A Guide for PCMH CCEs: Implementing a Successful Chronic Care Management Program for Your PCMH

LINDA J. PEPPER, PH.D., PCMH CCE

MATT ETHINGTON, CEO OF CHRONICCAREIQ
Introductions

LINDA J. PEPPER, PHD, PCMH CCE
MATT ETHINGTON, CEO OF CHRONIC CARE IQ
Agenda

- The Cost of Chronic Conditions
- What is the Solution?
- What is the CMS Chronic Care Management Program?
- Why is CCM Important For PCMHs?
- Why Don’t PCMHs Take Advantage?
- Going Beyond PCMH Consulting?
- Finding the Right Vendor Partner
- ChronicCareIQ – Success with CCM
- How can you partner with ChronicCareIQ to benefit your clients?
- Q&A
Big Problem Getting Bigger

Two Paths, Two Choices — Chronic Disease in The United States TOMORROW
On our current path, The United States will experience a dramatic increase in chronic disease in the next 20 years. But there is an alternative path. By making reasonable improvements in preventing and managing chronic disease, we can avoid 40.2 million cases of chronic conditions in 2023.

The Milken Institute’s projects could mean $6 trillion in treatment costs and lost economic output by 2023!

Source: Milken Institute – www.chronicdiseaseimpact.com
So What’s the Solution?

- The two primary reasons for poor outcomes in chronically ill patients:
  - The lack of care coordination and disease management
  - The lack of patient-centered care.

- Doctors now HOW to treat chronic disease, but don’t know WHEN.

- Patients spend on average only 5 hours a year in the doctor’s office.

We need better patient-centered coordinated care covering that time patients are NOT in a doctor’s office – non-face-to-face care.

*Source: Am J Crit Care 2007 sep. 16(5): 447-457*
Medicare to Start Paying Doctors Who Coordinate Needs of Chronically Ill Patients

By ROBERT PEAR  AUG. 16, 2014

WASHINGTON — In a policy change, the Obama administration is planning to pay doctors to coordinate the care of Medicare beneficiaries, amid growing evidence that patients with chronic illnesses suffer from disjointed, fragmented care.

Although doctors have often performed such work between office visits by patients, they have historically not been paid for it.

Starting in January, Medicare will pay monthly fees to doctors who manage care for patients with two or more chronic conditions like heart disease, diabetes and depression.

“Paying separately for chronic care management services is a significant policy change,” said Marilyn B. Tavenner, the administrator of the Centers for Medicare and Medicaid Services. Officials said such care coordination could pay for itself by keeping patients healthier and out of hospitals.
Funding Chronic Care Management Makes Good Business Sense!

- A hospital admission cost Medicare between $11,000 and $12,000
- At monthly reimbursement of $42.91, CMS can cover over 22 years of CCM by preventing only 1 hospitalization

Bottom Line – This makes sense for Medicare!
What does CCM mean for PCMHs?

Significant Revenue Opportunity
## CCM Estimated Potential Gross Annual Revenues

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<td>Estimated Annual Gross Revenue for PPC Physician</td>
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Sources: CMS.gov County Level Multiple Chronic Conditions, 2012; MGMA Cost Survey for Single Specialty Practices, 2013
You’re Already Invested – PCMH is Expensive

Investment requirements for becoming a PCMH

- New structural capabilities – average of **$30,991** in one-time costs or about **$9,814** per clinician
- Average costs of ongoing medical home activities - **$147,573** per year per practice
- Yearly new quality initiative activities - average of **$23,734**

December 2015 Journal of General Medicine report
CCM Payment Requirements
CPT Code 99490 - Implemented January 1, 2015

- **Eligible Beneficiary?** Medicare patients with two or more chronic diagnoses that are expected to last for a year or until death. Chronic conditions put the patient at significant risk and they need more management than the practice can provide in the clinic.

- **What does it Pay?** Approximately $42.91 per Patient per Month.

- **Who Can Bill For It?** Physicians, Clinical Nurse Specialists, Nurse Practitioners, and Physician Assistants may bill for this service. (Primary Care or Specialist) Non-clinical staff time cannot be counted.

- **What are the Requirements?**
  - Practice must be able to demonstrate 20 minutes of non-face-to-face time per patient per month managed by clinical staff working under the physician.
  - Patients must sign a consent form.
  - Practice must create and maintain a comprehensive care plan that can be electronically shared (not via fax)
  - Practice must have a 2011 or 2014 certified EHR – although providers are not required to be MU certified.
  - Only 1 provider can bill CCM per patient.
  - CPT code 99490 cannot be billed during same service period as TCM, home health, or certain End-State Renal Disease codes.

2. Medicare PFS Payment details: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/)
3. [www.ChronicCareIQ.com/CCMEducationCenter.com](http://www.ChronicCareIQ.com/CCMEducationCenter.com)
CCM Program is Aligned with PCMH!

- 24/7 Access to Care Management Services — Standard 1: A & B
- Continuity of Care in the Office — Standard 2:A
- Care Management of Chronic Conditions — Standard 4: A, B, C, & E
- Patient-Centered Care Plan — Standard 4:B
- Management of Care Transitions — Standard 5:A, B, C
- Coordination of Home and Community Providers — Standard 4:E
- Enhanced Communication Methods — Standard 1:A, B & C
- Electronic Capture and Sharing of Information by Patient Care Team — Standard 5:C
Why Don’t PCMHs Take Advantage of CCM?

National Chronic Care Management Survey Barriers

- Insufficient Reimbursement
- Lack of Awareness
- Compliance Concerns

More than half of the respondents (60%)—mostly those associated with smaller organizations—are concerned that they would have to hire additional staff to implement a CCM program.

Go Above and Beyond PCMH Consulting with CCM

- CCM can pay for PCMH! For clients wanting to be PCMHs, show them how they can support the cost of the care model through CCM.
- Help new or existing PCMH clients understand the value in the CCM payment.
  - Do the math – figure their potential for revenue.
  - Begin with Medicare patients identified in PCMH 4:A who may benefit from care management.
- Calm their fears – NOT a MANUAL process! No need for spreadsheets! The industry now has automated applications that save staff time and money.
- Integrate CCM requirements into PCMH client training.
- Encourage clients to use Initial Preventive Physical Exams and Annual Wellness Visits to educate patients about CCM benefits.
- CCM is HUGE opportunity to engage patients!
- Identify and qualify vendors with automated, robust CCM applications for your clients.
- Make sure PCMH care plans are aligned with CCM requirements. Don’t forget those new risk stratification requirements.
Patient-Centered Comprehensive Care Plan

- Comprehensive means COMPREHENSIVE!
  - Information from referrals and tests
  - Reconciled patient medications
  - Information from external doctor visits
  - Appropriate preventive screenings
  - Community resource use
  - Transportation problems
  - Patient support systems

- PCMH 4:A Identifying Patients for Care Management
  - Behavioral conditions, high cost/high utilization, poorly controlled conditions, social determinants, referrals and systematic process for selection and monitoring.
  - Bi-annual/quarterly health risk assessments that include behavioral health, resource use and social determinants.
  - Enhanced care monitoring for their identified patients.

- Adult Health Assessment templates can be modified to meet 2014 PCMH requirements.
Look for...

- Complimentary technology to current EHR
- Little to no disruption of current practice workflow
- Reasonable costs and with money-back guarantees.
- Flexible pricing models that allowing practices to build program until they can see real revenue.
- Applications should facilitate patient engagement – critical for improving the metrics on chronic care management
- Assistance with identification of eligible patients
- Vendor-developed program forms, patient education materials, program marketing materials, care plan suggestions, guides and instructions that are easy to follow
Add Value - Look For...

- Programs that **track both CCM and TCM**
- Near **real-time knowledge, tracking and monitoring** of patient conditions
- **Alerts** staff with emails, texts if patients are non-compliant or have problems
- Provides **actionable intelligence** allows staff to prevents episodic events requiring ED visits or hospitalization.
- Supports **electronic sharing of care plans** with internal and external care team members
- Provides **billing and compliance reports** for audits
- Comprehensive **staff training** and implementation with lots of **handholding**
- **Continuous service and updates** after the sale
PCMH and CCM Resources

**PCMH**
- [www.pcmh.ahrq.gov](http://www.pcmh.ahrq.gov)
- [www.communitycarenc.org](http://www.communitycarenc.org)
- [www.qualishealth.org](http://www.qualishealth.org)
- [https://www.healthit.gov/sites/default/files/pcmh_learning_resources.pdf](https://www.healthit.gov/sites/default/files/pcmh_learning_resources.pdf)
- [http://www.chcact.org/fqhc-resources/pcmh-resources/](http://www.chcact.org/fqhc-resources/pcmh-resources/)
- [https://www.pcpcc.org](https://www.pcpcc.org)
- [http://www.nwrpca.org/?page=RC_PCMH](http://www.nwrpca.org/?page=RC_PCMH)
- [http://www.aafp.org](http://www.aafp.org)

**CCM**
- [www.chronicareiq.com](http://www.chronicareiq.com)
In Summary - Tips for a Successful CCM Program

- Proactively provide solid CCM consulting for PCMH clients
- Do NOT outsource - too much risk and less profit.
- Look for applications that streamline CCM/PCMH workflow with minimal management requirements.
- Identify robust CCM applications with actionable intelligence that work well with existing practice HIT.
- Require “Done-for-you” forms, patient education, marketing brochures, etc.
- Automated and easy to use.
- Aligned with established care plans, diagnoses and barriers to care.
- Patient centric platform that engages patient to self-manage
- Invests in the practice’s success as a PCMH
- Cost effective and efficient
- Support and service after the sale is over
MATT ETHINGTON, CEO AND CO-FOUNDER
ChronicCareIQ – Background

- ChronicCareIQ began in 2014
- Development of technology based on personal chronic care patient experiences and knowledge of EHRs.
- Experience building an award-winning EHR company managing 45 million patient records across two continents provided insight on how to create a unique, easy to use CCM platform that streamlines the processes for the practice and patient.

The results = a turn-key patient engagement platform that prompts patients for responses about their health, provides real-time actionable intelligence and proactive care management between visits with documented compliance.
Top 3 Keys to Success

Focus
 ✓ Improve Care
 ✓ Cut Costs

Consistent Patient Engagement
 ✓ $42 is not a lot of money
 ✓ $502 is

Automation
 ✓ Too many details to manually track
 ✓ One-Off approach is doomed to fail
Patients download an app on their smart phone, tablet, and/or PC at no charge.

✓ Answer a few questions when they appear
✓ As easy to use as an alarm clock  
  • Don’t have to log into a portal.
✓ No set-up required at home
✓ Nothing to buy.

For Patients without Smart Phones:
  • Staff or caregivers may enter patient responses once per week.
  • Patients can log in via home computer or tablet.
### Practice Dashboard Collates Patient Responses

At-a-glance situational awareness of at risk population(s) - actionable intelligence
- View current status and trending speeds
- Customizable to individuals or populations
- Alerts trigger email and/or text
- Coordinates and incorporates third party physicians and patient advocates.
- Tracks required billing thresholds and penalty windows 30 days post-discharge

#### Dashboard

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Actionable Intelligence – Individually Identify Trends & Prevent Re-admission

- Displays patient trends
- Quickly identify problem areas
- Captures TCM metrics for additional revenue
- Displays patient metrics against ranges (i.e. BP, Glucose, etc.)
- Automates multiple workflows
CCIQ Provides Done for You Help and Forms with the CCM Education Center

ChronicCareIQ University
Achieve success with CCM using these guides, tips and patient engagement materials.

User Guides
- CCM Success Toolkit
- Administrative Guide
- Navigation Guide
- Patient Monitoring Workflow Guide
- Creating Protocols
- Existing Protocols

Sample Forms
- Patient Quick Start Sample
- Medicare Patient Letter
- Patient Consent Form Option 2
- Patient Consent Form Option 1
- CCM Stop Form
CCIQ Provides Patient Marketing and Educational Materials

Trifold Brochures and Patient Info Flyers

DOWNLOADING THE APP
You can put the ChronicCareIQ app on as many devices as you like at no charge. In addition to downloading the app to your phone or tablet, you can also access it from any web-connected computer.

iPhone or iPad
go to the App Store, search and download the ChronicCareIQ app, click Open

Android device
Go to Google Play, search and download the ChronicCareIQ app, click Open

Online use
Go to www.ChronicCareIQ.com and log in

Easy to Use
• Takes less than 30 seconds to respond
• Nothing to buy or install
• An easy-to-read on-screen clock to use
• Goes where you go
• No passwords or passwords to remember
• Large, legible type

Write your username and password here for future reference:

Username: ____________________________
Password: ____________________________

Address | Phone | Fax
www.website.com

HAVE YOU BEEN DIAGNOSED WITH TWO OR MORE CHRONIC DISEASES?

You may qualify for remote patient monitoring to help you:
• Better manage your diseases
• Reduce hospitalizations and ER visits
• Save money on out-of-pocket expenses
• Achieve better health

ChronicCareIQ is like taking your doctor home with you.

Ask if you qualify.

You’ll receive questions about your health on your smart phone or other device.

It’s QUICK to set up and EASY to use.

We’ll monitor your health and contact you if we detect a problem.
## CCIQ Reports Makes Billing CMS Easy!

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# Comprehensive Patient Reporting

## Report for Patient: Rodriguez, Roy

- **Name**: Rodriguez, Roy
- **Age**: 65
- **Patient ID**: 123456
- **Phone**: 555-555-5555
- **Diagnosis**:
  - I11.0: Hypertensive heart disease with heart failure
  - I70: Atherosclerosis
- **Feedback Status**: Alert
- **Response Score**: 95
- **Date of Birth**: 2/3/1951
- **Gender**: Male
- **Race**: White
- **Weight**: 156 lbs
- **Height**: 5'8"
- **DOB**: 2/3/1951
- **Gender**: Male
- **Race**: White
- **Weight**: 156 lbs
- **Height**: 5’8”
- **Home Number**: n/a
- **Mobile Number**: n/a

### Monitoring Physician
- **Physician**: Wright, Karen MD
- **Specialty**: Cardiology
- **Phone**: 555-652-3771

### Specialist Physician
- **Physician**: Jackson, Stephen MD
- **Specialty**: Emergency Medicine
- **Phone**: 555-530-0923

### Case Manager
- **Name**: Peel, Emma
- **Phone**: n/a

### Discharge Date
- **Date**: n/a

### CUN7
- **Code**: n/a

### First Call
- **Date**: n/a

### Discharge Nurse
- **Name**: Foster, Steve
- **Phone**: n/a

### Backup Manager
- **Name**: Fairfield, Angie
- **Phone**: n/a

### Days Skipped
- **Count**: 0
Comprehensive Audit Log

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Nurse</th>
<th>Status</th>
<th>Duration</th>
<th>Activity</th>
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<tbody>
<tr>
<td>2/01/2016</td>
<td>10:32 AM</td>
<td>Peel, Emma</td>
<td>Current (Answered)</td>
<td>5s</td>
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<tr>
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<tr>
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<td>Current (Answered)</td>
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Total: 52m 43s
Benefits of Using ChronicCareIQ’s Application

- **Minimal Investment**
  - No hardware to buy for the practice or the patients
  - No new hires! Use existing clinical staff to monitor dashboard – MA or LPN.
  - Bill Transitional Care and Chronic Care Management with the same program – two for the price of one!
  - Subscription-Based Monthly Payments
  - Single Solution - Enterprise Platform encompasses all specialties and all co-morbidities

- **Converts to Revenue Things You Currently Do for Free**
  - Refills and Med Changes, Conversations, Patient Education, Care Coordination, Answering Questions on the telephone… all count towards CCM when a patient is enrolled.

- **Better Patient Care**
  - 24/7 patient monitoring with alerts sent by email, text or phone when patients cross clinical thresholds.
  - Studies broadly show that monitored patients have delayed mortality, fewer hospitalizations, and report better quality of life.

- **Satisfies the Triple Aim, Improves Provider and Staff Satisfaction, Promotes Patient Satisfaction and Well Being, Higher Outcomes and Lower Costs**
How can PCMH CCEs work with CCIQ?
Partner with ChronicCareIQ

- ChronicCareIQ understands PCMHs and their needs
- ChronicCareIQ would like to partner with you in providing your clients a path to CCM success
- You choose the best way to partner with us
  - Recommendations to your clients
  - Contractual arrangements
    - Referral agreements
    - Sales,
    - Training Implementation
For more information, please contact

**www.ChronicCareIQ.com**
855.999.8089
Nick Hoback ext. 404
Nhoback@ChronicCareIQ.com

Linda J. Pepper, Ph.D., PCMH CCE
drlindapepper@mac.com