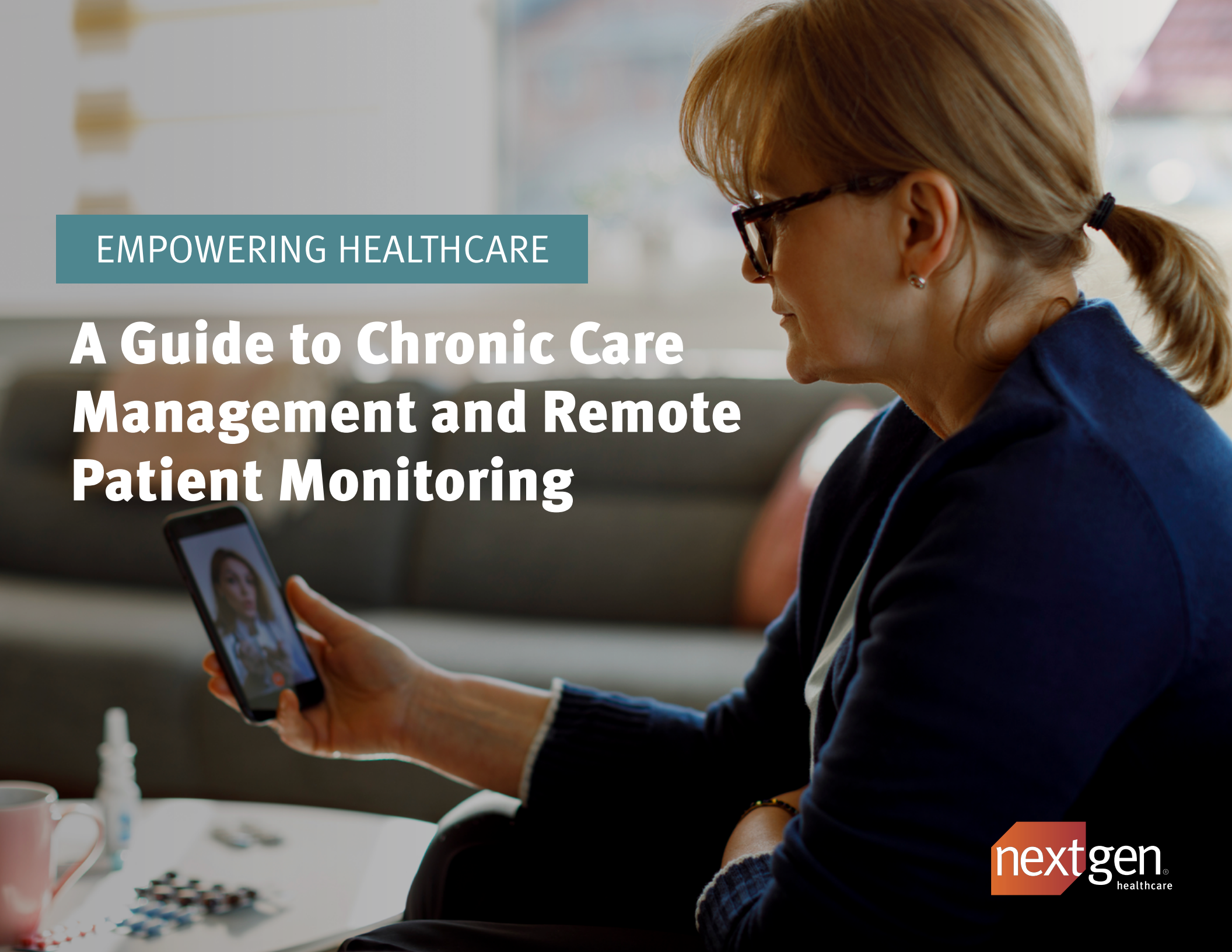

EMPOWERING HEALTHCARE

A Guide to Chronic Care Management and Remote Patient Monitoring

nextgen® healthcare

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Introduction

In the evolving realm of healthcare, recognizing the importance of Chronic Care Management (CCM) and Remote Patient Monitoring (RPM) is crucial for improving patient outcomes. As the prevalence of chronic illnesses continues to rise, healthcare professionals must adapt their practices to meet the increasing needs of their patients as well as payor expectations of performance.

CHAPTER 1

WHY NOW IS THE PERFECT TIME FOR CHRONIC CARE MANAGEMENT (CCM) AND REMOTE PATIENT MONITORING

To understand the urgency of embracing CCM, we need to recognize the current landscape.

Approximately 85% of adults in the United States are diagnosed with at least one chronic illness.

The Center for Medicaid/Medicare Services (CMS) reported in June of 2023 that amongst the aging population, 68.1% of Medicare Beneficiaries have 2 or more chronic illnesses. That amount jumps to 76.9% for patients with Medicare and Medicaid. This has extensive impacts on the current landscape of healthcare.

There are several CMS programs that support Remote Care Models. While the 2 most widely used are CCM and RPM, another Remote Care Model is Behavioral Health Integration (BHI) for patients with either mental health diagnoses or substance abuse diagnoses.

While CCM focuses on patients with two or more chronic conditions, Principal Care Management (PCM) focuses on high-risk patients with a single chronic condition. This allows specialists such as Cardiologists to also participate in remote programs. Luckily, this has never been more accessible.

1

Complexity of Multiple Chronic Conditions

As the number of individuals who grapple with multiple chronic conditions simultaneously rises, managing these complex cases requires a detailed care plan, more coordination of care, and comprehensive approaches to managing their conditions.

These models also ensure that each patient leverages their provider as a 'Medical Home' which avoids emergency room visits and mitigates escalations of their conditions. This type of early intervention also allows for the practice to identify patients who are not compliant and risk serious medical complications.

2

Patient-Centric Care Trend

Trending upward with the rise in chronic condition diagnoses is the shift toward patient-centric care. Remote Care Models such as CCM, RPM, BHI, and others align with this trend by empowering patients to actively participate in their healthcare journey. This fosters collaboration between healthcare providers and patients which leads to better health outcomes and increased adherence to care plans.

For CCM and BHI services, a Care Manager is available 24/7 for patients or care givers to ask real time questions and prevent potential exacerbation of conditions without having to call 911.

In patient satisfaction surveys, 70% of respondents attest to having the program be a positive influence in their care. RPM follows closing behind at 67% reporting improved patient satisfaction. This number jumps to 90% patient satisfaction with practices that collaborate with a vendor partner for services.

3

Technological Advancements and Telehealth

With many practices embracing telehealth and other remote care technologies, the groundwork is set for an easier transition to CCM and RPM. As technology advances at a break-neck speed, new technologies are being introduced in more accessible ways, enabling healthcare professionals to engage with patients more efficiently. Remote care models increase provider visibility into a patient's health status outside of the four walls of the practice.

4

Preparedness for Future Healthcare Challenges

As the healthcare landscape continues to evolve, embracing remote care programs enables healthcare professionals to proactively address the challenges posed by an aging population, increasing chronic conditions, and the need for more sustainable healthcare practices. It also frees up the provider to focus on in-office patients while a care management team focuses on the "between-visit care."

CHAPTER 2

BENEFITS OF REMOTE CARE PROGRAMS

The main impact of all these programs (CCM, RPM, BHI, or PCM) for practices is that the benefits of adopting it compound over time. When you ensure that those patients who need the most care can get to it in real time, patients are more engaged in their care. When they are more engaged, they are more likely to stay with the practice. This also allows providers to still deliver excellent care to them while being able to focus more on patients in the office. These all lead to better healthcare outcomes and decrease the overall strain on the healthcare system.

Preventive and Proactive Care

These programs emphasize preventive and proactive care, addressing health issues before they escalate. An RPM study conducted in 2023 by Health Snap monitored 2,761 hypertensive patients for 90 days. These patients, on average had a 10-point reduction in systolic blood pressure after the initial 90 days. The impact was even more pronounced on patients with Stage 2 hypertension with an average decrease of 20 points. This approach not only improves patient outcomes but also contributes to a more sustainable and effective healthcare system.

Cost-Effectiveness Opportunities

Studies, such as those highlighted earlier, demonstrate the cost-effectiveness of remote care programs. By effectively managing chronic conditions, ambulatory healthcare providers can potentially reduce hospital admissions and emergency room visits, resulting in a financial boon for both practices and patients. Patients get personalized care throughout the month without straining higher acuity facilities or their provider. The focus of the provider can shift from a mindset of triage to comprehensive care.

Holistic and Continuity of Care

Because of the array of programs that can be leveraged, a provider can determine which program or programs fit best for each patient. By custom selecting a program, the provider promotes a holistic care approach to cover the entire spectrum of a patient's well-being. Continuity of care is maintained through consistent engagement, continuing education, and device integration, which is especially beneficial for individuals with chronic conditions requiring ongoing attention.

CHAPTER 3

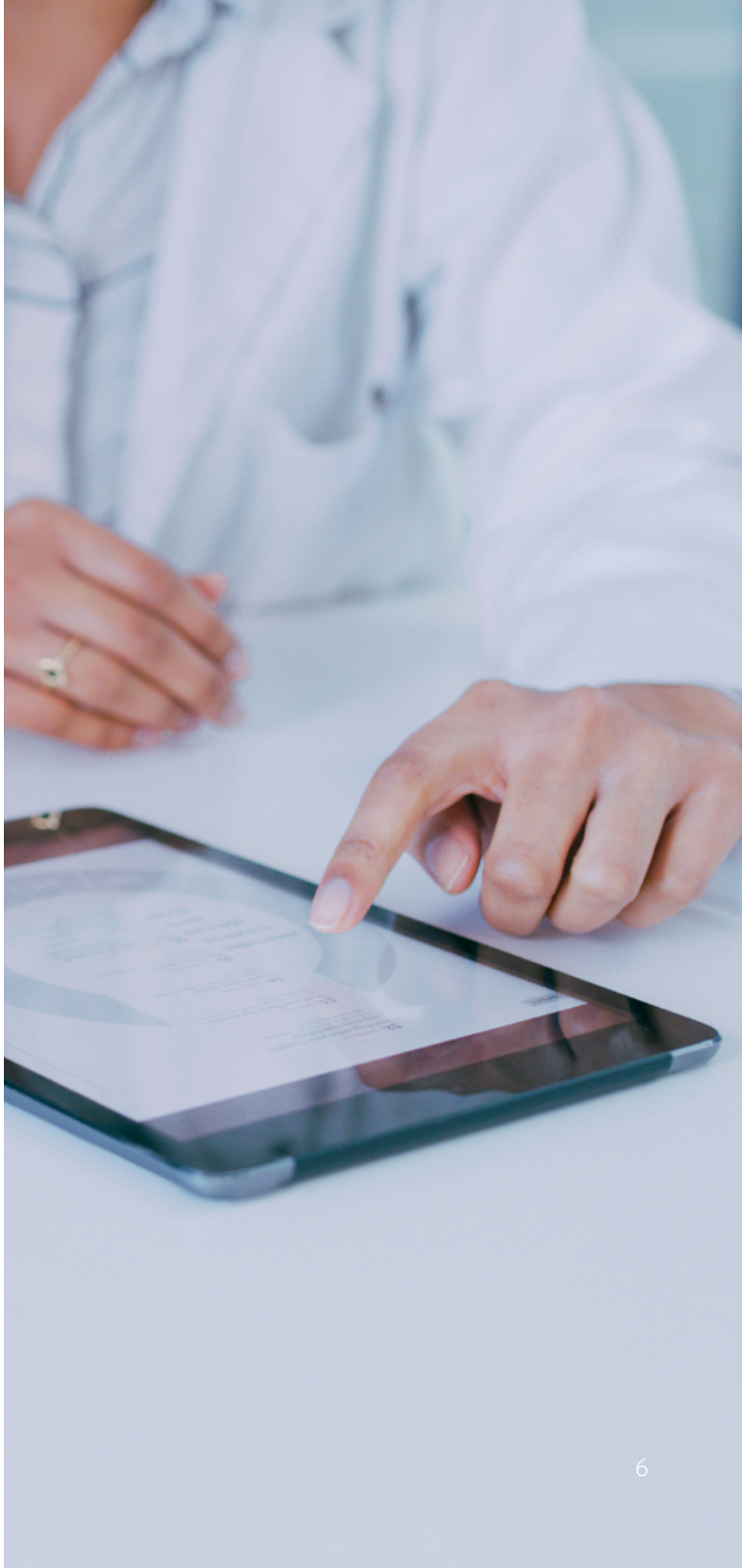
REMOTE CARE MANAGEMENT COMMUNITY-BASED MODELS

Now is certainly the best time to adopt these solutions, but what does that entail?

Remote Care management is an umbrella term for delivering elevated services needed by patients with chronic illnesses. This involves providing in-person, virtual, and at-home access to care tools.

The seven core elements of this comprehensive care approach are:

1. **Patient-centric care**
2. **Continuity of care throughout the continuum of care**
3. **Improved access to health information**
4. **Active caregiver engagement**
5. **Coordination of care**
6. **Evaluation and focus on Social Determinates of Health**
7. **24/7 care access to a licensed provider**



CHAPTER 4

EMPOWERING PATIENTS IN CHRONIC CARE

Empowering patients through tools like patient-centered care plans is an important part of chronic care management. When engaged, patients are more likely to comply with medications, attend follow-up appointments, and actively contribute to their overall health journey. This collaboration between healthcare providers and patients leads to better outcomes for patients and allows for providers to maintain focus on caring for their entire patient population.

CHAPTER 5

6 RESOURCES FOR NAVIGATING CARE MANAGEMENT SERVICES

Learning about the importance of remote care models and adopting these services into your existing portfolio is a great way to support your community. It is equally important to make sure that you are supported in this endeavor as well so that your deployment of CCM services is as successful as possible.

Here are 6 resources you'll need along your journey.

1. **Comprehensive RPM Guide —** Begin your Remote Patient Monitoring (RPM) journey the right way with this in-depth guide to getting started.
2. **Center for Medicare and Medicaid BHI Services Overview —** Utilize this resource to prepare for adding Behavioral health integration to your care management repertoire.
3. **The Medicare Learning Network®: Chronic Care Management (CCM) Booklet —** The Medicare Learning Network provides a CCM overview and examples of eligible chronic conditions (with applicable CPT codes), how to create and document comprehensive care plans, and management of care transitions.
4. **Chronic Care Management Summary Checklist —** Leave no detail missed with this encompassing CCM checklist.
5. **The Centers for Medicare & Medicaid Services (CMS): Connected Care Healthcare Professional Toolkit —** If there is one group to go to for resources on capturing the most income from Medicare and Medicaid with CCM it is CMS.
6. **American Academy of Family Physicians (AAFP) Chronic Care Management Coding Guide —** Make the financial transition to CCM a smooth one with this guide to CCM coding. AAFP provides additional resources that are sure to round out your practice's knowledge of adopting CCM services.

Conclusion

In conclusion, recognizing the importance of remote care models sets the stage for independent practices to address one of the greatest looming challenges in 2024 and beyond. Understanding the urgency, exploring the benefits, implementing community methods, empowering patients, and utilizing comprehensive resources collectively form a strategic approach to the successful adoption of CCM, RPM, BHI, and PCM.

NextGen Office understands the challenges these obstacles bring and is here to help you through this journey to adopting more care management services.

Embracing these steps not only meets the current needs of patients but also prepares your practice for a future where remote care is indispensable.

HOW CAN WE HELP YOU?

Contact us at 877-523-2120 or ngosalesteam@nextgen.com

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