

# OPPORTUNITY

CCM AND TCM: IT'S A WIN-WIN

December 9, 2015



## Today's Presenters

\*Litisha Turner RN,MS,BSN  
Sr. Clinical Consultant



\*Christy Erickson MSN, PMP  
Director Transformational Services



\*Sue D'Agostino, RN  
Sr. Clinical Consultant



**Your phone has been automatically muted. Please use the Q&A panel to ask questions during the presentation!**

The screenshot shows the Cisco WebEx Event Center interface. The main content area displays a presentation slide with the text "POSSIBILITY" and "Welcome to Today's Webcast". The slide also features the GALEN Healthcare Solutions logo and a photograph of a vehicle in a desert landscape. The interface includes a top menu bar with options like "File", "Edit", "View", "Communicate", "Participant", "Event", and "Help". A "Participants" panel on the right shows a "Q&A" icon. A "Q&A" panel is also visible at the bottom right, with a "Send" button. Red circles and arrows highlight the "Full Screen Mode" button (top right) and the "Q&A" button (top right), with a red arrow pointing from the "Q&A" button to the "Q&A" panel at the bottom right.

Click for Full Screen Mode

Click to open Q&A Panel

Ask: All Panelists

Select a panelist in the Ask menu first and then type your question here. There is a 256-character limit.

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## Chronic Care Management (CCM) and Transitional Care Management (TCM) Programs

- Why is it important?
- What is it?
- How to do it?

“To date, CMS has acknowledged only about 100,000 claims for eligible beneficiaries out of a pool of upwards of 35 million eligible (0.29%).”

**100,000**

**35,000,000**

## TCM

- Why is it important?

Organizations can bill **99495** or **99496** (CPT code) to increase quality patient care post discharge from inpatient care settings.

**Goal** to decrease inpatient re-admissions!

## TCM

Why is it important?


***Revenue potential***

E/M Coder versus TCM Code

***50% more potential revenue***

## TCM

What is it?



Within initial 30  
days post  
discharge

- ✓ Patient contact within 2 business days of discharge
- ✓ Non-face-to-face services (review of discharge instructions, care coordination)
- ✓ Follow up appointment within 7 or 14 days



## **Support staff non-face-to-face services**



Communication with patient, caregiver, with other community services utilized by the patient

Education provided to the patient or family

Assessment and support for treatment regimen and medication management

Identification of available community and health resources and facilitating access to those resources needed by the patient and/or family

## Physician non-face-to-face services



Reviewing discharge information

Reviewing/Follow Up on pending diagnostic tests and treatments

Interaction with other qualified health care professionals

Education of patient, family, guardian and/or caregiver

Referrals and arrangement of needed community resources

Required follow-up with community providers and services

## CCM

- Why is it important?



As of 1/1/15, organizations can bill **99490** (CPT code) for non-face-to-face time to Medicare beneficiaries with 2 or more chronic diseases.

**Total = \$42.50\*/month per patient**

## CCM

What is it?

- ✓ 2 or more chronic conditions expected to last at least 12 months
- ✓ 20 minutes of clinical staff time per month under direction of provider
- ✓ Chronic conditions placing a patient at risk (death, exacerbation, or functional decline)
- ✓ Comprehensive care plan developed, reviewed, and monitored
- ✓ Provided under general supervision

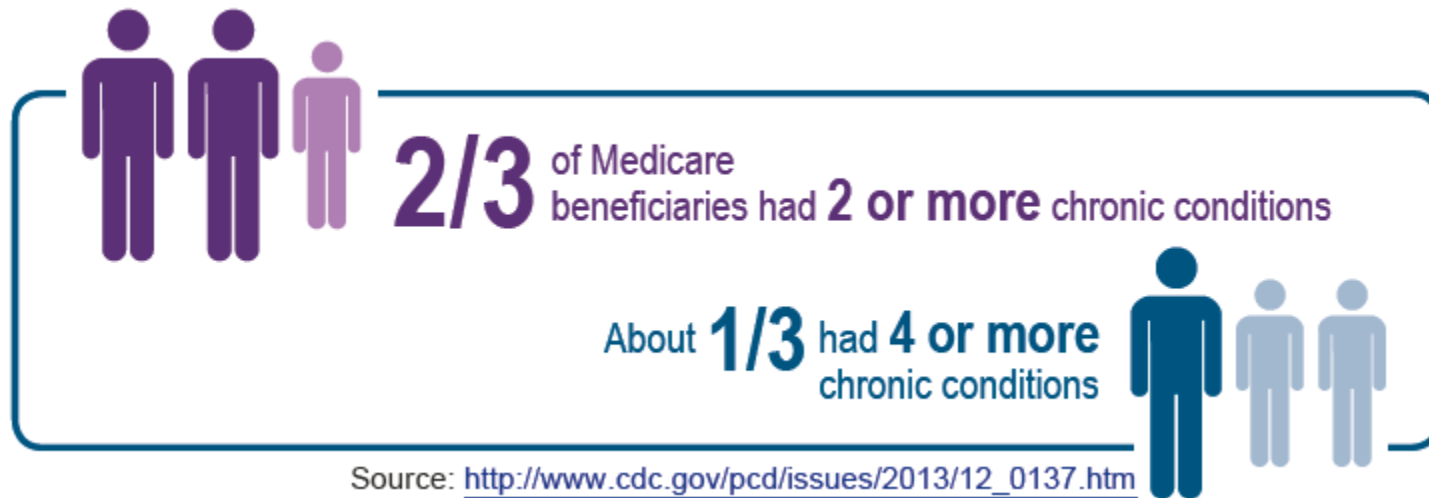
## CCM

- ✓ Patient Signed Consent
- ✓ 1 provider per patient can claim the CCM program enrollment
- ✓ Primary or Specialty care can utilize program
- ✓ EHR used must be MU-certified
- ✓ 24/7 access required

## Billable Services

- ✓ Health Coaching
- ✓ Care Coordination/Referrals
- ✓ Medication Management
- ✓ Providing Education

## CCM



## **CCM- Chronic Condition Examples**

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial Fibrillation
- Autism Spectrum Disorders
- Cancer
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Ischemic Heart Disease
- Osteoporosis

## CCM

Reimbursement  
single provider

- Patient population = 2,500 patients
- 30% of this total population is Medicare = 750 patients
- 70% of Medicare are fee-for-service (FFS) = 525 patients
- 70% of this FFS group have 2 or more conditions = 368 patients
- 75% of patients consent to participate = 276 patients
- Each patient can be billed 1x each month = \$42
- Monthly recurring revenue per physician for 276 patients = \$11,596

**Annual revenue per physician = \$139,104**

**If a group has 100 physicians, annual revenue would total \$13,910,400.**



## **CCM/TCM strategies**


- Assessment of patient population and gap analysis of CCM/TCM program requirements
- Develop of CCM/TCM program processes
- Configuration of all CCM/TCM workflows/set up
- Training to provider/clinical staff
- Implementation of CCM/TCM program

## Allscripts TouchWorks® EHR

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Password

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Organizational News  
Galen Webcast - All passwords set to Password01

MRE.MPM.LIVE - Desktop - Sue Dagostino

Covering For: MPMTEST,DR  
Task List Last Updated: 13:09

Physician Care Manager - Cover

[Priority](#) [All](#)

	Sent	Patient Name	Type	Priority	Provider
+ Messages (10)				*1 New	
+ Incomplete (5)				*4 New	
+ Orders (3)				*2 New	
+ Watch List (1)				*1 New	

Refresh

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[Referral Follow-up](#)

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[Outpatient](#)  
[Emergency](#)  
[Other Patient Lists](#)  
[Open Chart](#)  
[Orders](#)  
[Document](#)  
[Check Out](#)  
[Sign](#)  
[Hospital Sign](#)

## CCM Care Plan Examples

Intake PFSH HPI-CARD ROS-GEN COMP.PE CCM Plan Plan QUAL-CORE			
DM CCM			
<b>Patient Consent</b> * Patient consent is signed and on file. Action Plan with patient specific goals was reviewe...			
<b>DM Care Plan</b> Care Plan For Controlled Uncontrolled Diabetes Mellitus Type 1 Diabetes Mellitus Type 2			
<b>Action Plan-Goals</b>			
<b>Preventative Care</b>			
<b>Risk Reduction</b>			
Risk Reduction Managed By			
Target Weight Loss 5-10%			
Follow Up	<input type="radio"/> in 1 week <input type="radio"/> in 1 month <input type="radio"/> in 3 months	<input type="radio"/> in 6 months <input type="radio"/> in 9 months	<input type="radio"/> in 1 year <input type="radio"/> other
Current Status	<input type="radio"/> goal met	<input type="radio"/> goal not met	<input type="radio"/> initial goal setting
Target Diet Type			
Follow Up	<input type="radio"/> in 1 week <input type="radio"/> in 1 month <input type="radio"/> in 3 months	<input type="radio"/> in 6 months <input type="radio"/> in 9 months	<input type="radio"/> in 1 year <input type="radio"/> other
Current Status	<input type="radio"/> goal met	<input type="radio"/> goal not met	<input type="radio"/> initial goal setting
Eye Exam- No Retinopathy			
Follow Up	<input type="radio"/> in 1 week <input type="radio"/> in 1 month <input type="radio"/> in 3 months	<input type="radio"/> in 6 months <input type="radio"/> in 9 months	<input type="radio"/> in 1 year <input type="radio"/> other
Current Status	<input type="radio"/> goal met	<input type="radio"/> goal not met	<input type="radio"/> initial goal setting
Foot Exam-No Neuropathy/Infect			
Follow Up	<input type="radio"/> in 1 week <input type="radio"/> in 1 month <input type="radio"/> in 3 months	<input type="radio"/> in 6 months <input type="radio"/> in 9 months	<input type="radio"/> in 1 year <input type="radio"/> other
Current Status	<input type="radio"/> goal met	<input type="radio"/> goal not met	<input type="radio"/> initial goal setting
Influenza Vaccine-Annually	<input type="radio"/> Received this year	<input type="radio"/> Scheduled	<input type="radio"/> Refused
Current Status	<input type="radio"/> goal met	<input type="radio"/> goal not met	<input type="radio"/> initial goal setting

## CCM Care Plan Examples

Patient Consent	
*	
<b>DM Care Plan</b>	<b>DM Care Plan</b>
Care Plan For	Care Plan For: Uncontrolled, Diabetes Mellitus Type 2
<b>Action Plan-Goals</b>	<b>Action Plan-Goals</b>
<b>Goals</b>	<b>Goals:</b>
Target HbA1c % <6.5	Target HbA1c % <6.5: 7 (currently at 10)
Follow Up	Follow Up: in 3 months
Current Status	Current Status: initial goal setting
Target Blood Sugar mg/dl <110	Target Blood Sugar mg/dl <110: 130 (averages between 200-150)
Follow Up	Follow Up: in 3 months
Current Status	Current Status: initial goal setting
Target LDL mg/dl <100 mod risk	Target Triglycerides mg/dl <150: 200 (currently at 476)
Follow Up	Follow Up: in 3 months
Current Status	Current Status: initial goal setting
Target Systolic BP <130	Target Systolic BP <130: 130
Follow Up	Target Diastolic BP <80: 80
Current Status	Follow Up: in 3 months
Target HDL mg/dl <130 mod risk	Current Status: initial goal setting
Follow Up	

# CCM Care Plan Examples

Treatment Plan		
Treatment Plan		
Medication Treatment		
Insulin Use		
Insulin Pump		
Oral Agents		
Home Glucose Monitoring		
Fasting		
Pre-Prandial		
Post-Prandial		
Bedtime		
BG Monitoring		
Diabetes Education		

**Treatment Plan**

**Treatment Plan:**

**Treatment Plan Managed By:** Dr. Smith, PCP

**Medication Treatment:** Meds Reconciled

**Insulin Use:** Not using insulin

**Oral Agents:** Metformin

**Home Glucose Monitoring:** daily

**Fasting:** <120

**Diabetes Education:** dietary counseling, exercise counseling, hyper/hypoglycemic S&S

**Care Coordination:** Referral-Ophthalmology

**Diabetes Complications:** none

**Care Plan Review Date:** Nov 5, 2015

**Next Review Date:** Feb 5, 2016

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**Treatment Plan Managed By:** Dr. Smith, PCP

**Medication Treatment:** Meds Reconciled

**Insulin Use:** Not using insulin

**Oral Agents:** Metformin

**Home**

## CCM Care Plan Examples

LIPIDS CCM	
<b>Action Plan</b>	<b>Hyperlipidemia CCM Plan</b>
<b>Goals</b>	<b>Patient Consent</b>
Annual Lipid Profile	* Patient consent is signed and on file.
Current Status	
Target LDLC mg/dL	<b>Hyperlipidemia Care Plan</b>
Follow Up	Care Plan For: Pure hypercholesterolemia
Current Status	
Target Total Cholesterol	<b>Action Plan-Goals</b>
Follow Up	Goals:
Current Status	Annual Lipid Profile Follow Up: in 1 year
Target HDLC mg/dL	Current Status: initial goal setting
Follow Up	Target LDLC mg/dL(100-129): 140 (currently at 200)
Current Status	Follow Up: in 3 months
Target Triglyceride	Target Total Chol mg/dL(<200): 200 (current 300)
Follow Up	Follow Up: in 3 months
Current Status	Current Status: initial goal setting
Target NHDLC	Target Systolic BP mmHg <130: 130
Follow Up	Follow Up: in 1 month
	Target Diastolic BP mmHg <80: 80
	Follow Up: in 1 month (will come in for nurse visit for BP check, current borderline 140/90)
	in 3 months

## CCM Care Plan Examples

<b>Preventative Care</b>	
<b>Preventative Care</b>	
Risk Reduction Manage	
Influenza Vaccine (Ann	
Current Status	used
Stop Smoking Follow U	al goal setting
	year
	er
Current Status	
Physical Activity (as di	al goal setting ?
	year
	er
Current Status	
Colonoscopy Follow Up	al goal setting ?
	year
	er
Current Status	
Tobacco Cessation(19-	al goal setting ?
	year
	er
Current Status	
Wt Mgmt Target BMI 16-24.9	al goal setting

### Preventative Care

#### Preventative Care:

**Influenza Vaccine (Annually):** Received this year

**Current Status:** goal met

**Stop Smoking Follow Up:** in 3 months

**Current Status:** initial goal setting

**Physical Activity (as dir) FU:** in 3 months

**Current Status:** initial goal setting

**Colonoscopy Follow Up:** in 6 months

**Current Status:** initial goal setting

## Review of CCM Care Plan

- Electronic summary of: Physical, Cognitive, Psychosocial, Functional, Environmental assessments
- Record of all recommended preventative care services
- Med Rec and review of adherence, interactions and self management of meds
- Inventory of clinicians, resources, and supports specific to the patients



## CCM Follow Up Note

CCM Rev	<b>CCM FU Review</b>	
Care F	<b>Reason For Review</b>	
Follow Up	Follow Up For: Asthma, Diabetes	
	<b>Problem History</b>	
	PFSH:	
	<b>Past Medical History</b>	
	Last reviewed 11/20/15 Sue Dagostino	
	Diabetes mellitus	
	Anemia	
	Anxiety disorder 1/1/14	
	<b>CCM F/U Documentation</b>	
	<b>Medical</b>	
	Interval Events: hospitalization, ER visit	
	<b>Additional Info (dates)</b>	
	severe exacerbation/flare up manic episode w/admission x1 week	
	<b>Medication Compliance:</b>	
	Compliance: good compliance	
	Tolerance: fair tolerance	
	Control: fair symptom control	
	<b>Medication Self Management:</b> assistance required	
	<b>Psychosocial</b>	
	Psychosocial: Yes: feelings of depression, lack of friends, loss of pleasure w/activy, loss of pleasure w/others	
	Work/Activities Participation: partial participation	
	Household Composition: no change, living w/family, requires assistance	
	<b>Functional</b>	
	Home Safety Concerns: no change	
	Feels Safe at Home: Yes	
	No Threats of Violence/Injury: Yes	
	<b>Care Plan Follow Up</b>	
	Task and Time Spent #1:	
	Description of Task: Refilled prozac, lithium and atenolol	
	Time spent on call/task: 5 min	
	Task and Time Spent #2:	



# GALEN

HEALTHCARE SOLUTIONS

HOW GALEN CAN HELP

# Starting a CCM Program

- **Step 1- Figure out potential ROI**

<b>Medicare Chronic Care Program</b>	
Total Patient Population	ROI
Total Unique Medicare Patients	2500
Percent with 2+ chronic conditions	66%
Annual Number of Unique CCM Medicare Patient	1650
CCM Monthly Reimbursement per patient/per month	42.50
<b>Total Revenue Medicare CCM</b>	<b>841,500</b>
Population Based on Acceptance Level	ROI- Annual
Annual Number of Unique Medicare Patients	2500
Percent with 2+ chronic conditions	66%
Annual Number of Unique CCM Medicare Patient	1650
Percent acceptance into CCM Program	60%
Total CCM Enrolled Patients	990
CCM Monthly Payment	\$ 42.50
<b>Estimated Annual Revenue</b>	<b>\$ 504,900</b>

# Starting a CCM Program

## • Step 2- Know Hurdles

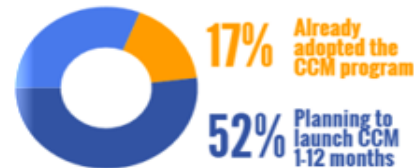
Per CMS, 35 million Medicare beneficiaries are eligible, only 100,000 beneficiaries submitted to date.

[http://www.modernhealthcare.com/article/20151013/NEWS/151019975?utm\\_content=20151013-NEWS-151019975](http://www.modernhealthcare.com/article/20151013/NEWS/151019975?utm_content=20151013-NEWS-151019975)

National Survey on Medicare Chronic Care Management Program Reveals Strong Interest Among Physicians, But Also Confusion

 **70%**

**Physician Participation**  
in the CCM program is projected to grow to nearly 70% by the third quarter of 2016



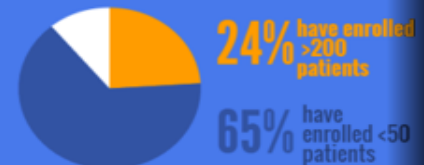
Of the providers currently participating, **84%** believe that CCM has had a positive impact on patient care.

**Key takeaways:**



*Ramp up takes time*

*Optimized workflow & staffing are necessary to reach full potential*



**67%** of providers are still unaware of or do not fully understand the CCM program

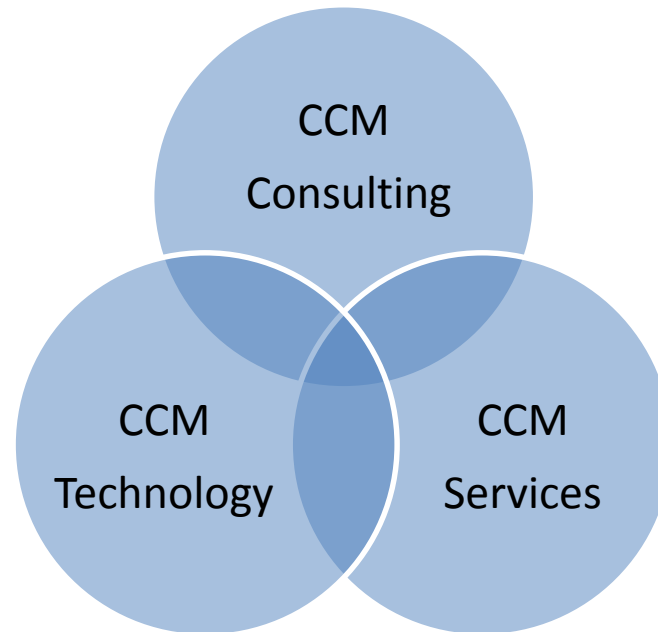


Learn more by downloading the survey results at <http://ccm.smartlinkmobile.com/survey/>

## **Starting a CCM Program**

- **Step 3- Identify gaps**
- **Step 4-Build your CCM Team**
- **Step 5- Define pilot CCM group**

# Galen CCM Solution



## CCM Consulting

- ☐ Program gap analysis and requirements review
- ☐ Policy/procedure development
- ☐ Target patient population analysis
- ☐ Staffing/role definition
- ☐ Program manager

## CCM Services

- ☐ Configuration
- ☐ Workflow design
- ☐ Testing of CCM build
- ☐ End user training
- ☐ Implementation/go live support



## CCM Technology

- ❑ Automation of patient identification
- ❑ Tasking and charge automation to support CCM workflows
- ❑ Reports of population and non-face-to-face time

## Why Galen's CCM solution?



Utilizes EMR, no  
additional software  
required

Maintain patient  
relationship

Increased ROI



**[transformation@galenhealthcare.com](mailto:transformation@galenhealthcare.com)**

# MUCH MORE THAN I.T.



**SOLVING FOR TODAY.  
PREPARING FOR TOMORROW.**

**GALENHEALTHCARE.COM**