CCM Program at Heywood Healthcare

Dear Medical Staff Colleagues,

A **chronic care management (CCM)** program is now being offered at Heywood Healthcare to meet the needs of Medicare patients who have at least 2 or more long-term chronic conditions. The CCM program will provide them with the best possible care between visits with their primary care physician (PCP) and specialists. The program is a multidisciplinary, patient centric, and team-based coordinated care disease management model.

Its overall goals are to prevent re-hospitalizations and visits to the emergency room, and to minimize the cost and the inconvenience of unnecessary visits and tests. The chronic conditions that are covered by Medicare for this program include a wide spectrum of diseases including heart failure, coronary artery disease, atrial fibrillation, hypertension, diabetes, COPD, arthritis, and depression.

The CCM program will support the patients overall care between visits, although the PCP and specialist will continue to be in charge of and supervise the routine care for each patient. The program coordinates the patient's care and services across all of their healthcare and community based providers, and offers both complex CCM and office based CCM services.

Complex CCM services are provided through our specialty care teams which include heart failure and diabetes. Complex, high risk, CCM patients are provided in-depth services through a team based approach. These services will assist the PCP with time consuming patient care issues allowing them more time for direct patient care improving their productivity.

Complex CCM services include:

- **Nurse care manager and physician -** will closely follow the patient between their PCP and specialist office visits. Both will monitor the patient through telephonic communication after an initial face to face enrollment office visit. Each patient will be followed telephonically for at least 20 minutes each month to fulfill Medicare billing requirements.
- **Transitional care pharmacy –** utilized for medication reconciliation and review, monthly packaging and home delivery.
- **Community health worker-** provides a cross-continuum of **resource support** for care coordination and evaluation of the social determinants of health.
- **Licensed social worker -**deliver dedicated behavioral health screening and intervention as required.

The office based CCM is initiated by the provider, in their office, for patients in need of more support in between visits. These patients will be followed by their providers' office staff. Participation in the CCM program will allow the provider to generate revenue for supportive telephonic services that are already being provided to their patients, but are presently unbilled. The CCM services provided to the complex care team patients may also be made available to the office-based patients.

There are presently multiple Medicare billing codes for CCM that can be used for the non-face to face encounters between the providers and their patients who have been enrolled in the program. The billing will be submitted at the end of each month, either by the office-based CCM provider or through the complex CCM care team specialist as appropriate after the accrued CCM time has been documented. A small copayment may apply in some instances for the services rendered to a patient who is taking part in the program

The complex CCM pilot program has recently concluded and we are now accepting patients for enrollment into the regular program. Patients are recruited for the program in several ways:

- **Through the evaluation of population health data**- high risk and high cost patients are identified, prescreened, and then invited by the CCM staff to participate in the program.
- **Complex patient referrals from a PCP practice** will be welcomed as a means of enrolling patients into the program.
- **Case management at the inpatient hospital level** will identify patients prior to discharge that are at increased risk and in need of further services and engagement on an outpatient basis. These patients will be referred to the CCM program on a consultative basis.
- **Office-based CCM patients** are identified and screened for the CCM program by the provider while in their office. Please note, the participating provider must utilize our Medicare approved guidelines and CCM care platform to support billing.

All patients enrolled in the CCM program will need to have an informed consent. This is obtained either over the phone or signed at any patient visit. An individualized, comprehensive care plan is also completed for each patient who is enrolled into our complex CCM care team. This care plan is made in partnership with the patient and is accessible for their personal review.

Our CCM team is committed to reduce re-hospitalizations and visits to the emergency room, improve medication reconciliation, enhance patient engagement and education, provide greater access to behavioral health services, and to improve the patient's social environment.