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THE IMPORTANCE OF CHRONIC CARE MANAGEMENT FOR PATIENT-CENTRIC CARE

LEVERAGING CCM FOR CONTINUOUS PATIENT CARE WITHOUT ADDED EXPENSE

AN ALANA HEALTHCARE WHITEPAPER

THE IMPORTANCE OF CHRONIC CARE MANAGEMENT FOR PATIENT-CENTRIC CARE

Chronic diseases are responsible for 7 of 10 deaths each year and treating individuals with chronic diseases accounts for 86% of our nation's healthcare costs.[1]

Chronic Care Management has been shown to increase outcomes and lower costs for chronically ill patients. Services include developing a comprehensive care plan, medication adherence, coordinating care with specialists, and chronic disease education.

COORDINATED SERVICES FOR IMPROVED OUTCOMES

It has been proven that patients who are actively engaged in their own care management planning are more likely to be consistent with activities that can contribute to improved patient care. Chronic Care Management strengthens the doctor-patient partnership based on quality of care rather than quantity of care.

Alana Healthcare's Chronic Care Management (CCM) program focuses on providing healthcare services either in the home or remotely in coordination with the physician's office to maintain and improve patient outcomes. The team-focused and partnership approach is especially important for patients with one or more chronic conditions, and especially the elderly who are living with chronic disease, to improve quality of life and reduce healthcare costs.

Alana Healthcare employs experienced respiratory therapists and nurses to help patients and their providers create a new culture of patient-centered care. This team-focused and partnership approach improves quality of life and reduces healthcare costs for chronic patients. Currently, Alana Healthcare focuses on providing education so patients can self-manage their health. Some examples of chronic disease care are:

- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Diabetes
- End Stage Renal Disease (ESRD) or Chronic Kidney Disease (CKD)

1. Centers for Disease Control and Prevention, http://www.cdc.gov/chronicdisease/index.htm.

PATIENT BENEFITS OF CHRONIC CARE MANAGEMENT

Chronic Care Management is a patient-engagement program. The program helps physicians and patients make more informed decisions about their health problems. CCM also provides more insight into patient compliance with the treatment plan because monthly telephonic education calls and check-ins occur more often than the usual schedule of office visits. Because of the frequency, problems can be identified sooner; if changes to a patient's treatment are required, the physician and certified clinician can respond quickly.

Patient Engagement: Encouraging patients to use CCM services drives patient engagement between office visits.

Better Health Outcomes: Better care delivery and greater patient participation contribute to better health outcomes, which is something that all practices aim for.

Increased Patient Compliance: Reminders for appointments and tests, descriptions of treatment, and increased knowledge of the management of their chronic disease offer patients a stronger sense they can do something good to better their health.

Reduced Emergency Visits: Patients with better management of chronic illnesses will reduce their emergency department visits and hospital stays, saving themselves and their insurance companies money.

WHY OUTSOURCE CHRONIC CARE MANAGEMENT?

Outsourcing CCM provides practices with the additional staffing and tools needed to increase efficiency, increase revenue capacity, and reduce overhead costs.

Although Medicare reimburses doctors for providing chronic care management (CCM) to their patients, providers face challenges with physician participation, patient education, effective procedures, and regulatory enforcement. Practices **must** have 24/7 access to care management systems, a channel for direct patient-provider contact, and the ability to handle changes between providers and environments to bill for CCM services.

Given the logistical complexities of in-house CCM billing, and the skills required to compile and analyze data available with a software platform, it is possible that most practitioners lack the bandwidth or experience to run in-house CCM. Recruiting, training, and equipping trained employees to provide full, reliable documentation and billing is costly.

CCM CODES AND REIMBURSMENT

CCM offers patients with two or more chronic conditions 20 minutes of non-face-to-face care management services each month to assist in managing their conditions, to raise awareness of risk factors, and to monitor prescription adherence, among other services.

There are five codes for reporting remote CCM services:

- **99490** non-complex CCM is a 20 minute timed service provided by clinical staff to coordinate care across providers and support patient accountability.
- **99439** non-complex CCM is each additional 20 minutes per month (limit 2)

- **99487** complex CCM is a 60 minute timed service provided by clinical staff to substantially revise or establish comprehensive care plan that involved moderate to high complexity medical decision making.
- **99489** complex CCM is each additional 30 minutes (cannot be billed with CPT code 99490)

- **99491** CCM services provided personally by a physician or other qualified health care professional for 30 minutes

PATIENT SUCCESS

Problem: Patient noticed edema in her ankles, as a result of fluid retention. Patient reported this to her CCM nurse during a monthly check in. The CCM nurse was able to educate the patient immediately on the signs/symptoms of CHF exacerbations to aide in avoiding a potential hospitalization. Patient stated afterwards she was able to take her diuretic PRN medications and call her cardiologist. With the guidance of her CCM nurse, she scheduled an appointment with her cardiologist where he completed additional testing.

Outcome: The patient took part in a monthly educational visit with her CCM nurse. Due to the patient's comfort level with her nurse, the patient proactively used her PRN medications and contacted her physician. The patient and physician were able to resolve a potential exacerbation without hospital utilization. Patient stated the CCM nurse was a wonderful resource, and her discussions with her nurse helped her understand the best course of action.

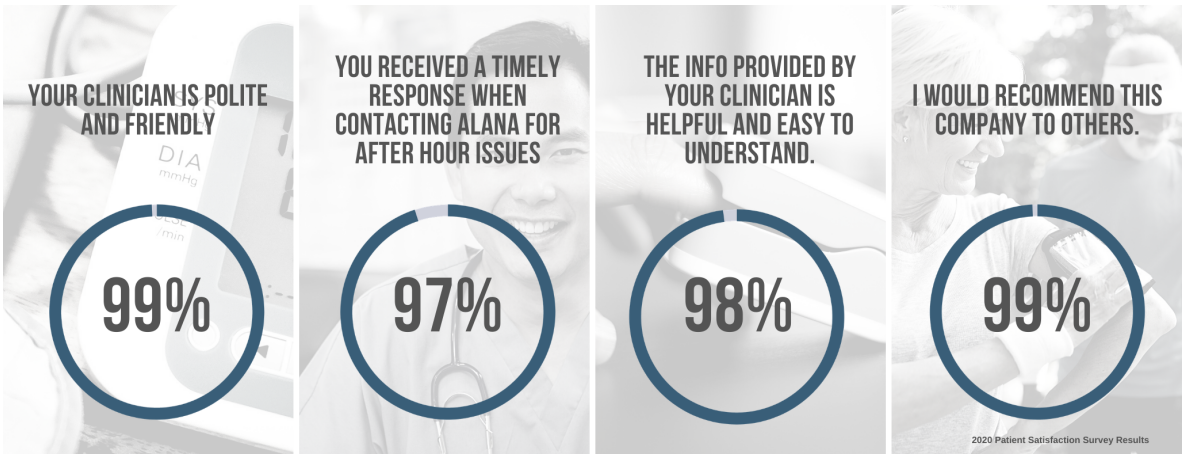
PATIENT SUCCESS

"My clinician has taken EXCELLENT care of me over the years. She is wonderful, caring and always alert to anything I might need. I am blessed to have her and so are you."

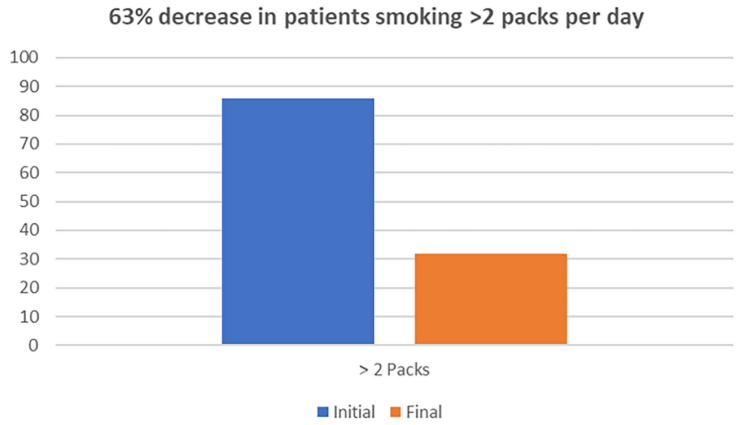
2020 Patient Satisfaction Survey

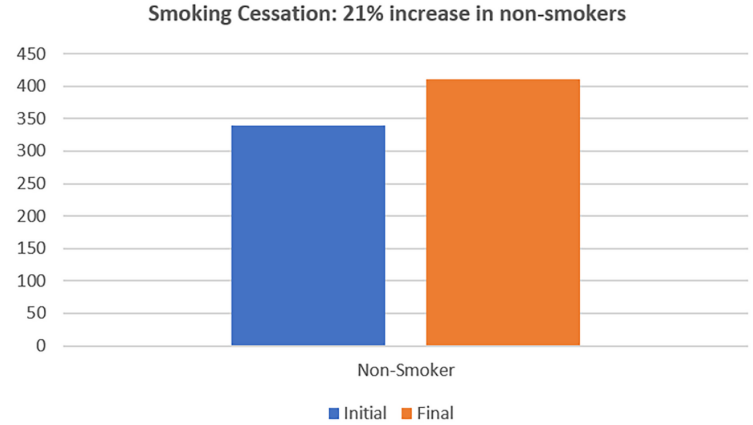
Details: Patient was given an Acapella Flutter Valve prior to his recent hospital discharge. He reported to CCM nurse that he didn't know how to use the device during a monthly call. The nurse instructed the patient on the proper use via phone, then emailed a video instruction for reference. The patient now reports he is able to successfully use his device to clear secretions and he is breathing much more easily now.

Details: Patient reported to her CCM nurse she wasn't sure how to perform her inhaler accurately. The nurse performed a video call to help instruct the patient on the correct technique for her particular MDI. The patient now reports that she was using her inhaler incorrectly, but she is using it correctly now and her breathing does not feel as labored.



Sample Alana Healthcare CCM Results





ALTERNATIVES - REMOTE PATIENT MONITORING AS AN ENHANCEMENT OR REPLACEMENT OPTION

Remote Patient Monitoring (RPM),
most often used after a hospital discharge or
between routine office visits, combines monitoring devices (e.g., blood pressure, pulse oximetry, weight scale) and a digital platform for extended patient care. This combination of services allows those devices to be monitored remotely by a licensed clinician and/or physician for continuity of care. RPM, as an addition to CCM, benefits patients from continuous monitoring in addition to the enhanced disease and overall health education, tools, and resources CCM provides, Typically, a patient candidate for RPM is also a candidate for CCM, however, not all CCM candidates will meet the tech requirements for RPM.

Remote patient monitoring reduces the healthcare costs of individuals who suffer from chronic conditions like chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and diabetes. Where previously these conditions required frequent medical appointments, remote patient monitoring provides real time monitoring and metrics to both the patient and their provider so immediate action can be taken, if necessary.

There are many benefits to the services provided Alana Healthcare's RPM program trium and an Alana Healthcare health coach. We monitor patient trends via our digital platform, so should a patient deviate from their baseline, we can immediately intervene to prevent an exacerbation. Our licensed team can triage alerts, not just report them to the healthcare provider monthly. We act on alarming readings and intervene when we receive these readings which includes contacting the patient, providing education, contacting MD, scheduling MD visit, etc.

If you would like to know more about Remote Patient Monitoring, email marketing@alanahealthcare.com and request a copy of our RPM whitepaper, **Remote Patient Monitoring and the Potential Impact on Your Practice: Providing care methodologies to monitor and educate patients on lifestyle modification and self-management of chronic illness.**

ABOUT ALANA HEALTHCARE

Alana Healthcare is a care management company providing high-touch clinical services for people living with chronic illness. Our coordinated and comprehensive medical care improves patient quality of life, streamlines provider services, and reduces overall health care costs.

The result for our partners is increased savings, a positive return on investment, decreased hospital utilization and readmissions, and improvement in HEDIS and STARS measures. For our patients, it means better clinical outcomes and an improved quality of life.

ALANA™
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Passionate Care, Proven Outcomes

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Representative *Smoking Cessation* data based on 1418 total members who were both admitted and graduated to an Alana Healthcare partner program during the period of Feb 2017- April 2021.

Representative *Packs Smoked per Day* data based on 1,070 total members who were both admitted and graduated to an Alana Healthcare partner program during the period of Feb 2017- April 2021. Members smoked two or more packs per day at the start of the program.