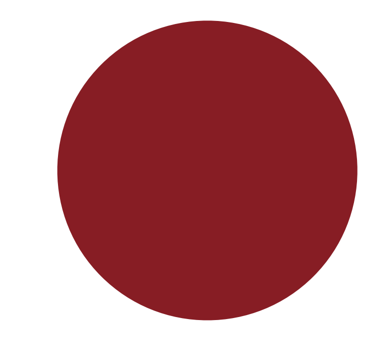
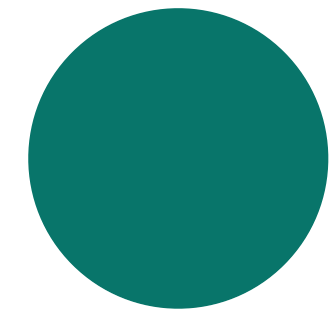
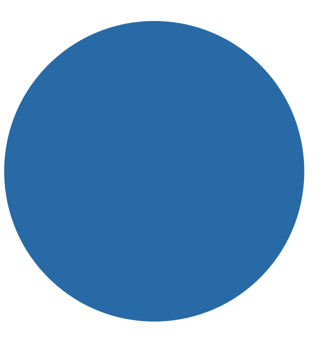
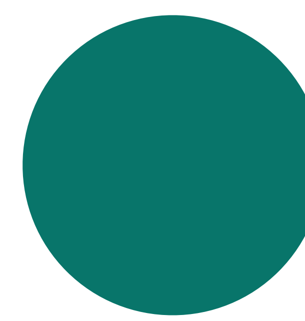
ENGAGE YOUR CHRONIC CARE PATIENTS

AND

manage them in a sustainable manner.

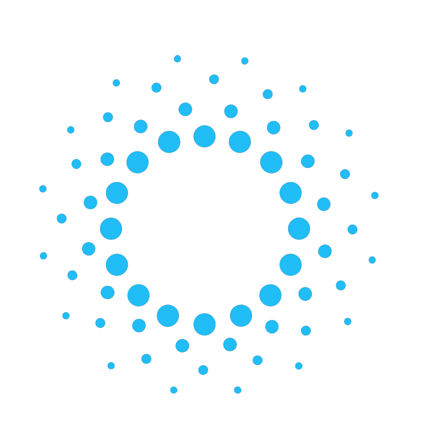
DR SONNY HYARE: SONNY@CONTINUITYCARE.COM

AMIT MALHOTRA: AMIT@CONTINUITYCARE.COM

+1-512-992-8885

WWW.CONTINUITYCARE.COM



CONTENTS

01 The Challenges of Chronic Care

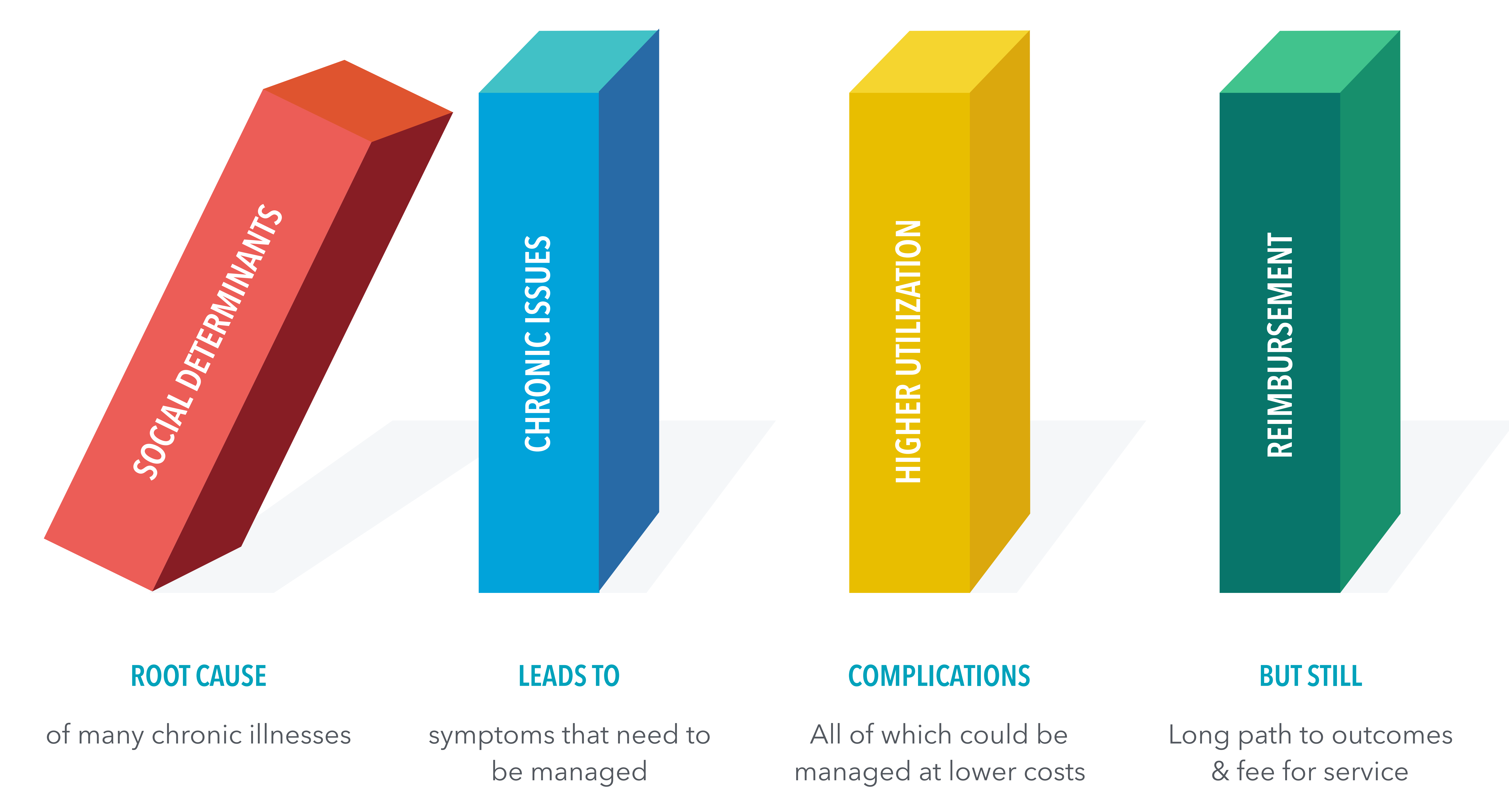
02 What is CCM?

03 Value: Patient

04 Value: Provider

05 Value: Payer

06 Preparing for Value Based Care


SOCIAL DETERMINANTS
CHRONIC ISSUES
HIGHER UTILIZATION
REIMBURSEMENT
ROOT CAUSE
of many chronic illnesses
LEADS TO
symptoms that need to be managed
COMPLICATIONS
All of which could be managed at lower costs
BUT STILL
Long path to outcomes & fee for service

SOME BACKGROUND ON CHRONIC CARE MANAGEMENT

CCM INITIATED IN 2015

The program encompasses the oversight and education activities conducted by health care professionals to help patients with chronic diseases and health conditions such as diabetes, high blood pressure, lupus, multiple sclerosis and sleep apnea learn to understand their condition and live successfully with it.

PROACTIVE DISEASE MANAGEMENT

This term is equivalent to disease management for chronic conditions. The work involves motivating patients to persist in necessary therapies and interventions and helping them to achieve an ongoing, reasonable quality of life.

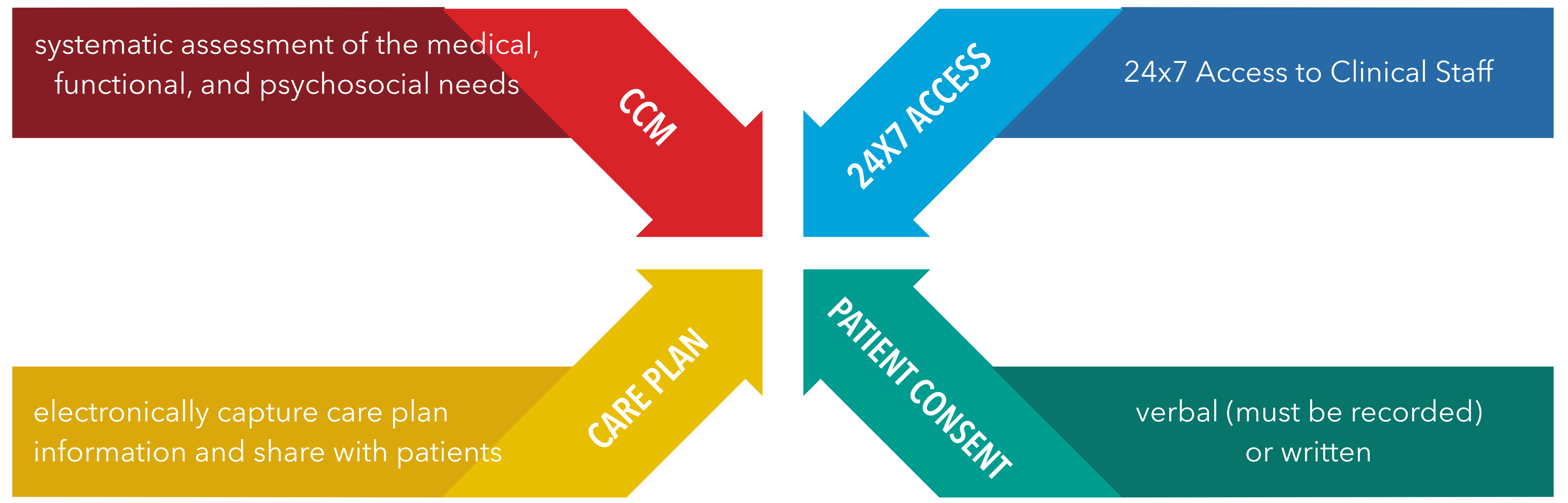
TYPE OF SERVICES

CCM services are generally non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.

FIVE FUNCTIONS

Practices that participate in Medicare's CCM program must have the staff, service and technical abilities to perform five functions during the required 20 minutes of non-face-to-face time with each patient each month.

MORE DETAILS ON THE PROGRAM - IT IS … COMPREHENSIVE



01 Develop and follow a comprehensive care plan

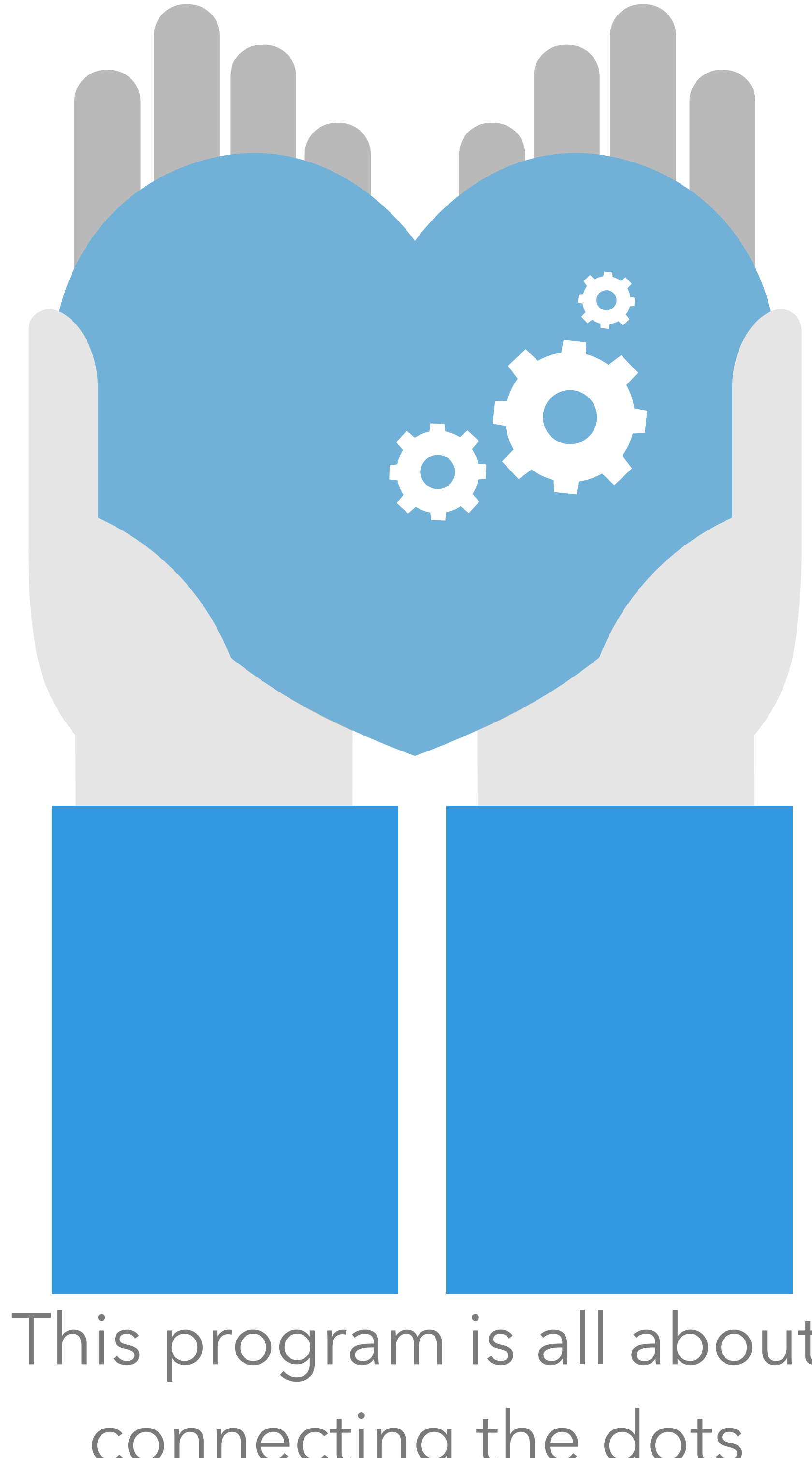
02 Perform medication reconciliation.

03 Manage all transitions of care

04 Coordinate care among all providers & Provide 24/7 access to urgent care services

05 Participating practices also must have the staff and technical expertise to collect and report data on how well they're performing on all five functions as well as the resulting impact on patient outcomes.

This program results in 12-20 touch points with the patients between Provider Visits.



This program is all about connecting the dots

STEPS TO ENGAGE PATIENTS

01 Initiating Visit - Initiation during an AWV, IPPE, or face-to-face E/M visit (Level 4 or 5 visit not required), for new patients or patients not seen within 1 year prior to the commencement of CCM services.

02 24/7 Access - Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week.

03 Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities. Home- and Community-Based Care Coordination

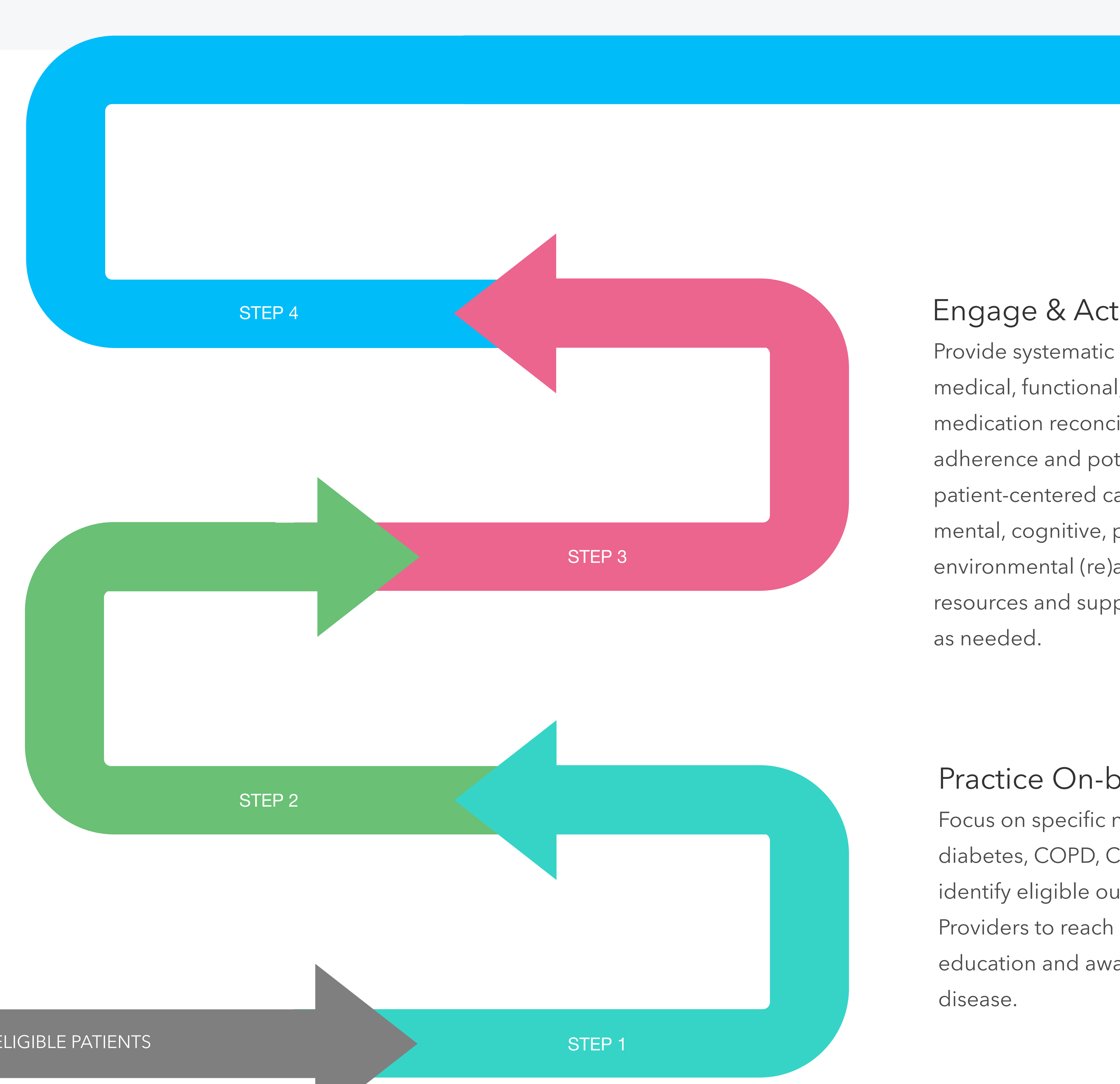
04 Patient Consent - Inform the patient of the availability of CCM services; that only one practitioner can furnish and be paid for these services during a calendar month; and of their right to stop the CCM services at any time (effective at the end of the calendar month)

FOUR STEPS TO IMPLEMENTING CCM

Value & Outcomes

Chronic Care management can increase quality of life for the patient. More closely understanding the patient's condition helps providers to identify abnormalities before they progress to dangerous, complex, and ultimately untreatable levels.

Impact MACRA and MIPS Programs. Increase RAF scores of patients in MSSP or other Risk Contracts



Engage & Activate

Provide systematic assessment of the patient's medical, functional, and psychosocial needs, medication reconciliation with review of adherence and potential interaction. Create a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports. Share plan with providers as needed.

Educate & Enroll

Care team reaches patients to enroll. Explains the value of the program, how the program works, the monthly scheduled nurse assessment visit, which should be treated like a regular visit. Explain the patient's obligation is for payment of coinsurance and deductibles.

Practice On-boarding

Focus on specific number of diagnosis such as diabetes, COPD, CVD, HTN, etc. Run reports to identify eligible outreach patients. Work with the Providers to reach out to patients and drive education and awareness of managing chronic disease.

PROGRAM BENEFITS

ACCESS

12-15 Human Touchpoints between visits

Proactive refills, screening, appointments, DME etc

access to records, information, questions

CARE

Concierge service, with Outcomes

True continuity of care

Personalized, someone caring for you

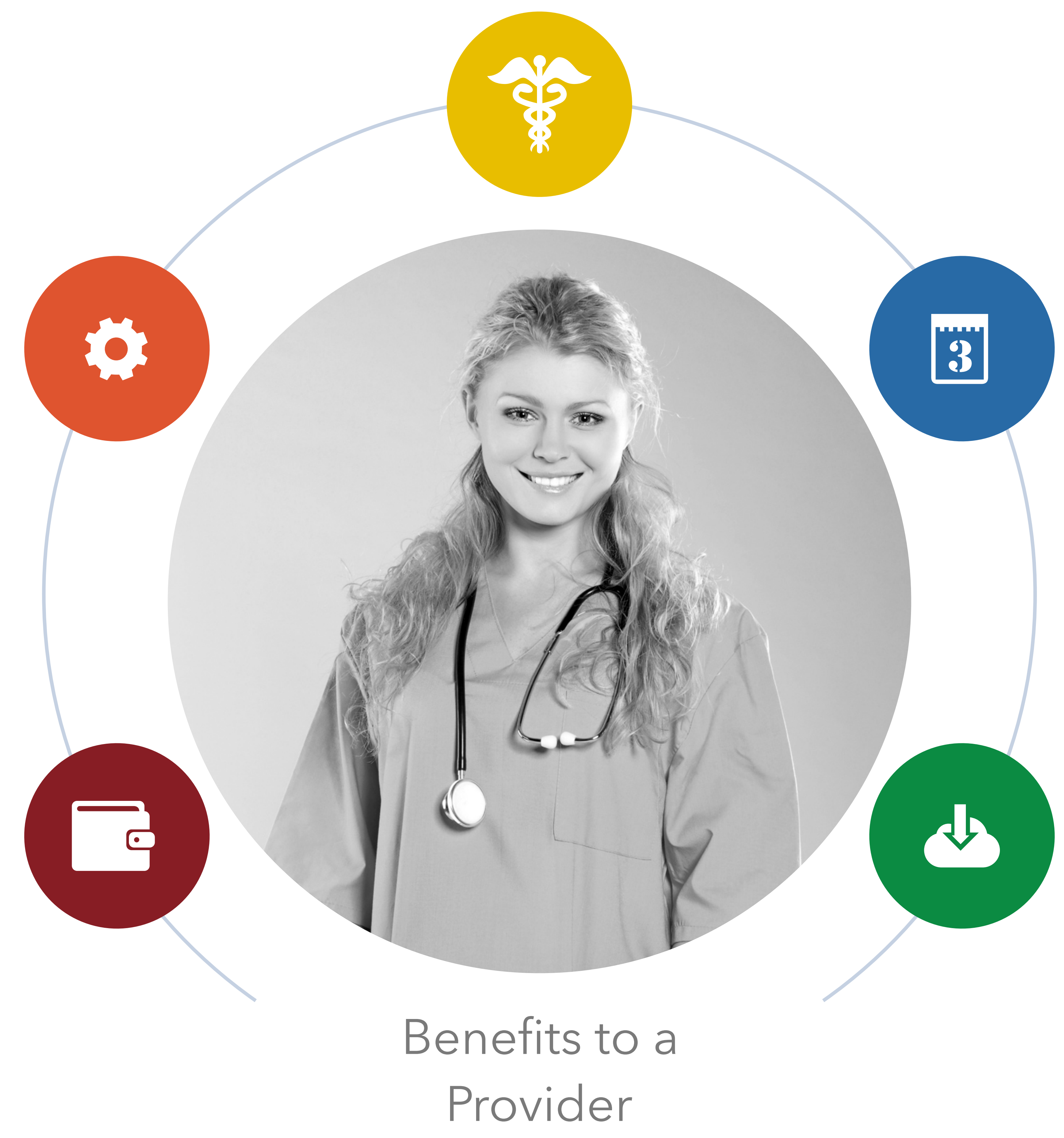
TESTIMONIALS

"Without this service, I would have never know my patient was self-medicating to cope with depression. Your call may have saved a dangerous situation for my patient. Thank you!"
-Doctor

Patient's spouse had passed a few weeks earlier. Our call found out patient was coping with alcohol and Xanax. Call allowed the patient to be seen immediately by her PCP to properly treat the diagnosis.

F lost his house in Harvey and was living with his daughter. He needed support to find a house. The Care Team found a section 8 program for rental assistance. We conveyed the information and guided the patient through the process. The patient allowed the patient a place of residence based on our services.

"This service has been great. I love the monthly touch points on my health and my goals. You are such a delight to speak to over the phone."
-A



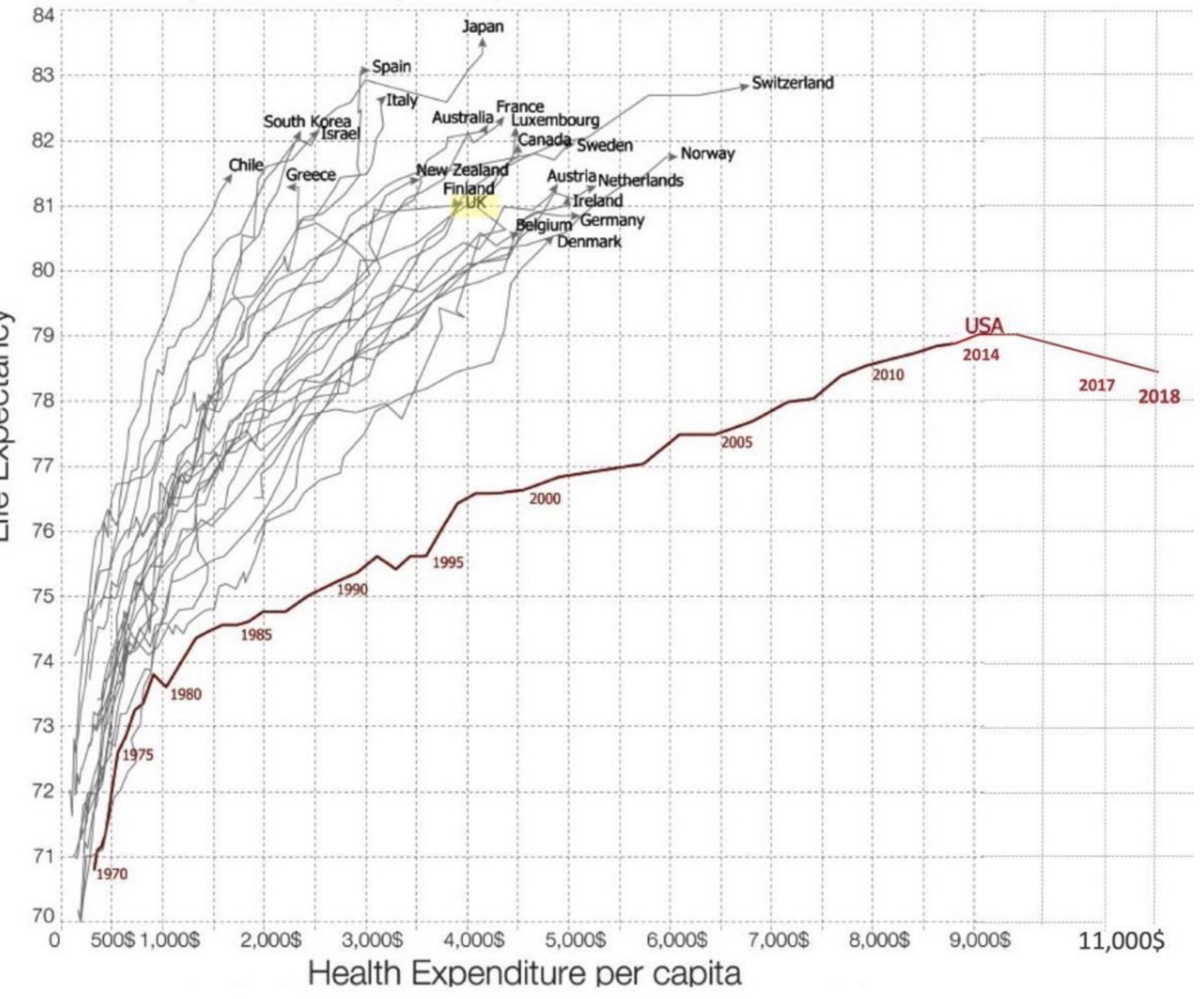
Benefits to a Provider

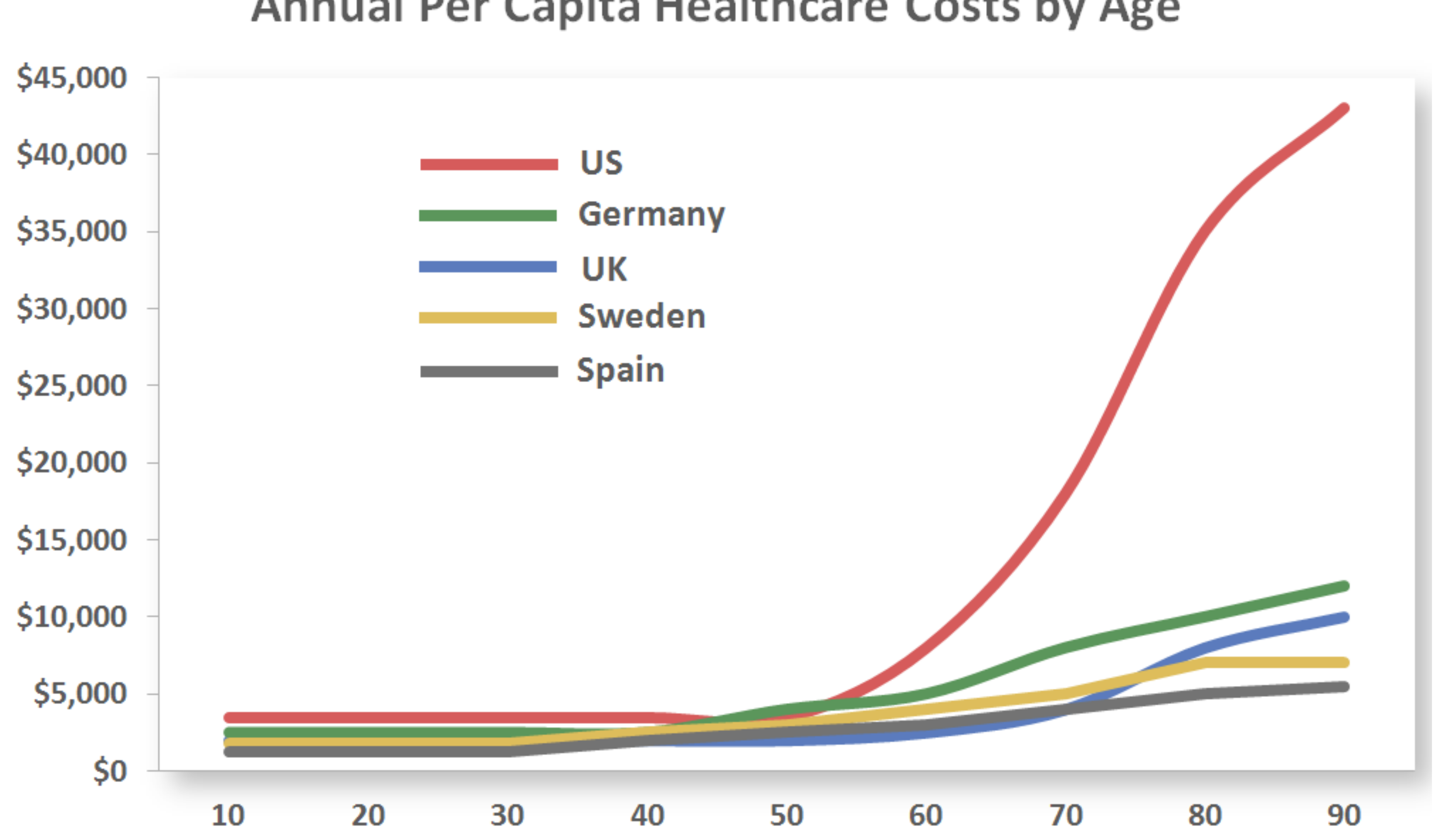
Enhance Utilization

Increase utilization and screening of services such as 99490, G0511, TCM, AWV (Medicare) and others at your clinic by reaching out to your patients and educating them on the importance these services have on their overall health and outcomes for the population.

These services provably result in follow ups and referrals. Patients are made aware of the need to see a provider for simple things such as questions arising from numbness from a foot exam that our team encourages in their calls with diabetics. Thus, resulting in significant positive outcomes for the diabetic population in this instance.

We are spending more, but getting less





And, 86% of costs are driven by Chronic Illnesses

FOCUS ON PATIENT GROWTH

Work with our Physician Partners to help guide them on the best outcomes for their patients.

PATIENT RETENTION

Right levers to engage and retain patients. "GrandKid" Effect. Care Plan Design, Metrics

TRUE CONTINUITY OF CARE

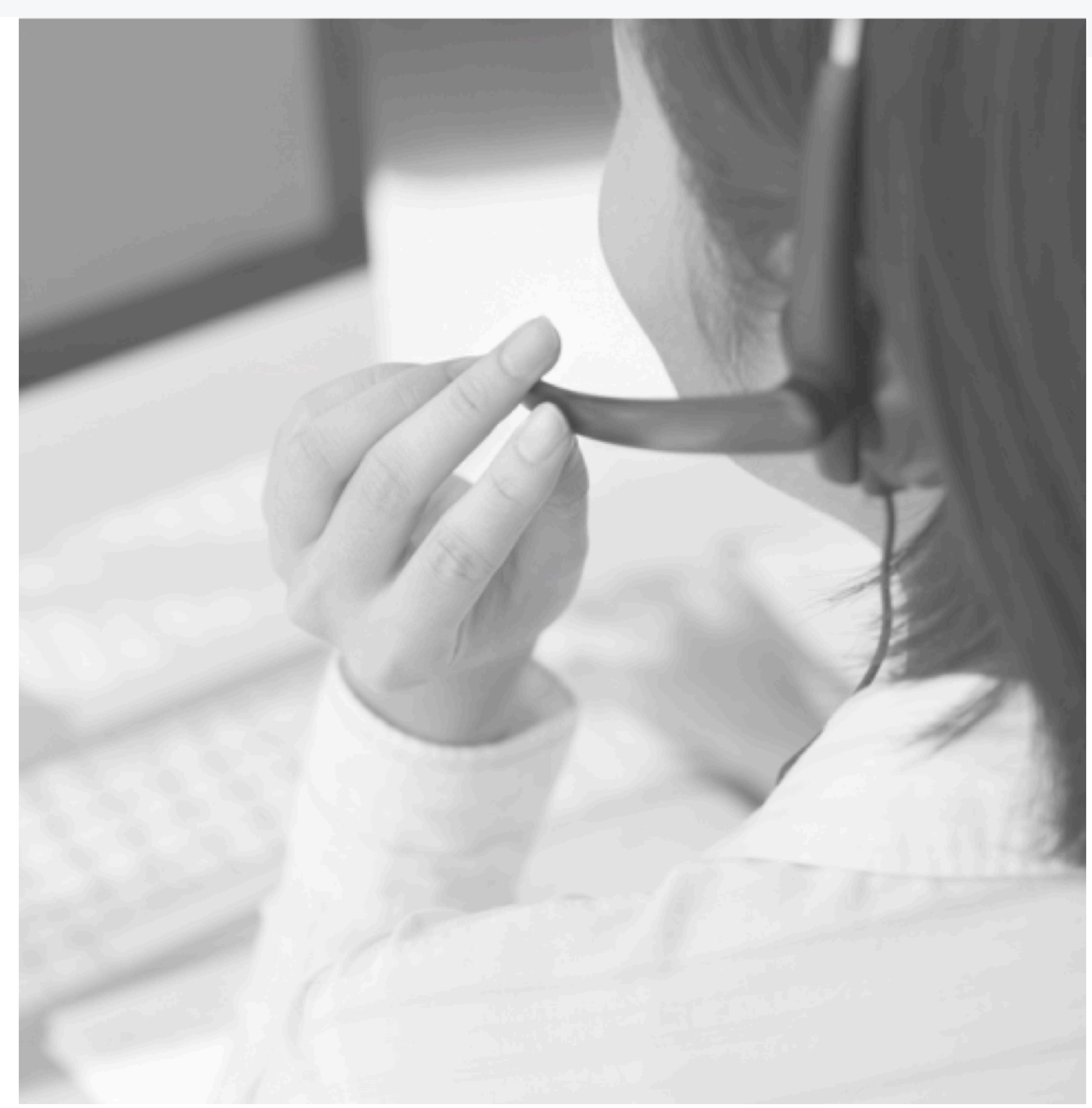
Close partnership between our staff and Partner Clinics. Focus on CPTs to clean Patient Chart.

PATIENT OUTCOMES

Patient goals on Hypertension, Hyperlipidemia, DM II, CKD etc.

PROBLEM LIST MAINTENANCE

Manage variations of Hypertension, DM2 etc and CCM//HCC/AWV/Cognitive Assessments for accurate PL, Med Rec, Care Teams and better data and patient outcomes.



A CASE STUDY

FOLLOW-UP
23% of our encounters resulted in follow up visits. Driving true patient engagement and partnership with their provider.

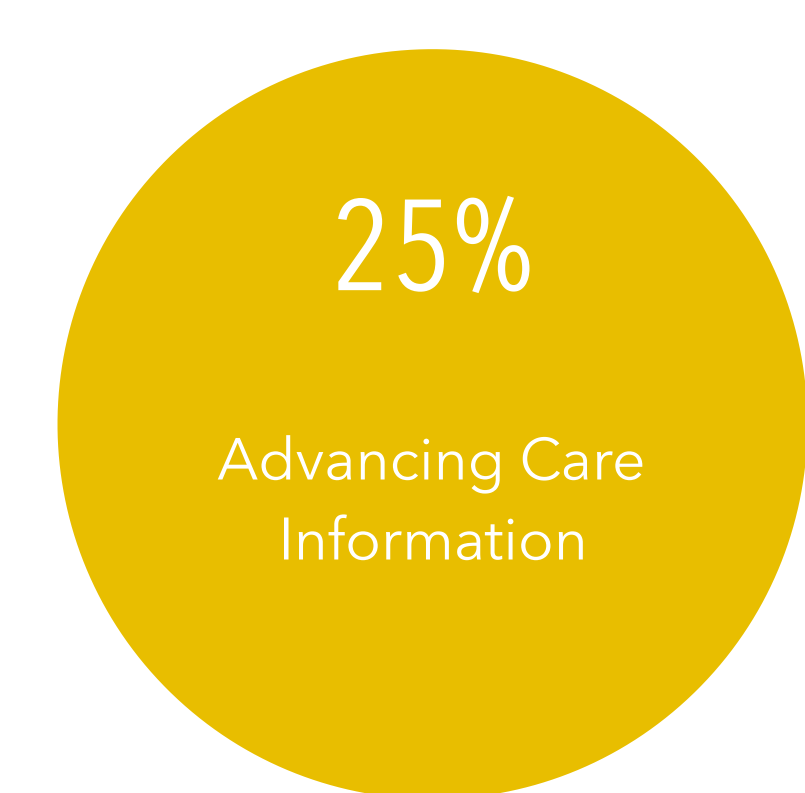
REFERRALS
21% of encounters resulted in referrals to specialists for much needed services critical to disease management.

DME
14% resulted in DME for Glucometers, Blood Pressure monitors, Walkers etc. Critical to manage chronic illnesses.

100% ELIGIBILITY FOR AWV
Integrate Care Planning as part of Annual Wellness Visits. Critical component in managing chronic illnesses, avoiding hospitalizations and improving quality (MACRA, MIPS)

RELEVANCE IN VALUE BASE CARE WORLD

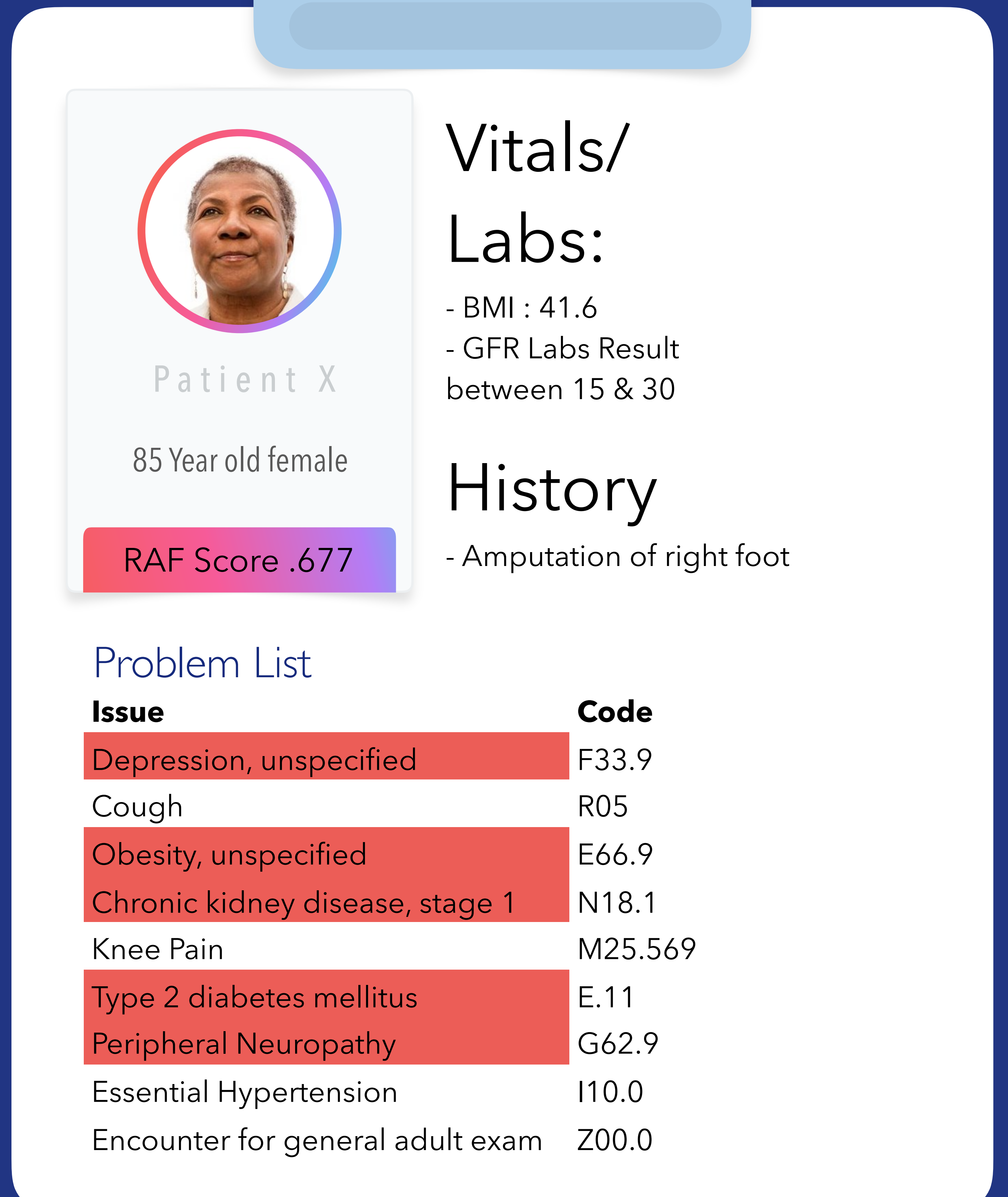
CCM AND MIPS CONNECT MEDICARE GOALS FOR PHYSICIAN PAYMENT REFORM AND VALUE BASED REIMBURSEMENT MODELS.



- Extending care between physician office visits
- Striking the right balance between infrequent expensive the provider encounters and frequent expensive provider encounters
- Providing opportunities to do the right thing for patients in the right settings
- Increase care coordination across the settings
- Improving patient outcomes

Risk Adjustment Example

SAMPLE PATIENT CHART REVIEW - HCC



Patient X

85 Year old female

RAF Score .677

Vitals/ Labs:

- BMI : 41.6
- GFR Labs Result between 15 & 30

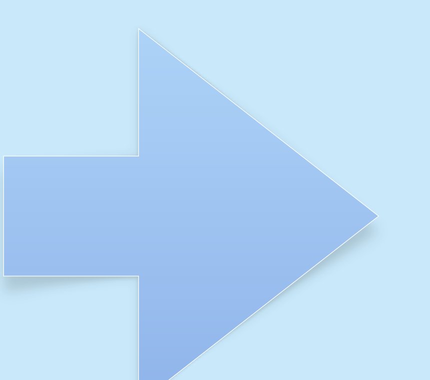
History

- Amputation of right foot

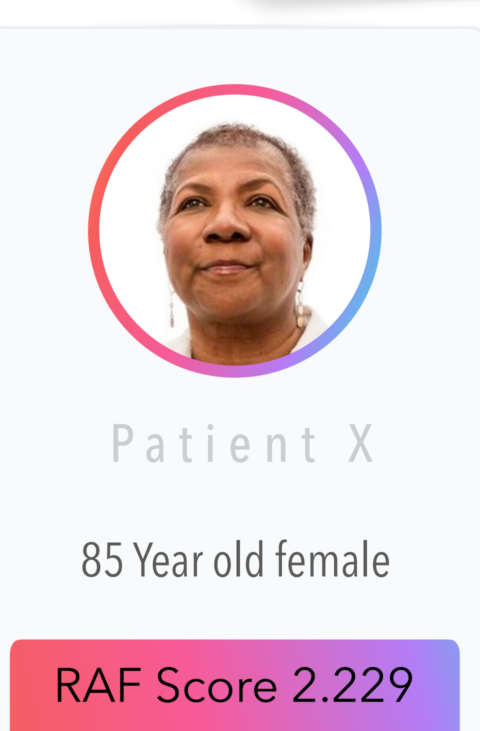
Problem List

Issue	Code
Depression, unspecified	F33.9
Cough	R05
Obesity, unspecified	E66.9
Chronic kidney disease, stage 1	N18.1
Knee Pain	M25.569
Type 2 diabetes mellitus	E.11
Peripheral Neuropathy	G62.9
Essential Hypertension	I10.0
Encounter for general adult exam	Z00.0

Annual Payment $6,499



By reviewing this patients record for their medical history, BMI, Lab Results, Vitals and their active problem list we are able to accurately capture this patient's risk score.



Vitals/ Labs:

- BMI : 41.6
- GFR Labs Result between 15 & 30

History

- Amputation of right foot

Issue	Code	RAF Score
Major Depressive disorder, single episode, full remission	F32.9	0.330
Body mass index (BMI) 40.0-44.9, adult	Z68.41	0.365
Complete traumatic amputation of right foot at ankle level, sequela	S98.011S	0.265
Chronic kidney disease, stage 4 (severe) - Based on Lab Values	N18.4	0.224
Diabetes mellitus due to underlying condition with diabetic Neuropathy	E.08.21	0.368

PMPM $1509

Annual Payment $18,108

Continuity Care can perform risk adjustment for all its patients as part of Chronic Care Co-ordination for all our patients.

Continuity Care: Confidential and Proprietary

Q&A

DR SONNY HYARE: SONNY@CONTINUITYCARE.COM

AMIT MALHOTRA: AMIT@CONTINUITYCARE.COM

+1-512-992-8885

WWW.CONTINUITYCARE.COM