CHRONIC CARE MANAGEMENT IS THE NEW APPROACH TO IMPROVING CHRONIC PATIENT CARE

Whether or not medical practices have heard about it, the federal government is moving ahead with changing the way it provides reimbursement for care of patients with chronic conditions. In 2015, The Centers for Medicare & Medicaid Services, or CMS, recognized Chronic Care Management – CCM – as a critical component of primary care. The Centers believe that an integrated approach to chronic care will contribute to better health – especially among the elder population.

The Centers subsequently took steps to adjust the Medicare Physician Fee Schedule (PFS) to encourage medical practices to provide more management services to Medicare patients with multiple chronic conditions. In addition to the in-office patient care and visits, Chronic Care Management covers non-face-to-face services which practices use to provide supplemental educational information, follow-up on health-related activities, and actively engage patients in pursuing improved health goals.

The foundational evidence for this change to quality of care was laid out in several research papers. In 2010, Gerard Anderson, Ph.D., Director of the Center for Hospital Finance and Management at Johns Hopkins Bloomberg School of Public Health, prepared an updated report of several earlier research papers for the Robert Wood Johnson Foundation®. Entitled, “Chronic Care: Making the Case for Ongoing Care,” Dr. Anderson unveiled the startling fact that “one in four Americans has multiple chronic conditions. That number rises to an astonishing three in four of Americans aged 65 and older.”

Because 75-85 percent of the nation’s health care dollars are spent on people with chronic conditions, the National Center for Chronic Disease Prevention and Health Promotion sited chronic disease as the public health challenge of the 21st century.

CMS is implementing a “Connected Care” campaign to raise awareness of the benefits of CCM for patients with multiple chronic conditions and provide health care professionals with resources to improve overall population health. Heavy on preventative patient care and better patient care, the guidelines can also lead to financial growth for the practice when implemented and rigorously followed.

WHAT IS CHRONIC CARE MANAGEMENT?

Chronic Care Management, or CCM, is the coordination of care services which are furnished outside of regular office visits. The target population is patients with two or more chronic conditions which are expected to last twelve months or longer, or until the patient's death. These conditions often place the patient at significant risk of death or functional decline, increase the likelihood of multiple hospitalizations, and involve a high level of medical care and follow-up. Certain behaviors on the patient's part, however, may lead to an enhanced quality of life or a delayed reduction in decline.

Some examples of chronic conditions which fall under the CCM guidelines would include:

- Addictions
- Alzheimer's
- Arthritis
- Asthma
- Atrial Fibrillation
- Autism
- Cancer
- Cardiovascular Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Hypertension
- Infectious Diseases
- Obesity
- Stroke/Neurological Condition

These conditions and other chronic diseases have been shown to be the leading causes of death and disability in America. Since they are a leading driver of health care costs, it is also hoped that taking direct aim at patients in the Medicare population will provide clues to improve overall population.

Chronic conditions generally require a high level of in-office care and follow-up, but there are certainly many steps which can be taken to increase preventative patient care and more fully involve patients in their own care regimens. Keeping appointments, monitoring glucose levels, having regular blood tests, following medication guidelines and increasing patient education can all lead to an improved doctor-patient relationship without having to increase the actual number of patient visits. In addition to the patient health benefits, eligible practitioners will be able to bill for at least 20 minutes or more of care coordination services per month.

Click here to watch a webinar on managing patients with chronic conditions.

PRACTICE ACTIVITIES FOR CHRONIC CARE MANAGEMENT

A medical practice which is about to engage in a CCM approach will want to look toward incorporating several types of activities that can count towards their minimum monthly service time, such as:

Patient Communication Procedures

Outside of, and in support of, the in-person visits, members of the practice staff can establish a regular communication routine with chronic care patients by telephone or through a secure online communication portal. These communications would serve the purpose of checking on patient health status, providing test reminders, reviewing medical records, and providing self-care education. This information would be added to the patient's health history and shared with other health care professionals as needed.

Electronic Health Records

This eliminates the need to maintain stacks of paperwork for each patient, and makes it easier to directly access and share relevant health information.

Sharing Patient Information

A great amount of inefficiency surrounds the process of making sure all health care providers have access to each patient's complete health history. Better upfront information sharing leads to improved care from varied providers, reduces administrative time compiling records, and prevents duplicate testing and contra-indicated medications or procedures.

Monitoring Medications

Since patients with several chronic conditions often seek care from multiple medical specialists, one primary source needs to be established to monitor the overall medications to look for possible allergic reactions, potential overdoses, and negative interactions.

Better Levels of Care Transition

Oftentimes when a chronic care patient seeks treatment, they are moved from a home environment to a hospital to a treatment center and back home again. At each level, the patient or family is often required to provide medical and prescription information, with hospital providers adding to or changing established medical regimens. When the patient is again released back to the primary care provider, there may be a great deal of confusion as to what the appropriate care routine should now be. These transitions can be better managed by providing more informed patient histories and facilitating improved follow-ups for discharged patients.

Improved Home Care

Many levels of nursing and therapeutic care can be provided on an at-home basis, so long as the primary provider is aware of, authorizes and documents these activities. Blood pressure readings, glucose levels, pain management, or changes in appearance/weight can all be assessed by the in-home provider and reported to the medical care facility for further action if needed.

Based on these activities, the clinician can then develop a comprehensive assessment and care plan for the chronic care patient that addresses all medical and psychosocial issues, as well as the underlying chronic condition or conditions. This plan is shared with the patient to establish a buy-in and motivate improved self-care. The provider may then involve personal care workers, visiting nurses, meal providers or day-care programs as needed to meet the goals of the plan.

PATIENT ACTIVITIES FOR CHRONIC CARE MANAGEMENT

The thought process behind building a stronger doctor-patient relationship based on quality of care instead of quantity of care is that patients who are actively involved in their own care management planning are more likely to be compliant with activities that will lead to better patient care.

Informed consent ensures that patients are aware of the nature of the program, and that they are totally on-board with following their treatment plan. Practices can then educate patients about the activities they can participate in to take better control of their own health outcomes by:

- Checking the patient portal regularly and monitoring their Electronic Health Record.
- Communicating with the designated contact person from the practice.
- Following-through on commitments to make and keep scheduled appointments for bloodwork and diagnostic tests.
- Adhering to medication schedules.
- Informing additional medical providers of their participation in the CCM program.
- Accessing educational resources to learn more about better managing their chronic health condition.
- Taking a more active and engaged role in their health.
- Striving to make positive changes that lead to enhanced health outcomes.

YOUR PRACTICE CAN REAP MANY BENEFITS FROM CHRONIC CARE MANAGEMENT

Helping patients lead happier and healthier lives is the primary reason most providers enter the medical profession, but far too often they get bogged down in administrative tasks that take them further away from actual patient care. CCM is as attempt to refocus attention on providing services that lead to better population health. Along with the moral imperative of improved care, it also provides many benefits to the individual practice:

Better Outcomes
Better care coordination and increased patient involvement leads to better health outcomes, and that is something all practices strive to achieve.

Reimbursement
Practices receive reimbursement for providing a minimum of 20 minutes of CCM services per patient in a given month.

Patient Involvement
Encouraging patients to use CCM services gives them the support and motivation they need to follow good health habits between visits to the office.

Increased Compliance
Appointment and test reminders, explanations of care, and increased education and access to their own information gives patients more of a feeling that they can do something positive to improve their health with their doctor's advice and guidance.

Improved Patient Satisfaction
Making CCM services available helps improve office efficiency, which leads to improved patient satisfaction.

Reduced Emergency Care
Patients with better control over chronic conditions can decrease emergency room visits and hospital stays, thereby reducing costs for their insurance providers.

Assured Revenue Stream
CCM provides another method of sustaining and growing your practice without adding additional facilities or an accompanying increase in necessary personnel. It provides additional resources and care for high-need patients, while allowing providers to continue providing care to the balance of their patient population.