**Innovation Award: Become a Pioneer by Diversifying Home-Based Care to Drive Revenue**

**Recommended CCM Implementation Roadmap**

This document is a customizable project plan for implementing Chronic Care Management (CCM) services. It outlines a 7-month phased roadmap covering planning, patient enrollment, care team training, program launch, and ongoing optimization. Each phase includes key tasks, deliverables, and timelines, along with recommended KPIs and risk mitigation strategies. Designed as a practical tool, it can be adapted to align with a program’s internal timeline, milestones, and quality metrics.

**1. Project Overview**

**Scope:**

* Identify and enroll eligible Medicare patients.
* Implement CMS-compliant CCM workflows and documentation.
* Establish a care coordination team.
* Integrate technology solutions for tracking, billing, and compliance.
* Monitor success metrics and ensure sustainability.

**Timeline:**

7-month implementation plan with ongoing evaluation.

**2. Project Phases & Timeline**

**Phase 1: Planning & Stakeholder Engagement (April-May 2025)**

**Key Tasks:**

✅ Identify leadership team.  
✅ Define program goals, scope, and success metrics.  
✅ Conduct a feasibility assessment (resources, staffing, technology).  
✅ Secure leadership buy-in and budget allocation.  
✅ Review CMS requirements for **CY2025 Physician Fee Schedule** compliance.

**Key Deliverables:**

* CCM Implementation Strategy Document
* Budget Plan
* Stakeholder Engagement Plan

**Phase 2: Patient Identification & Enrollment (May-June 2025)**

**Key Tasks:**

✅ **Identify Eligible Patients**

* Extract data from the EHR to identify Medicare patients with 2+ chronic conditions.
* Review active palliative care patients for eligibility.  
  ✅ **Patient Outreach & Consent**
* Develop patient education materials.
* Train staff on CCM benefits and how to obtain patient consent.
* Call eligible patients and obtain verbal or written consent.  
  ✅ **Develop Enrollment Workflow**
* Assign care team roles for outreach and documentation.
* Create standardized enrollment scripts & documentation templates.

**Key Deliverables:**

* Patient Eligibility List
* Enrollment Workflow & Documentation Templates
* Patient Consent Forms

**Phase 3: Care Team Training & Technology Integration (July-August 2025)**

**Key Tasks:**

✅ **Care Team Training**

* Educate staff on CCM billing, compliance, and documentation.
* Train in care coordination best practices and motivational interviewing.  
  ✅ **Technology & EHR Optimization**
* Ensure EHR supports CCM documentation & billing codes.
* Integrate care management software (if needed).  
  ✅ **Standardized Care Plan Development**
* Develop templates for care plans tailored to palliative care needs.
* Align care plans with patient goals of care and advanced directives.

**Key Deliverables:**

* CCM Training Manual
* EHR & Workflow Customization
* Standardized Care Plan Templates

**Phase 4: Program Launch & Initial Implementation (August-September 2025)**

**Key Tasks:**

✅ **Begin Monthly CCM Services**

* Assign each patient to a care coordinator.
* Schedule initial care plan reviews.
* Start non-face-to-face care coordination (phone calls, medication reviews, etc.).  
  ✅ **Billing & Compliance Monitoring**
* Ensure proper documentation of 20+ minutes/month of care coordination.
* Submit initial Medicare claims (CPT codes 99490, 99439, etc.).  
  ✅ **Patient & Caregiver Engagement**
* Monitor patient satisfaction & engagement levels.
* Provide patients with access to care coordination services.

**Key Deliverables:**

* Active CCM Patient Roster
* Billing & Documentation Audit Report
* Patient Engagement Survey

**Phase 5: Monitoring, Optimization & Expansion (October-November 2025)**

**Key Tasks:**

✅ **Evaluate Program Success**

* Track KPIs (hospitalizations, ER visits, patient adherence, billing revenue).
* Conduct staff and patient feedback surveys.  
  ✅ **Address Workflow & Compliance Gaps**
* Conduct internal audits for documentation & billing compliance.
* Provide additional staff training as needed.  
  ✅ **Expand CCM to Additional Patients**
* Based on outcomes, expand enrollment beyond the initial goal.

**Key Deliverables:**

* CCM KPI Dashboard
* Compliance & Billing Audit Summary
* Expansion Plan

**3. Key Performance Indicators (KPIs)**

**Clinical Outcomes**  
✔ Reduction in hospitalizations & ER visits (Example Target: 15% decrease).  
✔ Medication adherence improvement (Example Target: 90% adherence).  
✔ Care plan completion rates (Example Target: 95%).

**Financial & Operational Success**  
✔ CCM revenue generation (Example Target: $60,000+ in Medicare reimbursements).  
✔ Documentation compliance rate (Example Target: 100%).  
✔ Patient retention in the program (Example Target: 85% after 6 months).

**Patient & Provider Satisfaction**  
✔ Patient satisfaction score (Example Target: 4.5/5).  
✔ Provider engagement score (Example Target: 90% positive feedback).

**4. Risk Management & Mitigation Strategies**

| **Risk** | **Likelihood** | **Mitigation Strategy** |
| --- | --- | --- |
| Low patient enrollment | Medium | Proactive outreach, patient education, and scripting for staff |
| Staff burden & burnout | High | Adequate staffing, training, and role clarity |
| Billing & reimbursement issues | Medium | Regular internal audits & workflow optimization |
| Compliance challenges | High | Ongoing training & CMS policy reviews |
| Technology integration delays | Medium | Early planning & vendor support |

**5. Next Steps & Final Considerations**

* Finalize budget and obtain approvals
* Assign project leads for patient outreach, training, and compliance
* Begin patient identification and consent collection
* Implement technology solutions for tracking time spent on CCM activities
* Launch CCM services and begin billing within 4 months.