



CHRONIC CARE MANAGEMENT



Chronic Care Management Product

- Built by a care management expert physician as a solution for in-between visit care for high risk patients with multiple chronic conditions
- CCM is the only solution needed for a Solo practitioner, Group Practice, MSO's, ACOs, post-acute care—including CCM in long term care—health systems
- Our system supports risk stratification as well as multiple levels of CCM complexity

3 Top reasons to implement Chronic Care Management Service

- CMS recognizes that Chronic Care Management is a critical component of primary care that contributes to better outcomes and higher satisfaction for patients
- There is a great need to invest in primary care and comprehensive care management for chronic conditions
- There is a need for more centralized management of patient needs and extensive care coordination among practitioners and providers



Eligible Patient Module

Care Plan Module



CCM Charting

Billing and financial Module



CCM Features & Benefits

Call Management Module

Allows the practice to create individual campaigns for a single user or multiple users and integrated with cloud based call management module to increase productivity of a care coordinator.

Discrete Time Tracking

Robust “under the hood” time tracking architecture tracks all time spent on CCM in a fully compliant manner. Robust drill down/enhanced reporting is built in, should it be needed for an audit or other purposes. Every care management activity — is time-tracked and pulled into in a robust audit trail that meets Medicare’s 2017 CCM requirements. Practices have access to a robust reporting module where they can check their progress each month. Our team is clinically integrated with the patient’s practice team, and communicates in both informal, episodic ways based on an agreed upon protocol as well as formalized CCM reviews with the practice team each month. At month’s end, practices can easily generate a list of all patients that meet time thresholds. In case of audit, drill down of all time-tracked interactions can easily be shown to the auditor.



Campaign Management



Production Management

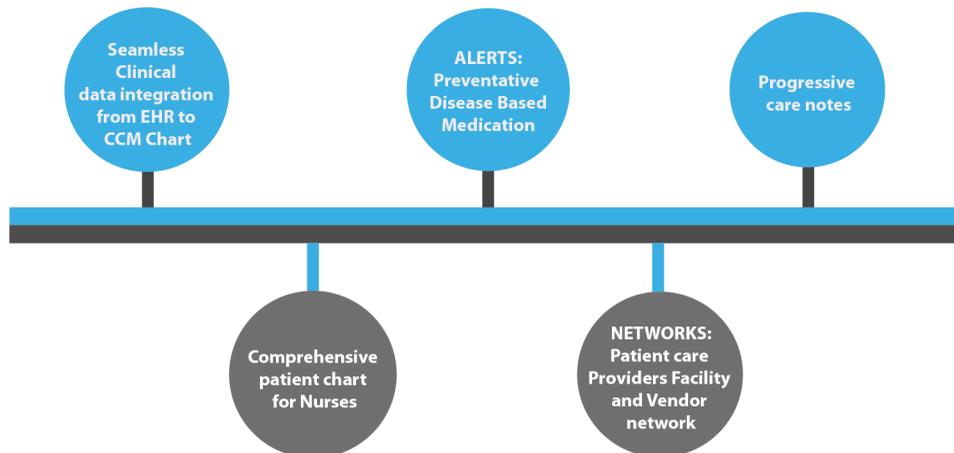


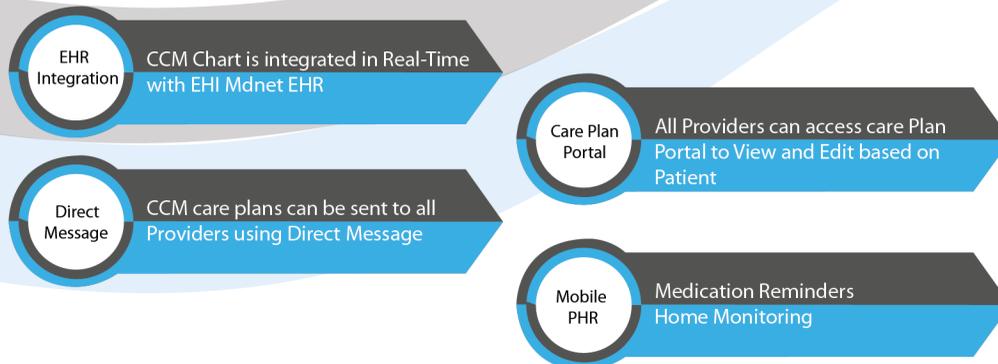
QA Management

Integrated Chronic Care Management Application

CCM chart is connected in Real-Time with Electronic Health Record and provides a comprehensive view for the care coordinators with the view of key disease based indicators and Gaps in care. CCM chart allows the care coordinators to view Disease based protocols based on Patient Chronic conditions and enables them to provide guidance and counseling to patients. CCM Chart is built around each patient that includes connectivity between all stakeholders involved in a patient’s care. Ideal for ACOs and organizations working to build a highly-connected care model.

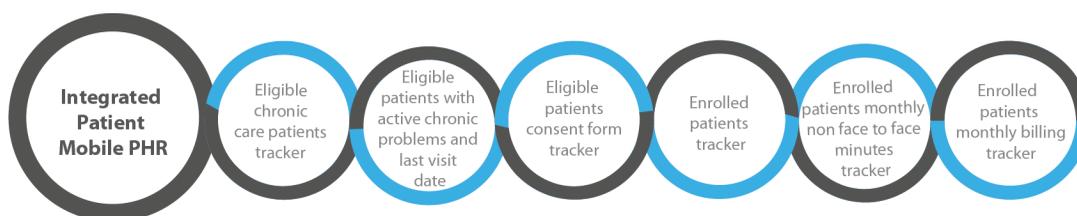
Care Coordinator sets up Patient based goals in consulting with Patients and this unique feature “puts goals in plain sight,” providing an important context of care direction in a patient’s own words. Our easy-to-use patient module is built with simple, one-click buttons, highly readable fonts and graphics, and more patient-friendly functionality.





Eligible Patients Module

Based on two or more chronic conditions expected to last 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation, or functional decline. Based on these conditions our tracker will show all the eligible patients for the practice and allows the practice to enroll and de-enroll the patients in real-time.



Care Plan

Our CCM application module enables a Provider to build customized Patient centered care plan with goals and targets for each Chronic disease after consulting with Patients and those plans are followed by the Care Coordinator during non-face to face calls.

- Integrated beneficiary health record: Comprehensive Patient health record for the Care Coordinator to review Provider assessments and other vital information's
- Beneficiaries goals, barriers and symptoms: Provider builds customized care plans based on Patient chronic condition, and socio economic barriers in consulting with Patients
- Treatment goals: Provider defines customized goals based on Patient lifestyles
- Gaps in Care: Recommended preventative health screenings are fulfilled
- Patient services: Based on State and City a list of available Medicare and Medicaid services are recommended to a Patients

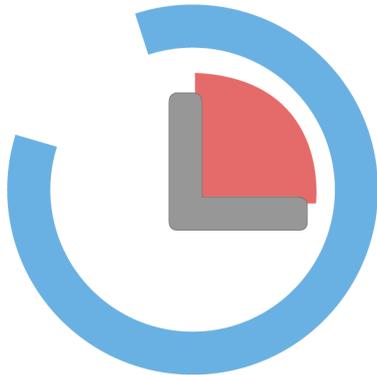


Billing and Financials

Practices can run several analytics on their populations, financial performance, referral patterns, and other metrics. Practice can also track monthly time tracking, activities tracking, gaps in care tracking, TOC visit tracking.

Patient Activity tracking

- Discharge Patients for TOC visit
- Task list for Nurses
- Task list for Patients
- High risk Patient list
- Gaps in Care Patient list
- Appointment reminder list
- Patients require transportation



Time Tracking

- Time spent over the Phone with Patient
- Time spent based on chart review
- Call attempts made to Patient
- Time spent on Nursing notes

Financial Dashboard

- Eligible Patients billed for the month
- Eligible Patients paid for the month
- Eligible Patients by Payers
- Revenue generated by month
- Accounts receivable report
- Nurses production by month
- Rejection and Denied reports



EHI CCM PROGRAM PREPARING DOCTORS FOR MIPS

Four Ways CCM Participation Prepares Doctors for MIPS (Merit-Based Incentive Payment System)
To succeed in both programs overlap in four ways, making it easier for physician practices to participate in MIPS if they're already participating in the CCM program.

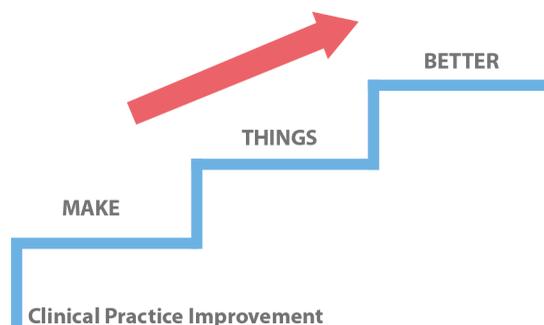
1. Quality measures

In the government's over 2,000-page set of regulations implementing MIPS, CMS published a roster of 271 quality measures from which doctors would choose, collect and report. Of those, CMS tagged 168 as "high priority" measures. 33 measures, including 22 high priority items, are common to the CCM program. Among the common metrics are performing medication reconciliation and following a comprehensive care plan.



2. Clinical practice improvement activities

MIPS regulations listed 93 improvement activities that participating practices could engage in as part of the program. Practices in CCM already would be doing many of those MIPS-sanctioned activities such as providing 24/7 access to clinicians and coordinating care across provider settings.



3. Advancing Care Information

Promotes patient engagement and the electronic exchange of information using certified EHR technology. Practices must optimize and upgrade their EHR systems and IT expertise to capture, aggregate and report the quality measures and other performance metrics required by MIPS. Practices in the CCM program would be doing that as they demonstrate their compliance with that program's requirements in order to get paid.

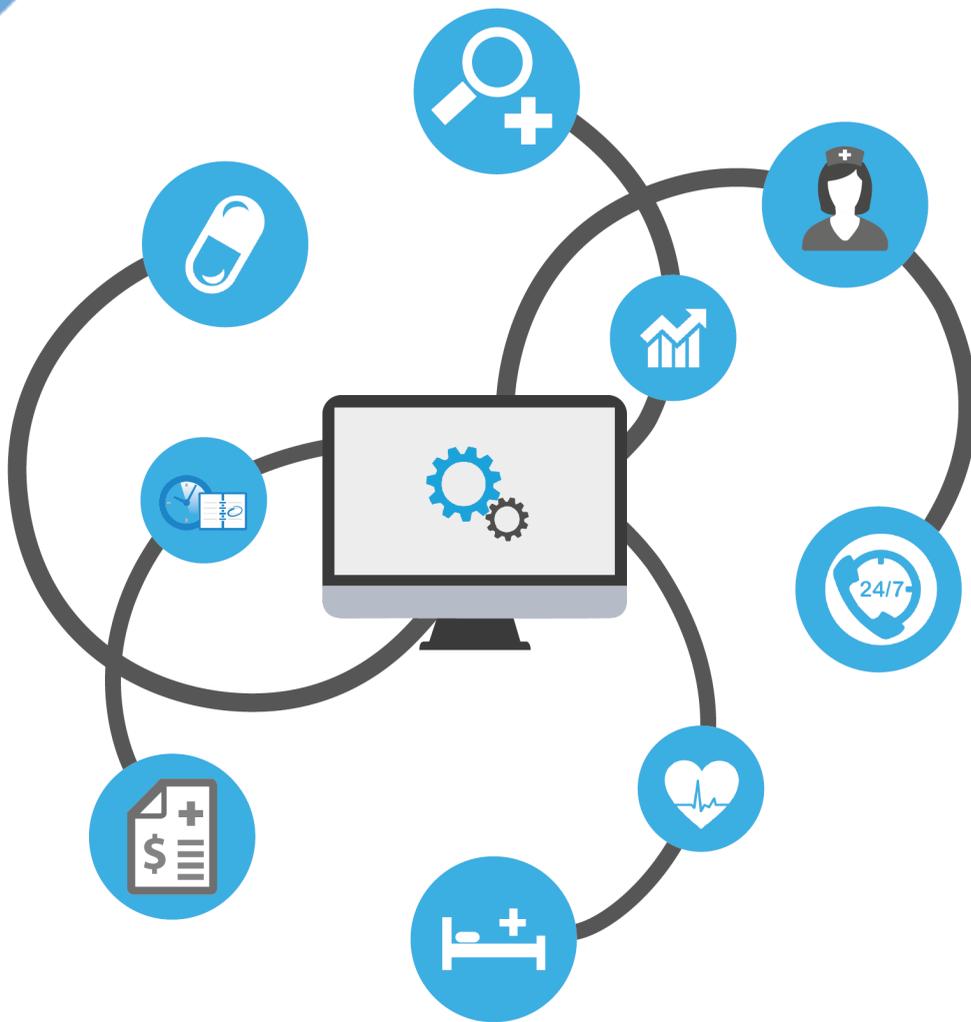


4. Resource use

Although this segment has been postponed, reducing utilization and costs will count for as much as 10 percent of a practice's final score in 2018. One of the goals of the CCM program is preventing avoidable hospital admissions and readmissions. CCM practices do that by providing patient care services that target several leading causes of preventable hospitalizations like poor care transitions and medication adherence.



CCM MANAGED SERVICE



CCM Managed Service

Chronic Care Management (CCM) is a CMS backed program designed to overcome the severe socio economic gaps in care afflicting the Medicare Population. Augmenting your capabilities with new technologies and a personalized nursing staff, CCM brings the patient closer to you. Our nurses act as your extended staff providing services tailored to your patient's needs. Through our monthly calls we increase patient compliance, identify hospital discharges, improve lifestyle conditioning, and more. All while allowing you to focus on managing patient condition and while we provide your patient care coordination outside your office environment. By taking advantage of CCM program, you improve the safety and health standards of your patients while improving your 2017 compliance with MIPS.

- 🔄 24/7 coverage with care coordinators
- 🔄 Our nurses are trained to identify indicators of hospital admission to avoid unnecessary ER and hospitalization visits
- 🔄 Lifestyle oriented protocols to help counsel patients to improve their health over a 1 year period
- 🔄 Medication adherence assistant
- 🔄 Share Care Plan with other care providers
- 🔄 Advanced Mobile Patient Health Portal to communicate and educate patients
- 🔄 Secure Messaging platform to coordinate with Practice and Care coordinator
- 🔄 CCM billing and collections

Practice Benefits



Improve patient experience through providing:

- Priority appointments
- Increase patient visits by identifying patients who have not visited the practice for more than 3 months
- Improve patient compliance by following up on discharged patients and booking Transition of Care appointment within 7 days of discharge from the facility
- Dedicated care coordinator to help patients in socio-economic needs
- Coordinating care between Specialist, Facilities and vendors to help patients fulfill Gaps in Care

Patient Benefits



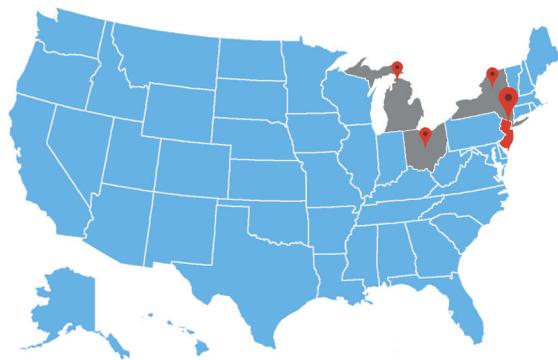
Getting patient needed services like:

- Transportation
- Medication copay assistance program
- Adult day care program
- Home care services
- Home help services

Educating Patients to take advantage of Following Programs:

- Medicare Savings Program
- Medicare Part D Program help
- Medicaid Senior assistant program
- Connecting Seniors to community centers
- Durable Medical Equipment
- Medication assistance program





Email www.ehiconnect.com
Contact 646-442-5468
Web address info@ehiconnect.com

