Montana CCM Improvement Cohort Learning Session 4

Presented by Savvy Jane

Homework items:

1. Pick 5 patients from at least 2 months ago and determine how much was paid for those CCM visits (if you have a program established).
2. Identify your protocol for monitoring CCM reimbursement. Confirm who in your organization is monitoring CCM denials. Start the conversation internally if one has not yet been started.
3. Identify your provider champion & if any opportunity exists to get buy-in from additional providers. Which providers are not participating in CCM that could be?
4. Continue monitoring:
    a. Your total Medicare/MAP patient population and how many of these patients visit your clinic monthly.
    b. Your total CCM enrolled patients and how that number is trending over time
5. Prepare questions for the upcoming open office hour.

TruBridge Test Patient

CCM Daily Workflow Best Practice

Start of Day Workflow

Goal: Create a consistent, efficient, and patient-centered process that ensures no care gaps, improves communication, and closes the loop on all open items.

Step 1: Identify Key Patients

Each Care Manager starts the day by selecting the first **10 assigned CCM patients** for focused attention.

Step 2: Complete "Start to Finish"

Work each patient from start to finish, completing all possible CCM activities in one session: reviewing, updating, documenting, and addressing issues.

Handling Incomplete Tasks

When an activity cannot be fully completed in one session, follow these best practices:

- → **Document the pending item:** Clearly note what is outstanding (e.g., “Left voicemail for external facility—awaiting callback”).
- → **Set a reminder:** Add it to your follow-up list or schedule a specific reminder.
- → **Move to the next patient:** Once all **actionable steps for today** are done for the current patient, proceed to the next in your daily list.

Review Recent Communications and Encounters

What to Review

Open the patient's chart and carefully examine:

- The last communication within the care team.
- The last office visit or encounter.

Key Questions to Ask

Consider the following critical questions:

- Is there anything urgent that needs immediate attention?
- Did the patient call about a pending referral or prior authorization?
- Was the patient referred to a specialist but hasn't been contacted yet?
- Has there been difficulty reaching the patient or closing the loop with the care team?

Best Practice: If you can resolve an issue during this review, address it immediately to close the loop in real time.

2. Medication Review and Follow-Up

Following a recent patient visit, a crucial step involves a comprehensive medication review. Please check the following key aspects:

New Prescriptions?

Confirm if any new medications were prescribed during the visit.

Medication Adherence

Verify if the patient has filled and started taking the prescribed medication.

Patient Tolerance

Assess if the patient is tolerating the new medication well, with no adverse effects.

Address Patient Issues: If the patient reports issues, side effects, or concerns about medication cost or non-adherence, it's critical to act promptly.

Immediate Action: Notify the provider immediately regarding any reported issues. For cost concerns or unfilled prescriptions, communicate with the provider and meticulously document the next steps to ensure continuity of care.

Goal: Strive to resolve all medication-related barriers within the same contact cycle whenever possible, ensuring optimal patient outcomes.

3. Care Plan Review and Update

Once the patient’s recent issues are resolved, it's time to thoroughly review and update their care plan:

Review Active Goals & Barriers

Open the Care Plan to assess current goals and identified barriers. Evaluate progress and ongoing relevance.

Advance Patient Goals

Identify goals that have been met or can be further advanced today, promoting continuous improvement.

Detect New Barriers

Promptly identify any new obstacles such as transportation issues, cost concerns, or access limitations.

Coordinate Appointments

Confirm all upcoming specialist appointments are accurately documented and scheduled within the plan.

Verify Specialist Records

Ensure all relevant specialist records are scanned into the patient's chart for comprehensive care.

Tip: Every time you update a care plan, think: “Does this reflect what’s happening with the patient right now?”

4. Preventive Care and Quality Measures

Every patient interaction should include a quality review focused on proactive health management:

Medicare Wellness Visits (AWV)

Check the date of the last AWV. If not completed, initiate scheduling directly. If the patient is unreachable, send a letter informing them about their AWV benefits and how to schedule.

Comprehensive Care Gap Review

Evaluate care gaps based on the patient's age, gender, and existing conditions. This includes, but is not limited to, the following key screenings and exams:

- Colonoscopy
- Mammogram
- Bone density scan (DEXA)
- Abdominal aortic aneurysm (AAA) screening
- Hepatitis C screening
- Diabetic eye and foot exams
- Essential Vaccinations (flu, pneumonia, shingles, etc.)

Goal: Close Care Gaps

Every Chronic Care Management (CCM) contact is an opportunity to contribute to closing one or more identified care gaps, enhancing overall patient health outcomes.

5. Communication and Documentation Standards

Document Every Contact

Document every contact or attempt clearly and concisely in the EMR.

Maintain Consistency

Use consistent language and timestamping for continuity.

Communicate Updates

Communicate updates to the provider via EMR message or task, especially for:

- Medication issues
- Unresolved referrals
- Care gaps that require provider action

Reminder: Documentation is both a clinical and billing requirement under CMS CCM regulations.

Savvy Jane Best Practice Mindset

> “Don’t just check the box — connect the dots.”

Every patient review should end with: “**What did I accomplish for this patient today, and what’s the next step?**”

Homework:

1. **Select 5 patients** from your active CCM panel, and work each patient **start to finish**, completing as many steps as possible:
    i. Review recent encounters and communications
    ii. Update care plan (if needed)
    iii. Reconcile medications
    iv. Check for open referrals, labs, or prior authorizations
    v. Document outreach and time spent
    vi. Note what tasks were completed, any barriers, and next steps
    a. Submit your reflection or bring to next discussion:
        i. What parts of the workflow ran smoothly?
        ii. Where did you lose time or run into roadblocks?
        iii. What steps could you standardize or batch for future efficiency?
2. **Email us directly with your biggest challenge**. We can provide organization-specific support tailored to your circumstances.
3. **Continue monitoring**:
    a. Your total Medicare/MAP patient population and how many of these patients visit your clinic monthly.
    b. Your total CCM enrolled patients and how that number is trending over time

Upcoming Dates:

Next Open Office Hour:

Friday, October 24th 12:00 PM - 1:00 PM

Next Cohort Session 5:

October 31, 2025, 12:00 PM - 1:00 PM

Feel free to reach out with any questions in the meantime!

Jill@savvyjane.com Jessica@savvyjane.com