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An Example of Value-Based Payment:

Chronic Care Management

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Your Life Your Health

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Value-based Payments are expected to focus more on outcomes – improvement in health – than process – doing “things” to or for patients. For instance value-based payments will focus more on whether patients with diabetes’ treatments are resulting in improved care rather than just whether patients with diabetes are receiving certain tests.

To promote this change, Health and Human Services (HHS) is designing new programs for payment which focus on outcomes even when they measure a process. One of those is the new Chronic Care Management (CCM) program. If patients who are treated through fee-for- service Medicare, as opposed to Medicare Advantage, and if healthcare providers can meet the rigorous standards, they can participate in the CCM program and be paid for it.

The Chronic Care Management payment is offered by CMS for the care of patients who have more than two chronic conditions and who are contacted each month for complex care management. The contact must result in an aggregate of 20 minutes of time spend in counseling with the patient by telephone or in person including time spent preparing a plan of care and treatment plan.

It is expected that this program will reduce the utilization of other services and decrease the cost of care for patients on Medicare while improving the quality of care they are receiving. The difficulty for providers is that the requires for payment are rigorous and the potential for healthcare providers being audit to determine if they are meeting the standards of care required is significant.

To participate in this program and to make sure that we comply with all standards, SETMA is designing a clinic decision support tool for documentation and auditing of the requirements. The following is the beginning of a tutorial for SETMA’s preparation for this task which includes documentation for:

1. Performed – to prove that the monthly contact with patients has been completed
2. Documented -- to prove that the patients included in the program meet all standards
3. Compared – each patient is compared to prove that exclusions are met, such as nursing home admission, home healthcare and transitions of care charges being submitted during same period.
4. Audited -- to prove to ourselves that all elements of the Chronic Care Management are being done and to be prepared to prove that all elements have consistently been met if we are audited.
5. Patient agreement for being involved in the CCM program.

The Chronic Care Management documentation will be launched from SETMA's AAA Home Template as seen below outlined in green:

SOUTHEAST TEXAS MEDICAL ASSOCIATES, LLP

Patient: Sex: Age: Patient's Code Status:

Home Phone: Date of Birth:

Work Phone: **Patient has one or more alerts!** [Click Here to View Alerts](#)

Cell Phone:

[Pre-Vist/Preventive Screening](#)
Patient Eligible For Medicare Preventive Exam

[Intensive Behavioral Therapy Transtheoretical Model](#)
[Bridges to Excellence View](#)

Preventive Care	Template Suites	Disease Management	Last Updated	Special Functions
SETMA's LESS Initiative I	Master GP I	Diabetes I	08/11/2015	Lab Present I
Last Updated: <input type="text" value="01/20/2015"/>	Pediatrics	Hypertension I	05/21/2013	Lab Future I
Preventing Diabetes I	Nursing Home I	Lipids I	04/08/2015	Lab Results I
Last Updated: <input type="text" value=""/>	Ophthalmology	Acute Coronary Syn I	//	Hydration I
Preventing Hypertension I	Physical Therapy	Angina I	//	Nutrition I
Smoking Cessation I	Podiatry	Asthma	//	Guidelines I
Care Coordination Referral	Rheumatology	Cardiometabolic Risk Syn I	09/23/2013	Pain Management
PC-MH Coordination Review	Hospital Care	CHF I	//	Immunizations Print
<i>Needs Attention!!</i>	Hospital Care Summary I	Diabetes Education	//	Reportable Conditions
HEDIS NQE ACO	Daily Progress Note	Headaches	//	Information
Elderly Medication Summary	Admission Orders I	Renal Failure	//	Charge Posting Tutorial
STARS Program Measures		Weight Management I	//	E&M Coding Recommendations
Chronic Care Management I				Drug Interactions I
CHF Exercise I				Infusion Flowsheet
Diabetic Exercise I				Insulin Infusion

The CCM is found at the link surround in green above. The Chronic Care Management Master template is shown below. It includes:

1. Primary and Secondary Insurance Designation -- The primary insurance will be Medicare Fee-for-Service. Because the patient will be responsible for the 20% which Medicare does not pay and because many of the patients who need this service cannot afford to pay their part which is \$8.60, it is important for us to know that they are insurance for this to be paid. Medicare does not allow providers simply to “forgive” the 20% required payment. In order to excuse patients from paying that amount, Medicare requires that three, registered

letters be sent to the patient, requesting payment. For the Chronic Care Management services, the patient's 20% is less than the cost of the collection-effort requirement.

2. Patient Status in regard to CCM participation
3. Primary Care Provider and Designated CCM contact
4. Time Tracing function to document time spent monthly on CCM
5. Patient's Current Chronic Problems
6. Tracked Problems and whether or not they are currently being tracked.
7. Current Medications and whether or not they have been reconciled
8. Current Allergies
9. Referrals
10. Appointment History and Upcoming Appointments.

Chronic Care Management

Patient: **Larry** **QTest**

DOB: **09/01/1959**

Primary Insurance:

Secondary Insurance:

Return

Print

Send to NextMD

Patient Status

Currently active in CCM? ☒ Y ☐ N

CCM Consent completed? ☒ Y ☐ N

Date Completed: [Print](#) **09/14/2015**

Enrolled in NextMD?

Primary Care Provider: **Holly, James L.**

Patient's Other Providers:

Designated CCM Contact:

Time Tracking - Today [A](#)

Date	Subject

Medical Home Coord Review

Pre-Visit/Preventive Screen

Patient's Current Chronic Problems

#	Diagnosis
1	Pancreatic cancer
2	Lipid metabolism disorder
3	Depression due to dementia
4	COPD (chronic obstructive pulmonary disease) with chronic bronchitis
5	Diabetes 1.5, managed as type 2
6	Tourette's disease
7	Compression fracture of spine
9	Discharge from ear
10	Both parents smoke
11	Testosterone 17-beta-dehydrogenase deficiency

Tracked Problems
Click for Detail

Category	Problem	Currently tracking?
Cardio Disease	Old myocardial infarction	<input checked="" type="radio"/> Y <input type="radio"/> N
CHF	CHF (congestive heart failure)	<input checked="" type="radio"/> Y <input type="radio"/> N
Depression	Depression due to dementia	<input checked="" type="radio"/> Y <input type="radio"/> N
Diabetes	Diabetes 1.5, managed as type 2	<input checked="" type="radio"/> Y <input type="radio"/> N
COPD/Asthma	COPD (chronic obstructive pulmonary disease)	<input checked="" type="radio"/> Y <input type="radio"/> N
Hyperlipidemia	Lipid metabolism disorder	<input checked="" type="radio"/> Y <input type="radio"/> N
Hypertension	Hypertension	<input checked="" type="radio"/> Y <input type="radio"/> N
Other	Dementia	<input checked="" type="radio"/> Y <input type="radio"/> N
Other	Hyperuricemia	<input checked="" type="radio"/> Y <input type="radio"/> N

Summary

Total Chronic Conditions: **40**

Total Tracked Problems: **9**

Current Medications (Double-click to Add/Edit) **Reconcile**

Brand Name	Generic Name	Dose	Sig Desc
ABILIFY	ARIPRAZOLE	2 mg	take 2.5 by oral route once
ASPRIN EC	ASPRIN	81 mg	inject by Subcutaneous route once daily DM250.50
LIPITOR	ATORVASTATIN CALCIUM	10 mg	take 1 tablet (10MG) by oral route every day at bedtime as needed
CELEBREX	CELECOXIB	50 mg	take 2 capsule by oral route 2 times every day
CELEBREX	CELECOXIB	50 mg	take 2 capsule by oral route 2 times every day
HYDROCODONE-ACETAMINOPHEN	HYDROCODONE/ACETAMINOPHEN	5 mg-500 mg	take 1 tablet by oral route every 6 hours as needed for pain
HYDROCODONE-ACETAMINOPHEN	HYDROCODONE/ACETAMINOPHEN	10 mg-300 mg	take 1 tablet by oral route every 8 hours as needed

Current Allergies (Double-click to Add/Edit)

Allergy	Date of Onset
NO KNOWN DRUG ALLERGIES	01/10/2013

☐ Allergies reviewed/updated today.

Referrals [Care Coordination Referral](#) [Diagnostic/Referral Orders](#)

Ordered	Status	Priority	Order	Ordered By
09/04/2015	obtained	Routine	EEG	James Holly
07/21/2015	completed	Immediate	EKG	James Holly
07/20/2015	completed	Immediate	Colonoscopy	James Holly
07/20/2015	cancelled	Immediate	Uroflowmetry	James Holly
07/20/2015	cancelled	Immediate	Thrombectomy	James Holly

[Community Resources](#)

Appointment History (3 Months)

Date	Kept	Provider	Type

Upcoming Appointments (3 Months)

Date	Kept	Provider	Type
09/28/2015	No	Holly, J	Established Patient - ASAP

The CCM requires the patient to have at least two chronic conditions and documentation for each condition being tracked is required. The following is taken from the above template and shows what conditions are being tracked. The example used is outlined in green and shows that this patient is being “tracked” for diabetes.

Patient's Current Chronic Problems		Tracked Problems Click for Detail		Currently tracking?
#	Diagnosis	Cardio Disease	Old myocardial infarction	<input checked="" type="radio"/> Y <input type="radio"/> N
1	Pancreatic cancer	CHF	CHF (congestive heart failure)	<input checked="" type="radio"/> Y <input type="radio"/> N
2	Lipid metabolism disorder	Depression	Depression due to dementia	<input checked="" type="radio"/> Y <input type="radio"/> N
3	Depression due to dementia	Diabetes	Diabetes 1.5, managed as type 2	<input checked="" type="radio"/> Y <input type="radio"/> N
4	COPD (chronic obstructive pulmonary disease) with chronic bronchitis	COPD/asthma	COPD (chronic obstructive pulmonary disease)	<input checked="" type="radio"/> Y <input type="radio"/> N
5	Diabetes 1.5, managed as type 2	Hyperlipidemia	Lipid metabolism disorder	<input checked="" type="radio"/> Y <input type="radio"/> N
6	Tourette's disease	Hypertension	Hypertension	<input checked="" type="radio"/> Y <input type="radio"/> N
7	Compression fracture of spine	Other	Dementia	<input checked="" type="radio"/> Y <input type="radio"/> N
9	Discharge from ear	Other	Hyperuricemia	<input checked="" type="radio"/> Y <input type="radio"/> N
10	Both parents smoke			
11	Testosterone 17-beta-dehydrogenase deficiency			

Total Chronic Conditions	Total Tracked Problems
40	9

When the Diabetes button outlined in green above is clicked the following pick list will be deployed: This allows the person calling the patient to efficiently document concerns the patient has with their care for the chronic condition involved.

Chronic Care Management - Diabetes

Tracked Diabetes Diagnoses

Primary: Diabetes 1.5, managed as type 2

Secondary: Chronic kidney disease, stage II (mild)
Morbid obesity

Return

Target HbA1c 6.5

Set Date 09/14/2015

HbA1c History

5.7	06/15/2015
5.7	06/15/2015
6.2	

Diabetes Consortium Data Set

Patient Concerns Related to Diabetes

*Patient concerns copy forward to future visits until changed.

Comments

Ccm Diabetes

Appetite - My appetite has been poor, what should I do?

Blood Sugar Log - Can I send my Diabetes Self Management log to my provider?

Education - I need to go to diabetes education.

Exercise - Can I begin exercise; what should I do?

Follow-up Visit - Should I come in sooner than my next visit?

Follow-up Visit - When is my next appointment?

Hemoglobin A1c - What was my last result; what is my goal?

Hypoglycemia - I am having more episodes of low blood sugar.

Medications - Can I change my medication?

Medications - I can't afford my medications.

Nausea - I have been feeling badly with some nausea.

Preventive Care - Am I up-to-date with my screening and preventive care?

Vision - I need a appointment for an eye examination.

Close

There are seven structured data fields for Chronic Conditions for SETMA's deployment of the CCM function; they are:

1. Cardiac Disease
2. CHF
3. Depression
4. Diabetes
5. COPD/Asthma
6. Hyperlipdemia
7. Hypertension

There are several non-designated fields to be used for other chronic conditions.

When completed, each Tracked Problem will have a CCM template similar to the one below for diabetes. When the Diabetes tab above is clicked the CCM tool shown below will be deployed. For diabetes, there will be a HbA1c target with a date for that being achieved. The last three HbA1c will be document automatically. The Diabetes Consortium Data Set which includes targeted goals will be listed as is seen below and a referral tool will be deployable from this template as well.

In addition, there is a place to document the patient's expressed concerns about their diabetes care and a place to denote whether diabetes was discussed in the current CCM contact with the details of the discussion and the treatment plan.

Chronic Care Management - Diabetes

Return

Tracked Diabetes Diagnoses

Primary	Diabetes 1.5, managed as type 2
Secondary	Controlled type 2 diabetes with renal manifestatio
	Chronic kidney disease, stage II (mild)

Target HbA1c 6.5

Set Date 09/14/2015

HbA1c History

5.7	06/15/2015
5.7	06/15/2015
6.2	04/08/2015

Diabetes Consortium Data Set

Diagnostic/Referral Orders

Patient Concerns Related to Diabetes
*Patient concerns copy forward to future visits until changed.

Follow-up Visit - When is my next appointment?	<input checked="" type="radio"/> Y <input type="radio"/> N	Scheduled appt for next tuesday with PCP
Medications - Can I change my medication?	<input checked="" type="radio"/> Y <input type="radio"/> N	No changes until seen by PCP
	<input type="radio"/> Y <input type="radio"/> N	
	<input type="radio"/> Y <input type="radio"/> N	

Comments

Time Tracking

Each patient enrolled in the CCM program must have a monthly contact. Between the planning and actually telephone contract the provider or nurse must spend at least twenty minutes to meet the requirement for a CCM payment. The following tools allow SETMA providers to document who completed the planning and who made the contract.

Chronic Care Management

Patient:
DOB:

Primary Insurance:
Secondary Insurance:

Patient Status
Currently active in CCM? ☒ Y ☐ N
CCM Consent completed? ☒ Y ☐ N
Date Completed: [Print](#)
Enrolled in NextMD?

Primary Care Provider:
Patient's Other Providers:
Designated CCM Contact:

[Return](#)
[Print](#)
[Send to NextMD](#)

Time Tracking - Today

Date	Subject

Chronic Care Management Time Tracking

Staff: Date:
Start:
Stop:
Total:

Subject:

Comments:

Be sure to click "Save" before "Close" or "Clear To Add."

[Clear For Add](#) [Delete](#) [Save](#) [Close](#)

It is expected that the CCM program will decrease hospital admission and re-admissions and that it will improve patient health as it increases patient activation, engagement and shared decision making.