Whitepaper

Tegria

Chronic Care Management: Solving Key Challenges to Implementation

Establishing Chronic Care Management programs have proven to be viable strategies to enhance revenue and improve clinical outcomes in physician practices who provide care to patients with chronic conditions.

The Centers for Medicare & Medicaid Services (CMS) has recognized, and continues to recognize, cost savings and improved clinical outcomes for patients enrolled in Chronic Care Management programs. This continued commitment has led CMS to make improvements to the current CCM code set, as well as revise documentation and care coordination requirements, lessening the burden for providers and practices.

However, providing chronic care services continues to pose significant challenges for medical groups that operate with limited resources. If your organization is ready to launch a CCM program, an effective, test the water approach, would be a CCM pilot program. By slowly integrating CCM into your practice, your practice can begin to reap the rewards while avoiding a tumultuous change in day-to-day operations and subsequent patient volumes. Consider launching your CCM pilot program with just one physician and their support staff before rolling this out on a larger scale.

Follow the steps below to implement a smooth CCM pilot program at your practice:

CCM: Steps to Launch

Assess

Conduct a thorough workflow analysis

CCM workflows can be quite complicated, which is why well-developed process maps and flowcharts are critical to launching your CCM pilot program. It's important that every task, handoff, and hard stop is accounted for and assigned to either the physician or the team member. This material should be developed with participation from the providers and staff that are performing the actual work. Make every effort to bring all newly enrolled CCM patients online with your Patient Portal.

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PlanEngage with your EHR vendor

Work with your EHR vendor to gain a full understanding of your systems CCM capabilities as well as limitations. If possible, schedule a demonstration of your systems CCM workflows. Record the demonstration to use as a resource to reference moving forward. Have your EHR Service Administrator put you in touch with other practices that have implemented successful CCM programs.

Identify eligible CCM patients

Use your EHR to generate a report of patients that have two or more chronic conditions. This is generally accomplished by running a patient registry report based on the more common CCM eligible diagnosis codes such as diabetes, COPD, and hypertension. Have your physician and clinical staff review the list of eligible CCM patients, identifying patients that are potential fits for the program.

Train

Training

The process maps and other materials that were developed during the workflow analysis stage should also be used to train providers and support staff. Use a test patient account to walk through the following key CCM processes: Patient Enrollment and Consent Processes | Creating, Maintaining, and Sending the Patient Centered Care Plan | Logging CCM Time | Monthly Reconciliation Process for Billing CCM Codes. The more training that takes place, the more seamless your process will be when rolled out on a larger scale.

Implement

Start small

Begin your CCM pilot program with a panel size of 50 enrolled patients for a period of two to four months. Remember that patients must have two (or more) conditions that are expected to last at least 12 months and place the patient at significant risk of death, acute exacerbation/decomposition, or functional decline if left untreated.

Time tracking

Make sure that your staff can easily track time spent on non-face-to-face patient care. Remember at least 20 minutes of clinical staff time must be documented for patients each month in order to bill for CCM services. Complex CCM mandates at least 60 minutes of staff time.

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Documentation

As part of CCM, patient consent, a comprehensive care plan, and any communication with providers must also be documented by staff members in the patient chart area of your EHR.

Communicate and Measure

Overcommunicate

Daily feedback is critical for ensuring success. Plan for at least a 15-minute daily huddle during the first two weeks. Use this time to quickly assess process issues and solicit feedback on solutions. Use a 1-hour weekly meeting to resolve major workflow issues, identify performance improvement opportunities and continuously revise and perfect your process maps.

Measure progress

Develop a project dashboard to monitor CCM pilot performance and include Key Performance Indicators (KPIs) specific to clinical, operational, and financial performance.

Following these simple steps to launch your CCM program will ensure your programs viability. When implemented correctly these strategies will not only lead to cost savings and improved clinical outcomes, they will also boost revenues and improve clinical outcomes.

If you have questions about starting a Chronic Care Management program and could use some additional support, feel free to reach out at **connect@tegria.com**

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