Chronic Care Management (CCM)

The Challenge

Six in 10 Americans live with at least one chronic disease like heart disease, stroke, cancer and diabetes.[1] Chronic diseases lead the causes of death and disability in the United States, and they also drive the nation's 4.1 trillion-dollar annual healthcare costs.[2] Our review of Medicare Fee-for-Service Emergency Department visits shows that many multi-visit patients have chronic conditions like diabetes and hypertension as a secondary diagnosis for many visits.[3]

The Idea

Chronic Care Management (CCM) is a value-based Medicare program to improve care coordination for patients with two or more chronic conditions with significant risk factors. Comprehensive care planning, medication management, community services and health education are included along with care transition support. Patients receiving CCM typically have higher satisfaction rates regarding their care.[4] CCM reimburses providers for coordinating services beyond regular office visits for qualifying patients.

Impact

In addition to increased reimbursement (CCM Revenue Estimator), providers implementing CCM see their patients visiting the hospital less frequently, with more engagement, better medication management and overall improved satisfaction.

For example, a small rural medical center in southwest Virginia engaged its pharmacist to implement CCM (see HQIN's CCM Toolkit) with approximately 58 participating patients. They consistently report that 80-90% of their patients have shown improvement in their conditions, primarily diabetes and hypertension, since beginning CCM.

[1] Chronic Disease Center (NCCDPHP) | CDC
[2] About Chronic Diseases | CDC
[3] How Medicare's Chronic Care Management Works (verywellhealth.com)
[4] Community Health Outcomes and Characteristics | HQIN

Steps for Implementation

1. Obtain leadership support.
2. Identify a champion.
3. Develop a plan and form your care/delivery team.
4. Identify, market and recruit eligible patients.
5. Enroll your patients.
6. Deliver CCM and engage patients.
7. Code, bill and receive reimbursement.
8. Continually evaluate successes.

Tips for Success

- Start with one staff member and one patient/client.
- Discuss the process with the larger team to share tips and successful approaches.
- Use different phrases to help patients know your intent/approach.
- Know when to involve an interpreter.
- Use various learning tools to accompany your conversation (pictures, large print, videos) (ensure that materials are no higher than a fifth-grade level).
- Involve a family member of the patient.

Resources

Chronic Care Management Toolkit | HQIN

CCM Revenue Estimator

Chronic Care Management Toolkit

MLN909188 – Chronic Care Management (cms.gov)

Put new ideas to work in your community:

CCM is one of several care transition interventions highlighted in HQI's Ideas That Work series. To explore other strategies for strengthening care coordination activities in your community, check out our YouTube Playlist and the HQIN Resource Center.

This material was prepared by Health Quality Innovators (HQI), a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW/HQI/QIN-QIO-0790-05/15/24