Participant Questions & Presenter Answers

Chronic Care Management - Medicare and Beyond | 09/20/18 Webinar

(Responses in **RED** were provided by Gayla HasenKamp, LPN, Care Coordinator, McCook Clinic, McCook, NE; responses in **BLUE** were provided by Ann Blanchard, BSN, RN, Director, Ambulatory Clinics, Nebraska Medicine, Omaha, NE)

For anyone that has recently started a chronic care management program, how did you decide which patients to include at first?
Did you look at top 50 or 100 users of the health care system?
Did you just enroll anyone that was being seen in the clinic and that was eligible?
How did your coordinators keep up with the sudden volume of patients involved?

GAYLA: I ran a report with that filtered out patients age 65 and older (can confirm later if they are indeed a Medicare recipient) and then added to the filter 2 or 3 chronic diagnosis. Our system would then identify patients of that age and those who had at least one of the diagnoses I entered. Even if only one of the diagnoses applied to a person, I always seemed to find that they had two or more other chronic diagnoses. The reports were then divided by provider and given to them. The providers chose the patients that they felt should be priority for the program and that would benefit from the extra oversight. At first, I just focused on the patients the providers chose that were already scheduled for appointments and arranged to visit with them the day of their upcoming appointment. In our case, those were not large numbers in a day so it is manageable for one care coordinator nurse.

ANN: At Nebraska Medicine, we are evaluating patient populations per clinic. In our process, we explain the program in detail to our patients and have the patient sign consent. The nurse in each clinic location runs a report the day prior to clinic to evaluate current eligible patients, that list is then prioritized based on patients with the highest risk score or those that the provider and clinic team have determined to be a rising risk patient. The volume began small with enrolling the highest risk patients, we have continued to expand with some clinics having over 200 patients enrolled. Our Nurse Care Coordinators (NCC) have modified their schedules for 1 or 2 hours per week planned specifically for CCM outreach to their patient population.

What elements are included in your electronic care plan that is required and are your goals areas allowed to be customized by a provider?

GAYLA:

- Goal
- Related Health Problem (diagnosis)
- Plan
- Barriers
- Outcome
- Comment section (where I enter notes each time the CP is updated---for instance what medication the patient is on for this diagnosis, any home monitoring the patient has done r/t this diagnosis (weight, BP, BS, etc.), lab results r/t this diagnosis, etc.)
- Our providers or anyone with access to the EMR could access and update the CP

ANN: Our EMR includes all CCM elements required by CMS. We do have common Medical Goals that can be selected by our providers and clinical team; however, every goal is customizable. There are sections within each goal to free text in information specific to the patient. Each patient enrolled in CCM has a "Patient Centered Goal."

How do you get a patient's a copy of this to meet the regulation?
GAYLA: If complete, I give a copy to the patient the day of their face-to-face visit/CCM enrollment day or it could be sent via the patient portal or mailed to the patient. I always am sure to document in my notes that the patient received a copy of the CP.

ANN: At Nebraska Medicine our patients are given an "After Visit Summary" AVS at the completion of each visit. The AVS is either printed out or if the patient is enrolled in our patient portal they can review the AVS electronically. We also have options to print directly from our longitudinal plan of care if patients or the clinic team prefer this view of the patient's medical information.

How often have you had CCM patients call after clinic hours?
GAYLA: I do not have this happen often. Our providers rotate staffing the local ER (no one else)—so patients have that access to providers that always have the patient's CP and EMR available to them.

ANN: Great question, we have not quantified this volume. We have a Medical Call Center that answers calls on the evenings and weekends. If the patient call is non-urgent and does not require triage, the patient's questions are sent forward to the clinic via an in-basket electronic message. In discussions with the clinical teams, they rarely see a question or concern from the Medical Call Center specific to a CCM patient. Generally these patients are higher risk so if they are calling in after hours, it is an urgent medical need that requires triage and clarification on direction per the on-call provider.

What version of Allscripts is McCook on—ProEHR or Touchworks?
If ProEHR, we would like to know which report you are running to get a list of potential CCM patients.
GAYLA: PRO---Launch (rocket icon)>Reporting Module>Enter Criteria>Save Criteria, etc, etc, etc…this is not my expertise, but it can be done! Is there someone in your facility that already runs reports from the system? IT?

How frequently do you call CCM patients? Is there a minimum number of times, i.e., once a week and/or is it individualized to the patient?
GAYLA: It varies greatly, depending on the CCM patient, how many incoming calls I am getting, if patients are good at answering my calls and/or returning calls after I leave a message. It is my understanding that CMS does not have a requirement regarding this—the reference to "monthly" is only in regards to the frequency of maximum billing (once per month if criteria met).

ANN: Our goal is to conduct an outreach monthly to 75% of the CCM enrolled patients. The outreach is individualized to the patient plan of care and patient centered goals.

If you have a patient that your conversation led into advance care planning vs. chronic disease management would you continue using the CCM codes?
GAYLA: I have not encountered this, so am unsure how this would be addressed.

ANN: We continue to use the CCM code. Many times, the advanced or as we call it complex care coordination is really the only time where 20 minutes or more of time is spent coordinating the patients care for that calendar month. We are seeing that over 80% of the time we are not spending 20 minutes or more per patient per month. We are completing additional data analysis to determine what our current average time spent in outreach is and if this has any correlation to readmission rates and ED utilization.
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Do Medicare patients have $10 copay each calendar month?
GAYLA: Yes—but, of course, only if you meet criteria and choose to bill out the appropriate CCM code for that month. Then, most secondary coverages pay a sum that leaves a co-pay of around $8 for the patient.

ANN: Agree with above statement and would add that the out-of-pocket expense is based on if the patient has met their deductible. On average we are seeing an out-of-pocket expense of $4.00-$6.00. Our Medicare patient population represents over 60% of our patients enrolled in CCM.

Is there reluctance from patient to pay $10.00?
GAYLA: A few will have an issue with this possibility, but again, as long as you are informative up front and assure them that the maximum will be once per month and not necessarily every month—having the signed consent that states this scanned into the chart is beneficial if there were to be issues.

ANN: We are seeing that our Medicare patient population appreciates the additional outreaches and peace of mind that the clinical team is paying "additional attention to them" coordinating their care even if they do not have an office visit that month. Adult children of our geriatric patient populations are some of our best early adopters in signing up for CCM.

How many patients does each care coordinator coordinate care for?
GAYLA: I am the only care coordinator in our clinic that does CCM. I have enrolled about 125 patients now, but probably about 20 of them are "in-active" due to having moved, expired, or have declined further involvement in the program. Recently, I am being allowed nearly all of my work time to be dedicated to the CCM program, so I hope to grow the program at a steadier pace—including BCBS recipients.

ANN: Our NCCs currently have a patient panel of 2,000-2,500 unique patients. Of those on average 200-300 is high risk or rising risk and are those that we are looking to have enrolled in the CCM program. We are continuing to evaluate our staffing model and the % of high-risk patients our NCC are coordinating care for, as this is a moving target.

You spoke about having some difficulty with the front phone staff for those that you have deemed a CCM patient. Have you done education with those that take the calls and are in essence "triaging?"
GAYLA: We need more education in our clinic in regards to keeping me informed about CCM patient calls and requests as well as status changes for CCM patients. I hope to address this in the future. "Pops-Ups" in the charts (of any kind) sometimes get over looked during busy, high call-load times.

ANN: Our phones are answered by Medical Receptionists. All clinical questions and concerns are routed to our NCCs.

For more Chronic Care Management information:
Great Plains QIN Care Coordination: https://greatplainsqin.org/initiatives/coordination-care/
CMS Chronic Care Management Services: https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/chronic-care-management.html
CMS CCM PDF: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

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