ChronicCareIQ
SUCCESS WITH CCM

Bowie Internal Medicine

How one practice rebooted its CCM program with ChronicCareIQ and is reaping the benefits

Dr. James Wang, MD is a strong advocate of preventive medicine and cares for many patients with diabetes and cardiovascular disease. He realized how his patients struggling with chronic disease could benefit from chronic care management, so when CMS introduced the CCM reimbursement program in 2015, he was in.

Dr. Wang practices with Bowie Internal Medicine, which has been serving its Maryland community right outside of Washington, DC for over 40 years. As a group of four physicians and two certified nurse practitioners specializing in gastrointestinal, adolescent, adult, and geriatric medicine, they see many patients with multiple chronic conditions.

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"We were very early adopters of the chronic care management program and had a lot of patients excited about the benefits," says Dr. Wang. The practice successfully enrolled many patients right off the bat, who thought the program was "cool," but after just six months most of them dropped out.

A GREAT IDEA GONE WRONG

"We were trying to go through the motions as best we could and had to treat these patients episodically," notes Dr. Wang. As the practice struggled to manage compliance, risk, and patient transitions while tracking staff time and billing, neither the patients nor the staff were seeing any benefits. As Dr. Wang sums it up: "We were using 1970s thinking with 2000s technology."

The entire team was committed to improving the care and outcomes for their many patients with multiple chronic conditions and worked very hard to put it all together. Without appropriate technology to facilitate patient communications and manage the data, it ended up being a tremendous burden on the staff.

The Medical Assistants were responsible for calling each and every CCM patient just to check in and see how he or she was doing. Unfortunately, the staff spent a lot of time making calls that went unanswered, and many patients felt the calls were unnecessary and even annoying.

A typical scenario for patients who have multiple chronic diseases without effective CCM is one in which they bounce in and out of the emergency room. For example, a patient experiences a spike in blood pressure, ends up in the ER, and after a few hours, the patient most likely is sent home with medication and instructions to follow up with their physician. This scenario does not support optimal patient care and is costly. Bowie Internal Medicine was still seeing this scenario play out despite CCM implementation.

CHRONICCAREIQ FITS THE BILL

It was evident manual CCM was not working, so the practice began evaluating other solutions. One of these solutions was ChronicCareIQ. According to Tiana Proctor, who's been running the CCM program for two years, "It got to the point where we had to find some way to keep the program viable or we would have to discontinue it

– once we saw ChronicCareIQ, our decision was set in stone."

ChronicCareIQ is a chronic care management solution that automates and facilitates the CCM data collection and reimbursement process and works with every EHR. As a turnkey system, the platform is simple to implement, customizable, user-friendly, and results in rapid ROI.

Patients can easily participate through an app, email, text, computer or whatever they're comfortable with. The data it collects is displayed on a color-coded dashboard that helps staff identify poorly trending patients or those that have crossed clinical thresholds. It simultaneously keeps robust audit and compliance logs and produces a monthly billing report of services to be submitted to CMS for reimbursement.

"With Chronic Care IQ, it's easy for patients to answer a few simple questions and that data gets pushed directly to us. We can get out in front and help break the typical cycle of hospitalization in today's healthcare model," says Dr. Wang.

Rather than just calling patients off a list without knowing upfront who may have a problem, the ChronicCareIQ dashboard enables clinical staff to prioritize calls and get in contact with those patients who are at risk and need medical attention. Patients are more receptive to a phone call, because they know it means there is an issue.

"Before, ChronicCareIQ, patients would decide to just go to the ER," says Tiana. "Now, we can use the data we've received from them to identify and proactively reach out those who need attention – we can adjust medications, 'talk them off the cliff', or bring them into the office for evaluation instead of the hospital."

WIN-WIN RESULTS

"It is definitely the best thing we have seen for managing chronic patients efficiently and easily capturing the time and compliance pieces for reimbursement," exclaims Tiana, "plus the patients all tell me how appreciative they are of the service."

"Today we have greater enrollment, better documentation, more reimbursement, and can now provide better care. It's a win."

"We have 're-booted' the program with the ChronicCareIQ system because patients actually like the way we collect their information and have come back into the CCM program with renewed optimism," says Dr. Wang. "Today we have greater enrollment, better documentation, more reimbursement, and can now provide better care. It's a win."

ChronicCareIQ

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ChronicCareIQ, the industry leader in patient engagement and disease management platforms, enables healthcare providers to keep tabs on fragile and chronic patients through their smart phones. Now reimbursed by Medicare, you'll generate significant net new monthly recurring revenue, automatically meet compliance requirements, and measurably reduce call volumes. Identified as a "Best Practice" by leading consulting groups and with patient engagement rates that exceed 80% on an average weekly basis, your practice, hospital, or health system can identify decompensating patients in real time, manage risk to prevent unnecessary hospitalization or ED visits, and advance material steps with payment reforms. Visit us at ChronicCareIQ.com

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