

# Reflecting on Our Homework: Kick-off Call Review

Let's revisit the key actions from our last call:

- Secure 5 new patient enrollments.
- Implement EMR flagging for all CCM patient enrollments.
- Review and understand your organization's sliding scale policy.

**Let's discuss: What challenges did you encounter, and what successes did you achieve?**

# Chronic Care Manager Daily Workflow & Productivity Checklist

For Onboarding and Ongoing CCM Staff



## The Day Before

- Review the next day's clinic schedule for patients with 2+ chronic conditions.
- Flag potential new CCM enrollees—especially:
  - Patients with multiple office visits in the past 6 months
  - Recent hospitalizations or ED visits
  - High-risk chronic conditions (e.g., CHF, diabetes, CKD)
- Prepare and print CCM consent forms for flagged patients.
- Deliver consents to the front desk team for check-in packets.
- Message providers or medical assistants to alert them about enrollment opportunities.



## Morning of Clinic Day

- Participate in the morning huddle with front desk, MAs, and providers.
  - Go over flagged patients for possible enrollment.
  - Clarify workflow roles (e.g., who discusses CCM with patient).
- Confirm consents are staged and ready at the front desk.
- Watch for walk-ins or unscheduled high-risk visits to enroll.



## Daily Productivity Expectations

- ◆ New CCMs: Goal = 5 patients per day, start to finish, with full documentation review.
- ◆ Experienced CCMs: Goal = 10 patients per day.

Each patient should be worked from start to finish including:

- Review last chart note and provider communication
- Check if any urgent tasks are outstanding:
  - Was a new medication prescribed? Did the patient pick it up?
  - Was a follow-up appointment recommended but never scheduled?
  - Were referrals, labs, or imaging ordered but not completed?
  - Did the staff fail to reach the patient for a follow-up? If so, try again.



## Ongoing Patient Review Tasks

- Check if the patient has completed their Annual Medicare Wellness Visit. If not:
  - Call to encourage scheduling
  - If unreachable, send a follow-up letter
- Follow the CCM checklist:
  - Complete or update care plan
  - Review provider-guided goals and set patient-centered goals
  - Update specialist involvement and referrals
  - Update problem list in EMR
  - Conduct medication reconciliation:
    - With patient by phone
    - In person during clinic visit
    - Or via call with pharmacy if needed

# Chronic Care Management (CCM) Checklist:

Insurance: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Chronic Diagnosis(es): \_\_\_\_\_

Date of Last Medicare Wellness Visit (MWW): \_\_\_\_ / \_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Attributed to ACO: Yes or No

## CCM Workflow Checklist

Please check each item as completed:

- CCM Enrollment - Send Welcome Letter and Annual Anniversary Letter
- Provider Review - Ensure provider has reviewed and approved the problem list.
- Care Plan Review & Distribution - Review with patient and mail a copy of the care plan
- Referrals & Prior Authorizations - Follow up on referrals
  - Manage medication and diagnostic imaging prior authorizations
- Care Plan Creation - Develop and document care plan (minimum twice per year via phone call)
- Care Plan Review & Distribution - Review with patient and mail a copy of the care plan
- Gaps in Care Review - Conduct review one month prior to the Annual Wellness Visit
- Medication Reconciliation - Complete **three times per year for high-risk patients**
  - May be conducted via phone (with pharmacy or patient) or in person
  - Include all prescribed and over-the-counter medications
- Hospital Transition of Care - Immediate follow-up required post-discharge
  - Send Hospital Discharge Care Plan
- Quality Care Monitoring - Review lab results and maintain regular patient contact (Diabetic education, reviewing blood sugar logs or blood pressure log with patient)
- Continuation of Care - Obtain external records (e.g., imaging, consult notes) via call or print

# CCM New Enrollment Template

- **Date of Consent:**
- **Consent Form Scanned (Y/N):**
- **Verbal Consent Documented (Y/N):**
- **Last Medicare Annual Wellness Visit Date:**
- **Most Recent Relevant Lab Results:**

## Patient-Centered Care Plan

- **Care Plan Creation Date:**
- **Provider Responsible for Care Plan:**
- **Chronic Conditions (as documented in EHR):**
- **Patient-Centered Goals & Objectives:**

## Care Team & Support Services

- **Primary Care Provider (PCP) Name:**
- **Assigned Care Coordinator:**
- **Key Planned Interventions:**
- **Upcoming Care Coordinator Contacts:**
- **Upcoming Scheduled Lab Work:**
- **Next Scheduled Appointments (General):**
  - **Specialists Consulted (Name & Next Appointment Date):**
- **Current Medication List (as documented in EHR):**

Initiate patient contact to detail the CCM program and establish a preliminary care plan. Send a Welcome letter and the patient's individualized care plan via mail within the first month of enrollment.

# Chronic Care Management Program – Medication Reconciliation Template

## Patient Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ MRN: \_\_\_\_\_

Date of Medication Review: \_\_\_\_\_

Care Coordinator: \_\_\_\_\_

## Type of Encounter

- Phone call with patient
- Phone call with pharmacy
- In-person visit with patient (medications brought to visit)

## Medication Review Summary

Instructions: List all medications currently prescribed, verify with the patient or pharmacy, and indicate any discrepancies or issues.

Medication Name	Dosage	Frequency	Prescribing Provider	Patient Taking as Prescribed?	Notes / Discrepancies

## Medications Not Taken as Prescribed

List any medications the patient is not taking as prescribed, with explanation (e.g., side effects, affordability, confusion):

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## Medications No Longer Taken

List any medications the patient has stopped taking and reason:

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## Pharmacy Contact (if applicable)

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

Date Contacted: \_\_\_\_\_

Spoke With: \_\_\_\_\_

Notes from Pharmacy Discussion:

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## Care Coordinator Notes & Follow-Up

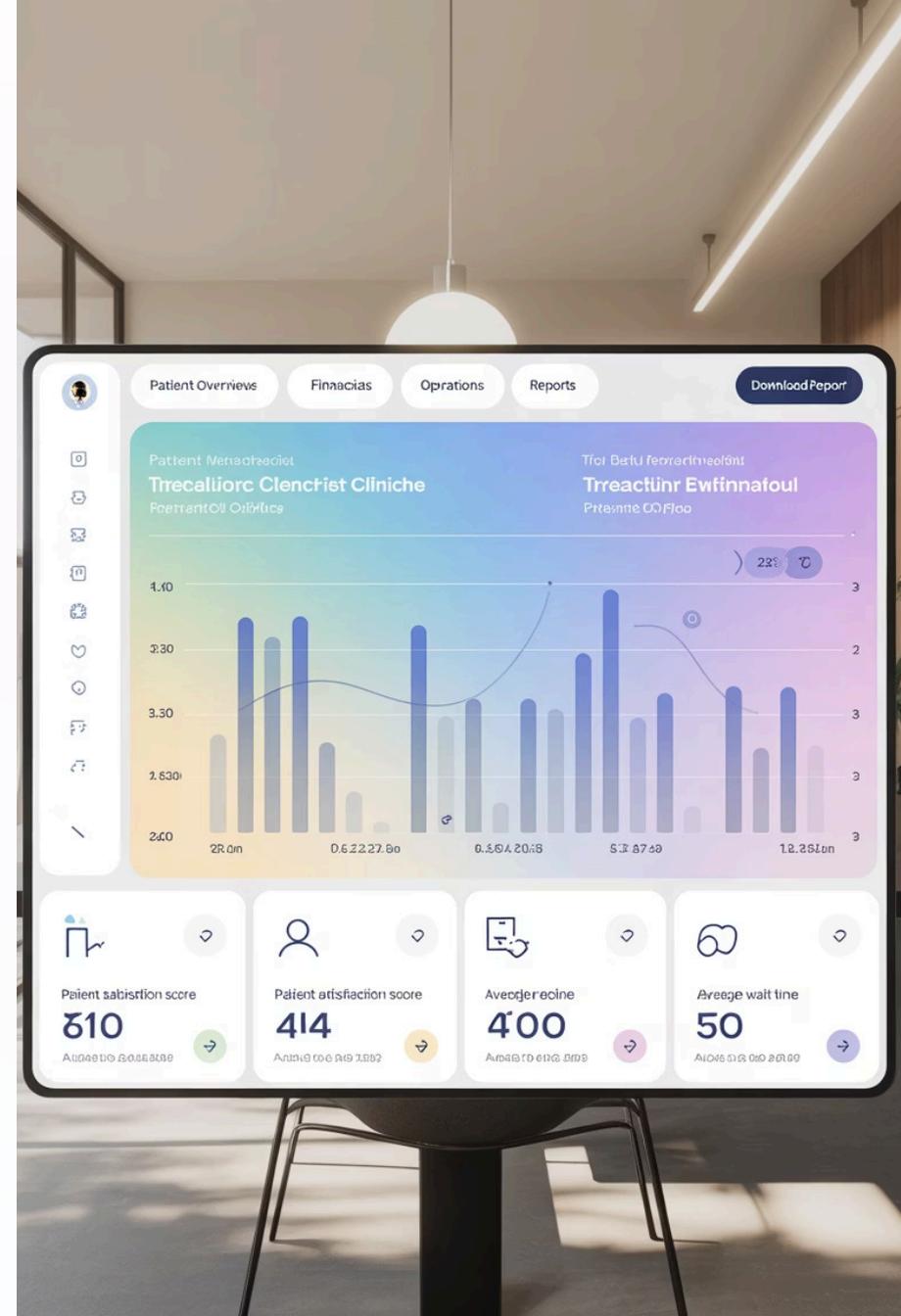
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Follow-up Actions Required: \_\_\_\_\_

# Using Data to Drive Stronger CCM Programs

Transforming care coordination through strategic measurement and actionable insights for rural health clinic leaders



# Data Isn't About Spreadsheets — It's About Strategy

## Strategic Vision

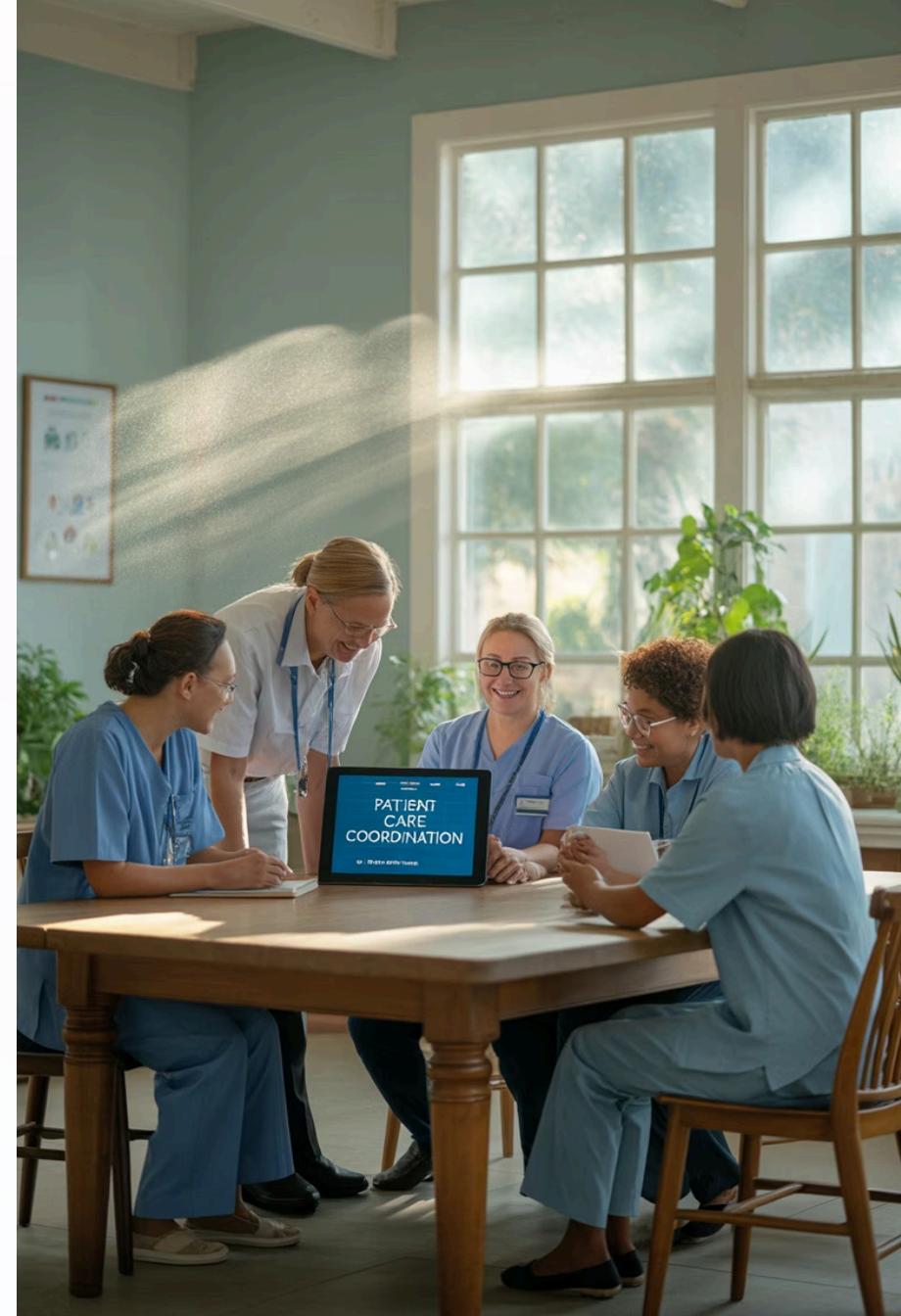
Data transforms CCM from a checkbox program into a revenue-generating, patient-improving cornerstone of your practice

## Simple Tools

Rural health clinics don't need expensive analytics platforms — you need focused questions and consistent tracking habits

## Clear Visibility

CCM success depends on visibility into enrollment patterns, care gaps, and financial opportunities hiding in plain sight



# Know Your Baseline: CCM Enrollment Rate

"You can't grow what you can't measure."

Most rural clinics enroll only **10–20%** of eligible Medicare patients in CCM programs. Yet CMS data shows that **70% of Medicare patients** actually qualify for chronic care management services.

## Benchmark Goals

- **Short-term target:** 25–30% enrollment
- **Long-term goal:** 50%+ enrollment
- **Excellence standard:** 60%+ enrollment

01

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## Count Total Patients

Medicare + Medicare Advantage patients in your practice

02

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## Count CCM Enrollees

Current patients actively enrolled in your CCM program

03

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## Calculate Your Rate

$\text{Enrolled} \div \text{Total Eligible} \times 100 = \text{Your enrollment percentage}$

# The Revenue Reality: What You're Missing

**\$62**

**Monthly Revenue**

Per enrolled CCM patient

**\$744**

**Annual Value**

Per patient per year

**\$74K**

**Missed Opportunity**

100 unenrolled eligible patients

CCM represents one of the few programs that allows rural health clinics to generate significant revenue *without requiring additional patient visits*. This recurring monthly revenue can justify hiring additional care coordinators, investing in practice management software, and demonstrating clear ROI to clinic leadership.

✔ **Quick Exercise:** Multiply your eligible-but-unenrolled patients by \$62, then by 12 months. That's your annual missed revenue opportunity sitting in your patient database right now.



# Daily Operations: Your CCM Dashboard

## Daily & Weekly Tracking

### Patient Outreach Pipeline

Patients due for monthly check-ins, care plan updates, or initial enrollment calls

### Coordinator Productivity

New enrollments per care coordinator to identify training needs or capacity issues

## Monthly Reporting

- **Enrollment trends:** Are you growing consistently?
- **Disenrollment patterns:** Why are patients dropping out?
- **Outreach conversion:** How many calls result in enrollments?
- **Panel management:** 100–150 patients per full-time coordinator

Start with Excel or your EHR's built-in reporting tools. You don't need expensive business intelligence software to answer the questions that matter most to your clinic's success.

# Predictive Analytics: From Reactive to Proactive

Once you establish consistent tracking habits, you can shift from responding to problems to preventing them. Use your existing data to identify high-value enrollment opportunities and care gaps before they become expensive complications.



## Frequent ER Utilizers

Target patients with 2+ emergency visits in 6 months for immediate CCM outreach and intensive care coordination



## High-Risk Diagnoses

Prioritize patients with CHF, COPD, diabetes, or multiple chronic conditions for proactive enrollment



## Care Gap Indicators

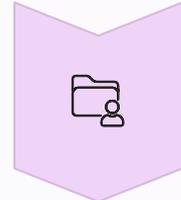
Flag patients with missed appointments, overdue labs, or medication adherence issues





# Building Your Risk Stratification Framework

Risk stratification is the systematic process of identifying patients who are most likely to benefit from proactive chronic care management. It shifts your clinic from reactive care to preventative interventions, optimizing resources and improving patient outcomes.



## Data Aggregation

Combine clinical, demographic, and claims data.



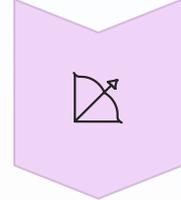
## Risk Assessment

Use algorithms to predict future health events.



## Patient Stratification

Segment patients into low, moderate, and high-risk groups.



## Targeted Interventions

Tailor care plans and outreach based on risk level.

# The Four Pillars of CCM Risk Assessment

Effective Chronic Care Management relies on a holistic understanding of each patient. By integrating data from these four critical areas, clinics can build a robust risk stratification framework to identify and support those who need it most.



## Clinical Data

Key information including diagnoses, active medications, lab values, and chronic conditions to paint a picture of medical complexity.



## Utilization Patterns

Insights into past healthcare usage such as emergency room visits, hospitalizations, and referrals to specialists, indicating high-cost episodes.



## Social Determinants of Health (SDOH)

Non-clinical factors like transportation barriers, housing instability, food insecurity, and social isolation that profoundly impact health outcomes.



## Behavioral Factors

Patient behaviors like medication adherence, appointment compliance, and lifestyle choices that influence disease progression and management.



# Clinical Data Points That Matter Most

Beyond broad categories, specific clinical indicators in a patient's record provide critical insights for precise risk stratification. These data points allow your clinic to pinpoint patients who are at the highest risk for adverse events and would benefit most from proactive chronic care management.

## High-Risk Diagnoses

- **Chronic Heart Failure (CHF):** Patients with frequent exacerbations or recent hospitalizations for cardiac events.
- **Chronic Obstructive Pulmonary Disease (COPD):** Persistent symptoms, frequent rescue inhaler use, or history of acute respiratory events.
- **Diabetes with Complications:** Presence of neuropathy, nephropathy, retinopathy, active foot ulcers, or consistently poor glycemic control.
- **Multiple Chronic Conditions:** Patients managing three or more interacting chronic conditions, increasing overall complexity and risk.

## Lab Value Red Flags

- **HbA1c >9%:** Indicates uncontrolled diabetes, signaling a high risk for long-term complications and immediate intervention needs.
- **eGFR <30 mL/min/1.73m<sup>2</sup>:** Represents severe kidney dysfunction (CKD Stage 4/5), requiring urgent and specialized management.
- **Uncontrolled Blood Pressure:** Consistent readings of >140/90 mmHg, significantly elevating cardiovascular risk and highlighting inadequate management.
- **Elevated LDL Cholesterol:** Levels consistently above target despite lifestyle or medication interventions, increasing atherosclerotic disease risk.

## Medication Complexity

- **Polypharmacy:** Patients concurrently taking five or more prescription medications, increasing the risk of adverse drug interactions and non-adherence.
- **High-Risk Medications:** Use of medications such as opioids, anticoagulants, or high-dose insulin, which require careful monitoring due to their narrow therapeutic index or significant side effects.
- **Frequent Medication Changes:** Multiple adjustments to medication regimens within a short period, potentially indicating instability in chronic condition management or difficulty achieving therapeutic goals.
- **Non-Adherence History:** Documented patterns of missed doses, refills, or appointments related to medication, leading to uncontrolled conditions.

# Utilization Patterns: Reading the Warning Signs

Patient utilization data provides crucial insights into health stability and care gaps. Monitoring these patterns allows clinics to proactively identify individuals at high risk, enabling timely interventions and preventing costly adverse events before they escalate.

-  **Emergency Department Usage**  
Frequent ED visits (e.g., 2+ in 6 months) are often a red flag for uncontrolled chronic conditions, inadequate primary care access, or unaddressed social determinants of health.
-  **Hospital Readmissions**  
Unplanned readmissions within 30 or 90 days indicate potential care gaps post-discharge, insufficient care coordination, or a decompensating underlying condition.
-  **Specialist Referrals**  
Patients seeing multiple specialists without clear coordination or having frequent visits highlight fragmented care that could lead to medication conflicts or missed diagnoses.
-  **Primary Care Gaps**  
Missed primary care appointments or overdue preventive screenings (e.g., mammograms, colonoscopies, annual physicals) suggest patient disengagement or barriers to essential care.

## Hospital Admissions



## Emergency Room Visits



# Social Determinants: The Hidden Risk Multipliers

In rural health settings, social determinants of health (SDOH) significantly amplify health risks, often overshadowing clinical factors. Addressing these non-medical elements is crucial for effective chronic care management, as they profoundly impact patient access, adherence, and overall well-being.

## Transportation Barriers

Long distances to healthcare facilities, limited or non-existent public transportation, and personal vehicle issues prevent rural patients from accessing essential appointments, pharmacies, and specialist care. This often leads to missed appointments and delayed interventions.

- **Challenge:** 45-minute drive to nearest clinic.
- **Impact:** Irregular follow-ups for chronic conditions like diabetes.

## Economic Factors

Lower average incomes, fewer job opportunities, and higher rates of uninsured or underinsured individuals in rural areas create financial strain. This impacts a patient's ability to afford medications, healthy food, and necessary medical supplies.

- **Challenge:** High out-of-pocket costs for prescriptions.
- **Impact:** Patients skipping medication doses to save money.

## Social Isolation

Geographic remoteness, an aging population, and dispersed communities can lead to significant social isolation. Lack of family support or community networks affects mental health, medication adherence, and the ability to navigate complex health systems.

- **Challenge:** Elderly patient living alone.
- **Impact:** No one to assist with appointment reminders or medication management.

## Housing & Food Security

Substandard housing conditions and limited access to nutritious, affordable food (food deserts) directly influence chronic disease management. Patients may struggle to follow dietary recommendations or maintain stable health due to environmental factors.

- **Challenge:** Lack of nearby grocery stores with fresh produce.
- **Impact:** Difficulty managing diet for conditions like heart disease or diabetes.



# Creating Your Risk Scoring System

Implementing a comprehensive risk scoring system is pivotal for proactive chronic care management. It allows healthcare providers to quantify patient risk across various domains, facilitating targeted interventions and personalized care plans. This framework combines clinical, utilization, social, and behavioral factors into a single, actionable score.



## Low Risk

### 0-3 Points

Patients generally stable with controlled conditions and minimal barriers. Focus on preventive care and routine monitoring.



## Moderate Risk

### 4-7 Points

Patients showing signs of emerging instability or with a few identified risk factors. Requires more frequent monitoring and early intervention strategies.



## High Risk

### 8+ Points

Patients with complex, uncontrolled conditions or multiple significant risk factors. Demands intensive care coordination, frequent follow-ups, and comprehensive support.

## Risk Factor Point Assignment

Assign points based on the presence and severity of each factor:

Clinical Indicators		
HbA1c >9% or eGFR <30	2	Uncontrolled diabetes or severe kidney dysfunction
Uncontrolled BP (>140/90) or Elevated LDL	1	Persistent readings despite treatment; increased cardiovascular risk
Multiple Chronic Conditions (3+)	2	Increased complexity of care and potential for drug interactions
High-Risk Diagnosis (CHF, COPD, Diabetes with complications)	1	Significant impact on daily life and health stability
Utilization Patterns		
Frequent ED visits (2+ in 6 months)	2	Indicates uncontrolled conditions or lack of primary care access
Hospital Readmission (within 30 days)	3	Severe care gaps or decompensating health post-discharge
Frequent Uncoordinated Specialist Visits	1	Risk of fragmented care and medication conflicts
Missed Primary Care Appointments (2+ in 6 months)	1	Suggests disengagement or access barriers to essential care
Social Determinants of Health (SDOH)		
Significant Transportation Barriers	1	Prevents access to appointments and pharmacies
Economic Hardship (affecting medication/food)	2	Inability to afford essential health-related needs
High Social Isolation	1	Lack of support for health management and emotional well-being
Food Insecurity or Unstable Housing	2	Directly impacts ability to manage diet and maintain stable health
Behavioral & Adherence Issues		
Documented Medication Non-Adherence	2	Skipped doses, missed refills, directly impacts treatment efficacy
Lack of Self-Management Engagement	1	Limited participation in self-care activities (e.g., diet, exercise)
Substance Use	2	Interferes with chronic disease management and overall health

# Implementing Risk-Based Care Protocols

Leveraging patient risk scores is crucial for tailoring chronic care management (CCM) interventions effectively. By segmenting patients based on their identified risk levels, healthcare providers can allocate resources strategically, deliver personalized care, and proactively address evolving health needs, ensuring timely and impactful support.



## Low Risk Patients

For stable patients with controlled conditions and minimal barriers, care focuses on maintaining health and preventing complications. This includes **quarterly check-ins**, routine preventive screenings, and health education to promote ongoing self-management.



## Moderate Risk Patients

Patients showing early signs of instability or with a few identified risk factors receive more proactive support. This involves **monthly contacts**, detailed care plan adjustments, and targeted interventions to address emerging issues and prevent escalation.

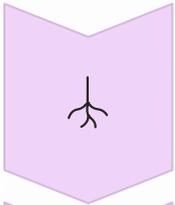


## High Risk Patients

For those with complex, uncontrolled conditions or multiple significant risk factors, intensive, coordinated care is paramount. This protocol features **weekly or bi-weekly contacts**, dedicated care team involvement, and comprehensive support services to stabilize health and mitigate risks.



# Building Your CCM Analytics Foundation



## Start Simple

Use existing EHR reports and basic Excel tracking. Perfect systems kill momentum — functional systems create results.



## Automate Gradually

Set up alerts for patients due for Annual Wellness Visits, overdue labs, or CCM monthly contacts.



## Scale Systematically

As your data habits mature, invest in more sophisticated tools and expanded tracking capabilities.

 Remember: Don't wait for the perfect analytics platform. Start with the tools you have today and build your data discipline incrementally.

# You Don't Need a Million-Dollar System

You need curiosity, a handful of key metrics, and the courage to start asking better questions about your CCM program's performance.

Small data habits create transformational changes in patient care and clinic revenue. The question isn't whether you have time for analytics — it's whether you can afford to operate without clear visibility into your CCM program's potential.



# Your Data-Driven CCM Challenge

Pick one metric to track starting next week. Just one.

Whether it's your enrollment percentage, coordinator panel size, or patient drop-off rate — choose one measurement that matters and commit to tracking it consistently.

## Suggested Starting Points:

- **CCM enrollment rate:**  $\text{Current enrollees} \div \text{eligible patients}$
- **Monthly revenue per coordinator:**  $\text{CCM billing} \div \text{FTE coordinators}$
- **Patient retention rate:** Enrollees staying active for 6+ months
- **Care gap closure:** Overdue services completed through CCM outreach

❓ **Discussion Question:** What's the one CCM metric you're committed to tracking when you return to your clinic? Share your choice and accountability partner up!





**Questions???**

# Homework:

- 1) Review CCM templates and build into EMR
- 2) Enroll 10 new patients. Please
- 3) Identify your EHR champion - someone who can help you learn how to run reports and use your EHR's CCM Dashboard (if applicable). Find out what reporting capabilities your EHR has for CCM.
- 4) Review the CCM Program Build Checklist - this will be emailed to you after today's session

Please feel free to email us directly if you have any questions!

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# Open office hour and Next Cohort

Open Office Hour: Friday, September 12th 12 - 1pm (MT)

Learning Session: Thursday, September 18th 12 - 1pm (MT)