Measure What Matters

Proving Value and Scaling Your CCM Program for Growth

May 5, 2026

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Where Weve Been and Where We Are Going

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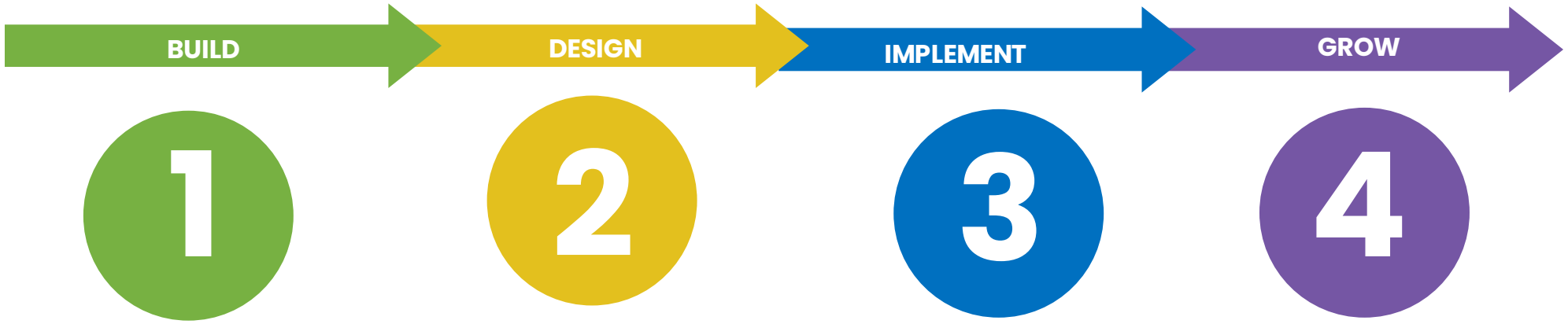


BUILD

It's important to realize that by implementing change, you require employees to step outside of their comfort zone. They aren't going to do so willingly unless you can.

DESIGN

Understanding that there's a need for change and wanting change to happen are two different things. When people honestly want to see positive change, they'll go.

IMPLEMENT

There's no point in trying to implement change unless the people whose jobs are changing know how to get things done. Getting through this step could be as simple as.

GROW

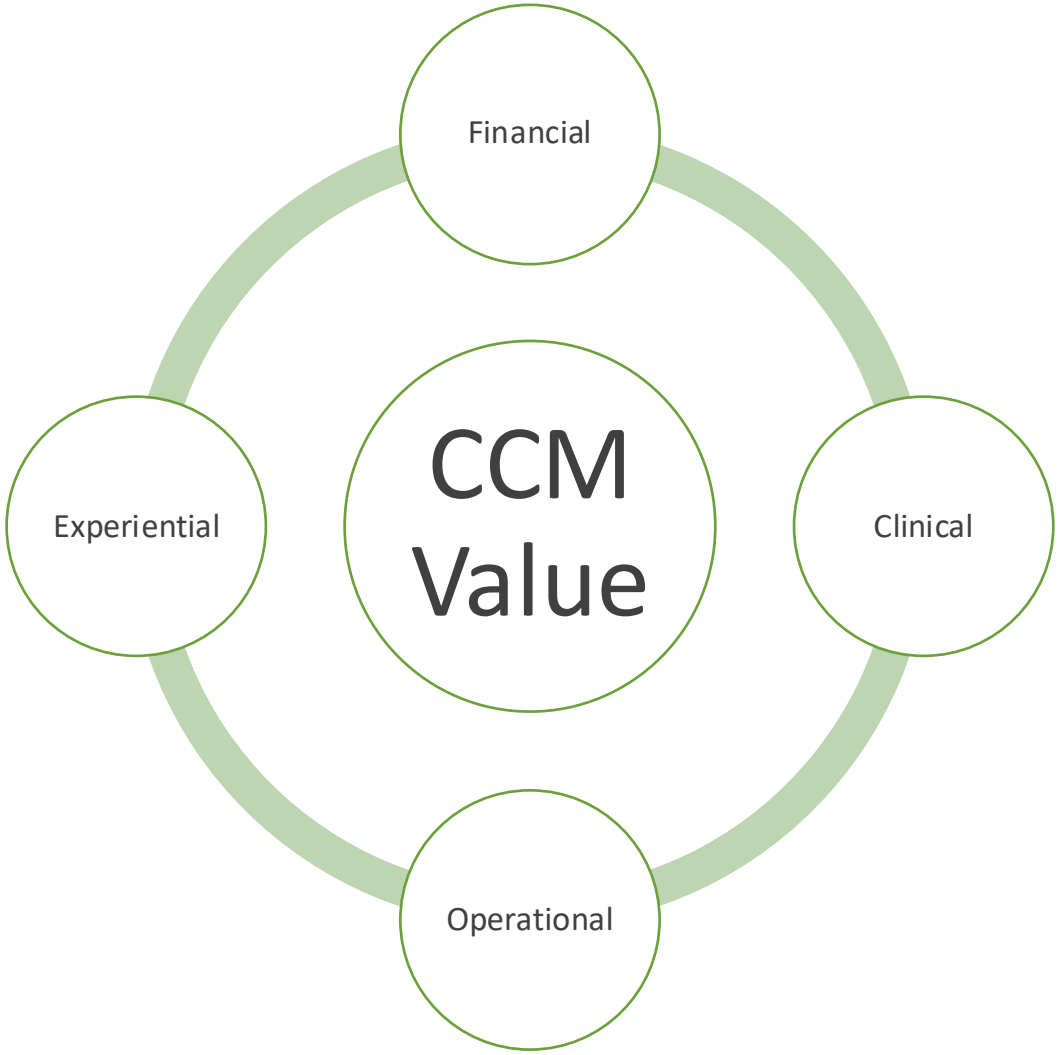
Knowing how to do something doesn't necessarily mean that you can do it in practice. Here's a simple example. When you were a kid, you knew that to ride a.

Chronic Care Management Implementation and Sustainability

Why Measurement Matters

- Measurement is Essential Because:
  - Rural margins are thin
  - Workforce resources are limited
  - Payers demand proof of value
  - Boards need financial clarity
  - Communities depend on sustainability

The CCM Value Framework



Measuring Financial Success

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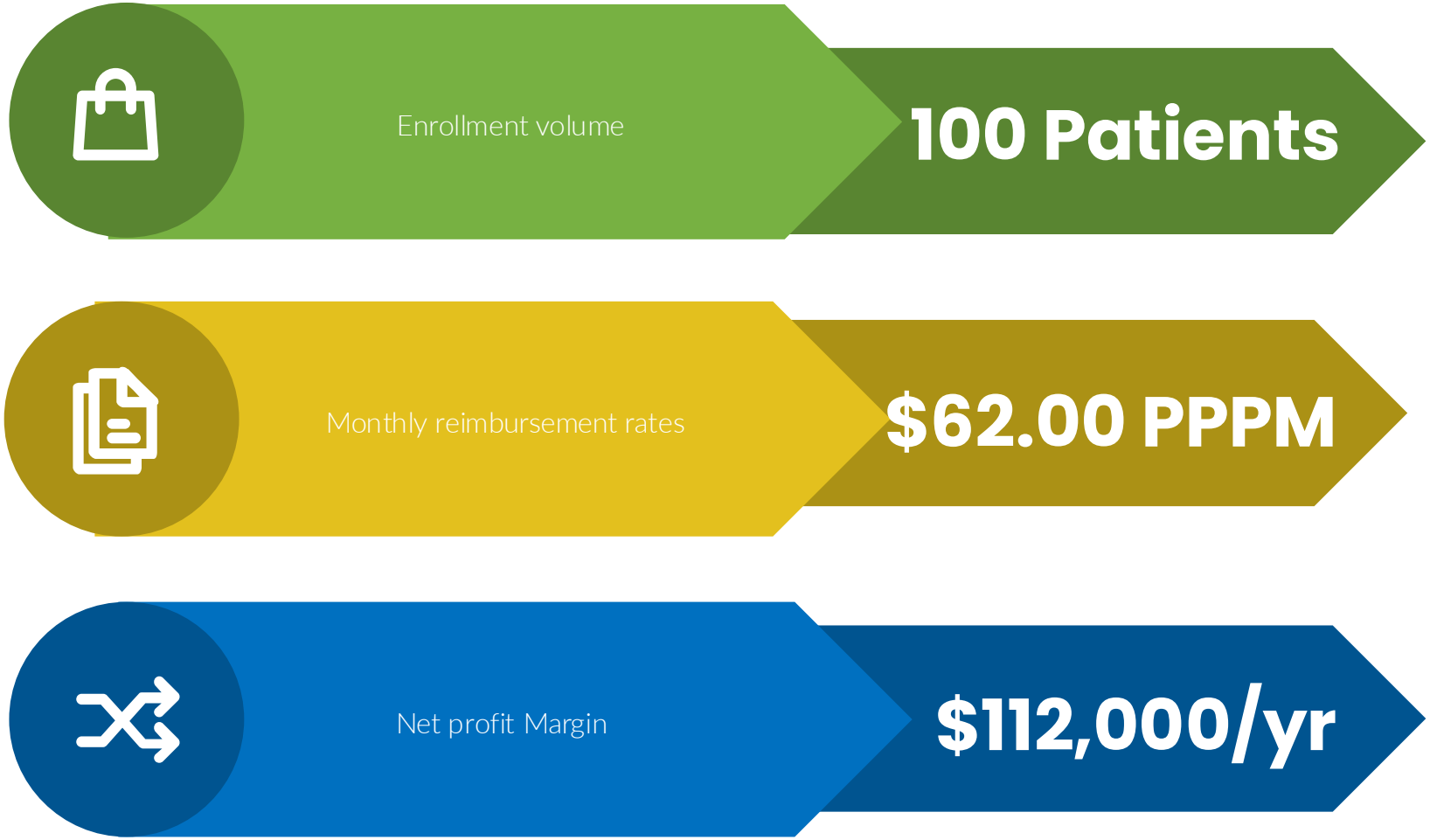

CCM is a revenue-generating population health strategy

Hidden Financial Value of CCM

Provider Efficiency

Addresses non-visit care needs outside of the exam room

Reduced ED Utilization and Readmissions

Early symptom management, improved medication adherence, and proactive approach to prevent avoidable visits

Improved Value-Based Payments

Improved chronic disease control and care gap closure to strengthen performance

Improved Risk Adjustment Capture

Enhanced documentation capture of condition complexity, supporting appropriate reimbursement

Measuring Clinical Success

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CCM programs improve

- ER visit utilization
- Hospital readmission rates
- Preventable hospital admissions
- Chronic disease control
- Preventative care compliance

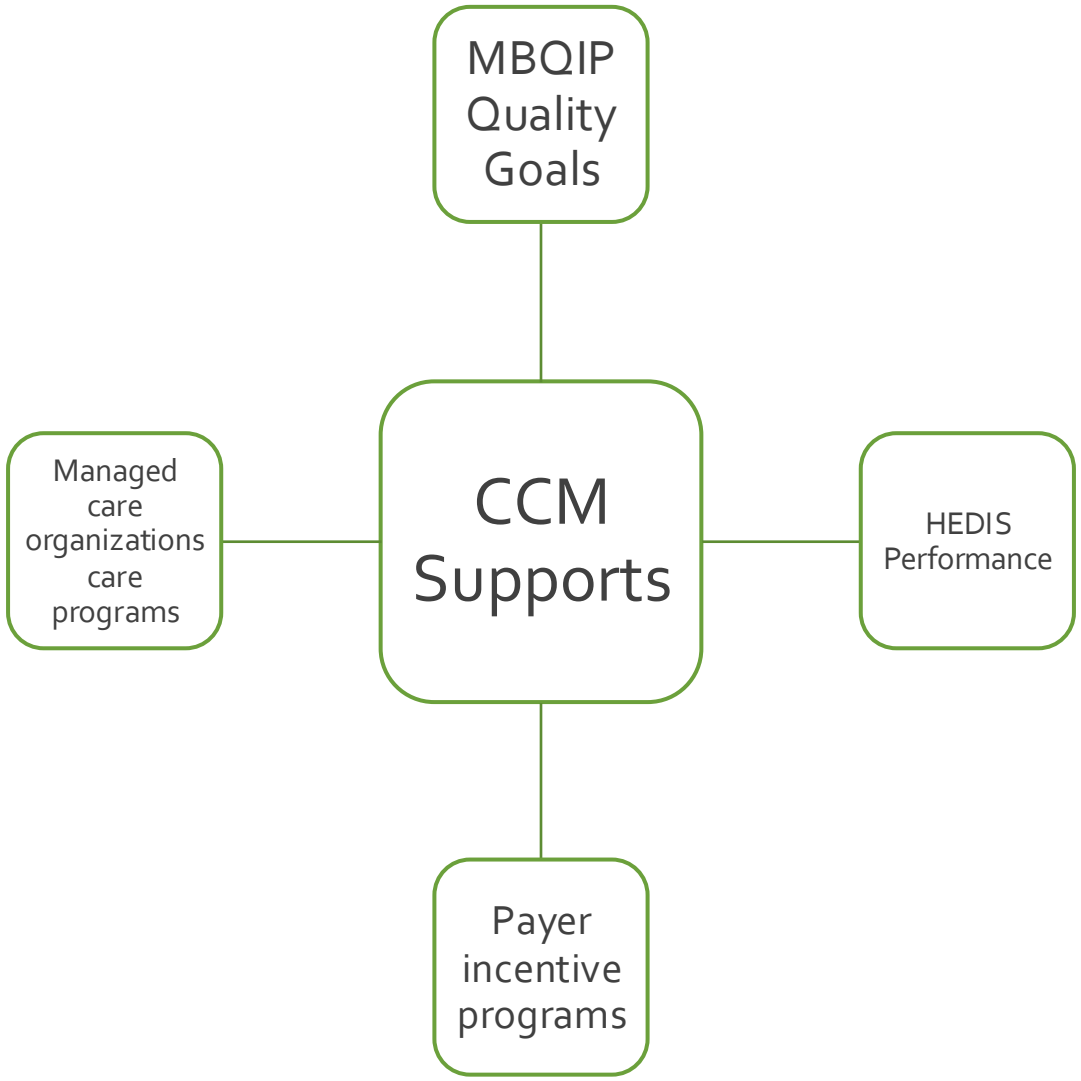
Key indicators

- HgbA1C control
- Blood pressure management
- Lipid control
- Preventative measure gap closure

Clinical Outcomes Matter Most

- Decrease ER utilization
- Improved chronic disease management
- Decrease hospital readmission
- Improve care gap closure
- Improve patient outcomes

CCM & Value-Based Care Alignment



Measuring Operational Success

- Operational Metrics:
  - Staff productivity
  - Time per patient
  - Outreach completion rates
  - Documentation accuracy
  - Workflow adherence

Patient Experience Impact

- Evaluate:
  - Perceived access to care
  - Care coordination satisfaction
  - Confidence in managing conditions
  - Reduced anxiety about health

Provider Experience Impact

- Provider Benefits:
  - Better visit preparedness
  - Reduced crisis care
  - Improved care planning
  - Stronger patient relationships

Building Effective CCM Dashboards

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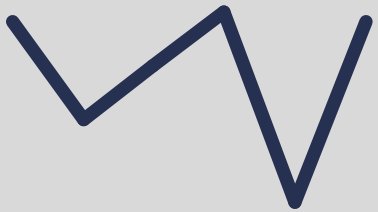
Financial

100% of patient encounters billed were reimbursed

73%



Clinical

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Type your desired text.

Referrals

Operational

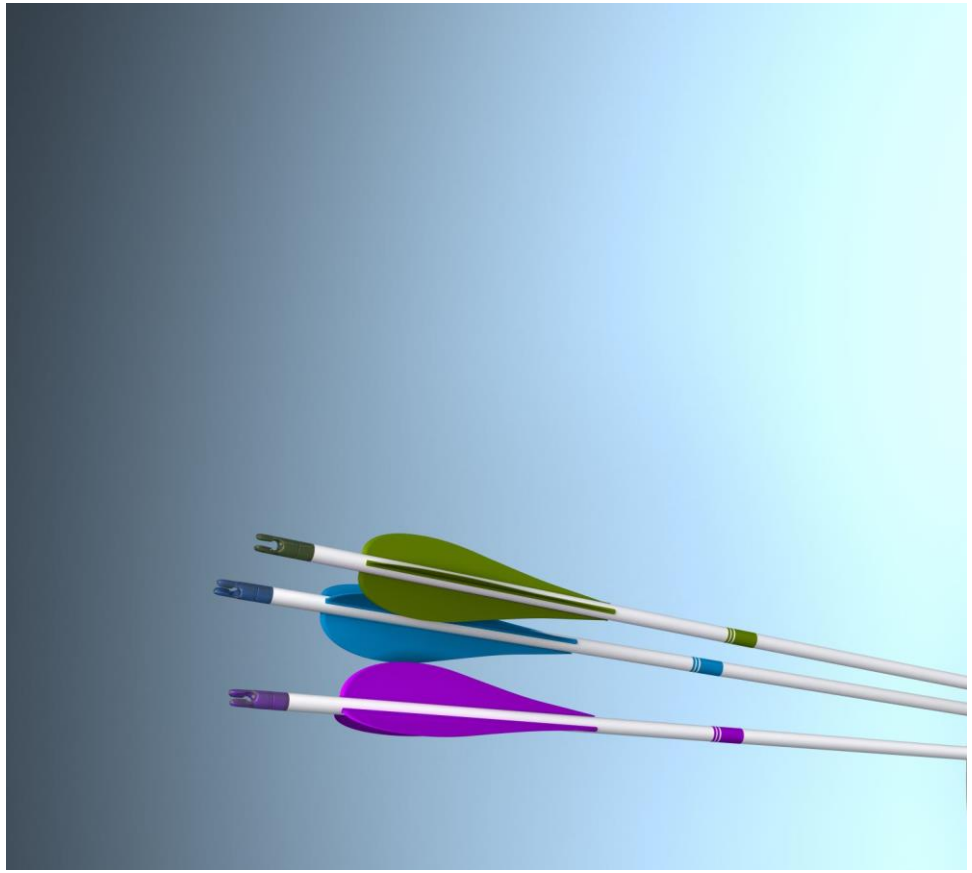
120

Patients enrolled.

2 FTEs.

Experience

Scorecards for Leadership Reporting

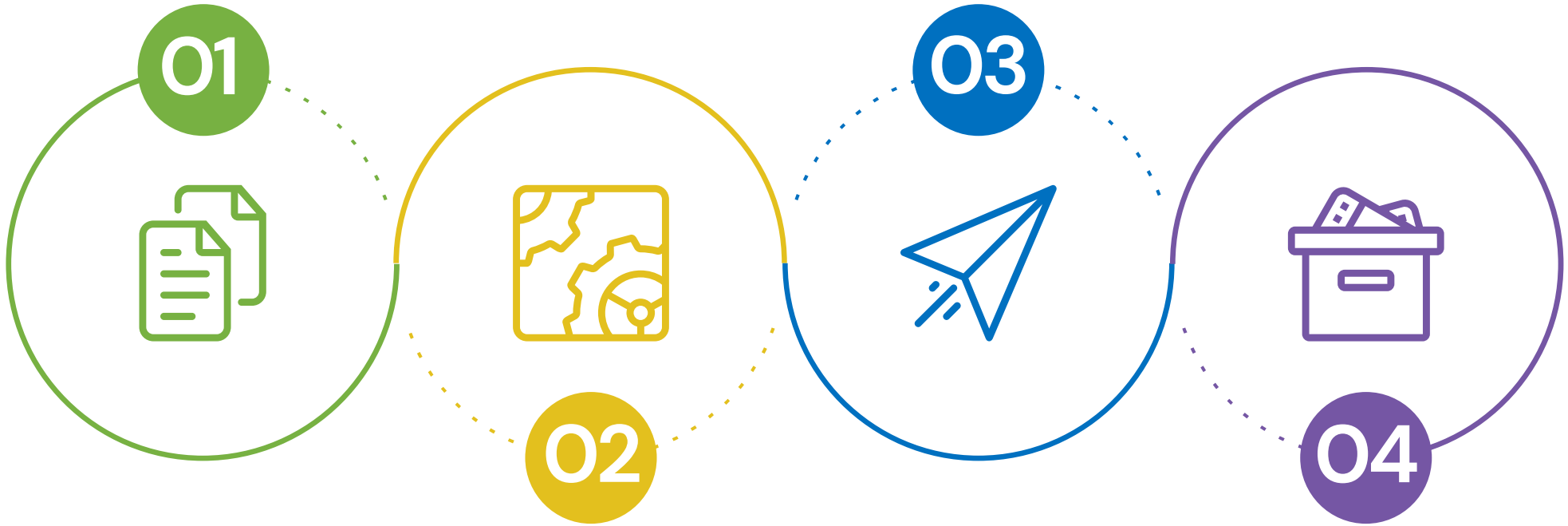


- Monthly Scorecard Should Include:
  - Enrollment trend
  - Revenue trend
  - Clinical outcomes
  - Staffing efficiency
  - Program risks

Communicating CCM Value to Boards

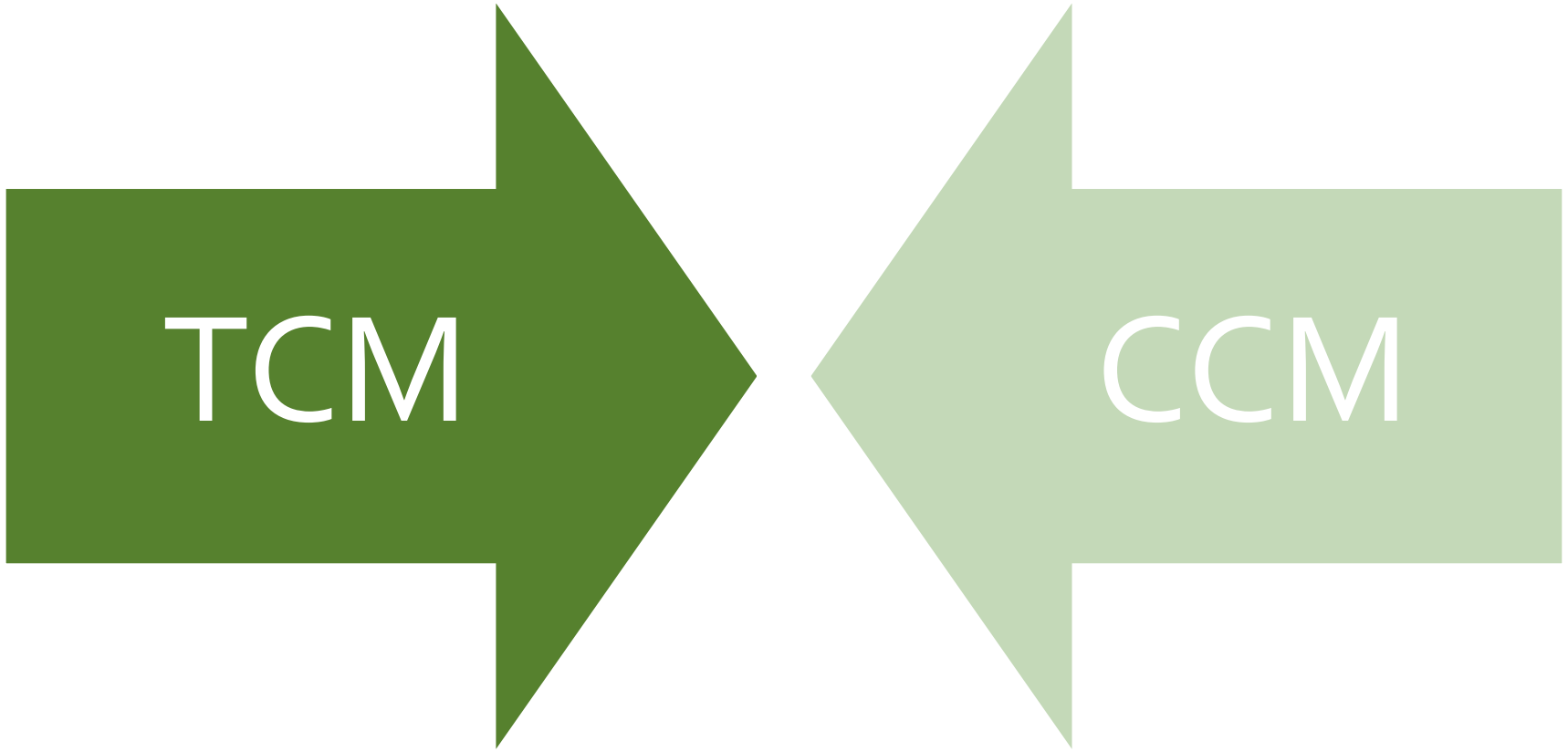
- Effective Board Communication:
  - Simple metrics
  - Trend visualization
  - Patient stories
  - Financial projections

Continue Improvement Framework



Identifying Growth Readiness

Expanding into Transitional Care Management



Remote Patient Monitoring/Therapeutic Monitoring

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RPM

- Collection and analysis of patient physiologic data that is used to develop and manage a treatment plan related to a chronic or acute health illness or condition
    - For example, weight loss related to behavioral health medications

RTM

- Use of Medical devices to monitor a patient's health response to treatment using non-physiological data
    - For example, monitoring medication adherence and response treatment in behavioral health patients

Behavioral Health Integration

2. Behavioral Health Integration (BHI)

- **Code:** 99484
- **Eligibility:** Any diagnosed behavioral health condition (e.g., depression, anxiety)
- **Requirements:** Monthly services including care planning, tracking, and psychiatric consultation
- **Strategic Value:**
  - Integrates mental health into primary care
  - Supports whole-person care and SDOH response
  - Improves quality scores on behavioral health metrics

Care Management Services

- **Principal Illness Navigation**
  - Covers principal illness navigation services for patients with a serious condition that is expected to last at least 3 months and puts them at high risk for one or more of the following:
    - Hospitalization
    - Nursing home placement
    - A sudden worsening of preexisting symptoms
    - Physical or mental decline
    - Death
  - PIN is a type of care management service that helps patients understand their medical condition or diagnosis and guides them through the healthcare system, examples of conditions applicable:
    - Severe mental illness
    - Substance abuse disorders
    - Cancer

Building a Population Health Strategy

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CCM=Foundation

TCM=Transition

RPM=Monitoring

BHI=Whole Person

Future of Care Coordination

- Trends:
  - Risk-based payment expansion
  - Technology integration
  - Workforce redesign
  - Community partnerships

Key Leadership Takeaways

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Measure consistently

Communicate clearly

Improve continuously

Expand strategically

CCM Blue Print

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Build

Design

Implement

Measure & Scale

QUESTIONS

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