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MICMT
Complex Care Management Course

MICMT
Michigan Institute for Care Management & Transformation

Complex Care Management Course Training Agenda

Description	Mode	Topic	Time allotment
Pre-work	Self-study Videos, Reading, PPT review	Patient Centered Medical Home	60 minutes
Pre-work	Self-study Video, Article, PPT review	Team-based care	30 minutes
Pre-work	Self-study Video, PPT review	Social Determinants of Health	60 minutes
Pre-work	Self-study PPT review, Video	Care Planning	60 minutes
Pre-work	Self-study Recorded webinar & Document review	Billing and Coding	60 minutes
Pre-work	Self-study PPT review & Document review	Medication Reconciliation	30 minutes
In Person	Welcome No CE time	Introduction and overview of the day	30 minutes 8:30 a.m. – 9 a.m.
In Person	Didactic Inter-active Real play Simulation	Team-based Care Expanded roles Primary Team Assessment and Shared Care	60 minutes 9 a.m. – 10 a.m.
In Person	Didactic Inter-active Real play Simulation	Paradigm Shift	60 minutes 10 a.m. – 10:30 a.m.
In Person	Break No CE time		10 minutes 10:30 – 10:40 a.m.
In Person	Didactic Inter-active Real play Simulation	Care Management Process	60 minutes 10:40 – 11:40
	Lunch No CE time		40 minutes 11:40 – 12:00 p.m.
In Person	Didactic Inter-active Scenario application	Sustainability and Billing	60 minutes 12:00 – 1:00 p.m.
In Person	Inter-active Real play Simulation	Care Management Application of the CM Process	30 minutes 1:00 p.m. – 1:30 p.m.
In Person	Inter-active Real play Simulation	Application of CM skills Case Study - Mary	30 minutes 1:30 p.m. – 2:00 p.m.
In Person	Inter-active Real play Simulation	Application of CM skills Case Study – Mr. Lawson	30 minutes 2:00 p.m. – 2:30 p.m.
In Person	Didactic Real-play Inter-active	Team Communication and Embedment	60 minutes 2:30 p.m. – 3:30 p.m.
In Person	Inter-active	Day in the Life	30 minutes 3:30 p.m. – 4:00 p.m.

Disclosure to Participants

Criteria for Successful Completion

Attendance at the entire event and submission of an evaluation form.

Conflict of Interest:

There is no conflict of interest for anyone with the ability to control content for this activity.

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Introduction

Introduction

MICMT Complex Care Management Course

Mi-CCSI Center for Clinical Systems Improvement

MICMT Michigan Institute for Care Management & Transformation

Welcome!
HOUSEKEEPING
Review Folder & Agenda

Group Activity 1

Introductions

- Your name
- Your discipline
- Your practice location
- How long have you been in your role
- What do you want to get out of the training

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Learning Objective

- Describe Michigan Institute for Care management and Transformation goals and resources available for physician office team members
- Also. . . for Your Information: Michigan Care Management Resource Center joined the newly formed MICMT – January 1, 2019
  - As we evolve, you will see both MICMT and MiCMRC branding and logos on many resources
  - They are under construction and ask for your patience!

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Disclosures

- There is no conflict of interest for anyone with the ability to control content for this activity.
- Participants who successfully complete the 5 hr self-study and attend the entire one-day in person session will receive 12 contact hours.
- A passing score of 80% on the MICMT post-test, meets the MICMT BCBSM requirement for re-imbursement of training fees.
- This continuing nursing education activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. ONA # 22558
- *This course is approved by the Michigan Social Work Continuing Education Collaborative-Approval # 080819-03. # CE Hours approved: 12.0 The Collaborative is the approving body for the Michigan Board of Social Work.*

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Michigan Institute for Care Management and Transformation (MICMT)

- *Who they are:*
  - Partnership between University of Michigan and BCBSM Physician Group Incentive Program
- *Goal of MICMT:*
  - To help expand the adoption of and access to multidisciplinary care teams providing care management to populations served by the physician community in order to improve care coordination and outcomes for patients with complex illness, emerging risk, and transitions of care

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MICMT Team Members

- Hae Mi Choe, PharmD
  - Executive Director
- Marie Beisel, MSN, RN, CCM, CPHQ
  - Administrative Manager Senior Healthcare
- Alicia Majcher, MHSA
  - Operations Director
- Julie Geyer, BBA
  - Senior Project Manager
- Sandy Becker, MA
  - Data Analyst
- Judy Avie, BSN, M.Ed. IT, RN
  - Program Manager
- Scott Johnson, BBA, MSA, RN
  - Project Manager
- Sarah Fraley, LMSW, ACSW
  - Project Manager
- Betty Rakowski, BSN, RN, MA Ed
  - Curriculum Designer
- Nicole Rockey, PharmD
  - Pharmacist
- Cindy Stevens
  - Administrative Assistant Sr.
- Julie Wolf
  - Administrative Assistant Sr.

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MICMT Care Management Resources

- Statewide Live and Recorded Webinars
- Billing resources
- Topics Pages - ex. Team based care, Chronic Conditions, Palliative Care, SDOH, Behavioral Health

- eLearning Modules
- Care Management 101
- Care Management/ Team Based Success Stories and Best Practice Sharing
  - Tools
  - Quality
- MICMT Complex Care Management Course offered monthly

Michigan Care Management Resource Center website
www.micmrc.org

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MICMT Complex Care Management In-Person Course Curriculum:

- Introduction
- Paradigm Shift
- 5 Step Process
- Team Based Care
- Sustainability and Billing
- Case Studies

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MICMT Statewide Complex Care Management Course Post Test and Evaluation

Logistics:

- The MICMT CCM Statewide Post Test and evaluation is web based
- A web link to the CCM Post Test and evaluation will be provided to you at the end of today's training
- Test Scoring
  - Occurs real-time when you submit your responses. You will receive Pass/fail notification prior to closing the test
  - Upon achieving a passing test score, you will continue on to the evaluation
  - Lastly an e-mail is sent to you with notification of MICMT CCM Course Post test "Pass" status
  - For Questions contact: **micmt-requests@med.umich.edu**

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Statewide Complex Care Management (CCM) Course Completion

Successful Completion of the CCM course includes:

- Complete the self-study modules
- Completion of the 1 day in-person
- Complete the Michigan Institute for Care Management and Transformation (MICMT) Statewide Complex Care Management Post test and the MICMT Statewide course evaluation
  - Achieve a passing score on the Post Test of 80% or greater
    - If needed, you may retake the Post Test
- Complete the Mi-CCSI CE requirements (post-test and evaluation)

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Care Management Programs

Michigan Care Management Programs for Practices who meet Criteria to Participate:

- State Innovation Model (SIM)
  - http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64491---,00.html
- Comprehensive Primary Care Plus (CPC+)
  - https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
- BCBSM Provider Delivered Care Management (PDCM)
  - http://www.bcbsm.com/providers/value-partnerships/physician-group-incentive-prog/models-of-care.html
- Priority Health Care Management
  - Log in online at priorityhealth.com/provider. You'll find care management information and more in Procedures & Services > Medical/Surgical Services > Care Management. Here, you'll also find a link to Priority Health's printable Expanded Services Contracted Billable Codes listing.
- Others based on organization contracts with various payers

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Care Management Introduction
Creating or refining your role description

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Contacts

micmt-requests@med.umich.edu
www.miccsi.org
Sue.vos@miccsi.org

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Team Based Care

MICMT Complex Care Management Course

Team Based Care

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Learning Objectives

- Define team based care in the primary care physician office
- Review tools for team-based care
- Provide some resources for learning more about team-based care

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Define Team Based Care in the Primary Care Physician Office

Team Based Care

The provision of health services to individuals, families, and/or their communities

- by at least two health providers
- who work collaboratively with patients and their caregivers,
- to the extent preferred by each patient,
- to accomplish shared goals within and across settings to achieve coordinated, high-quality care.

https://www.pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care#fig1

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Goals of Team Based Care

- Well-implemented team based care has the potential to improve:
  - Comprehensiveness
  - Coordination
  - Efficiency
  - Effectiveness
  - Value of care
  - Satisfaction of patients and providers

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Benefits of Team Based Care

Practices with a team based environment report:

- Increased office efficiency, more hours of coverage, shorter wait times
- Improved services, patient education, behavioral health, self-management support, care coordination, and closing gaps in care
- Increased patient and staff satisfaction
- Improved financial outcomes

* https://pcmh.ahrq.gov/sites/default/files/attachments/creating-patient-centered-team-based-primary-care-white-paper.pdf

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Time for Change

Dr. Robert begins a 20-minute visit with Mr. Hub, a diabetic, by looking through the chart to find the dates and results from his most recent hemoglobin A1c, low-density lipoprotein cholesterol, eye examination, and prostate-specific antigen tests.

Dr. Robert then spends 5 minutes comparing the medication bottles brought by Mr. Hub with office medication list.

Reviewing the health maintenance form, she leaves the room to request a medical assistant to draw up pneumonia and influenza immunizations.

Dr. Robert learns that Mr. Hub has been unable to obtain an appointment with the urologist for a prostate biopsy; she promises to help arrange the appointment herself.

As Mr. Hub leaves, Dr. Robert realizes that she did not need a medical degree to accomplish any of the tasks performed during the medical visit.

How could team based care help Dr. Robert and Mr. Hub?

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Team Based Care – Video

https://www.youtube.com/watch?v=jXwCg5zrL-w

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What does teamwork look like in your practice?

- Who are your team members?
- Are there expanded roles for team members?
- Does your practice use guidelines, standing orders, protocols, collaborative practice agreements or other tools?
- How does your team communicate?

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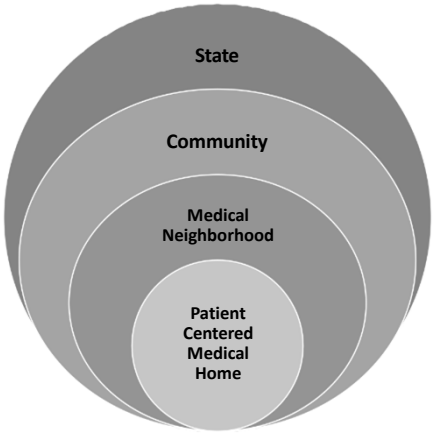
Who is the expanded Team?



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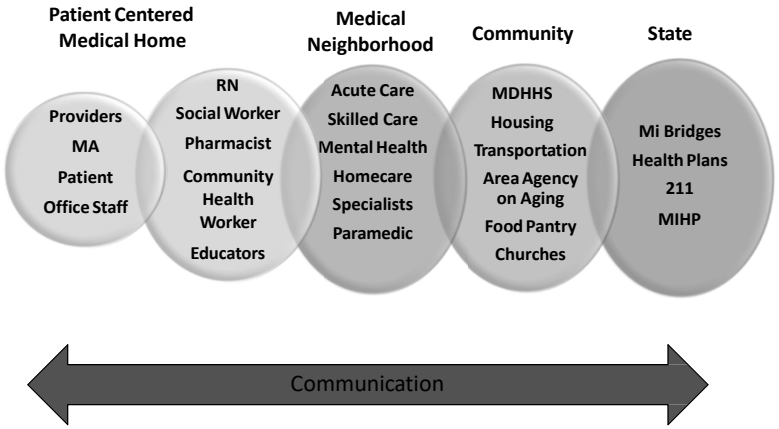
Who is on the Team?



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PCMH Team Expanded Roles

PCP	Office clerical Referral Management	MA Panel Management	RN - CM	SW CM – Behavioral Health Specialist	Clinical Pharmacist Medication Management	Community Health Worker
• Annual Physical • Orders preventive care • Diagnosis, discussion of treatment options and management of acute and chronic conditions • Coordination of care and care team • Referrals to specialists • On call	• Assist with outreach to help patient establish overdue appointments • Assist patients with obtaining referral appointment, having preauthorization orders, and obtaining follow-up reports	• Collaborate with providers in managing a panel concerning preventive services. Provides services to chronically ill patients such as self-management coaching or follow-up phone calls. • Scrub chart, provides pre-visit screenings and reviews medication list	• Provide care management for high-risk patients • chronic illness, monitoring response to treatment, and titrating treatment according to delegated order sets or Collaborative Practice Agreements.	• Provide behavioral health services in the practice or by referral protocol or Collaborative practice agreements (agreement may be in the practice or at another site) • Urgent BH patient need	• Medication review for patents on 5 or more medications • Review prescribing practices • Assist patients with problems such as non-adherence, side effects, understanding medications, medication management challenges, • Titrate medication for selected groups of patient under standing orders • Manages chronic conditions according the Collaborative Practice Agreements	• Provides self-management support, coordinates care, help patients navigate the healthcare system and access community services
	Quality Improvement Activities Team conducts QI activities to monitor quality measures and improve metrics with involvement of patient and families Program Targets Team monitors program targets and make changes to improve MacColl Center for Healthcare innovation, Primary Care Team Assessment Guide - http://www.improvingprimarycare.org/assessment/full					

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Tools to Assess Team Role Expansion

- Primary Care Team Assessment Guide
  MacColl Center for Healthcare Innovation
  http://www.improvingprimarycare.org/assessment/full

- Share the Care - LEAP Primary Care Team Guide
  http://www.improvingprimarycare.org/search/resources?keyword=share+the+care

*

Handout 2b and 2c
Also Found on Team Based Topic Page MICMRC

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1

Communication:

- *SBAR* = Situation, Background, Assessment, Recommendation
- Clear charting documentation in the EHR
- Messaging
- Huddles

2

Expanding Roles:

- Collaborative Practice Agreements
- Standing Orders
- Order Sets

*

Care Team Members - Communicating with Providers

- Communication between provider and care team:
  - G9007
    - Remember this is billable when face to face, over the phone
    - BCBSM includes secure web conference or video

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SBAR

- Situation – What is the concern?
  A very clear, succinct overview of pertinent issue.
- Background – What has occurred?
  Important brief information relating to event. What got us to this point?
- Assessment/Analysis – What do you think is going on? Summarize the facts and give your best judgement.
- Recommendation - What do you recommend? What actions do you want?

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SBAR – Video Examples: Ineffective Communication

https://youtu.be/CtdNQ-sfKg8

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SBAR – Video Examples: Effective Communication

https://youtu.be/fsazEArBy2g

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SBAR – Your Turn! Activity 6

Scenario:

28 year old pregnant (32 weeks) female recently moved to Ypsilanti, MI from Flint to share an apartment with her sister and her 2 children. The patient has not set up OB care yet. She has just run out of her Lisinopril to control her blood pressure. She needs an appointment as well as medications to cover her until she can be seen. She has no means of transportation.

- **Situation** – What is the concern?
  A very clear, succinct overview of pertinent issue.
- **Background** – What has occurred?
  Important, brief information relating to event. What got us to this point?
- **Assessment/Analysis** – What do you think is going on?
  Summarize the facts and give your best judgement.
- **Recommendation** – What do you recommend?
  What actions do you want?

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Huddles and Meetings

Huddle	Meeting
Max of 10 minutes	30-60 minutes
Preferably daily, but may also be weekly	Usually every other week or monthly
Goal is to review patients who are coming in *that day or that week* Review any high risk patients, complex care plans Assure that any ED or IP visits are communicated Assure gaps in care are known on each patient and there is a plan to address them	Goal is to review performance on key metrics and address barriers to the process, like: • Are the providers giving a warm hand-off to the care manager? • Do the office staff have a way of referring to the care manager? • Who is scheduling and does everyone have access to the care manager's schedule?
Participants minimally include PCP, MA, Staff RN, and Care Manager	Minimally include a representative from each role, front and back office, billing, PCP, Care Management, MA, Office Manager

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Other Communication Modalities

- Documentation in the chart – this is an excellent way to communicate what happened without being able to update the PCP on every detail
- Messaging within the EHR
- **Main Point: Work out with your provider and team how they prefer to know what happened during your visits!**

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Expanding Team Roles: Collaborative Practice Agreements

- A collaborative practice agreement defines what the PCP and Care Manager agree are in their scope of work.
  - Usually, this expands beyond the normal licensure parameters → allows a Clinical Pharmacist to titrate meds, for example.

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Standing Orders

- Standardize protocols and delegate work from the provider to the teams.
- Standing orders examples:
  - Immunizations, medications, or procedures
  - Preventive care or chronic disease management
  - Referrals, scheduling or answering phones

To view examples of standing orders: https://cepc.ucsf.edu/standing-orders

https://www.jabfm.org/content/25/5/594

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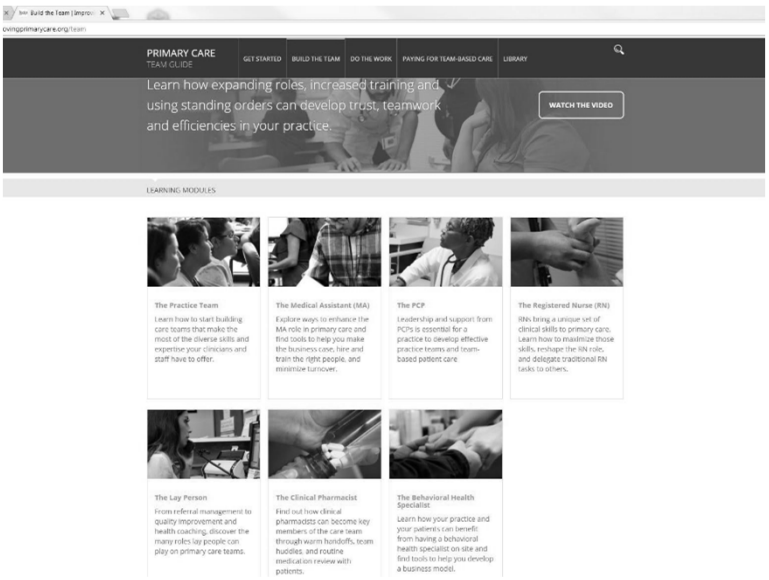
Resources



Reference: "The Primary Care Team Guide", LEAP Primary Care Team, http://www.improvingprimarycare.org/team

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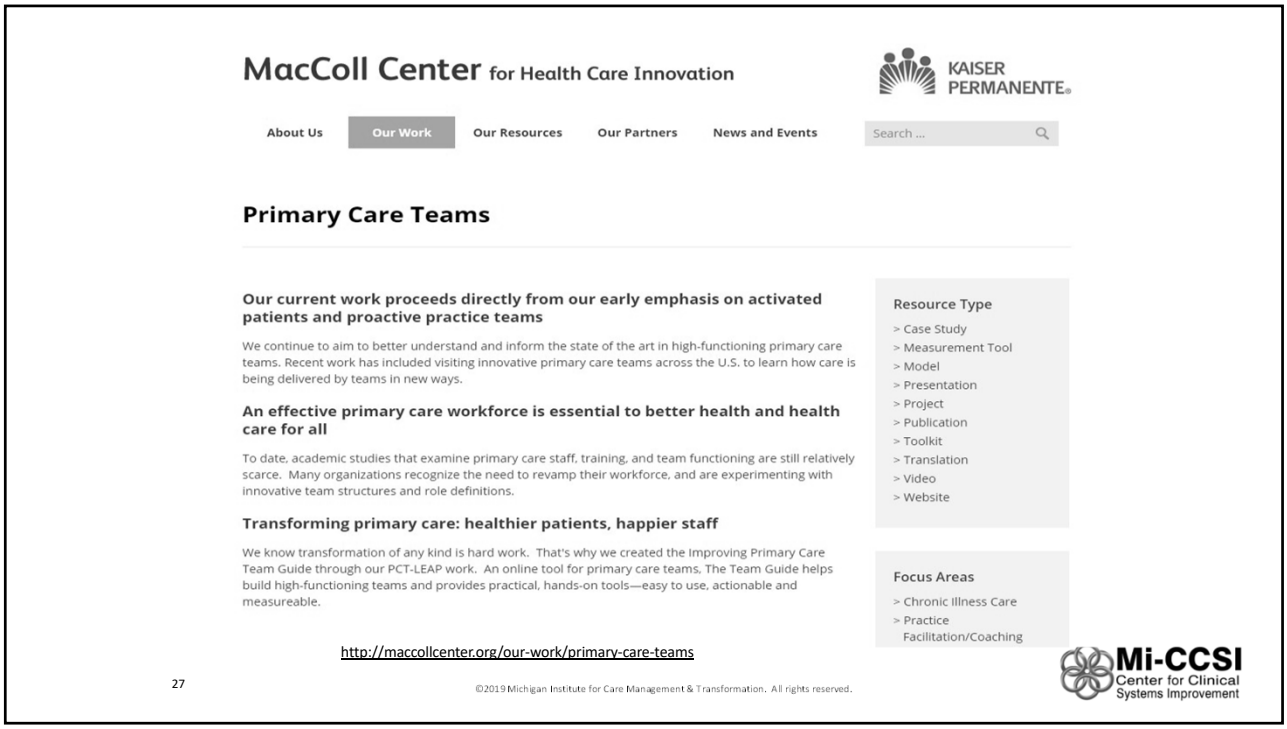

http://maccollcenter.org/our-work/primary-care-teams

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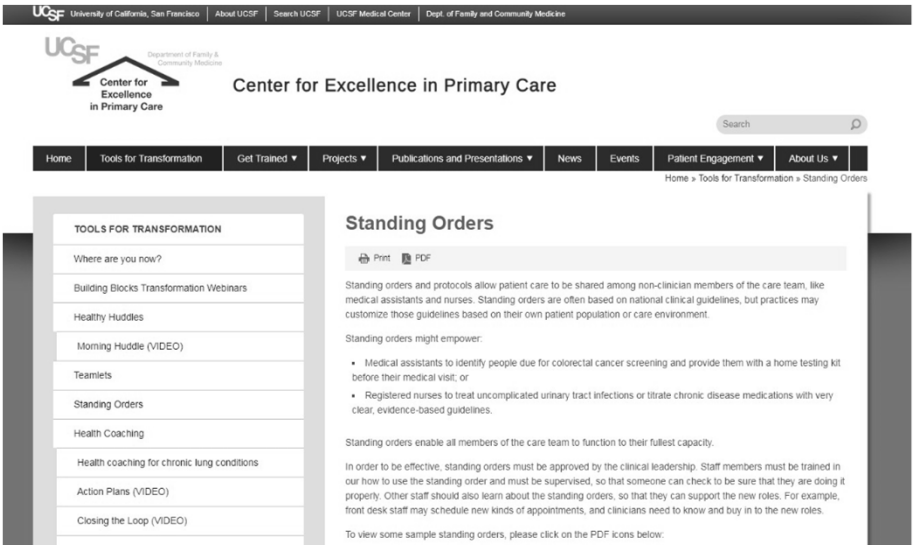

https://cepc.ucsf.edu/standing-orders

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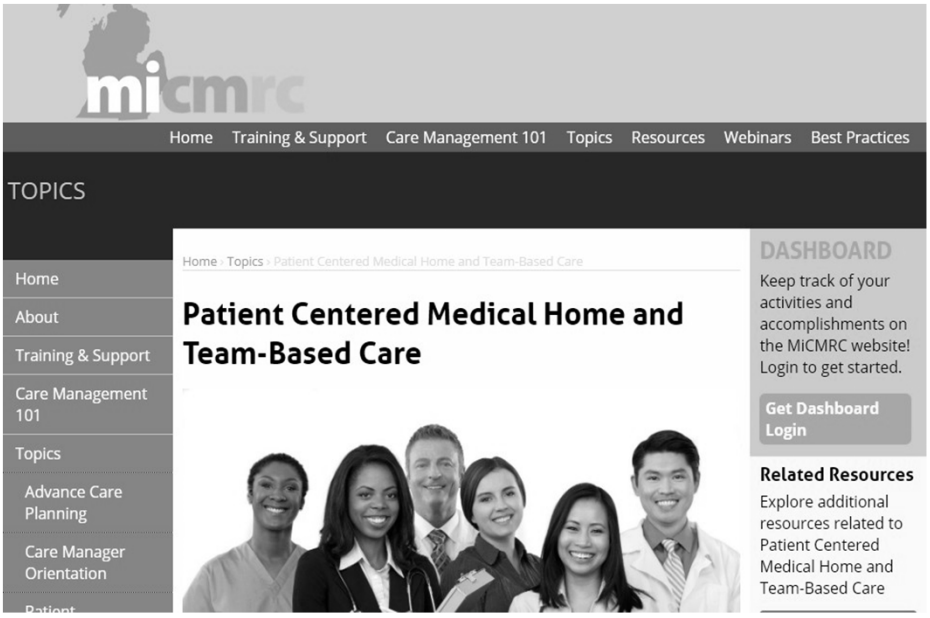

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Additional Resources

- **MiCMRC website** Topic page: "Patient Centered Medical Home and Team Based Care" http://micmrc.org/topics/patient-centered-medical-home-and-team-based-care
- **Practice Assessment | Improving Primary Care Guide RWJ** http://www.improvingprimarycare.org/search/resources?keyword=practice+assessment
- **Key Elements of Highly Effective Teams from American Academy of Pediatrics** http://pediatrics.aappublications.org/content/pediatrics/133/2/184.full.pdf
- **American Academy of Family Physicians**
- **American Medical Association**

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Reference Guide Available on MICMT

Leap - Assessment of Team Roles and Task Distribution Tool

MacColl Primary Care Team Guide Assessment

Team Huddle Checklist

SIM PCMH Key Roles of Care Coordinator/Care Manager

Care Management Responsibilities

Bellin Core Concepts for Team Based Care

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Paradigm Shift

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Paradigm Shift

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Learning Objective

- Describe the care management paradigm shift from the standard medical approach to the patient centered approach.

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Approach to Care Management:

Standard Medical Approach	Patient Centered Approach
• Focused on fixing the problem	• Focused on patient's concerns, perspectives, and values
• Paternalistic relationship	• Egalitarian partnership
• Assumes patient is motivated	• Match intervention to stage of change
• Advise, warn, persuade	• Emphasize personal choice
• Ambivalence means that the patient is in denial	• Ambivalence is a normal part of the change process
• Goals are prescribed *	• Goals are collectively set in collaboration between patient and provider

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Persuasion Exercise Activity 4

- Patient: Role play a patient where behavior change is a goal…(quitting smoking, losing weight, checking blood sugars, socializing more), you are ambivalent and somewhat resistant to change
- Care Manager: Use instructions on handout to respond to patient

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Persuasion Exercise Activity Part A

Patient:

Role play a client where behavior change is a goal…you are ambivalent and somewhat resistant to change

Care Manager:

1. Explain why the client should make the change
2. Give at least 3 specific benefits that would result from making the change
3. Tell the client how to change
4. Emphasize how important it is for the client to make the change
5. Tell the client to make the change

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Persuasion Exercise Activity Part B

Patient:

Role play a client where behavior change is a goal…you are ambivalent and somewhat resistant to change

Care Manager

1. Why would you want to make this change?
2. How might you go about it, in order to succeed?
3. What are the three best reasons to do it?
4. On a scale of 0-10, how important is it for you to make this change?

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Video Example of Paradigm Shift:

The Ineffective Physician: Motivational Interviewing Demonstration

https://youtu.be/80XyNE89eCs

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Video Example of Paradigm Shift:

The Effective Physician: Motivational Interviewing Demonstration

https://youtu.be/URiKA7CKtfc

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Care Management

5-Step Process

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Care Management Five Step Process

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Learning Objective

- Relate key work which is completed in each step of the five step care management process

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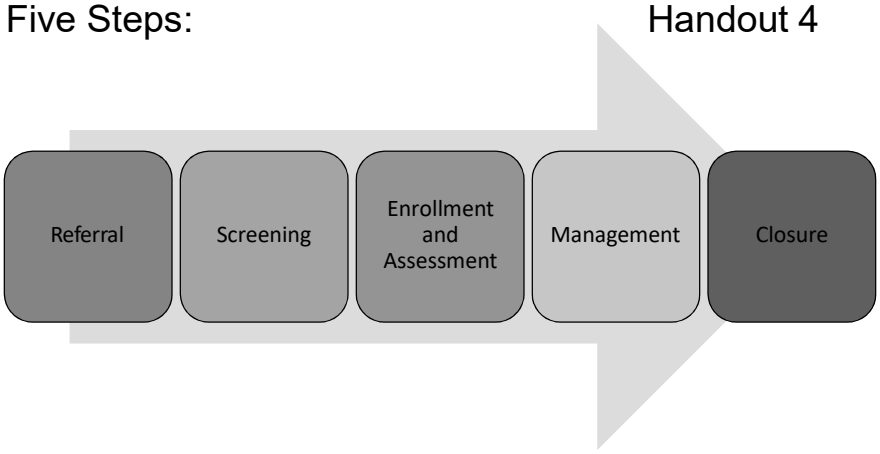
Care Management Process 5 Step Process and Key Work

Care Management Process

Five Steps: Handout 4



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Step 1: Referral into Care Management

Referral into Care Management

It is important to manage your referral processes!!!

Work with your practice team to assure the population you work with is directly related to practice and PO metrics

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A1c control, BP control, ED Utilization, Inpatient Utilization

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Referral into Care Management

Proactive Patient Identification

- Risk Stratification →
  - look for high risk patients to impact utilization measures
- Registry lists →
  - identify 'lost to follow up' patients to support improving quality measures such as A1c and BP
  - Develop a criteria with the provider that could become a standing order for referral

*

Passive Patient Identification

- Referrals from physicians
- Standing orders based on patient parameters

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Risk Stratification

Risk stratification is ideally an intentional, planned and proactive process carried out at the practice level to effectively target clinic services to patients.

http://www.njafp.org/sites/ethos.njafp.org/files/risk_strat_peskin_distribution_final.pdf

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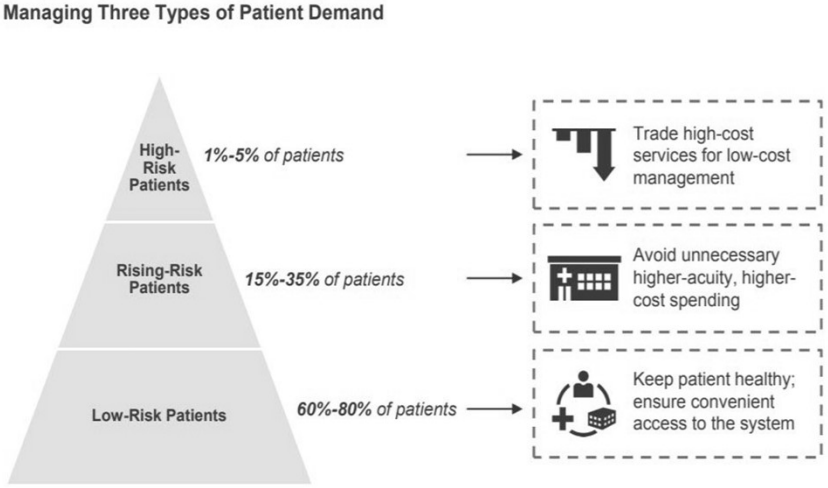
The Risk Pyramid



SOURCE: "Mind the Gap", The Advisory Board Company.
https://www.advisory.com/-/media/Advisory-com/Research/PHA/Research-Study/2017/Mind-the-Gap-Managing-the-Rising-Risk-Patient-Population.pdf

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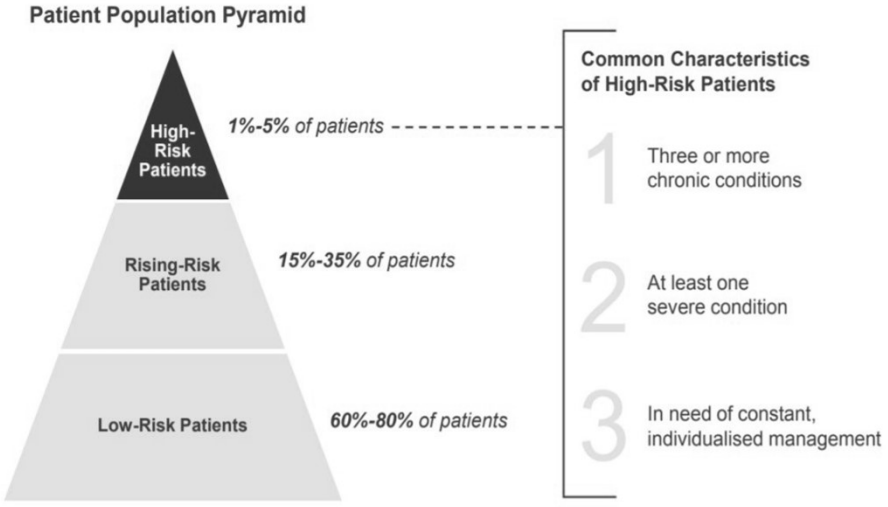
High Risk – the Initial Focus!



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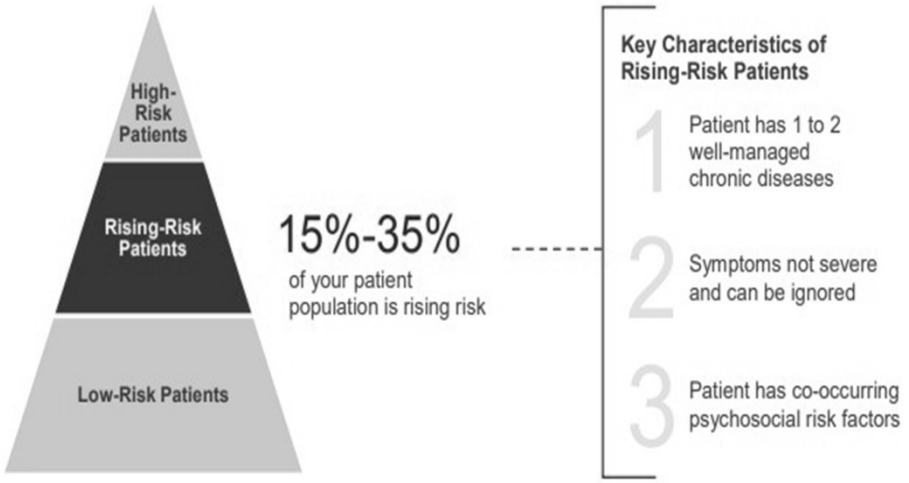
Rising Risk – yearly 18% of rising risk escalate to high-risk when not managed



11 SOURCE: Addressing the Needs of Your Rising-Risk Patients 2017, https://www.advisory.com/research/population-health-advisor/research-briefings/2018/addressing-the-needs-of-your-rising-risk-patients

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How does your office risk stratify?

Strategy	Description	Care Manager example strategy
Basic	**No clear risk assigned** to the full population of patients.	Review lists of patients from registries – diabetics, asthmatics, and Payer with Provider. Providers can risk stratify based on their patient knowledge. CMs can supplement with screenings (SDOH, depression, etc.) *Remember that each patient the provider reviews with you means a G9007 billable code!
Intermediate	**Hospital discharges risk stratification** no internal process that assigns risk.	Strategy to use inpatient admissions risk score. Care manager and office staff share work based on discharged risk score.
Advanced	**Automatic method** of assigning risk to the entire population.	Standing referral to Care Management protocol based on risk score.

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Care Manager Risk Stratification Tools

1. **Payer list based on internal risk tools which may influence Incentive programs for patient identification**
   - Lists have a column that describes # of hospitalizations / ED visits, comorbidities, etc.
   - Discussing patients is a good 1st step that is also billable!
2. **Social Determinants of Health Screenings**
   - A strong predictor of readmission is social isolation – so knowing whether or not a patient has social support can help inform the best approach to supporting that patient*.
3. **Patient Activation Screenings**
   - Patient Activation Measure (PAM) by Insignia, other patient activation tools.
4. **Behavioral Health Screenings**
   - PHQ-9 and other mental health screenings.

13 *https://www.sciencedirect.com/science/article/abs/pii/S1071916406007421

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Post Hospitalizations: Risk of Readmission

High-Risk Patients	Moderate-Risk Patients	Low-Risk Patients
Admitted two or more times in the past year Unable to Teach-Back, or the patient or family caregiver has a low degree of confidence to carry out self-care at home	Admitted once in the past year Moderate degree of confidence to carry out self-care at home, based on Teach Back results	No hospital admissions in the past year High degree of confidence and can Teach-Back how to carry out self-care at home

14 http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionsfromHospitaltoHomeHealthCareReduceAvoidableHospitalizations.aspx

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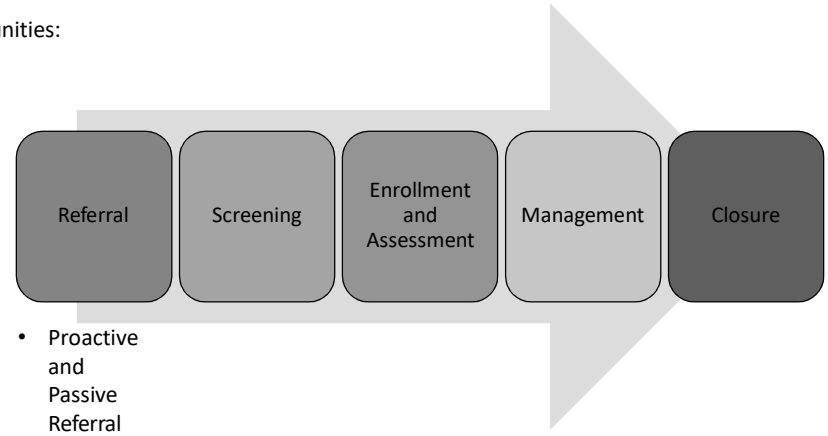
Care Management Process

Billing Opportunities:



Key Items:

- Proactive and Passive Referral processes

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Case Study

Mr. B – High Risk

- 83 years old
- Increasing symptoms of fatigue, weakness, SOB
- Hospitalized 3 months ago, HF exacerbation
- History of HTN, CAD, MI
- Temporarily living with daughter
- Unsure about his medications
- Feeling low
- High salt diet
- Worried about living arrangements
- Wants to be in own home
- Trouble sleeping
- Requires assistance with ADLs

Mrs. A – Rising Risk

- 70 years old
- Has type II diabetes for last 10 years without complication
  - Recently started on insulin
  - blood sugar out of control
- HTN – BP controlled with medication

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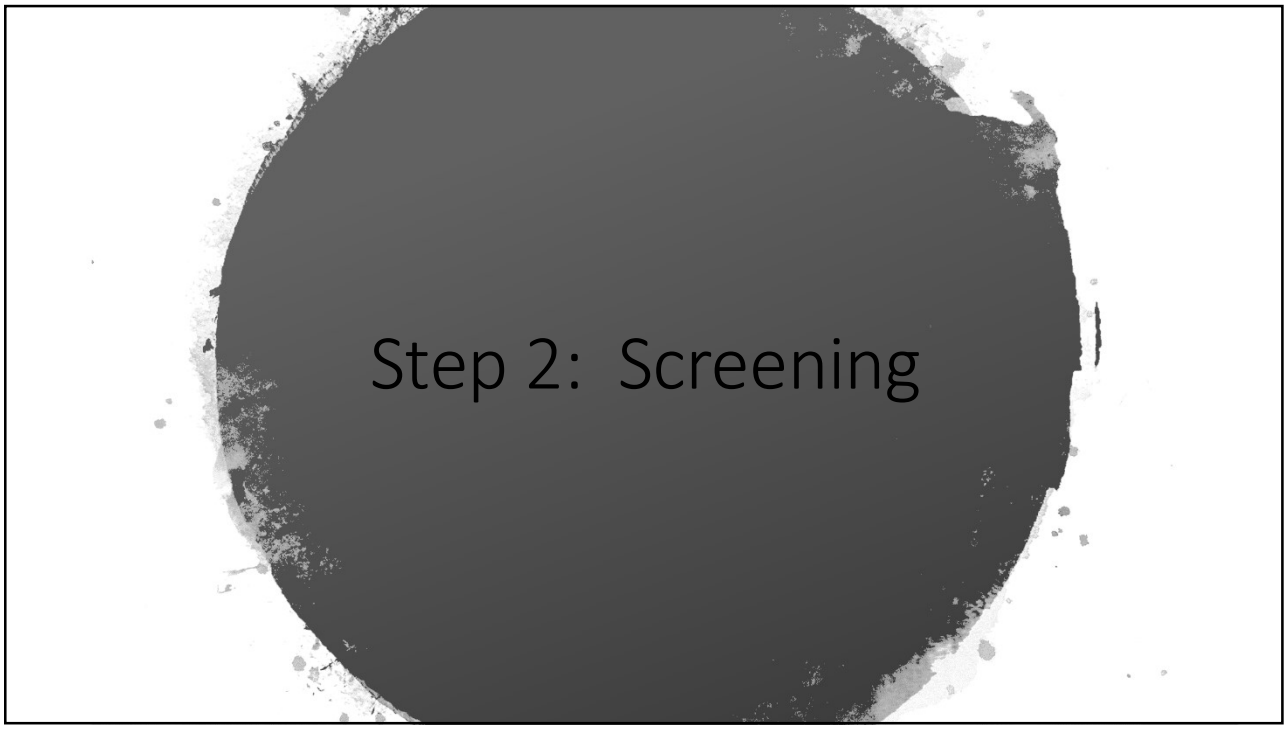

Screening

- Screenings give patient context and support development of the patient Care Plan

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Types of Screening

- Social Determinants of Health
- Social Support Structures:
  - home environment, social relationships
- Limitations and barriers:
  - what's keeping the patient from being a good steward of their health
- Physical/emotional/cognitive functioning
- Self-care ability:
  - health understanding, health literacy, engagement, confidence
- Behavioral Risk:
  - Anxiety, depression, stress, mental health symptoms

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What Are Social Determinants Of Health (SDOH)?

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Social Determinants of Health Objectives:

- What are Social Determinants of Health
- How do Social Determinants of Health impact a person's overall health and well-being
- How Social Determinants of Health can be evaluated
- What resources exist
- The care manager's role in addressing Social Determinants of Health

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What are Social Determinants of Health?

- **Social determinants of health are the conditions in which people are born, grow, live, work and age.**
- They include factors such as:
  - Socioeconomic status
  - Education
  - Neighborhood and physical environment
  - Employment
  - Social support networks
  - Access to health care

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SDOH Domains

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF

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SDOH Examples:

Patient:
Mr. W does not understand the instructions on his pill bottle for his CHF. He ends up in the hospital due to taking his medication incorrectly.
Mrs. H calls an ambulance and is taken to the ER for a low blood sugar reaction because she has no transportation to get to her primary care office.
Mrs. A's son is hospitalized for an acute asthma exacerbation. The family has been unable to pay for heat this month and it is December.

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How Do SDOH Impact Health?

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SDOH and the Triple Aim

https://youtu.be/OtYf0RsSCTs

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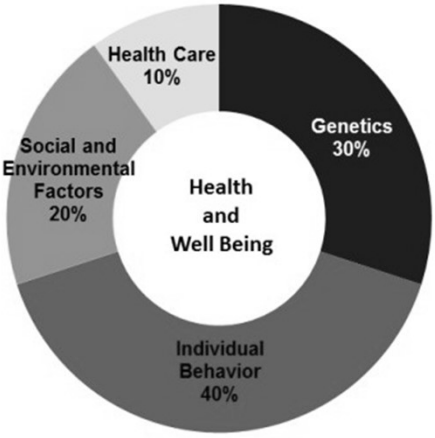
Social Determinants Impact on Health



SOURCE: Schroeder, SA. (2007). We Can Do Better — Improving the Health of the American People. *NEJM*. 357:1221-8.

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How To Identify SDOH

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Identifying a SDOH Need

1. Screening options:
   - Screen all patients once per year with their annual visit.
   - Screen patients from specific program, SIM, Priority.
   - Screen all patients referred to care management.
2. Probing questions to get to the root cause of the barriers to receiving care

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Screening Tool

- SIM Suggested SDOH Screening tool:

SIM SDOH Domains	
Healthcare	Family Care
Food	Education
Employment & Income	Transportation
Housing & Shelter	Personal and Environmental Safety
Utilities	General If yes, would you like to receive assistance with any of these needs? Are any of these needs urgent?

To access SIM suggested SDOH screen tool – MICMT Care Management Reference Guide

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Screening Process

- The process is different at each office. Investigate:
  - Who initiates the SDOH screening tool in your office?
  - Where does the screening tool go once it is completed by a patient?
  - Who addresses a positive screen?
  - Who provides the resource, and how?
  - Who follows up on the resources provided?

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SDOH within the Comprehensive Assessment

- Baseline for both the medical, behavioral **and** *social needs*
  - Patient's typical day
  - How the patient functions in their daily life
  - Identify family/caregiver support
  - Ability of caregiver to carry out necessary tasks
  - Patient and caregiver needs and wellbeing
  - Clarify patient's preferences regarding community participation and goals of care
- Prioritize risks through Maslow's Hierarchy of Needs
  - Provides an ordered structure to needs for the clinical team
  - Prioritize interventions

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Health Literacy

The Facts:

- **90 million adults**, nearly half of the adult population, lack literacy skills needed to understand and act on health information and health system demands

- **12% of U.S. adults** have the health literacy proficiency to perform complex health tasks such as using a table to calculate an employee's share of health insurance costs

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http://www.iom.edu/~/media/Files/Activity%20Files/PublicHealth/HealthLiteracy/HealthLiteracyFactSheets_Feb6_2012_Parker_JacobsonFinal1.pdf

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AMA Health Literacy

https://youtu.be/BgTuD7l7LG8

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Adverse Childhood Experiences (ACES)

- Are intense and frequently occurring sources of stress children may suffer
- Prolonged stress in childhood has life-long consequences for health and well-being. It can disrupt early brain development and compromise nervous and immune systems
- 10 types of childhood trauma measured in the ACE Study
  - Five are personal
    - Physical, verbal, or sexual abuse
    - Physical or emotional neglect
  - Five are related to other family members
    - Parent who's an alcoholic
    - Mother who's a victim of domestic violence
    - Family member in jail
    - Family member diagnosed with a mental illness
    - Disappearance of a parent through divorce, death or abandonment
- **As the number of ACEs increases, so does the risk for unfavorable outcomes**
- *

https://www.cdc.gov/violenceprevention/acestudy/about_ace.html

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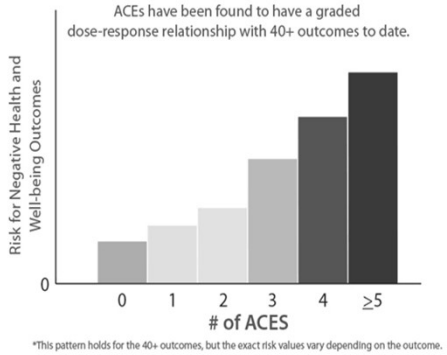
ACES

ACES can have lasting effects on….

Health (obesity, diabetes, depression, suicide attempts, STDs, heart disease, cancer, stroke, COPD, broken bones)

Behaviors (smoking, alcoholism, drug use)

Life Potential (graduation rates, academic achievement, lost time from work)



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https://www.cdc.gov/violenceprevention/acestudy/about_ace.html

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Addressing SDOH

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Addressing SDOH – Community Linkages

Practices

- Have a Community Resource binder (paper or online). It is a PCMH capability.
- Use online resources such as the MI Bridges, Michigan 2-1-1.
- Connect the patient with the resource.
- **Follow up** to check patient used the resource.
- Document linkages in the medical record.

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Community Linkages

- Creating sustainable, effective linkages
- Between the clinical and community settings
- To improve patients' access to preventive and chronic care services
- By developing partnerships between organizations that share a common goal of improving the health of people and the communities in which they live
- These linkages connect clinical providers, community organizations, and public health agencies

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html

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Community Linkages - GOALS

- Coordinating health care delivery, public health, and community-based activities to promote healthy behavior
- Forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services
- Promoting patient, family, and community involvement in strategic planning and improvement activities
- Collaborations between clinical, community, and public health organizations offer a win-win scenario for participating organizations, clinical teams, and patients

* https://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html

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Patient	Care Team	Community Linkage
Mr. W **Did not understand the instructions on his pill bottle for his CHF**. He ends up in the hospital due to taking his medication incorrectly	Mr. W is referred and called by the **primary care practice pharmacist** for medication reconciliation and medication management	The practice has an established relationship with **the local pharmacy who provides bubble packs** for Mr. W. The pharmacist ensures Mr. W. receives the bubble packs and that this intervention works for him and he is satisfied
Mrs. H **Calls an ambulance for a low blood sugar reaction** no transportation to get to her primary care office	Mrs. H is followed by the Primary Care Practice **Medical Assistant or Community Health Worker** and is provided with transportation resources	The **practice has a relationship with the 3 local transportation providers** in the area. The appropriate one is referred. Follow up is done by the MA/CHW to ensure the service happened and the MA/CHW ensures the patient was satisfied with the outcome
Mrs. A's son is hospitalized for an **acute asthma exacerbation** unable to pay for heat this month and it is December	Mrs. A is referred to **the social worker** at the primary care practice who assists Mrs. A with utility resources	The practice has a connection with a local resource. The contact person, known to the social worker, agrees to provide the resource. Follow up is done with the patient to ensure closure of need and to assess patient satisfaction with the outcome

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Addressing SDOH – Individualized Plan of Care

Document Needs for Ongoing Support

- Social needs that can't be addressed with a community resource today
- Focus on barriers that can be addressed now
- Self-management goals related to addressing social needs can be a way of documenting progress

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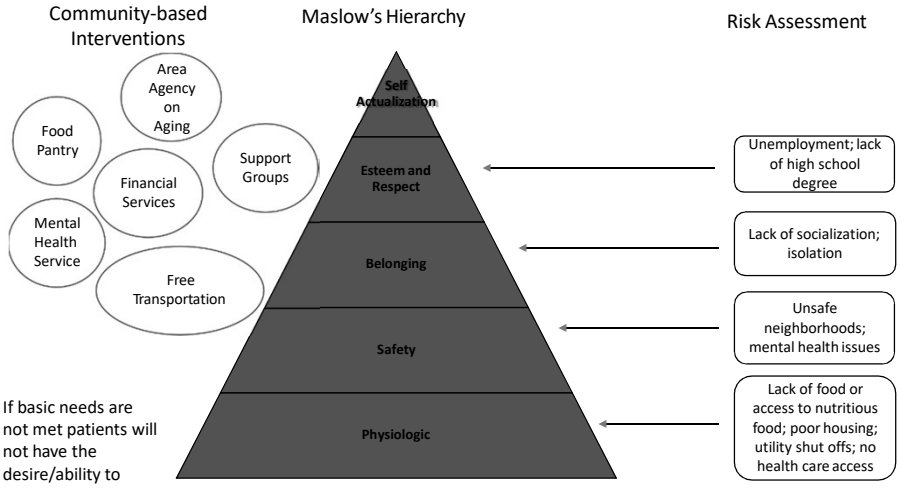
SDOH – Prioritization & Organization



If basic needs are not met patients will not have the desire/ability to engage in health care discussions

Adapted from: Beck, A.F., Henize, A.W., Kahn, R.S., Klein, M.D. (2015, October). A road map to address the social determinants of health through community collaboration. *Pediatrics*, 136(4) Retrieved from, http://pediatrics.aappublications.org/content/136/4/e993

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Screening/Assessment

Mr. B

- Medical record
- PCP
- Patient story
- SDOH screening
- Hospital discharge report
- Care giver support - patient's daughter

Mrs. A

- Medical record
- PCP
- Patient story
- SDOH screening
- Care giver-spouse

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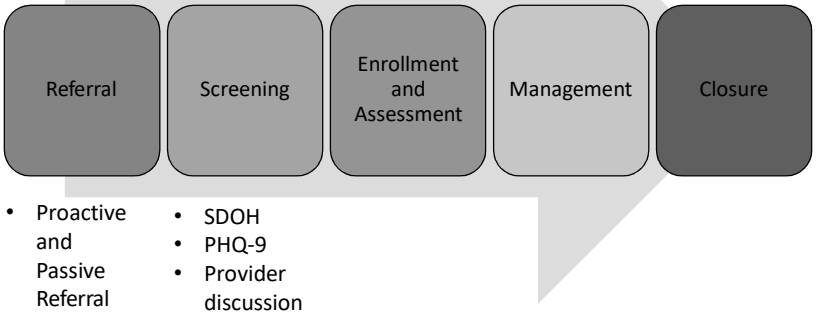
Care Management Process

Billing Opportunities:

- G9007 team conference



Key Items:

- Proactive and Passive Referral processes
- SDOH
- PHQ-9
- Provider discussion

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Step 3: Enrollment and Assessment

Provider Discussion

Why have the Provider discussion?

- Speaking with the provider is an excellent way to determine whether or not the patient would be appropriate for care management.
  - Providers often has knowledge of patient's circumstances - psychosocial, readiness for change
  - Provider input saves time!

- Your role – initiate the conversation.
  - State why you think the patient may benefit from care management services
  - Identify possible care management services and team members

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Determination for Care Management

- Patient would benefit from care management services but a determination made to not enroll

- Consider options to offer support for patient
  - Link to community resources
  - Reaching out to the patient's health care plan care manager

For Medicaid Managed Care – see contact list for the plan's care management services	Blue Cross Health and Wellness, call 800-775-2583

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Engagement

- What is it?
- How do you achieve it?
- Resources
  - eLearning and topic page

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Enrollment: Patient Engagement Strategies

- Warm handoff from PCP is best
- If warm handoff is not possible
  - Quick Tools
    - CM elevator speech or greeting face to face in office
    - CM Phone script
    - Care Management Flyer
    - Care Management Brochure
  - Building a trusting relationship
  - Assess patient's readiness

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Enrollment: Patient Engagement

- Getting started:
  - Ask patient/caregiver:
    - "Dr. Smith asked me to contact you. He thinks you may benefit from a service we offer."
    - "My name is Beth, a nurse with Dr. Smith's office. He wanted me to call you regarding a service to help you manage your diabetes."
    - "Dr. Smith asked me to call you about the concerns you have about your health."

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Enrollment: Comprehensive Assessment

- The Comprehensive Assessment is billed through the G9001 code.
  - Note that a G9001 code doesn't *have* to be the first code billed for a patient. It is the code for the comprehensive assessment.
- Physician discussion G9007

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Enrollment: Assessment

- Use information from screenings to develop a understanding of the patient's self-care ability.
- Organize information into a (SWOB) analysis
  Strengths / Weaknesses / Opportunities / Barriers
  - **Strengths** → behaviors / social structures / attributes that support the patient being a self-manager of their own health
  - **Weaknesses** → behaviors / social structures / attributes that do not support the patient self-managing their health
  - **Opportunities** → things the patient wants to accomplish that the care manager can leverage to help the patient avoid negative health outcomes or high cost events
  - **Barriers** → things the care manager can help diminish, like a positive on a SDOH screen

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Organizing Screening Info to Develop a Care Management Plan

Strengths	**Weaknesses**
behaviors / social structures / attributes that support the patient being a good steward of their own health.	behaviors / social structures / attributes that do not support the patient to be a good steward of their health.
Opportunities	**Barriers**
things the patient wants to accomplish that the care manager can leverage to help the patient avoid negative health outcomes or high cost events.	things the care manager can help diminish, like a positive on a SDOH screen.

1. Patient Goals
- Goals come from the patient's perceived opportunities, with the care manager helping to reduce barriers.
- Align with the provider's care plan goals and the outcomes that our programs seek to improve (A1c, BP, ED utilization, IP utilization)

2. Follow Up Plan
- Determine how frequently you will see the patient face to face and how often you will do phone check-ins.

Clinical foundation → provider discussion, med rec, clinical history, problem list, utilization history

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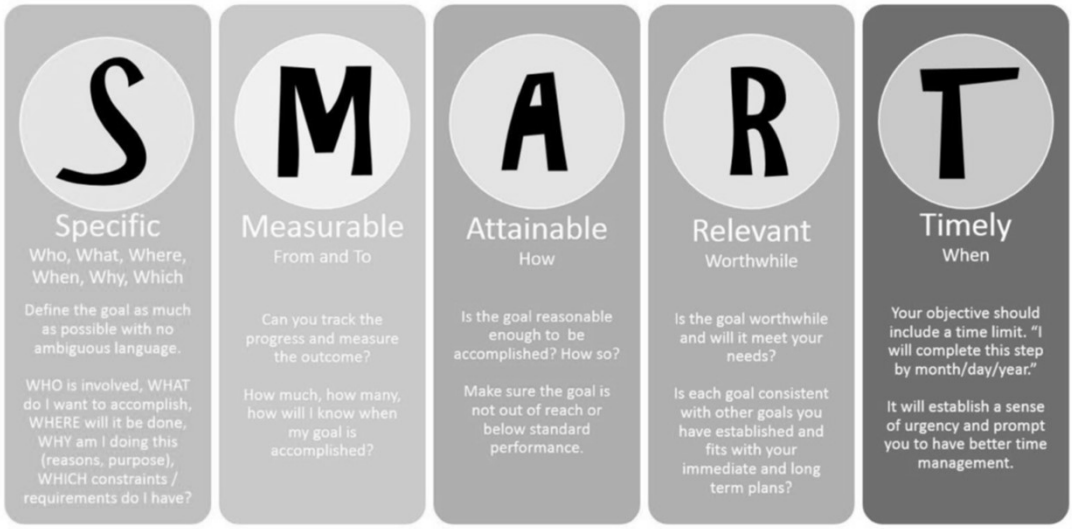
SMART Goals check handout



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Enrollment/Assessment - Activity 5

Mr. B – in person

- Document consent
- Level of understanding
- SDOH – positive screen
  - Transportation
  - Home environment
- Self care ability
- Support network
- Why patient unable to sleep
- Diet
- Depression screening
- Medication reconciliation

Mrs. A - phone

- Document consent
- Level of understanding
- SDOH – no needs
- Support network
- Depression screening
- Medication reconciliation
- Self care ability
- Diet, behavior/lifestyle

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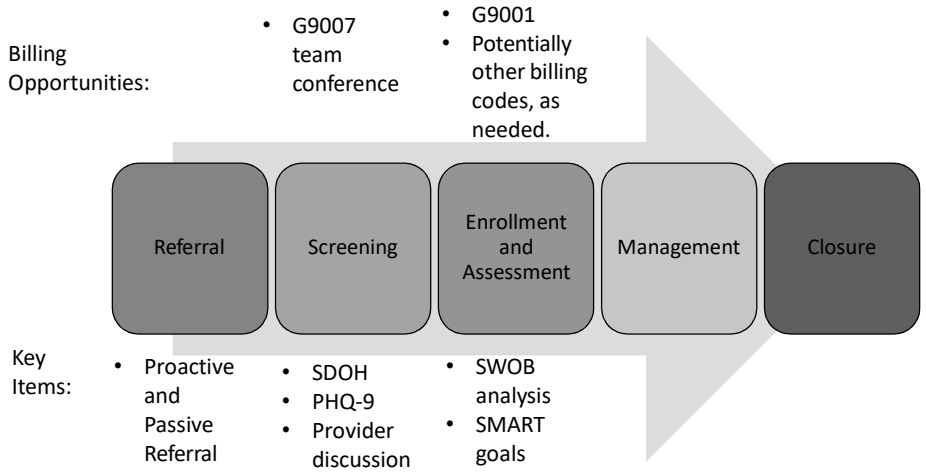
Care Management Process



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Management

The initial follow up care plan is based on:

1. The perceived level of support the patient might need to accomplish their goals.
   - Does the patient need episodic or longitudinal care management?

2. Whether the bulk of the screening and risk observations landed in the
   - "Strengths / Opportunities" side
   - "Weaknesses / Barriers" side

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Episodic vs. Longitudinal Management

Episodic

- Otherwise stable patients going through TOC
- Newly unstable chronic condition
- Short-term, goal oriented

Longitudinal

- Combination of multiple comorbidities
- Complex treatment regimens
- Behavioral and social risks
- Ongoing relationship

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2018 & 2019 CPC+ IMPLEMENTATION GUIDE: GUIDING PRINCIPLES AND
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Plan of Care – Patient Goals and Follow up

The patient goals and follow up plan are derived from:

- Conversations with the provider about the patient
- Conversations with the *patient* to develop goals
- Screenings:
  - Social Determinants of Health
  - Social Support Structures:
    - home environment, social relationships
  - Limitations and barriers:
    - what's keeping the patient from being a good steward of their health
  - Physical/emotional/cognitive functioning
  - Self - care ability or Patient Activation Level:
    - health understanding, health literacy, engagement, confidence
  - Behavioral Risk:
    - Anxiety, depression, stress, mental health symptoms

*

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Management – Plan of Care and Goals

Mr. B

- Comprehensive Plan of Care - Longitudinal
  - Collaboration with physician office team members, specialists, community agencies/resources, health plan care manager
  - When to call the PCP office

Mrs. A

- Short-term episodic care
  - Diabetes action plan

What are some short and long term goals for each patient?

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Management - Interventions

Mr. B

- Team members:
  - Pharmacist
  - SW
  - Dietitian
- Heart Failure action plan
  - Daily weights
  - When to call the PCP

Mrs. A

- Team members:
  - Diabetic educator
  - Patient and husband teach back on insulin use
- Diabetes action plan
  - When to call the PCP

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Management: Assessing Progress

- Determine the cadence of follow up visits based on:
  - Reassessment of patient's SWOB analysis – including re-screenings on a regular basis, progress with meeting SMART goals
  - If patient's identified needs met
  - Health status and outcomes

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Management
Follow up

Mr. B

- Long-term longitudinal
- Weekly to start
  - Daily weights
  - Dietary changes
- Follow up on transportation

Mrs. A

- Short-term Episodic
- Weekly to start
  - Follow up on insulin use
  - Blood sugar monitoring

What next?

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Care Management Process

	Referral	Screening	Enrollment and Assessment	Management	Closure
Billing Opportunities:		• G9007	• G9001 • Potentially other billing codes, as needed.	• All billing codes	
Key Items:	• Proactive and Passive Referral processes	• SDOH • PHQ-9 • Provider discussion	• SWOB analysis • SMART goals • Follow up plan	• Re-screen • Actively work to reduce barriers • Support goal progress	

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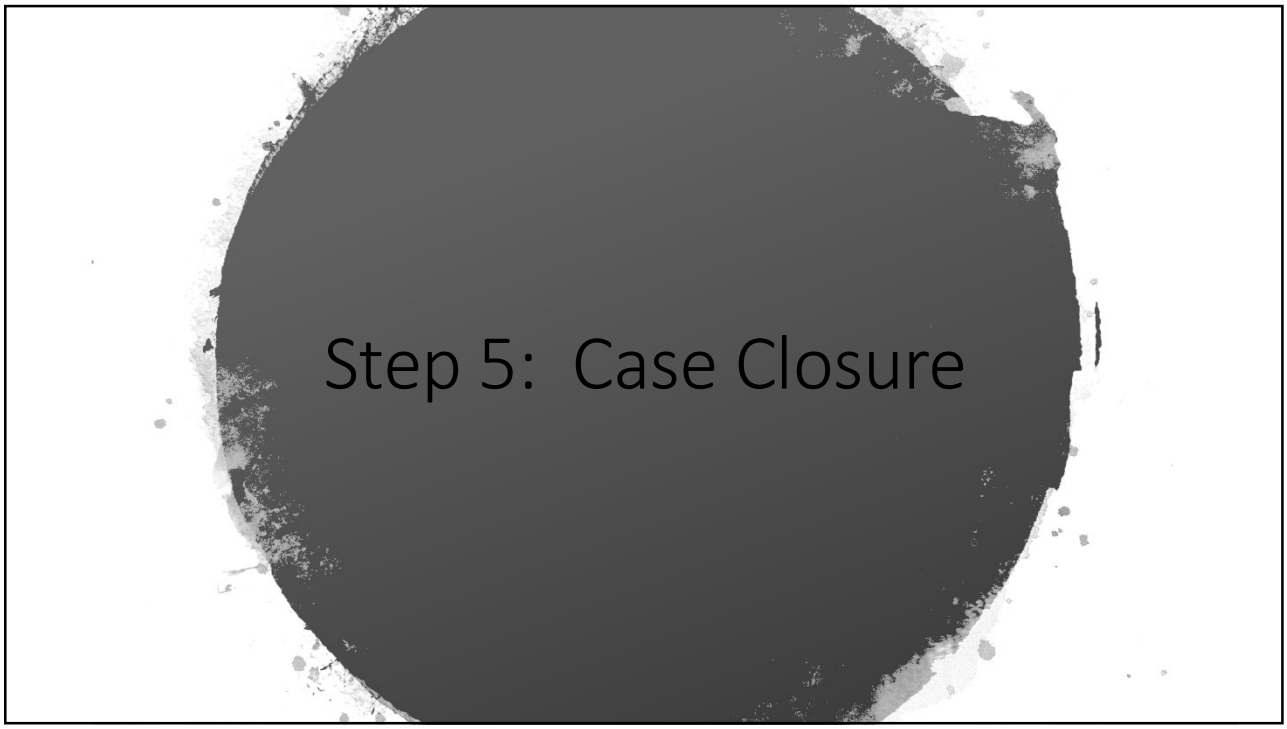

Case Closure

- Reasons for case closure:
  - Patient has met their goals and is discharged from care management services
  - Patient moves out of region/state
  - Patient expires
  - Patient is admitted to hospice care

Note:

- Be sure primary care physician is in the loop for case closures. This conversation is another potential billing opportunity (G9007)
- Discussion with patient (G9002)
- CPT 98966-67-68

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Case Closure

Mr. B

- Not appropriate for case closure, PCP in agreement
  - Chronic condition symptoms and exacerbations ongoing
  - SDOH barriers exist

Mrs. A

- Appropriate for case closure and PCP in agreement
  - Understands use of insulin
  - Blood sugars in control

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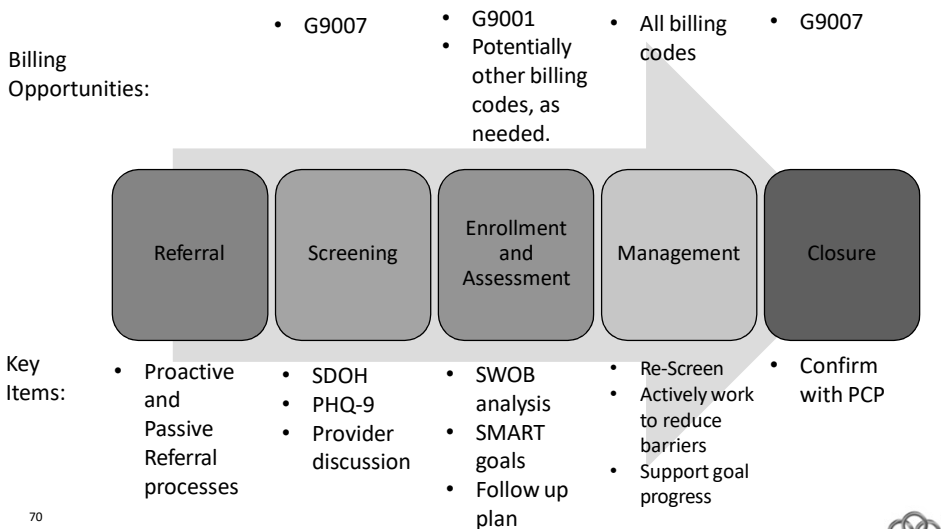
Care Management Process



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Reference Guide

Care Manager Introduction Phone Script

Care Management Explanation Flyer

SIM SDOH Screening Script Example

Michigan Community Resources

Michigan Medicaid Health Plan Contact Information

MDHHS Community Mental Health Services Programs

ACES Resiliency Screening

Michigan 2-1-1 Informational Guide

SIM SDOH Screening Tool

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Health Literacy

- **Agency for Health Research and Quality**
  - **http://www.ahrq.gov/patients-consumers/patient-involvement/ask-your-doctor/index.html**
  - **http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2.html**
- **US Department of Health and Human Services Health Literacy**
  - **http://health.gov/communication/literacy/**

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ACES – recorded webinar

- **SIM PCMH Initiative Pediatric Office Hours: ACES and SDOH Screening**

Presented by:

Jane Turner, MD, FAAP

Professor Health Programs, Pediatrics and Human Development, Michigan State University

Jodi L. Spicer, MA

Adverse Childhood Experiences (ACES)/Youth Suicide Prevention Consultant

Division of Chronic Disease and Injury Control

Michigan Department of Health and Human Services

ACCESS THROUGH MiCMRC.org https://micmrc.org/webinars/pediatric-office-hours-aces-and-sdoh-screening

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 http://www.lib.umich.edu/taubman-health-sciences-library/plain-language-medical-dictionary

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WORKSHEET

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Sustainability & Billing

MICMT Complex Care Management Course

Sustainability and Billing

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MICMT
Michigan Institute for Care Management & Transformation

Objectives

- Relate care manager activities to the tracking and billing codes
- Relate caseload and care management activity billing to sustainability
- Demonstrate use of billing codes in daily care management work

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2

Key Topics

- Describe the payment and value model for care management programs
- Review the sustainability model for care management
- Describe patient care situations and the corresponding billing codes

3

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Payment and Value Model

The Value of Care Management: a Practice Perspective

- Value
  - Decreased cost and improved patient outcomes
- Success for the practice
  - Making it easier to take care of patients – added team members to assist with complex patients
  - Improving performance on payer quality / utilization programs *(i.e. earning incentive money and being financially sustainable)*

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The Value of Care Management: a Payer Perspective

- Payer programs that fund care management use billing codes and outcomes to evaluate the success of care management programs.
  - Billing shows how much of the population we're able to reach
  - Outcomes show the impact of that outreach **(focus on ☆A1c, BP, Inpatient Utilization, and ED Utilization)** ☆

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Good news: BCBSM, PH, SIM use the same codes

Face to face w/ patient	• G9001 - Initiation of Care Management (Comprehensive Assessment) • G9002 - Individual Face-to-Face Visit
Group Visits w/ patient	• 98961 - Education and training for patient self-management for 2–4 patients; 30 minutes • 98962 - Education and training for patient self-management for 5–8 patients; 30 minutes
Telephone w/ patient	• 98966 - Telephone assessment 5-10 minutes of medical discussion • 98967 - Telephone assessment 11-20 minutes of medical discussion • 98968 - Telephone assessment 21-30 minutes of medical discussion
Care Coordination on behalf of patient (not with patient or provider)	• 99487 - First hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month • 99489 - Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (An add-on code that should be reported in conjunction with 99487)
Provider engaging codes	• G9007 - Coordinated care fee, scheduled team conference • G9008 - Physician Coordinated Care Oversight Services (Enrollment Fee)
Advanced Care Planning	• S0257 - Counseling and discussion regarding advance directives or end of life care planning and decisions

For all BCBSM PDCM codes: Provider liability if patient does not have Provider Delivered Care Management Benefit (BCBSM)

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G9001 – Comprehensive Assessment

- BCBSM
  - Individual, face to face (or video for commercial)
  - One per patient per day
- Priority Health
  - Individual, face to face
  - May be billed once annually for patients with ongoing care management
- The goal is to develop a plan of care that is based on how well the patient is able to steward their own care and the provider's care plan goals.
  - Patient self-management goals are an integral piece.

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G9001

- The Comprehensive Assessment / G9001 is a face to face meeting that results in a care management plan that all care management team members and the patient will follow.

- The Care Management Plan consists of 2 main things:
  1. Patient-driven goals
  2. Follow up and support plan

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G9002 – Face to Face Visit

- BCBSM (Commercial and Medicare Advantage): Quantity Billing
  - Individual, face to face or video
  - If the total cumulative time with the patient adds up to:
    - 1 to 45 minutes, report a quantity of one; 46 to 75 minutes, report a quantity of two;76 to 105 minutes, report a quantity of three;106 to 135 minutes, report a quantity of four

- Priority Health (Commercial, Medicare Advantage, Medicaid): No Quantity Billing
  - In person visit with patient, may include caregiver involvement
  - Used for treatment plan, self management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change

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G9001 vs. G9002

- G9001 is used to develop the holistic care management plan that will be followed by you and the patient.
- G9002 is used to discuss specific aspects of a care plan either as part of the follow up steps within a developed care management plan or for the development of a focused care plan in the absence of a comprehensive care management plan.

** The G9001 doesn't have to be the first code billed on a patient.

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G9007 – Team Conference

- PCP and at least one care team member formally discuss a patient's care plan
- Can be billed once per day per patient regardless of time spent

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98966, 98967,98968 -Phone Service Codes

Call with patient or care giver to discuss care issues, progress towards goals

- 98966 for 5-10 minutes
- 98967 for 11-20 minutes
- 98968 for 21-30 minutes

BCBSM:

- Licensed or Unlicensed care team member. MAs may bill the 98966 only

Priority Health:

- MUST Be a QHP – MA's do not meet this criteria/requirement
- MA does not bill for these codes

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99487, 99489 – Care Coordination On Behalf of Patient, not with patient

- 99487 – First 31 to 75 minutes of clinical staff time directed by a licensed or unlicensed team member working on behalf of the patient with someone other than the patient or provider
  - Examples:
    - Coordinating DME for a patient
    - Reaching out to a resource to help support a SDOH need

- 99489 – Each additional 30 minutes after 75 minutes per calendar month

Priority Health

- 99487: 60 minutes of clinical staff time directed by physician or other QHP per calendar month
- 99489: each additional 30 minutes per calendar month
  - Care coordinated by physician, QHP. Patient need not be present
  - Once per patient per calendar month

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G9008 – Physician Coordinated Care Oversight Services (Enrollment Fee)

- Physician delivered service
- BCBSM no ***quantity limit*** and can include the following: F2F, Video or telephone. This does not include email exchange or EMR messaging
  - Communication with Paramedic, patient, other health care professionals not part of the care team
- Priority Health:
  - Billed one time per practice during time patient is a member of the practice
  - CM, patient, & provider need to have a discussion but do not need to be present at the same time for those discussions to take place

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Incentive Programs for Care Management:

BCBSM

- Value Based Reimbursement (i.e. increase on every E&M code and PDCM code)
  - Up to 161% available
  - In 2019:
    - 5% of this is VBR for the billing codes for having 2 touches on 3% of the population
    - 11% is for Quality and Outcomes, focusing on A1c (1.5%), BP(1.5%), IP utilization (6.5%), and ED utilization(1.5%)
    - PCMH Designation 15% through 9/1/20
- Fee For Service on all codes billed
  - **no patient co-pay / provider liability**

Priority Health

- Annual PMPM payment if outreach to up to 5% of the population has 2 billed codes (average $2.64 pmpm)
- Fee For Service on all codes billed
  - **no patient co-pay**

SIM

- $2.75 - $7.00 PMPM care management and care coordination payments on Medicaid patients, assuming the goal of 2.5% eligible patients with a 'billed' code is achieved (reduction by $0.15 if not achieved).
- Incentive payment opportunity in 2019

CPC+ also includes care management, but it isn't so specific in it's funding.

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Activity / Billing Progress Reports

- Each Program sets benchmarks for number of patients receiving care management services at the practice level.
- Each program also sends a progress report to the PO; **work with your PO to devise a best strategy for tracking progress towards program goals**.
  - Priority Health sends through Filemart to PO Representatives on a monthly basis.
  - BCBSM sends through the EDDI mailbox on approximately a quarterly basis.
  - SIM program updates through the MDC reports on an approximately monthly basis.

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Common Outcomes Goals

- ***Quality***
  - Controlled HgA1c
  - Controlled Blood Pressure
- ***Utilization***
  - decrease emergency department visits
  - decrease hospital admissions

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Outcomes Goals – Be Part of the Strategy

- Each Care Manager should learn their PO's strategy and which of the core measures the PO is focusing on.
- Then, the Care Manager and office leadership should develop a plan for how they will also impact the selected metrics.

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What is sustainability?

- Sustainability is how the care manager service in your office maintains itself financially…
  - i.e. it's how you pay for yourself!

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How can you help make your service sustainable?

Program Financial Support

Identify which programs your office(s) are in that support care management:

- CMs help achieve program goals, and therefore can increase the program revenue.
- Each CM should track and make sure that the outreach levels dictated by the payer programs are achieved.
  - PO Leads can help provide reports that show progress.
  - Some office managers don't want to share the financial revenue. If that's the case, ask them to work with the PO lead to understand the program revenue coming to their office for care management work.

Billing Revenue

Work with the office manager / PO lead to identify a billing goal based on case mix in your office.

- It's important for everyone to start out with common expectations of a billing goal.
- What is an example of a billing goal?
  - Some start with a minimum of 8- 10 billable codes / day or 40-50 billable codes / week. This includes face to faces, team conferences, etc.
- Some offices only allow their care managers to work with patients whose insurance covers the service. Others are more inclusive.

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Is a minimum of 8-10 codes in a day feasible??

Many groups don't evaluate on a day to day basis. It's easier to look at a month or a week, as the patient load on a given day is variable.

Review the example to the right for a "day in the life" that shows how you might get up to 10 billable type activities per day or 50 per week.

Week-long review:

- Pre-work (before the week starts):
  - review schedule & identify potential patients based on payer, risk, diagnoses. Send those patients as a list to the provider.
- Scheduled weekly 15 minutes with Provider to review complex patients and face to face patients for that week (10 patients; 10 G9007 codes)
- Target seeing 1-3 new patients per week and 3-4 existing patients in face to face visits per day
  - 1-3 G9001 codes
  - 15-20 G9002 codes
- Conduct follow up phone call visits; at least 4 phone calls per day
  - 20 phone calls / week (98966 -98968)

That sums to 46 - 53 codes per week.

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Before we start… Activity 7

- The following series of examples are intended to show a couple of common situations for billing codes.
- They are NOT comprehensive.
- The 1st Thursday of every month is a BCBSM Monthly Billing Q&A session at noon (see reference guide for details, or www.micmrc.org/training/care-management-billing-resources)
- If you have questions on specific situations, please reach out to valuepartnerships@bcbsm.com

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High Risk Patient

- Patient is flagged as high risk by a payer list.
- Care manager discusses overall care plan goals with provider, and it is determined the patient is appropriate for care management.
- Care manager reviews the chart, recent screenings (SDOH, PHQ-9), problem list, medications, and utilization history.
- Care manager sees the patient in a face to face visit and evaluates the patient's current ability to steward their health, identifying strengths, weaknesses, opportunities, and barriers.
- Patient develops a SMART goal, and the care manager connects the patient with various resources that address identified barriers.
- Care manager discusses care plan with the provider. Provider agrees with the care plan.
- Patient and care manager agree on a follow up plan.
- Care manager documents in the chart and adds the appropriate billing codes.

24 Identify the BCBSM billing code: **G9007**, G9001.
PH **G9008**, G9001

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Face to Face Visit and Follow Up Care Plan

A patient comes into the office to be evaluated by their PCP. After the evaluation the PCP introduces the patient to the care manager (CM).

- During the conversation with the patient the CM assesses that there is not a clear understanding about asthma management.
- CM conducts a medication review, teaches how to use peak flow and keep a log, provides an asthma action plan.
- CM and patient agree to follow up in one week via a phone visit.
- This initial visit with the patient was 60 minutes. PCP and patient agree with the care plan.

Note how this is different from the G9001!

Identify the BCBSM billing code: G9002, G9008
For Priority Health it would be the G9002, and if discussed with the provider afterwards, a G9007

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Coordination of Care

- Care manager contacts the home health agency to schedule in-home visits and conduct a safety assessment.
- In addition a call was made to the DME provider to arrange for delivery of home O2.
- Time spent coordinating care was 35 minutes.

Identify the billing code: 99487

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Gaps in Care

- RN notices during chart review that several of the patients who are in his/her patient population have not received their cancer screenings, even though the RN and provider reminded them.
- RN shows the list to the Medical Assistant.
- Medical Assistant calls the patient to discuss gaps in care and facilitate closing the gaps.

Identify Billing Code: 98966 only applicable to BCBSM.
Does not apply to Priority Health as the MA is not a QHP.

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Interdisciplinary Team

- Patient with diagnosis of diabetes, COPD and HTN. Patient screens positive for SDOH – food insecurity, struggling to afford medications, lacks caregiver support.
- An interdisciplinary team conference was held with the Clinical Pharmacist, SW CM and PCP to modify the plan and discuss the initial plan of care with the team, which includes:
  - The SW CM schedules a virtual face to face visit with the patient regarding the lack of caregiver support and social isolation, which is linked with admissions.
  - The Clinical Pharmacist follows up on the ability to afford medications and the chronic diseases, conducting a comprehensive assessment of the patient.
  - Both SW CM and Clinical Pharmacist follow up with the team at their regular huddle.

Identify billing code: G9007, G9001, G9002

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Advance Directives

- CM conducts a 20 minute in person* meeting with a patient regarding their advance directives.
- During the discussion information is given to the patient to review regarding advance directives.
- Discussion includes:
  - how the patient prefers to be treated
  - what the patient wishes others to know
- CM and patient agree to follow up via a phone call in 2 weeks.

Identify the BCBSM billing code: S0257
* Note: this code allows for phone visit and meeting may be with the patient, care giver, or family member. For Priority Health use the Advance Care Planning code 99497.

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Reducing ED visits

- Proactive patient education to consider the PCMH practice first for acute healthcare needs, suggesting nearby urgent care, or ED for true emergency.
- Follow up each ED visit with a call to identify issues, coordinate follow up care, and encourage seeking care through the practice rather than the ED when appropriate. Often, this can be performed by a medical assistant.
- **Only applicable to BCBSM** Medical assistants, operating under a protocol, may call patients, ask if the ED physician recommended follow up care, coordinate the needed care, transfer to clinician for issues requiring immediate medical assessment or guidance, encourage the patient to bring in all medications, etc.

Identify Billing code: 98966

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Phone Service

CM speaks with a patient via the telephone.

- CM reviews the patient's asthma action plan and reviews the symptoms that indicate worsening symptoms and asthma exacerbation.
- Also reinforces when to call the office.
- In addition, CM asks the patient about interest in attending an asthma Group Visit. Patient indicates interest and CM provides the information regarding the asthma Group Visit.

CM and patient agree on follow up in one week via in person visit at the office.

This meeting takes 20 minutes.

Identify the billing code: 98967

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Patient Visit – Face to Face

The patient returns to the office one week later to meet with CM:

- During the visit CM and patient discuss symptoms, medications, SMART goals.
- Patient states he/she has not needed to use the rescue inhaler and feels they now have a better understanding of how to care for his/her self. You again review the action plan and state you will follow up in one month.

Identify the billing code: G9002

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G/CPT Billing Code Resources – Care Management Services

Billing resources – Michigan Care Management Resource Center website

- BCBSM - PDCM Billing online course, PDCM Billing Guidelines for Commercial and Medicare Advantage
- Priority Health – Go to Priority Health website – then click on provider manual – then procedures and services – medical/surgical services – then scroll down and click on care management.
- State Innovation Model
- Centers for Medicare & Medicaid – Transitional Care Management, Chronic Care Management, Behavioral Health Integration

Additional Billing resources: https://micmrc.org/training/care-management-billing-resources

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Medicare Billing

- We are not able to advise you on Medicare billing practices due to nuances in financial structure.
- However, the following slides contain information regarding "incident to" billing, which your practice may want to explore further for Pharmacist billing.

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Additional Medicare Resources

- Hospital-based Clinic – Pharmacist "incident to" billing
  - Medicare Benefit Policy Manual – Chapter 6, 20.5.2

- Office Based Clinic – 99211 billing
  - Medicare Claims Processing Manual – Chapter 12, 30.6.4

- "Incident to" billing information
  - Medicare Benefit Policy Manual – Chapter 15, 60.1 and 60.3

- "Incident to" Services – Documentation and Correct Billing

- CMS Chronic Care Management Services

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- CMS Transitional Care Management Services

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

Note: See CCM course resource guide to access the pdf documents

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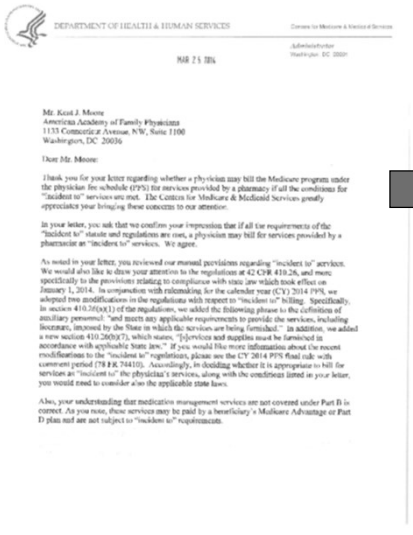
"Incident to" Billing



DEPARTMENT OF HEALTH & HUMAN SERVICES

Mr. Kent J. Moore
American Academy of Family Physicians
1133 Connecticut Avenue, NW, Suite 1100
Washington, DC 20036

Dear Mr. Moore:

Thank you for your letter regarding whether a physician may bill the Medicare program under the physician fee schedule (PFS) for services provided by a pharmacy if all the conditions for "incident to" services are met. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

In your letter, you ask that we confirm your impression that if all the requirements of the "incident to" statute and regulations are met, a physician may bill for services provided by a pharmacist as "incident to" services. We agree.

As noted in your letter, you reviewed our manual provisions regarding "incident to" services. We would also like to draw your attention to the regulations at 42 CFR 410.26, and more specifically to the provisions relating to compliance with state law which took effect on January 1, 2014. In conjunction with rulemaking for the calendar year (CY) 2014 PFS, we adopted two modifications in the regulations with respect to "incident to" billing. Specifically, in section 410.26(a)(1) of the regulations, we added the following phrase to the definition of auxiliary personnel: "and meets any applicable requirements to provide the services, including licensure, imposed by the State in which the services are being furnished." In addition, we added a new section 410.26(b)(7), which states, "[s]ervices and supplies must be furnished in accordance with applicable State law." If you would like more information about the recent modifications to the "incident to" regulations, please see the CY 2014 PFS final rule with comment period (78 FR 74410). Accordingly, in deciding whether it is appropriate to bill for services as "incident to" the physician's services, along with the conditions listed in your letter, you would need to consider also the applicable state laws.

Also, your understanding that medication management services are not covered under Part B is correct. As you note, these services may be paid by a beneficiary's Medicare Advantage or Part D plan and are not subject to "incident to" requirements.

"In your letter, you ask that we confirm your impression that if all the requirements of the "incident to" statute and regulations are met, a physician may bill for services provided by a pharmacist as "incident to" services. We agree."

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Medicare “incident to” Billing

https://petitions.whitehouse.gov/response/pharmacists-and-social-security-act

Official Centers for Medicare & Medicaid Services Response toRecognize pharmacists as health care providers!
This response was published on January 17, 2014.

Pharmacists and the Social Security Act

By Jonathan Blum

Thank you for your petition on recognizing pharmacists as health care providers under the Social Security Act. As you noted, pharmacists are not recognized in the Social Security Act as health care providers who are authorized to bill and receive payment for their services from Medicare. To do so would require a change to the statute by Congress.

But we recognize and value the trusted role that pharmacists play in the community, and their importance to patient care -- in particular to Medicare beneficiaries who need prescription medications.

The term "provider" is defined in Medicare regulations at 42 C.F.R. §400.202 and includes hospitals, skilled nursing facilities, and home health agencies. That term does not include pharmacists. Moreover, the Medicare law specifically authorizes the health care providers who can bill and receive payment from Medicare. For instance, section 1861(r) of the Social Security Act defines "physicians" under the Medicare program. This definition includes, with various restrictions and exceptions, doctors of medicine and osteopathy, doctors of dental surgery and dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. The statute also authorizes several specific non-physician practitioners including nurse practitioners, clinical nurse specialists, physician assistants, nurse midwives, clinical psychologists, and physical therapists to bill and receive payment from Medicare for their professional services that fall within their State scope of practice.

So while pharmacists are not recognized as "providers" who are authorized to bill and receive payment for their services from Medicare, they can receive payment for their services when furnished to Medicare beneficiaries in certain circumstances. For example, pharmacists can receive payment for furnishing services "incident to" the services of a physician or non-physician practitioner. The requirements under the "incident to" provision must be met, including the supervision requirements. The physician or non-physician practitioner who bills for the "incident to" services that the pharmacist furnished would receive payment from Medicare, and the pharmacist would receive payment from the physician or non-physician practitioner based on the agreement established by the parties involved.

Pharmacists can also be paid under Part D by Medicare prescription drug plans to dispense prescription drugs as well as to provide medication therapy management services to patients to identify problems and perform medication reconciliation.

Please visit CMS.gov for additional information.

Jonathan Blum is the Principal Deputy Administrator at the Centers for Medicare & Medicaid Services.

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WORKSHEET

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Team Communication Activity

Team Communication
Didactic, Embedment, Real-play

Embedment discussion points from the John Hopkin's School of Nursing "Guided Care":

- Embedment
  - Meet with team members during orientation
  - Seek opportunity to observe them in their role
  - Invite the team to observe you in your role and interactions with patients
  - Establish structure for communication about changing status of patients

- Practice office norms
  - Who does medication refills
  - Process for scheduling appointments
  - Expectations with returning phone calls and emails/patient portal
  - Managing patient flow
  - Billing and documentation
  - Covering off-hours and on-call
  - Requesting schedule and payroll changes/holidays/weather/etc..

- The nurse's mantra…….
  - Collaborate with everyone. Displace no one.

- Tips for success
  - Focus on common goals and shared values – the patient
  - Be an active listener
  - Present ideas positively with confidence
  - Avoid negative or critical remarks
  - Try to understand the other point of view
  - Assume the best about the other people's intentions
  - Do not take things personally

- Use TACTFUL Communication
  - T – think before you speak
  - A – apologize quickly if you make a mistake
  - C – Converse, do not be patronizing or sarcastic
  - T – Time your comments carefully
  - F – Focus on behavior, no on personality
  - U – Uncover hidden feelings
  - L – Listen

Read the SBAR Article: "Using SBAR Communications in Efforts to Prevent Patient Rehospitalizations"

List the 4 steps to complete prior to reviewing the case with the provider:

1. _____
2. _____
3. _____
4. _____

Crosswalk this to PDCM starting with the example provided in the article.

	Meaning of Letter	Information	Data to Include	Crosswalk Example
S	Situation	What is going on?	Patient name Current problem	Dr. Jones, I'd like 5 minutes of your time for a situation that has come up for Mr. B, and really should be addressed before the end of the day
B	Background	What is the context and background	• Patient's age, gender • Diagnosis • Other pertinent information, as appropriate to the problem • Recent history • Medications, allergies • Etc.	
A	Assessment	What physical, behavior and social assessment data will the provider want to know? What do you think the problem is?	Pertinent assessment findings Perform a comprehensive assessment to identify the barriers and assets before contacting the provider Name the problem	
R	Recommendation	What do you think will correct the problem?	Suggestions to resolve the problem to avoid untoward events such as hospitalizations and ER visits	

Summary:

- Effective teamwork is critical to achieving the goals of patient care
- Teams have a common focus and shared values – the patient's health and wellbeing
- There are multiple opportunities to establish effective working relationships with the office providers and staff
- Effective teamwork evolves over time; it is enhanced by conscious effort and social skills

Real play

Working in groups of 2-3

- Using the Mr. B. case study below, develop an SBAR communication
- Real play with your partner
    - Share experiences as the person reporting off the information
    - Share experiences as the person listening to the SBAR

Mr. B

- Age 83
- Increasing symptoms of fatigue, weakness, shortness of breath
- Hospitalized 3 months ago for exacerbation of his Heart Failure
- History of hypertension, coronary artery disease, Myocardial infarction
- Temporarily living with his daughter
- Unsure about his medications
    - Specifically, in the hospital they held his hydrochlorothiazide and on discharge did not give any directions on what to do about that
- States feeling "low"
- Not following the low sodium diet – can't stand the food without seasoning
- Worried about his living arrangements
- Wants to go back home but his daughter is concerned about that
    - He has fallen once – no injuries other than bruises on his forehead
- He's having trouble sleeping
- He is unable to complete his own activities of daily living without some assistance
    - Tires easily and needs help dressing
    - He can do his own personal hygiene
- He completed the SDOH screening
    - Needs assistance with transportation to medical appointments
    - Has housing needs (based on wanting to return home)

Situation:

Background:

Assessment:

Recommendations:

WORKSHEET