



**CHRONIC CARE
MANAGEMENT**



Care Coordination Orientation Packet

MARCH 2023

Chronic Care Management For Nurses

Chronic Care Management (CCM) is defined as the non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more), significant chronic conditions. In addition to office visits and other face-to-face encounters (billed separately), these services include communication with the patient and other treating health professionals for care coordination (both electronically and by phone), medication management, and being accessible 24 hours a day to patients and any care providers (physicians or other clinical staff). The creation and revision of electronic care plans is also a key component of CCM.

The designated CCM clinician (YOU) must establish, implement, revise, or monitor and manage an electronic care plan that addresses the physical, mental, cognitive, psychosocial, functional and environmental needs of the patient as well as maintain an inventory of resources and supports that the patient needs. Only one clinician can bill for any particular patient. It will be important that the patients understand only one of their likely multiple physicians will be able to bill for CCM services.

Definitions:

- *Eligible professional (EP)* – The CCM codes can only be billed by a physician, advanced practice registered nurse, clinical nurse specialist, or physician assistant.
- *Chronic condition (CPT)* - states that patients must have “2 chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.” CMS did not provide guidance as to what diagnoses would meet this definition. Examples: Alzheimer’s or dementia, arthritis, asthma, atrial fibrillation, cardiovascular disease, depression, diabetes, hypertension, infectious diseases.
- *Comprehensive Care Plan* – This is an electronic summary of the physical, mental, cognitive, psychosocial, functional, and environmental assessments, a record of all recommended preventive care services, medication reconciliation with review of adherence and potential interactions and oversight of patient self-management of medications, an inventory of clinicians, resources, and supports specific to the patients, including how the services of agencies or specialists unconnected to the designated physician’s practice will be coordinated. Including assurance of care appropriate for patient’s choices and values.
- *Clinical Staff* – Licensed clinical staff members (including APRN, PA, RN, LPN, clinical pharmacists, and “medical technical assistants” or CMAs) who are directly employed by the clinician (or the clinician’s practice) or a contracted third party *and* whose CCM services are generally supervised by the clinician, whether provided during or after hours. Thus the “incident to” rules do not necessarily require that the clinician be on the premises providing direct supervision. So, in other words, we are a representation of the doctor.

- **Barriers** - are list of things which may restrict the patient following a care plan. One needs to identify the barriers that comes up with patient centred care plan. Unless you understand the barriers, you cannot devise a patient centred care plan (emphasis on patient centred by CMS). The U.S. Preventive Services Task Force is an independent, volunteer panel of national experts in disease prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services. USPTF recommendations are at a disease level may/will not work for a cohort as there are barriers at individual levels. USPTF guidelines is the base and needs to be modified taking in to account the individual barriers.

We have classified common barriers to the following categories:

Barriers are not at disease level, instead it is at individual level according to the definition of patient centred care plan in CCM by CMS. The provider, while discussing the care plan with the patients, will select all the applicable categories of barriers to the individual patient.

Compound effects of conditions are very common for comorbidity. For example, a lifestyle change recommendation to exercise for diabetics will not be the same as for a comorbid condition of diabetes and COPD. It is not possible for the patient, as it will be unable to follow the exercise recommendations when he/she cannot breathe. So, this may be a barrier for comorbid condition of diabetes and COPD or asthma.

Active Daily Living includes physical limitations/adaptations to get around and going about things. *The whole concept behind CCM is to give the patients the tools, education, and support to maintain active daily living and self-manage their conditions.* This is more of a goal for a patient with comorbid conditions. This barrier is usually chosen there is a caregiver.

Compound effects of medications are very common. Medication for one disease affects another (therapeutic and side effects) health condition. This is the whole idea behind medication management. If this is a barrier for a patient, then the patient needs to be followed up on medication through CCM calls, secure text messages, portals etc.

Schedule and coordination of medication (hard to keep on top of different medication at different times). Again, a very common barrier for geriatrics, depending. Where the patient indicates this as barrier, then the care plan recommendation could be providing the daily medication through a pill pack.

Total burden of medications and side effects of medications. Here counselling helps as well as other tools such as supplements to manage side effects or making the patient understand/educate the necessity for the medications.

Lack of knowledge about conditions. Many comorbid chronic patients lack the knowledge of the conditions which becomes very negative. Patient education is a great way of making the patient knowledgeable of the condition.

Financial constraints. Again, very common. You can always recommend community support for medication, nutrition, health coaching etc.

Low self-efficacy. Which is a sense of loss, an "I'm falling apart" situation. Very common when one has multiple chronic conditions. Interventions like BHI can be included in the care plan.

Burden of the dominant effect. Such as "I can live diabetes and not COPD." If the patient has this, the emphasis of the doctor is to keep the dominant disease under more control. All the patients with multiple chronic conditions have this barrier. Counselling recommended.

Most Common Chronic Conditions

Hypertension (HTN) is another name for high blood pressure. It can lead to severe complications and increases the risk of heart disease, stroke, and death. Blood pressure is the force exerted by the blood against the walls of the blood vessels. The pressure depends on the work being done by the heart and the resistance of the blood vessels. Medical guidelines define hypertension as a blood pressure higher than 130 over 80 millimeters of mercury (mmHg), according to guidelines issued by the American Heart Association (AHA) in November 2017. Around 85 million people in the United States have high blood pressure. Hypertension and heart disease are global health concerns. The World Health Organization (WHO) suggests that the growth of the processed food industry has impacted the amount of salt in diets worldwide, and that this plays a role in hypertension.

So for this reason, a detailed assessment of blood pressure and diet are important. If hypertension is an issue for the patient, asking how often blood pressure is assessed is your basic question. How often? What are the results? What medications do you take for your blood pressure and are you having any side effects to those medications? How about your diet (get examples or a typical meal)? As for salt intake, how much and how often? Activity and mobility? Do you do any exercise and how long? Stress can also be a pretty big factor in hypertension. Asking the patient about coping is a good leading question as well.

Hyperlipidemia (High Cholesterol) Cholesterol is a chemical compound that the body requires as a building block for cell membranes and for hormones like estrogen and testosterone. The liver produces about 80% of the body's cholesterol and the rest comes from dietary sources like meat, poultry, eggs, fish, and dairy products. Foods derived from plants contain no cholesterol. Cholesterol content in the bloodstream is regulated by the liver. After a meal, cholesterol in the diet is absorbed from the small intestine and metabolized and stored in the liver. As the body requires cholesterol, it

may be secreted by the liver. When too much cholesterol is present in the body, it can build up in deposits called plaque along the inside walls of arteries, causing them to narrow. So again, diet or fatty food intake and exercise or activity are important here. Asking specific questions to probe into those two topics would be important in assessing hyperlipidemia management.

Diabetes is a disease that affects your body's ability to produce or use insulin. Insulin is a hormone. When your body turns the food that you eat into energy (also called sugar or glucose), insulin is released to help transport this energy to the cells. Insulin acts as a "key." Its chemical message tells the cell to open and receive glucose. If you produce little or no insulin, or are insulin resistant, too much sugar remains in your blood. Blood glucose levels are higher than normal for individuals with diabetes. There are two main types of diabetes: Type 1 and Type 2.

What is Type 1 diabetes?

When you are affected with Type 1 diabetes, your pancreas does not produce insulin. Type 1 diabetes is also called juvenile diabetes since it is often diagnosed in children or teens. This type accounts for 5-10 percent of people with diabetes.

What is Type 2 diabetes?

Type 2 diabetes occurs when the body does not produce enough insulin, or when the cells are unable to use insulin properly, which is called insulin resistance. Type 2 diabetes is commonly called "adult-onset diabetes" since it is diagnosed later in life, generally after the age of 45. 90-95% of people with diabetes have this type.

Questions to ask here would revolve around taking blood sugars, how often? The results? Do they know what to do in a low/high result? Insulin doses and timing? Diet and exercise play a key role here as well. Questions about diet and dosing and timing are important to get optimal results of the insulin. Other general health questions are needed as well. Questions about foot care and grooming are very important. Due to peripheral neuropathy, small cuts on the feet can turn into major wounds quickly. Asking about good footwear and nail care would classify as good assessment questions.

Chronic Obstructive Pulmonary Disease (COPD) is a lung disease that includes chronic bronchitis and emphysema. In 80-90% of cases, it is caused by smoking. Other causes of COPD can include genetic reasons (alpha-1 antitrypsin deficiency), occupational dusts and chemicals, second-hand smoke, frequent lung infections as a child, wood smoke and other biomass (animal dung, crop residues) fuel used for cooking. COPD develops over time. In most cases, COPD is diagnosed in people over 40 years of age. Someone with COPD may not realize that they are becoming shorter of breath until it becomes very hard to do simple tasks like walking up stairs. When you have COPD, your lungs are obstructed or blocked, making it hard to breathe.

In chronic bronchitis, your airways become swollen and can be filled with mucus, which can make it hard for you to breathe. In emphysema, the air sacs (alveoli) in your lungs are damaged which can make it hard for you to breathe.

Questions we want to ask here should revolve around breathing ability and quality. Do you manage well with medications? Do you often feel short of breath? Can you maintain adequate activity without breathless episodes? Does heat/cold effect your breathing?

Activity/Exercise for the prevention of disease and/or chronic conditions. –Exercising as a senior may delay or even prevent diseases like diabetes, cancer, stroke, heart disease and osteoporosis, just to name a few. Exercise can help alleviate symptoms of depression and improve the mood in general. Guidelines for older adults aged 65 and over who are generally fit and have no health conditions that limit their mobility should try to be active daily and should do at least 150 minutes of moderate aerobic activity such as cycling or walking every week.

9 Best Types of Exercise for Older Adults

- Swimming. There is a reason swimming is called the world's perfect exercise!
- Yoga
- Pilates
- Bodyweight Training
- Resistance-Band Training
- Walking
- Cycling
- Strength and Aerobic Classes

Basic Questions about exercise and its details is what you probe question wise here. Do you exercise? What do you do? How much/how long? Do you have any limitations (wheelchair bound, walker, bedfast)? If not mobile, do you do stationary range of motion (ROM) exercise?

Diet and Nutrition: Food provides the energy and nutrients you need to be healthy. Nutrients include proteins, carbohydrates, fats, vitamins, minerals and water.

Studies show that a good diet for seniors reduces the risk of osteoporosis, high blood pressure, heart diseases and certain cancers. As seniors age, they might need less energy. But they still need just as many of the nutrients in food. To get them they should choose a variety of healthy foods. Encourage them to avoid empty calories, which are foods with lots of calories but few nutrients, such as chips, cookies, soda, and alcohol. Rather, help them to pick foods that are low in cholesterol and fat, especially saturated and trans-fats

Saturated fats are usually fats that come from animals. Look for trans-fats on the labels of processed foods, margarines, and shortenings.

Seniors should be asked if they are maintaining a healthy diet. Are you getting enough fruits and vegetables? Enough water (imperative)? Do you follow a balanced diet? Are you able to prepare meals yourself? Do you get help with meal prep? Can they get out to shop? Do they need Meals on Wheels or any assistance? If they are diabetic, are they managing blood glucose well?

Quality Assurance

The Quality Assurance (QA) department is on the ball making sure the calls and documentation are on point! Quality assurance is the administrative and procedural activities implemented in a quality system so that requirements and goals for a valid call will be fulfilled. We listen to the calls and make sure the valid calls are more than suitable! We strive for excellent calls and patient care.

Calls **MUST** maintain QA with the following requirements to be a valid call:

- The Chronic Care Management or CCM program **MUST** be mentioned in identifying the call.
 - Asking about a follow up appointment. If or when it has been made. An appointment must be made if it has been more than 3 months since the last doctor's visit. If you cannot make the appointment, please message the practice accordingly. If you are not able to make this appointment, you must send a message.
 - Going over medications and side effects. Also expediting a refill if necessary.
 - Asking about any possible Emergency Room visits or hospital admissions. Specific details must be obtained from the patient for documentation. Dates, place, reasons and any follow up is required. **This is mandatory!**
 - One or more of the chronic conditions should be spoken about. Details documented.
 - 2-3 barriers should be addressed. If you have addressed the barriers and do not use the template, document with BARRIERS.
 - The disposition should be documented correctly.
 - Calls must be at least 3-4 minutes in length minimum (approximate)
- We realize each call is different and sometimes obtaining all this information can be challenging, but they are Medicare requirements and calls will be rejected if they lack necessary details. Some calls may be subject to review. Please know that we do our very best to make sure you get as many valid calls as possible.

The Introduction Call

An introduction call is our first opportunity to start building a relationship with the patient. Here is where we let the patient know about all we do and make sure they have an understanding of what the calls will entail for the future. We must also acquire an informed verbal consent. The patient should be informed of the Chronic Care Management program and that the following services shall be available to them for help with management of their chronic diseases:

- ✓ The facilitation of follow up appointments with the doctor
- ✓ Prescription refills
- ✓ Referrals
- ✓ Transportation

- ✓ Home care
- ✓ Constant communication with the practice through messaging
- ✓ And 24h access to assistance with non-emergent needs

The Follow Up Call

The next month would be the FOLLOW UP CALL. This is where we get to check up on the patient and see how the last month has been. We also extend our services to the patient in this call. In order for this call to be a VALID CALL some non-negotiable criteria must be met.

The following **MUST** be mentioned and assessed for the call to be VALID:

CCM - The mention of CCM or Chronic Care management: This is because we want to be consistent with mentioning the program every time. We want the patient to identify with the call as a pleasant one, by a company that cares. Also, we want to try and avoid any confusion to the patient. By just introducing yourself by the doctor's name, the patient may think it is the doctor's office calling. It causes a circle of confusion that is rectified by simply mentioning the CCM program.

ER Visit and/or Transition of Care (TOC): With every F/U call we need to know if the patient has been in the hospital in between CCM calls. If there has been an Emergency Room visit, but no admission, it is a valid call. We still need to know dates and details of this visit. If the patient has visited the hospital and has been admitted and discharged within the last 10 days before the call; this is Transition of Care or more commonly referred to TOC. We cannot bill for this call. It is not valid.

Medications: We make sure that the patient is taking all their medications. We also check if there are any changes to the medications or any side effects. If the patient is in need of a refill, we will gladly do so. We can do this through our messaging system if the practice permits us to use it. You can find specific nurses instructions under the heading NURSE INSTRUCTIONS. **IT IS IMPORTANT TO ALWAYS LOOK UNDER NURSE INSTRUCTIONS AND FOLLOW ACCORDINGLY.**

Follow up appointment: The conversation should not be completed before arranging or enquiring about the next F/U. Again, the NURSE INSTRUCTIONS will guide you on how you bring this up with the patient. Some practices allow us to make the appointment for the patient and some want us to have the patient call them directly. **IT IS IMPORTANT TO LOOK UNDER NURSE INSTRUCTIONS AND FOLLOW ACCORDINGLY.**

Chronic Condition: Since our patient has 2 or more chronic conditions, we would like you to ask about one or more of them in the conversation. Example: Hypertension: "How's your blood pressure Mr. Smith? Do you measure your blood pressure at home or at your doctor's office? Do you know what the last reading was? How is your diet? Are you trying to avoid fatty foods and salt"? *Our most common conditions will follow in this package.*

Barriers: It is imperative to discuss 2-3 barriers with the patient (clarification above). These are located on the left-hand column at the bottom of custom notes. We need to expand our notes to identify any barriers they have with medical care. This is a Medicare requirement. Medicare needs to know what inhibits good medical care for the elderly. In other words, anything that hinders the patient to acquire appropriate health care. **DURING THIS TIME, PLEASE MENTION COVID 19 WHILE SPEAKING ABOUT THE BARRIERS. SCRIPT TO FOLLOW.**

The following are the headings of the Barriers:

- Physical Inactivity
- Medication adherence
- Poor Diet
- Lack of health screening
- Socio-economic barriers
- Insufficient sleep
- Poor stress management
- Instrumental activities

Messaging: It is part of The Chronic Care Management Program to be in constant contact with the practice. So, appointments should be made. Appointments should be made when they have not seen the doctor for 3 months or more. Exceptions would include when something ails the patient from going to see the doctor. An example would be a fall they had recently or cold/flu like symptoms that prevent them from getting out. Anything you think could be an exception should be monitored and the doctor should know about it as well. We will go into detail about the exceptions.

Appointments: **We must make appointments for the patient to see the doctor every 3 months.**

If the patient has not seen the doctor, you must insist that an appointment is made on behalf of the doctor. The doctor is in full support of us making appointments for the patient if they have not seen the doctor in 3 months. If you have tried your best to make that appointment and the patient refuses, you must send a message to the practice. If the patient is not willing to make an appointment at the time, you must message the practice to let them know (when appropriate). This is monitored.

Disposition: This is how you document or label the call.

SUCCESSFUL BILL-F/U-DIALER: A valid call when you have spoken to the patient this month and the call was generated from your campaign through the fire calling

SUCCESSFUL-BILL -F/U-MANUAL: A valid call when you have spoken to the patient and the call was made manually. This is the first call of the month disposition.

SUCCESSFUL BILL-INCOMING: A valid call when you receive an incoming call from the patient

SUCCESSFUL-BILL- INTRO-DIALER: A valid call when you have spoken to the patient for the first time and the call was made through your campaign through the fire calling

SUCCESSFUL-BILL-INTRO MANUAL: A valid call when you have spoken to the patient for the first time and the call was made manually

SUCCESSFUL-BILL-FOLLOW UP VALID: This disposition is used when you have already spoken to the patient twice this month. For example, if the patient leaves you a voicemail and you have returned the call. This may be regarding requests for appointments, refills, or general questions.

TRANSITION OF CARE: For when the patient has both been admitted and discharged from hospital or facility in the last 10 days before the call. If it has been more than 10 days, it would be a valid call.

More on (TOC) to follow.

SUCCESSFUL-BILL-2ND CALL OF MONTH: A valid call for the second call of the month (this call must be AT LEAST 1 week after the first call of the month was made).

NOT INTERESTED IN 2ND CALL: This disposition should be chosen if the patient does NOT want the second call of the month. This disposition will remove the second call all together.

NOT IN SERVICE: When the number is not in service

NOT REACHABLE OR NOT AVAILABLE: When you cannot reach the patient. This may be because the phone keeps ringing or if someone other than the patients answers and tells you that the patient is not available at the moment.

VOICEMAIL: When you have left a voice mail for the patient. You **must leave** voicemails for any patient who has a voice mailbox.

LANGUAGE BARRIER: If you find there is a language barrier in your call, use this disposition. If it is Spanish, let one of the Spanish speaking nurses know through V3. It will be assigned to one of them for future. If it is any other language, please let management know. You can update under language preferences on the CCM chart.

NOT SEEING DOCTOR: If the patient is not seeing the doctor documented. Please deactivate the patient after clicking this disposition.

DECEASED: If you find the patient has deceased, first notify the practice/physician. Document. Then deactivate the chart.

INPATIENT ADMITTED: When the patient is actually an inpatient in either hospital or rehab. Document and reschedule under preferred call. This will then schedule a call for TOC

NO CALL BACK/PATIENT REFUSED PROGRAM: This is when the patient has voiced that they do not want to be called. Deactivate the patient's chart after clicking this disposition.

PATIENT HUNG UP: When the patient hangs up on you.

TEST-TRAINING PURPOSES: Use this during your training period only or when you are testing a new module on a patient chart.

Call Monitoring

You have a “number” goal of calls to make per day. There is also a “number” of dialed calls to make. All incoming and outgoing dialed calls are documented. Please make sure you click the correct disposition for each and every call that you make in order to receive credit for that call. The amount of dialed calls are monitored this way. Also, you must make sure to leave a voicemail when allowed and document that you have left a voicemail through the voicemail disposition. In the event you can not leave a voicemail, you must use the “not reachable or not available” disposition. You have your 90-day probationary period in order to achieve your numbered goal. We do not expect that you get that goal right away, but we’d like to see improvement as every day goes by. Your screen will be monitored daily by a member of the management team during your 90 days and randomly after your probation.

Best Practice Tips

SMILE: When you smile on a phone call, your voice just sounds warmer, friendlier, and more receptive to the patient on the phone. This might be a lot to ask after a long day or when dealing with a less than cooperative patient, but that may be when you need it the most.

SHOULDER’S BACK AND CHIN UP: While your patients cannot see your posture or attire, confidence can be heard in the tone of your voice and choice of words. A lack of confidence is anything that indicates “I can’t help you”. Always let your patient know that you can do whatever it takes to help them. Monitor your tone of voice and speak clearly.

COPY THAT!: Acknowledgement is a key to communication. You offer the patient reassurance and clarify that you understand what is being said. “I understand” “This must be difficult for you”.

DON’T BE A ROBOT: Checklists are problematic for a number of reasons. They tend to utilize close-ended questions and avoid gathering situational information that could be relevant and ignore the patient’s expectations. When we sound like we are reading from a list it can also be perceived that this call is sales/robo-call as opposed to a medical follow up.

CHANNEL YOUR KATIE COURIC: This woman can give an interview! When you are on a call, keep control but pay attention to what your caller is trying to tell you. Take notice to speech patterns, weird comments and any information that does not fit in the conversation.

USE YOUR LISTENING EARS: Research shows that LISTENING is where struggling comes from phone nursing. We sometimes miss cues for more prevalent information. There are three types of listening.

- **ACTIVE LISTENING:** entails urging the patient to continue and letting him/her know that you are involved in the call. It can be as simple as saying “go on” or “tell me more”.
- **EMPATHETIC LISTENING:** involves taking the patients emotions into consideration and showing that you care about the call and what they are going through at the moment.

In Case of Emergency

If there is a situation that you feel is an emergency (decreased LOC, danger, suicide, etc). Your first line of action is to strongly encourage the patient to call 911 or the doctor's office. Remember, you are a mandated reporter! You cannot keep this to you yourself. The patient's life could be in your hands. You must inform management of the occurrence. Please follow the Emergency Protocol handout for further instructions.

Malpractice Insurance

You are required to purchase malpractice insurance. Insurance is not only important to protect the company, but to protect your nursing license as well. This is nonnegotiable. Although, an up-front cost, a reimbursement will be provided. 50% will be refunded on next pay and 50% refunded in 6 months. Your malpractice insurance should be purchased every year on the anniversary of the purchase. You will be required to produce proof of insurance at that anniversary in order to make calls.

Nursing License

In addition to the protection of insurance, you are required to renew your nursing license every year. It is your responsibility to ensure you are always licensed in order to interact with our patients. It is illegal to practice as a nurse without a license. In the event that your license has not been renewed, calls will be placed on hold until proof of renewal is provided.