Why Providers Are Embracing Chronic Care Management

Providers ask a few very important questions when they evaluate bringing another person or entity into the care of their patients.

1
First, can I trust my patient relationships with this person or organization?

2
Second, are they going to provide the level of quality care that my patient deserves?

3
Third, will it cost me additional time and/or money?

Unfortunately, there are not many organizations that offer services that can answer these questions adequately. However, that is changing. Providers today are beginning to recognize the wisdom of CMS in establishing Chronic Care Management.

Yes, physicians and organizations must vet CCM providers' capabilities, protocols, and resources prior to choosing a vendor. But choosing correctly can be a big win for the providers, their patients, and the bottom line of the organization.

What Is Chronic Care Management?
Chronic Care Management (CCM) was developed by CMS in 2015 to address the needs of patients who are in danger of health degeneration. A Medicare recipient with two or more chronic conditions who has seen their provider in the last twelve months is eligible to be invited into the program. Once consent has been obtained, the centerpiece of the CCM program is ongoing monthly engagement between the CCM care coordinator and the patient. These are billable monthly encounters. The requirement is that the CCM care coordinator spends at least 20 minutes of documented time working with or on behalf of the patient. In addition, the CCM program must provide 24/7/365 access to their care management team.

Can I Trust My Patient Relationships Will Be Elevated?
There are several underlying purposes of CCM that impact patient relationships. One is that the CCM care coordinator focuses on executing the care plan created by the patient and their provider. This creates a seamless connection between the CCM program and the relationship previously established between the patient and their provider.

The CCM care coordinator must also develop a level of trust and rapport so that the patient will feel comfortable sharing issues or concerns that the provider and their teams need to be aware of.

In addition, a CCM program can have a positive impact on the patient-provider relationship when addressing social issues. A CCM care coordinator might discover and address various social issues such as:

- **Food & Nutrition**
- **Living Conditions**
- **Utilities**
- **Safety**
- **Transportation**
- **Exercise**
- **Social Support**
- **Stress**

The number one comorbidity in the senior population is loneliness. A good Chronic Care Management nurse is a friend and backstop who provides emotional comfort and social support to our most treasured and vulnerable individuals.

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Elevating Care and Quality
With ChartSpan's CCM, data has shown that year-over-year E&M encounters increase by roughly eight percent. These are proactive medical visits that keep patients healthy. Hospital readmission rates and unnecessary ED visits have also been shown to decrease for patients participating in a CCM program.

Consider an example incoming phone engagement between a patient and a CCM nurse:


Patient: **"Would you please call me an ambulance?"**


ChartSpan Nurse: **"Before I do, what seems to be the problem?"**


Patient: **"I ran out of oxygen."**


ChartSpan Nurse: **"Do you always call an ambulance when you run out of oxygen?"**


Patient: **"Yes!"**


ChartSpan Nurse: **"I tell you what, I will have the oxygen delivered to you within the hour. Will that work?"**


Patient: **"Yes. Thank you!"**

In this example, the patient and their loved ones avoid a stressful, time-consuming, and expensive trip to the hospital, and the patient still receives the medical care that they need.

What Will It Cost?
This is the good news. Chronic Care Management through ChartSpan has no up-front fees. ChartSpan is truly a pay-for performance model, charging only for active enrolled patients. Clinics net a profit of 35% to 50% of collected revenue. When was the last time your organization generated that kind of a margin with no investment and without doing the work?

Are There Other Opportunities for Revenue and/or Savings?
Yes, there are many. From a revenue standpoint, ChartSpan assists clients in identifying and setting appointments for patients to close **care gaps**. On average, ChartSpan will assist in closing 2–3 open care gaps per patient each year.

ChartSpan can also increase the volume and efficiency of Annual Wellness Visits (AWVs). There are no deductibles, nor co-insurance charges related to AWVs. Imagine increasing your AWV volume by three to five fold while being reimbursed for the time to get them scheduled.

Population Health Management
For the last few decades, the healthcare industry has been giving a great deal of lip service to population health management. As an industry, we have sought ways to truly impact the health of significant segments of the population but have not always succeeded. Chronic Care Management, when properly implemented, provides a proven and significant impact to the health of the most vulnerable segment of people we serve.

Through a Chronic Care Management program, you can help hundreds of patients with Social Determinants of Health needs. Care coordinators can assist patients with finding housing, food, transportation, utility, social support, and safety resources, from food pantries to exercise programs and support groups.

The Takeaway

There are very few programs today that overlap the fee-for-service – value-based care chasm. Savvy healthcare leaders have begun to realize Chronic Care Management is one of those programs, and when deployed properly, can generate a tremendous amount of financial and intangible patient value. Providers are embracing Chronic Care Management because it elevates the level of care their patients receive.