eTransX



› Making CCM **Simple**, **Effective**, and **Pain Free**

Implementing a Chronic Care Management (CCM) program does not have to be complicated. eTransX, through its partnership with CareHarmony, acts as a seamless extension of your practice, providing a turnkey CCM solution that spans both software and care coordination services to deliver a high impact program for your chronically ill patients.

Working in concert with your practice, our team of experienced, clinical care coordinators performs all non face-to-face care coordination for your patients between office visits. As a result, your patients are able to better manage their chronic conditions and your practice is able to secure the documentation required to bill for CCM billing code 99490.

› A Win-Win: **Better Care** for Your Patients & **New, Recurring Revenue** for You

eTransX fills the 20 minutes of billable time with value-added coordination activities that keep your patients healthy. A recent study by the American Academy of Family Physicians found that a care coordination program, similar to our program, in a primary care setting significantly improved 16 different HEDIS measures spanning diabetes, CAD, and prevention services[1]. While improving your patients' experiences and medical outcomes is the primary focus of CCM, the revenue potential makes it a win-win proposition. Practices can earn $40.39/month providing CCM services for qualified patients, which translates to more than $240K per year with 500 enrolled patients.

› Helping Your Patients **Better Manage** Their **Chronic Conditions**

John Bloom
77 year old diabetic with asthma, living home alone and enrolled in eTranX's CCM program by his primary care physician Dr. Wilson.

Jane
A veteran nurse with years of experience in a geriatric setting is matched with John based on John's condition and specific needs.

Care Planning
Jane creates an evidence-based, personalized care pathway, shared with the entire care team, that addresses John's asthma, diabetes, and other health concerns.

Routine Assessments
Jane conducts a series of assessments, including a depression assessment for John's loneliness, and takes action on the findings.

Patient Education
Jane coaches John on nutritional habits and helps him cut down on starchy foods – following up bimonthly.

Referral Management
Jane helps John schedule an appointment with his endocrinologist to re-evaluate his Metformin dosage.

Patient Monitoring
Jane checks in with John twice a month on his glucometer readings and alerts Dr. Wilson when John has been getting elevated readings for an entire week.

› You **Don't** Have to Go It Alone

So you've decided to take advantage of CCM to benefit your patients and your practice. You can weigh a couple of options: do it yourself or leverage eTransX's turnkey solution.

No Recruiting, No Hiring, No Hassle

CMS requires 20 minutes minimum per patient per month in order to bill for CCM—this time adds up quickly. For 500 patients this could be anywhere from 2 to 3 additional full-time employees (FTEs) to recruit, hire and manage, not to mention the additional office space you'd need to house these FTEs.

Skip the Night Shift

CMS requires 24/7 access to care coordination services as part of CCM. Remove this burden from you and your employees. Rest easy knowing that our clinical staff are available for your patients around the clock every day of the year.

Save Time, Energy and Money

Building and maintaining a CCM program is not an easy task. From constructing personalized care plans to creating standard protocols and processes for care coordination, it takes much more than just hiring staff to build a successful CCM program—it takes time and energy. You have enough on your plate providing care for your parents, why manage another program that will pull you away from your patients when eTransX can take care of it for you? eTransX's off-the-shelf solution ensures that you will spend less time and energy setting up and managing a CCM program and more time reaping the benefits.

Make technology simple, not complex

CCM has complex technology requirements which cannot be handled by your current EHR without additional modules and fees. Our comprehensive care coordination platform, complete with mobile and desktop patient applications, was designed around CCM workflows, making it easy for our care coordinators to become a productive extension of your practice and for you to stay on top of your CCM activity.

Be stress free and audit compliant

CCM has 12 scope of service requirements that spans multiple functions including legal, operations, and technology. Navigating these complex requirements can be stressful and risky—false claims can cost providers up to $11,000 per claim and even more if a Civil Monetary Penalty (CMP) is imposed. Our implementation team has experience running CCM and has worked directly with CMS to get clarity around all the CCM requirements. Our turnkey solution can keep your practice audit compliant, avoiding costly penalties.

> **Long term, this [CCM] pays for itself through reduced complications, reduced readmissions, and reduced emergency department visits. We cannot afford for them to not have this service.**[2]
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> **- Martha Leclerc, Vice President, Office of Health Reform and Strategic Payment, Sanford Health**

Interested?

To learn more about how eTransX can simplify the transition to chronic care management, please contact us at **(888) 221-4971** or visit us online at **www.etransx.com.**

Footnotes:

1. The Benefits of Using Care Coordinators in Primary Care. American Academy of Family Physicians – December 2013.
2. Modern Healthcare, 09/17/15, Why most docs skip Medicare's chronic-care management fee (and how some are making it work)

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