CHRONIC CARE MANAGEMENT

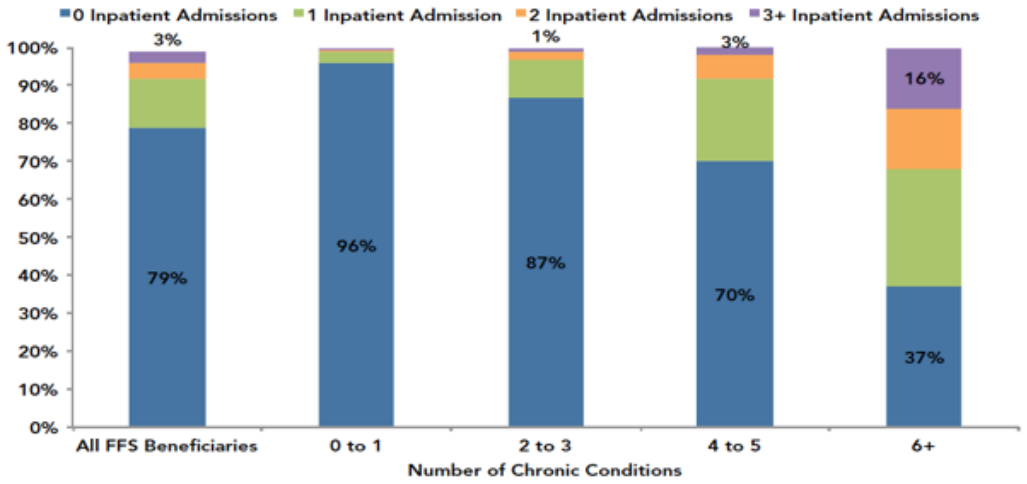
Chronic Care Management, LLC

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

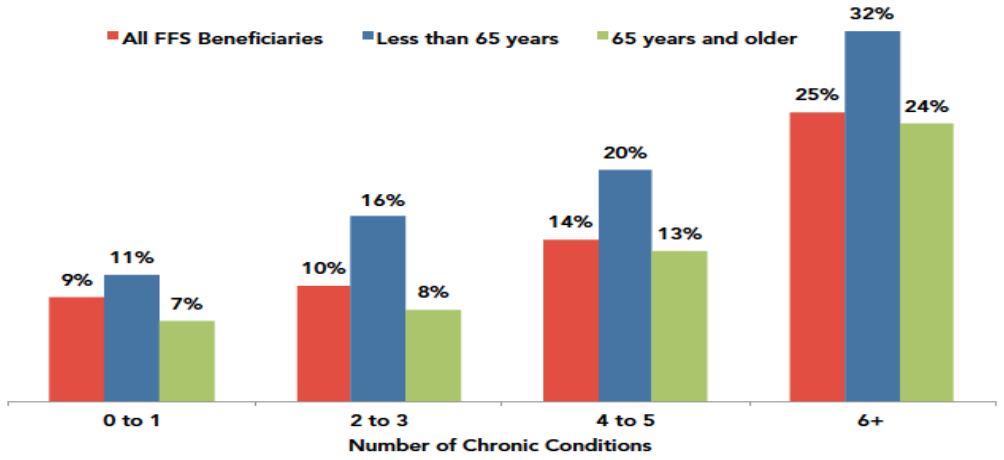
August, 2017

A Higher Number of Chronic Conditions Predicts Utilization and Spending

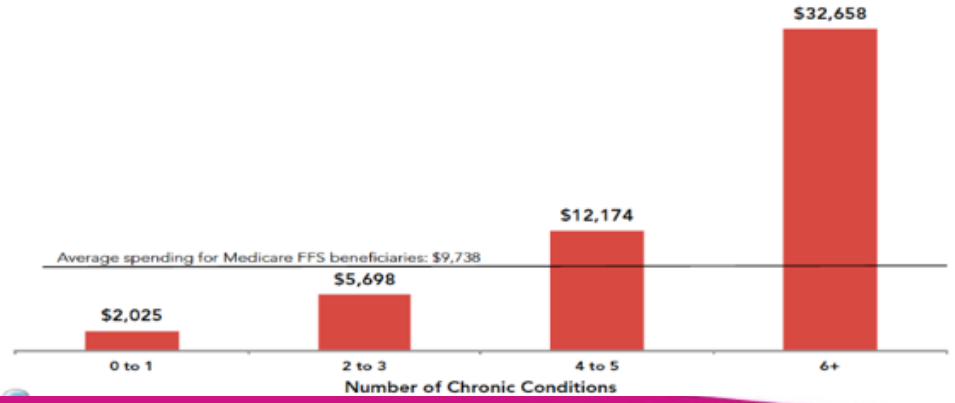
Percentage of Medicare FFS Beneficiaries by Number of Inpatient Admissions and Number of Chronic Conditions



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

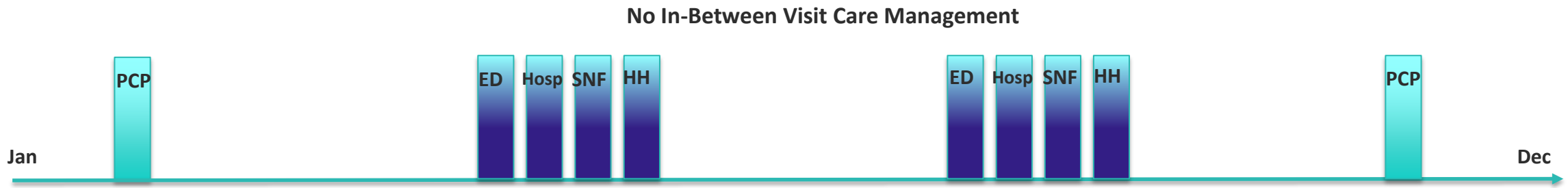


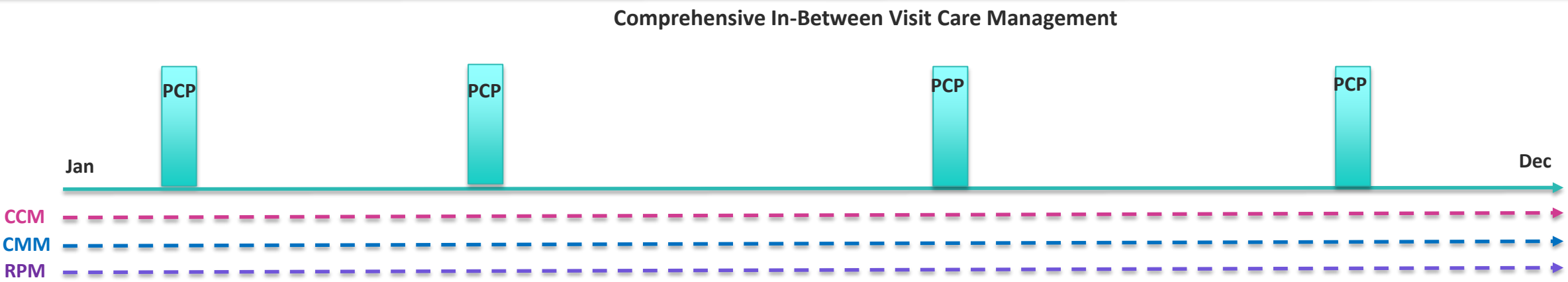
Total Annual Medicare Spending for Medicare FFS Beneficiaries by Number of Chronic Conditions

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		

Source: Chronic Conditions Among Medicare Beneficiaries, Chartbook: 2012; Medicare spending on chronic conditions. See Centers for Medicare and Medicaid Services, chronic conditions charts: 2014.

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:

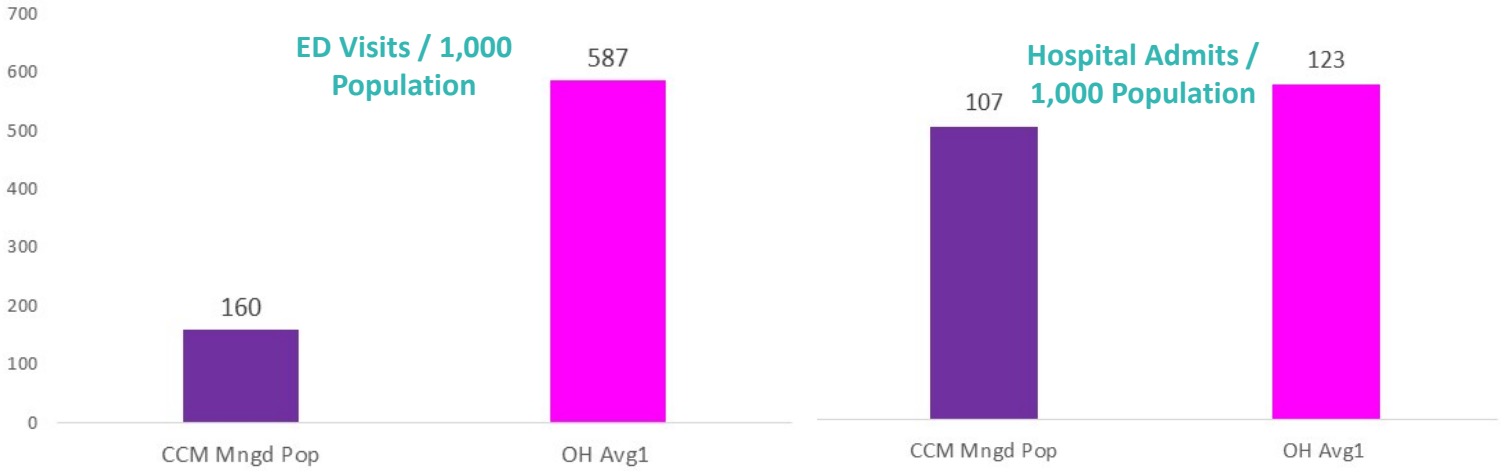
- Access CCM consented patient's medical record
- Conduct CCM activities
- Speak with patients about potential gaps in care monthly while communicating with providers and office staff continuously.

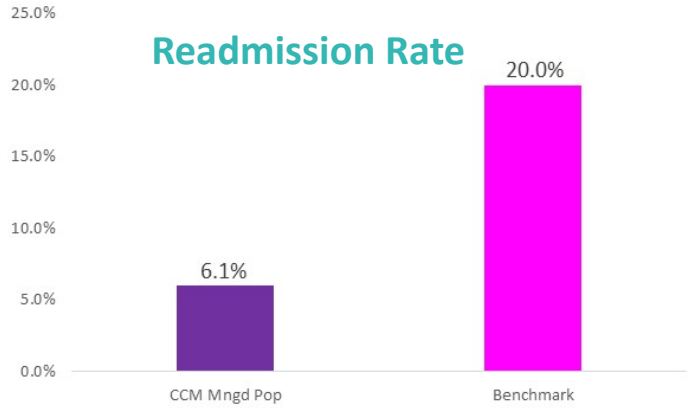
CCM's technology platform assures meaningful "in-between visit" linkage between provider, CCM team and patient/caregiver.

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.

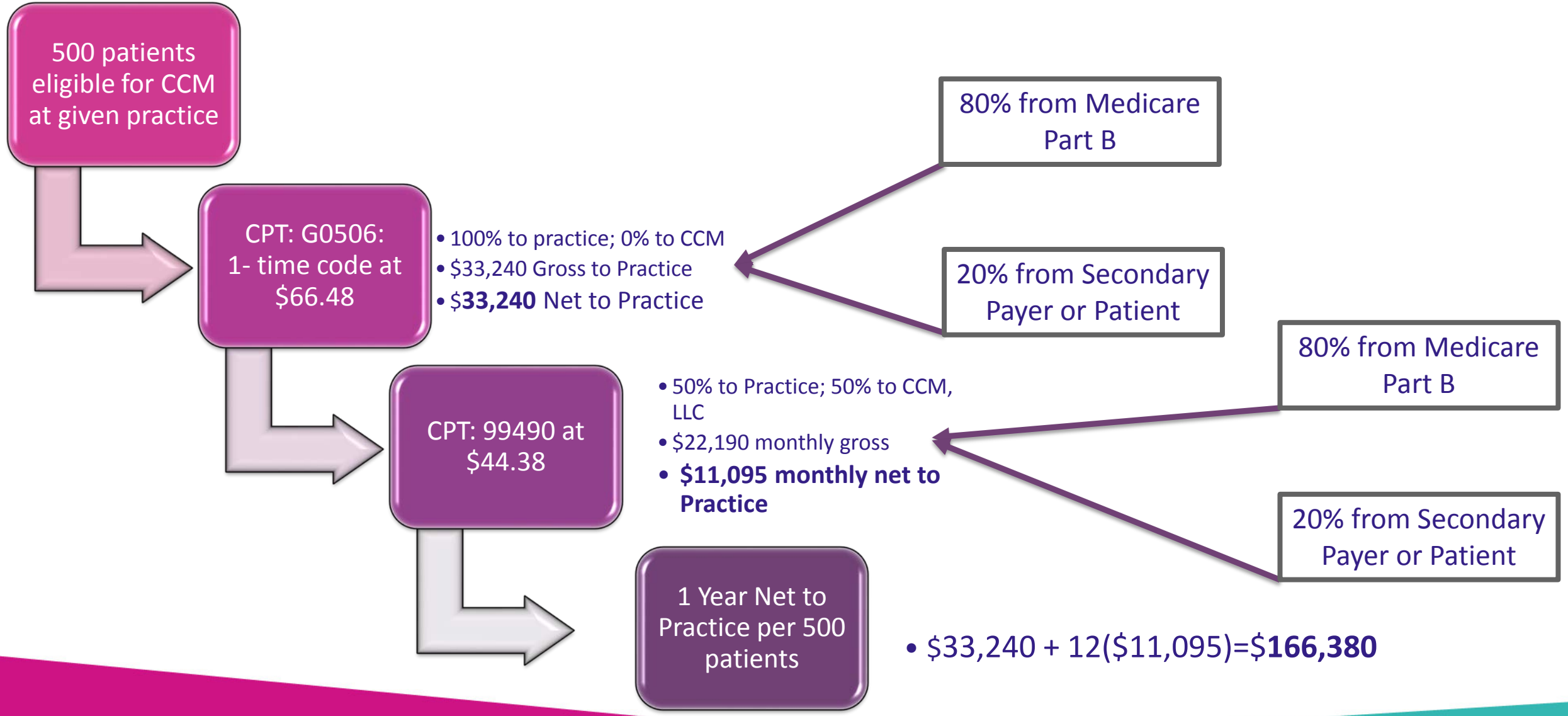
*** This code is not included in reimbursable charges to CCM, LLC. 100% of Medicare reimbursement is retained by the provider.**

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

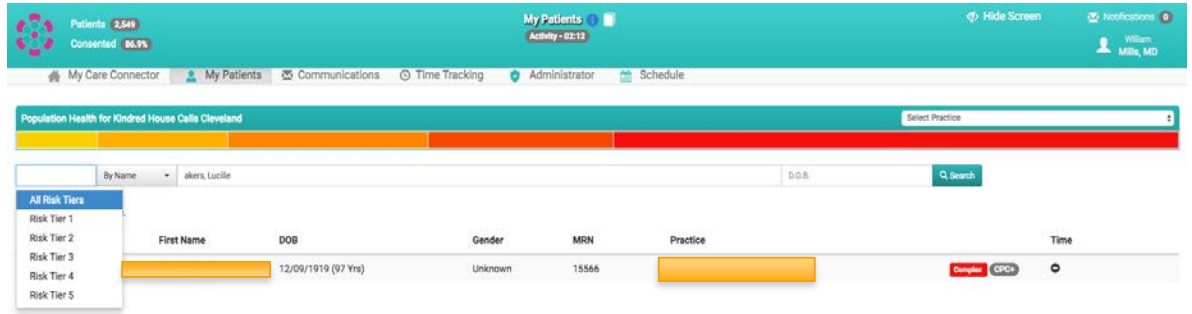
Based on 500 eligible patients at a given practice, this illustrates CCM reimbursement. Deploying a CCM program practice-wide can help increase engagement with care management goals, driving significant new revenue streams for practices (Rates below vary slightly by practice location).



DRIVING PATIENT AND PROVIDER ENGAGEMENT

We Enable Risk Stratified Patient Identification and Management

Highest Risk Patients are Presented to Chronic Care Coordinators Schedule First

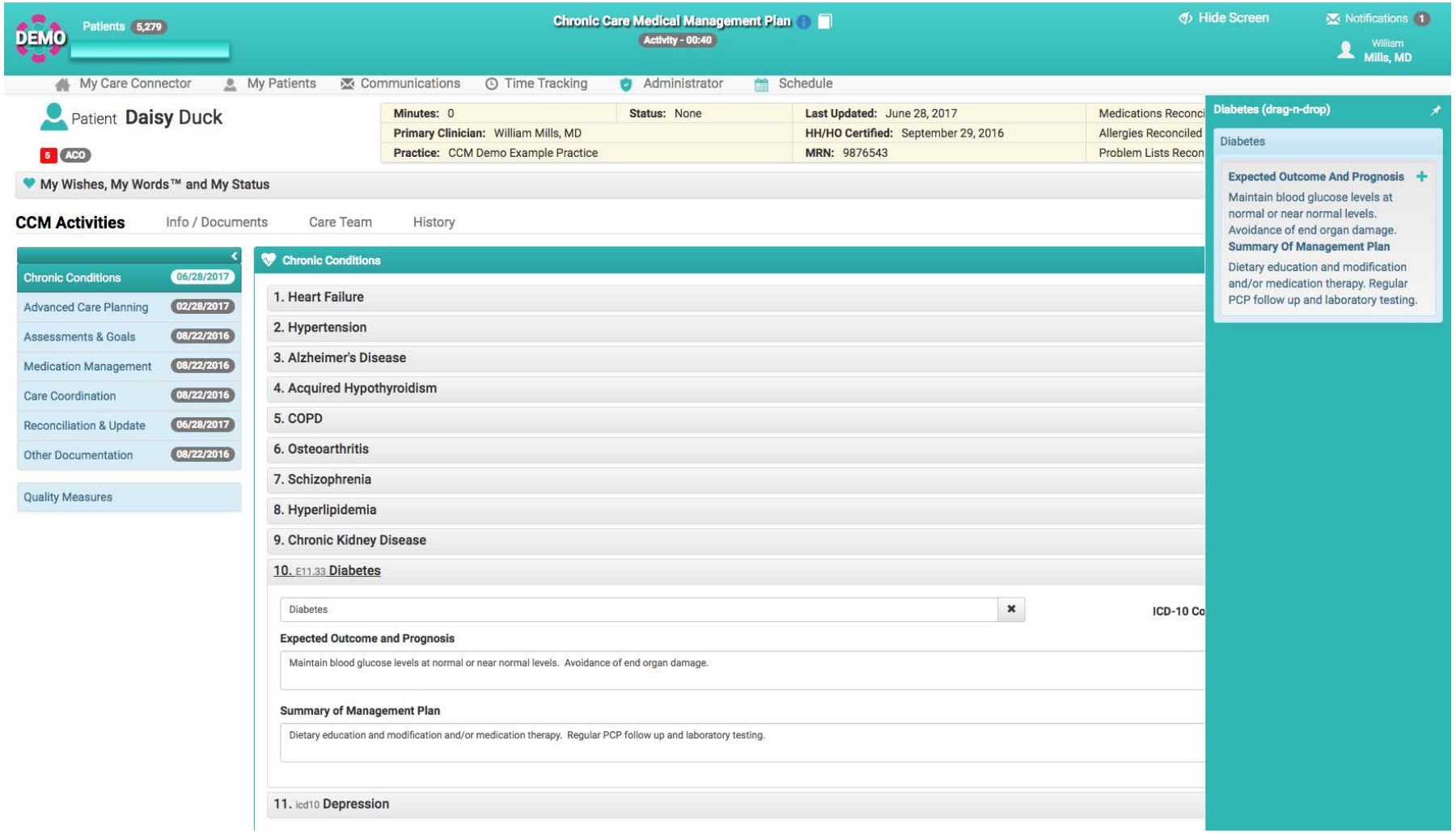


Name | MRN | Enter Patient Name (Last or Last, First) | Search | Refresh

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

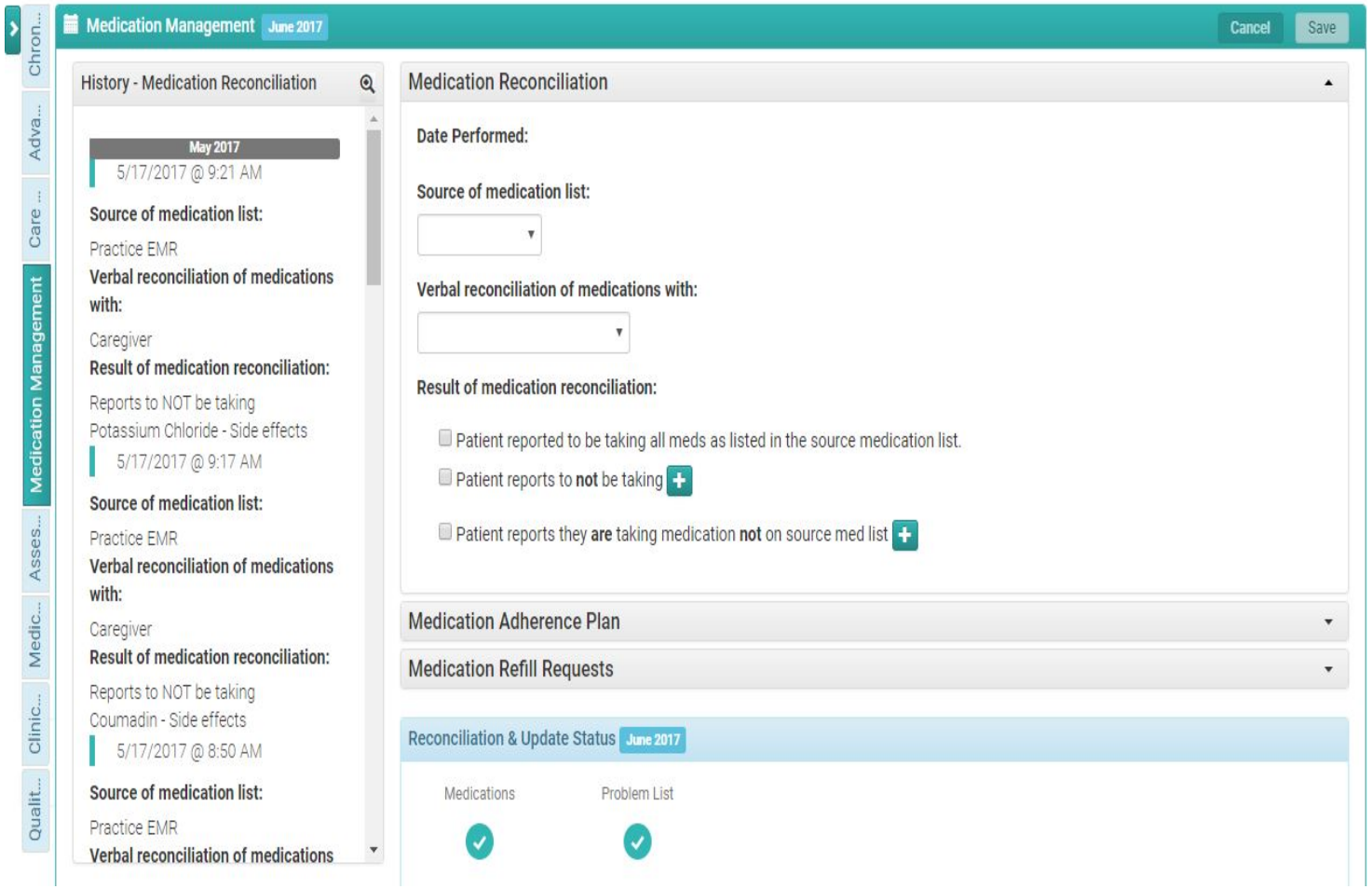


- Built to support complex patients with multiple chronic conditions
- Drives Quality Payment Program success
- Drives care management staff workflow

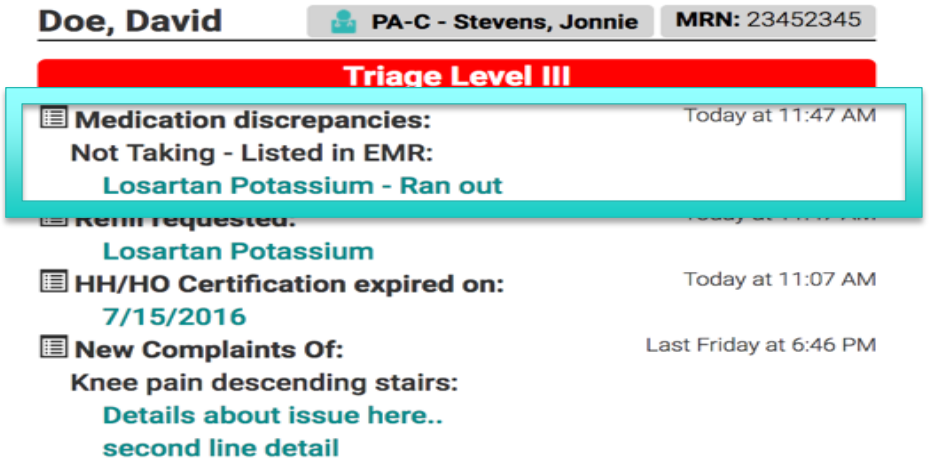
Every Enrolled Patient Receives a Goal-Directed Care Plan
and a Medication Reconciliation Each Month

- Available in the cloud for patients and providers from anywhere

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



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



Sample of Evidence-Based Assessment: Falls Risk Assessment

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

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

☐ Reviewed - No Changes

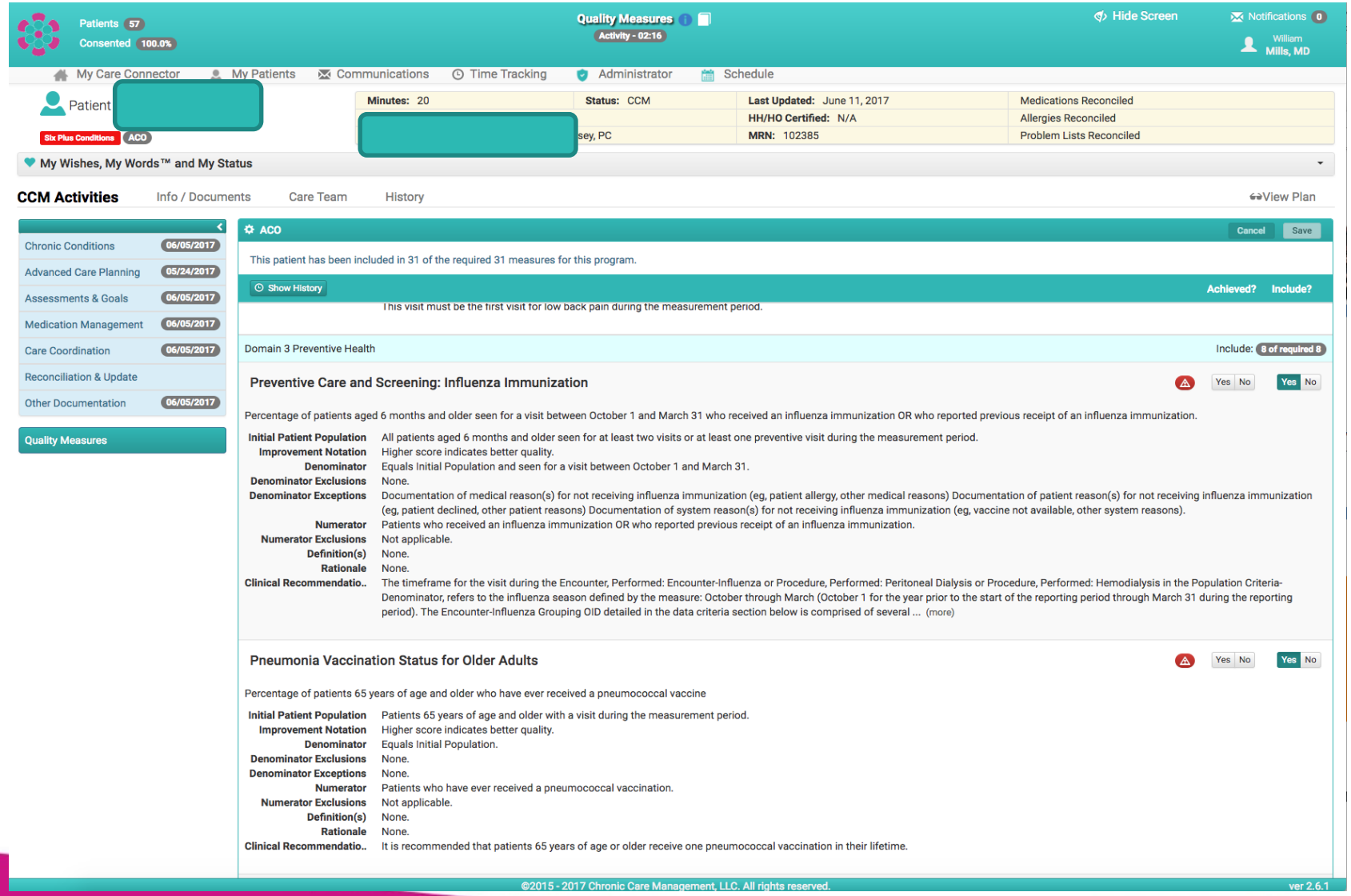
Age: 74 **Gender:** Male Incontinent Transfers Cardiovascular Disease

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

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

Example Preventive Care / Vaccinations



Every Enrolled Patient Receives a Goal-Directed Care Plan

and a Medication Reconciliation Each Month

CHRONIC CARE MANAGEMENT

Last Updated Chronic Care Medical Management Plan
June 12, 2017

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

Daisy **Duck**

My Current Status / How I'm doing this month
I am feeling very tired this month. Able to ambulate better

My Wishes, My Words™
The most important thing to be is to be comfortable and not in pain.

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

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 referreal

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; Diptheria, 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

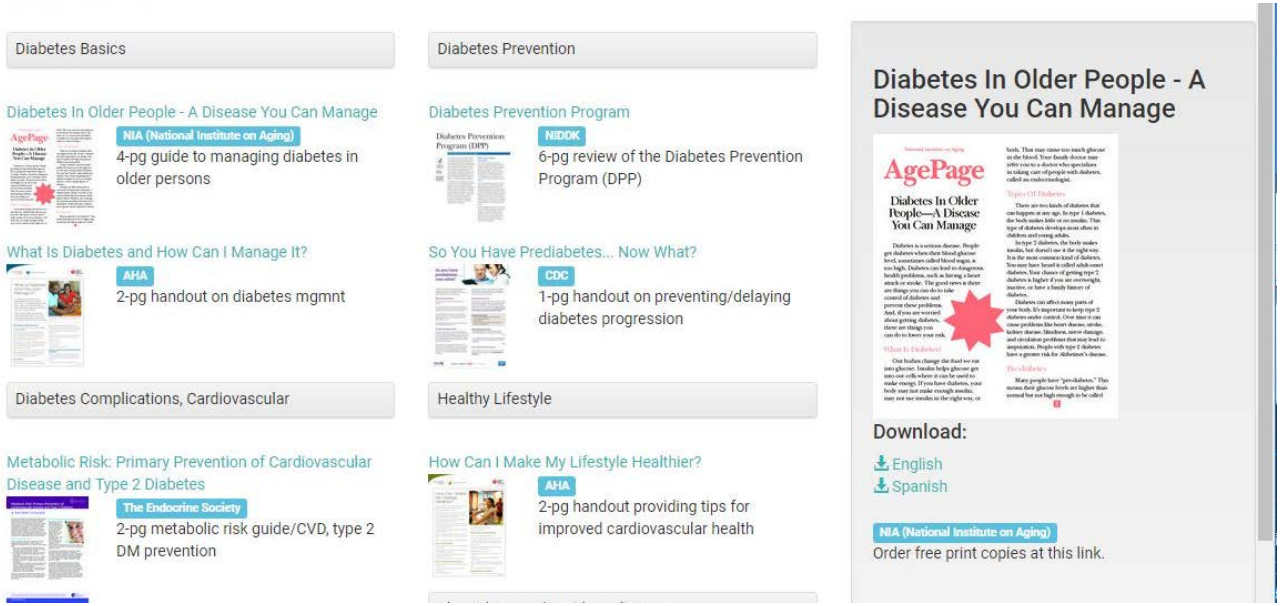
Allergy & Hay Fever; Asthma; Ear Conditions; Eye conditions; Throat/Mouth Conditions; Upper Respiratory Infections; Vertigo

Infectious Disease

Bone & Joint Infections; Eye & ENT Infections; Fungal Skin & Nail Infections; Gastrointestional 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;



Questions