ChronicCareIQ

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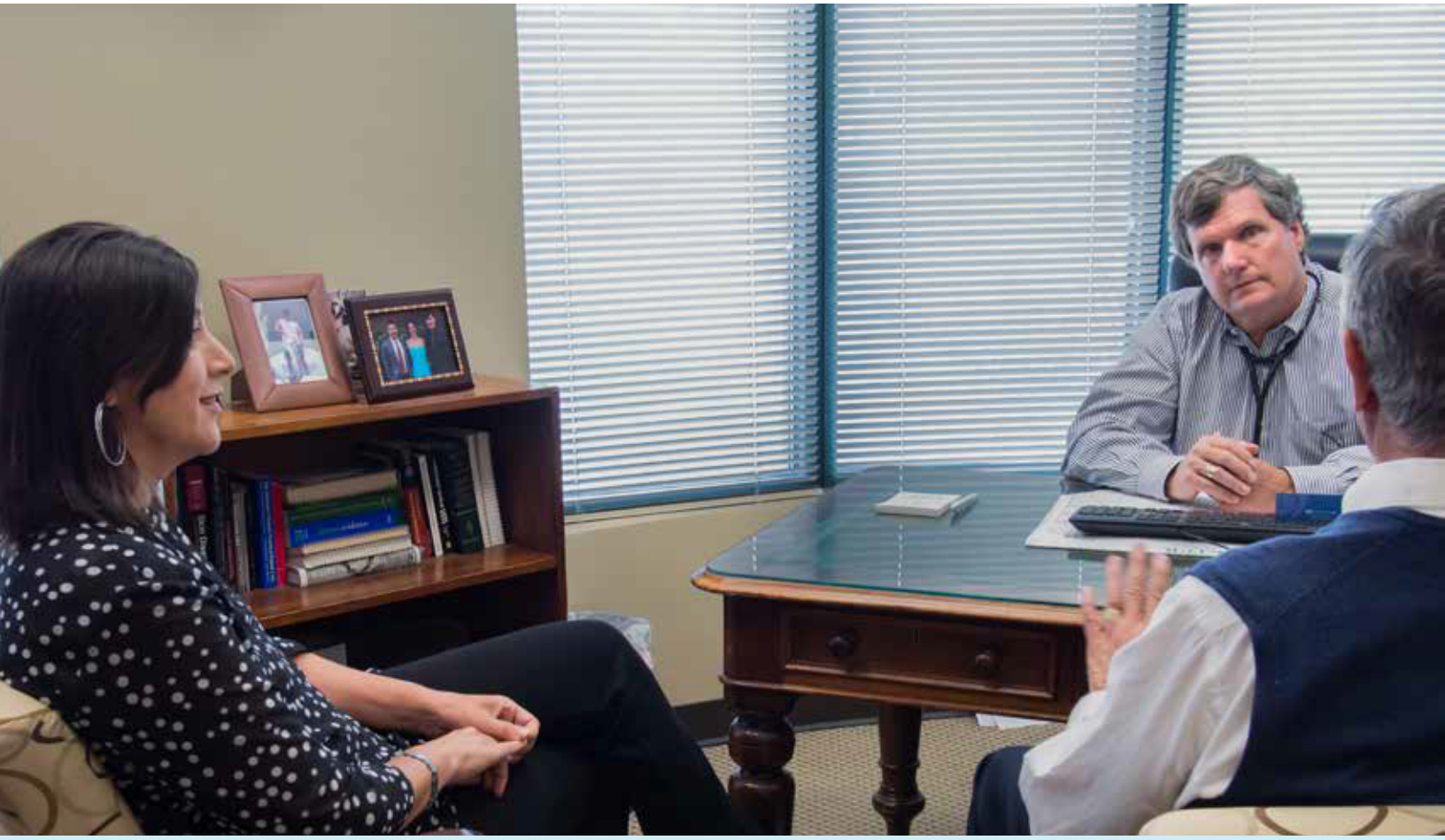


# Creating a Successful Chronic Care Management Program

*A Review from an Internal Medicine Practice*

James H. West, MD, has been in private practice in Internal Medicine in the North Atlanta area since 1989. He graduated from Clemson University in Biochemistry in 1982 and received his doctorate in medicine at Medical College of Georgia in 1986. He completed his internship and residency at the University of Tennessee in Chattanooga. Today, Dr. West remains Board Certified in Internal Medicine and runs an established practice in Atlanta, GA. During his career, he has served as a Hospital Section Chief in Internal Medicine and as the Principal Investigator for medical research on numerous drug trails in hypertension, hyperlipidemia, and other primary care topics. Dr. West has been affiliated with the largest national concierge network of physicians for the past five years and has served on their advisory board for the last three years. His primary focus throughout the years has been providing optimized, advanced, and compassionate care to his patients.

*"We're now reimbursed by all of our payers: commercial, advantage plans and straight Medicare."*

Dr. West was excited to learn about the Medicare payment reform, Chronic Care Management (CCM), which reimburses providers for non-face time spent managing chronic illness. Unfortunately, he knew he did not have all of the resources to easily satisfy the requirements to bill the new CPT code 99490. Dr. West then began to investigate CCM vendors. He saw that there were quite a number of options available and struggled with the concept of billing the patient for services he had always provided for free. "What added value does billing for 20 minutes of non-face to face time give to my patients? And how is that improving my level of care for my patients? Many of my patients who are on Medicare have to pay a co-payment for E&M services I provide. So why would patients enroll in a CCM program that adds a monthly cost, albeit small, and receive no tangible added value? They wouldn't and they shouldn't!"

The real intent of the CMS CCM program is to address the staggering statistics around chronic care; 85% of the healthcare spend is on patients with chronic illnesses and 7 out of 10 deaths are attributable to chronic illnesses.

Dr. West specifically wanted a CCM vendor partner that could provide better patient engagement to help him deliver a higher level of care to his patients. He rejected the concept of outsourcing to a third party call center. "Why would I outsource my core competency and pay over half of the reimbursement in fees? I would be taking on all of the risk and get little for it," says Dr. West. After reviewing a number of vendors, Dr. West decided to work with ChronicCareIQ. "ChronicCareIQ offers real added value to our practice." ChronicCareIQ converts patients' smart phones into monitoring devices that periodically prompt them to answer simple questions that pertain to their health status.

The patients' answers are then auto-scored and displayed on a color-coded dashboard in his office. His staff can easily see if a patient has crossed any preset clinical thresholds or is trending poorly so they can intervene prior to an acute episode which may require a trip to the emergency room or hospitalization.

Dr. West has now been providing CCM services to

his patients for 6 months. He currently has 60 active patients enrolled with ChronicCareIQ. "We started slowly and wanted to ensure that we received payment," Dr. West explains. "We're now being reimbursed by our commercial payers, advantage plans and Medicare."

An unexpected benefit was reduced call volumes. The first to be enrolled were CCM eligible patients that made frequent calls to the office. After which Dr. West and staff noticed a significant reduction in call volume. "Patients felt comfortable that we were monitoring their status and their need to call into the office on a regular basis was virtually eliminated. We had one patient with hypertension who would call when she noticed a slight rise in her blood pressure. She was well controlled but felt compelled to call to report slight variances," Dr. West says. "After we enrolled her in ChronicCareIQ, her calls almost completely stopped and we have better communication!"

*"We are better in touch with our patients; patients feel better knowing that they have daily or regular contact with our office; and we have improved communication with less phone calls"*

Dr. West reports the overall benefit from their CCM program is really multi-factorial. "We are better in touch with our patients; patients feel better knowing that they have daily or regular contact with our office; and we have improved communication with less phone calls."

Dr. West has structured his CCM program so that his wife, Patty, a Registered Nurse, spends part of her time enrolling the patients and monitoring the dashboard. After Dr. West provides a comprehensive patient exam and develops a Patient Centered Care Plan, Patty reviews the CCM program with the patient and/or caregivers. She has them sign a consent form, downloads ChronicCareIQ onto their smart phone, and uploads their personal care plan into the system. She walks the patient or their caregiver through answering their questions the first time so they will be ready the next time they are prompted to respond. Patty also easily monitors Dr. West's patients currently enrolled. The office is now enrolling 4 or 5 patients per week in their CCM program. "The color coded dashboard makes it easy for me to know which patients may need attention," states Patty. If a patient's status changes from green to red, Patty confirms the information with the patient before involving another nurse or Dr. West. "I can call the patient immediately and confirm the patient is experiencing real issues that need the attention of the doctor," says Patty. Dr. West finds that this kind of filtering process more quickly identifies patients in need, reduces multiple calls and messages, and increases office productivity.

About 75% of Dr. West's patients enrolled use the free ChronicCareIQ app on their smart phone to answer their questions. Many of the other 25% log in at their website to answer their questions and those without any technology receive a call once per week from Patty. The time spent using the program is automatically tracked and logged. Non face-to-face time spent outside the software can also easily be added which aids CCM compliance requirements. For instance, if Dr. West refills a medication or changes a care plan, he simply copies Patty in the EHR. She then manually adds that time within ChronicCareIQ. "The EHR remains the repository for all clinical documentation, so I just add 'Rx refill,' and

select 7 minutes in ChronicCareIQ." "We really do not have trouble documenting 20 minutes of non-face to face time per patient per month," Dr West says.

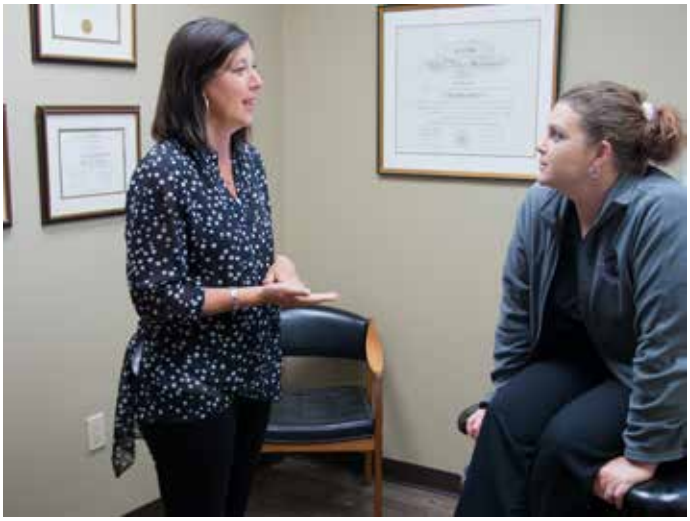
Dr. West's practice administrator, Ginny Skipper, does the billing for the CCM services. "The CCIQ program allows me to know which patient has reached 20 minutes and exactly what day that was achieved. Our Medicare regional billing center (Cahaba) requires that the Date of Service be the day when the non-face to face time reaches 20 minutes for each patient. We have been receiving payment from the Medicare Advantage Programs and other third party payers as well."

Dr. West cannot yet specifically identify the lack of complications as a result of monitoring patients with CCIQ, but he is sure it has helped. "When patients and my practice are monitoring their health status, we have the best chance of averting an acute event," he says.

"I have an elderly CHF patient who is cared for closely by her daughter. The daughter would bring in notes and figures but only on scheduled visits. On one visit, I was alarmed that my patient had gained 16 pounds. However, her daughter was unaware of the weight gain. We tried to treat her as an outpatient, but she was in heart failure and had to be admitted. After she was discharged, we enrolled her into our CCM program and monitored her weight and other parameters daily. Where before, her daughter was keeping her notes and figures in her spiral notebook, she is now entering them into her phone and my patient has not had a heart failure exacerbation since," Dr. West examples.

Dr. West continues to enroll patients in ChronicCareIQ. He recommends enrollment to eligible patients when he changes their medications so he can keep track of them until their next visit in 4 to 6 weeks. "We have a patient with extremely labile hypertension. I have her on multiple hypertensive mediations. She used to feel compelled to call the office when her blood pressure spiked. So we set her up on the in ChronicCareIQ using our hypertensive protocol. Her status may change to red, but now Patty calls her immediately to check if she has already taken an extra dose of medication."

"Every patient is different. Our CCM program with ChronicCareIQ lets us customize protocols specific to that patient's needs. We can alert the patient to answer questions multiple times a day, daily, or a few times a week. Our patients enrolled in our CCM program are engaging at a rate above 85% every week" remarks Dr. West.



*"This kind of elevated care is not happening anywhere else. Even as a concierge physician, I could have never provided this level of care without this technology"*

To follow up immediately on a blood pressure reading for the day or how it is running two days from now, there was no way we could have done it. Our CCM program with ChronicCareIQ is helping us to truly comply with the spirit of the CMS CCM program and satisfying the healthcare triple aim," concludes Dr. West.

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ChronicCareIQ, the industry leader in Chronic Care Management and patient engagement, enables healthcare providers to keep tabs on fragile and chronic patients through their smart phones, computers, text or email. In use from Hawaii to Maine from the solo providers to the largest healthcare systems in America, you can generate significant new revenue, improve outcomes, automate billing compliance, and reduce the workload associated with complex patients while ensuring they receive better care. Identified as a "Best Practice" by leading consulting groups and with patient engagement rates that exceed 80% on an average weekly basis, your practice, hospital, or health system can identify decompensating patients in real time, manage risk to prevent unnecessary hospitalization or ED visits, and advance material steps with MACRA and payment reforms. Visit us at ChronicCareIQ.com

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