WACMHC

Washington Association of Community & Migrant Health Centers

Putting PCMH into Practice: A Transformation Series

Care Management & Support (CM)

August 8, 2018

WEBINAR FACILITATOR

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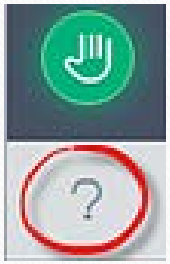
HOUSEKEEPING

- Your lines are currently muted
- We'll address questions at the end of the presentation
- You can ask a question in the following ways:



RAISE YOUR HAND FUNCTION - your line will be unmuted and you can ask the question verbally

QUESTIONS FUNCTION – type your question in the box and the facilitator will read it aloud

- This webinar is being recorded. A recording will be sent to you in a follow-up email.

Care Management & Support (CM) Pre-Work Questions

1. Describe your organization's systematic approach to identifying at-risk patients who may benefit from more intensive services (care management).

2. Which members of the care team at your organization are responsible for care planning tasks for at-risk patients?

2017 NCQA PCMH Standard 4: Care Management and Support (CM)

Advancing Healthcare
Improving Health

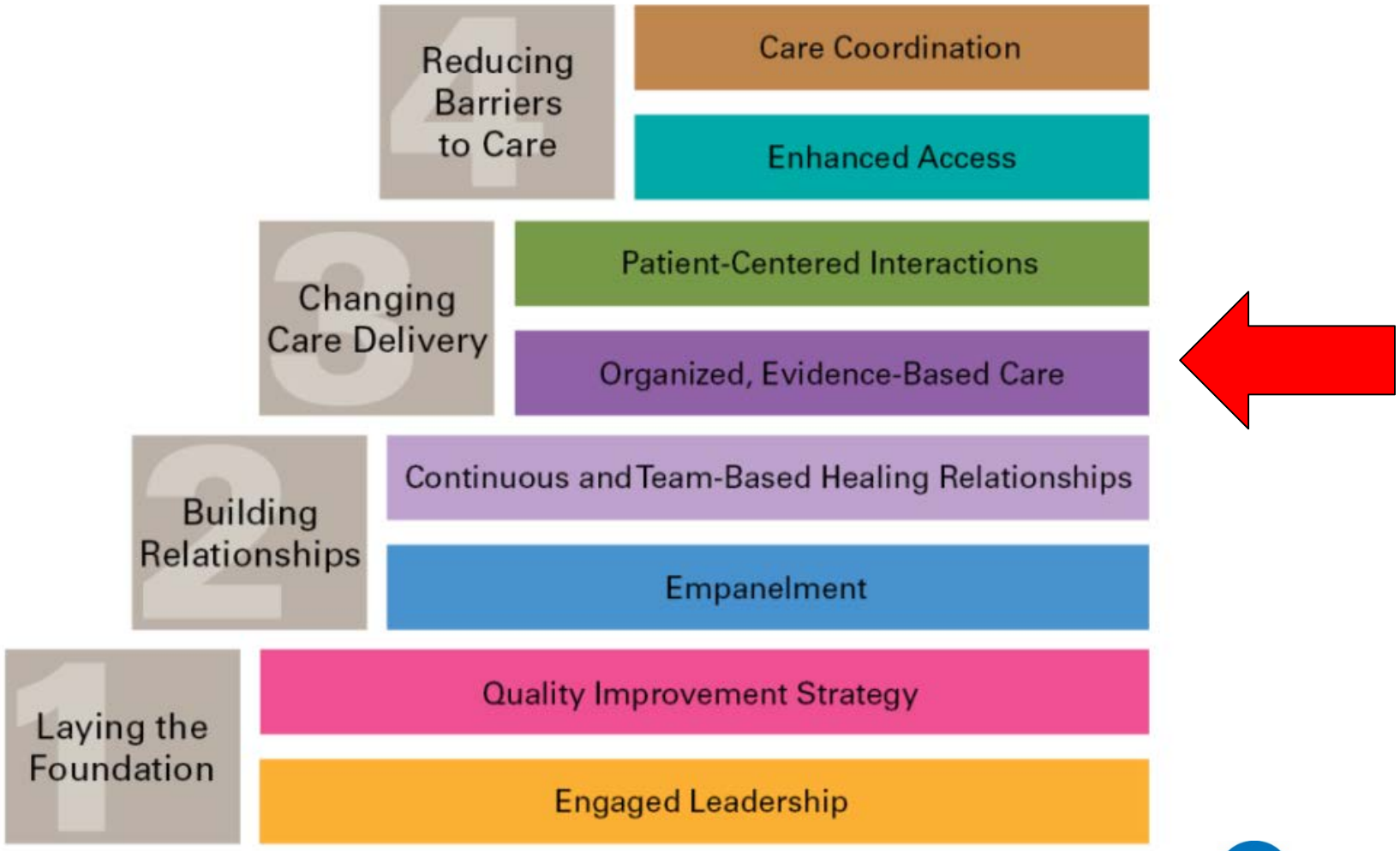
Objectives

- Identify high-risk patients in order to plan, manage, and coordinate patient care for high-risk patients in partnership with patients/families/caregivers
- Consider how to utilize patient information to collaborate with patients/families/caregivers to develop a care plan that addresses barriers and incorporates preferences and lifestyle goals.

6

- Would like to see samples of meeting the concepts (that aligned with 2014 standards)

Change Concepts for Practice



Key Changes for Organized Evidence-Based Care

- Self-management support - Empower and prepare patients to manage their health and health care
- Delivery system design - Ensure the delivery of effective, efficient clinical care and self-management support
- Decision support - Promote clinical care that is consistent with scientific evidence and patient preferences
- Clinical information system - Organize patient and population data to facilitate efficient and effective care
- Community - Mobilize community resources to meet needs of patients


The practice identifies patient needs at the individual and population levels to plan, manage and coordinate patient care in partnership with patients/families/caregivers.

Care Management and Support (CM)

- 2 Competencies
- 9 Criteria
- One criteria requiring a documented process = CM 09 Elective – makes care plan accessible across external care settings


COMPETENCY A
The practice systematically identifies patients who may benefit from care management.

Competency A Criteria

- CM 01 Identifying Patients for Care Management (Core). Aligns with PCMH 2014 4A
- CM 02 Monitoring Patients for Care Management (Core). Aligns with PCMH 2014 4A
- **CM 03 Comprehensive Risk-Stratification Process (Elective 2 Credits)**

Competency A Criteria - CM 01 (Core) Identifying Patients for Care Management

A. Behavioral health conditions.

B. High cost/high utilization.

C. Poorly controlled or complex conditions.

D. Social determinants of health.

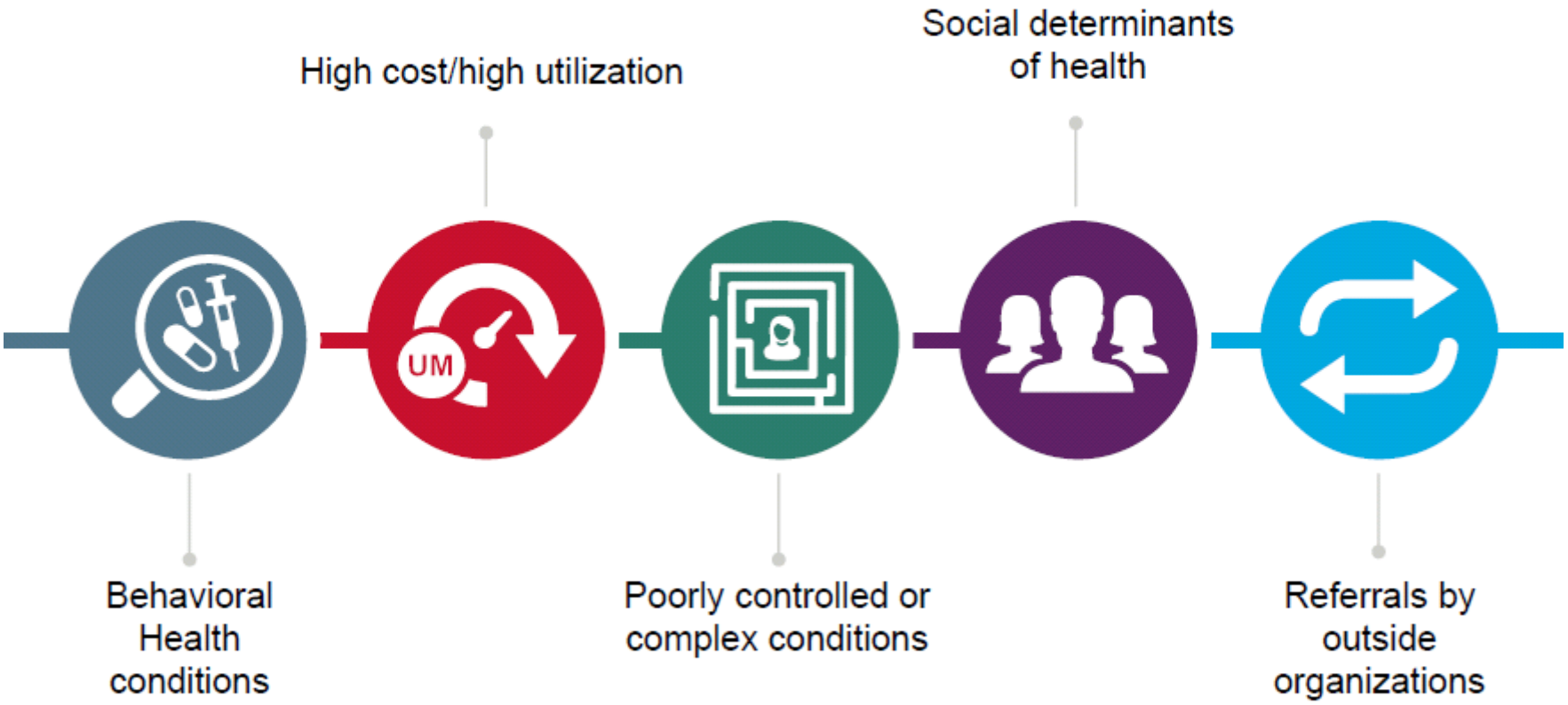
E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/ family/caregiver.

Evidence = Protocol for identifying patients for care management for at least three categories ***OR*** CM03

Care Management and Support

CM 01-02: Core Criteria

- The practice must include at least three categories in its criteria



CM 01 - (t) OR CM 03
CM 02 - (r)

Identifying & Monitoring Patients for Care Mgmt

CM 01: Example

- Behavioral health patients identified – positive PHQ 9
- High utilizers – two or more ER visits in 6 months
- Two or more hospital admissions in past year
- Poorly controlled (multiple co morbidities) – HgbA1C > 9; uncontrolled hypertension
- Social determinants of health – education level < grade 8

Utilizing the criteria outlined above and in our Patient Care Planning and Management protocol, it is determined that 83 patients or 9% of the population serviced at the Ashland center could benefit from care management.

CM 02

Denominator = 893 patients

Numerator = 83 patients

Percentage of patients identified as benefiting from care management = 5%

CM 01

Heartland's primary care teams include a clinician, a medical assistant and a health coach (AmeriCorps member). The care team extends to include a shared behavioral health consultant, psychiatric clinician, referral coordinator, triage nurse, medical records coordinator, and front office representative.

Based on diagnosis and/or health status, patients receive care management as a part of their health support at Heartland. Patients are identified for care management during pre-visit planning in daily huddles.

Factor 1: Behavioral health conditions.

Patients diagnosed with schizophrenia are identified as patients who would benefit from care management.

Patients are identified as having schizophrenia through ICD-10 codes and Heartland is able to run registry reports and maintain lists of all patients who are diagnosed with schizophrenia. Not all patients recommended for care management are subsequently care managed due to other influencing factors

Factor 2: High cost/high utilization.

Patients diagnosed with chronic heart failure with 2+ hospitalizations in the past year are identified as patients who would benefit from care management.

Patients are identified as having chronic heart failure through ICD-10 codes and Heartland is able to run registry reports and maintain lists of all patients who are diagnosed with chronic heart failure. Heartland then drills into this list of patients to see which patients have had 2+ hospitalizations in the past year. Not all patients recommended for care management are subsequently care managed due to other influencing factors.

Factor 3: Poorly controlled or complex conditions.

Patients diagnosed with diabetes whose latest a1c was >9% are identified as patients who would benefit from care management.

Patients are identified as having diabetes through ICD-10 codes and Heartland is able to run reports and maintain lists of all patients who are diagnosed with diabetes whose latest a1c was >9%. Not all patients recommended for care management are subsequently care managed due to other influencing factors.

CM 01 Additional Detail from NCQA

- Question: We receive reports on high utilizers from an external data source which represents 80% of our total population. Could this report on 80% be used to represent data on high utilizers "across the practice", or do we have to figure out another way to gather report on the utilization patterns of the remaining 20% to meet this criteria?

- Answer: Thank you for your question. External data resources must encompass at least 75% of the patient population, so that is acceptable. If you have any further questions please do not hesitate to reach out.

Competency A - CM 02 (Core)
Identifying Patients for Care Management

- Evidence = Report. Patients who fit multiple criteria count once in the numerator; the practice must identify at least 30 patients

- Small practices or satellite sites may share a care management population if less than 30 patients are identified in CM 01

Competency A Criteria - CM 02 (Core) Identifying Patients for Care Management

- The practice determines its subset of patients for care management, based on the patient population and the practice's capacity to provide services
- The practice uses the criteria defined in CM 01 to identify patients for this subset

CM 01 and CM 02

Heartland Community Health Center **PCMH 4A – Identify Patients for Care Management**

Patients who are homeless are identified as patients who would benefit from care management.

Patients are identified as being homeless upon patient intake at Heartland. Health coaches, during the intake, ask about living situation and documents it in structured data. This is updated as the patient's living situation changes. Heartland is able to run registry reports and maintain lists of all patients who are homeless. Not all patients recommended for care management are subsequently care managed due to other influencing factors.

Factor 5: Referrals by outside organizations (e.g., insurers, health systems, ACO), practice staff or patient/family/caregiver.

Heartland accepts referrals from outside organizations, practice staff and/or patient/family/caregiver for care management.

Factor 6: The practice monitors the percentage of the total patient population identified through its process and criteria. (CRITICAL FACTOR)

Percentage of Population Needing Care Management (7.27.16-7.27.17)		
Number of Patients Identified for Care Management	Total Patient Population	% of Patients
287	2918	10%

Care Management and Support

CM 02: Example

Patients Needing Care Management

	Behavioral Health	High Cost/ Utilization	Poor Control/ Complex	Social Determinants of Health	Referrals	Total Patients
Patients in Registry (may be listed more than once)	120	35	200	10	10	375
Unique Patients in Registry	-	-	-	-	-	343
Total Patients in Practice	-	-	-	-	-	3000
Patients Needing Care Management	-	-	-	-	-	11.4% (343 patients)

Competency A - CM 03 (2 Credits) Comprehensive Risk - Stratification Process - ***New***

- The practice demonstrates that it can identify patients who are at high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes
- Practice identifies and directs resources appropriately based on need
- Evidence = Report

CM 03 (Credit) The practice may use it's own method to identify patients who are at high risk in order to meet CM 03 (*AND also meets* CM 01)

Additional Detail from NCQA - CM03

- Question: For CM 03, is there an expectation of a minimum number of criteria (behavioral health, social determinants, multiple chronic conditions, other?) to be considered when a practice is developing their comprehensive risk-stratification process as described in CM 03.

- NCQA's response: NCQA is not prescriptive how the risk stratification is done for their population but the practice must include every patient. For CM03, you need to assign a score for each patient in the practice. The categories in CM 01 do not need to be included but can be considered when assigning a risk score. **If a practice is able to demonstrate CM03 then they would automatically get credit for CM01.** The intent for both is for the practice to be able identify their high-risk/patients in need of care management. CM 03 looks at systems/programs that generate risk stratification for the practice. NCQA is looking for the practice to apply a risk-stratification process to help identify the patients at the highest risk.

COMPETENCY B
For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/ caregivers to develop a care plan that addresses barriers and incorporates patient preferences and lifestyle goals.

Competency B Criteria

- CM 04 Person-Centered Care Plans (Core)
- CM 05 Written Care Plans (Core)
- CM 06 Patient Preferences and Goals (1 Credit)
- CM 07 Patient Barriers to Goals (1 Credit)
- CM 08 Self-Management Plans (1 Credit)
- **CM 09 Care Plan Integration (1 Credit)**

CM 04 (Core)
Person-Centered Care Plans

- Problem list
- Expected outcome/ prognosis
- Treatment goals
- Medication management
- May also address community and/or social services

- A schedule to review and revise the plan, as needed.
- Aligns with PCMH 2014 4B and 4C
- Evidence = Report ***OR*** Record Review Workbook and examples

Competency B - CM 05 (Core)
Written Care Plans

- The practice may tailor the written care plan to accommodate the patient's health literacy and language preference. (i.e., the patient version may use different words or formats from the version used by the practice team).
- Evidence = Report ***OR*** Record

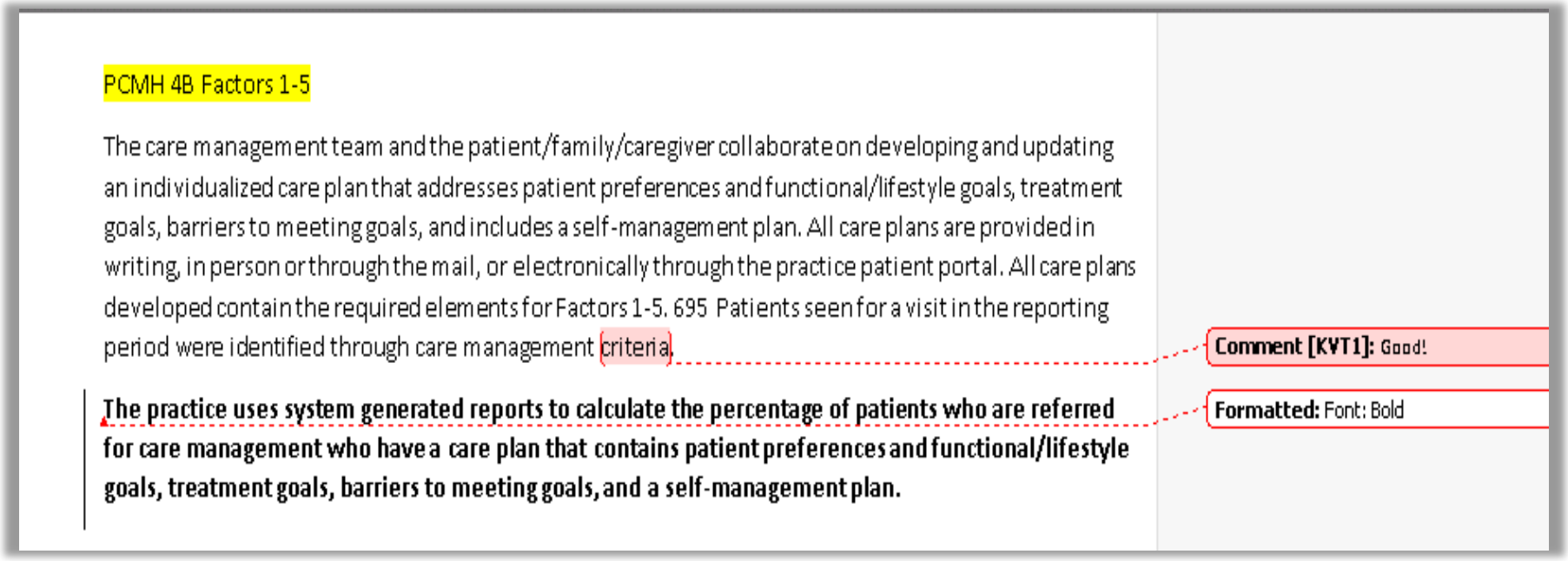
  Review Workbook and examples

Additional Detail from NCQA - CM05

- Question: Our process includes giving the patient a printed copy of the care plan at each visit, however, our EHR does not make note that the care plan was printed. How else can we demonstrate evidence of this if we are using the chart review option?

- NCQA's response: The intent of this requirement is to provide evidence that the care plan has been provided to the patient and that information has been documented in the patient's medical record. The care plan should be provided in writing either during/after the relevant visit. So it could be for example a mailed letter, a print out provided to the patient, or available in the patient portal. Please note that the practice may demonstrate either (1) a report, or (2) a completed Record Review Workbook and patient examples showing where and how the information is documented in the patient medical record. The practice may create its own report with a numerator, denominator, and date range to demonstrate that reports were given to patients.

Evidence Method 1 Example



PCMH 4B Factors 1-5

The care management team and the patient/family/caregiver collaborate on developing and updating an individualized care plan that addresses patient preferences and functional/lifestyle goals, treatment goals, barriers to meeting goals, and includes a self-management plan. All care plans are provided in writing, in person or through the mail, or electronically through the practice patient portal. All care plans developed contain the required elements for Factors 1-5. 695 Patients seen for a visit in the reporting period were identified through care management criteria.

The practice uses system generated reports to calculate the percentage of patients who are referred for care management who have a care plan that contains patient preferences and functional/lifestyle goals, treatment goals, barriers to meeting goals, and a self-management plan.

Comment [KVT1]: Good!

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Evidence Method 1 Example

Documentation of Factor 1- Incorporates Patient Preferences and Funtional Lifestyle Goals				
Report Ran: 11/26/2016				
Reporting Period: 08/01/2016 - 10/31/2016				
Provider	Patients identified through care management criteria with a visit between 08/01/16 and 10/31/16	Documented in Care Plan: Patient Preferences and Functional/Lifestyle Goals	% of Patients with Documented Patient Preferences and Functional/Lifestyle Goals	
OVERBY	135	92	68.15%	
BURNETT	57	55	96.49%	
DEGRAW	143	128	89.51%	
KIRBY	77	75	97.40%	
BAILEY	7	6	85.71%	
RATLEY	64	64	100.00%	
WIKE	167	93	55.69%	
PINDER	45	32	71.11%	
NBFP Total	695	545	78.42%	
PCMH 4B Factor 2				
Documentation of Factor 2- Identifies Treatment Goals				
Report Ran: 11/26/2016				

Evidence Method 2 RRWB and Examples – From a Person-Centered View

How can I overcome any barriers? - Como puedo superar cualquier barrera?	Join a community class, group/Unirse a una clase, grupo comunitario;Get a text,e-mail reminder from [redacted] to turn off the tv,video games/Obtener un texto, llamada o E-mail de [redacted] recordando apagar la TV, video juegos. **PCMH 4B; 3 - Potential Barriers**
Provider Goal - Meta del Provedor	No more that 2 hours of screen time (tv, video games, cell phone) per day./ No mas de 2 horas por dia de tiempo en la pantalla or monitor (TV, video juegos, telefono celular) **PCMH 4B; 2 - Treatment Goals**
What might stop me from reaching my goals? - Que puede detenerme de alcanzar mis metas?	Limited, no family support/Limitado, No soporte familiar

What might stop me from reaching my goals? - Que puede detenerme de cumplir mis metas?	Time Management challenges/Retos de control del tiempo
By next visit - Para la siguiente visita	1-2 pounds/1-2 Libras
What type of exercise are you willing to do? - Que tipo de ejercicios estas dispuesto(a) a hacer?	Walking/Caminar;Running/Correr **PCMH 4B; 1 - Patient Preferences and Goals**
How can I overcome any barriers? - Como puedo superar cualquier barrera?	Text or e-mail reminder from THCC to exercise/Recordatorio de ejercicios de parte de THCC por medio de texto, llamada o e-mail.

Competency B - CM 06 (1 Credit)
Patient Preference and Goals – Aligns with PCMH 2014 4B

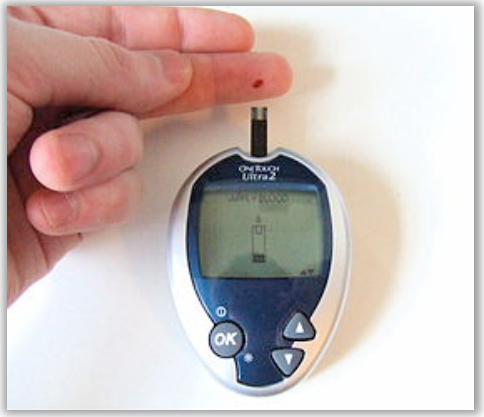
- Incorporates patient preferences and functional lifestyle goals in the care plan. **Functional/lifestyle goals** can be **individually meaningful activities that a person wants to be able to perform** but may be at risk due to a health condition or treatment plan.
- Evidence = Report ***OR*** Record Review Workbook and examples

Competency B - CM 07
(1 Credit)
Patient Barriers to Meeting Goals

- Addressing barriers supports successful completion of the goals stated in the care plan. Barriers may include physical, emotional, or social barriers.
- Aligns with PCMH 2014 4B
- Evidence = Report ***OR*** Record

  Review Workbook and examples

Competency B - CM 08
(1 Credit)
Self-Management Plans



- The practice works with patients/families/ caregivers to develop self-management instructions to manage day-to-day challenges of a complex condition.
- Aligns with PCMH 4B
- Evidence = Report ***OR*** Record
- Review Workbook and examples

Care Plan vs. Shared Care Plan

Care Plan/Treatment Plan	Shared Care Plan
Completed by clinician or RN	Shared care plan is co-developed – RN, SW, BH, Patient, Provider
Directions and instructions	Person-centered elements: goals (and steps to get to those goals) and barriers
Clinician-centric	Emphasizes the person's central role in managing their own health

Shared Care Plan Operational Definition

1. Treatment goals – chronic condition follow-up, preventive health goals, diagnostic follow-up (NCQA CM 04)
2. Patient's self-management goals (NCQA CM 06, CM 08)
3. Assessment of patient's barriers to health and well-being & potential solutions and resources to overcome barriers (NCQA CM 07)
4. Care coordination information: primary care team, specialists and community resources beyond primary care team (NYS PCMH CM 09)
5. Shared care plan follow-up frequency (NCQA CM 04)

Additional elements may include: patient's confidence in ability to manage health (rated on a scale 1 – 10), self-rated health status (excellent, very good, good, fair, poor), original date of plan and date of latest update, advance directive, health care proxy.

Shared Care Plan – Patient Example

Healthy Lifestyle: Healthy lifestyle choices will help you feel better.
Eat well, increase your physical activity, get enough sleep, practice relaxing. The basics of good health are hard to do when you have little energy. Slowly increasing your activity level through activities you enjoy can help other areas of physical wellbeing, including rest.

Scale 1-10 the degree your general health has been affected by this illness:

less 1 2 3 4 5 6 7 8 9 10 more

Every day during the next week I will be active by _____ for _____minutes.

___ I will avoid foods with high fat, high sugar and high caffeine content.

___ I will drink _____ glasses of water each day.

___ I will try to sleep for _____ hours each night.

Other healthy behavior:
_____
_____

Adapted from brochure designed and formatted by Lori Scanlan-Hansen, BSN, MS, Lake City Medical Center. May be edited as needed for individual patients or facility use.

Spirituality: Spend time doing things that feed your spirit and feel healing to you.
Think about the things that you feel strongly or passionately about (or have in the past). What gives your life meaning? Do you feel connected with others? Participate in religious activities if this is important to you. Find quiet time for self-reflection and restoring your sense of hopefulness for the future. Nature walks, meditation, music, inspirational reading, or time with a valued friend can be healing to the spirit.

Scale 1-10 the degree which this illness has affected your spirit:

less 1 2 3 4 5 6 7 8 9 10 more

During the next week, I will spend at least _____ minutes each day for healing my spirit through self-reflection or other activities such as:
_____
_____
_____
_____
_____
_____
_____

Recreation/Hobbies: Make time for pleasurable events.
Even though you may not feel as motivated, or get the same amount of pleasure as you used to, commit to scheduling some fun activities every day. Enjoy a hobby, listen to music, go out into nature for a walk, or attend a sporting event.

Scale 1-10 the degree which this illness has affected your hobbies/leisure life:

less 1 2 3 4 5 6 7 8 9 10 more

Every day I will spend at least _____ minutes doing recreational activity.

I will list at least five hobbies or recreational activities I enjoy:
_____
_____
_____
_____
_____
_____
_____

Updated 9/2015

Competency B - CM 09 (1 Credit) Care Plan Integration (shared care plan) - ***New***

- The care plan is accessible across external care settings. It may be integrated into a shared electronic medical record, information exchange, or other cross-organization sharing tool or arrangement.
- Evidence = Documented process ***AND*** evidence of implementation

Additional Detail from NCQA - CM09

- Question: Can you provide an example of how the care plan would be made available across settings of care? Through a secure interface? Other?
- Answer: For CM 09, the practice must demonstrate its capability to make their patient's care plans available securely to other care settings, such as hospitals, specialists, or other care facilities that could be managing patient care. The way in which this care plan is shared may vary and NCQA is not prescriptive, but examples include sharing care plans via shared medical records, HIEs or other shared systems that enable staff from different care settings to view the patient's care plan for continuity and optimal care coordination while the patient receives care from multiple settings. Scenarios in which these systems may be shared could include if a practice is part of an integrated health systems, ACO, Clinically Integrated Network or another arrangements that enable sharing of the patient's care plan across settings. If the practice does have a capability like this, it must provide its documented process that outlines how these care plans are made available across settings as well as demonstrate evidence of this information sharing during the virtual check-in with an evaluator.

Additional Detail from NCQA - CM09

- Question: We make our care plan accessible to external partners through our NextGen shared system, however, not all of our external partners are utilizing the NextGen system. We must use a manual process to share care plans with those who are not connected through NextGen. Does this meet the intent of CM 09?

  NCQA's response: Thank you for your question. Yes, it sounds like this would meet the intent of CM 09 as long as both processes are outlined in the documented process. If you have any further questions please do not hesitate to reach out.

Questions?

Join us for the Series!

Care Coordination & Care Transitions

Wednesday, September 12, 12-1 PM

REGISTER HERE

Learning Objectives:

- Identify opportunities to improve your organization's process for closed-loop tracking of lab results, imaging tests, and referrals.

- Consider your organization's current methods of connectivity with health care facilities that support safe care transitions.

Upcoming WACMHC Trainings

Lean Boot Camp Office Hours
August 14| 12:00 – 1:00 pm
REGISTER HERE

NAHQ CPHQ Review Course
August 16-17 | Seattle, WA
REGISTER

Please complete the evaluation after the end of the session. Your feedback is appreciated!

Questions? Contact the WACMHC Practice Transformation Team at QualityImprove@wacmhc.org