# Implementation of chronic care management services in a patient-centered medical home

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## Chronic Disease Management in the Elderly

- In 2010, over two-thirds of Medicare beneficiaries were reported to have two or more chronic conditions. Of these, 14% had six or more.[1]
- Studies report a significantly greater number of hospitalizations, readmissions, and overall Medicare spending in relation to patients with a greater number of chronic conditions.[1]
- Adherence to medications is a major factor in managing chronic conditions safely and effectively, especially in the geriatric population.[2]
- Pharmacists are well-positioned to address and improve adherence.

## Chronic Care Management (CCM)

- Created by Centers for Medicare and Medicaid Services in January 2015
- Recognized as a critical component in the practice of primary care that contributes to improved control of chronic diseases and reduced spending
- Billable, 20-minute, non-face-to-face coordination of care services
- Any "clinical staff" can provide the service under general supervision
- Eligible patients include patients with ≥2 chronic disease states[3]
- Requires that a care plan be documented electronically in the patient's medical record, as well as be provided to the patient

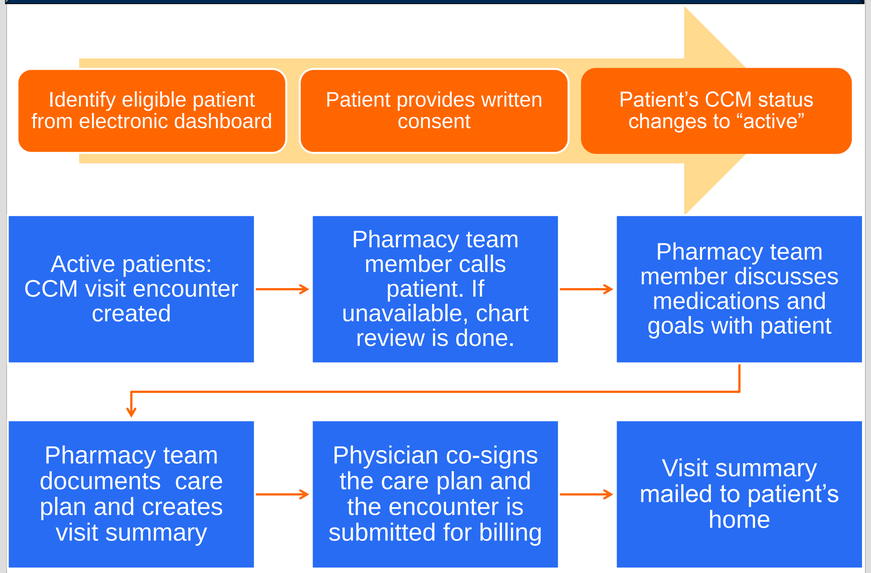
## Clinic Description

- Rosa Parks Wellness Institute for Senior Health (RP-WISH), a patient-centered medical home (PCMH) within an academic medical center
- Serves a population of over 3000 patients ages 60 and older
- Interdisciplinary practice involving geriatricians, physician specialists, nurse practitioners, nurses, pharmacists, and a social worker
- Pharmacy team includes pharmacy residents and pharmacy students

## Key Steps for Implementation

1: Select patient pool that will receive the service → 2: Design workflow to meet CCM requirements → 3: Designate roles to clinic staff to promote efficiency

## CCM Service Workflow at RP-WISH




- Visit summary includes: pertinent laboratory values, health status, up-to-date medication list, self-care management goals, and dates/times of future appointments with healthcare providers

## Using CCM to Improve Quality of Care

- Scope of interventions provided during CCM phone call or chart review:

| Medication discrepancies identified and resolved | Barriers to adherence identified and addressed | Health maintenance needs reviewed | Diet and lifestyle coaching provided |
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## Current Status and Future Direction

- Initiated service in August 2015. To date, there are 151 patients enrolled.
- Plan to begin analyzing outcomes in Summer of 2016
- Expected impact:

| Clinical Outcomes | Health Maintenance | Cost |
|---|---|---|
| • Improved blood pressure control<br>• Improved hemoglobin A1c<br>• ↓Emergency department (ED) visits | • Improved medication adherence<br>• ↑Medicare Annual Wellness Visits<br>• ↑Health screenings<br>• ↑Vaccination rates | • Revenue to the clinic<br>• Cost avoidance (i.e. ED visits) |

## References

1. Chronic conditions among Medicare beneficiaries. Centers for Medicare and Medicaid Services. 2012.
2. Berg JS, Dischler J, Wagner DJ, Raiaa JJ, Palmer-Shevlin N. Medication compliance: a healthcare problem. Annals of Pharmacotherapy. 1993;27(suppl):S5-S24
3. Chronic Care Management Services. Department of Health and Human Services Centers for Medicare and Medicaid Services. May 2015.