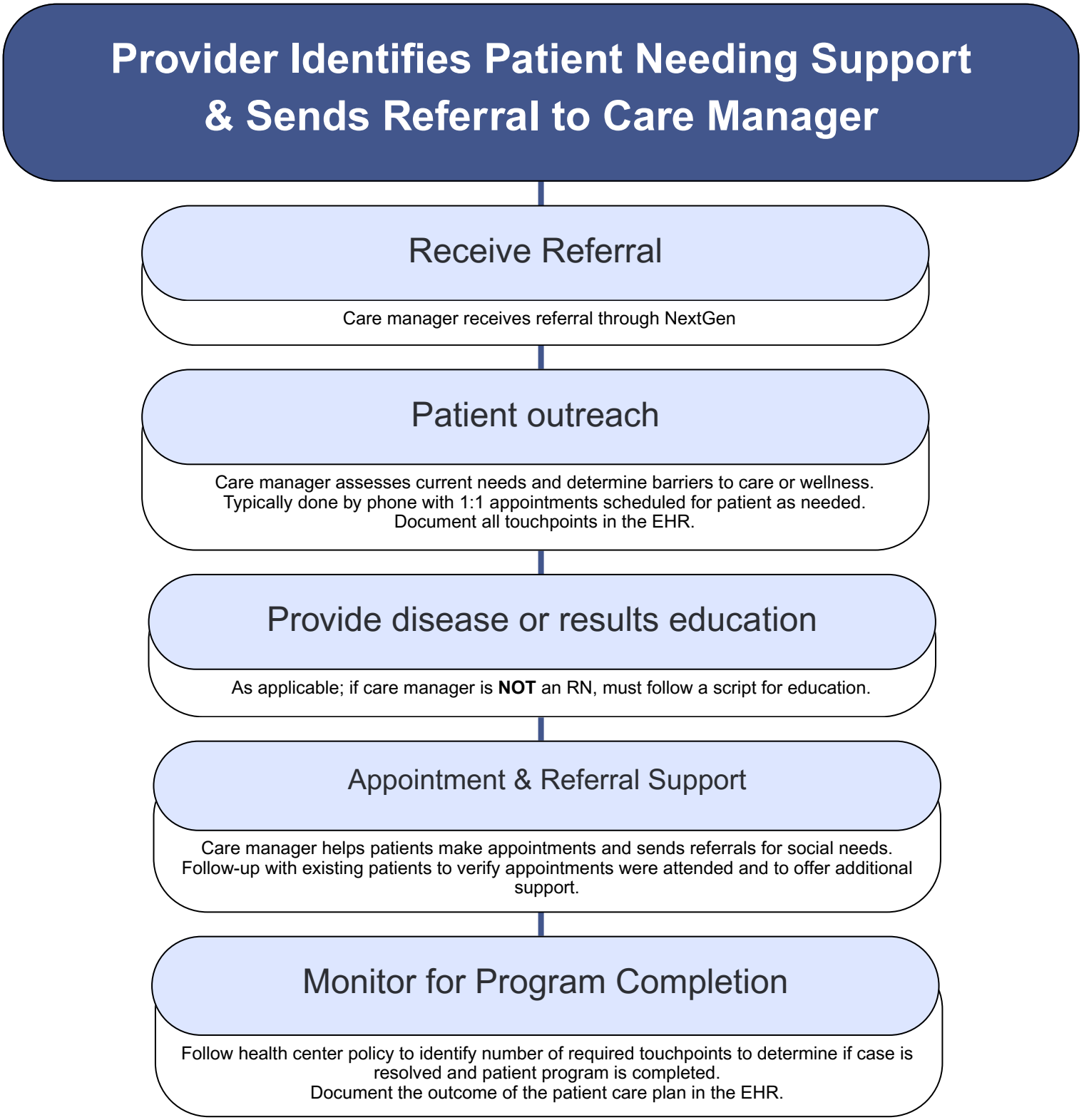
Care Coordination Workflow

Follow these steps for care coordination of patients needing to schedule a specialist follow-up appointment, including monitoring for the outcome of the appointment and notifying the provider when needed.

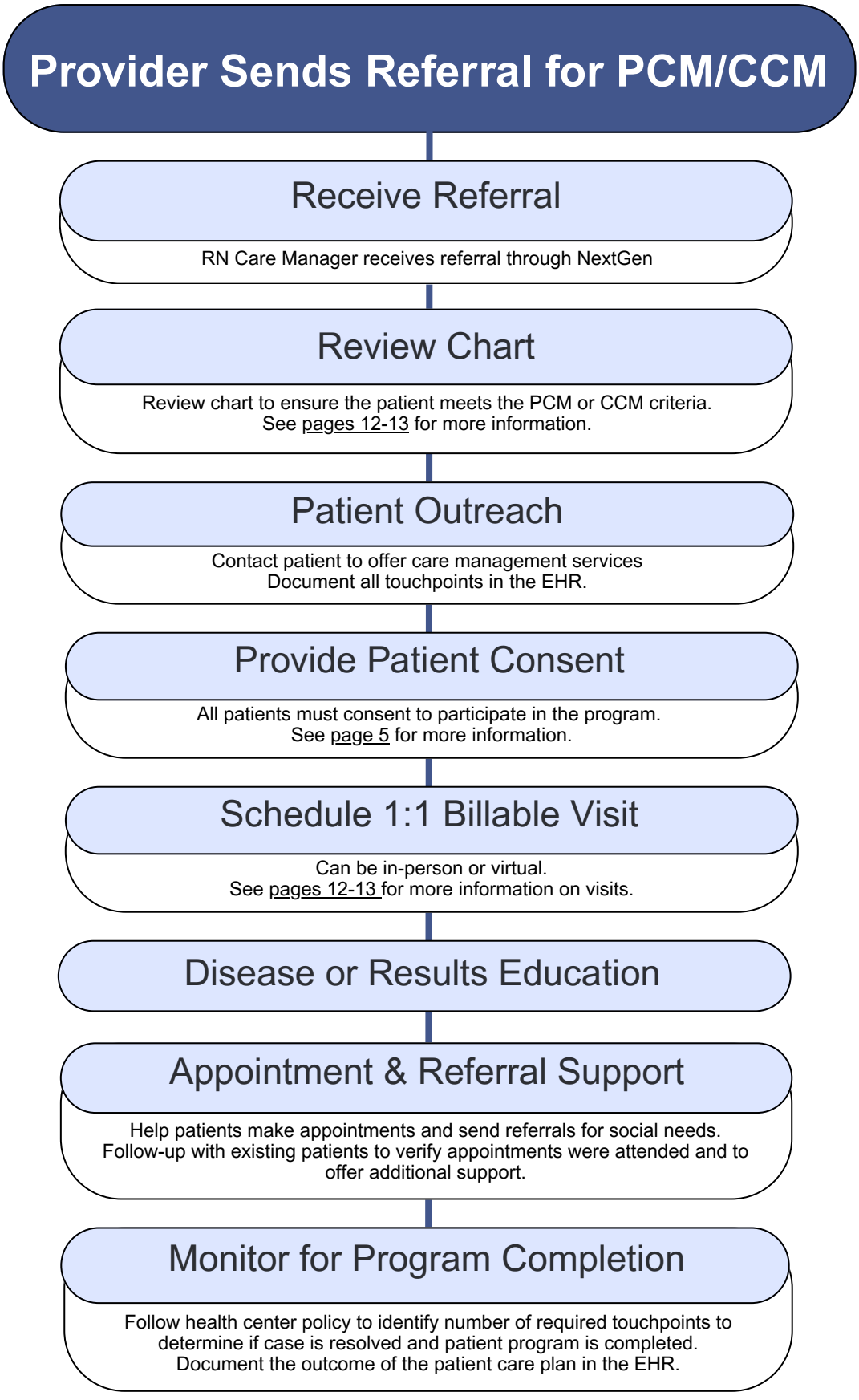
Transition of Care Workflow

Review the workflow and consider which approach you are currently utilizing and if the alternative may be a better fit. Follow this workflow for patients transitioning from the hospital or emergency department visits.

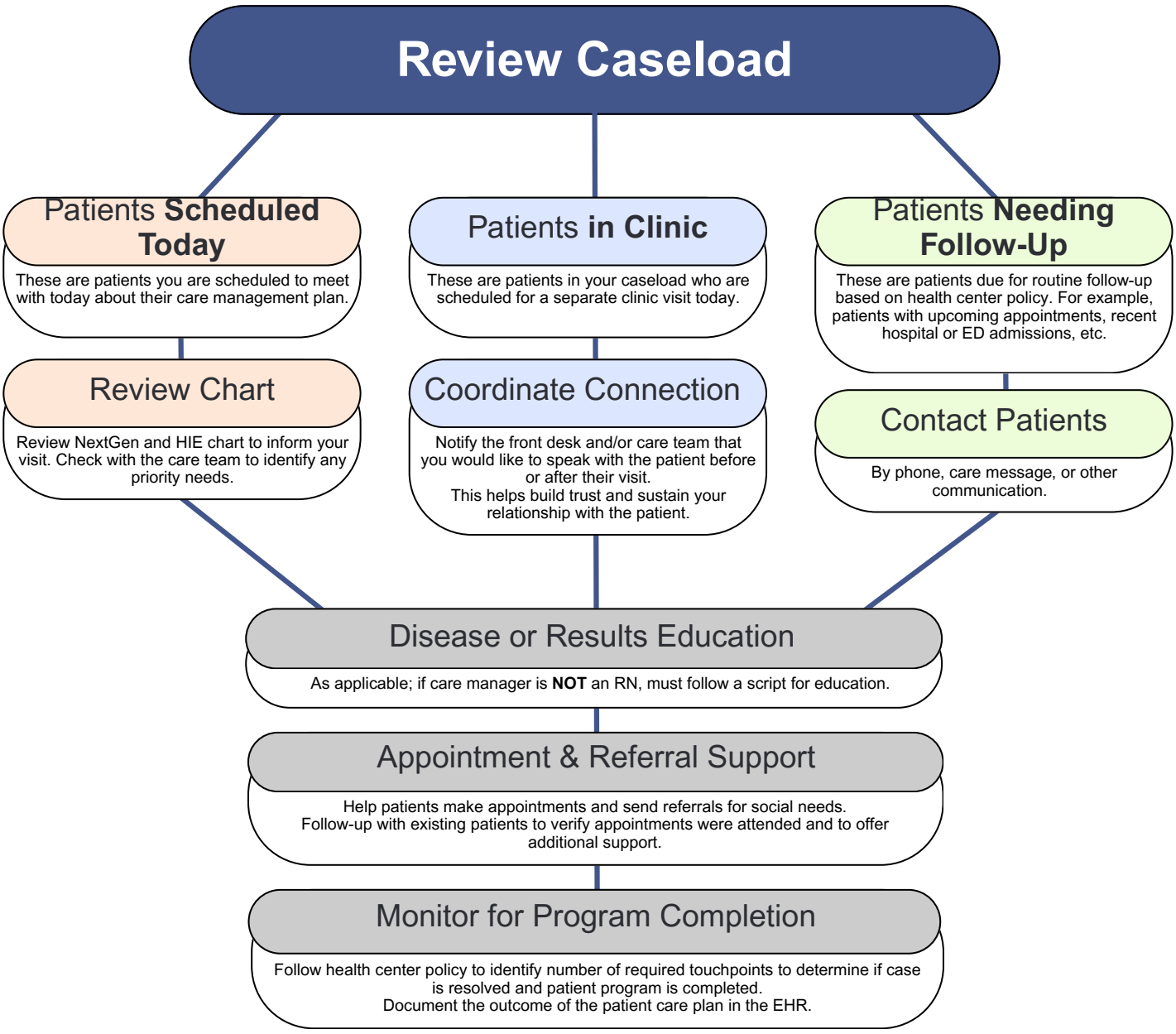
Sample *General Care Management* Workflow



Sample *New Patient PCM & CCM* Workflow



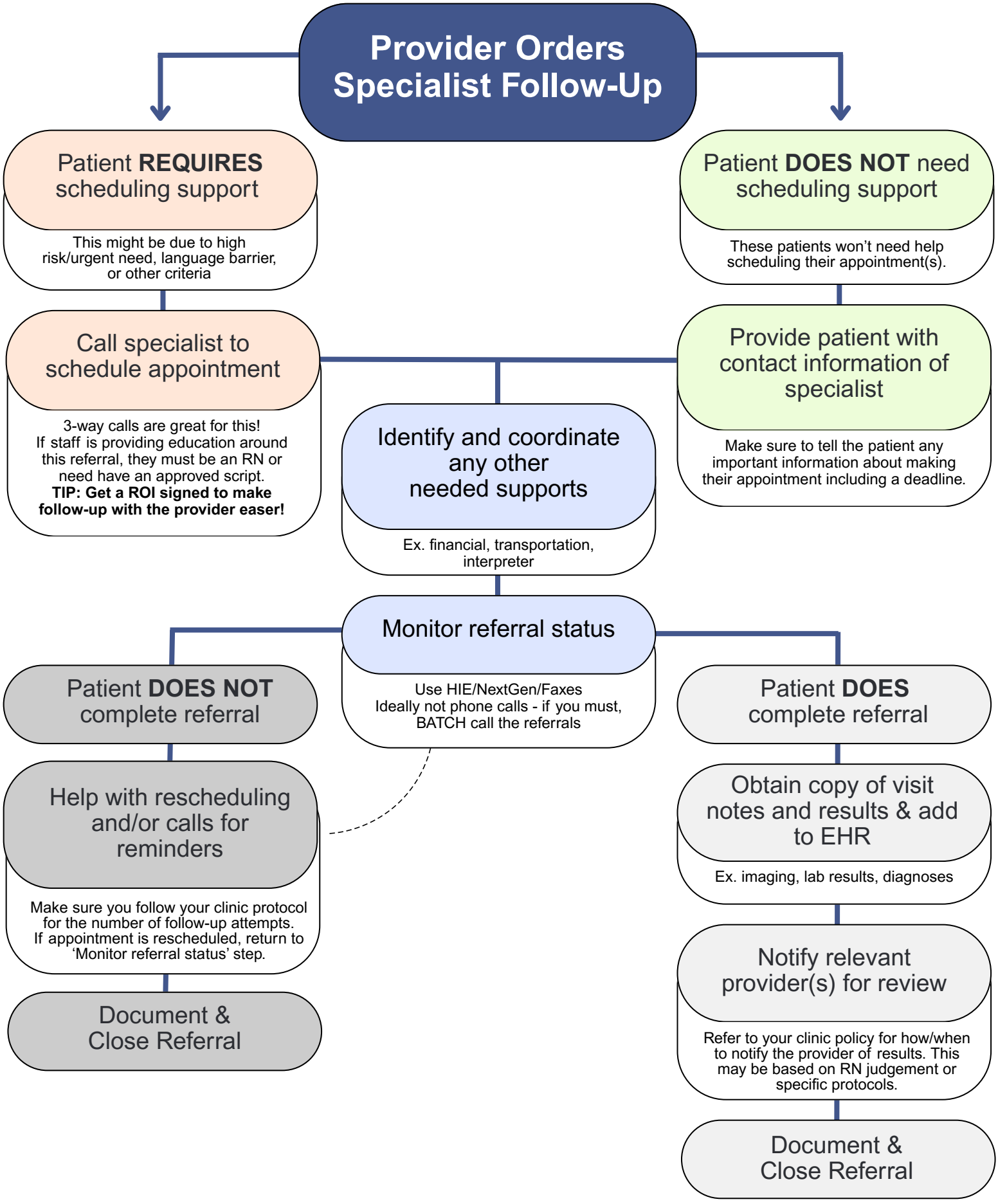
Sample *Existing Patient PCM & CCM* Workflow



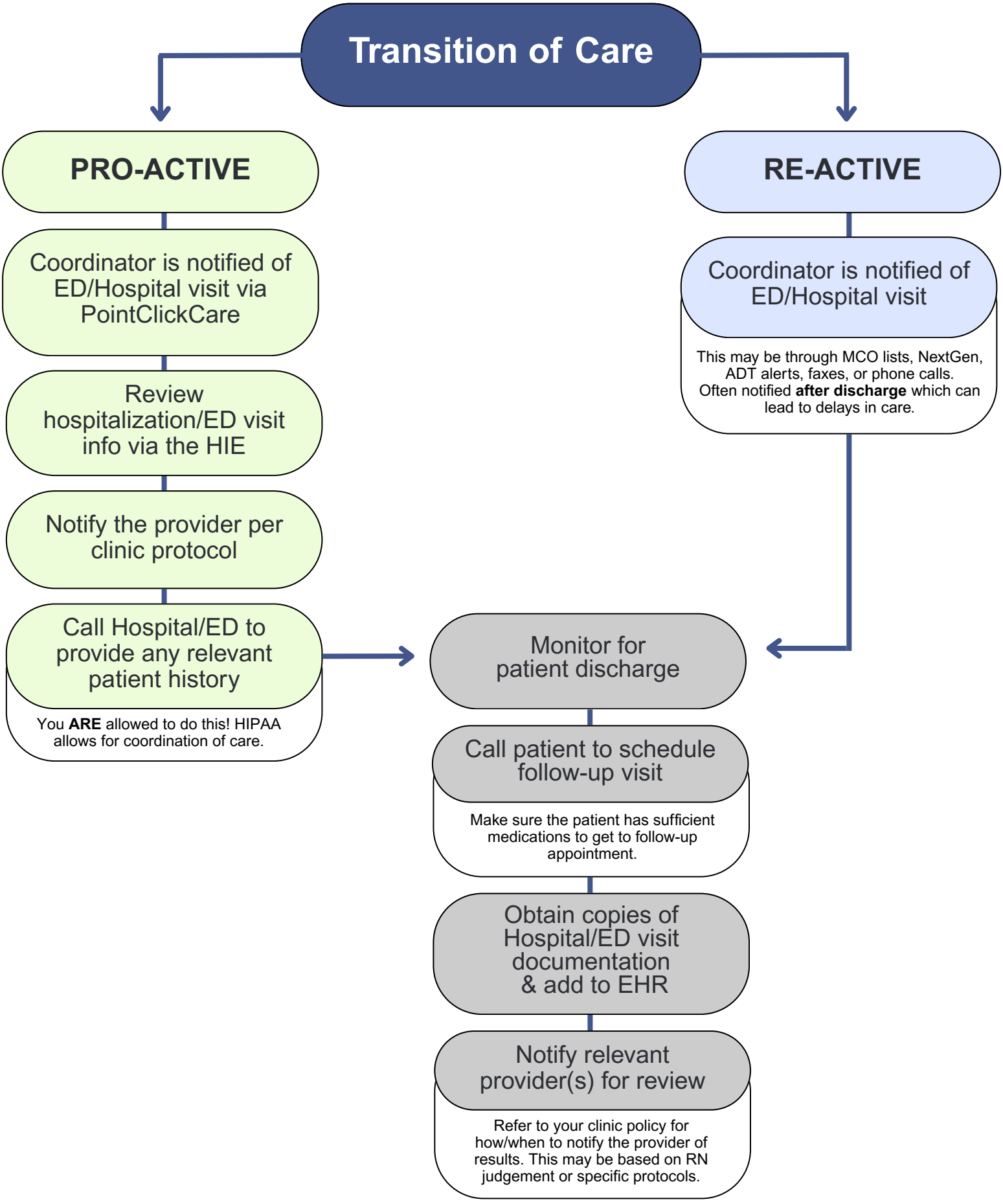
Examples of Chronic Conditions include, but aren't limited to:

- Alzheimer's disease
- Arthritis
- Asthma
- Autism
- Blindness
- Cancer
- Cardiovascular disease
- Deafness or hearing impairment
- Diabetes
- Endometriosis
- Epilepsy
- Fibromyalgia
- Heart disease
- High blood pressure
- HIV / AIDS
- Hypertension
- Migraines
- Obesity
- Psoriasis
- Sickle Cell Anemia
- Sleep apnea
- Thyroid disease
- Tuberculosis

Sample *Care Coordination* Workflow



Sample *Transition of Care* Workflow



Billing for Services

The following pages provide information on the associated billing codes and requirements for Medicare reimbursement of Chronic Care Management and Principal Care Management. Medicare is currently the only public insurance provider offering reimbursement of care management services. Speak with your billing department to ask about requirements and rates for care management services reimbursement of private payers.

Chronic Care Management (CCM) Reimbursement

CCM Billing Criteria:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored

BILLING CODE	DEFINITION
99490	First 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99439	Each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99491	First 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.
99437	Each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service). Report when extensive assessment and care planning outside of the usual effort described by the billed E/M code is performed by the billing provider.

Complex Chronic Care Management Reimbursement

Complex CCM Billing Criteria:

- CCM criteria *AND* moderate or high complexity medical decision making

BILLING CODE	DEFINITION
99487	First 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99489	Each additional 30 minutes of clinical staff)me directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Principal Care Management (PCM) Reimbursement

PCM Billing Criteria:

- One complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- Condition requires development, monitoring, or revision of disease-specific care plan
- Condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities
- Ongoing communication and care coordination between relevant practitioners furnishing care

BILLING CODE	DEFINITION
99424	First 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
99425	Each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99426	First 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month
99427	Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Measure Your Impact

Reviewing data regularly will help you understand if your care management program is working. In the long-term, that data can be used to identify areas for program improvement and to determine program value in terms of cost savings, clinical improvements, or improvements in care.

Use the lists below to help you identify different data points and frequencies to evaluate your care management program.

Are care management staff meeting expectations?

Monthly

Staff capacity:

- How many FTE are currently working in care management?
- How many Care Manager (CM) positions are currently open?
- What is the assigned caseload of each CM?

Staff engagement:

- How many 1:1 patient meetings are scheduled each week?
- How many scheduled 1:1 patient meetings are kept vs. no-show?
- How many virtual touchpoints are completed with patients each week? (Phone calls, text messages, etc.)

Quarterly

Staff satisfaction:

- What is the turnover rate for CM roles?
- How do CM staff perceive their roles? What do they need to feel successful?

Program compliance:

- How many total patients are eligible for CM? Out of that total, how many were referred to CM?
- What proportion of referred patients complete enrollment in CM?
- When a patient is referred to CM, how long is it taking for CM to contact them?
- Do all patients enrolled in CM have a signed consent on file?
- Are patients being contacted for CM services at your clinic's established frequency (weekly, monthly, etc.)?
- For billable CM services, how often is the billing code being entered properly?

Measuring Your Impact

Are patients receiving case management benefiting from the program?

Quarterly

Engagement

- How many total patients are currently enrolled in CM?
- How many total patients were discharged from CM within the measurement period?
- What proportion of discharged patients are due to program completion, program withdrawal, or unable to contact?
- What proportion of enrolled patients have attended more than one CM visit?
- What is the average number of touchpoints per patient for enrolled CM patients?

Disease Management

- Are patients enrolled in CM meeting standards of care for their chronic disease? (i.e. prescribed correct medications, scheduled for correct health screenings, completing lab draws at recommended frequency)
- Are patients enrolled in CM completing recommended preventative health measures? (i.e. attending well-adult visits, completing cancer screenings, etc.)
- Are patients enrolled in CM taking their medications as prescribed?

Utilization:

- Are patients enrolled in CM attending their scheduled primary-care visits? What is the no-show rate within your CM population?
- Are patients enrolled in CM attending their referrals to specialty providers?
- What proportion of patients enrolled in CM had a hospitalization or ED visit within the measurement period?
- Is there any change to frequency of unscheduled acute visits within the measurement period?

Is the clinic seeing a larger impact (ROI) from the case program?

Annually

Financial:

- What is the cost to operate the current care management program? (Staff time, technology needs, etc)
- How many billable visits were completed? What proportion of those were approved and reimbursed?

Clinical Quality:

- Is there any change to applicable UDS measures? (i.e. A1c control, statin therapy, IVD, cancer screenings)
- Is there any change to patient satisfaction as reported by patient satisfaction surveys?

Staff satisfaction:

- How does the clinical team perceive team-based communication?

Care Manager Brain Sheet: Daily Planning

This daily planning tool can be used by care managers to help organize their day and monitor patient progress through the program

First, review your caseload and write in all the CM visits scheduled for the day and any associated notes. Then, review your caseload for any patients with other clinic visits that day and write them in the associated column. You may want to touch base with these patients as your availability allows. Review your hospital/ED admissions list and fill out the corresponding table with admitted patients information. Monitor these patients for discharge and notify providers as needed. Use the F/U List box to list any patients you need to connect with that day.

Download the printable PDF HERE.

Time	Scheduled CM Visits (Top Priority)	CM Patients in Clinic (Meet with as available)
8:00 AM	Pt: Toby F. PCP: Holly NP Reason: CM orientation	Pt: PCP: Reason:
8:30 AM	Pt: PCP: Reason:	Pt: PCP: Reason:
9:00 AM	Pt: PCP: Reason:	Pt: Michael S. PCP: Dr. Lewis Reason: Burn
9:30 AM	Pt: Roy A. PCP: Dr. Palmer Reason: Full Hour!	Pt: PCP: Reason:
10:00 AM	Pt: PCP: Reason: New diabetes, print log template	Pt: Darryl P. PCP: Dr. Nunez Reason: Dental
10:30 AM	Pt: PCP: Reason:	Pt: PCP: Reason:
11:00 AM	Pt: PCP: Reason:	Pt: PCP: Reason:
11:30 AM	Pt: PCP: Reason:	Pt: PCP: Reason:
12:00 PM	Pt: PCP: Reason: LUNCH	Pt: PCP: Reason:
12:30 PM	Pt: PCP: Reason:	Pt: PCP: Reason:
1:00 PM	Pt: PCP: Reason:	Pt: Angela M. PCP: Reason: Psych f/u, *task for BP log*
1:30 PM	Pt: PCP: Reason:	Pt: Stanley R. PCP: Dr. Smith Reason: ED f/u - New meds!
2:00 PM	Pt: PCP: Reason:	Pt: PCP: Reason:
2:30 PM	Pt: PCP: Reason:	Pt: PCP: Reason:
3:00 PM	Pt: PCP: Reason:	Pt: PCP: Reason:
3:30 PM	Pt: PCP: Reason:	Pt: PCP: Reason:
4:00 PM	Pt: PCP: Reason:	Pt: PCP: Reason:
4:30 PM	Pt: PCP: Reason:	Pt: PCP: Reason:

Hospital/ED to Monitor for D/c

Patient	Hosp.	D/c?	Notes
Kelly G.	CHI	Exp. Fri	Baby boy, Dr. Lewis to follow
Erin H.	Kearney Reg	?	Call SW 402-444-4444

F/u List

- ☐ Phyllis V. - f/u mammo
- ☐ Creed B. - d/c? unresponsive
- ☐ Meredith P. - check in call, due for annual visit
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

Notes

Additional Resources

The resources linked below provide additional information on many of the topics covered in this toolkit.

Program Development

What is a Care Manager?
Care Management Framework
Case Management Fact Sheet
Case Management Framework and Guiding Principles
Care Coordination Self Assessment
CMS Chronic Care Management Booklet
NACHC Care Management Action Guide
RN Care Manager Job Description
Chronic Care Management Specialist Job Description
Care Coordinator Job Description
Case Manager Description

Billing

FQHC Care Management Billing and Coding
NACHC CCM Reimbursement Tips
CMS Information for FQHCs

Measuring Your Impact

Case Management and Program Evaluation
HECMA Program Evaluation Rubric
AHRQ Care Management Evaluation

References

American Academy of Family Physicians
National Association of Community Health Centers
ChartSpan
Health and Wellness Medical Services
Case Management Society of America
Centers for Medicare & Medicaid
InFlight Health - Care Management Impact
Agency for Healthcare Research and Quality

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