Care Coordination:
Chronic Care Management Through PCMH

Every patient deserves exemplary care.

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The History of PCMH with TCT

“Simplification leads to clarity and clarity allows the provider to focus on improving everyday services to their patients and their own bottom line.”

Sandra C. Canally, RN
Founder and CEO
The Compliance Team

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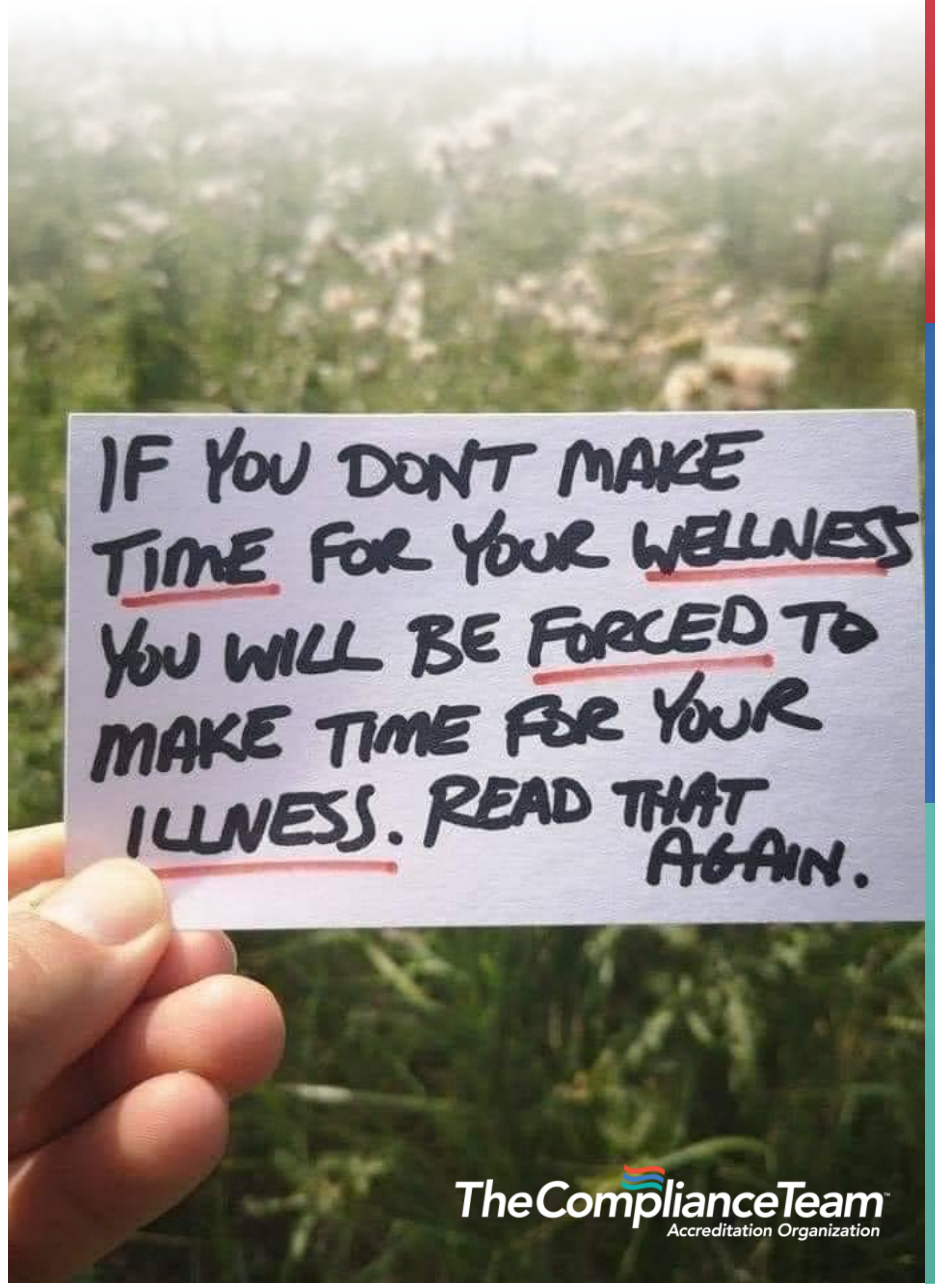
Learning Objectives

Understand the "WHY" of Care Coordination

Hear opportunities to improve the Care Coordination model

Gain tips for overcoming barriers in rural communities



What is Care Coordination?

*"…**deliberately** organizing patient care activities and sharing information among all of the participants concerned…"*

Care Coordination | Agency for Healthcare Research and Quality (ahrq.gov)

- Assessing patient needs and providing resources
- Working to identify "what matters most" and developing goals.
- Fostering and encouraging patient engagement.
- Streamlining access to care when and where it is best for the patient.

Dictionary.com: "Harmonious combination or interaction"

Care Coordination

Care Coordination involves regular communication between health professionals, to ensure that quality care is consistently provided to patients. The Primary Care Provider should serve as the “hub” and be aware and incorporate other facets of the patients’ care.

A person’s emotional, social, mental, spiritual, and behavioral needs have just as much of an impact on their overall physical health. Addressing all parts of their situation — not just the traditional, physical ones — is known as **whole person care**.

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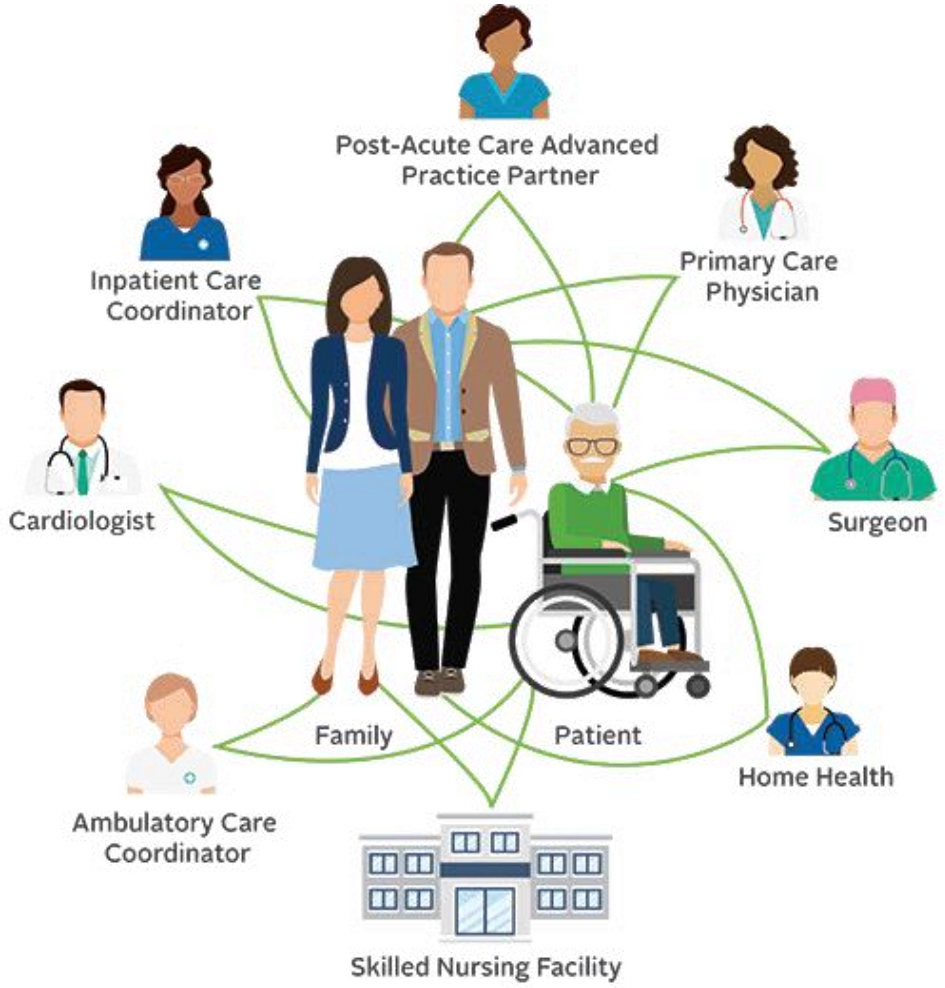
When Care Needs to be Coordinated

- Follow up after discharge from the Emergency Department
- Care between PCP and specialists
- Transitions between “home” and facilities (SNF, inpatient hospital stays)
- When social services need to be coordinated
- After labs or diagnostic screenings
- When new or complex medications are prescribed



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Care Coordination

When care is coordinated well, the patient and his or her doctors, nurses, other health care providers, family, and other caregivers communicate with each other so that everyone has the information they need.

Care coordination programs can improve patients' experiences with the health care system and their health outcomes as well as reduce wasteful spending in the long run.

Beyond the 4 Walls and 15 Minutes

“Ruth”

- 55y/o female w/ COPD
- Monthly ED visits and/or Inpatient stays
- Labeled as “high utilizer”
- Placed with a Care Coordinator
- Collaboration with pharmacy and pulmonologist
- Visit to her apartment revealed mold
- Worked with her family to get her moved into new apartment
- The next quarter she had 2 visits with her PCP, but not acute exacerbations.
- Only one ED visit the next quarter due to influenza.
- No hospitalizations for the year.

WHY is This Important?

- Promotes greater efficiency and quality,
- Improves outcomes and patient satisfaction,
- Reduces utilization of $$$ services such as ER visits and hospitalizations.
- Provides the patient with confidence in the “team” and builds relationships.
- Generates Revenue for the practice. Stay tuned!
- It’s the right thing to do!

Meaningful Patient Engagement

Engaged patients are also known as “activated patients,” meaning they engage in positive behaviors such as managing their own healthcare.

- Step 1: **Inform Me** General information about services provided by the practice and information about their health such as diagnoses, lab results, medications and treatment.
- Step 2: **Engage Me** Providing self-management tools and ways to get the patient involved in managing their own care such as the patient portal, medication reminders, etc.
- Step 3: **Empower Me** Get feedback on how the practice can better serve the patient. Ask them to share information from home such as blood pressures, weight, etc.
- Step 4: **Encourage Me** Provide feedback that is valuable and effective. Focus the feedback around what matters to the patient.

Social ~~Determinants~~ Drivers of Health

QUESTION:

What percentage of a person's overall health is determined by what happens in the healthcare setting?

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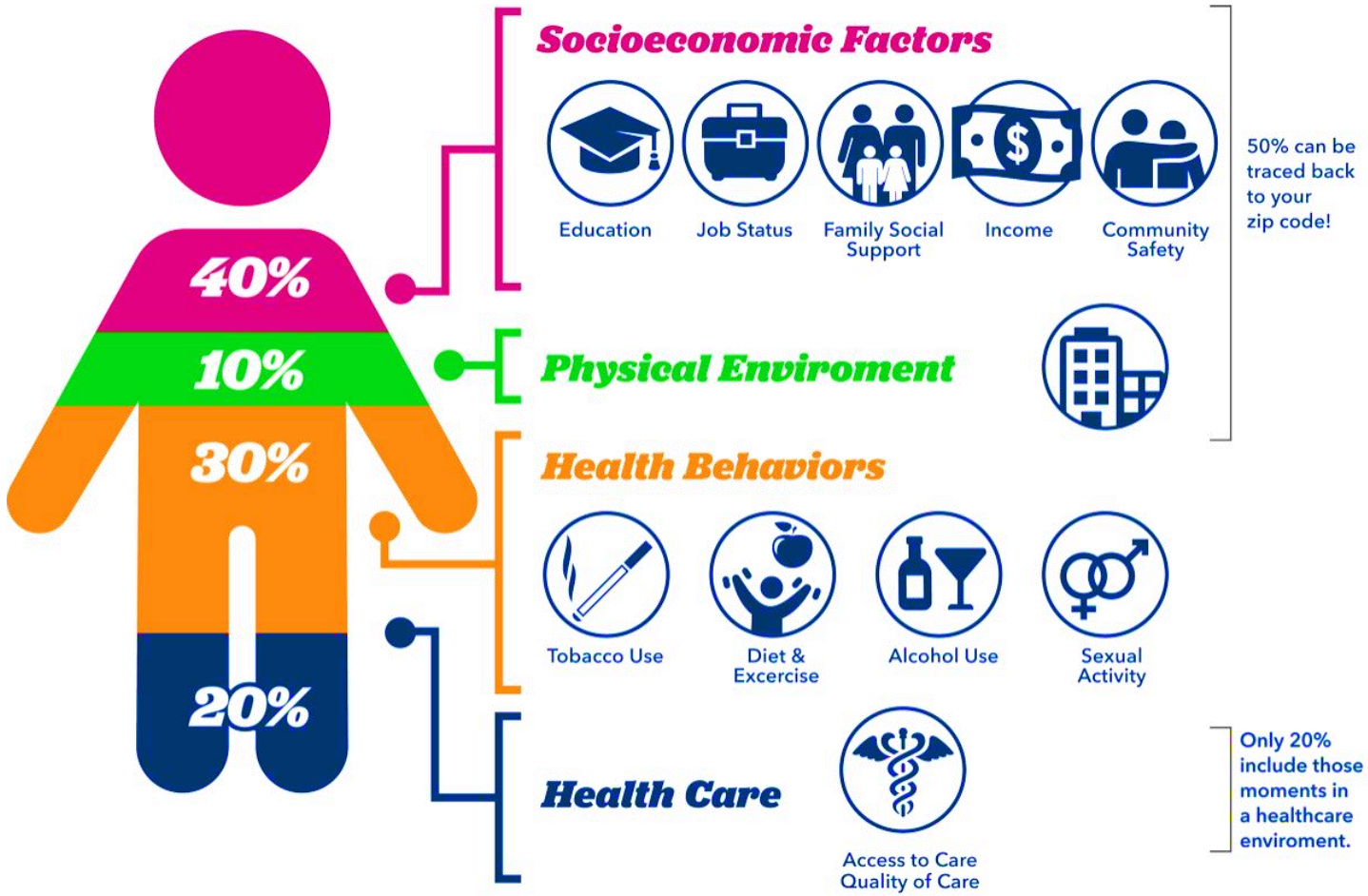
SDOH

80% of what makes up someone's health is determined by what happens outside of the clinic or hospital.



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

https://noahhelps.org/sdoh/

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The Challenges

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The Opportunities

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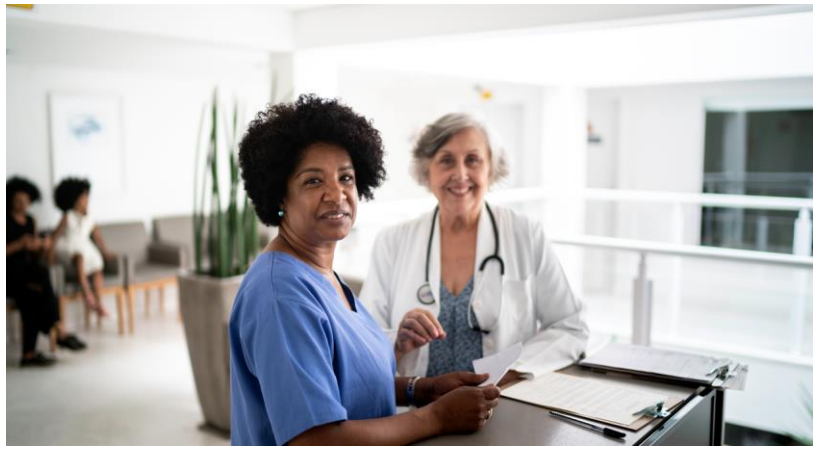
What is Chronic Care Management?

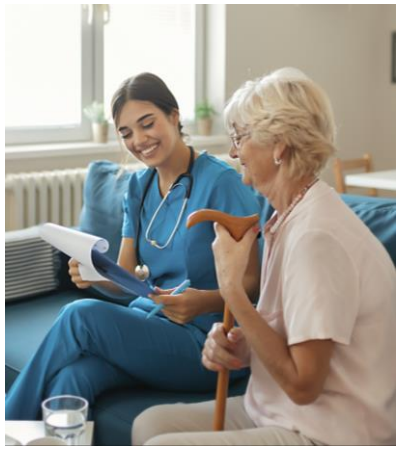
Twenty minutes of services provided to Medicare beneficiaries who have multiple (2 or more) chronic conditions.

Principal Care Management requires only one chronic condition, but 30 minutes of time.

CMS initially patterned this program specifically for PCMHs because they are uniquely prepared to embrace and succeed with the CCM model.

You are doing this work. Get paid for it.





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Umbrella Code

- We are finalizing the addition of chronic pain management and behavioral health integration services to the RHC and FQHC specific general care management HCPCS code, **G0511**, which aligns with changes made under the PFS for CY 2023. Since the requirements for the chronic pain management and behavioral health integration services are similar to the requirements for the general care management services furnished by RHCs and FQHCs (which are the current services for which RHCs and FQHCs can use HCPCS code G0511) the payment rate for HCPCS code G0511 will continue to be the average of the national non-facility PFS payment rates for the RHC and FQHC care management and general behavioral health codes (CPT codes 99484, 99487, 99490, and 99491) and PCM codes (CPT codes 99424 and 99425) Payment will be updated annually based on the PFS amounts for these codes, which is how these updates are made currently.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule

Financial Rewards of CCM

G0511	RHC	Care mgt., RHC/FQHC*	$77.94 (2023)

- 25 patients — $1,949 per month
- 50 patients — $3,897 per month
- 100 patients — $7,794 per month
- 200 Patients — $15,588 per month

Examples of Diagnoses

Examples of chronic conditions include, but aren't limited to:

Alzheimer's disease and related dementia

- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Hypertension
- Infectious diseases like HIV and AIDS

Initiating Visit

- Before CCM services can start, we require an initiating visit for new patients or patients who the billing practitioner hasn't seen within 1 year.

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Patient Consent

- Written or verbal consent is required before billing for CCM services. This helps the patient to understand the additional benefits they are receiving, ensure they are engaged and make them aware of their cost sharing responsibilities. Informed consent is only required once unless they switch to a different CCM practioner.
- It is important to inform the patient that only 1 practitioner can furnish and bill CCM services during the calendar month.
- The patient has the right to refuse CCM services at any time.

AGREEMENT TO RECEIVE MEDICARE CHRONIC CARE MANAGEMENT SERVICES

As of Jan. 1, 2015, Medicare covers chronic care management services provided by physician practices per calendar month. I understand that my primary care physician, named below, is willing to provide such services to me, including the following:

- Access to my care team 24-hours-a-day, 7-days-a-week, including telephone access and other non-face-to-face means of communication,
- The ability to get successive, routine appointments with my designated primary care physician or member of my care team,
- Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medication management,
- Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values,
- Management of my care as I move between and among health care providers and settings, including the following:
    - Referrals to other health care providers,
    - Follow-up after I visit an emergency department,
    - Follow-up after I am discharged from the hospital or other facility (e.g., skilled nursing facility),
- Coordination with home- and community-based providers of clinical services.

I understand that as part of these services I will receive a copy of my comprehensive plan of care.

I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose, instead, to receive these services from another health care professional after the calendar month in which I revoke this agreement. Medicare will only pay one physician or health care professional to furnish me chronic care management services within a given calendar month.

I understand these chronic care management services are subject to the usual Medicare deductible and coinsurance applied to physician services.

I hereby indicate by signature on this agreement that _____ is designated as my primary care physician for purposes of providing Medicare chronic care management services to me and billing for them.

My signature also authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in chronic care management services.

This designation is effective as of the date below and remains in effect until revoked by me.

Patient Name (please print): _____
Patient Date of Birth: _____

Patient or Guardian Signature: _____
Date: _____

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Comprehensive Care Plan

- Patient-centered
- Electronic or physical copy must be provided to the patient
- Share with other providers and individuals involved in care

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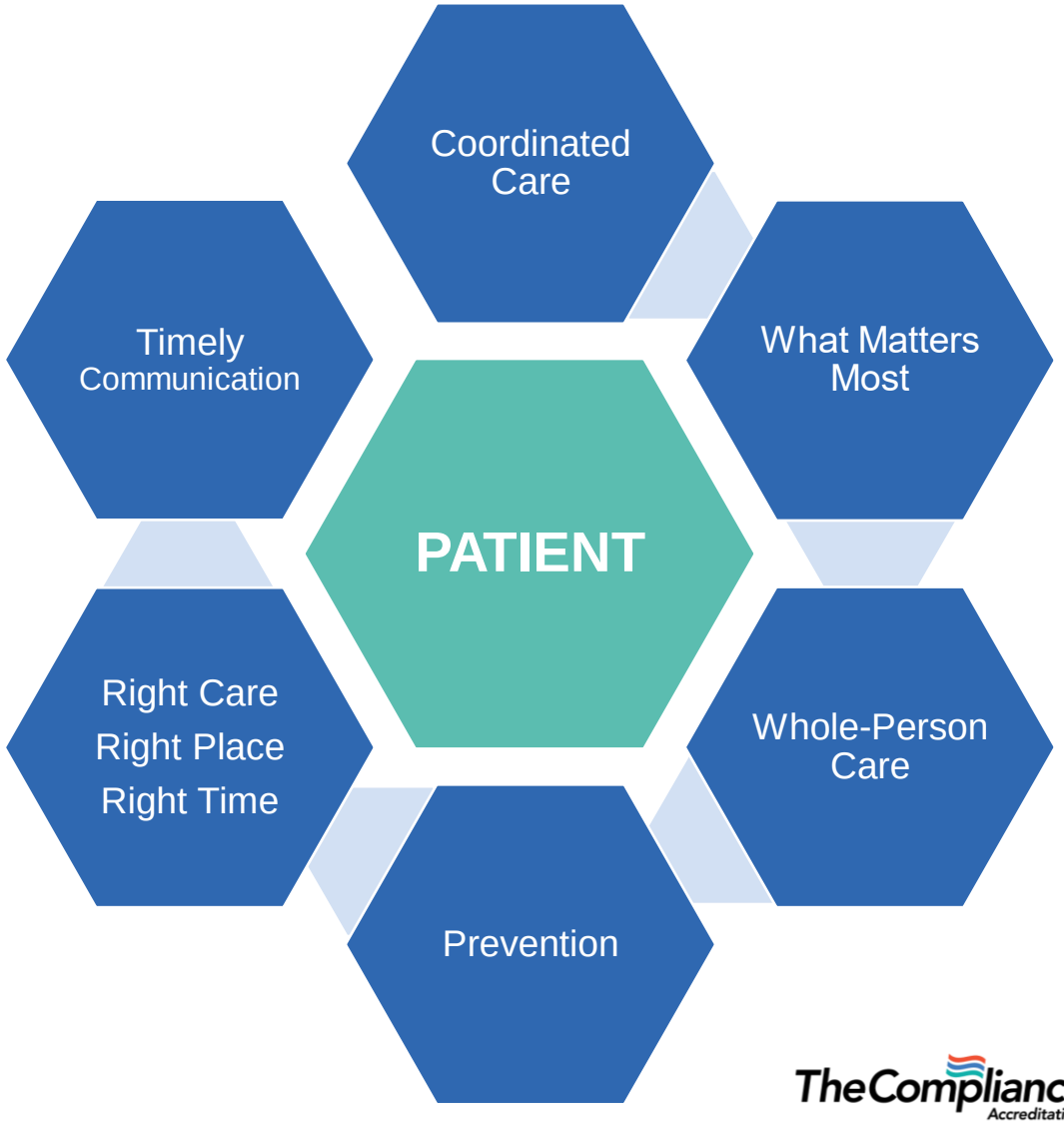
CCM Resources

- https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CCM-Toolkit-Updated-Combined-508.pdf
- MLN909188 – Chronic Care Management (cms.gov)

Patient-Centered Medical Home Core Principles

- Anything taking you away from patient care is heading in the wrong direction!
- Primary focus should be centered around patient care.
- Efficiency in daily operations allows providers to concentrate on “What Matters Most” to the patient!



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Summary of Standards

PCMH 1.0 The organization utilizes a team-based approach for patient-centered coordinated care.

PCMH 2.0 The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

PCMH 3.0 The organization provides patient education and self-management tools to patients and their family/caregivers.

PCMH 4.0 The organization provides advanced access to its patients.

PCMH 5.0 The organization provides patient follow-up.

PCMH 6.0 The organization evaluates its quality performance and improvement quarterly.

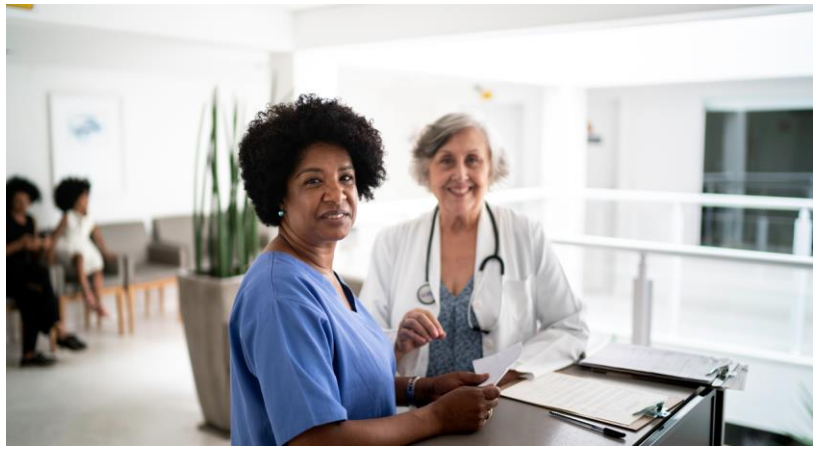
PCMH 7.0 The organization ensures patient health records are complete.

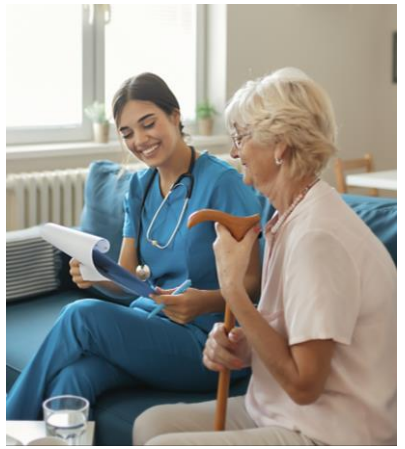
PCMH 8.0 The organization understands the impact of social determinants of health and health equity.

Team Based Coordinated Care

Providers, Nurses, Assistants, Clerical, family members, Pharmacists, and community resources…

Everyone Working Together
to Improve Overall Care





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The Art of the Huddle

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Team Huddle Checklist

Use this modifiable checklist to lead your team through efficient, effective huddles at the beginning of the clinic day or session.

Date:	Start time:
Huddle leader:	
Team members in attendance:	
Check in with the team	
	How is everyone doing?
	Are there any anticipated staffing issues for the day?
	Is anyone on the team out / planning to leave early / have upcoming vacation?
Huddle agenda	
	Review today's schedule
	Identify scheduling opportunities • Same-day appointment capacity • Urgent care visits requested • Recent cancellations • Recent hospital discharge follow-ups
	Determine any special patient needs for clinic day • Patients who are having a procedure done and need special exam room setup • Patients who may require a health educator, social work or behavioral health visit while at the practice • Patients who are returning after diagnostic work or other referral(s)
	Identify patients who need care outside of a scheduled visit
	Determine patient needs and follow up • Patients recently discharged from the hospital who require follow up • Patients who are overdue for chronic or preventive care • Patients who recently missed an appointment and need to be rescheduled
	Share a shout-out and/or patient compliment
	Share important reminders about practice changes, policy implementation or downtimes for the day
	End on a positive, team-oriented note • Thank everyone for being present at the huddle
	Huddle end time:

Source: AMA. Practice transformation series: implementing a daily team huddle. 2015.

Team Huddle

- Stand up
- Meet before the daily schedule starts
- Be consistent-have a plan
- Check-in and announcements
- Use visuals- score cards, dashboards, bulletins
- Preview patients coming in
- Identify potential challenges/concerns
- Keep meeting short- no more than 10 minutes
- Be courteous and respectful
- Positive feedback and praise

Go Team!

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Care Plans: PCHIP™ Patient Centered Health Improvement Plan™

What is a PCHIP™ ?

A plan of Medical Care and support which…

- is unique to each patient and their specific needs
- is culturally and linguistically sensitive
- addresses the social determinants of health
- respects the patient's goal for optimal well-being

Helpful Tip: PCHIPs are for patients that you identify as high risk. Not all patients require a PCHIP.

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Advanced Access

Providing the **right care** at the **right time** and the **right place**!

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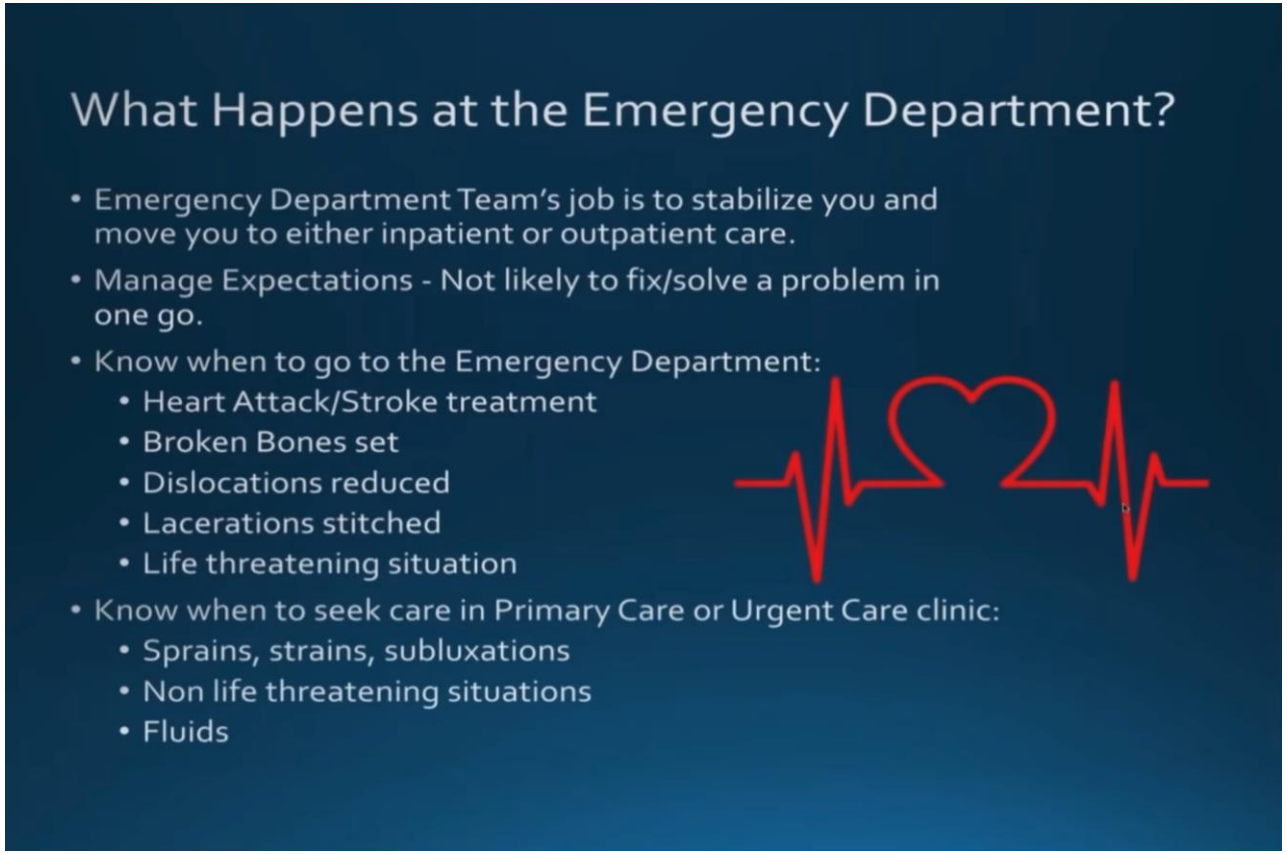
Meeting the Needs

- Same day appointments for urgent illness;
- Evidence of expanded weekday, evening, and/or weekend appointment offerings; and
- Call coverage or arrangement for after-hours emergencies twenty-four hours a day and seven days a week.



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Lowering the Cost of Care

The U.S. could save $67 billion each year if everyone used a primary care provider as their principal source of care. Every $1 increase in primary care spending produces $13 in savings!

https://www.medicaleconomics.com/view/delivering-value-healthcare-starts-increased-primary-care-investment

Primary Care
Community Resources

Ambulatory Care
Home Services $$

ED Utilization
Hospitalization $$$$$

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PCMH Benefits to the Patient

- Same day appointments for urgent illness and expanded appointment hours
- After-hours triage service and phone access to an on-call provider
- Implementation of a team-based approach to coordinated care
- Assigned care coordinator who develops relationships with patients and provides direct access to the care team

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PCMH Benefits to the Practice

As a TCT Exemplary Provider®, you demonstrate to Federal and State regulatory agencies, payors, and the community at large that you deliver exceptional, safe, and quality care. Recognition is key to reimbursement and payors respond. What are payors looking for?

Lower cost and improved outcomes

PCMH is the foundation for our value-based payment future!

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Resources

We are here to help!

Available as part of the accreditation package, TCT has a wide range of tools and resources for the Patient Centered Medical Home program at no cost including:

- Webinars
- Templates for Policies and Procedures
- Patient Satisfaction Survey Portal
- Quarterly Improvement project guidance
- CCM program implementation tools
- Individual support with an Accreditation Advisor

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Questions

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