Expanding Pharmacy Impact: Transitional Care Management and Chronic Care Management

Activity Number: 0217-0000-16-1118-L04-P  1.50 hours of CPE credit; Activity Type: A Knowledge-Based Activity

Monday, October 24, 2016
9:15 a.m. to 10:45 a.m.
Great Halls 1 & 2

Moderator: Kim L. Kelly, Pharm. D., FCCP, BCPS
President, Kelly Diabetes Associates, LLC, Cupertino, California

Agenda

9:15 a.m.  
Transitional Care Management: Benefits to Patients and Providers  
Christie A. Schumacher, Pharm. D., BCPS, BCACP  
Associate Professor, Midwestern University Chicago College of Pharmacy, Chicago, Illinois

10:00 a.m.  
CCM-Addressing the Needs of Chronic Care Patients...Finally!  
Betsy Shilliday, Pharm. D.  
Director of the Advanced Practice Provider (APP) Center, Assistant Medical Director of the  
Internal Medicine Clinic, University of North Carolina, Chapel Hill, North Carolina

Conflict of Interest Disclosures
Kim L. Kelly: no conflicts to disclose  
Christie A. Schumacher: no conflicts to disclose  
Betsy Shilliday: no conflicts to disclose

Learning Objectives
1. Discuss the requirements for implementation and reimbursement for TCM services.
2. Describe the outcomes of TCM services, both patient outcomes and reimbursement data.
3. Discuss potential barriers to implementation of TCM services.
4. Discuss the requirements for implementation and reimbursement for CCM services.
5. Describe the outcomes of CCM services, both patient outcomes and reimbursement data.
6. Discuss experiences in implementing CCM Services.

Self-Assessment Questions
Self-assessment questions are available online at www.accp.com/am
Transitional Care Management (TCM): Benefits to Patients and Providers

Christie Schumacher, Pharm. D., BCPS, BCACP, BC-ADM, CDE
Associate Professor, Pharmacy Practice
Midwestern University Chicago College of Pharmacy
Clinical Pharmacist, Advocate Medical Group
Chicago, IL
October 24, 2016
Conflict of Interests

- Dr. Christie Schumacher has no conflicts of interest to disclose
Learning Objectives

• Discuss the requirements for implementation and reimbursement for TCM services
• Describe the outcomes of TCM services, both patient outcomes and reimbursement data
• Discuss potential barriers to implementation of TCM services
Audience Participation

• Yes or No:
  • Are pharmacists involved in transitional care management (TCM) services at your clinical practice site?
Audience Participation

• Yes or No:
  • Of those involved in TCM services, does your practice bill CPT codes 99495 and 99496?
Transitional Care Management (TCM) Services

• Effective January 1, 2013
• Under Physician Fee Schedule Medicare will pay for 2 CPT codes for TCM services
  • 99495
  • 99496
• Includes services provided to a patient whose medical and/or psychosocial problems require moderate- or high-complexity medical decision making during transitions
• Implemented to improve discharge care coordination and ensure patients are seen in their physician’s office
Where are Transitions of Care Occurring?

<table>
<thead>
<tr>
<th>Patient transitioning from:</th>
<th>Patient transitioning to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital setting</td>
<td>The patient’s community setting</td>
</tr>
<tr>
<td>• Acute care</td>
<td>• Home</td>
</tr>
<tr>
<td>• Rehabilitation hospital</td>
<td>• Domiciliary</td>
</tr>
<tr>
<td>• Psychiatric hospital</td>
<td>• Assisted living</td>
</tr>
<tr>
<td>Partial hospitalization or observational status in a hospital</td>
<td>• Nursing facility (not a skilled facility)</td>
</tr>
<tr>
<td>• Including partial hospitalization at a community mental health center</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility/nursing facility</td>
<td></td>
</tr>
<tr>
<td>Long term care hospital</td>
<td></td>
</tr>
</tbody>
</table>

What is Required to Bill TCM

- Two current procedural terminology (CPT) codes to report TCM:

<table>
<thead>
<tr>
<th>99495 Transitional Care Management Services with the following required elements:</th>
<th>99496 Transitional Care Management Services with the following required elements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge</td>
<td>Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge</td>
</tr>
<tr>
<td>Medical decision making of at least <strong>moderate complexity</strong> during the service period</td>
<td>Medical decision making of at least <strong>high complexity</strong> during the service period</td>
</tr>
<tr>
<td>Face-to-face visit within <strong>14</strong> calendar days of discharge</td>
<td>Face-to-face visit within <strong>7</strong> calendar days of discharge</td>
</tr>
</tbody>
</table>

## Medical Decision Making

<table>
<thead>
<tr>
<th>Moderate Complexity</th>
<th>High Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple possible diagnoses and/or management options</td>
<td>Extensive number of diagnoses and/or management options</td>
</tr>
<tr>
<td>Moderate complexity of medical data to be reviewed</td>
<td>Extensive complexity of medical data to be reviewed</td>
</tr>
<tr>
<td>Moderate risk of significant complications, morbidity,</td>
<td>High risk of significant complications, morbidity, and/or mortality as well as</td>
</tr>
<tr>
<td>and/or mortality as well as comorbidities</td>
<td>comorbidities</td>
</tr>
</tbody>
</table>

Time Requirements

• The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days

Who Is Eligible to Bill TCM?

- Physicians of any specialty
- Non-physician providers (NPPs) who are legally authorized and qualified to provide the services in the state they are furnished:
  - Certified nurse-midwives (CNMs)
  - Certified nurse specialists (CNSs)
  - Nurse practitioners (NPs)
  - Physician assistants (PAs)

TCM Components

• An interactive contact
• Non-face-to-face service
• A face-to-face visit
TCM Components - Interactive Contact

- Interactive contact with the patient and/or caregiver within 2 business days following discharge
  - Telephone, email or face-to-face
  - Any health care professional, including pharmacists, can conduct the 2-day post-discharge contact
- Attempts to communicate should continue after the first 2 attempts until successful
- If 2 or more separate unsuccessful attempts in the 2 day period are documented in the medical record and all other TCM criteria are met → you may report the service
- Addresses patients needs beyond scheduling face-to-face visit

## TCM Components - Non-Face-to-Face Service

<table>
<thead>
<tr>
<th>Services provided by licensed clinical staff (e.g. pharmacists)</th>
<th>Services to be provided by physicians or NPPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate with agencies and community services the patient uses</td>
<td>Obtain and review discharge education</td>
</tr>
<tr>
<td>Provide education to the patient, family, guardian, and/or caretaker to support self-management</td>
<td>Review need for or follow-up on pending diagnostic tests and treatments</td>
</tr>
<tr>
<td>Assess and support treatment regimen adherence and medication management</td>
<td>Interact with other health care professionals who will assume or reassume care of the patient’s system-specific problems</td>
</tr>
<tr>
<td>Identify available community and health resources</td>
<td>Provide education to the beneficiary, family, guardian, and/or caregiver</td>
</tr>
<tr>
<td>Assist the patient and/or family in accessing needed care and services</td>
<td>Establish or re-establish referrals and arrange for needed community resources</td>
</tr>
<tr>
<td></td>
<td>Assist in scheduling required follow-up community providers and services</td>
</tr>
</tbody>
</table>

TCM Components - Face-to-Face Visit

• The Physician or NPP must furnish one face-to-face visit within certain time frames as described
  • CPT Code 99495 – Transitional care management services with moderate medical decision complexity
    • Face-to-face visit within 14 days of discharge
  • CPT Code 99496 – Transitional care management services with high medical decision complexity
    • Face-to-face within 7 days of discharge

TCM Components - Face-to-Face Visit

• Medication Reconciliation
  • Must occur no later than day of face-to-face visit
    • TCM medication reconciliation requires that the medications on discharge be reconciled with the medications that the patient was taking previously
  • Goes beyond making a medication list
    • Appropriateness
    • Timing
    • Interactions
    • Laboratory monitoring
    • Adverse events

Billing TCM Codes

• Can only be billed by one physician or NPP for one individual during the 30-day period after discharge

• If more than one physician submits a claim for TCM services, Medicare will pay the first claim
  • The billing physician assumes responsibility for the patient’s post discharge TCM service

• Bill using the 7th or 14th day as the date of service

How is TCM Different?

- Specific time frame
- Goes beyond caring for patients medical needs
- More care coordination, education and clinical management during the critical time period after discharge
- Includes management/coordination of services for all medical conditions and activities of daily living
  - Not only hospitalization follow-up
Who Qualifies for TCM?

- TCM codes can be utilized on new or established patients
Discharge Counseling

• The discharge visit does not count towards TCM
• Initial contact must occur after the patient has left the hospital
  • 2 business days
• Designed to make sure the patient has the support necessary until they have their face-to-face visit within the 7 or 14 days as prescribed
  • The initial contact can be phone, email, patient portal, or direct face-to-face
Paying For Pharmacist’s Time

- Billing 99495 generates ~$60 more than billing 99214
- Billing 99496 generates ~$90 more than billing 99215
- Compensate for the practice and clinical staff time allocated for TCM services
- Pharmacists can perform medication reconciliation, disease state education and assist in other care coordination tasks to free up physician time to see additional patients
How Can Pharmacists Get Involved?

• Think about ... Why do patients get readmitted?
  • Patients may not completely understand their diagnoses
  • Lack of discussion about care goals
  • Confusion about what medicines they should take and when they should take them
  • Lack of communication of important information to primary care providers
  • Patients do not keep appointments after discharge
  • Family members may not know how to help provide care at home
  • Lack of awareness of who to contact after discharge
  • Premature discharge

# Opportunities for Pharmacist Involvement

<table>
<thead>
<tr>
<th>Interactive contact component</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform the phone call within 2 days of discharge</td>
<td>Evaluate for changes in symptoms since hospital discharge</td>
</tr>
<tr>
<td>Review medications and discharge instructions</td>
<td>Update medication list in EMR</td>
</tr>
<tr>
<td>Provide disease state education</td>
<td>Does patient have tools to be successful outpatient?</td>
</tr>
<tr>
<td>Schedule appointment in clinic, if not made already</td>
<td>Refer to appropriate personnel for transportation or social service needs</td>
</tr>
<tr>
<td>Document telephone encounter in the EMR</td>
<td>Alert physician of any urgent needs before clinic visit</td>
</tr>
</tbody>
</table>
## Opportunities for Pharmacist Involvement

### Face-to-face component

Pharmacists embedded in the physician’s practice can work with physician and other multidisciplinary team members to provide TCM

Before patient arrives the pharmacist may review discharge summary and discuss issues with healthcare team that need to be addressed during the upcoming visit

Upon patient arrival, nurse or medical assistant performs check-in and vitals

Clinical pharmacist provides medication reconciliation and disease state education
Opportunities for Pharmacist Involvement

Face-to-face component continued

- Physician provides physical exam component
- Together the pharmacist, physician and other health care team members develop a plan
- Pharmacist can perform visit wrap-up which may include patient education and teach-back to assess whether the patient understands the information conveyed during the visit
- The physician bills appropriate TCM code
- Fits into the interdisciplinary patient-centered medical home model
Results of Pharmacist involvement in TCM – University of North Carolina

- Hospital readmission rates and interventions in multidisciplinary team visit coordinated by a clinical pharmacist practitioner vs. physician-only team
- 140 patient visits for 124 patients from May 2012 to January 2013
- Patients seen by the multidisciplinary team had a 30-day readmission rate of 14.3% compared with 34.3% by physician-only team
  - P=0.010
  - RRR 58.3%
- Interventions completed during the visits also statistically different
  - Multidisciplinary team completed interventions more frequently
  - Addressed nonadherence, initiated a new medication and discontinued a medication

J Manag Care Spec Pharm. 2015 Mar;21(3):256-60.
TCM in an Accountable Care Organization (ACO)

- Advocate Medical Group (AMG) Southeast Center
- Advocate is one of the largest ACOs in the country
  - Over 250 clinic locations in the Chicagoland area
TCM in an Accountable Care Organization (ACO)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percentage of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage</td>
<td>59%</td>
</tr>
<tr>
<td>Full Risk</td>
<td></td>
</tr>
<tr>
<td>Medicare FFS (Majority) – Shared Savings Program</td>
<td>19.4%</td>
</tr>
<tr>
<td>Commercial Full Risk</td>
<td>11.3%</td>
</tr>
<tr>
<td>Fee For Service</td>
<td>8%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>1.8%</td>
</tr>
<tr>
<td>Self Pay</td>
<td>0.4%</td>
</tr>
<tr>
<td>Average Age</td>
<td>14 – 96</td>
</tr>
</tbody>
</table>
TCM in an Accountable Care Organization (ACO)

- Capitated reimbursement model
  - Medicare Advantage and Commercial Full Risk
    - Focus on keeping the patient well – no additional reimbursement received
  - Medicare shared savings
- Bill 99211 for all patients as an internal tracking tool to measure number of individual visits
- Bill 90036 for patients seen the same day as their physician
  - No charge office visit
- Patient are not charged a co-pay to see a mid-level provider for medication and disease state management
TCM in an Accountable Care Organization (ACO)

- Incentive to focus on preventative health care
  - Meet performance measures
  - Prevent hospitalizations
  - Decrease cost
- Breeds team model of care
Identifying The Need

• Heart failure (HF) transitions of care
  • In 2008, 313 patients who were hospitalized for a HF exacerbation were readmitted within 30 days of their hospital stay for a subsequent HF hospitalization
  • Risk cost of $2.4 million was estimated for 30 day readmissions
  • 36% of these patients were admitted again in the one year period for heart failure
The Patient Centered Medical Home (PCMH) Team at AMG Southeast

• PCMH Includes:
  • 6 PCPs
  • 1 Cardiologist
  • 1 Pharmacist ➔ 3 Pharmacists
    • Collaborative practice agreements / Practice by protocol
  • 1 Advanced practice nurse ➔ Pharmacist
  • 1 Physician assistant
  • 1 Dietician
  • 1 Nurse
  • 3 Care managers
Task (EMR message) from care manager or physician

Identifying Patients For TCM

HF discharge list

Physician consult during post-hospital clinic visit

Daily hospital census - List of patients hospitalized with diagnosis of HF
Role of the Pharmacist in TCM

Within 2 days of discharge

- Review discharge paperwork. Call patient to assess clinical status, ensure patient understands changes made, is adherent and has resources needed. Schedule appointment in clinic if not already scheduled

Within 7 days of discharge

- Pharmacist conducts a joint post-hospital follow-up visit with physician.
TCM Face-To-Face Visit Structure

Before patient arrives
- Health care team reviews the discharge summary and discusses issues that need to be addressed during the upcoming visit, such as laboratory and/or diagnostic tests

Check-in
- Medical assistant takes vitals and assesses referrals and adherence to scheduled appointments

30 – 60 minutes
- The patient spends 30-60 minutes with the pharmacist providing medication reconciliation and disease state education

5 minutes
- Pharmacist discusses patients with physician
TCM Face-To-Face Visit Structure

10-15 minutes
- The physician provides physical examination component and together the pharmacist and physician develop a plan and discuss with patient

5 minutes
- Medical assistant provides referrals and assists with follow-up tasks
- *Pharmacist discusses patient with care manager

15 - 30 minutes
- *Care managers meet with patient to facilitate scheduling and access, transportation and patient home care needs
Demographics and Cost Savings

<table>
<thead>
<tr>
<th>Data From First 10 months of TCM and HF Service Provided By Clinical Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Patients Managed by clinical pharmacist</td>
</tr>
<tr>
<td>Total Number of Patients with HF</td>
</tr>
<tr>
<td>Ethnicity/Race (HF only)</td>
</tr>
<tr>
<td>Gender (HF only)</td>
</tr>
<tr>
<td>Inpatient admissions for the 111 HF patients in the 10 months prior to PCMH implementation</td>
</tr>
<tr>
<td>Inpatient admissions for the 111 HF patients in the 10 months post-PCMH implementation</td>
</tr>
<tr>
<td>Average Cost per HF admission</td>
</tr>
<tr>
<td>Potential Cost Avoidance for the 111 HF patients based on pre/post-enrollment</td>
</tr>
</tbody>
</table>
Results From Implementation

• In the first 18 months, only 3 of ~150 patients managed by clinical pharmacist for HF had a 30 day readmission

• Readmission rate for AMG
  • 8% (2013)
  • 14% (2014)
  • 15% (2015)
  • 18-25% national average
Implementation Challenges

• Physician support
  • Education sessions at MD meetings
  • Coordination with MD schedules

• Workflow not consistent at different centers

• Skill of team members is variable and not consistent
  • Who is capable of filling this role?
    • Finding the right person for the right site
    • Maximizing skill sets based on training
    • Communication with patients and health care team

• TCM is hopefully not a full time job
  • Sporadic

• Collaborative practice limitations
Tips for Success

• Initiate and Communicate!
  • If unable to reach patient via phone, see them at PCP appointment
  • Give patient your contact information to give to other providers
  • Reach out to providers and caregivers involved in care transitions
  • Understand workflow of health system to improve efficiency
  • How well can you educate and motivate the patient?
    • Goes beyond med rec
    • Can you connect?

• Anticipate!
  • Patient needs
    • What does the patient care about?
    • Information overload?
    • Supplies
    • Cost of new medications
  • Provider needs
    • Referrals
    • Lab monitoring and orders
      • Doesn’t end after TCM visit
        • Who will follow-up?
    • Patient’s hospitalization history
    • Medication recommendations
References

• Cavanaugh JJ, Lindsey KN, Shilliday BB, Ratner SP. Pharmacist-Coordinated Multidisciplinary Hospital Follow-up Visits Improve Patient Outcomes. J Manag Care Spec Pharm. 2015 Mar;21(3):256-60.
Transitional Care Management (TCM): Benefits to Patients and Providers

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Chronic Care Management (CCM)-Addressing the Needs of Chronic Care Patients...Finally!

Betsy Bryant Shilliday, PharmD, CDE, CPP, BCACP, FASHP
UNC Eshelman School of Pharmacy and School of Medicine
UNC Health Care
Chapel Hill, NC
October 24, 2016
Conflict of Interest

• I have no conflicts of interest to disclose
Learning Objectives

• Discuss the requirements for implementation and reimbursement for CCM services
• Describe the outcomes of CCM services, both patient outcomes and reimbursement data
• Discuss experiences in implementing CCM services
I am familiar with the CCM codes & requirements

A  Yes
B  No
My institution is currently providing & billing for CCM services

A  Yes
B  No
C  Plan to in the future
D  Don’t know
Pharmacists at my institution are currently providing & participating in billing of CCM services

A  Yes
B  No
C  Plan to in the future
D  Don’t know
Requirements for CCM Services and Reimbursement
Development of CCM Services

Goal: Support care management within the primary care setting to improve the health and care for beneficiaries while reducing spending.

- Payment for non-face-to-face services
  - At least 20 minutes of clinical staff time per month
  - Directed by a physician or other qualified health care professional

Application of CCM Services

• Began January 1, 2015
  • Rural Health Clinics & Federally Qualified Health Centers began January 1, 2016
• CPT Code: 99490
• Requirements are complex!
Required Elements

• Patient meets eligibility requirements
• Patient consent in writing & documented in EHR
• Patient informed of how to revoke CCM services
• Patient-centered care plan for all health issues
  • Provided to the patient & documented in the EHR
• Approved CCM provider
• Only one CCM provider can furnish & be paid during a calendar month
  • Minimum of 20 minutes of care

General Requirements

• Certified Electronic Health Record (EHR) or other electronic technology
  • Secure messaging for non-face-to-face communication
• 24 hr/day, 7 days/wk access to healthcare provider
• Continuity of care with CCM provider or care team
• Care management of chronic conditions
• Management of care transitions
• Coordinating and sharing patient information with practitioners and providers outside the practice

Patient Eligibility

“Patients with multiple (two or more) chronic conditions 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.”

Patient Consent Process

When:

• Initiated during qualifying visit:
  1) Annual Wellness Visit (AWV),
  2) Initial Preventative Physical Exam (IPPE), or
  3) Comprehensive Evaluation and Management (E&M) visit

• Prior to furnishing or billing the CCM service or if the patient changes CCM practitioner

Patient Consent Process

Discussion should include:

1. What is CCM
2. How to access the elements of the service
3. How the patient’s information will be shared with providers
4. How cost-sharing (co-insurance and deductibles) applies to these services
5. How to revoke the service
6. Only one provider furnishes/paid per month

Patient Consent Requirements

1. **Obtain written agreement to CCM services**
   Including authorization for the electronic communication of medical information with other providers

2. **Documentation in the patient’s medical record**
   The service explanation, offer, and patient’s decision to accept or decline the CCM service

Comprehensive Care Plan Requirements

1. Must address all health issues
2. Must be provided to the patient
3. Accessible electronically at all times
4. Shared with outside providers

## Comprehensive Care Plan Components

<table>
<thead>
<tr>
<th>Elements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem list</td>
</tr>
<tr>
<td>Expected outcomes and prognosis</td>
</tr>
<tr>
<td>Measurable treatment goals</td>
</tr>
<tr>
<td>Symptom management</td>
</tr>
<tr>
<td>Planned interventions and identification of the individuals responsible for each intervention</td>
</tr>
<tr>
<td>Medication management</td>
</tr>
<tr>
<td>Community/social services ordered</td>
</tr>
<tr>
<td>Description of how services of agencies and specialists outside of the practice will be directed/coordinated</td>
</tr>
<tr>
<td>Schedule for periodic review and, when applicable, revision of the care plan</td>
</tr>
</tbody>
</table>

Billing Practitioner

• Physician

• Non-physician practitioner:
  • Certified Nurse Midwife
  • Clinical Nurse Specialist
  • Nurse Practitioner
  • Physician Assistant

• Only one practitioner may be paid for the CCM service for a given calendar month

Service Provider & Time

• Services provided by a physician, non-physician practitioner, or clinical staff
  • Non-clinical staff time cannot be counted

• Minimum of 20 minutes of monthly care
  • Time of care must be documented during the month

CCM Supervision of Clinical Staff

- Clinical Staff time is provided “incident to” the CCM provider
- Follow “incident to” rules, except: CMS exception allows general supervision (rather than direct supervision) of clinical staff by the physician or other appropriate practitioner

Billing Logistics

- Co-insurance DOES apply = patient pays ~$8
- Cannot be billed during the same service period as:

<table>
<thead>
<tr>
<th>Service</th>
<th>Billing Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitional Care Management</td>
<td>CPT codes 99495–99496</td>
</tr>
<tr>
<td>Home health care/hospice care</td>
<td>HCPCS codes G0181/G0182</td>
</tr>
<tr>
<td>End-Stage Renal Disease services</td>
<td>CPT codes 90951–90970</td>
</tr>
<tr>
<td>CMS advanced primary care demonstration projects or other</td>
<td>n/a</td>
</tr>
<tr>
<td>initiatives</td>
<td></td>
</tr>
</tbody>
</table>

How are you feeling?

A  I’ve got this!

B  Overwhelmed...
CMS Findings

• CCM codes underutilized
  • Only approximately 275K of the ~ 55 million Medicare beneficiaries received CCM in 2015
  • Total reimbursement for CCM in 2015 ~ $37M

• Barriers to implementation:
  • Low reimbursement
  • Administrative burden
  • Low provider engagement
  • Identification of patients
  • Patient cost sharing


Proposed Changes for 2017

• Add on G-code for extensive assessment and care planning by billing provider
  • GPPP7 = $63.68

• Addition of Complex CCM codes
  • Current CPT 99490 (20 minutes) = $40.97
  • Complex CCM (CPT 99487, 99489)
    • 99487 (60 minutes) = $92.66
    • 99489 (each additional 30 minutes) = $46.97
  • Use of Complex CCM codes determined by:
    • Moderate to high complexity medical decision making
    • Nature of care planning performed
    • Service time provided

Proposed Changes for 2017

• Written consent no longer required
  • May be verbal if documented in medical record
• 24/7 access to care & continuity of care
  • 24/7 care for “urgent” needs
• Electronic care plan
  • No longer required to be available 24/7
  • Can transmit care plan via fax
  • Patient receipt can be written or electronic
• Initiating Visit
  • Only required for new patients or patients not seen by the provider within past 12 months

Outcomes of CCM Services

- UNC Internal Medicine -
UNC Internal Medicine Clinic (IMC)

• 13,224 patients accounting for 39,000 visits/year

• Providers
  • 22 Medical Attending Faculty – 8 FTE
  • 78 Medical Residents – 6 FTE
  • 9 Advanced Practice Providers
    • 2 Physician Assistants – 1.8 FTE
    • 2 Nurse Practitioners – 0.7 FTE
    • 3 Clinical Pharmacist Practitioners – 1.6 FTE
    • 3 Social Workers – 2.5 FTE
    • 1 Dietician – 1 FTE

• Staff
  • 4 Care Assistants
  • 16 Personal Business Associates
  • 13 Nurses
UNC IMC Patient Population

Payer Mix
- Medicare: 48%
- Medicaid: 30%
- Commercial: 14%
- Uninsured: 8%

Health Composite Score
- Green Zone (Low Risk): 58%
- Yellow Zone (Moderate Risk): 21%
- Red Zone (High Risk): 21%
UNC IMC - CCM Population

Health Composite Score (n=181)

- **Green Zone** (Low Risk): 3%
- **Yellow Zone** (Moderate Risk): 22%
- **Red Zone** (High Risk): 75%
CCM Pilot

• July 2015
• Consent during AWVs
• Manual tracking
  • Consent
  • Monthly care
• Interactions documented in the EHR
• Led to coordinated efforts, standardized processes & EHR build
Pilot Enrollment

Total CCM Enrollment by Week

Baseline: 3/7-3/11
3/14-3/18
3/21-3/25
3/28-4/1
4/4-4/8
4/11-4/15
4/18-4/22
4/25-4/29
5/2-5/6
5/9-5/13
5/16-5/20
5/23-5/27
5/30-6/3
6/6-6/10
6/13-6/17
6/20-6/24
6/27/7/1
7/4-7/8
7/11-7/15
7/18-7/22
7/25-7/29
8/1-8/5
8/8-8/12
8/15-8/19
8/22-8/26

UNC Internal Medicine Clinic data

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Tracking Weekly Enrollment

CCM Enrollment by Week

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UNC Internal Medicine Clinic data
Enrollment - Friendly Competition

CCM Enrollment by Provider

 UNC Internal Medicine Clinic data
Enrollment - Intervention Effect

Total CCM Enrollment by Week

- Baseline
- 3/7-3/11
- 3/14-3/18
- 3/21-3/25
- 4/4-4/11
- 4/18-4/22
- 4/25-4/29
- 5/2-5/6
- 5/9-5/13
- 5/16-5/20
- 5/23-5/27
- 6/6-6/10
- 6/13-6/17
- 6/20-6/24
- 6/27-7/1
- 7/11-7/15
- 7/18-7/22
- 7/25-7/29
- 8/1-8/5
- 8/8-8/12
- 8/15-8/19
- 8/22-8/26

- OE Mtg, Video
- All Hands
- BPA
- Academic Detailing
- OE Mtg

UNC Internal Medicine Clinic data
Enrollment – Intervention Effect

Total CCM Enrollment by Week

0 50 100 150 200 250


OE Mtg, Video

OE Mtg

All Hands

BPA

Academic Detailing

UNC Internal Medicine Clinic data
Best Practice Alert Tracking

BPA Summary Report

UNC Internal Medicine Clinic data
Enrollment – Intervention Effect

Total CCM Enrollment by Week

- Baseline
- 3/7-3/11
- 3/14-3/18
- 3/21-3/25
- 3/28-4/1
- 4/4-4/8
- 4/11-4/15
- 4/18-4/22
- 4/25-4/29
- 5/2-5/6
- 5/9-5/13
- 5/16-5/20
- 5/23-5/27
- 5/30-6/3
- 6/6-6/10
- 6/13-6/17
- 6/20-6/24
- 6/27-7/1
- 7/4-7/8
- 7/11-7/15
- 7/18-7/22
- 7/25-7/29
- 8/1-8/5
- 8/8-8/12
- 8/15-8/19
- 8/22-8/26

UNC Internal Medicine Clinic data

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Enrollment – Intervention Effect

Total CCM Enrollment by Week

- Baseline
- 3/3-3/11
- 3/14-3/18
- 3/21-3/25
- 3/28-4/1
- 4/4-4/8
- 4/11-4/15
- 4/18-4/22
- 4/25-4/29
- 5/2-5/6
- 5/9-5/13
- 5/16-5/20
- 5/23-5/27
- 5/30-6/3
- 6/6-6/10
- 6/13-6/17
- 6/20-6/24
- 6/27-7/1
- 7/4-7/8
- 7/11-7/15
- 7/18-7/22
- 7/25-7/29
- 8/1-8/5
- 8/8-8/12
- 8/15-8/19
- 8/22-8/26

UNC Internal Medicine Clinic data

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2016 ACCP Annual Meeting
Utilizing Annual Wellness Visits

UNC Internal Medicine Clinic data
Outreach Time by Total Population

UNC Internal Medicine Clinic data
Outreach Time by Patient

UNC Internal Medicine Clinic data
Lessons Learned
Lessons Learned

• Know your eligible population
• Have a process owner
• Start with a small pilot & physician champion
• Consider targeting patients during AWVs
• Requirements are complex
• Chronic Care Plans can be time consuming
Lessons Learned (continued)

• PCP relationship is key in successful enrollment
• Continuous quality improvement is critical
• Engagement of all care team members is important
• Tracking data is priceless
Questions?
Chronic Care Management (CCM)-Addressing the Needs of Chronic Care Patients...Finally!

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