

Chronic Care Management Program

Roughly six in ten adults in the United States have at least one chronic condition, according to the [Centers for Disease Control and Prevention](#). Perhaps even more compelling, the CDC also reports that about four in ten adults have two or more chronic conditions. These patients deserve every opportunity to live full, rich lives with the support of a high-quality medical team.

Yet, chronic care management is often considered complex, time consuming, and burdensome. That's not for lack of care and effort on the provider's part—quite the opposite actually! It's more that with increased patient loads and the very real potential for burn out, there's simply too much to do and not enough time in the day.

Fortunately, there is a solution. A chronic care management program combined with a powerful, intuitive software solution can actually save time and money while also improving patient outcomes. Keep reading to find out more about chronic care management programs including:

- What is chronic care management?
- What conditions qualify for chronic care management?
- How do you create a chronic care management program?

What Is Chronic Care Management?

At a high level, chronic care management (CCM) refers to the variety of services—in particular, those that fall outside of standard office visits—that medical professionals provide to patients with chronic conditions. These services might include things like: virtual visits or telehealth, remote patient monitoring, symptom management, patient education, or the coordinating of additional support services.

Essentially, chronic care management offers a vehicle for providers and care teams to build continuous relationships with their patients through comprehensive care plans, consistent and remote communication, medication management, and more.

What Is Chronic Care Management for CMS?

It's impossible to address CCM without mentioning the Centers for Medicare & Medicaid Services (CMS). The term chronic care management first hit the market in 2015, when it was rolled out by the CMS as a new, separately billed service that falls under the Medicare fee schedule. For CMS, chronic care management is a solution for patients with at least two chronic conditions—with the ultimate goal of both reducing treatment costs and improving patient health outcomes.

What Are the CMS Chronic Care Management Guidelines?

The primary chronic care management requirements established by CMS include:

- Patients must have two or more chronic conditions that are expected to last at least 12 months or until death. What conditions are considered chronic by CMS? There are a number of conditions, but some examples include Alzheimer's, arthritis, cancer, cardiovascular disease, COPD, diabetes, and hypertension.
- Chronic conditions must present a significant health risk to patients.

- Care teams must obtain patient consent, either verbal or written.
- Physicians must establish and implement a comprehensive care plan in a certified electronic health record (EHR) that is regularly updated.
- Patients must have 24/7 access to one member of their care team in the event of an urgent need.
- Patients must receive enhanced, non-face-to-face communication with their care team.
- Care teams must spend a minimum of 20 minutes per month on non-face-to-face CCM services.

What Is a Chronic Care Management Program?

A CCM program is a way for providers and healthcare organizations to manage the treatment and relationship of patients with chronic conditions. These programs typically have documented workflows that lead a patient from program enrollment through appointment scheduling, necessary screenings, required consent, education, care and medication management, and so much more.

How Do I Start a CCM Program?

In general, there are six basic steps to starting a chronic care management program. With that said, creating, implementing, and maintaining a CCM program is certainly more nuanced than that. The size of your practice, the needs of your practice and your patients, and the amount of resources you have available—both monetary and otherwise—are sure to impact your CCM program. All of these factors are also compounded by growing patient numbers, an increase in acute conditions, tight budgets, staffing shortages, and physician burnout and stress.

1. Assess Your Current Capabilities and Resources

Before anything else, it's critical to assess what you already have in place and what you may need. There are many ways to go about this. For example, you might perform a SWOT analysis (strengths, weaknesses, opportunities, threats). Alternatively, you could simply evaluate and document existing resources and potential gaps. Asking these questions can help:

- Roughly how many patients do you have with multiple chronic conditions? How many patients can you realistically manage in a CCM program currently and in the future?
- What are the most prevalent chronic conditions you treat in your practice? Which of these conditions can you most effectively manage with CCM?
- How frequently do you or a member of your care team currently interact with patients?
- What barriers might your patients face when participating in chronic care management?
- Do you currently use remote patient monitoring devices? Would you like to incorporate them?
- Do your patients currently have 24/7 access to you or a member of their care team?
- Are you currently using an EHR system, and is it certified?
- Do you have an appropriate number of staff who can check in with patients? If not, what resources might be able to assist you?
- How does your current technology stack support CCM? What new technology infrastructure might you require?
- How is your documentation currently maintained? Are there improvements that need to happen?
- Is your chronic care management billing system effective? Are you up to date on the various chronic care management CPT codes, including CPT 99490, CPT 99491, CPT 99439, CPT 99437, CPT 99487, and CPT 99489? Full descriptions are available annually through [CMS](#).
- What resources do you have to monitor program goals and outcomes over the short and long term?

Finding the necessary staff, technology, or infrastructure to effectively build out a CCM program can be difficult—and you're not alone! Fortunately, there are chronic care management solutions like [TimeDoc Health](#) that are committed to providing excellent, reliable 24/7 patient support with dedicated care teams, enrollment assistance, and an intuitive software platform.

2. Identify Patients Who Are Eligible

Once you've evaluated existing resources and built a plan to acquire any additional tools or supports you may need, it's time to start identifying which of your patients are eligible.

First, you need to identify the patients that meet the basic criteria. For Medicare, patients are likely to be eligible if they have two or more chronic conditions that are expected to last at least 12 months or until death and that present a significant health risk. The conditions listed earlier in this article can act as a guidepost in these decisions.

Next, you may wish to narrow your results to a more manageable cohort. This can be done in multiple ways, such as:

- Identifying those patients who are most likely to benefit from chronic care management. This might include those who are most in need of consistent communication or those who are most likely to engage with the program.
- Identifying those conditions you are most equipped to support right now. Will you focus solely on high-risk patients with these conditions, or will you grow your program to enroll medium- or low-risk patients, too?

Finally, you should begin recruitment. Consider creating a pamphlet you can provide to eligible patients. For some practices, you may wish to create an outreach campaign to inform potential candidates about what a CCM program is and how it can help them. As you do this, ensure you're providing education around chronic care management and the kinds of services they'll receive. And, don't forget to acquire consent from patients before beginning care.

3. Leverage Value-Based Care (VBC)

[Value-based care](#) is a type of reimbursement that ties patient outcomes and care quality with billing and payments. With VBC, providers are reimbursed for offering quality care that ultimately furthers goals like improved preventive care and decreased hospital readmissions. This differs from the traditional fee for service (FFS) model that reimburses for services rendered.

So why is value-based care and chronic care management useful? VBC aligns quite well with the goals of a CCM program—to provide better care for patients, to improve health for community populations, and to lower costs associated with care—so it's a natural fit. And, with the [Physician Value-Based Modifier](#) (PVBm), high-performing providers can even receive financial rewards that can be used to invest in further improving a chronic care management program or other high-value initiative.

4. Create Care Plans for Patients

As you begin to enroll patients, working with them is critical to creating personalized, individual care plans that address functional, medical, and psychosocial needs and goals. Ideally, these care plans

should be collaborative in nature. Helping patients feel involved can improve both patient experience and engagement while also reducing some of the stressors related to a new program.

To ensure smooth conversions, appropriate goal setting, and proper documentation, it may be helpful to develop a chronic care management template that can be used in these initial discussions and future appointments. Templates may include space for:

- Top patient and/or provider concerns
- Expected outcomes of participating in a CCM program
- How to achieve these outcomes and what metrics you'll track
- Planned interventions and how you or your patient can accomplish and track them

[TimeDoc](#) offers physician-created care plan templates that synchronize with your EHR to help ease the burden of new resource creation.

5 Assign, Hire, or Outsource Care Coordinators

To improve the likelihood of a successful CCM program, you'll need to designate one or more care coordinators who can oversee the program, act as a point of contact, and organize patient care. It's possible you already have staff members who can assume these responsibilities. If not, you may need to hire new staff or outsource the work to a third-party vendor.

Hiring new staff members can work well, but for a lot of providers it may not be in the budget to hire one or more full-time employees. Instead, consider turning to an experienced third-party vendor like [TimeDoc Health](#). Our team of trained care coordinators has an abundance of experience working with individuals with chronic conditions—which means you can rest assured that your patients are working with professionals who are excellent at building trust and rapport.

6. Offer Staff Chronic Care Management Training

CCM programs are complex, and their success often hinges on highly-trained care coordinators who understand the ins and outs of chronic care management. Training topics may include:

- Responsibilities, such as scheduling appointments, coordinating care, and performing check-ins
- Commercial insurance or Medicare chronic care management guidelines
- The designated chronic care management workflow and other protocols
- Documentation requirements and best practices
- Billing and reimbursement guidelines
- Technology, software, and tool utilization

At [TimeDoc Health](#), our medically trained care coordinators are thoroughly trained in CCM, so they can begin working with you and your patients quickly and effectively.

7. Utilize Effective Technology Solutions

When it comes to CCM programs, the right technology solutions can provide significant time savings. These tools allow providers and care coordinators to spend less time on paperwork and documentation and more time with patients. When researching a CCM program technology solution, seek out the following capabilities:

- **Drives ROI** of your CCM program with reporting functionality to understand the financial impact of your program
- **Reduces time spent on billing** with reporting features that automatically tabulate charges based on existing documentation
- **Automates and streamlines care planning** with templates that sync with your EHR
- **Maintains Medicare compliance** with monthly encounter summaries, patient consent data, and care plans to make audits a breeze
- **Documents time** spent with a patient easily with enhanced EHR integrations
- **Increases care staff efficiency** with dashboards for program size, patient population, and care management productivity

[TimeDoc Health](#) offers all of these features and more, in addition to trained care coordinators, to provide a comprehensive, end-to-end solution for CCM programs.

8. Monitor, Evaluate, and Improve Your Program

In the final step, it's essential to develop a plan to monitor, evaluate, and improve your CCM program as time goes on. As technology continues to advance and more and more patient data and support services become available, you'll be able to refine your program to save money and improve patient outcomes.

- **Monitor:** With a CCM program [software solution](#), you'll be able to view dashboards about financials, program size, patient population, productivity, and more. You should also review information regarding hospital readmissions, medication adherence, and patient engagement to capture a complete picture.
- **Evaluate:** Review the data you've gathered regularly—whether that's monthly, quarterly, or annually—to identify trends, successes, and growth opportunities. Consider setting benchmarks to understand whether or not you're meeting your goals and what you might need to do to get there.
- **Improve:** Take action. Based on your analysis, what areas can you improve upon, and how will you accomplish it? Set a detailed plan of action with reasonable SMART goals (Specific, Measurable, Achievable, Relevant, and Time-Bound), share it with your team, and check in regularly to track progress.

TimeDoc Health: Chronic Care Management, Simplified

Healthcare organizations and medical providers deserve cutting-edge software programs and other solutions that can help them more effectively implement and manage their CCM programs. At TimeDoc Health, we're on a mission to do just that—to help you create patient success stories by improving their quality of life with the power of CCM programs.

With TimeDoc Health, you can access:

- Experienced, flexible, and trained care coordinators to support your efforts
- Time savings with CCM billing and automated reports
- Comprehensive training sessions on how to best use and implement the TimeDoc platform
- Physician-created templates that support services for each of your patients
- Assistance with billing for behavioral health integration (BHI), transitional care management (TCM), and complex CCM codes

Ready to find out how TimeDoc Health can revolutionize your chronic care management program?

[Request a demo today.](#)