Community Health Worker Sustainability

A Case Study of Chronic Care Management

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The Mid-America Regional Council has supported the KC Regional Community Health Worker Collaborative since 2016. The Collaborative focuses on capacity building, advocacy and sustainability of the profession.

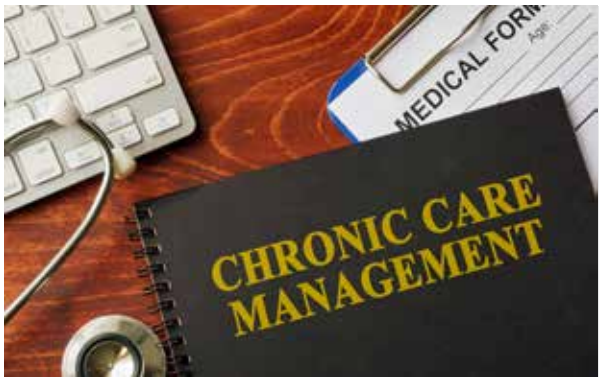
Please contact CHWinfo@marc.org if you have questions, comments or need further information.

This brief is a follow up to the **Reimbursement Strategies for Employers of Community Health Workers toolkit**, providing a real world example of how one Federally Qualified Health Center (FQHC) — the Community Health Center of Southeast Kansas (CHC/SEK) — incorporated community health workers (CHWs) into delivery of the Medicare Chronic Care Management benefit and billed CHWs' time to Medicare.

The Community Health Center of Southeast Kansas is a non-profit organization serving 19 communities in Kansas. It opened in 2003 and is driven by its mission to ensure everyone has access to quality health care and to eliminate barriers that traditionally exist within the health care environment — high costs, lack of affordability and poorly coordinated care.[1]

Overview: Chronic Care Management

Chronic Care Management (CCM)[2] is a Medicare primary care benefit that can be provided both during and outside face-to-face patient visits and is designed to improve patient health and care. To receive CCM, patients must have two or more chronic conditions that are expected to last at least 12 months or until the patient's death and/or put the patient at risk of significant decline.



For Original Medicare, CCM includes the following service elements:[3]

- **Comprehensive recording** of the patient information, including demographic and health information in an Electronic Health Record (EHR).
- **Comprehensive care plan** for all a patient's health issues that focuses on chronic condition management and is person-centered and stored in an electronic manner; considers physical, mental, cognitive, psychosocial, functional and environmental assessments; and includes an inventory of resources and supports.
- **Assures access to care and continuity in care** including 24/7 patient access to care and health information; provides continuity of care with a designated practitioner or member of the care team; offers various modes of communication with their practitioners (e.g. phone, secure messaging, etc.).
- **Provides comprehensive care management** including assessing a patient's medical, functional and psychosocial needs; ensuring timely receipt of preventive services; managing care transitions, and coordinating and sharing patient information promptly across care providers; reviewing medications and patient medication self-management; and coordinating with home- and community-based service providers.

Other key components of CCM in Original Medicare include:

- **Supervision**: Physicians, Certified Nurse Midwives, Nurse Practitioners and Physicians Assistants may bill for CCM. Clinical staff — defined as employees or individuals working under contract with the billing practitioner — may furnish CCM services under the direction and general supervision of the billing practitioner on an incident to basis.[4]
- **Initiating visit:** Prior to furnishing CCM, an initiating visit, where the practitioner discusses CCM with the patient, is required. Qualifying initiating visits include Annual Wellness Visits (AWV), Evaluation and Management Visits, or an Initial Preventive Physical Exam.
- **Patient consent:** Prior to furnishing CCM services, the patient must provide verbal or written consent for CCM that must be documented in the patient's medical record.
- **Billing:** Practitioners may bill for clinical staff to furnish CCM in 20-minute increments. See the **Medicare Learning Guide** and the **Centers for Medicare and Medicaid Services guidance for FQHCs** for more detailed billing rules including billing codes.

Community Health Center of Southeast Kansas and Chronic Care Management

The Community Health Center of Southeast Kansas began offering chronic care management with CHWs in the delivery model to Original Medicare and Medicare Advantage patients beginning in 2020. This brief provides an overview of how the CHC/SEK structured its CCM program and how CHWs play a critical role in furnishing CCM.

Chronic Care Management at CHC/SEK

Under the CHC/SEK CCM program, patients enrolled in CCM receive comprehensive care management. Services include health education for chronic diseases and chronic disease prevention; compliance with routine care (making and maintaining appointments with providers); medication management; managing transitions between levels of care and communication among providers; and addressing barriers to care. To participate in CCM, the patient must be established with a CHC/SEK provider.

Team-based Approach to CCM

A CCM team is responsible for furnishing CCM services to patients. The CCM team consists of a CHC/SEK provider, a Nurse Care Manager (NCM), a CHW and a Coordinator.

- The **CHC/SEK provider** provides the initiating visit, monitors ongoing patient medical care,

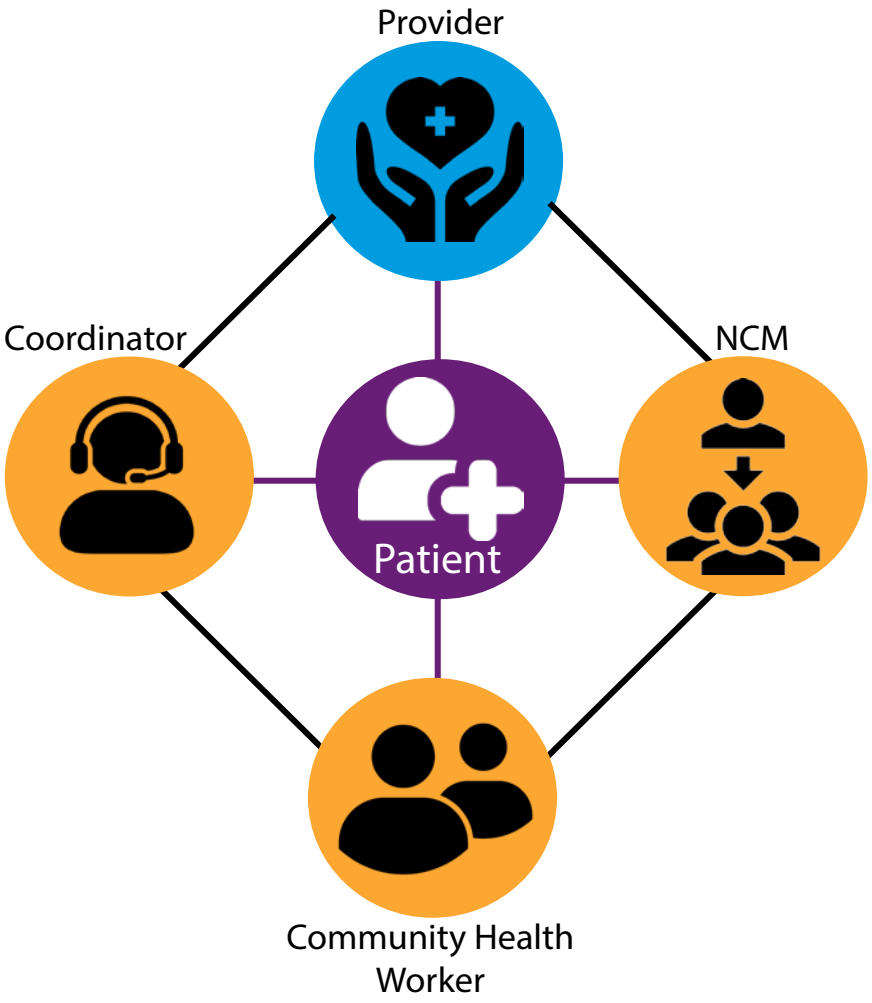
develops and monitors the overall plan of care of which the CCM plan is a component, and provides general supervision for the furnishing of CCM.

- The **NCM** completes the initial patient assessment and develops the CCM care plan, which identifies whether a CHW is needed to support the patient. This CCM care plan is a component of the patient's overall care plan and embedded within a CCM module in the electronic health record (EHR). The CCM plan is signed off on by the provider to whom the patient is assigned.

The initial assessments completed by the NCM include: PRAPARE, Patient Health

Questionnaire (PHQ9), health risk assessment (similar to Medicare AWV assessment which would not be repeated if the patient recently had an AWV). The NCM is the primary contact for CCM, but the patient is free to maintain frequent contact with any member of the care team.

- The **CHW** serves as a liaison between the patient and the care team. Under CCM, CHWs provide individual patient support to understand and access health insurance benefits and when to access different levels of care, manage transitions between levels of care, support patients as needed when insurance does not cover services (e.g., transportation to appointments), provide health education (e.g., Diabetes Prevention Program), conduct social risk assessment on barriers to care, refer and connect to community resources, and conduct home visits and complete environmental assessments (e.g., falls risk). All these services are included in the care plan and, therefore, billable to CCM.
- The **Coordinator** supervises the CHW and performs administrative program management activities such as managing referrals to the program, managing consents and chart reviews, ensuring all information to maintain compliance is collected, and marketing CCM to the various CHC/SEK clinics. Coordinators complete either CHW training or CHW supervisory training. CHC/SEK tries to maintain a ratio of one coordinator to eight CHWs among all programs to ensure CHWs receive adequate support.



Value of CHWs on CCM Team

The CHW is able to form trusting relationships with patients and work with the patients in the clinic, as well as in home and community settings, to identify barriers to care. As a central member of the care team, the CHW participates in case conferencing with the NCM and provider and regular team meetings to advocate for the patient and educate the care team on the community and environmental barriers patients face to maintain adherence to treatment plans and medications. Ultimately, this knowledge improves the provider and NCM interactions with the patient and their ability to develop whole person plans of care.

Referrals to CCM

The Community Health Center of Southeast Kansas receives CCM referrals in two ways:

- **Patient identification through the EHR:** The NCM identifies patients who qualify through the EHR and meets with the provider and patient during a visit to explain CCM and possible co-pay requirements.
- **Provider referral:** Providers refer patients to the NCM for assessment. When the NCM receives a referral from a provider, the NCM reaches out to the patient to educate on CCM and possible co-pay requirements.

Under both referral pathways, patients must consent to receive CCM. Consent is obtained verbally and documented in the EHR.

CCM Caseloads

Caseloads for the CCM team are around 100 patients per NCM. Patients generally do not want to "graduate" from CCM because they build trust with the NCM and CHW. Therefore, once goals are obtained, CHC/SEK keeps the patient enrolled in CCM (but doesn't bill Medicare) until the patient needs support again.

During active engagement, contact is generally at least once a month with a minimum engagement of 20 minutes in order to bill for CCM. During the initial month, risk assessments and care plan development take longer.

Monitoring CHW Activities

CHW activities are monitored through a CCM module in the EHR, which allows the Coordinator and NCM to monitor patient contacts and activities on a daily basis. Furthermore, the Coordinator has weekly one-on-one meetings with the CHW, and monthly team meetings (unless needed more frequently). The Coordinator, NCM and CHW are physically located in the same office, so the proximity encourages day-to-day interaction among the CCM team.

CHW Training Requirements

As long as the CHW is working under the general supervision of a licensed designated health provider, there are no licensing or credentialing requirements for clinical staff in CCM. However, all CHWs employed by CHC/SEK are expected to obtain the Kansas CHW Certification.

Documentation

Medicare requires the following to be documented:

- Patient consent.
- Initiating visit with their provider within the last year to establish that the patient has at least two chronic health conditions.
- Provider-established care plans must be updated at least every 12 months.
- Time spent and activities furnished for each CCM patient by each care team member.

The Community Health Center of Southeast Kansas documents all CCM activities in the EHR including all education provided, assessments performed and results of assessments over time to track improvement, social determinants of health needs and referrals, details of discussions with patient, encounter setting, coordination with other providers or levels of care, and time spent with patient.

Billing and Reimbursement

The Community Health Center of Southeast Kansas bills for CCM using HCPCS code G0511. On a monthly basis, administrative staff confirms all time spent by the CCM team is documented in the EHR. Once confirmed, the administrative staff runs a report that identifies any patient where staff has spent at least 20 minutes with the patient. Time calculations are aggregate of all CCM team members and include both direct patient contact (e.g., face-to-face, two-way audio or telemedicine) and collateral time spent outside of direct patient contact conducting activities on behalf of the patient (e.g., research transportation or childcare resources).

Finance staff will develop claims based on time reports and back-office staff will review those claims and patient insurance status prior to submission to the Centers of Medicare and Medicaid Services or Medicare Advantage plan.

For CHC/SEK, the Original Medicare 2024 rate (adjusted by the Relative Value Unit) is $56.22 for the 20 minutes. For CCM for FQHCs, G0511 can be billed once per month. In addition, there are rules on concurrent billing (see the **Medicare Learning Network** guide). Medicare Advantage plans may establish their own rates.

Financial Analysis

To support provision of CCM, CHC/SEK employs three NCMs and two CHWs dedicated to the CCM team. A cost analysis confirmed that billing G0511 once per month per patient for a caseload averaging around 100 patients per NCM covers the cost of the three NCMs and 50% of the cost to employ the two CHWs.

Outcome Measurement

The Community Health Center of Southeast Kansas tracks **uniform data system quality measures** on all patients that it reports to the Health Resources Services Administration annually. In addition, CHC/SEK tracks emergency department visits, falls risks, routine care adherence (e.g., annual wellness visit attendance) and medication requirements. For CHWs, CHC/SEK tracks specific measures including time spent with patients, location of service, county of service, type of service (e.g., food assistance, medication assistance, education to patient, etc.), mileage, time spent transporting patients, and percentage of appointments held/canceled/no show. For CCM specifically, Medicare recommends the care plan is updated on an annual basis.

Sample CHC/SEK CCM Workflow

PATIENT REFERRED FROM PROVIDER OR NCM IDENTIFIES PATIENT THROUGH EHR

- NCM educates patient on CCM
- NCM receives consent
- NCM completes initial assessments and creates CCM care plan in the EHR
- Provider signs off on CCM care plan

IF CHW SERVICES ARE RECOMMENDED IN CCM CARE PLAN

- CHW contacts patient to address social determinants of health
- Execute CCM care plan, address SDOH needs, support care coordination, provide patient support and advocacy
- CHW and NCM document time and services provided per patient monthly
- CHC/SEK bills monthly for aggregate care team time spent per patient

Lessons Learned

The Community Health Center of Southeast Kansas recommends including other departments in the development of the model and workflows. Including the quality team, EHR team, billing team and providers was critical. Their early involvement led to buy-in and adoption and, ultimately, a successful roll-out of the program.

Furthermore, providers learned — through experience and success stories — the impact CHWs can have to improve the delivery of care. Providers learned that CHWs can help triage access to community resources that the nurse or provider cannot. CHWs can lift the burden of care and reduce the amount of time spent with patients triaging resource needs. In addition, understanding more about non-clinical needs can improve the providers interactions with patients and improve care plans.

Key Regulatory Requirements

CHC/SEK staff recommend reviewing **Chronic Care Management Medicare Learning Network Guide** prior to implementing CCM.

About the Community Health Center of Southeast Kansas

The Community Health Center of Southeast Kansas opened its doors in 1997 as a community outreach program of Mt. Carmel Regional Medical Center, with a focus on helping children be ready for school, and addressing health needs for low-income families. CHC/SEK became an independent organization in 2003 with 11 employees serving 3,300 patients. Today, the organization has more than 1,000 employees serving more than 80,000 patients annually across eastern Kansas and northeast Oklahoma. Services include medical, dental, behavioral health, pharmacy and support services. **www.chcsek.org**

Endnotes

1. https://chcsek.org/
2. This brief examines Chronic Care Management only. It does not examine Complex Chronic Care Management.
3. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf
4. Ibid.

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