



CHRONIC CARE
MANAGEMENT

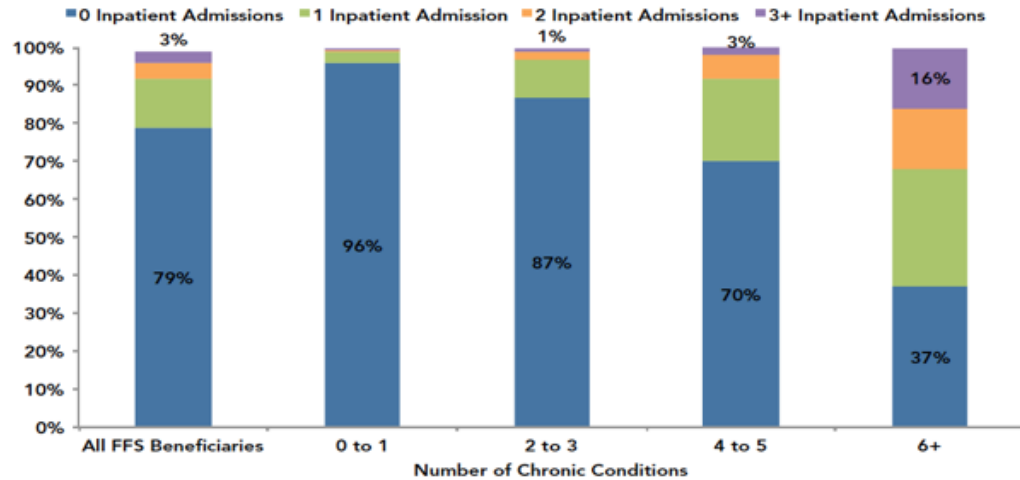
Chronic Care Management, LLC

**Enhancing the Chronic Care Management of Patients While
Empowering Practices with New Revenue**

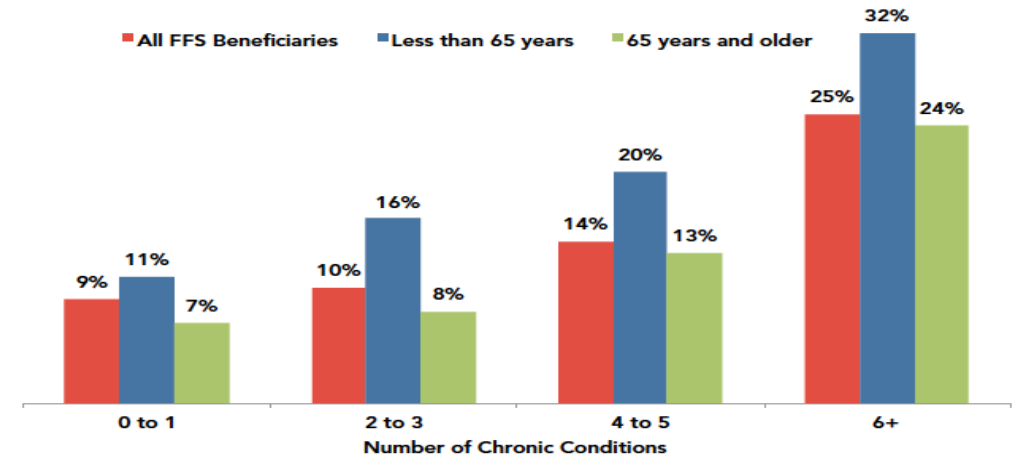
August, 2017

A Higher Number of Chronic Conditions Predicts Utilization and Spending

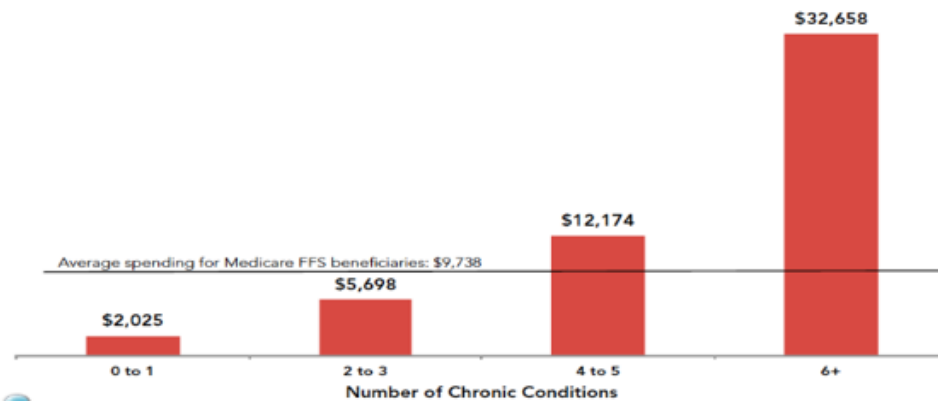
Percentage of Medicare FFS Beneficiaries by Number of Inpatient Admissions and Number of Chronic Conditions



Percentage of Hospital Readmissions Within 30 Days of Discharge by Number of Chronic Conditions and Age



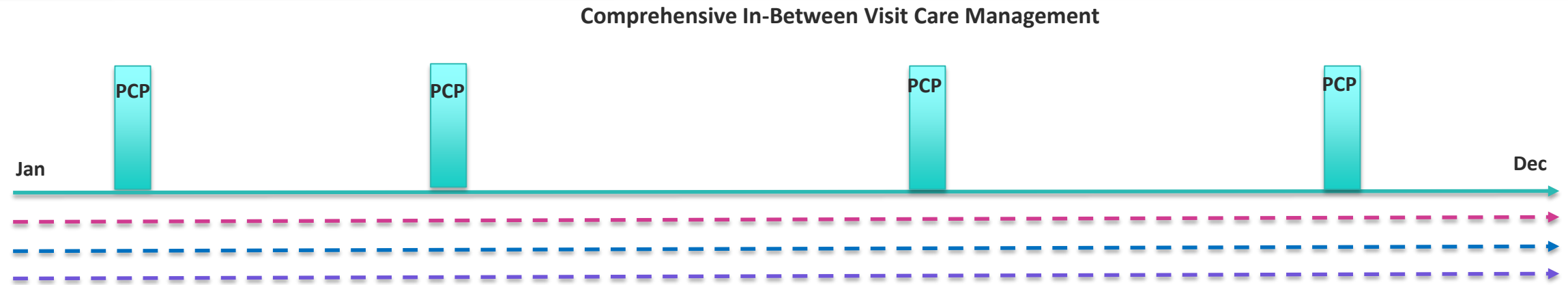
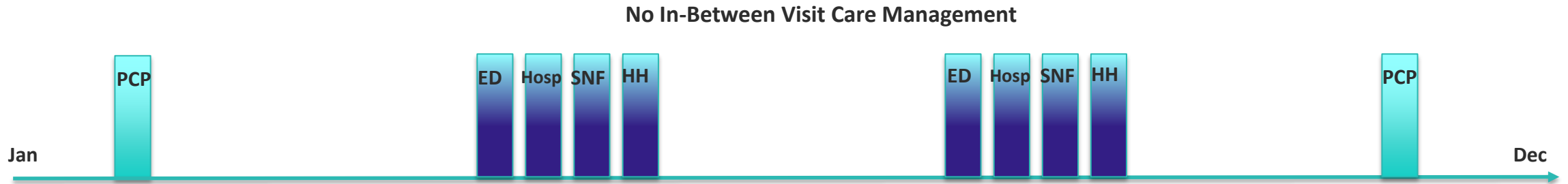
Per Capita Medicare Spending for Medicare FFS Beneficiaries by Number of Chronic Conditions



Total Annual Medicare Spending for Medicare FFS Beneficiaries by Number of Chronic Conditions

Medicare Spending: Fee-For-Service Beneficiaries by Number of Chronic Conditions, 2014			
Number of Chronic Conditions	Total Medicare Spending	Percent of Beneficiaries	Percent of Total Medicare Spending
0 to 1 condition	\$21,669,516,527	35%	7%
2 to 3 conditions	\$58,273,430,854	30%	18%
4 to 5 conditions	\$82,724,744,278	21%	26%
6+ conditions	\$161,282,073,665	15%	50%
Total	\$323,949,765,324		

Overall Goal and Tactics to Deliver Quality Care Management to a Chronically Ill Person



- CCM**
- Comprehensive Care Planning
 - Drive PCP visits
 - Advance Care Planning
 - Quality Measure Attainment
 - Assessments
- Chronic Care Management

- CMM**
- Access to Right Meds
 - Regular Med Reconciliation
 - Medication Adherence
 - Polypharmacy reduction
- Comprehensive Medication Management

- RPM**
- Home Safety
 - Connected Home Biometric Device Bundles
 - Condition-specific alerts
- Remote Patient Monitoring

OUR PROGRAM AND OUTCOMES DATA



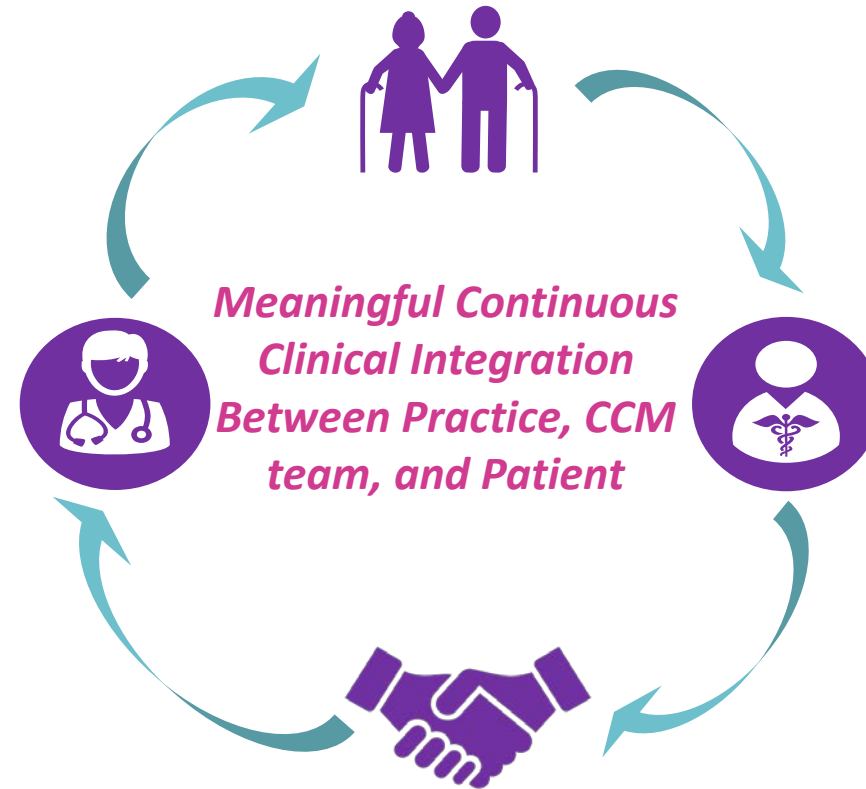
Chronic Care Management, LLC

The Clinically Integrated CCM Solution of Choice

CCM Care Plan review meetings
established and conducted between
CCM and practice teams.

CCM Provider of Record:

- Informed of patient needs
- Informed of gaps in “in-between visit care”
- Communication is guided by a collaboratively-developed Triage protocol.



Trained Chronic Care Coordinators:

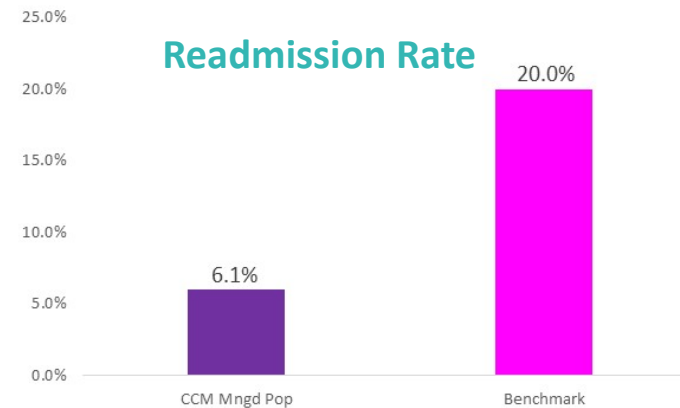
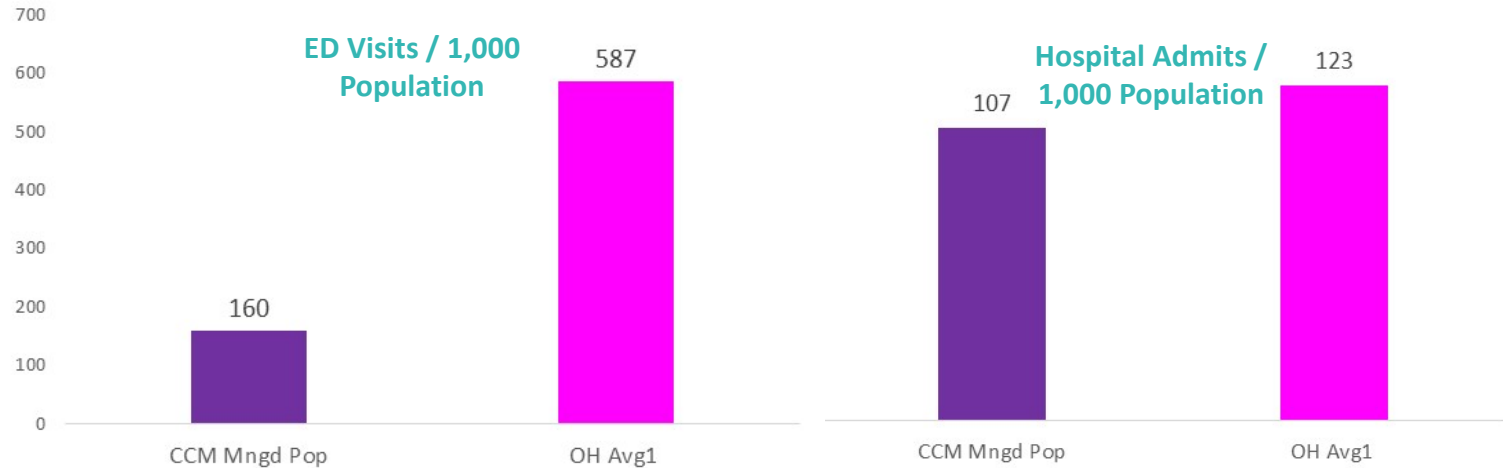
- Access CCM consented patient’s medical record
- Conduct CCM activities
- Speak with patients about potential gaps in care monthly while communicating with providers and office staff continuously.

CCM’s technology platform assures meaningful “in-between visit” linkage between provider, CCM team and patient/caregiver.

Health System Primary Care Institute CCM: Example of Current Client Outcomes

Below charts summarize early utilization outcomes for patients enrolled in the CCM, LLC program

Program data show that the core CCM activities the collaboration between the Health System Primary Care Institute and Chronic Care Management, LLC can help improve clinical outcomes and can be associated with low acute care utilization.



Note 1: CCM utilization data obtained through mining the practice EMR as well as from asking the patient directly if they have been in the hospital or ED.

Note 2: Comparison data from the Kaiser Family Foundation; www.kff.org

Chronic Care Management Program

BILLABLE CODES



CPT CODE 99490

\$44.38

CCM code for 20 minutes of non-face-to-face clinical staff time directed by a physician or other qualified health professional each month, to coordinate care for beneficiaries who have two or more serious chronic conditions that are expected to last at least 12 months.



CPT CODE 99487

\$98.59

Complex CCM code that requires substantial revision of a care plan, moderate or high complexity medical decision making, and 60 minutes of clinical staff time.



CPT CODE G0506*

\$66.48

Add-on code to the CCM initiating visit, for providing a comprehensive assessment and care plan to patients.

*** This code is not included in reimbursable charges to CCM, LLC.
100% of Medicare reimbursement is retained by the provider.**



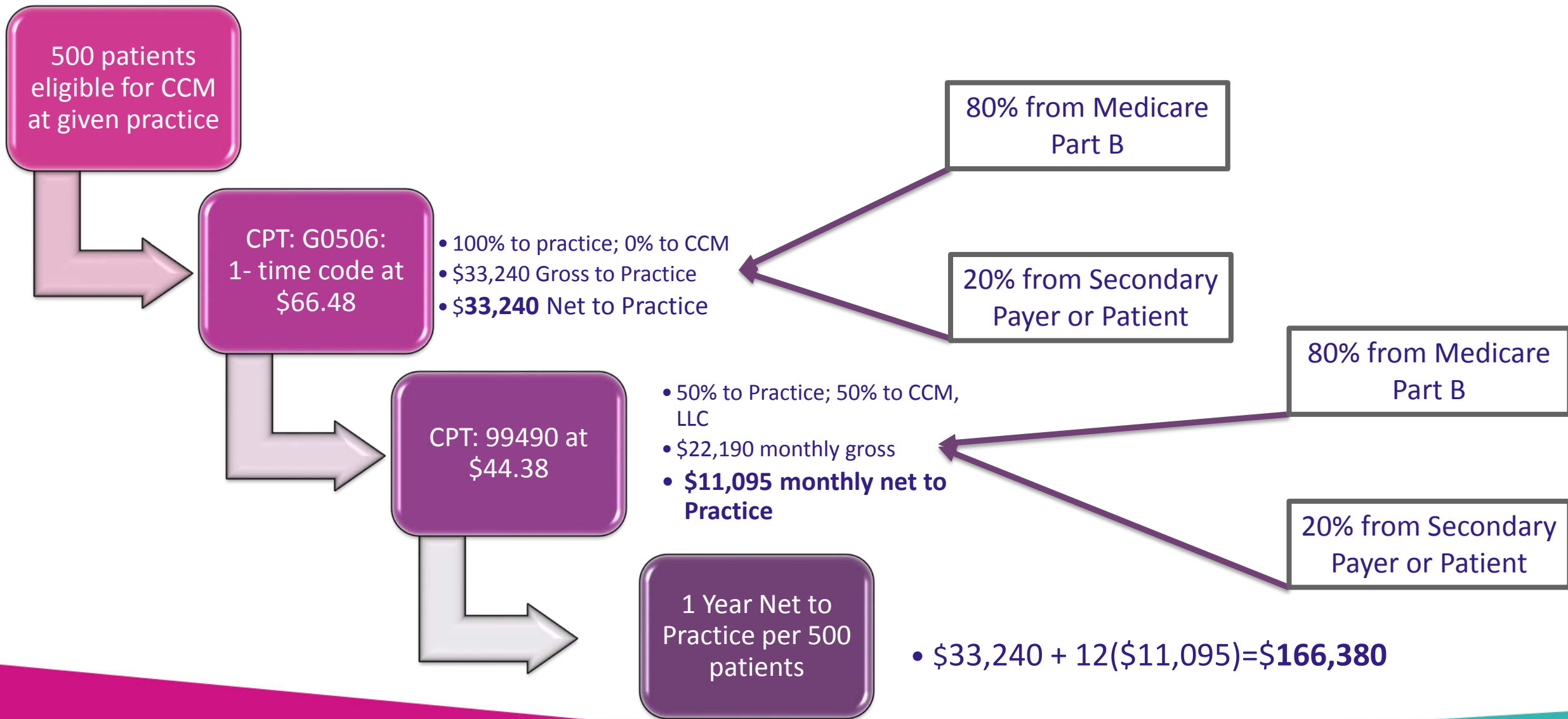
CPT CODE 99489

\$49.99

Extended complex CCM add-on code for each additional 30 minutes of clinical staff time.

Medicare Fee-For-Service Program: CCM Reimbursement Flow

Based on 500 eligible patients at a given practice, this illustrates CCM reimbursement. Deploying a CCM program practice-wide can help increase engagement with care management goals, driving significant new revenue streams for practices (Rates below vary slightly by practice location).



DRIVING PATIENT AND PROVIDER ENGAGEMENT

We Enable Risk Stratified Patient Identification and Management

Highest Risk Patients are Presented to Chronic Care Coordinators Schedule First

The dashboard shows a header with 'Patients: 2,549' and 'Consented: 86.9%'. A navigation bar includes 'My Patients', 'Communications', 'Time Tracking', 'Administrator', and 'Schedule'. A search bar is set to 'By Name' with 'akers, Lucile' entered. A dropdown menu for 'All Risk Tiers' is open, showing options from Risk Tier 1 to Risk Tier 5. Below, a patient record for 'akers, Lucile' is displayed with a DOB of 12/09/1919 (97 Yrs), Gender of Unknown, and MRN of 15566. The record is marked as 'Complex' and 'CPCr'.

Name		MRN	Enter Patient Name (Last or Last, First)		Search	Refresh		
Last Name	First Name	Phone	Care Location	Time	Last Updated	Status	Stratification	Practice Name
Boya	Tom	(216) 454-4000		0	12/01/2016 - 2:23 PM		Complex	CCM Demo Example Practice
Duck	Daisy	(440) 248-6500		0	09/13/2016 - 12:58 PM		Complex	CCM Demo Example Practice
LTCPatient	Trident	(252) 985-1371		0	08/02/2016 - 9:50 AM		Complex	CCM Demo Example Practice
Duck	Donald	(440) 248-6500		0	09/11/2016 - 11:01 AM		Complex	CCM Demo Example Practice
Test	Jill	(216) 333-1234		0	07/27/2016 - 1:56 PM		Tier 4	CCM Demo Example Practice
Doe	David	(599) 595-9599		0	07/20/2016 - 2:09 PM		Tier 4	CCM Demo Example Practice
Doe	Harper	(333) 444-5555		0	08/30/2016 - 4:12 PM		Tier 4	CCM Demo Example Practice
Abelity	Ai	No phone num...		0	07/27/2016 - 11:25 AM		Tier 4	CCM Demo Example Practice

Goal-Directed, Patient-Centered Care Management Workflow Support:

Driving evidence-based care management goals

The screenshot displays the Chronic Care Medical Management Plan interface for patient Daisy Duck. The top navigation bar includes 'Patients 5,279', 'Chronic Care Medical Management Plan', 'Activity - 00:40', 'Hide Screen', and 'Notifications 1'. The patient's name 'Daisy Duck' is prominently displayed, along with a table of key information: Minutes: 0, Status: None, Last Updated: June 28, 2017, Primary Clinician: William Mills, MD, HH/HO Certified: September 29, 2016, Practice: CCM Demo Example Practice, MRN: 9876543, and Medications Reconciled. Below this, the 'CCM Activities' section lists various tasks with dates, such as 'Chronic Conditions' (06/28/2017), 'Advanced Care Planning' (02/28/2017), and 'Assessments & Goals' (08/22/2016). The 'Chronic Conditions' list includes Heart Failure, Hypertension, Alzheimer's Disease, Acquired Hypothyroidism, COPD, Osteoarthritis, Schizophrenia, Hyperlipidemia, Chronic Kidney Disease, Diabetes (E11.33), and Depression (icd10). A pop-up window for 'Diabetes (drag-n-drop)' shows the 'Expected Outcome And Prognosis' (Maintain blood glucose levels at normal or near normal levels. Avoidance of end organ damage.) and the 'Summary Of Management Plan' (Dietary education and modification and/or medication therapy. Regular PCP follow up and laboratory testing.).

- Built to support complex patients with multiple chronic conditions
- Drives Quality Payment Program success
- Drives care management staff workflow

**Every Enrolled Patient
Receives a Goal-Directed
Care Plan
and a Medication Reconciliation
Each Month**

- Available in the cloud for patients and providers from anywhere

Medication Management and Reconciliation: Goal is Ascertaining the Correct Med List

The screenshot displays the 'Medication Management' interface for a patient named David Doe. The left sidebar shows a navigation menu with 'Medication Management' highlighted. The main window is titled 'Medication Reconciliation' and shows a history of reconciliation events. The most recent event, dated 5/17/2017 at 9:17 AM, shows a reconciliation performed using 'Practice EMR' as the source. The result indicates that the patient reports they are taking medication not on the source med list. Below this, there are sections for 'Medication Adherence Plan' and 'Medication Refill Requests'. At the bottom, a 'Reconciliation & Update Status' section shows 'Medications' and 'Problem List' both with green checkmarks, indicating they are up to date.

- Medications Reconciled with Patient or Surrogate
- Discrepancies/Non-Adherence Alerted to Practice

Doe, David PA-C - Stevens, Jonnie MRN: 23452345

Triage Level III

- Medication discrepancies:** Today at 11:47 AM
Not Taking - Listed in EMR:
Losartan Potassium - Ran out
- Remit requested:** Today at 11:47 AM
Losartan Potassium
- HH/HO Certification expired on:** Today at 11:07 AM
7/15/2016
- New Complaints Of:** Last Friday at 6:46 PM
Knee pain descending stairs:
Details about issue here..
second line detail

Sample of Evidence-Based Assessment: Falls Risk Assessment

Identified Risk Communicated to Practice: Opportunity for Preemptive Falls Risk Reduction

Reviewed - No Changes

Age: **74** Gender: **Male** **Incontinent** **Transfers** **Cardiovascular Disease**

Any Fall Risks?

None

Muscle weakness / Mobility / Assistive devices
requires assistance when standing or walking - balance - mobility - gait deficit

Visual deficit
cataracts, glaucoma - deficit even with correction

Cognitive impairment
dementia /alzheimer's

History of falls
per the patient/caregiver or EMR

Fear of falling
per the patient

Medications
patient is taking 4 or more medications per the EMR

Environmental Hazards
any Environmental Assessment "Any safety concerns" are selected

Existing Diagnosis of Postural Hypotension
only per EMR

Cardiovascular disease
heart failure, CHF, angina

+

Any Fall Risks?

5/12/2016 @ 1:47 PM

Any Fall Risks?

5/12/2016 @ 1:47 PM

Any Fall Risks?

5/12/2016 @ 1:47 PM

Any Fall Risks?

5/12/2016 @ 1:47 PM

Care Management Core Package Incorporates all Major Quality Payment Program eCQMs into Monthly CCM Workflow:

Example Preventive Care / Vaccinations

Patients **57**
 Consented **100.0%**

 Quality Measures **1**
 Activity - 02:16

 Hide Screen
 Notifications **0**

 William Mills, MD

My Care Connector My Patients Communications Time Tracking Administrator Schedule

Patient	Minutes: 20	Status: CCM	Last Updated: June 11, 2017	Medications Reconciled
		HH/HO Certified: N/A	MRN: 102385	Allergies Reconciled
		se, PC		Problem Lists Reconciled

My Wishes, My Words™ and My Status

CCM Activities Info / Documents Care Team History View Plan

ACO
Cancel Save

This patient has been included in 31 of the required 31 measures for this program.

[Show History](#)

	Achieved?	Include?
<p>Domain 3 Preventive Health Include: 8 of required 8</p>		
<p>Preventive Care and Screening: Influenza Immunization Yes No Yes No</p> <p>Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.</p> <p>Initial Patient Population All patients aged 6 months and older seen for at least two visits or at least one preventive visit during the measurement period.</p> <p>Improvement Notation Higher score indicates better quality.</p> <p>Denominator Equals Initial Population and seen for a visit between October 1 and March 31.</p> <p>Denominator Exclusions None.</p> <p>Denominator Exceptions Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons) Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons) Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons).</p> <p>Numerator Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization.</p> <p>Numerator Exclusions Not applicable.</p> <p>Definition(s) None.</p> <p>Rationale None.</p> <p>Clinical Recommendation. The timeframe for the visit during the Encounter, Performed: Encounter-Influenza or Procedure, Performed: Peritoneal Dialysis or Procedure, Performed: Hemodialysis in the Population Criteria-Denominator, refers to the influenza season defined by the measure: October through March (October 1 for the year prior to the start of the reporting period through March 31 during the reporting period). The Encounter-Influenza Grouping OID detailed in the data criteria section below is comprised of several ... (more)</p>		
<p>Pneumonia Vaccination Status for Older Adults Yes No Yes No</p> <p>Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine</p> <p>Initial Patient Population Patients 65 years of age and older with a visit during the measurement period.</p> <p>Improvement Notation Higher score indicates better quality.</p> <p>Denominator Equals Initial Population.</p> <p>Denominator Exclusions None.</p> <p>Denominator Exceptions None.</p> <p>Numerator Patients who have ever received a pneumococcal vaccination.</p> <p>Numerator Exclusions Not applicable.</p> <p>Definition(s) None.</p> <p>Rationale None.</p> <p>Clinical Recommendation. It is recommended that patients 65 years of age and older receive one pneumococcal vaccination in their lifetime.</p>		

Quality Measures

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Every Enrolled Patient Receives a Goal-Directed Care Plan and a Medication Reconciliation Each Month



Daisy Duck

My Current Status / How I'm doing this month

I am feeling very tired this month. Able to ambulate better

Patient Information

D.O.B.
02/01/1932

Gender
Female

Email
william.mills@kindred.com

Phone
(440) 248-6500

Address
30575 Bainbridge Road 2b
Solon, OH - 44139

Medical Record Number
9876543

Pay Source
Medicare

H.I. Claim Number
1234567890

Last Updated Chronic Care Medical Management Plan
June 12, 2017

Medications Reconciled
September 2016
Allergies Reconciled
September 2016
Problem List Reconciled
September 2016

My Wishes, My Words™

The most important thing to be is to be comfortable and not in pain.

Primary Clinician Information

Primary Care Clinician
MD, William Mills
CCM Demo Example Practice

Email
primary@ccm.com

Phone
(123) 456-1234

Address
123 Success Dr
Successville, OH - 12345

Patient Consent

Patient consent document on file
May 2, 2016

HH / HO - certified until
September 29, 2016

Chronic Kidney Disease

Expected Outcome and Prognosis
Gradual asymptomatic decline in kidney function.

Summary of Management Plan
Determine etiology. Develop long term management plan based on etiology, including risk factor reduction. Avoid nephrotoxic medications and insults. Advanced Care Planning.

E11.33 Diabetes

Expected Outcome and Prognosis
Maintain blood glucose levels at normal or near normal levels. Avoidance of end organ damage.

Summary of Management Plan
Dietary education and modification and/or medication therapy. Regular PCP follow up and laboratory testing.

Advanced Care Planning

Patient's Advanced Directives on file
No
No: Patient has Advanced Directive but it is not on file

POLST/MOLST in Place
Yes
Yes: On file in patient chart

Emergency plan in place
Yes
Yes: Patient has an emergency plan in place. Daily weights and a new weight-based CHF protocol added for patient at August 1 PCP visit. Patient to take 40 mg extra lasix if she gains > 2lbs in a day or >5lbs in a week and call PCP office for further instruction.

Code Status
DNR-Arrest

Medication Management

Medication compliance plan
Help from daughter to eat breakfast.

Would patient benefit from a specialized medication assessment plan?
Yes, the following medication assessment is recommended: ExactCare Pharmacy referral

Medication Adherence Concerns?
Yes. There are adherence concerns as follows: difficulty eating breakfast

Medication Administration Plan
Patient to take own meds with pill box/periodic dispensing oversight.

Would patient benefit from a complete medication management Program?
Yes, the following medication management program is recommended: ExactCare Pharmacy TM comprehensive medication management.

CCM Patient /Caregiver Educational Resource Portal

Practical Content Covers Conditions and Concerns Across the Spectrum

Chronic Care Medical Management Plan

Health Educational Content

Adult Nutrition, Weight & Fitness

Dietary Supplements & Complementary Medicines; Fatigue & Energy; Fitness, Adult; Fitness, Older Persons; Nutrition & Heart health; Nutrition, Adult; Obesity, Diet; Obesity, Physical Activity; Sleep conditions

Immunizations

Chickenpox (Varicella), Pediatric; Diphtheria, Pediatric; H Flu Type B, Pediatric; Hepatitis A & B, Pediatric; Immunization Basics, Pediatric; Immunization Posters, Pediatric; Immunization Safety, Pediatric; Influenza Vaccine, Pediatric; Measles, Mumps, Rubella, Pediatric; Pertussis, Pediatrics; Pneumococcal Disease, Pediatric; Polio, Pediatric; Rotavirus, Pediatric; Tetanus, Diphtheria, Pertussis Immunization, Pediatric

Allergy, ENT & Ophthalmology

Allergy & Hay Fever; Asthma; Ear Conditions; Eye conditions; Throat/Mouth Conditions; Upper Respiratory Infections; Vertigo

Infectious Disease

Bone & Joint Infections; Eye & ENT Infections; Fungal Skin & Nail Infections; Gastrointestinal Infections; Hepatitis; Herpes Infection; HPV Infection; Infestations; Skin, bacterial infections; Throat/Mouth Conditions; Urethritis/Cervicitis/PID; Zika Virus Disease; Bacterial infections, dermatological; Cellulitis; Cough & Cold; Ebola Virus Disease; Enterovirus D68; HIV Basics; HIV Special Considerations; Immunizations, Adult; Influenza Prevention; Influenza Treatment; Lower Respiratory Infections; Parasitic Infections; STD Prevention; Syphilis; Tuberculosis; Viral conditions; Zika Virus Disease

Neurology & Psychiatry

ADHD; Alcoholism Basics; Alcoholism, Special considerations; Anxiety & PTSD; Bipolar disorder; Brain Basics; Concussion & Brain Injury; Depression Basics; Depression Treatment; Depression, Special Considerations; Insomnia/Sleep Disorders; Neurological disorders; Neuromuscular conditions; Schizophrenia/Psychosis; Seizure disorders; Stroke and TIA; Suicide; Concussions; Sports; Demosia; & Delirium

Diabetes Basics

Diabetes In Older People - A Disease You Can Manage



NIA (National Institute on Aging)

4-pg guide to managing diabetes in older persons

What Is Diabetes and How Can I Manage It?



AHA

2-pg handout on diabetes mgmnt

Diabetes Complications, Cardiovascular

Metabolic Risk: Primary Prevention of Cardiovascular Disease and Type 2 Diabetes



The Endocrine Society

2-pg metabolic risk guide/CVD, type 2 DM prevention

Diabetes Prevention

Diabetes Prevention Program



NIDDK

6-pg review of the Diabetes Prevention Program (DPP)

So You Have Prediabetes... Now What?



CDC

1-pg handout on preventing/delaying diabetes progression

Healthy Lifestyle

How Can I Make My Lifestyle Healthier?



AHA

2-pg handout providing tips for improved cardiovascular health

Diabetes In Older People - A Disease You Can Manage

Diabetes is a serious disease. People get diabetes when their blood glucose level, sometimes called blood sugar, is too high. Diabetes can lead to long-term health problems, such as having a heart attack or stroke. The good news is there are things you can do to take control of diabetes and prevent these problems. And if you experience any of the above symptoms, there are things you can do to lower your risk.

What Is Diabetes?

Our bodies change the food we eat into glucose. Insulin helps glucose get into our cells where it can be used to make energy. If you have diabetes, your body may not make enough insulin, or you may not use it as well as you need to. In this case, the glucose stays in your blood. This can lead to health problems.

Types of Diabetes

There are two kinds of diabetes that can happen at any age. In type 1 diabetes, the body makes little or no insulin. This type of diabetes develops most often in children and young adults.

Type 2 Diabetes

In type 2 diabetes, the body makes insulin, but doesn't use it right. This is the most common kind of diabetes. It usually happens in older people with diabetes. The chance of getting type 2 diabetes is higher if you are overweight, inactive, or have a family history of diabetes.

Diabetes can affect most parts of your body. It's important to keep type 2 diabetes under control. That means it can cause problems like heart disease, stroke, kidney disease, blindness, nerve damage, and foot problems that may lead to amputation. People with type 2 diabetes have a greater risk for Alzheimer's disease.

Prevention

Many people have "pre-diabetes." This means their glucose levels are higher than they need to be, but not high enough to be called diabetes.

Download:

- English
- Spanish

NIA (National Institute on Aging)

Order free print copies at this link.

Questions