eClinicalWorks CASE STUDY

Naples Internal Medicine Associates

Implementing Chronic Care Management to Improve Patient Outcomes

The Challenge

How to effectively implement a Medicare rule that pays medical providers up to $42 per patient, per month, for providing non-face-to-face Chronic Care Management services to patients with two or more chronic health conditions.

The Solution

Working with eClinicalWorks, Naples Internal Medicine Associates educated their patients about CCM, identified and signed up those eligible for the program, and used eClinicalWorks to implement the program promptly after January 1, 2015.

The Results

Naples is now able to bill Medicare for monthly non-face-to-face time for about 400 patients, has reduced hospitalizations between 20% and 25% and reports that between 90% and 95% of participants are happy with the CCM program.

Challenge and Opportunity in Florida

Naples Internal Medicine Associates is a small practice located in Naples, Florida, serving hundreds of patients in the city and surrounding communities. Dr. Pavan K. Anand and associates serve a patient population that reflects the demographics of Southwest Florida, including significant numbers of patients age 55 and older, and many over the age of 65 who have multiple chronic medical conditions.

As defined by the Centers for Disease Control (CDC), chronic medical conditions include, but are not limited to: Alzheimer's disease and related dementia, arthritis, asthma, atrial fibrillation, autism spectrum disorders, cancer, chronic obstructive pulmonary disease, depression, diabetes, heart failure, hypertension, ischemic heart disease, and osteoporosis.

Nationwide, two-thirds of Medicare beneficiaries have two or more chronic conditions, while one-third of Medicare beneficiaries have four or more chronic conditions.[1]

1 http://www.cdc.gov/pcd/issues/2013/12_0137.htm

According to Dr. Anand, between 20% and 25% of his patients ages 65-70 have two or more chronic conditions, and that percentage rises through each five-year cohort, such that 35% of those ages 70-75, 40% of those ages 75-80, and more than 60% of those over age 80 have two or more chronic conditions.

Solutions: CMS Responds to an Aging Population

In Florida and throughout the U.S., an aging population means greater demand for geriatric medical services, while continuing cost pressures have led to the adoption of new care and payment models for preventive care.

Those trends are accentuated in Florida, which remains a popular retirement destination for many Americans, and which is expected to continue to experience strong population growth over the next 20 years. According to the U.S. Bureau of the Census, 17.3% of Florida's residents were age 65 or older in 2010. That figure is estimated to reach 21% by 2020, and nearly 25% by 2030, when the state's population will have increased from the current 20 million to more than 26 million.[2]

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Beginning January 1, 2015, a CMS Chronic Care Management rule allows medical providers to bill $42 per month for each patient in a traditional fee-for-service Medicare program who has two or more chronic health conditions, has agreed in writing to participate in the CCM program, and is willing to pay a monthly copayment of $8.

Solutions: Naples Internal Joins the Program

The CCM program had been launched well ahead of January 2015, as a pilot program in selected practices around the country, including an upstate New York practice operated by one of Dr. Anand's friends. That practice had seen significant success over the course of three years, and Dr. Anand's colleague kept him informed about his success imple-

2 http://edr.state.fl.us/Content/population-demographics/data/Pop_Census_Day.pdf

menting CCM. So, when the full program was launched, the decision to join was an easy one for Naples.

"We basically had been doing a lot of this work already, we just had not been reimbursed," Dr. Anand said. "Now, not only can we provide more services, but we can provide more comprehensive services. We're finding that we're having a little bit more interaction with patients now."

Dr. Anand explained that Naples begins the search process for eligible patients by looking for those who have been hospitalized in the past for chronic medical conditions, including diabetes, hypertension, heart failure, strokes, or any type of vascular problems linked to a higher risk of re-hospitalization.

The importance of screening is tied directly to strong statistical evidence that chronic medical conditions represent a significant increase in the likelihood of hospitalizations. According to a 2012 report by the Centers for Disease Control, only 4% of patients who either had no chronic conditions or had just one such condition were hospitalized in 2010. For those with two or three conditions, 13% were hospitalized at least once. For those with four or more conditions, the rates of hospitalization and re-hospitalization in a given year rise steeply.[3]

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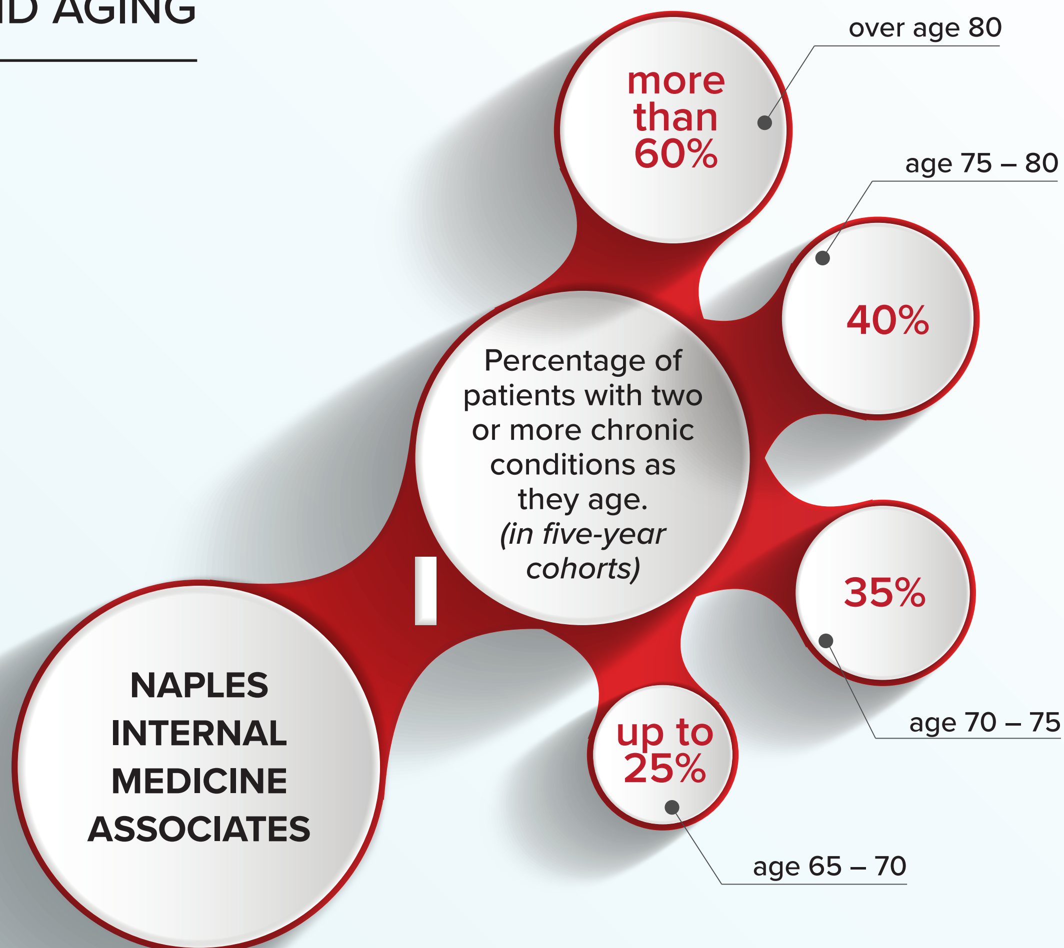
As the CCM program start date approached, Naples began to spend an extra few minutes with each eligible patient during their regular office visits, telling them about the potential benefits of the program and obtaining written consent for their participation. Having patients sign up ahead of time helped facilitate a quick and effective start after January 1, 2015.

Solutions: How eClinicalWorks Helps

Proper implementation of the CCM program begins with a clear understanding of what time counts toward the rule's requirement of spending at least 20 minutes per month of non-face-to-face time with eligible patients.

3 https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/chronic-conditions/downloads/2012chartbook.pdf



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The time spent explaining the program to the patient during an initial face-to-face office visit, cannot be counted. But once a patient is enrolled, providers can count a wide variety of activities toward that 20-minute monthly requirement, including telehealth visits, phone calls, documenting and reviewing the case, assessing a patient's overall health needs, and even consulting with other physicians.

Keeping track of all those details – and doing so for hundreds of patients each month – requires a comprehensive, reliable and nimble Electronic Health Record.

According to Dr. Anand, eClinicalWorks provided all the tools his practice needed for a successful implementation, including access to dashboards to help identify CCM-eligible patients, automated billing rules to receive reimbursement for visits, the creation and management of care plans, 24/7 electronic access to patients, and automated patient reminders for easier recruitment and management.

Dr. Anand noted that Naples divided its eligible CCM program patients into three groups, according to how much non-face-to-face time each needed. For some patients—those needing 20 minutes of additional time every two or three months—a medical assistant could be assigned to handle the work. More time- and labor-intensive patients—those requiring 20 to 45 minutes or more of additional care each month—would generally fall under the purview of a registered nurse, while those requiring the most time would be assigned to a registered nurse or a nurse practitioner.

Solutions: Working Toward Better Patient Health

The practice's goal, Dr. Anand said, is both to try to keep patients with multiple chronic conditions from returning to the hospital, and to encourage them to take at least a few modest steps toward achieving a greater sense of well-being.

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For approximately 350 to 400 of the patients enrolled in the CCM program, Naples has been consistently recording at least 20 minutes per month of non-face-to-face time each month since January 2015.

The practice creates a care plan for each patient, either when the patient comes into the office for their regular visit, or following their release from the hospital after an illness, injury, or treatment for a chronic condition. The plan ensures that the patient has a direct contact at the practice, and then encourages the patient to remain proactive in the management of their own health. Using protocols in the eClinicalWorks software, Naples can ensure that each patient's medications are reconciled to avoid adverse reactions and that the patient can communicate with a specific care plan manager.

And the quality of that communication – like the planning that goes into customizing the care for each patient – goes well beyond diagnoses and prescriptions.

"Naples uses a tremendous amount of physical therapy and a decent amount of nutrition," Dr. Anand said. "We're also using a little bit of alternative medicine, such as yoga, biofeedback, nutrition counseling, and weight loss using apps – all of which we have found to be very helpful. We don't provide such services ourselves, but direct our patients to other agencies that can provide what they are seeking."

"Patients react well to services where they are kept on less medication and have more human interaction in this digital world," Dr. Anand said, adding that more than 90% of Naples' patients are happy to participate in the CCM program.

Although there is a copayment of $8 per month, many patients have that covered by a secondary insurance, so that they don't necessarily pay directly.

"The patients who do pay directly are enthusiastic about paying," he said, "because they realize the value of all the time we spend doing things like prior authorizations of their medications, and making sure their medications aren't interacting with those prescribed by other physicians."

Results: Reducing Hospitalizations

While patients have been enthusiastic about the CCM program, and the anecdotal evidence of effectiveness is strong, any practice wants to be able to quantify its success.

Dr. Anand said that a typical case might involve a heart failure patient just out of the hospital. Naples establishes goals for what that individual's weight should be, what their nutritional program should look like,

what medications they are on, and what consultations may be necessary with other providers, such as a cardiologist.

Those consultations sometimes result in adjustments to medications or dosages, with positive effects that can be measured in lab results. And soon, patients see that they are no longer going to the hospital as frequently as before the CCM program was put in place.

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“We have seen about a 20% to 25% reduction in hospitalizations,” Dr. Anand said. “We are in the process of hiring more staff, and delineating the groups. It has been quite successful. And we have not used email blasts to reach our patients on this. We feel it was more important to interact with them one on one, in a personal way, during their regular, face-to-face appointments.”

Results: Keeping Patients Engaged

Another key to the success of the CCM program lies in what happens after implementation. Dr. Anand said that about 50% of patients involved with the program choose to stay in touch with his practice through the eClinicalWorks Patient Portal.

“They prefer to use email because they are busy, traveling, golfing, and they can access it when they are ready,” he said.

That level of engagement works well with a system that grants all medical staff access to patient records. Providers can call up an individual’s care plan, review therapies and medications, track results of visits and labs, note drug interaction warnings, and answer any questions that the patient may have.

Results: Lessons and Recommendations

With a CCM program in place and helping achieve better health for patients, Dr. Anand can offer other practices a few tips when it comes to preparation and implementation.

- Practices should educate all their Medicare patients about the Chronic Care Management program and potential reimbursements. While many of those patients will not be eligible for the program at present, they may develop one or more additional chronic conditions in the near future, and thus become eligible. Educating them about CCM well ahead of time makes it easier for practice and patients to quickly gear up for the more intensive care needed to safeguard their health.

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- Naples' success has been in part a function of using the eClinicalWorks electronic platform, which consolidates everything in one spot. And the time management module is key, he said, because "for those times that you normally, out of habit, just took care of things, now you can click on a button and use that time period to count toward the amount of time you need to spend with each patient."

- Practices should avoid wordy care plans, Dr. Anand cautions, in favor of those that are very simple and very straightforward. "That way," he said, "you don't have a long care plan, so that every time someone who is dedicated to the patient reviews it, they won't have to read for a minute and a half to figure out what the plan is."

- It is also important to avoid having too many goals, even when a given patient faces many health issues. "We have some patients who are obese, who have diabetes, and who have heart failure," Dr. Anand said. "If we can have just one goal to get them to exercise, something as simple as walking to pick up the newspaper every day, that would be beneficial."

- Finally, while there is no reason not to join the CCM program, Dr. Anand said the main fear many practitioners have is that they will need to hire additional staff in order to achieve the monthly time targets and properly review patient cases. That decision, he said, depends upon the number of participants in the program. "Three hundred to four hundred is manageable with existing staff," he said. "Above that, say above 500 patients, you're going to have to hire more staff. The good news is that with proper implementation, the reimbursements for participating in the CCM program should be sufficient to cover the costs of those additional staff members."