Chronic Care Management

10-Bed Critical Access Hospital
2 Rural Health Clinics
5 MDs and 4 PA's on Staff
Cover Approximately a 5-County Area

Roles

- Paula Ryan, BSN, RN, MHA CNO
- Jennifer Klanecky, BSN, RN, Chronic Care Manager

Objectives:

- Setting up a Chronic Care Management Program
- Building Efficiencies for Success over the Years
- Quality Improvement Outcomes
- Documentation Requirements, Billing, and Coding for CCM

What is Chronic Care Management?

- Chronic Care Management is defined as the non-face-to-face services provided to patients who have two or more chronic conditions.
- Provide care coordination between visits.
- Continue partnership with the patients to optimize health, increase quality of life, prevent hospitalization and emergency department utilization.

Getting Started

- Not a program that will start overnight.
- Learning the ropes and incorporating change
- Staff Buy-in
- Outside support from our ACO
- Don't get into the weeds, keep it simple
- Communication
- Interdepartmental Team meetings

Who is Eligible for CCM?

- Patients who have 2 or more chronic conditions that are expected to last 12 months (or until death) that place the individual at significant risk of death, acute exacerbation, or functional decline.

How to find patients?

- Reviewing the schedule for the week.
- Monitor the ER and inpatient lists.
- Run reports to find high cost patients.
- Ask triage nurses which patients are calling frequently.
- Identify patients during Medicare Wellness Visits.
- Dx: CHF, DM, COPD

Consent

- You must get written or verbal consent before billing the patient for CCM. It must include the following:
  - Availability of CCM services
  - Possible cost sharing responsibilities
  - Only 1 provider can furnish and bill CCM services during a calendar month
  - Patient's right to stop CCM services at any time.

Who can document time?

- Licensed clinical staff members including
  - MD
  - APRN
  - PA
  - RN
  - LSCSW
  - LPN
  - Clinical Pharmacists

What services count toward CCM time?

- Phone calls and emails with the patient.
- Prescription management/medication reconciliation.
- Coordinating care (by phone or other electronic communication) with other clinicians, facilities, community resources, and caregivers.

Documentation must include

- Patient demographics
- Problems
- Medication
- Allergies
- Care plan
- Care coordination
- Ongoing clinic care

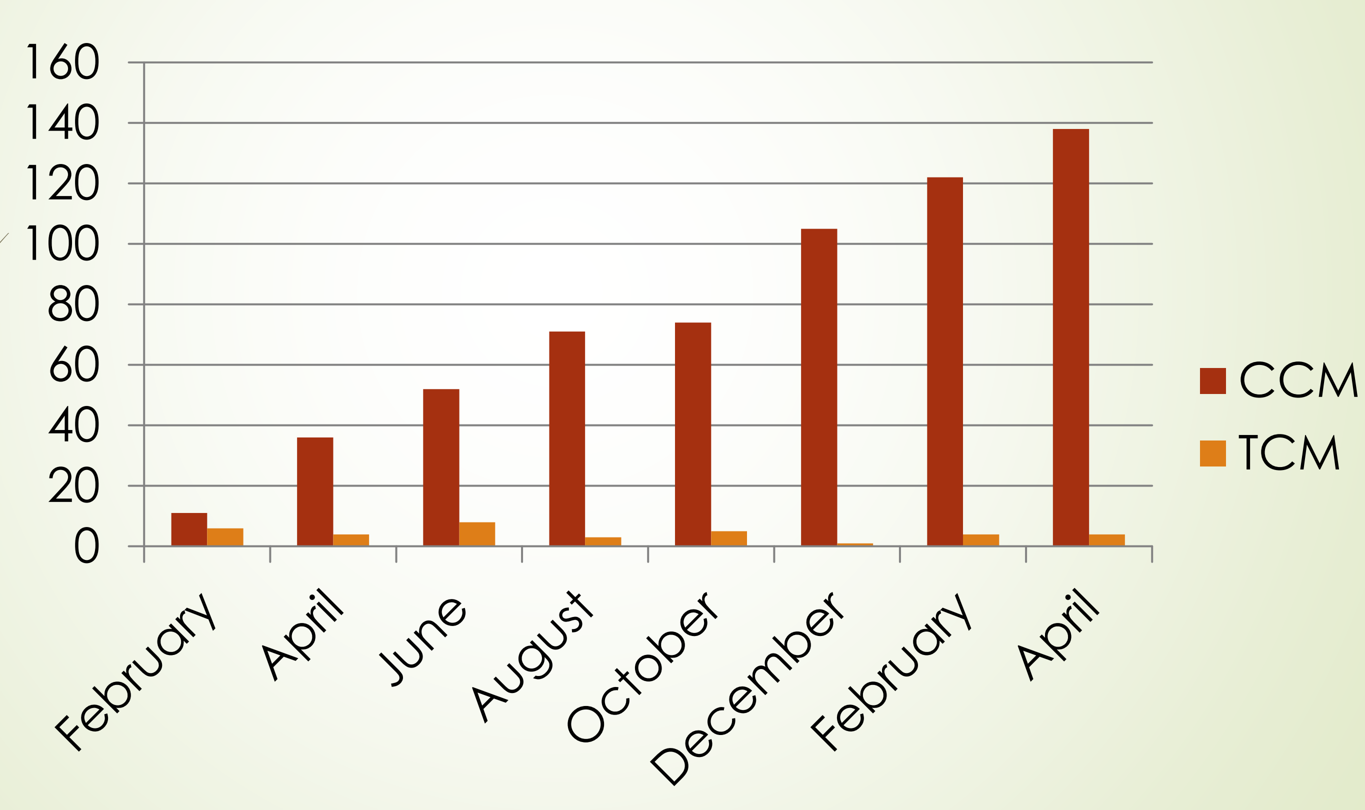
What do you talk to the patient about?

- Address Preventative Measures (mammogram, colonoscopy, pneumonia vaccine, flu vaccine, fall screening, ect)
- Current symptoms (pain, edema, shortness of breath)
- Home monitoring (blood sugar and blood pressure)
- Patient's healthcare goals
- Home safety
- Social support

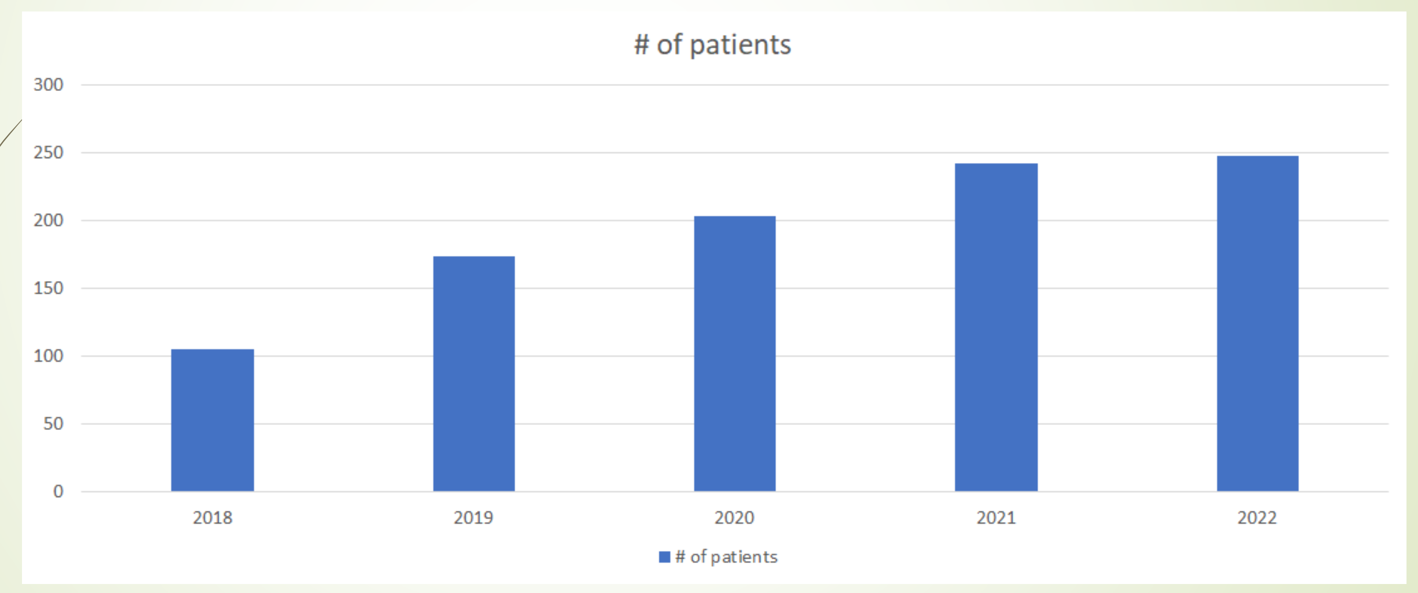
People We Collaborate with

- Social worker
- Pharmacy
- Providers/clinic nurses
- Assisted Living staff
- Home Health/Hospice
- 55+ Program staff (Mental Health)
- Cardiac Rehab
- Pulmonary rehab
- Wellness Center

Growth the First Year



CCM Growth Over the Years



Building Efficiencies

- Keep a list of CCM patient on a shared excel spreadsheet
- Each CCM patient is called every month
- Have the same nurse call the same patients each month for continuity
- Build a template in EHR to address required documentation
- Same nurses do TCM calls to transition patients to CCM if appropriate

When can CCM be billed?

- CCM services can be billed when 20 minutes or more is documented within 1 calendar month.
- The patient can not be receiving Home Health Care or be in a Nursing home.

Billing & Codes

- Same dx code from month to month
- CCM Code G0511 in Rural health, 99490 of not rural health
- Medicare Advantage patient calls have to be at least 25 days apart
- CMS reimbursement rate for 2022 is $79.25
- TCM –post acute care calls
  - f/u visit within 14 days 99495
  - f/u visit within 7 days 99496

Revenue

- 2,890 CCM visits in 2022
- X $82.00 per visit
- $236,980 made in 2022

Improving Quality Outcomes for Patients

- Decreased hospitalizations and ER visits
  - Success stories
- Improved BP control-giving patients BP monitors and f/u
  - October 2020-45% BP control
  - October 2022-68% BP control
- Decreased Triage calls, patient calls CCM nurse directly

Post-Acute Care

- Transitional care refers to the coordination and continuity of health care during a movement from one healthcare setting to either another or to home.
- A phone call to the patient within 2 business days of discharge.
- Confirm discharge medications are being taken as ordered.
- Confirm that patient has a follow up scheduled within 7-14 days after discharge.
- The clinic and hospital collaborate to track patients who leave our facility to a higher level of care. Our goal being to provide follow-up and transitional care post discharge from other facilities.

And Now What, Again!

- Looking towards Future:
  - Commercial insurances offering reimbursement for CCM/Quality Improvement
  - Addressing Social Determinants of Health
  - Build a Wellness Center for the Community.

Questions.....

- Paula Ryan, RN BSN MHA
  - Chief Nursing Officer
  - pryan@hcmc.us.com

- Jennifer Klanecky, RN BSN
  - Manager of Chronic Care Services
  - jklanecky@hcmc.us.com