# Chronic Care Management

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## OBJECTIVE

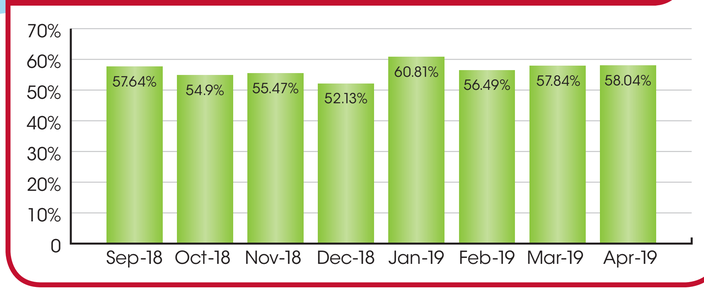
Expansion of the Chronic Care Management Program by the hiring and training of a dedicated CCM Nurse. The CCM nurse will also help to schedule Welcome to Medicare and Annual Medicare Wellness visits as well as assist with development of Transitions of Care Management. Our goal is to provide quality, patient centered care management that will help patients and providers meet their goals as a team.

## BACKGROUND

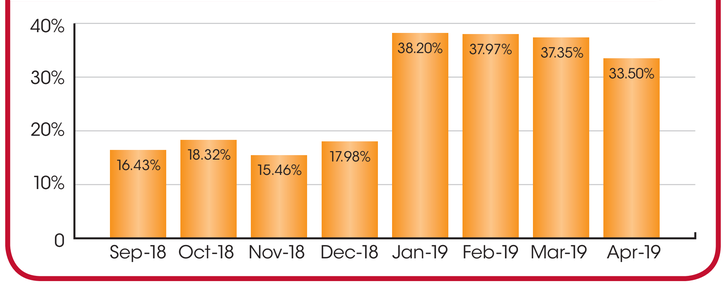
- Three Phase Chronic Care Management Green Belt Project started with phase one of increasing Initial and Annual Medicare Wellness Visits in August 2018.
- Chronic Care Management Pilot done in Diabetic Education Department with 10 Hastings Family Care patients started in September 2018, with manual documentation of time and manual billing.
- Chronic Care Management build in EPIC approved in July 2018 and completed with GO-Live in November 2018.
- Hastings Family Care started enrolling patients in CCM in November 2018.
- Due to clinic workflow changes, billing concerns and no dedicated CCM nurse at HFC, enrollments put on hold in December 2018 (patients still being enrolled in Diabetic Ed).

*The Compass Practice Transformation Network is supported by Funding Opportunity Number CMS-1L1-15-003 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the views of the U.S. Department of Health and Human Services or any of its agencies.*

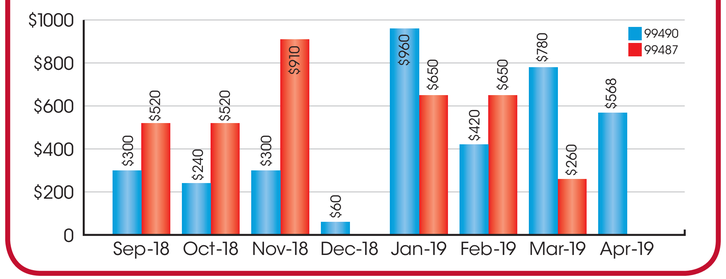
## CMS 165 CONTROLLING HIGH BLOOD PRESSURE



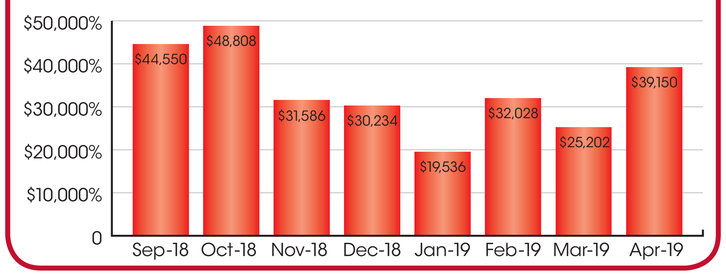

## CMS 122 HBG A1C POOR CONTROL




## CHRONIC CARE MANAGEMENT REVENUE




## MEDICARE WELLNESS REVENUE




## ACTIONS TAKEN

- Chronic Care Management Nurse job description created.
- CCM nurse and workflow shadowing done at multiple clinics.
- Current workflow broken down and reviewed to look for barriers.
- Billing and coding issues discovered and and resolved.
- CCM reports reviewed and updated to meet needs for MLH.
- Presentation and approval of CCM Nurse position by executive team.
- CCM education and training provided to Blue Hill Medical Clinic. Blue Hill Medical currently enrolling patients.
- Hired CCM Nurse for Hastings Family Care.
- Development of new workflow for chronic care management patient eligibility and enrollment by CCM nurse.

## NEXT STEPS

- Increase CCM enrollment with a goal of 50 patients by December 2019.
- Research and education to providers on CCM Care Planning and utilizing code G0506.
- Research and implementation of Transitional Care Management.
- Rollout of CCM to other MLH Primary Care Clinics.

**$102,960** (25% CCM Eligible Medicare Patients Revenue) **MINUS** **$40,019** (Average Clinic LPN Salary)

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= **157% ROI**