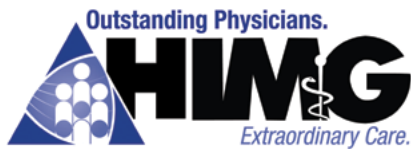


A1c Control in Diabetes

A Chronic Care Management Approach in Primary Care™ | 2018





Introduction

Huntington Internal Medicine Group (HIMG) is an independent, multispecialty health care practice based in Huntington, WV, with approximately 80 providers. A pioneer in the implementation of chronic care management (CCM) services, HIMG has developed a highly successful CCM program and achieved excellent results in treating and managing Medicare diabetes patients with multiple chronic conditions and elevated A1c levels. This white paper will examine how diabetes patients participating in HIMG's CCM program are cared for, with the intention of helping other medical group practices develop, implement, or enhance their own CCM programs for similar patients.

Contents

- 2 Introduction
- 3 Background
- 4 How CCM Works
- 5 HIMG Diabetes Care Plan Development
- 6 Successful A1c Control Among HIMG's CCM Diabetes Patients
- 7 Key Takeaways From HIMG's CCM Program
- 8 Conclusion

Discussion

This white paper highlights HIMG's success in controlling A1c levels among its CCM diabetes patients, and how HIMG develops individualized care plans to manage this population. Elements of HIMG's efforts that are explored include:

- An overview of how CCM works, and the services provided
- Care plan development for HIMG diabetes CCM patients
- A1c control outcomes for HIMG diabetes CCM patients
- Examples of successful diabetes CCM patient interventions
- Key elements HIMG has identified for a successful CCM program
- Considerations underlying financial stability for the program
- Next steps and looking forward

Background

Chronic health conditions are estimated by the Centers for Disease Control and Prevention to affect 117 million adults in the U.S., one-quarter of whom have two or more chronic conditions.¹ The impact of chronic disease on population health and health care spending are considerable: As much as 86% of all health care spending is accounted for by individuals with chronic and mental health conditions.¹

As a result, the Centers for Medicare & Medicaid Services (CMS) implemented reimbursement codes for chronic care management (CCM) services in 2015. The billing codes associated with CCM services allow providers to receive payment for time spent managing Medicare patients with two or more chronic conditions, of which arthritis, cancer, cardiovascular disease, diabetes, and obesity are among the most common.

Given that more than half of HIMG's patient population is enrolled in Medicare, the practice eagerly embraced the CCM program as a means to develop the resources and tools to improve health among this population. Those with diabetes, for example, can benefit from closer attention to medication therapy management and lifestyle factors, which can help overcome obstacles that may impact their ability to engage consistently with providers.

“The CCM program is beneficial in a number of ways. It actually allows us to provide care and services to patients the way we would like, and address their concerns fully at any time. It has taken some of the workload off our staff. But the one who benefits most is the patient, as they have greatly improved access to care.”

—Shawn Coffman, MD

HIMG Patient Population Profile



30,021

Total Unique Primary Care Patients Seen (2016–2017)



1,481

CCM Program Enrollment as of December 2017

Overall HIMG Chronic Disease Burden



6,733

Diabetes Patients Seen (last 12 months)



17,420

Hypertension Patients Seen (last 12 months)



2,264

COPD Patients Seen (last 12 months)

¹ Centers for Disease Control and Prevention. (2017). Chronic Disease Prevention and Health Promotion: Chronic Disease Overview. Retrieved from <https://www.cdc.gov/chronicdisease/overview/index.htm>

How CCM Works

“The patients really appreciate the clinical access. Being able to get their questions answered and their problems solved quickly has added efficiency to the practice. The patients get high-touch personal service. For the physician, with all the new mandates and data that need to be reported, the CCM program allows a practice to add staff for quality patient care and be reimbursed for the associated costs.”

—Terrence Triplett, MD

CCM is non-face-to-face care coordination services provided by clinic staff to Medicare patients who have two or more chronic medical conditions that are expected to last at least 12 months or until the patient's death, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. One provider can bill CMS for 20 minutes of CCM services per patient per month, and 60 minutes for complex CCM services. Complex case add-on services can also be billed.

CCM services can be provided by a physician, nurse practitioner, physician assistant, or clinical staff associated with those practitioners. CCM is typically conducted by primary care providers.

CCM Services That Qualify for Reimbursement

- Use of a Certified Electronic Health Record (EHR)
- Continuity of care with a designated care team member
- Comprehensive care management and care planning
- Reconciliation of medication and allergy lists and working with the patient for compliance
- Coordination with home- and community-based clinical service providers
- Provision of care transition after a hospital or skilled nursing unit discharge
- Twenty-four-hour access to the physician or a member of the physician's care team

EHR as a Critical Component of CCM for HIMG Diabetes Patients

- EHR is required by CMS for CCM reimbursement
- Custom software developed by HIMG takes existing EHR further by integrating patients' medical records with their care plans
- EHR integration with CCM encounter records provides access to detailed patient histories to all providers at any time
- Date- and time-stamping of CCM activities in the EHR and care plan supports the administrative components necessary to document services for CMS reimbursement

Patient Care Stories

“In February 2017, an HIMG CCM patient had an A1c level of 10.1%. She received education on diabetes diet plans and was referred to a dietician. In October 2017, her A1c level was 6.1%. Guidance and education drastically changed her outcome.”

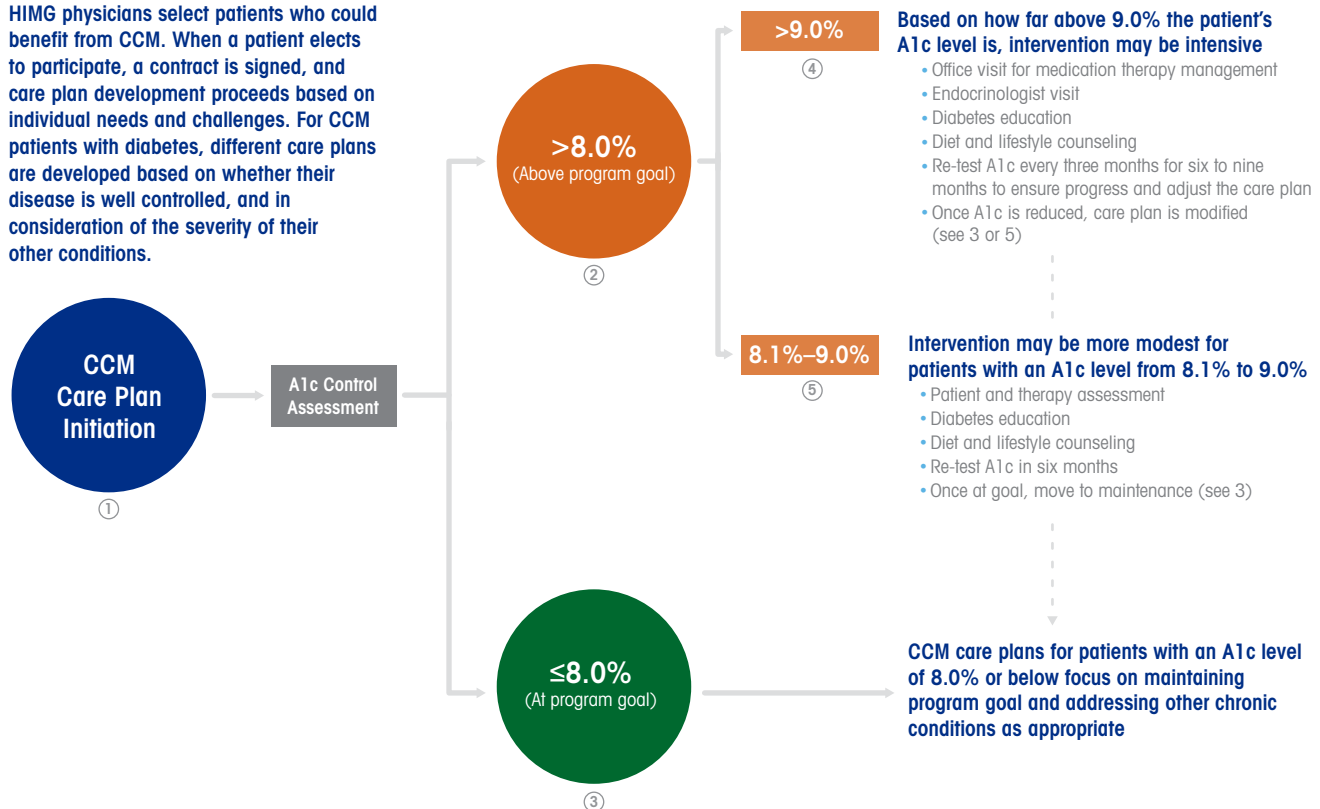
—Jennifer Casey, LPN

HIMG Diabetes Care Plan Development

HIMG's physicians have long-standing relationships with patients who have diabetes in addition to other chronic conditions. Their evaluation of candidates for the CCM program focuses on criteria such as whether patients are non-compliant, have frequent questions or ongoing concerns, or have recently been hospitalized. Once enrolled, CCM plans are then individually tailored and modified as patterns of patient response are established.

CCM Care Plan Considerations for A1c Control

HIMG physicians select patients who could benefit from CCM. When a patient elects to participate, a contract is signed, and care plan development proceeds based on individual needs and challenges. For CCM patients with diabetes, different care plans are developed based on whether their disease is well controlled, and in consideration of the severity of their other conditions.



"In March 2017, one of HIMG's CCM patients had an A1c level of 16.5%. In January 2018, her A1c level was 9.2%. Further, her blood sugar level at the outset was 495 mg/dL, and by January 2018 had dropped to 170 mg/dL. After 10 months of education on diet and lifestyle, as well as improved medication therapy compliance, she is now functioning at a higher level."

–Sarah Fuller, LPN

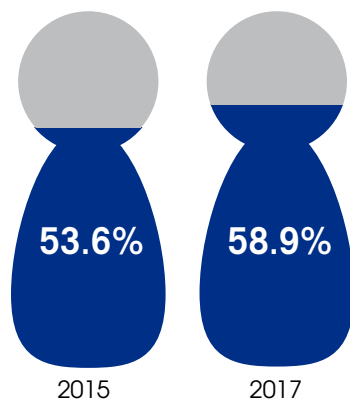
Successful A1c Control Among HIMG's CCM Diabetes Patients

HIMG had 401 diabetes patients who participated in its CCM program from 2015 through 2017. As of December 2017 (58.9%), the share of these patients with an A1c level of $\leq 7.0\%$ was 5.3 percentage points greater than in January 2015 (53.6%).

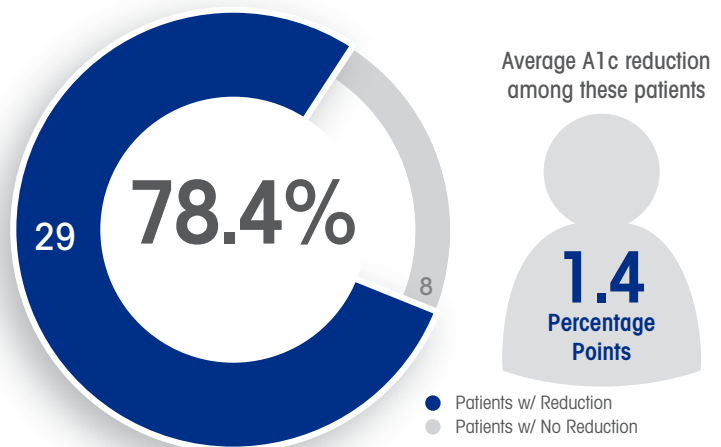
Further, 78.4% of HIMG CCM diabetes patients with an A1c level higher than 9.0% in January 2015 achieved a reduction by the end of 2017. During this period, the overall percentage of HIMG CCM diabetes patients with an A1c level above 9.0% decreased from 9.2%, to a notably low 7.0%.

HIMG CCM Diabetes Patients with an A1c Level of $\leq 7.0\%$ or $>9.0\%$

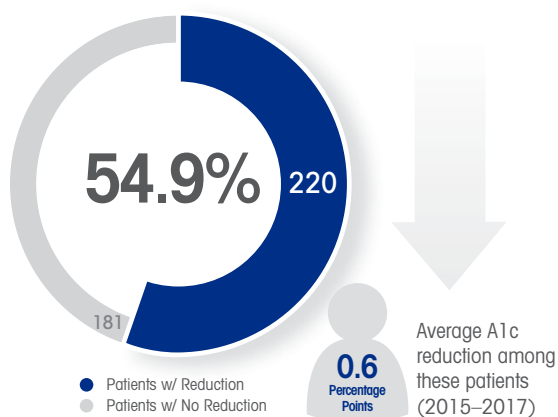
Percentage of Patients
With an A1c $\leq 7.0\%$ From 2015 to 2017



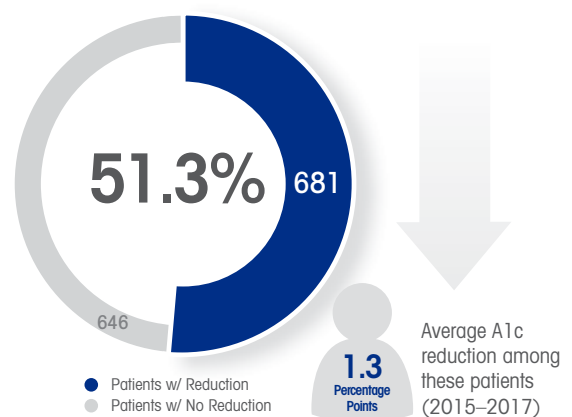
Number and Percentage of Patients With an A1c $>9.0\%$
Who Had an A1c Reduction From 2015 to 2017



HIMG CCM Diabetes Patients Overall



HIMG Diabetes Patients Age 65+ Overall



Data source: HIMG © 2018

Key Takeaways From HIMG's CCM Program



Relationships

According to HIMG Primary Care Manager Jonna Hughes, the most important factor in the success of the practice's CCM program is the relationship that CCM nurses establish with patients and their families. Regular monthly contact builds a rapport that patients do not typically achieve with physicians, leading to additional insights and interventions.



The Right People

CCM nurses need to have a depth of experience with multiple chronic conditions, usually attained only after several years of practice. These nurses must also be able to embrace the potential they have to influence patient care on a large scale. Of all the elements required for a successful CCM program, HIMG learned that scaling up their care manager nursing team was the most difficult to achieve.



Information Technology Investment

HIMG's information technology team developed its own software to interface with the practice's electronic health record (EHR) in order to establish time- and date-stamped encounter data for each patient contact. The software also contains the patient's history, and CCM program elements, such as care plans and suggested testing protocols. Such an investment is not mandatory for successful CCM. However, HIMG concluded that it would support scale-up and reduce administrative burdens.



Physician Involvement

As with any clinical-care improvement initiative, physician buy-in is crucial to allocate the financial resources and time required to implement a CCM program. At HIMG, the improvements in patient outcomes and provider quality scores achieved by its physician champion paved the way for unanimous acceptance throughout the practice.



Sustainability

For a CCM program to be successful, it must be at least revenue neutral. HIMG's CCM financial considerations, detailed below, indicate that program sustainability is achievable.

Achieving Sustainability in CCM

CMS reimburses for **20** minutes of care per patient per month.



At HIMG, reimbursement averages **\$37.05** per patient per month (PPPM); complex patients average **\$67.01** PPPM.

One LPN can engage with up to **200** patients per month.



HIMG billed **12,657** CCM codes from January to October 2017.



HIMG realized **\$465,253** in CCM revenue from January to October 2017.



Additional revenue is realized from walk-in visits, ancillary testing and other services for CCM patients.

Savings in overall health care spending from more **effective disease management**.





Conclusion

Since implementing its CCM program in 2015, HIMG has achieved notable improvements in A1c levels for CCM patients who have diabetes in addition to one or more other chronic conditions.

Moving forward, HIMG's focus in 2018 is the implementation of new tools to evaluate overall patient risk scores in order to further refine their ability to identify patients with the highest needs. The intent is to support broader population health management by more effectively allocating resources.

HIMG also is working to engage more complex patients in its CCM program, particularly those receiving specialty care treatment. Together, these efforts will greatly expand the number of patients with whom HIMG can interact and further its ability to improve patients' health and lives.