Telehealth In Practice

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Chronic Care Management in Telemedicine

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Webinar Series Topics

- Why You Should Develop a Telemedicine Practice
- How to Choose a Telemedicine Platform
- Telemedicine Pre-Visit Workflow
- Telemedicine Visit Workflow and Documentation
- Urgent Care in Telemedicine
- **Chronic Care in Telemedicine**
- Marketing Your Telemedicine Practice
- Value Metrics in Telemedicine

Webinar Series Topics: On Demand

- On Demand: Team Troubleshooting
- On Demand: Professionalism & Legal Considerations
- On Demand: Best Practices & Caring Communication
- On Demand: Telemedicine Billing

TexLa Telehealth Resource Center

- The TexLa Telehealth Resource Center is a federally-funded program designed to provide technical assistance and resources to new and existing Telehealth programs throughout Texas and Louisiana.
- The F. Marie Hall Institute for Rural and Community Health at Texas Tech University Health Sciences Center is the support representative for Texas. Well-Ahead Louisiana, the chronic disease prevention and healthcare access arm of the state Department of Health, is the support representative for Louisiana.

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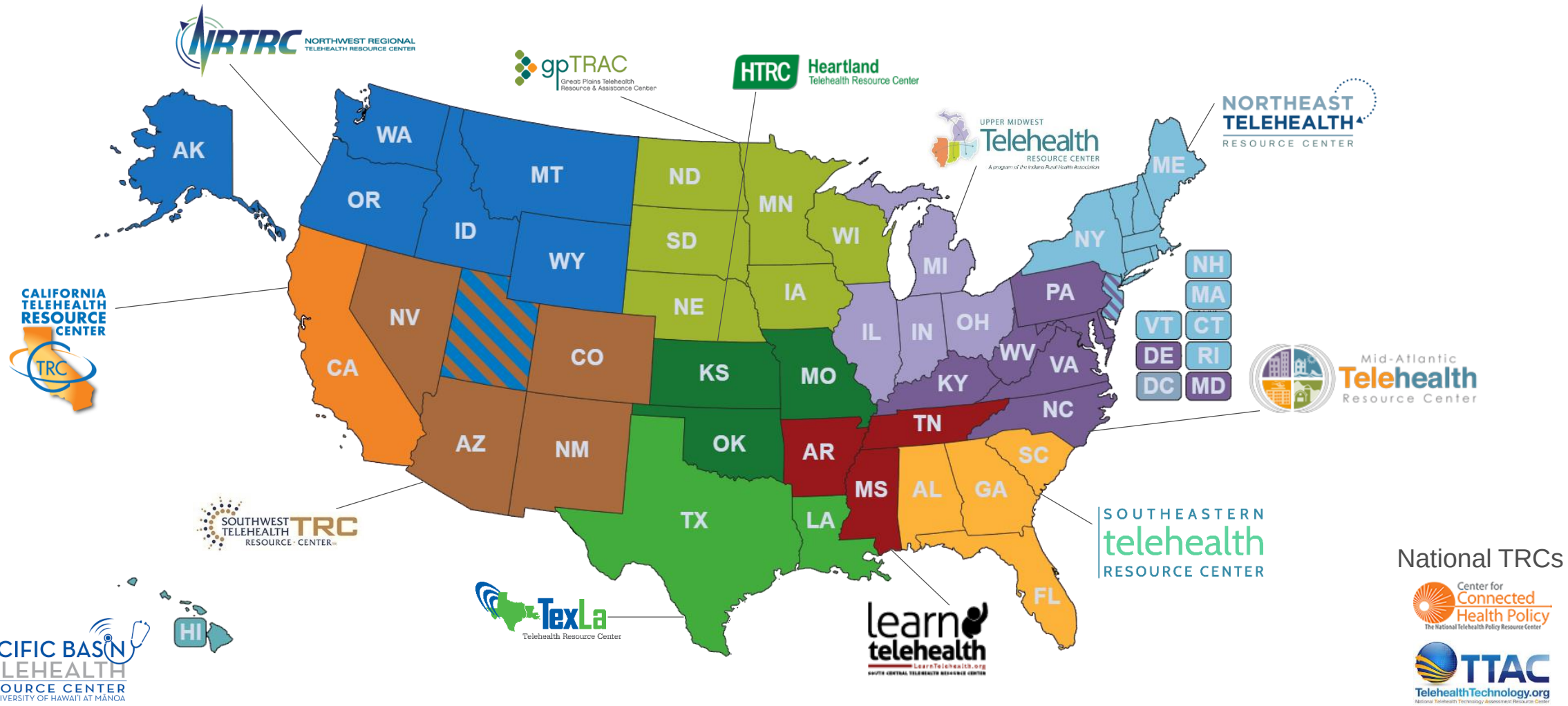

National TRCs

Center for Connected Health Policy
The National Telehealth Policy Resource Center

TTAC
TelehealthTechnology.org
National Telehealth Technology Assessment Resource Center

Source: National Consortium of Telehealth Resource Centers www.telehealthresourcecenters.org

Speaker

- Ted J. Hudspeth, MD, FAAFP
  - Grew up in Amite, LA
  - BS in Microbiology at LSU Baton Rouge
  - Doctorate at LSUMC in New Orleans
  - Family Practice Residency at LSUMC Shreveport
  - Practices at Ochsner Health Center Hammond and Ochsner Hospital of Baton Rouge since 1993
  - Currently serving as the Ochsner Medical Director of Informatics of the Baton Rouge Region

Q&A FROM PREVIOUS SESSIONS

“Start by doing something necessary then do what’s possible; and suddenly you are doing the impossible.”

—Francis of Assisi

OVERVIEW

Overview

- Chronic diseases
- What is chronic care management?
- Provider requirements
- Templates
- Coding
- Outsourcing

CHRONIC DISEASES

Chronic Diseases

- Conditions that last 1 year or more
- Require ongoing medical attention
- Limit daily activities
- Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States
- Leading drivers of the nation's $3.8 trillion in annual health care costs

What are Common Chronic Diseases?

High Blood Pressure	Arthritis	Diabetes	Congestive Heart Failure	Chronic Kidney Disease
High Cholesterol	Depression	COPD	Alzheimer's Disease	Atrial Fibrillation
Ischemic Heart Disease	Cancer	Osteoporosis	Asthma	Stroke

Chronic Disease Risk Factors

Many chronic diseases are caused by a short list of risky behaviors:

Tobacco use and exposure to secondhand smoke

Poor nutrition, including diets low in fruits and vegetables and high in sodium and saturated fats

Lack of physical activity

Excessive alcohol use

Chronic Disease Statistics

- 99% of Medicare spending is on patients with chronic conditions
- 7 of the top 10 causes of death in 2014 were from chronic diseases
- 6 in 10 adults in the U.S. have a chronic disease
  - 2 out of 3 adults have two or more chronic diseases
- People with chronic conditions account for 86% of national healthcare spending
- Racial and ethnic minorities receive poorer care than whites on 40% of quality measures, including chronic care coordination and patient-centered care

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Sources: CMS, CDC, Kaiser Family Foundation, AHRQ

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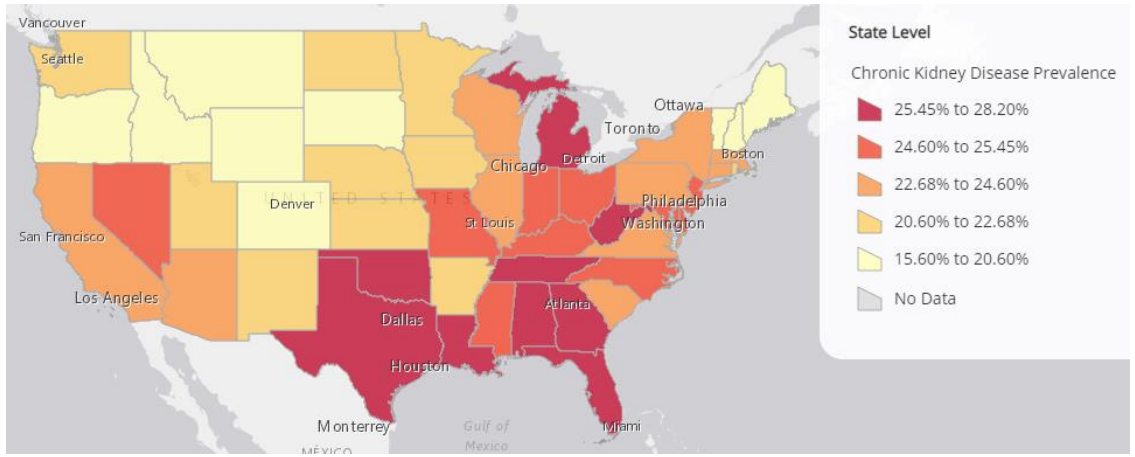
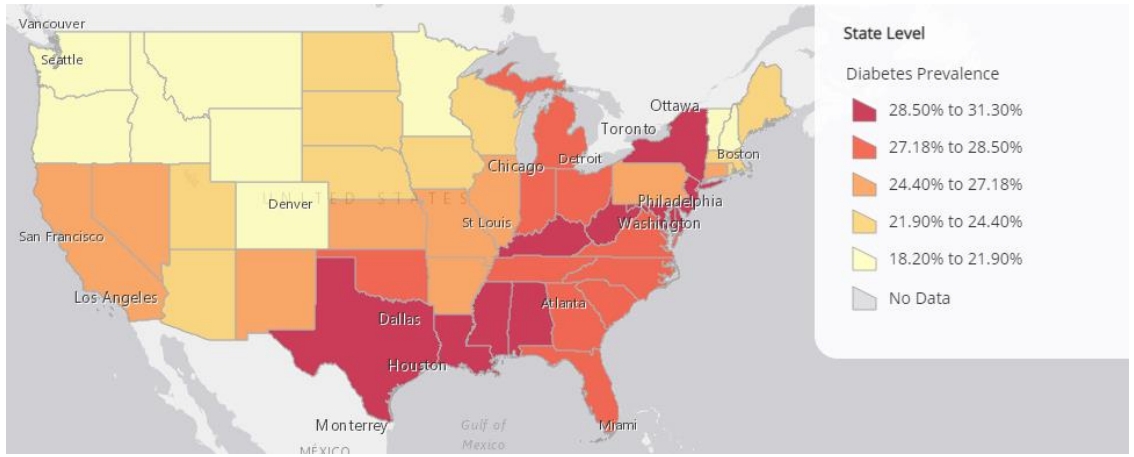
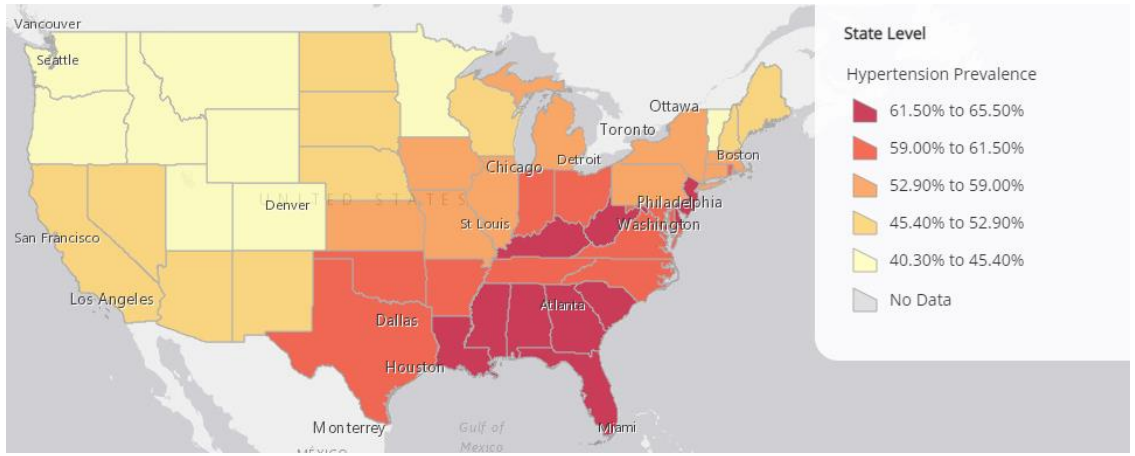
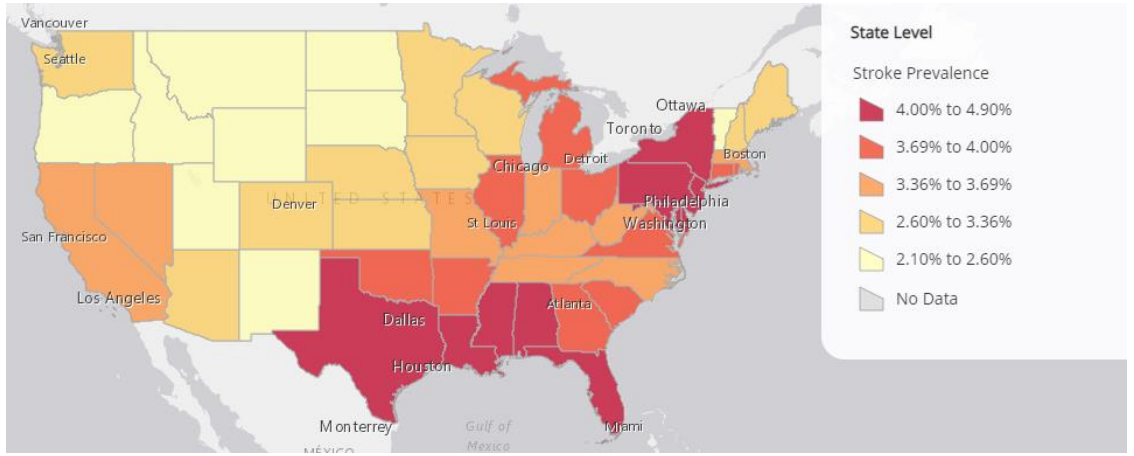
Chronic Care Prevalence Examples



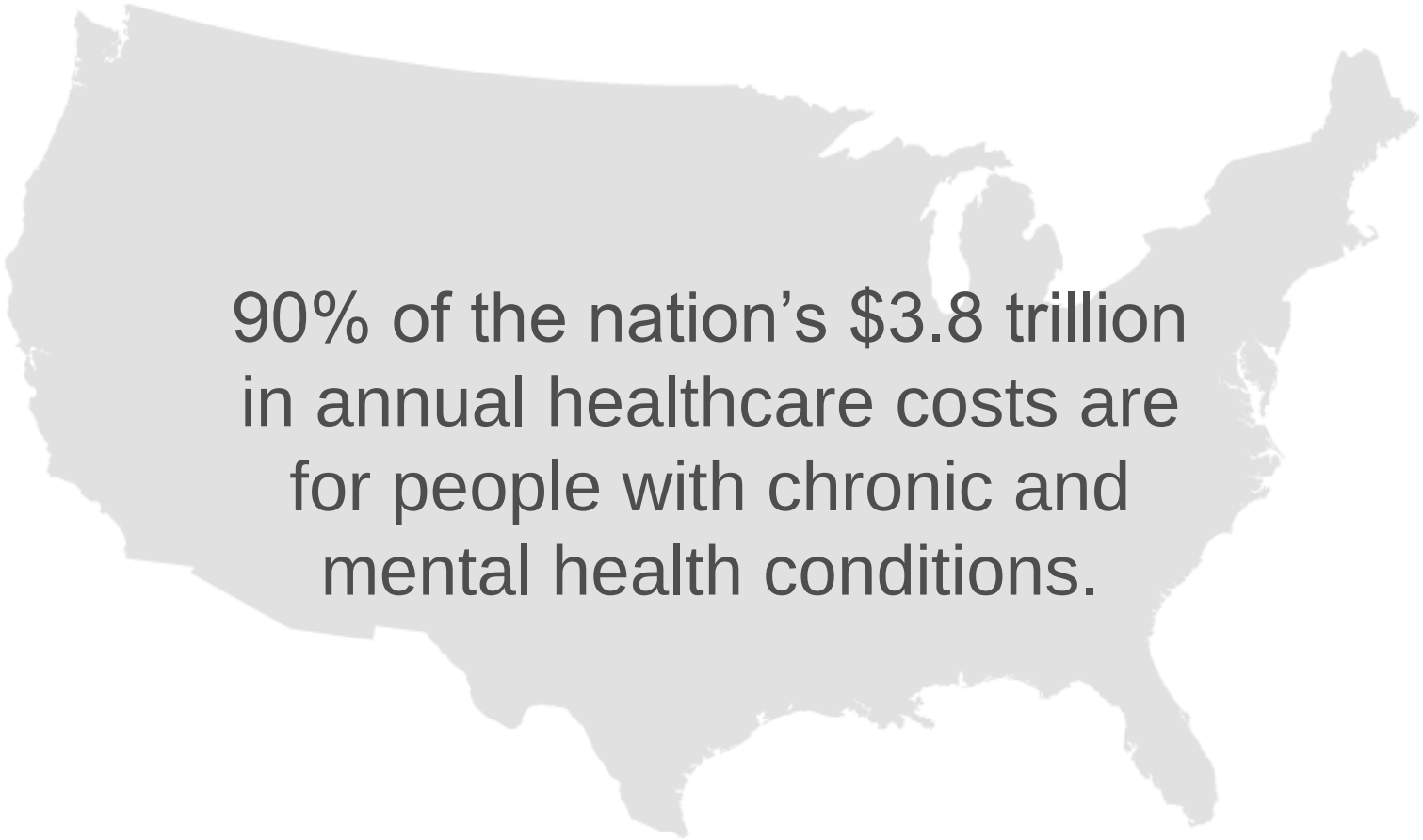






Source: [CMS Chronic Condition Data]

Chronic Care Expenditures



90% of the nation’s $3.8 trillion in annual healthcare costs are for people with chronic and mental health conditions.

WHAT IS CHRONIC CARE MANAGEMENT?

Chronic Care Management (CCM)

- Services and billing codes introduced by CMS in 2015 to benefit physicians and patients
- Physicians are reimbursed for extra care coordination services provided to patients with chronic conditions outside of office visits
- Intended for patients who otherwise may be more likely to visit the hospital to receive the monitoring they need to avoid being admitted

CMS's Connected Care Flyer

CONNECTED CARE

THE CHRONIC CARE MANAGEMENT RESOURCE

The Centers for Medicare & Medicaid Services (CMS) has adopted separately billable codes to improve payment and access to chronic care management (CCM) services for Medicare beneficiaries with two or more serious chronic conditions.

Health care professionals have an opportunity to be separately paid for important services while improving Medicare patients' self-management, health outcomes, and patient satisfaction.

Practitioner Eligibility

- Physicians
- Certified Nurse Midwives
- Clinic Nurse Specialists
- Nurse Practitioners
- Physician Assistants

Patient Eligibility

- A patient may be eligible for CCM services if:
  - The patient has multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient; and
  - The chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline

Initiating Visit

- Initiation during an Annual Wellness Visit, Initial Preventive Physical Exam, or face-to-face E/M visit (Level 4 or 5 visit not required), for new patients or patients not seen within 1 year prior to the commencement of CCM services

PROVIDER REQUIREMENTS

Structured Recording of Patient Information Using Certified EHR Technology

- Structured recording of demographics, problems, medications, and medication allergies using certified EHR technology
- A full list of problems, medications, and medication allergies in the EHR must inform the care plan, care coordination, and ongoing clinical care

24/7 Access and Continuity of Care

- Provide 24/7 access to physicians or other qualified health care professionals or clinical staff
  - Including providing patients/caregivers with means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week
- Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments

Comprehensive Care Management

- Care management for chronic conditions including:
  - Systematic assessment of the patient's medical, functional, and psychosocial needs
  - System-based approaches to ensure timely receipt of all recommended preventive care services
  - Medication reconciliation with review of adherence and potential interactions
  - Oversight of patient self-management of medications

Comprehensive Care Plan

- Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed
- Must at least electronically capture care plan information and make this information available timely within and outside the billing practice as appropriate
- Share care plan information electronically (can include fax) and timely within and outside the billing practice to individuals involved in the patient's care
- A copy of the plan of care must be given to the patient and/or caregiver

Comprehensive Care Plan

- Typically includes, but is not limited to:
  - Problem list
  - Expected outcome and prognosis
  - Measureable treatment goals
  - Symptom management
  - Planned interventions and identification of the individuals responsible
  - Medication management
  - Community/social services ordered
  - Description of how services of agencies and specialists outside the practice are directed/coordinated
  - Schedule for periodic review
    - When applicable, revision of the care plan

Management of Care Transitions

- Management of care transitions between and among health care providers and settings, including:
  - Referrals to other clinicians
  - Follow-up after an emergency department visit; and
  - Follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities
- Create and exchange/transmit continuity of care document(s) timely with other practitioners and providers

Home and Community-Based Care Coordination

- Coordination with home and community-based clinical service providers
- Communication to and from home and community-based providers regarding the patient's psychosocial needs and functional deficits must be documented in the patient's medical record
- Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, internet, or other asynchronous non-face-to-face consultation methods

Patient Consent

- Inform the patient of:
  - The availability of CCM services
  - Only one practitioner can furnish and be paid for these services during a calendar month
  - Their right to stop the CCM services at any time (effective at the end of the calendar month)
- Document in the patient's medical record that the required information was explained and whether the patient accepted or declined the services
- Medical Decision-Making
  - Complex CCM services require and include medical decision-making of moderate to high complexity (by the physician or other billing practitioner)

Physician Testimonial about Chronic Care Management

- 117 million adults have one or more chronic health conditions
- 1 in 4 adults have two or more chronic health conditions

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CHRONIC CARE MANAGEMENT TEMPLATES

What is the Shared Care Plan?

- The Shared Care Plan is a free, easy-to-use, Personal Health Record that lets you keep track of vital health information in case of an emergency
- You can also share this information with your family, physicians and other people you feel should have access to this information

Shared Care Plan Documentation Sections

- General Information
- Care Team
- About Me
- Diagnoses
- Next Steps
  - Concerns
  - Goals
  - Steps to take
- Health Log
- Medications
  - Current and discontinued
- Allergies and Contraindications
- History
  - Surgeries and procedures
  - Hospitalizations
  - Immunizations

General Information

Electronic Shared Care Plan

- If you would like to have an electronic Shared Care Plan housed on a secure website, please go to www.yourclinicwebiste.com to join
  - The information you enter online will be accessible to you and the people you specify from any web ready computer around the world
  - The information can also be printed out as needed

Critical Information Available in an Emergency

- The Shared Care Plan is a place to record key information that medical personnel need access to in an emergency
- If you carry your Shared Care Plan with you or let your emergency contact know where it is, the information is available to emergency personnel
  - This means that even if you are unable to communicate, your critical information is still available to healthcare professionals

How Can I Make the Most of My Shared Care Plan?

- Fill out as much information as you can in your Shared Care Plan
- Ask for that information from your clinic(s) at your next visit
- Bring a copy of your Shared Care Plan with you to all of your health care appointments
- Ask your Care Team members (such as doctors, nurses, therapists, pharmacists, care-givers, family or friends who help you in your journey towards better health) to look at your Shared Care Plan for a current picture of your health and to help you keep the information accurate, up-to-date, and complete
- Work together to define problems
- Keep a copy of your Advance Directives (if you have these) with your Shared Care Plan at all times to make your wishes known and have the legal documents available in the case of an emergency

What are Advanced Directives?

- Advanced Directives state your preferences for end-of-life decisions and includes:
  - Healthcare Advance Directives (Living Will):
    - A legal form that doesn't require a lawyer; communicates your wishes about artificially prolonging your life if you are unable to make your wishes known
  - Physician Order for Life Sustaining Treatment (POLST):
    - A bright green form you and your physician must complete and sign together; states your preferences for end-of-life medical care
  - Durable Power of Attorney for Health Care:
    - A legal form that doesn't require a lawyer; allows you to name a person as your health care agent—someone who can make decisions about your medical care if you are unable to make the decisions for yourself
  - For more information on Advanced Directives, talk to your Doctor

Care Team

Care Team

- Emergency Contacts
  - Your Emergency Contact is the person you would like called first should you have an emergency
  - Your Backup Emergency Contact is the person you would like called if your primary Emergency Contact is unavailable

Contact	Name	Phone	Alternate Phone
Emergency Contact			
Backup Emergency Contact			

Care Team

- Care Team Members
  - Care Team Members are people and/or organizations who help you manage your health
  - Anyone who you feel has a role in your health care can be part of your Care Team

Appointments	Name	Phone	Fax	Role	Comments

Care Team

- Insurance Providers
  - Record here any insurance policies you use for your health care

Type of Insurer	Center Name	Policy Number	Group Number	Phone	Address
Primary Medical					
Secondary Medical					
Prescription Drug					

About Me

About Me

- I want the person working with me to know...
  - This section is for you to record important details about your health and life that will help health care professionals understand your needs

The Most Important Information About Me:

About Me

	Vision	Hearing	Speech	Mobility	Transport	Other
I have challenges with:						

	English	Español	Other
My primary language is:			

	O+	O-	A+	A-	B+	B-	AB+	AB-
My blood type is:								

	Yes	No	Comments
Special diet needs:			

About Me

	Yes	No	Comments
My religion or spirituality impacts my healthcare:			

	Advanced Directives	POLST	Power of Attorney	Comments
I have:				

	Alone	With Partner	With Family	With Others	Assisted Living	Nursing Home	Other
I live:							

Comments

	Reading	Being Spoken To	Being Shown	Listening to Tapes	Seeing Visuals	Other
I learn best by:						

About Me

	Yes	No	Comments
I have access to the internet:			
Additional Information			

Diagnoses

Diagnoses

- My chronic and long-term diagnoses
  - This is a list of all the conditions you have been diagnosed with and are managing

Diagnoses	Description	Date Diagnosed	Diagnosed By	Comments

Next Steps

Next Steps

- Where I am: my concerns
  - This section helps you identify the types of problems or concerns you are currently facing as you manage your health
  - Sharing your concerns helps your Care Team assist you with next steps

	Manage Health	Memory	Family	Emotional	Financial	End of Life	Spiritual Support	Healthcare Access	Other
Concerns									
Details									

Next Steps

- Where I want to be: life goals
  - A life goal is a motivating reason you are working toward better health

Completed	Goal Descriptions

Next Steps

- How I’m getting there: Next Steps
  - Next Steps are small, short-term steps that you are ready and willing to take towards obtaining your life goals

Completed	Date	Goal Descriptions
		Step:
		Action:
		Step:
		Action:
		Step:
		Action:

Set and Document Self-Management Goals Collaboratively with Patients

- Identify self-management tools, including the following:
  - An action plan that includes goals and describes behavior (e.g., increasing activity by walking 15 minutes, 3 times per week)
  - A review of the patient's confidence level (e.g., on a scale of 1 to 10, how confident are you that you can meet your goals?)
  - A follow-up plan
- Review the tool with the multidisciplinary team, including all those who will be involved in its use-physicians, nurses, volunteers

Set and Document Self-Management Goals Collaboratively with Patients

- Test the tool with a few patients and revise as indicated
  - Retest with additional patients and different populations
- Establish and/or review goals with patients as part of the planned visit and follow-up
- Assess patients' skill, understanding, and confidence in managing their disease
- Give patients a copy of goals and place a copy in the chart

Self-Management Goal Tips

- Make sure staff are comfortable with the self-management philosophy and trained in behavioral techniques
- Train lay workers to set goals with patients
- Create a system to communicate goal changes with other providers caring for patients (pharmacy, nursing, lay community workers, etc.) so that they can reinforce them
  - For example, write new goals (e.g., “walk 15 minutes, 3 times per week”) on a prescription pad and give to patients to show to other providers
- Develop a process and train providers so that the self-management process can fit in the 15-to 20-minute visit, if necessary
  - It does not require a long session

Self-Management Goal Tips

- Work with patients to define goals
- Don’t prescribe goals or use checklists
- Include family and caregivers in setting goals
- Use groups for patient goal setting
- Have medical assistants ask patients about goals when taking vitals
- Have providers review goals with patients briefly
- Assign staff to arrange follow-up with patients
- Document goal setting in the registry
  - Include some specifics of the goal and the date(s)

Health Log

Health Log

- Health Indicators
  - This is the place to record health indicators such as:
    - Blood pressure
    - Cholesterol and weight
    - The goal values that you want to reach or maintain and to monitor them over time

Health Log

Indicator	Goal	Comments
Date	Value	Comments

Medications

Medications

- Prescribed medications
  - These are medications that a health care professional has advised you to take, including:
    - Medications
    - Vitamins and supplements available over-the-counter

Medications

Start Date	Prescribed By	Name & Strength	Directions	Use	OTC ?	B	L	D	N
Comments									
Comments									
Comments									

Medications

- Additional medications
  - Add any other medications that you are taking and that no health care professional has advised you to take, including:
    - Herbal supplements, vitamins, etc.

Start Date	Prescribed By	Name & Strength	Directions	Use	OTC ?	B	L	D	N
Comments									
Comments									

Medications

- Discontinued medications
  - This is a list of all medications that you are no longer taking

Start Date	Stop Date	Prescription By	Name & Strength	Directions	Use	Reason Discontinued
Comments						
Comments						

Allergies

Allergies

- Allergies/intolerances
  - These are substances (drug, food, or otherwise) that cause a bad reaction when you take, inhale or in some way come in contact with them

Substance	Date	Type	Stopped By	Reaction

Contraindications

- Contraindications
  - These are substances (both drugs and food) that interact badly with your condition or medications that you are already taking

Substance	Reason	Recommended By

History

History: Procedures and Surgeries

- Procedures and surgeries
  - Here you can keep track of any procedures and surgeries you've had
    - These can range from a biopsy to a CAT scan to a mammogram

Description	Date Admitted	Comments

History: Hospital Visits

- Hospital visits
  - Keep track of any hospital visits you've had
    - Include visits to the emergency room and longer in-patient stays for observation and so forth, but do not duplicate stays listed under surgeries

Description	Date Admitted	Comments

History: Immunizations

- Immunizations
  - Vaccines taken to prevent illness
    - It is important to keep a record of these in case you are ever exposed to a serious contagious disease

Vaccine	Dose Number in Series	Date

CHRONIC CARE MANAGEMENT CODING

Non-Complex vs. Complex Chronic Care Management

- Non-Complex CCM and Complex CCM services share a common set of service elements
- They differ in the amount of clinical staff service time provided, the involvement and work of the billing practitioner, and the extent of care planning performed

Non-Complex and Complex CCM Similarities

Non-Complex vs. Complex Chronic Care Management

- Previously explained on slides 24-33 under “What Is Chronic Care Management?” and “Provider Requirements”
  - 24. Initiating Visit
  - 26. Structured Recording of Patient Information Using Certified…
  - 27. 24/7 Access and Continuity of Care
  - 28. Comprehensive Care Management
  - 29. Comprehensive Care Plan
  - 30. Comprehensive Care Plan
  - 31. Management of Care Transitions
  - 32. Home and Community-Based Care Coordination
  - 33. Patient Consent

Non-Complex and Complex CCM Differences

Non-Complex CCM: CPT 99490

- Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
  - Comprehensive care plan established, implemented, revised, or monitored (assumes 15 minutes of work by the billing practitioner per month)
  - Physician Fee Schedule for 99490

Non-Complex CCM: CPT 99491

- Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements:
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline
  - Comprehensive care plan established, implemented, revised, or monitored
  - Physician Fee Schedule for 99491

Complex CCM: CPT 99487

- Complex chronic care management services, with the following required elements:
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline
  - Establishment or substantial revision of a comprehensive care plan
  - Moderate or high complexity medical decision making
  - 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
  - Physician Fee Schedule 99487

Complex CCM: CPT 99487 and CPT 99489

- Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
  - List separately in addition to code for primary procedure
- Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately
- Report 99489 in conjunction with 99487
- Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month
- Physician Fee Schedule 99487 and Physician Fee Schedule 99489

Special Instructions

- CPT code 99491:
  - Includes only time that is spent personally by the billing practitioner
    - Clinical staff time is not counted towards the required time threshold for reporting this code
- CPT codes 99487, 99489, and 99490:
  - Time spent directly by the billing practitioner or clinical staff counts toward the threshold clinical staff time required to be spent during a given month
- CCM services that are not provided personally by the billing practitioner are provided by clinical staff under the direction of the billing practitioner on an “incident to” basis (as an integral part of services provided by the billing practitioner), subject to applicable state law, licensure, and scope of practice
  - The clinical staff are either employees or working under contract to the billing practitioner whom Medicare directly pays for CCM

Provider Experience

- Providers will receive a monthly payment of $42 per patient per month (there is regional variation)
  - Patients need to pay 20% of this fee
- Care can be billed for care team activities totaling at least 20 minutes of non-face-to-face “chronic care management services” each month, such as:
  - Health coaching over the phone or secure email
  - Care coordination and referrals
  - Medication management
- Services can be provided by clinical and non-clinical staff, including nurses, health coaches, and certified medical assistants
  - The new payment code is “99490”

One Physician's Numbers

- Patient population for one physician: 2,500 patients
- 30% of this total population is Medicare: 750 patients
- 70% of Medicare are FFS: 525 patients
- 70% of this FFS group have 2 or more conditions: 368 patients
- 75% of patients consent to participate: 276 patients
- Each patient can be billed 1 time per month: $42
- Monthly recurring revenue per physician for 276 patients: **$11,596**
- Annual revenue per physician: **$139,104**

CHRONIC CARE MANAGEMENT PROVIDERS

Should You Outsource Chronic Care Management?

- CCM requires an investment in technology and infrastructure
- A recent Porter Research survey states that 88% of practices are trying to manage the CCM program themselves, using only their EHR system and current resources
  - However, outsourcing or co-sourcing CCM can help practices take a crawl, walk, run approach to value-based care
- Some practices avoid CCM entirely because of the time and costs associated with the program
- Outsourcing or co-sourcing CCM has proven to be an attractive alternative in some cases because outsourcing provides practices with the staffing resources and expertise necessary to maximize productivity, earning potential, and avoid the additional personnel costs

RESOURCES

Chronic Disease Data Downloads

- Spending County Level: All Beneficiaries, 2007-2018 (ZIP)
- Prevalence State/County Level: All Beneficiaries by Age, 2007-2018 (ZIP)
- Prevalence State Level: All Beneficiaries by Race/Ethnicity and Age, 2007-2018 (ZIP)
- Prevalence State Level: All Beneficiaries by Sex and Age, 2007-2018 (ZIP)
- Prevalence State Level: All Beneficiaries by Medicare-Medicaid Enrollment and Age, 2007-2018 (ZIP)
- Utilization/Spending State Level: All Beneficiaries, 2007-2018 (ZIP)

Health Professional Resources for Chronic Care Management

- CMS Connected Care Toolkit
- Chronic Care Management Services Fact Sheet (PDF)
- Chronic Care Management Outreach Campaign on Geographic and Minority/Ethnic Health Disparities
- Chronic Conditions in Medicare
- Chronic Conditions Data Warehouse
- Searchable Medicare Provider Fee Schedule

Resources

- Texas Medical Association Telemedicine Vendor Evaluation
- American Medical Association (AMA) Digital Health Implementation Playbook
- Centers for Medicare & Medicaid Services (CMS) General Provider Telehealth and Telemedicine Toolkit
- National Telehealth Technology Assessment Resource Center
- TexLa Telehealth Resource Center

Resources

- American Health Information Management Association Telemedicine Toolkit
- Center For Connect Health Policy Current State Laws And Reimbursement Policies
- CMS General Provider Telehealth and Telemedicine Tool Kit
- Patient Take Home Prep Sheet
- Consumer Technology Association Digital Health Directory

References

- The Best 10 Free and Open Source Telemedicine Software
- Comparing the latest telehealth solutions
- Technical Specifications for Selected Platforms
- Telemedicine Vendor Evaluation
- AMA Telehealth Implementation Playbook
- Picking The Right Telehealth Platform For a Small or Solo Practice

References

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- Leading Age Technology Selection Tools
- Best telemedicine software of 2021
- National Telehealth Technology Assessment Resource Center (TTAC)
- Videoconferencing–Technology Overview

Contact Information

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  - Louisiana Health Professionals Facebook group

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QUESTIONS?

Thank You for Joining Us!

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