Success in Chronic Care Management

How RHC's can benefit from improving outcomes.

Because every patient deserves exemplary care.

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Learning Objectives

Understand the "WHY" of Care Coordination

Hear opportunities to improve the Care Coordination model

Gain tips for overcoming barriers in rural communities

Beyond the 4 Walls and 15 Minutes

"Ruth"

- 55 y/o female with COPD.
- Monthly ED visits and/or inpatient stays.
- Labeled as "high utilizer".
- Placed with a Care Coordinator.
- Collaboration with pharmacy and pulmonologist.
- Visit to her apartment revealed mold.
- Worked with her family to have her moved into new apartment.
- Next quarter she had two visits with her PCP, but not acute exacerbations.
- Only one ED visit next quarter due to influenza.
- No hospitalizations for the year.

What is Care Coordination?

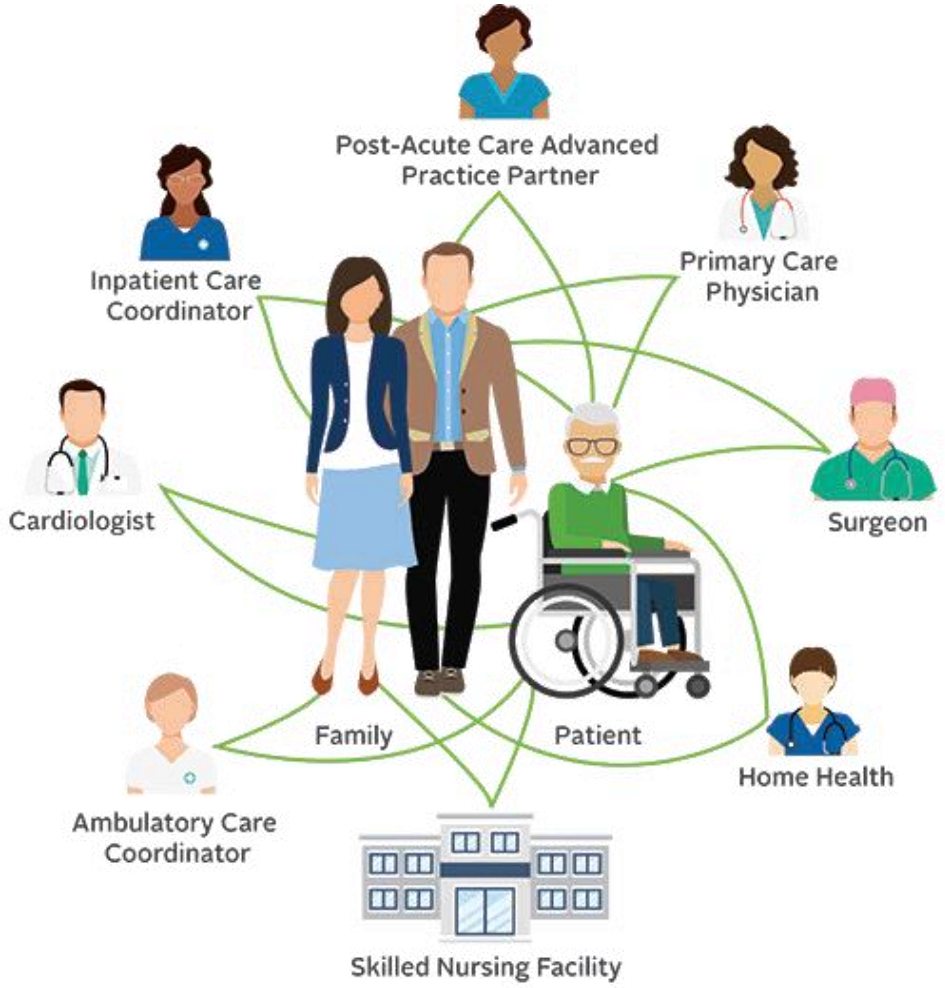
*"…**deliberately** organizing patient care activities and sharing information among all of the participants concerned…"*

Care Coordination | Agency for Healthcare Research and Quality (ahrq.gov)

- Assessing patient needs and providing resources
- Working to identify "what matters most" and developing goals.
- Fostering and encouraging patient engagement.
- Streamlining access to care when and where it is best for the patient.

When Care Needs to be Coordinated

- Follow up after discharge from the Emergency Department
- Care between PCP and specialists
- Transitions between “home” and facilities (SNF, inpatient hospital stays)
- When social services need to be coordinated
- After labs or diagnostic screenings
- When new or complex medications are prescribed



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WHY is This Important?

- Promotes greater efficiency and quality,
- Improves outcomes and patient satisfaction,
- Reduces utilization of $$$ services such as ER visits and hospitalizations.
- Provides the patient with confidence in the “team” and builds relationships.
- Generates Revenue for the practice.
- It’s the right thing to do!

Importance of Primary Care

Primary care is the greatest opportunity to improve health care quality and lower cost.

Every $100 spent on healthcare in the US, approx. $5 is spent on primary care.

Every $1 invested in primary care saves the healthcare system up to $13.

Doubling the nation's current spending on primary care would more than pay for itself in savings.

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The Big Picture

- 90% of the nation's $4.1 trillion in annual healthcare expenditures are for people with chronic and mental health conditions.
- "Nothing kills more Americans than heart disease and stroke. More than 877,500 Americans die of heart disease or stroke every year—that's one-third of all deaths."
- "In 2017, the total estimated cost of diagnosed diabetes was $327 billion in medical costs and lost productivity."

https://www.cdc.gov/chronicdisease/about/costs/index.htm

Value-Based Care Models

Accountable Care Organizations (ACOs)

- Network of physicians, hospitals, and other providers; providing coordinated, quality care.
- Eliminate unnecessary treatments and diagnostics; focusing on prevention.
- Risk dependent upon agreement ranging from no to high downside.
- Savings created through metric performance.

Bundled Payments

- Collective model of care combines reimbursement for a group of providers in a lump sum.
- Incentivized to deliver and coordinate care efficiently during an episode of care.
- If care isn't sufficient/efficient, larger downside risk for providers.
- Predetermined costs for select services.
- Savings based on reduced cost created by providers.

Patient-Centered Medical Homes

- Team managing patient's primary care to increase quality and coordination.
- Coordinate whole-person care.
- Low level of downside risk for providers with high reward based on performance.
- Graded based on patient access, engagement, and outcomes.

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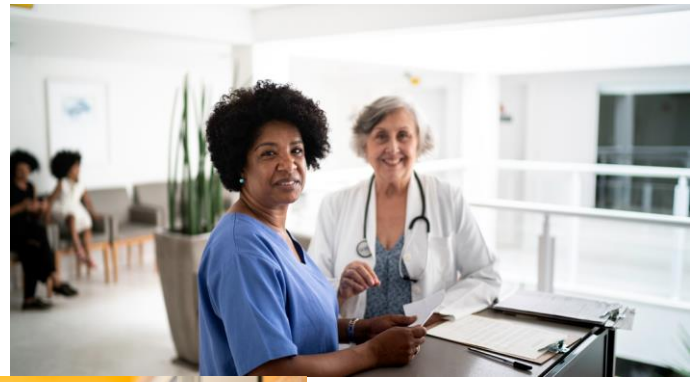
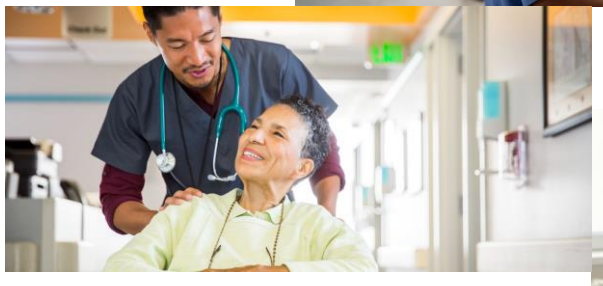
What is Chronic Care Management?

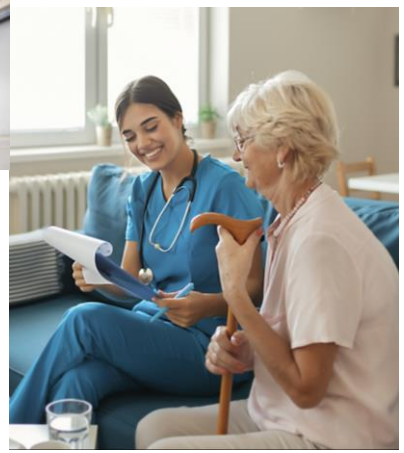
Twenty minutes of services provided to Medicare beneficiaries who have multiple (2 or more) chronic conditions.

Principal Care Management requires only one chronic condition, but 30 minutes of time.

CMS initially patterned this program specifically for PCMHs because they are uniquely prepared to embrace and succeed with the CCM model.







You are doing this work. Get paid for it.

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CCM/General Care Management G0511

Adding in four new buckets of care management

1. Remote Physiologic Monitoring (RPM)
2. Remote Therapeutic Monitoring (RTM)
3. Community Health Integration (CHI)
4. Principal Illness Navigation (PIN)

$71.68

Allowing multiple G0511s per patient per month

CMS.gov https://www.cms.gov/center/provider-type/rural-health-clinics-center

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2024 Care Management Codes (Bold=new)

Physician Fee Schedule Code	Description
G0323	General Behavioral Health Integration (BHI)
99487	Complex CCM (over 60 minutes of care management per month)
99490	Basic CCM (20 minutes of care management)
99491	30 minutes or more of CCM furnished by a physician or other qualified health professional
99424	30 minutes or more of Principal Care Management furnished by physicians or non-physician practitioners
99426	30 minutes or more of PCM services furnished by clinical staff under the supervision of a physician or non-physician practitioner
G3002	Chronic pain management first 30 minutes
G3003	Chronic Pain Management (each additional 15 minutes)
99453	**Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment**
99454	**Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days**
99457	**Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes**
99458	**Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes**
99091	**Collection and interpretation of physiologic data (e.g. Blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days**
98975	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment**
98976	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days**
98977	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days**
98980	**Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes**
98981	**Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes**
G0019	**Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit**
G0022	**Community health integration services, each additional 30 minutes per calendar month**
G0023	**Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month,**
G0024	**Principal Illness Navigation services, additional 30 minutes per calendar month**

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Financial Rewards of CCM

G0511	RHC	Care mgt., RHC/FQHC*	$71.68 (2024)

- 25 patients — $1,792 per month
- 50 patients — $3,584 per month
- 100 patients — $7,168 per month
- 200 Patients — $14,336 per month

G0511 Recommendations

CCM: provide 20 minutes of CCM services and can be combined with other services

CCM + RPM: provide 20 minutes of CCM services and 20 minutes of RPM services

PCM + RPM: provide 30 minutes of PCM services for patients with one chronic condition and 20 minutes of RPM services

CCM +BHI: consider offering 20 minutes of BHI services with 20 minutes of CCM services

How CCM Effects Healthcare Costs

- ~~$7,526~~ $6,638 Average Annual Cost of Patient with Multiple Chronic Conditions enrolled in CCM program, equating to nearly $900 in annual spending.
- CCM Programs are the rare “Dual Stream” of provider revenue (Fee-for-Service & Shared Savings) that drive Value-Based Care cost savings.

Effective CCM programs drive patients into the practice for more preventative care visits.

Requirements for GCM/CCM

- Verbal or written consent
- Care plan updated at least annually
- 24/7 access to care
- Appropriate documentation

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Patient Consent

- Written or verbal consent is required before billing for CCM services. This helps the patient to understand the additional benefits they are receiving, ensure they are engaged and make them aware of their cost sharing responsibilities. Informed consent is only required once unless they switch to a different CCM practioner.
- It is important to inform the patient that only 1 practitioner can furnish and bill CCM services during the calendar month.
- The patient has the right to refuse CCM services at any time.

Benefits to the patient

Copy of Care Plan

Opt-out

Co-pay

AGREEMENT TO RECEIVE MEDICARE CHRONIC CARE MANAGEMENT SERVICES

As of Jan. 1, 2015, Medicare covers chronic care management services provided by physician practices per calendar month. I understand that my primary care physician, named below, is willing to provide such services to me, including the following:

- Access to my care team 24-hours-a-day, 7-days-a-week, including telephone access and other non-face-to-face means of communication,
- The ability to get successive, routine appointments with my designated primary care physician or member of my care team,
- Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medication management,
- Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values,
- Management of my care as I move between and among health care providers and settings, including the following:
    - Referrals to other health care providers,
    - Follow-up after I visit an emergency department,
    - Follow-up after I am discharged from the hospital or other facility (e.g., skilled nursing facility),
- Coordination with home- and community-based providers of clinical services.

I understand that as part of these services I will receive a copy of my comprehensive plan of care.

I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose, instead, to receive these services from another health care professional after the calendar month in which I revoke this agreement. Medicare will only pay one physician or health care professional to furnish me chronic care management services within a given calendar month.

I understand these chronic care management services are subject to the usual Medicare deductible and coinsurance applied to physician services.

I hereby indicate by signature on this agreement that _____ is designated as my primary care physician for purposes of providing Medicare chronic care management services to me and billing for them.

My signature also authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in chronic care management services.

This designation is effective as of the date below and remains in effect until revoked by me.

Patient Name (please print): _____
Patient Date of Birth: _____

Patient or Guardian Signature: _____
Date: _____

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Co-Pay (Biggest Barrier)

- CMS is restricted and can't waive the co-insurance.
- Cost isn't a small thing. Address it with the patient and be transparent.
- Demonstrate for them what it might save them over time.
  - Hospitalization co-pay can be around $1600 and that would pay for 5 years of CCM services.
  - Are we being positive when we speak to the patient about the service?
  - "Fast Pass"- a benefit is being able to have access to their clinical team when THEY need it.

Comprehensive Care Plan

- Patient-centered
- Electronic or physical copy must be provided to the patient
- Share with other providers and individuals involved in care

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Patient Name: _____ Date: _____

Patient-Centered Health Improvement Plan

Care Plan developed in collaboration with patient by: _____

Patient Name: _____ Date: _____

Patient-Centered Health Improvement Plan

Problem:

_____

Barriers:

_____

_____

Plan to overcome barriers:

_____

_____

Goals:

_____

_____

Plan:

How: _____

Where: _____

When: _____

Frequency: _____

Confidence rating_____ (0-10)

Support System: Who can help?

_____

_____

Follow up:

_____

Care Plan developed in collaboration with patient by: _____

Advanced Access

Providing the **right care…** at the **right time…** at the **right place**!

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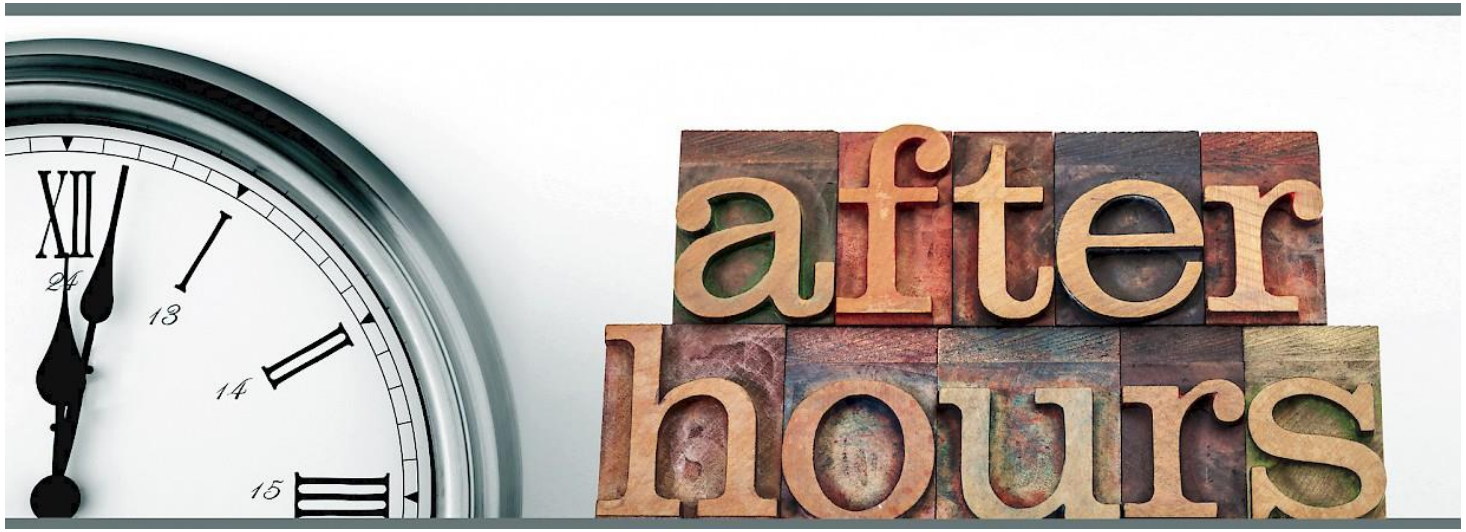
Meeting the Needs

- Same day appointments for urgent illness;
- Evidence of expanded weekday, evening, and/or weekend appointment offerings; and
- Call coverage or arrangement for after-hours emergencies twenty-four hours a day and seven days a week.



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CCM Documentation for Billing

- Eligible CCM billing code.
- Qualifying diagnosis codes.
- Minutes spent on CCM activities.
- Description of CCM activities.
- Identification of staff performing CCM activities.

Where Do We Start??

New Chronic Care Management Certification

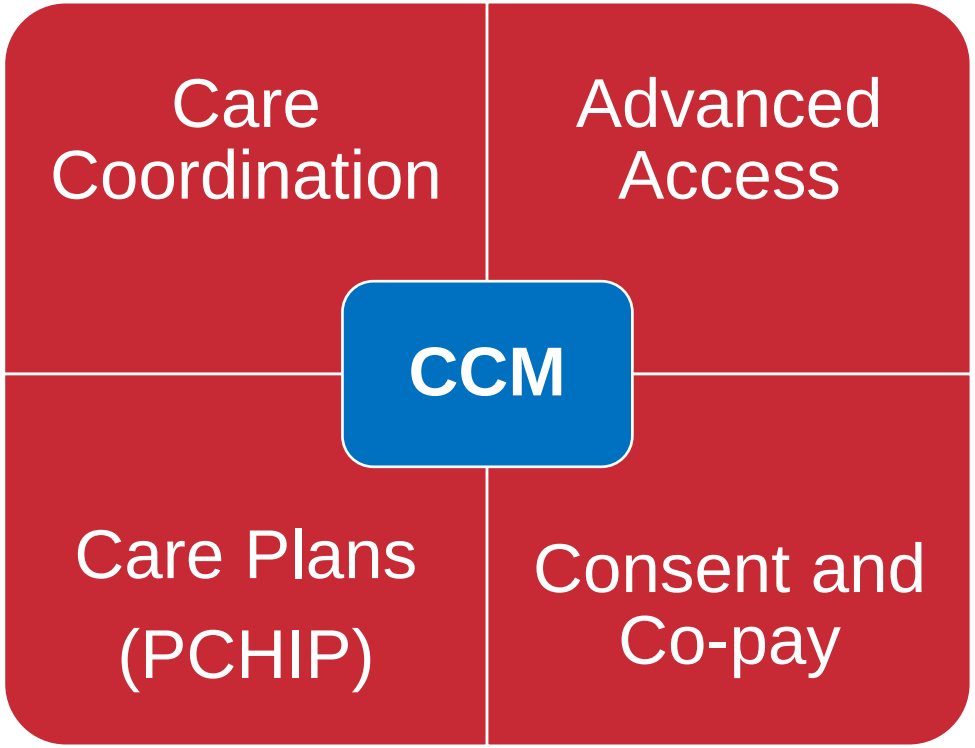
-Improved Patient Outcomes

-Foundation for a successful CCM program

-Access to tools, templates and support

-Additional revenue of $71.68

-Stepping stone to Patient-Centered Medical Home accreditation by meeting 50% of the standards



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The Art of the Huddle

Team Huddle Checklist

Use this modifiable checklist to lead your team through efficient, effective huddles at the beginning of the clinic day or session.

Date:	Start time:
Huddle leader:	
Team members in attendance:	
Check in with the team	
	How is everyone doing?
	Are there any anticipated staffing issues for the day?
	Is anyone on the team out / planning to leave early / have upcoming vacation?
Huddle agenda	
	Review today's schedule
	Identify scheduling opportunities • Same-day appointment capacity • Urgent care visits requested • Recent cancellations • Recent hospital discharge follow-ups
	Determine any special patient needs for clinic day • Patients who are having a procedure done and need special exam room setup • Patients who may require a health educator, social work or behavioral health visit while at the practice • Patients who are returning after diagnostic work or other referral(s)
	Identify patients who need care outside of a scheduled visit
	Determine patient needs and follow up • Patients recently discharged from the hospital who require follow up • Patients who are overdue for chronic or preventive care • Patients who recently missed an appointment and need to be rescheduled
	Share a shout-out and/or patient compliment
	Share important reminders about practice changes, policy implementation or downtimes for the day
	End on a positive, team-oriented note • Thank everyone for being present at the huddle
	Huddle end time:

Source: AMA. Practice transformation series: implementing a daily team huddle. 2015.

Team Huddle

- Stand up
- Meet before the daily schedule starts
- Be consistent-have a plan
- Check-in and announcements
- Use visuals- score cards, dashboards, bulletins
- Preview patients coming in
- Identify potential challenges/concerns
- Keep meeting short- no more than 10 minutes
- Be courteous and respectful
- Positive feedback and praise

Go Team!

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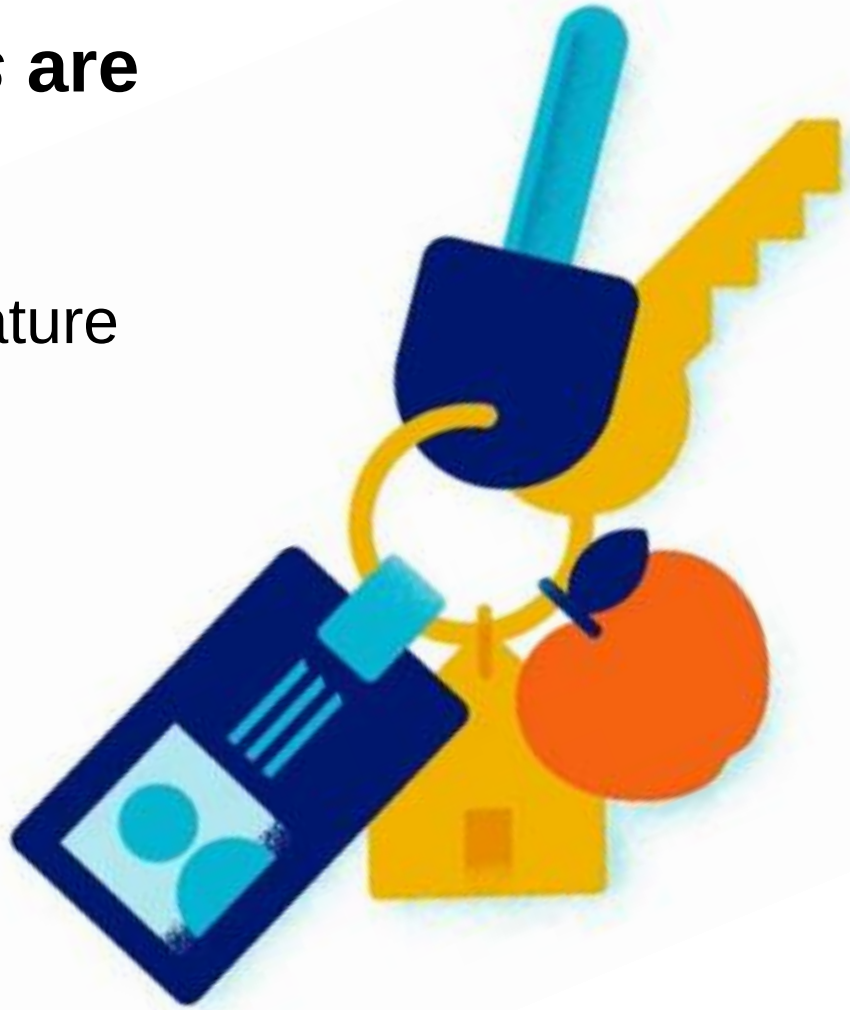
Social ~~Determinants~~ Drivers of Health

Social determinants and _social drivers_ are often used interchangeably.

- *Social determinants* of health, by the very nature of the word, are predetermined or fixed.

- *Social drivers* of health are similar. They affect health outcomes, but it's important that these influences aren't treated as finite.



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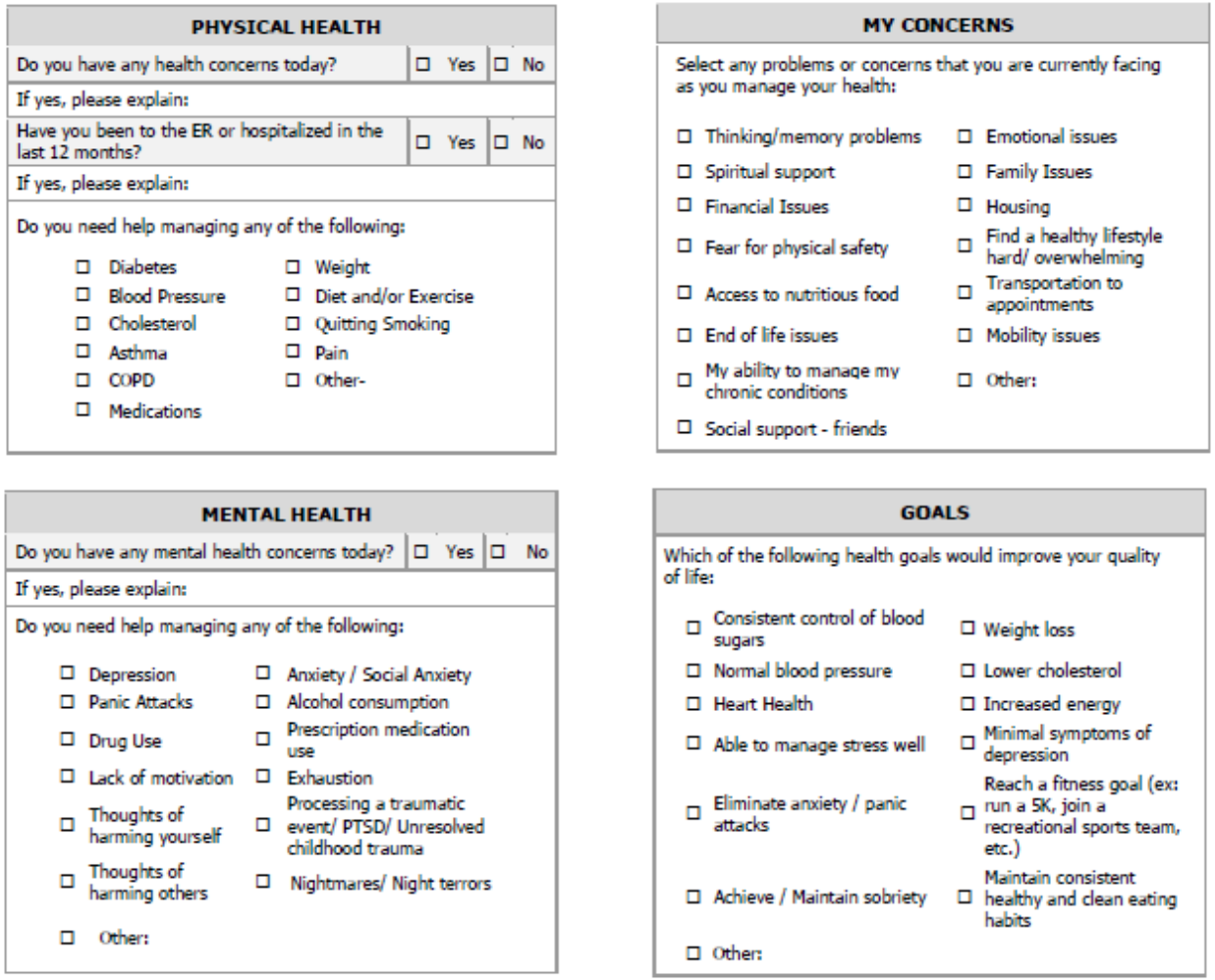
Needs Assessment

- Who gets one?
- How often?
- Is staff trained to assess and address?
- What is your follow-up?



PHYSICAL HEALTH

Do you have any health concerns today? ☐ Yes ☐ No

If yes, please explain:

Have you been to the ER or hospitalized in the last 12 months? ☐ Yes ☐ No

If yes, please explain:

Do you need help managing any of the following:

- ☐ Diabetes
- ☐ Blood Pressure
- ☐ Cholesterol
- ☐ Asthma
- ☐ COPD
- ☐ Medications
- ☐ Weight
- ☐ Diet and/or Exercise
- ☐ Quitting Smoking
- ☐ Pain
- ☐ Other-

MY CONCERNS

Select any problems or concerns that you are currently facing as you manage your health:

- ☐ Thinking/memory problems
- ☐ Spiritual support
- ☐ Financial Issues
- ☐ Fear for physical safety
- ☐ Access to nutritious food
- ☐ End of life issues
- ☐ My ability to manage my chronic conditions
- ☐ Social support - friends
- ☐ Emotional issues
- ☐ Family Issues
- ☐ Housing
- ☐ Find a healthy lifestyle hard/ overwhelming
- ☐ Transportation to appointments
- ☐ Mobility issues
- ☐ Other:

MENTAL HEALTH

Do you have any mental health concerns today? ☐ Yes ☐ No

If yes, please explain:

Do you need help managing any of the following:

- ☐ Depression
- ☐ Panic Attacks
- ☐ Drug Use
- ☐ Lack of motivation
- ☐ Thoughts of harming yourself
- ☐ Thoughts of harming others
- ☐ Other:
- ☐ Anxiety / Social Anxiety
- ☐ Alcohol consumption
- ☐ Prescription medication use
- ☐ Exhaustion
- ☐ Processing a traumatic event/ PTSD/ Unresolved childhood trauma
- ☐ Nightmares/ Night terrors

GOALS

Which of the following health goals would improve your quality of life:

- ☐ Consistent control of blood sugars
- ☐ Normal blood pressure
- ☐ Heart Health
- ☐ Able to manage stress well
- ☐ Eliminate anxiety / panic attacks
- ☐ Achieve / Maintain sobriety
- ☐ Other:
- ☐ Weight loss
- ☐ Lower cholesterol
- ☐ Increased energy
- ☐ Minimal symptoms of depression
- ☐ Reach a fitness goal (ex: run a 5K, join a recreational sports team, etc.)
- ☐ Maintain consistent healthy and clean eating habits

Identify a life goal or reason that motivates you to work towards better health.

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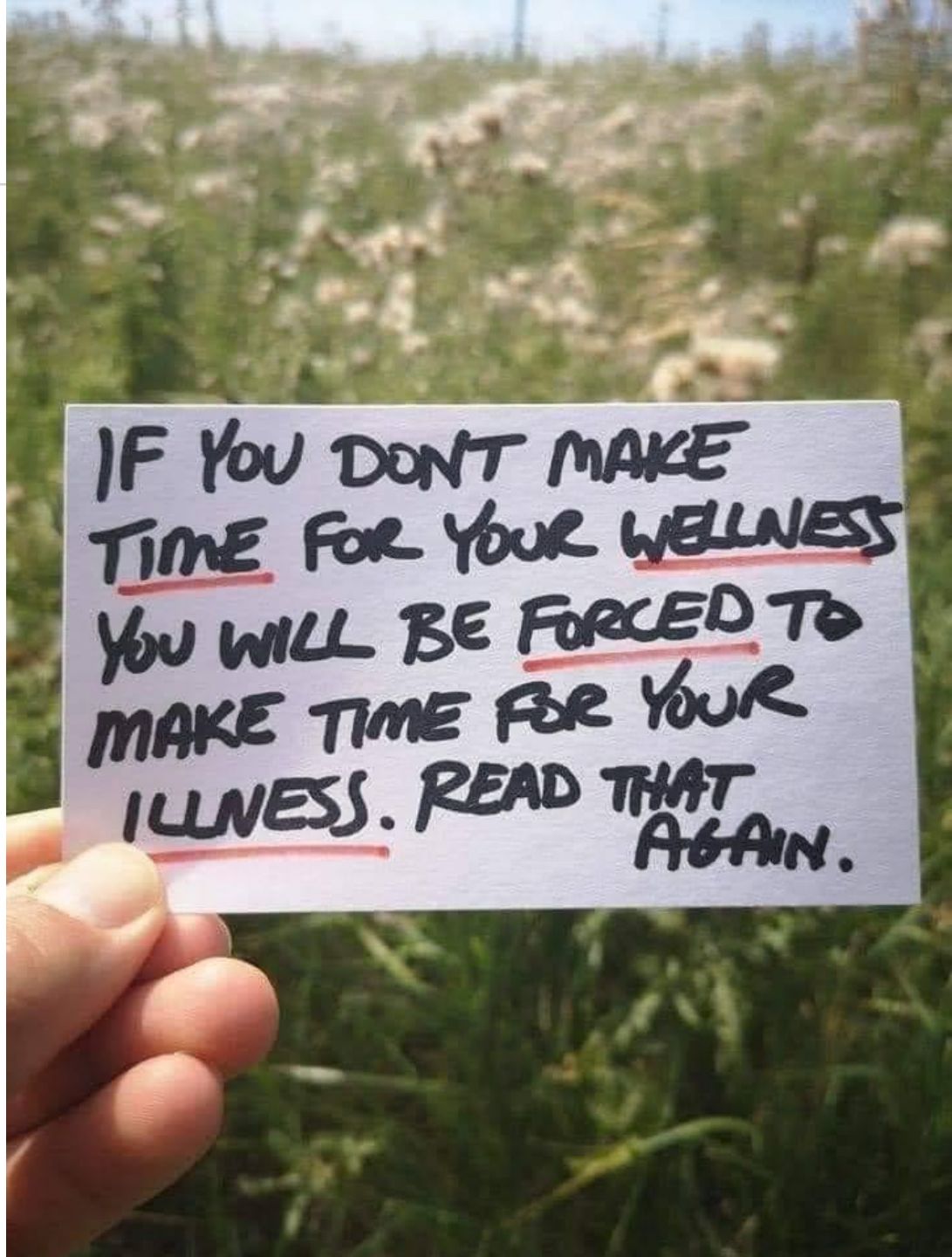
Wellness Visits

Why should you do them?

- Wellness visits are an efficient way to capture preventive screenings and close care gaps.
- Not all the work has to be done by the provider.



Benefits of CCM (recap)

- Better quality care
- Improved outcomes
- Lower healthcare costs
- Engaged patients
- Net new revenue
- Happier providers and staff

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Let’s Do This!

- CCM Certification Program with TCT
- Identify your population
- Select 5-10 patients to start
- Follow the claims
- Adjust staffing
- **Enroll! Enroll! Enroll!**

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Questions

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