Implementing Chronic Care Management in FQHCs: Lessons Learned from the Field

PURDUE UNIVERSITY

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REGENSTRIEF CENTER FOR HEALTHCARE ENGINEERING

IPHCA
Indiana Primary Health Care Association

Great Lakes PTN

CCM Implementation Initiative

- Cohort of 10 FQHCs within Indiana
- Training on lean methodology to implement CCM
- Focus on patients with poor A1C control

CCM 101

- Chronic Care Management (CCM)- non-face-to-face services provided to Medicare patients who have multiple, significant chronic conditions. Services are provided monthly.

While some commercial payers may offer similar codes, the ones discussed in this presentation are specific to Medicare Part B beneficiaries.

Chronic Care Management 101

- Why is it important?
  - Allows for better care coordination for patients with multiple chronic conditions
  - Can improve patient engagement and outcomes
  - Can reduce total cost of care by limiting unnecessary ED utilization and unnecessary hospitalizations

Chronic Care Management 101

- Aligning Quality
  - Components of PCMH
    - Care management
    - Empanelment
  - Can improve clinical quality measures
    - Meaningful Use submission
    - UDS reports/ HRSA Clinical Quality Improvers bonus
    - MCE Quality Programs
  - Can supplement group visits for improved outcomes

Chronic Care Management 101

- What patients are eligible for services?
  - Medicare Part B beneficiaries who meet the following criteria:

"2 chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline."

Chronic Care Management 101

- How does CCM work?
  - Clinician identifies patient as eligible for services and engages patient to obtain consent to participate
  - Establish a care plan that can be accessed 24/7
  - Doctor, or affiliated clinical staff, engage patients monthly to address items related to their conditions
  - Document appropriately to bill the correct corresponding code (based on time)- $62

CCM Standard Work

- New processes might be required:
  - Identification of potential patients
  - Who will each patient be assigned to?
  - Recruitment/documentation of consent
  - Timely development of care plan after consent
  - Completion of non-face-to-face services
    - Who will own these tasks?
    - Alerts of 20 minute achievement
  - Notification to billing team when CCM services have been completed

CCM Cohort Specifics

- 4 groups through the LDI training with projects launched
- 5 groups still in training process with launch time in October
- A handful of groups dabbled in CCM prior to participation

Lean Daily Improvement Training

- Flipped classroom approach to training
- A virtual training from PHA that:
  - Trains staff to establish new standard work
  - Educate colleagues on new work
  - Implement standard work
  - Track successes and challenges daily/weekly
  - Adjust standard work to meet metrics

CCM Standard Work

- What are the cohort participants tackling?
  - Process for identifying eligible patients
  - Enrollment process
    - Documentation of accept/decline
  - Ideal patient outreach time
  - Billing capture

Initial Success

- Actively pulling patient lists from AZARA DRVS
- Actively contacting patients about CCM opportunity
- Learning ideal time to call patients
- Successfully billing CCM encounters

Initial Findings

- Root cause of patients declining participation
  - Copay is barrier for some
- Single source failure point for project success
  - Only 1 person does a task and vacation/ conferences delay progress
- Managing patients contact time preference
- Medicaid denied claims

Hurdles

- Eating the elephant mindset
- Organizational readiness
- Staff education/buy-in
  - Time to work on projects
- EHR challenges

Using the Time Wisely…

- What comes after the standard work is defined?
  - Interacting with patients!
  - Make it worthwhile interactions
    - Use motivational interviewing
    - Avoid yes/no communications
    - Address the whole person, not just A1c

Using the Time Wisely…

Idea Generator

- Diabetes A1c
- Hypertension
- Depression

- Poly-pharmacy
- SDOH
- Health literacy

Summary

- Cohort of practices working through training and implementation together
- Bright spots and standard work can be shared
- Network with peers to learn ways to use 20 minutes for full impact
- Spread
  - CCM to other disease states
  - LDI process to other new standard work

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