

Title

Needs and Objectives

Setting and Participants

Description of Program/Intervention Evaluation - Measures of success Discussion / reflection / lessons learned

Online resource URL (optional)

Implementation of the Medicare Chronic Care Management Program in an Academic General Internal Medicine Clinic

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OBJECTIVES:

We aimed to determine the best practices for implementation of a Medicare Chronic Care Management (CCM) Service in an academic General Medicine Clinic. We worked to improve all elements of the service including patient identification, patient enrollment, development of care plans, physician and patient education, content of the telephone management, and linkage to community services.

SETTING and participants:

The University of North Carolina Internal Medicine Clinic cares for approximately 13,000 patients with approximately 4,600 with Medicare as their primary insurance. The clinic includes Faculty physicians, Resident physicians, and Advanced Practice Providers and has a Licensed Practical Nurses clinical staff. We employ 4 Care Assistants (CAs) who are college graduates aspiring to pursue medical careers. CAs were providing outreach calls to patients with certain chronic diseases such as diabetes and depression prior to this intervention. The clinic uses EPIC@UNC as the electronic health record (EHR). The participants in this project are providers, staff, and Medicare beneficiaries at the UNC Internal Medicine Clinic.

DESCRIPTION OF PROGRAM: The Chronic Care Management Program is a reimbursable Medicare service for beneficiaries that began in January 2015 to reimburse providers for a minimum of 20 minutes of non-face-to-face care per month with 2 or more chronic medical conditions. Implementation began in early 2016 with one provider and expanded to include the entire clinic in June 2016. A multidisciplinary quality improvement team was formed. Early efforts included 1 provider and registered dietitian studying the requirements and testing documentation phrases that would assist in meeting the enrollment consent and comprehensive care plan requirements. We then spread the process to more providers utilizing academic detailing and a video module.

We collaborated with the EHR team to build tools to streamline and systematize enrollment and patient tracking. A registry was created to manage the patients enrolled and tools were built to document and bill monthly outreach.

Care Assistants and care managers provided monthly non-face-to-face outreach. The project team built numerous documentation tools in the EHR with algorithms and drop-down boxes as well as an overall checklist which were designed as a framework to assist CAs in conducting a focused yet thorough discussion of each patient's medical conditions during monthly outreach. The content of the outreach focuses on helping to facilitate the plan previously agreed upon by the patient and provider. The CAs were also trained in Motivational Interviewing (MI).

Multiple small PDSA cycles were utilized to refine and improve each of these processes.

MEASURES OF SUCCESS: We successfully implemented telephone care management in our clinic. As of September 23rd, 2016, we had enrolled 273 patients with 453 phone calls billed. We have enrolled an average of 9 (range: 1-23) patients per week and billed an average of 50 (range: 1-143) phone outreach encounters per month. In addition, we spent an average of 1500 minutes a month (range: 0-3000minutes) on patient outreach with an average length of call lasting 22 minutes per patient (range: 0-60+ minutes). Our practice embraced this model with over 88% of providers participating in enrollment.

Training the CAs in MI was effective. CAs received an anonymous survey before and after implementation of the CCM Checklist, rating their comfort and efficiency in conducting CCM calls on a 5-point Likert scale ranging from 1 (very uncomfortable/inefficient) to 5 (very comfortable/efficient). Mean level of comfort was initially 3.33 and improved to 4.33 with use of the Checklist. Baseline mean comfort with MI was 2 prior to training and improved to a mean of 4 after training. Level of comfort applying MI techniques to other issues outside of smoking cessation counseling was a mean of 4 after training was completed. After one week CAs had begun to apply it to other health care issues such as exercise and weight loss.

DISCUSSION: We have effectively established processes and tools to enroll patients in CCM and provide monthly outreach. We are working to improve efficiency in the enrollment process using EHR tools, streamlining outreach encounters with further templating and decision support, and addressing the most common concerns for both patients and providers. Thus far CCM has helped support team-based care. Reimbursement for this may provide opportunities to fund team-based documentation in clinic visits. Future directions will look at impact on care quality and healthcare utilization.