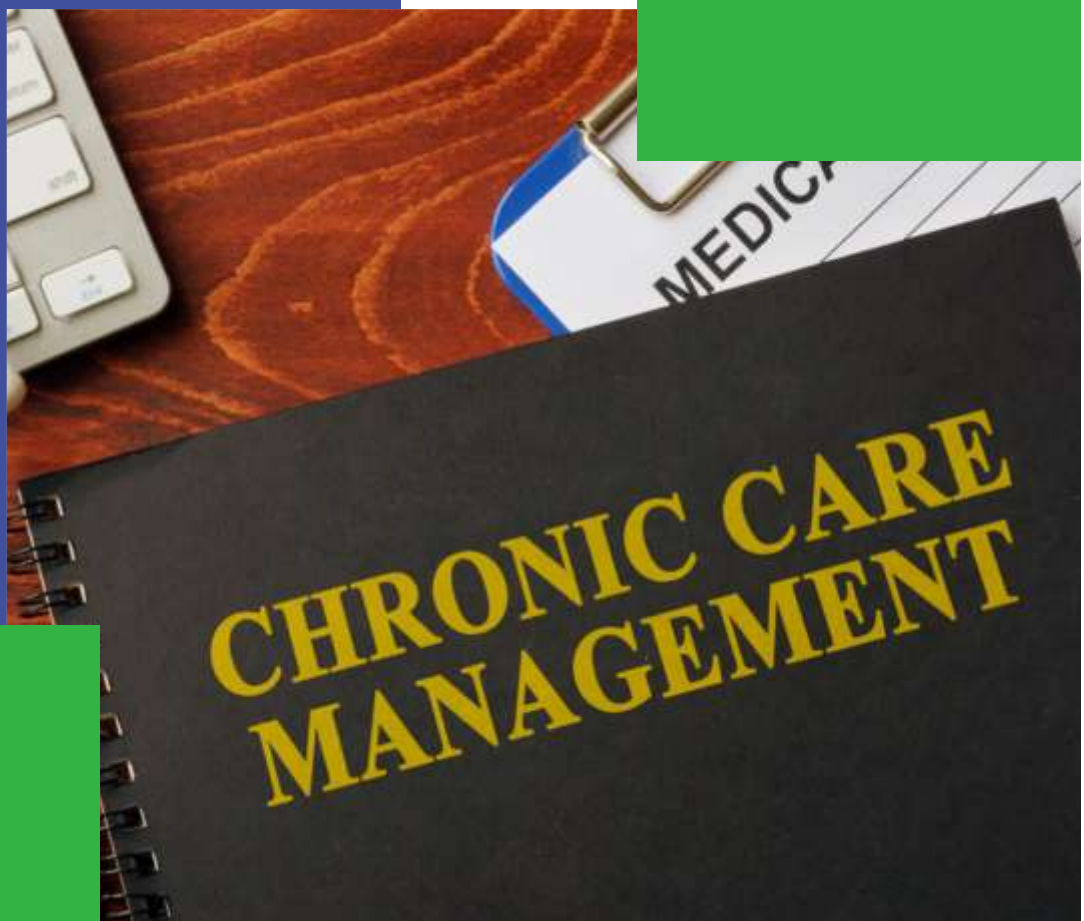
Health.
Wealth.
Safe.

A Complete Guide on

Chronic Care Management



Introduction

Chronic care management made its way into the medical field entirely in 2015. Centers for Medicare and Medicaid Services (CMS) is a medicare part B benefit. The physicians and non-physicians enjoy separately paid service under the medicare service; it was created because the complexity of taking care of patients with chronic illnesses was recognized.

Patients with chronic illnesses like diabetes, multiple sclerosis, and sleep apnea usually find themselves making regular visits to their healthcare provider because of their complicated treatment program. Also, many of these patients are at risk for fragmentation because patients can suffer from multiple chronic illnesses, and these patients are more likely to be attended to in case of an emergency than others.

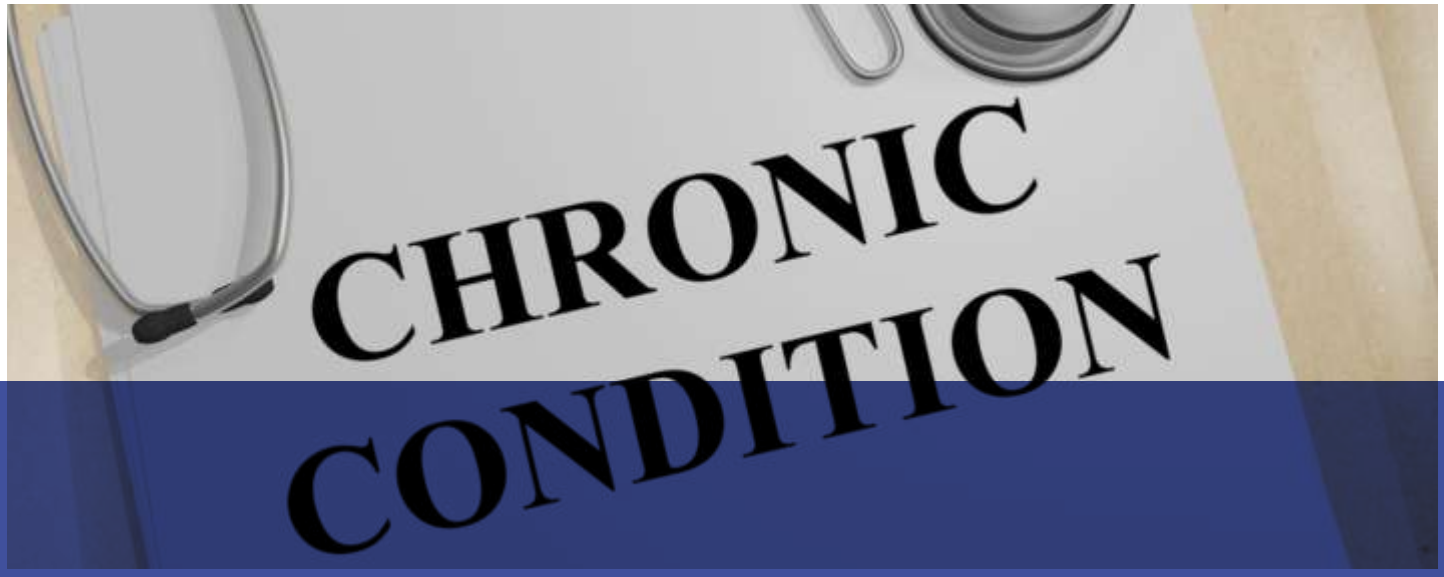
Introducing CCM into the medical world has made it easier to monitor these patients effectively and offers compensation to medical personnel who provide services to chronic care management. The system has proven cost-effective and improves outcomes.

What is a Chronic Care Management Program?

A chronic care management program is a program that provides care services for patients with two or more chronic diseases expected to last at least 12 months or until the death of the patient, or if the patient's condition increases their risk of death, functional decline, or exacerbation, and allows a continuous relationship with their health care team.

It allows the healthcare provider to efficiently oversee the patient's condition within and without the traditional hospital setting. The Chronic Disease Management program allows the health care team to bill the patients for the time spent managing their conditions. Including helping to create a detailed care plan, interactive remote communication and supervision, supervising their medicine plan, and supervision of care between providers.

The chronic care management detailed care plan includes the patient's medical history, personal information, the expected result of the chronic care management program, the list of the patient's health care providers, medications, including other services needed to manage the patient's health. The reason for this care plan is so the patients can understand their health.



Why is Chronic Care Management Important?

Chronic care management has proven to be very important in managing patients with chronic conditions because most times, patients with chronic diseases need more than medical care. Their treatment regimen requires them to make drastic lifestyle changes, and for them to keep to these changes, they need the support of their health care team and families.

Chronic care management programs motivate patients to stick to their regimen plans which helps improve their health. The program also allows patients better understand their disease and monitor their progress, which makes them more receptive to collaborating with their health care team in identifying and solving problems they might encounter in the course of their treatment.

It is evident that the traditional treatment method is not an ideal method of treating chronic patients, but a biopsychosocial method of treatment is the best alternative to achieve an improved state.

What Types of Services Can Be Provided Under Chronic Care Management?

Patients with multiple chronic diseases under CCM are entitled to a wide range of services provided under the Chronic Care Management Program. Some of these chronic care management services include:

- Care management and transitional care management services
- The CCM beneficiary has access to communication with the health care provider face to face, by phone, or even electrically for care management
- Community referral resource and linkage
- Overseeing community and social support services
- Education and support on disease self-management
- Health coaching
- Health education, including health literacy
- Interventions to reduce falls and risk factors for falls
- Medication supervision
- Preventive health counseling
- Symptom management

How Does Chronic Care Management Work?

The program starts with face-to-face interaction between the patient and their health care provider, after which the health care will create a detailed health care plan of the patient, which will be used to monitor the patient. That way, the patient won't need to go for face-to-face visits again until the necessary scheduled regular office visits.

Also, each month, the health care provider will access the patient's condition and oversee care with pharmacies and other health care providers. This way, the patient gets refills at due time and also access to other health services needed. Also, the patient is aware of every little change in their condition or health plan. The patient has every equipment and service they might need available at home.

Patients benefiting from the chronic care management plan have 24/7 access to their medical team to their care plan and health information. They can also contact any member of their health care team at any time of the day and any day of the week via telephone, email, or electronic patient portal. And even if the office is locked, there's always someone available to pick your call and direct you to emergency service if the case calls for it.

The purpose of Chronic Care Management, after all, is to ensure that patients have access to continuity of care and are provided with their medical, functional, and psychosocial needs that will help keep them healthy.

Benefits of Chronic Care Management

There are many benefits of the chronic care management system to both health care providers and the patient. These benefits include:

Patients participating in the Chronic Care Management program have a reduced likelihood of needing an emergency room or observation care in the hospital, unlike chronic disease patients who are not participating in Chronic care management. More so, hospitalizations due to several chronic diseases like diabetes, congestive heart, and several more drastically reduced, and patients reported that they were more satisfied with their healthcare plan.

Other benefits include:

- Patients enjoy personalized attention and patient care.
- Patients have access to teams consisting of known and trusted health care providers who have been actively involved in the patient's health care regime.
- Patients receive support between visits which help them maintain good health.
- Proactive care allows health care to be aware of every health issue and prevent patients from going into an emergency.
- It reduces the cost of revenue patients spend on managing their health conditions. It also saves costs for hospitals as the resources spent towards caring for patients with chronic diseases reduce drastically.

What are the Six Essential Elements of Chronic Care Management?

The chronic care model was developed to improve the quality of healthcare services offered to patients with chronic diseases. It is a visual guide to a thorough, incorporated reorganization of the care delivery important in improving patient care delivery. Putting the long-term health goals and needs of the patient at the center of the health care system and shifting the bulk of work from the physician's shoulders and distributing it to every member of the health care team including the patients.

The chronic care model contains six essential elements of a health care system. When integrated into a patient's health care regime, the chronic care management essential elements ensure quality care and management of the patient's chronic diseases.

These essential elements include:

- **Community resources**
- **Health system**
- **Self-management support**
- **Delivery system design**
- **Decision support**
- **Clinical information systems**

Studies have shown that the healthcare team should pay utmost attention to these six elements to attain substantial improvements in the quality of care. Making a change in all these six elements may prove difficult, which is the cause of establishing a toolkit that describes four phases to integrate the six elements fully. The phases include:

Phase 1: Getting Started

Phase 2: Process the Priorities for Improvement

Phase 3: Redesign Care and Business Systems

Phase 4: Sustainable improve performance

Although the chronic care model was developed to increase the quality of health across several patients with chronic diseases by improving the relationship between the patient and their health care team, it has been noted that improvement needs to occur at all stages of the organization for this to work.

While this tool focuses on improvements in the physician's practice level, the clinical and business levels also require support from the finance and managerial department staff. It implies that for this to work, every level of the organization, no matter the size, has to be involved.

Eligibility To Get Chronic Care Management

Patients eligible for the Chronic Care Management Program have multiple chronic conditions, that is, two or more, and are expected to last 12 months or until the death of the patient. Likewise, patients whose chronic conditions put them at great risk of death, acute exacerbation/decompensation, or functional decline.
Some of the chronic situations consist of :

Alzheimer's disease

Arthritis

Asthma

Autism

Cancer

Cardiovascular disease

Dementia

Depression

Diabetes

Heart disease

High blood pressure

Hypertension

HIV/AIDS

Lupus

Multiple sclerosis

For patients to be enrolled in the chronic care management program, they should have a face-to-face interaction with their healthcare provider. The physician explains all about the program to the patient, and the patient can ask any questions they have relating to chronic care management.

If the patient agrees to participate in the CCM program before being enrolled, they need to give either verbal or written consent. If the patient is giving verbal consent, the practitioner should ensure that they record the date and time the verbal consent was given. A situation may arise when the information will be needed.

The physician should also check with their biller or secondary insurance if they cover 20% of the patient's payment since medicare already covers 80%. If not, the patient will be paying the 20% copay. After the patient has filled the form or given verbal consent, the practitioner should engage them in chronic care management.

Best Practices for Chronic Care Management

The best practices for a successful chronic care management program include the following;

1. Ensure patient eligibility: before a physician engages a patient in the chronic care management program, they should ensure that the patient satisfies one of the chronic care management eligibility criteria.

2. Be aware of who is to bill the patient: beneficiaries of the chronic care management program can be billed not only by physicians but also by their assistants, clinical nurse specialists, nurse practitioners, certified nurse-midwives. Federal-funded health centers (FQHCs) and rural health clinics (RHCs) are also eligible. But only a practitioner and hospital can receive CCM compensation for the patient each month.

3. Patients' written or verbal consent must be documented: before the practitioner starts engaging the patient in CCM, they must have received consent, either written or verbal, from the patient and documented it in case the need for it arises in the future. Consent is received after the practitioner has fully explained to the patient and made them understand that they can stop receiving the services at any point in time. Only a practitioner and hospital have the right to receive payment from them.

4. Creating a detailed care plan: CCM requires that health care providers create a detailed care plan for the patient and make the plan available to the patient, caregiver, or other providers if necessary. They can also make the care plan available as an electronic copy through the patient's portal.

5. The health care provider should track every time spent on the patient: this includes non-face-to-face services like calls, prescription supervision, medication reconciliation, and care coordination with other practitioners and healthcare facilities.

6. Partner with care coordination service: for physicians interested in CCM but lacking adequate staff, they can consider partnering with care coordination service

Health Wealth Safe is equipped with care managers that communicate in multiple languages and check on your patient's health status through timely calls, once every month. We will thereby, be connected with respective doctors and physicians for prescription refills, care plan reviews, and much more.

With 5 teams invested into your practice to engage, distribute, educate, bill, and analyze your practice you will increase your practice revenue, and bring your patients closer to you than ever. Health Wealth Safe's RPM and CCM programs help your patients live to 100.

Use Health Wealth Safe for your Remote Patient Monitoring (RPM) and Chronic Care Management (CCM) solutions for a seamless healthcare service.

Chronic Care Management Software Cost (Factors & Value)

Chronic care management software offers a smooth interaction between the healthcare team and the patient. The physician can manage all of their patients and monitor them from a central location, creating comprehensive health care plans and other features that simplify the CCM program.

You can find chronic care management software ranging from as low as $.99 per patient per month to as high as $8 per patient per month, depending on what plan you opt for and what software company you decide to use.

Chronic Care Model Components You Should Know

The chronic care model was first developed in the mid-1990s by the MacColl Center for Health Care Innovation staff at Group Health Research Institute, led by Edward H. Wagner, MD, MPH. It was developed to improve the health care offered to patients with the patient, healthcare provider, and the organization collaborating to improve health care for chronic patients.

The model consists of six components of the healthcare delivery defined by ICIC, and they include:

1. Health system/ organizational support: creating a culture, organization, and mechanism that supports and promotes safe, high-quality care

2. Clinical Informations System: in charge of organizing patient and population data to promote efficient and effective care

3. Delivery System Design: ensures the delivery of efficient and effective clinical care with self-management support

4. Decision support: promotes clinical care in consistence with scientific evidence and patient preference

5. Self-management support: educate and prepare patients towards managing their health and health care

6. Community resources: mobilize community resources to meet patient needs

Complex Chronic Care Management

Chronic Care Management and Complex chronic care management are almost the same, with slight differences. They both require that the patient is with two or more chronic diseases expected to last at least 12 months or until the patient's death, or if the patient's condition increases their risk of death, functional decline, or exacerbation.

While non-complex CCM requires at least 20minutes of clinical staff per month spent on face to face meetings with the patient and can be directed either by the physician or other health care provider to monitor patients and is termed CPT 99490, complex CCM requires at least 60 minutes per month to revise or establish comprehensive care plan involving moderate to high complexity medical decision making and is called CPT 99490.

CPT 99491 is the code used for face to face meetings with a physician or other qualified healthcare professional that lasts 30monutes per calendar month in non-complex CCM; while CPT 99489 is used when the patient's face to face time with medical practice is increased by 30 mins in complex CCM.

Simplifying Chronic Care Management in Your Practice

To incorporate CCM into your practice, follow these steps to make the process easier:

1. Identify patients: take note of patients with multiple chronic conditions that will live for at least a year, so you can identify them and explain the process to them.

2. Explain CCM: fully explain CCM to the patient and make them understand that they can stop receiving the services at any point in time, and only a particular practitioner and hospital have the right to receive payment from them.

3. Obtain consent: consent should be obtained before engaging the patient in CCM. You should obtain consent, either written or verbal, from the patient and document it in case the need for it arises in the future.

4. Develop and share a detailed personalized care plan: create a detailed care plan for the patient and make the plan available to the patient, caregiver, or other providers if necessary. Also, make the care plan available as an electronic copy through the patient's portal.

5. Oversee non-face-to-face care: non-face-to-face care kike calls, emails, prescription refill, follow-up on referrals should be documented in the EHR. Also, document the time spent with the patient on non-face-to-face care and ensure it's up to at least 20 minutes per calendar month.

6. Bill for the CCM service: bill CPT 99490 once all CCM requirements have been met. You should also check with their biller or secondary insurance if they cover 20% of the patient's payment since medicare already covers 80%. If not, the patient will be paying the 20% copay.

Conclusion

Chronic care management is an effective way to improve patients' health with chronic diseases, reducing their risks for frequent hospital visits and emergencies. It is also a source of revenue for healthcare and is less time-consuming and cost-effective. If you want to incorporate CCM into your healthcare center and you hardly have the time, or you're finding it difficult, health technology companies have stepped up to make the prices easier, better, and more simplified.