CMS will Begin CCM Promotion to Beneficiaries:
Are you Prepared for Patient Engagement?
0
Building Leaders – Transforming Hospitals – Improving Care
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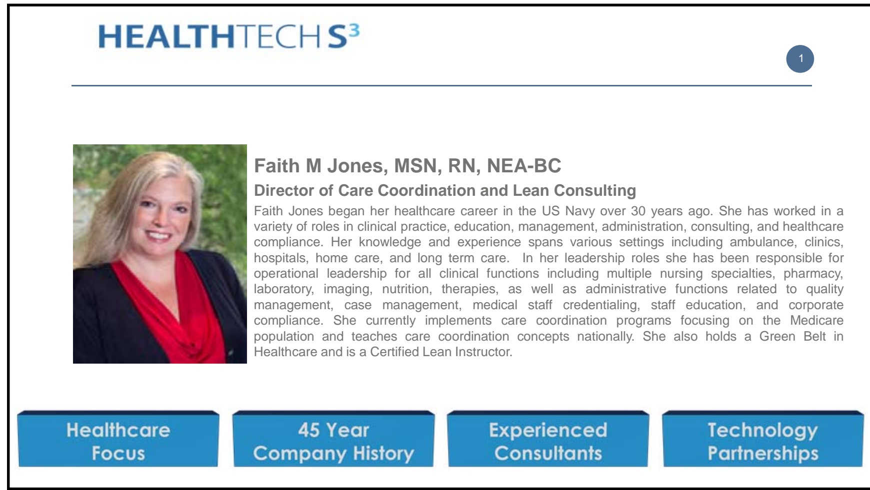
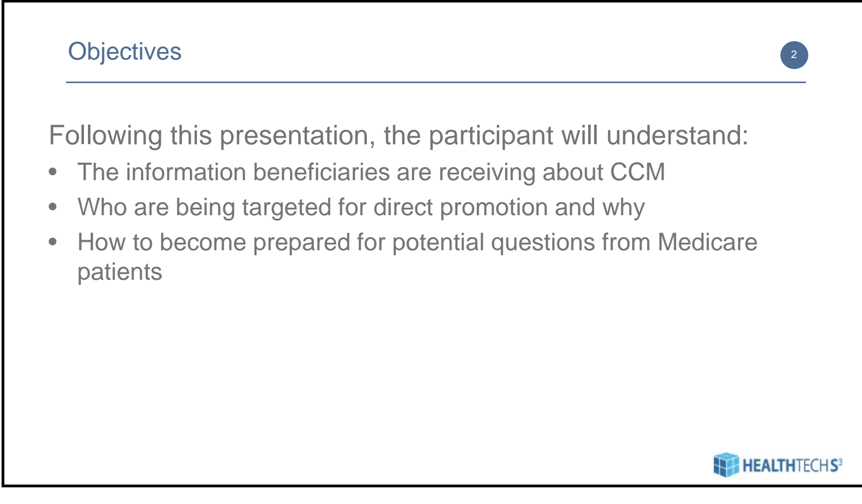

HEALTHTECHS3
1
Faith M Jones, MSN, RN, NEA-BC
Director of Care Coordination and Lean Consulting
Faith Jones began her healthcare career in the US Navy over 30 years ago. She has worked in a variety of roles in clinical practice, education, management, administration, consulting, and healthcare compliance. Her knowledge and experience spans various settings including ambulance, clinics, hospitals, home care, and long term care. In her leadership roles she has been responsible for operational leadership for all clinical functions including multiple nursing specialties, pharmacy, laboratory, imaging, nutrition, therapies, as well as administrative functions related to quality management, case management, medical staff credentialing, staff education, and corporate compliance. She currently implements care coordination programs focusing on the Medicare population and teaches care coordination concepts nationally. She also holds a Green Belt in Healthcare and is a Certified Lean Instructor.
Healthcare Focus
45 Year Company History
Experienced Consultants
Technology Partnerships


Objectives
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Following this presentation, the participant will understand:
The information beneficiaries are receiving about CCM
Who are being targeted for direct promotion and why
How to become prepared for potential questions from Medicare patients
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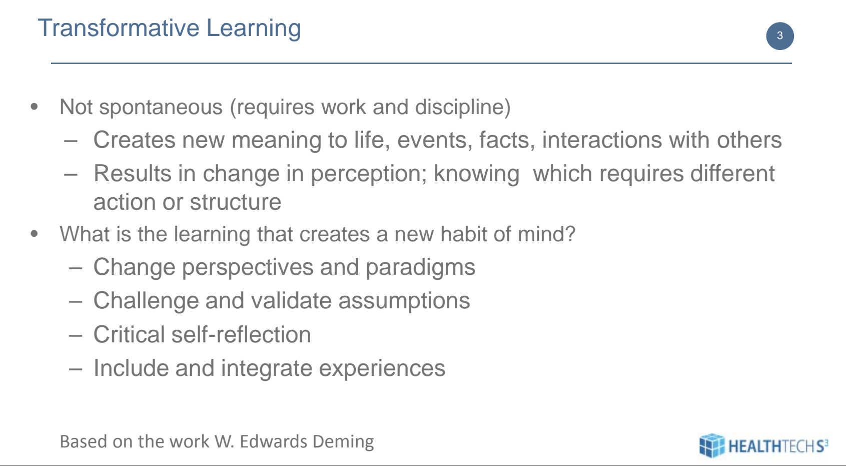
Transformative Learning
3
Not spontaneous (requires work and discipline)
– Creates new meaning to life, events, facts, interactions with others
– Results in change in perception; knowing which requires different action or structure
What is the learning that creates a new habit of mind?
– Change perspectives and paradigms
– Challenge and validate assumptions
– Critical self-reflection
– Include and integrate experiences
Based on the work W. Edwards Deming
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Transformational Learning: 1st Reflection

- Think of a time in your life (situation or incident) where you were vulnerable.
  - Where were you?
  - Who was involved?
  - What happened?
  - What made you feel vulnerable?
  - Make note of your feelings

Developed by Jane Taylor and Pat Rutherford

Transformational Learning: 1st Reflection

- Take a few minutes and share those stories and feelings in small groups

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Transformational Learning: 1st Reflection

- What advice did you or would you have liked to give those who influenced your experience?

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Transformational Learning: 2nd Reflection

- Think of a time in your life when someone provided you genuinely *"helpful"* help.
  - What was your experience?
  - What did you feel?
  - Describe the characteristics of *"helpful"* helping

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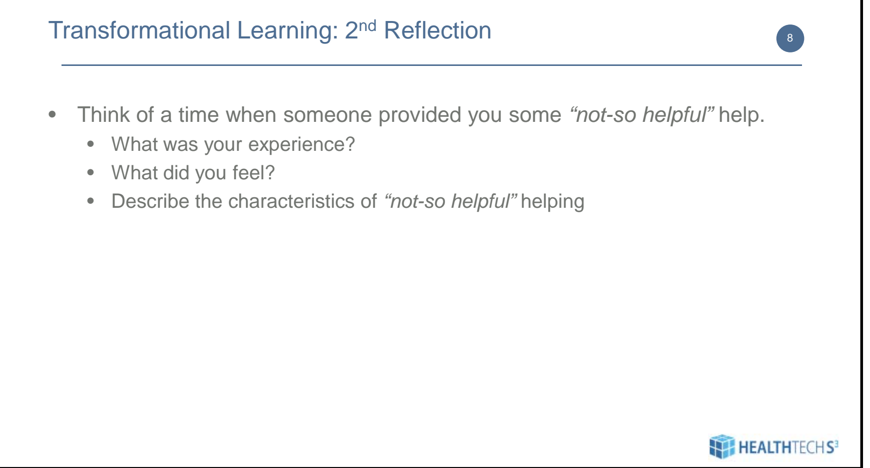
Transformational Learning: 2nd Reflection
8
Think of a time when someone provided you some "not-so helpful" help.
What was your experience?
What did you feel?
Describe the characteristics of "not-so helpful" helping
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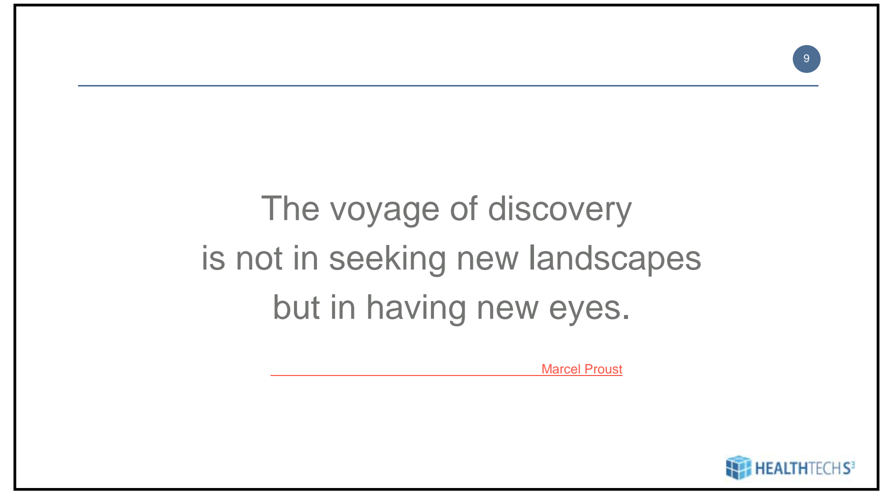
9
The voyage of discovery
is not in seeking new landscapes
but in having new eyes.
Marcel Proust
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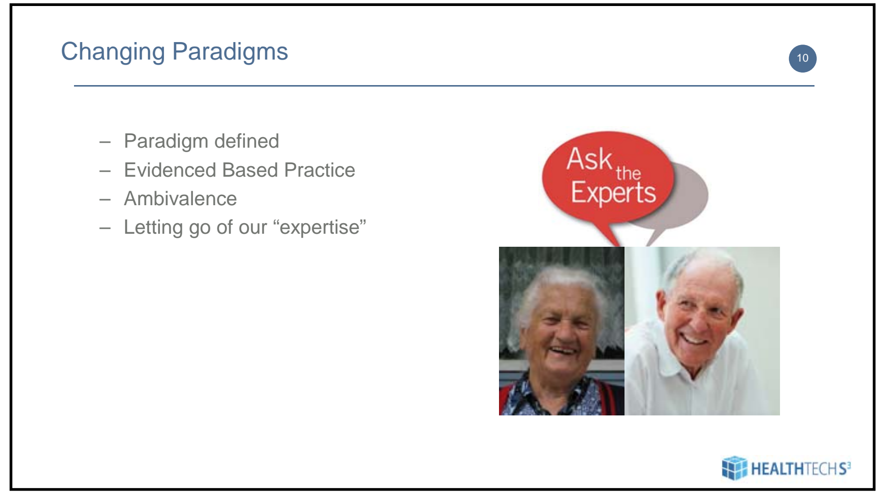
Changing Paradigms
10
Paradigm defined
Evidenced Based Practice
Ambivalence
Letting go of our "expertise"
Ask the Experts
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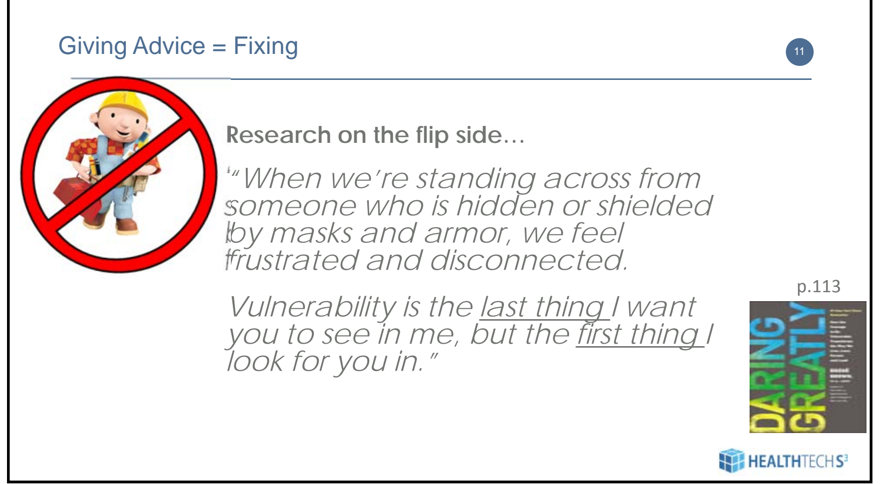
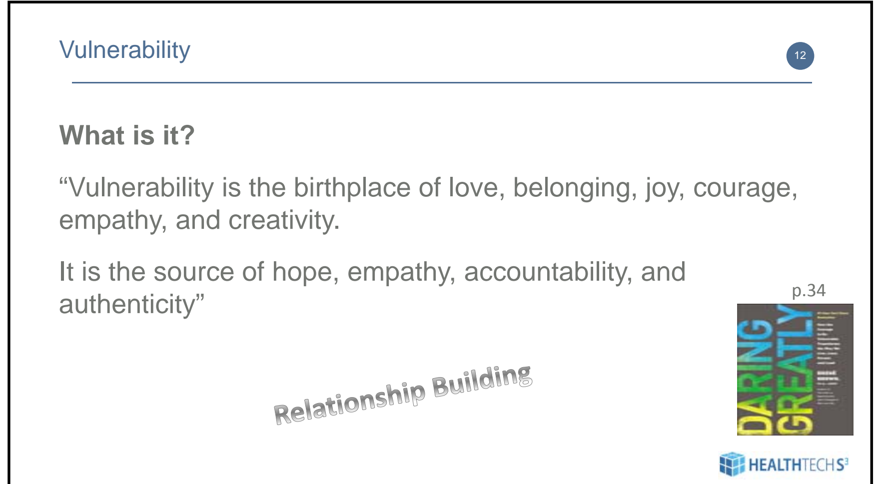

Giving Advice = Fixing
11
Research on the flip side…
"When we're standing across from someone who is hidden or shielded by masks and armor, we feel frustrated and disconnected.
Vulnerability is the last thing I want you to see in me, but the first thing I look for you in."
p.113
DARING GREATLY
HEALTHTECHS3



Vulnerability
12
What is it?
"Vulnerability is the birthplace of love, belonging, joy, courage, empathy, and creativity.
It is the source of hope, empathy, accountability, and authenticity"
p.34
Relationship Building
DARING GREATLY
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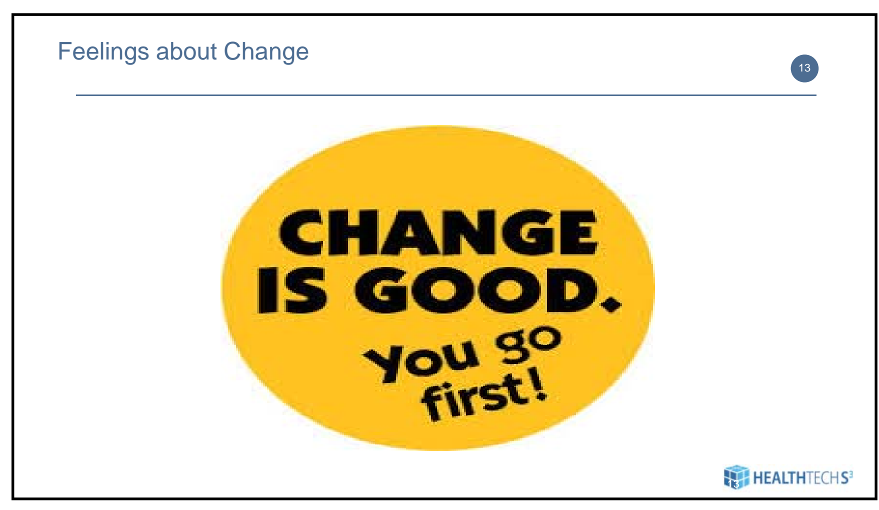

Feelings about Change
13
CHANGE IS GOOD.
You go first!
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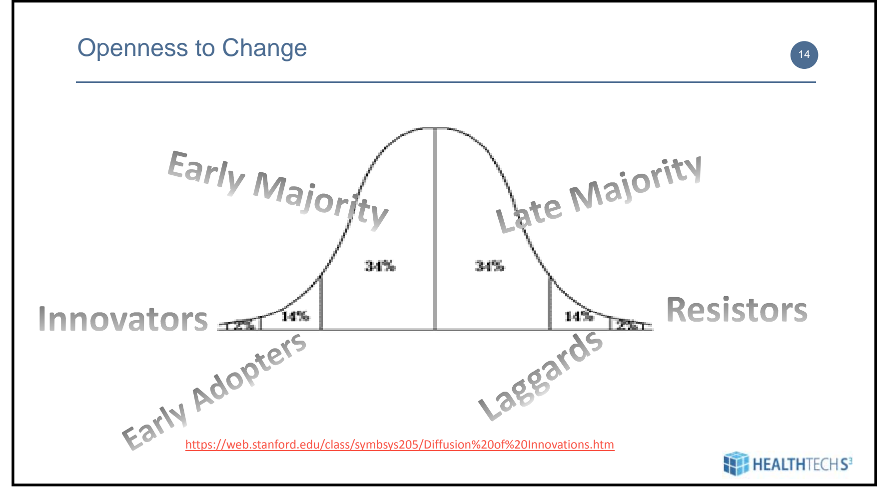

Openness to Change
14
Early Majority
Late Majority
Innovators
Resistors
2%
14%
34%
34%
14%
2%
Early Adopters
Laggards
https://web.stanford.edu/class/symbsys205/Diffusion%20of%20Innovations.htm
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Biggest Bang for our Buck
15
What Makes Us Healthy
GENETICS 20%
ENVIRONMENT 20%
HEALTHY BEHAVIORS
50%
What We Spend On Being Healthy
88%
MEDICAL SERVICES
HEALTHY BEHAVIORS 4%
OTHER 8%
http://cdn.bipartisanpolicy.org/wp-content/uploads/sites/default/files/HEALTHY_1.pdf
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Changing View of Non-Compliant
16
– What is important to you?
– Motivation Interviewing Skills
– Being present
– Listening for "Change Talk"
– Realistic goal setting
– Commitment
The journey of a thousand miles begins with a single step.
Celebrate Each Step
Life Long Process
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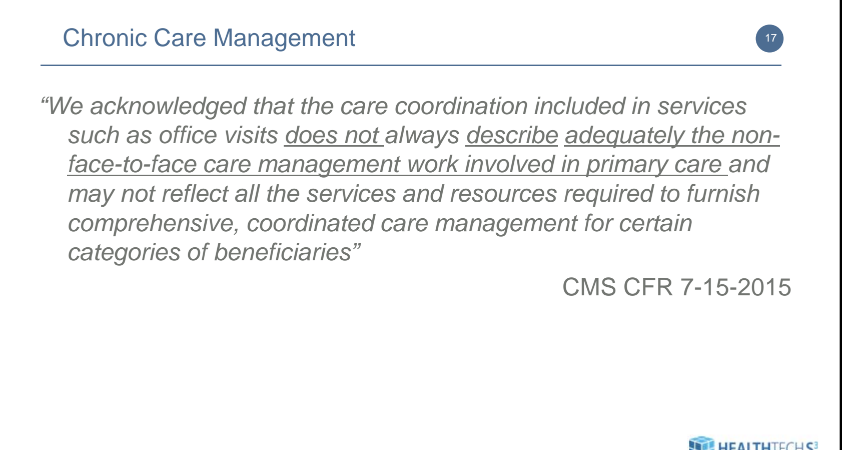
Chronic Care Management
17
"We acknowledged that the care coordination included in services such as office visits does not always describe adequately the non-face-to-face care management work involved in primary care and may not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain categories of beneficiaries"
CMS CFR 7-15-2015
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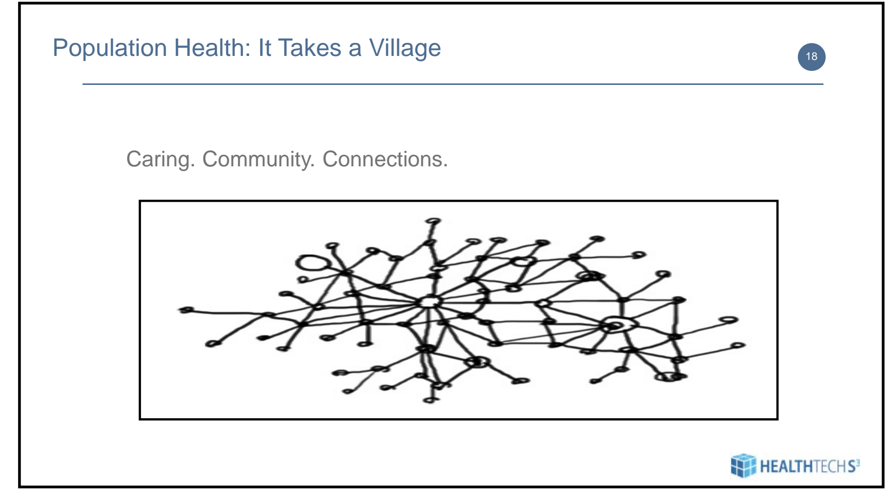
Population Health: It Takes a Village
18
Caring. Community. Connections.
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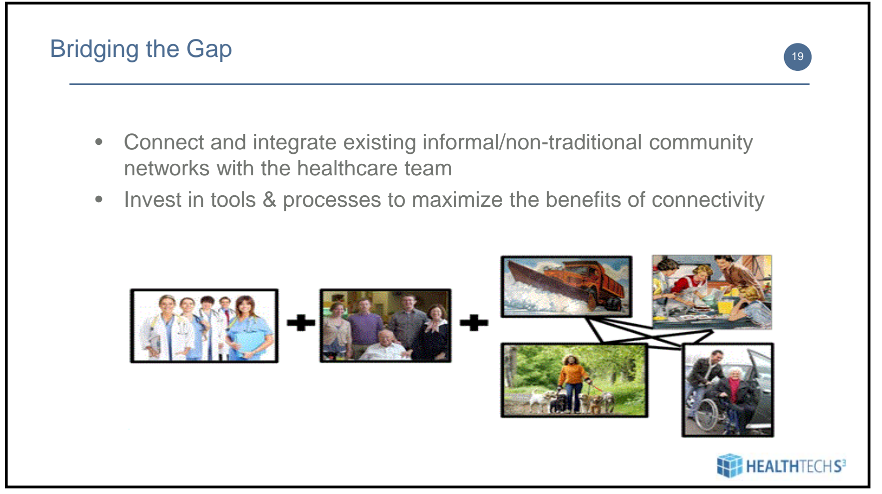
Bridging the Gap
19
• Connect and integrate existing informal/non-traditional community networks with the healthcare team
• Invest in tools & processes to maximize the benefits of connectivity
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Elements for CCM

Practice Eligibility	Patient Eligibility
• Qualified EMR • Availability of electronic communication with patient and care giver • Collaboration and communication with community resources & referrals • After hours coverage • Care Plan Access • Primary Care Provider supervision of clinical staff	• Medicare Patient • Two or more chronic conditions expected to last at least 12 months or until the death of the patient • At significant risk of death, acute exacerbation, decompensation, or functional decline without management • Patient Consent • CCM initiated by the primary care provider

2017 Regulation Updates

Practice Eligibility	Patient Eligibility
• Qualified EMR • After hours coverage • Availability of electronic communication with patient and care giver ✓ **Collaboration and communication with community resources & referrals** ✓ **Care Plan Access** ✓ **Primary Care Provider supervision of clinical staff**	• Medicare Patient • Two or more chronic conditions expected to last at least 12 months or until the death of the patient • At significant risk of death, acute exacerbation, decomposition, or functional decline without management ✓ **Patient Consent** ✓ **CCM initiated by the primary care provider**

Family of Codes

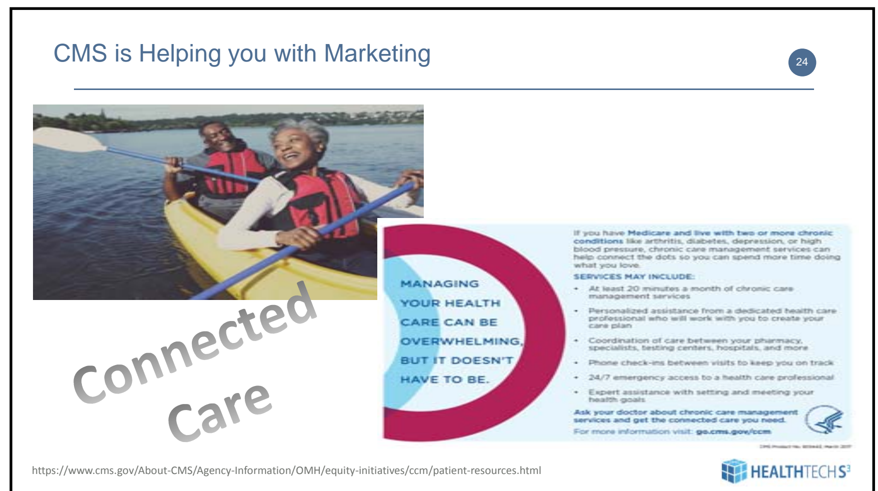
CCM	Complex CCM

99490
• All elements of program are met as previously discussed
• At least 20 min of clinical staff time in the month
• Billed only once per calendar month
• **Applies to PFS clinics, RHCs and FQHCs.**
	99487 and 99489
	• All elements of program met as previously discussed PLUS
	  – Moderate or high complexity medical decision making;
	• At least 60 min of clinical staff time in the month.
	  – Use code 99489 for each additional 30 min of clinical staff time in a month
	• Billed only once per calendar month
	• **Only applies to PFS clinics**
	  – **RHCs and FQHCs may not bill**

Payment Codes for 2017

Chronic Care Management (CCM)

- Billed per calendar month for 20 plus minutes of care coordination
  - CPT Code 99490
  - National Average Reimbursement **~$42.70**
- Billed per calendar month for 60 plus minutes of Complex Chronic Care Management
  - CPT Code 99487
  - National Average Reimbursement **~$93.66**
- Billed with 99487 for additional 30 min per calendar month for Complex Chronic Care Management
  - CPT Code 99489
  - National Average Reimbursement **~$47.00**


CMS is Helping you with Marketing
24
Connected
Care
MANAGING
YOUR HEALTH
CARE CAN BE
OVERWHELMING,
BUT IT DOESN'T
HAVE TO BE.
If you have Medicare and live with two or more chronic conditions like arthritis, diabetes, depression, or high blood pressure, chronic care management services can help connect the dots so you can spend more time doing what you love.
SERVICES MAY INCLUDE:
At least 20 minutes a month of chronic care management services
Personalized assistance from a dedicated health care professional who will work with you to create your care plan
Coordination of care between your pharmacy, specialists, testing centers, hospitals, and more
Phone check-ins between visits to keep you on track
24/7 emergency access to a health care professional
Expert assistance with setting and meeting your health goals
Ask your doctor about chronic care management services and get the connected care you need.
For more information visit: go.cms.gov/ccm
https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/ccm/patient-resources.html
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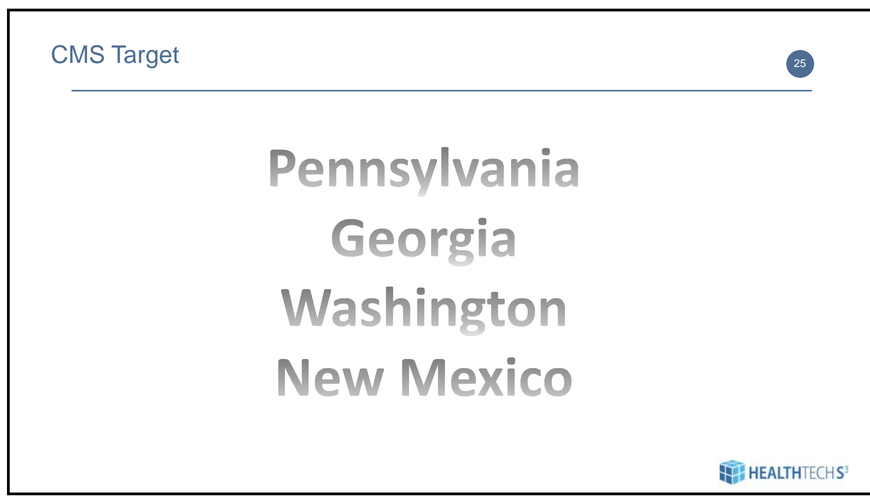
CMS Target
25
Pennsylvania
Georgia
Washington
New Mexico
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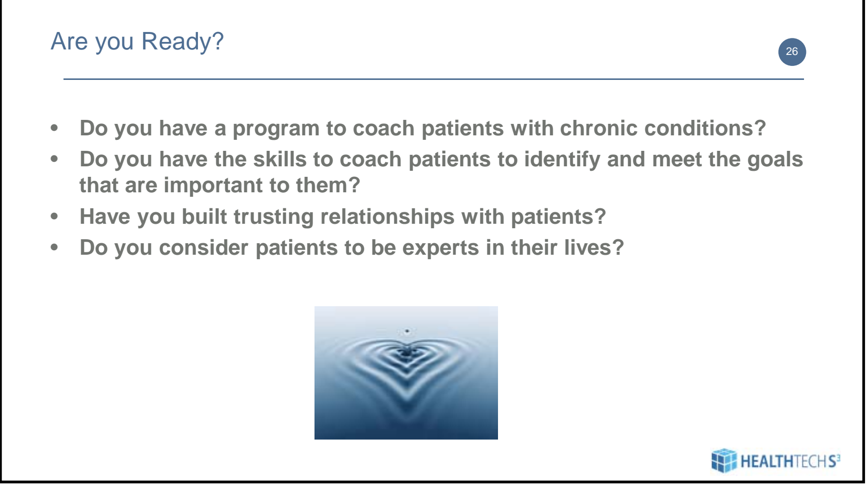
Are you Ready?
26
Do you have a program to coach patients with chronic conditions?
Do you have the skills to coach patients to identify and meet the goals that are important to them?
Have you built trusting relationships with patients?
Do you consider patients to be experts in their lives?
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Thank You
27
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strategy solutions support
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