Lunch & Learn Webinar

Care Coordination: Understanding the Team Based Care & Revenue Opportunities in Primary Care

National Nurse-Led Care Consortium

Care Coordination: Understanding the Team Based Care & Revenue Opportunities in Primary Care

January 15, 2020

Faith Jones, MSN, RN, NEA-BC, HealthTechS3

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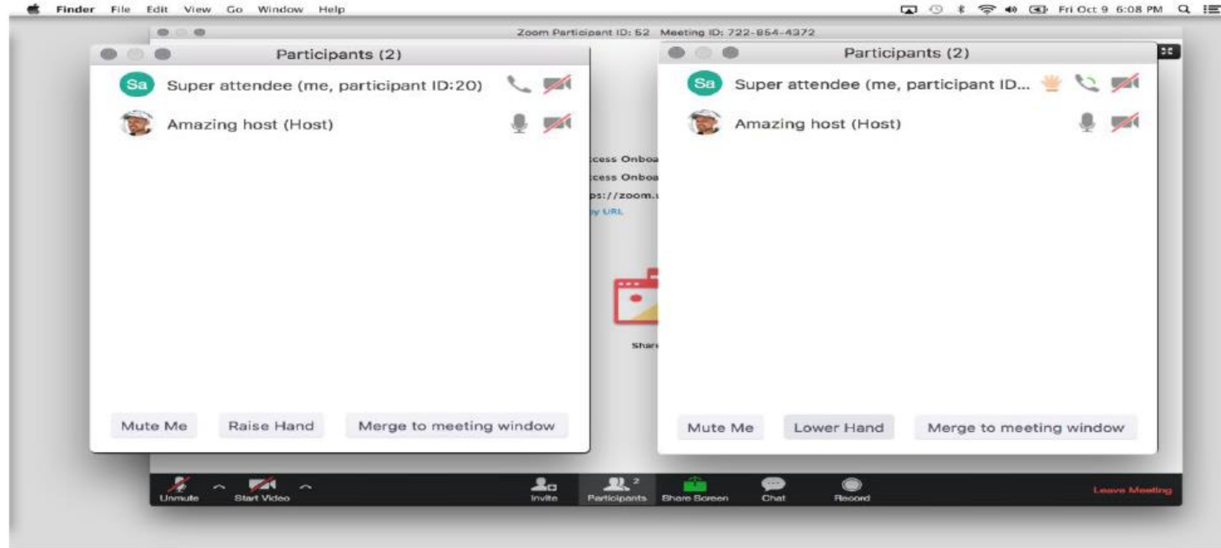
Housekeeping Items



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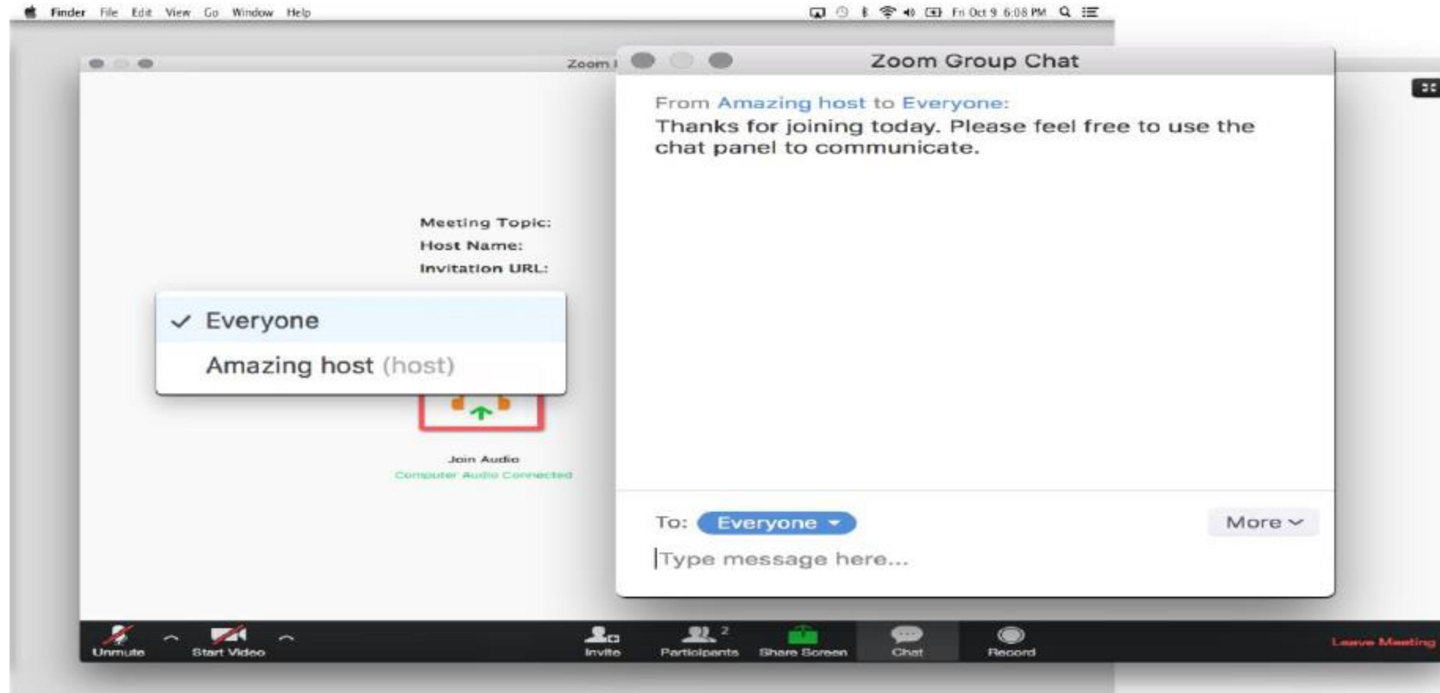

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Steps to Receive Free CE Credit

AANP will review attendance list after webinar is complete.

Participants who attend entire live presentation qualify for CE credit.

- **REQUIRED:** attend at least **55 minutes** of presentation
- **REQUIRED:** access & connect to presentation slide-deck

Participants who qualify for CE will receive a detailed email from NNCC on how to obtain CE credit.

Completion of a quiz will be required to receive CE credit.

You will receive the certificate 2-3 weeks after the webinar is completed

Questions can be directed to: jbird@nncc.us

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Care Coordination:

Understanding Team Based Care & Revenue Opportunities In the Primary Care Setting

Objectives

Following this presentation, the participant will understand:

- The elements of a team based care approach
- The services that can be delivered under a team based care model
- The billing and reimbursement implications of implementing team based care

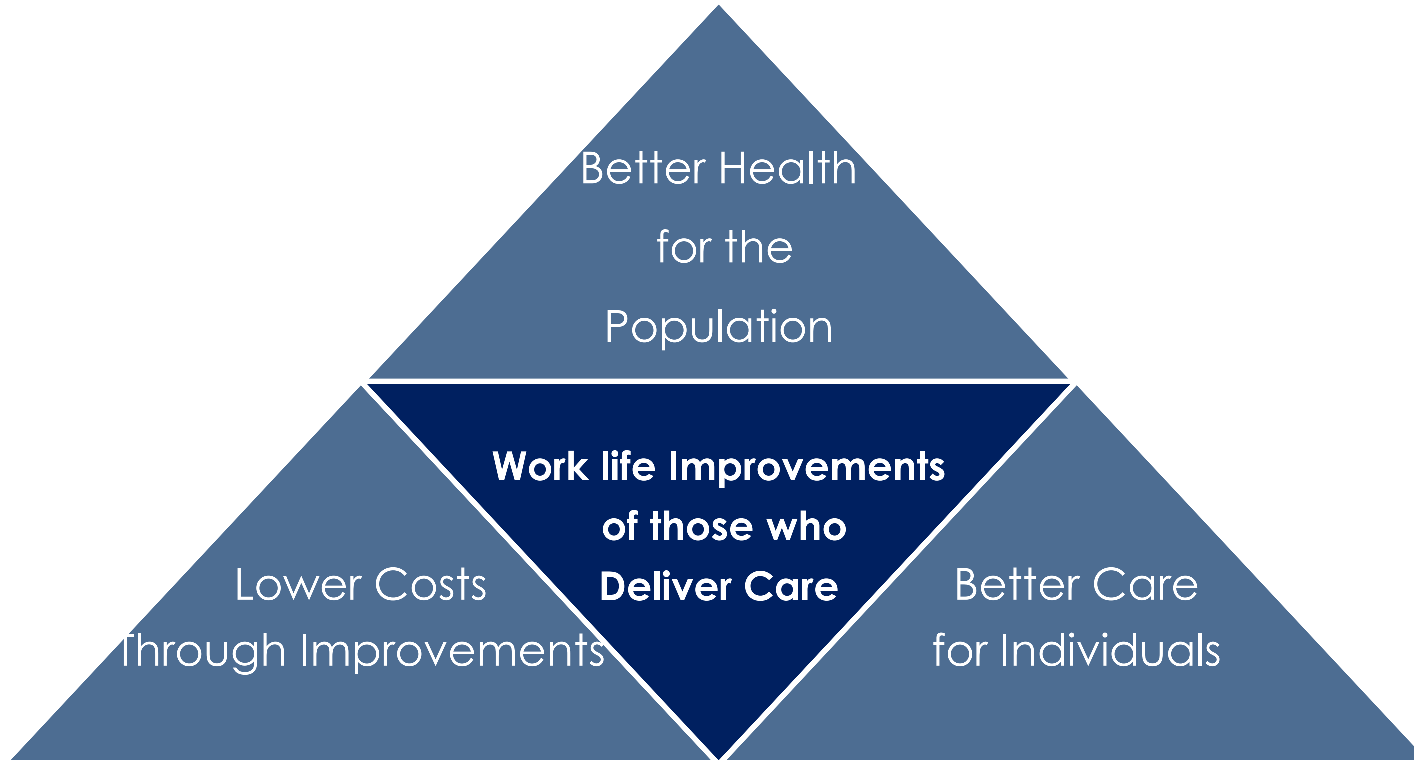
Changing Models

"Our goal is to recognize the trend toward **practice transformation** and overall improved quality of care, while preventing **unwanted** and **unnecessary** care"

CMS CFR 11-12-2014

Triple Aim

Quadruple Aim



Science Behind Burnout

" Physician burnout is associated with reduced adherence to treatment plans, resulting in negatively affected clinical outcomes"

1

http://www.annfammed.org/content/12/6/573.full.pdf+html

Identifying Burnout

HOW DO I KNOW IF I'M BURNED OUT?

- "Burnout has been described as the inverse of wellness. Wellness is the state of good physical, mental, and emotional health, which puts burnout on the other end of that spectrum. Many providers are somewhere in the middle, exhibiting some or all of these signs of burnout:
  - **Emotional Exhaustion**- feeling emotionally depleted and no longer able to give to others emotionally
  - **Depersonalization/Cynicism-** having a distant or uncaring attitude toward patients and work
  - **A Low Sense of Personal Accomplishment-** a tendency to negatively regard yourself and your accomplishments at work."

Take Burnout Quiz

https://www.soulhoneycoaching.com/

From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

EXPANDED ROLES

- Expanding the role of nurses and other clinical staff in the practice to work to the highest level of licensure

APPROACHES TO WORKFLOW

- Team based documentation
- Pre-visit planning
- Co-locating for communication

http://www.annfammed.org/content/12/6/573.full.pdf+html

Care Delivery Models

"…new and evolving care delivery models, which feature an increased role for non-physician practitioners (often as care coordination facilitators or in team-based care) have been shown to improve patient outcomes while reducing costs, both of which are important Department goals as we move further toward quality- and value-based purchasing of health care services in the Medicare program and the health care system as a whole."

HEALTHTECHS3

Vol. 80 Wednesday, No. 135 July 15, 2015, P 226

Team Based Care

Care Coordination uses a Team Based Care Approach

Shared goals: The team—including the patient and, where appropriate, family members or other support persons—works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members.

Clear roles: There are clear expectations for each team member's functions, responsibilities, and accountabilities, which optimize the team's efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts.

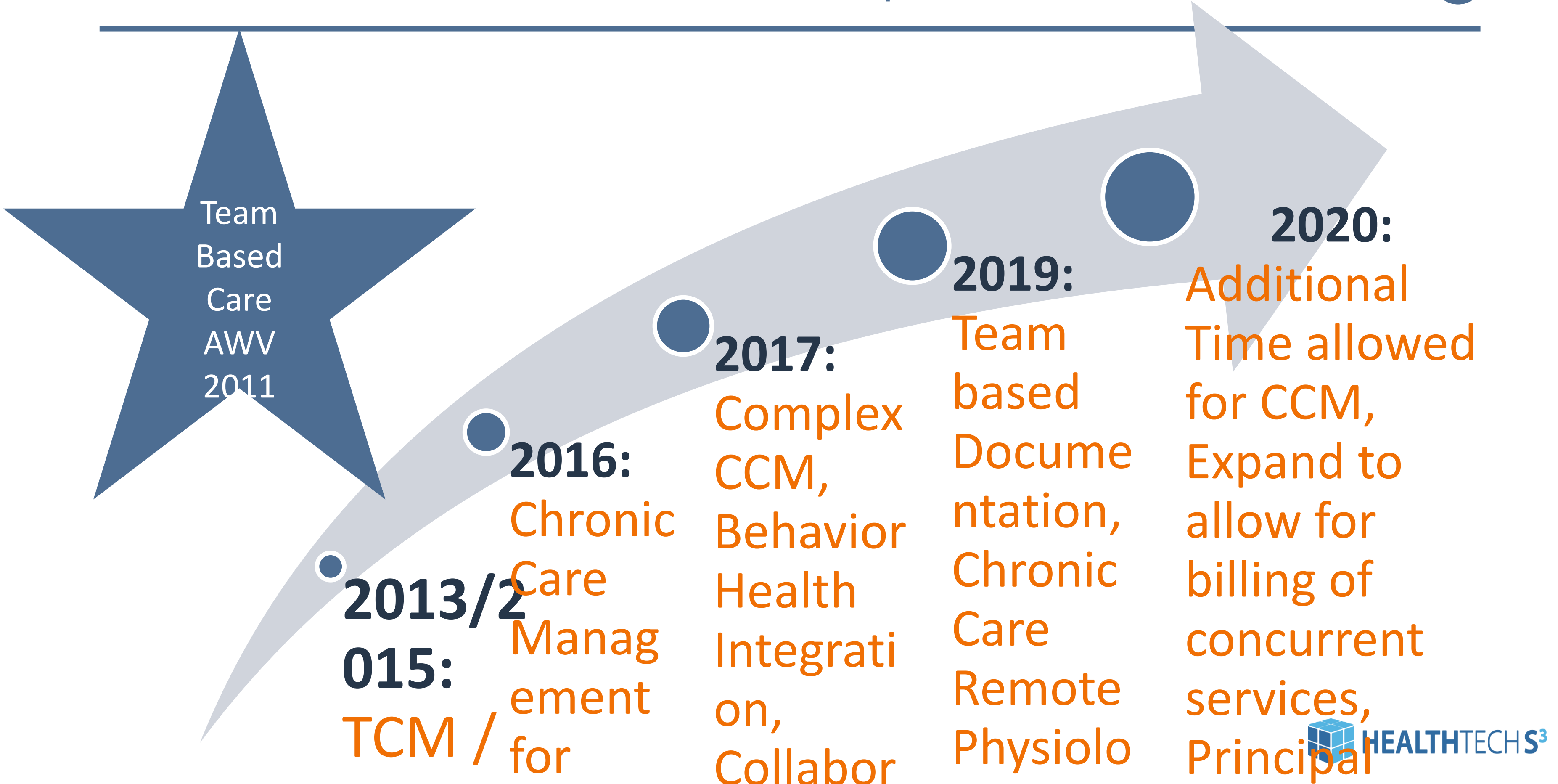
Mutual trust: Team members earn each other's trust, creating strong norms of reciprocity and greater opportunities for shared achievement.

Effective communication: The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.

Measurable processes and outcomes: The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time.

Source: Mitchell et al., 2012

Care Coordination Growth and Development



HEALTHTECHS3

How Well is Care Coordination Working?

"…CMS estimated that approximately 3 million unique beneficiaries (9% of the Medicare FFS pop) received [care coordination] services annually, with a higher use of CCM, TCM and advance care planning services"

Noted outcomes:

"reduced readmission rates, lower mortality, and decrease health care costs"

Vol. 84, No. 221/Friday, November 15, 2019/Rules and Regulations p.62685

Care Coordination Trifecta

Annual Wellness Visit

AWV

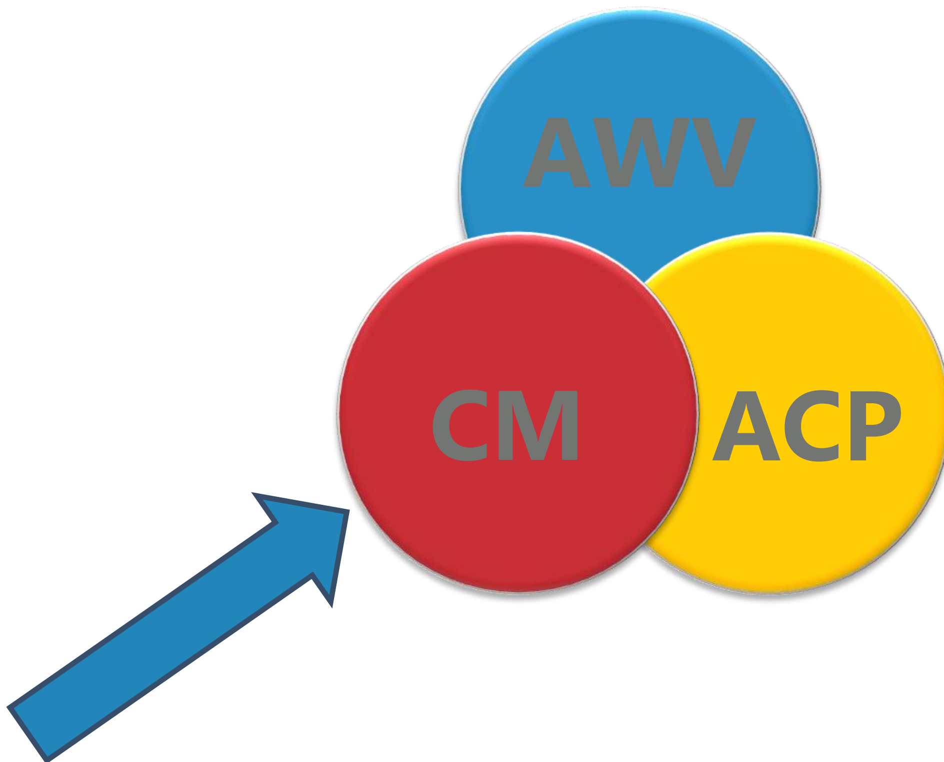
Care Management
TCM, CCM, BHI, CCRPM, PCM

CM

ACP

Advance Care Planning

Care Management



Transitional Care Management (TCM)

- Patient does not need to be enrolled or agree to service
- Elements include:
  - An interactive contact
  - Non face to face reviews by clinical staff
  - Medication Reconciliation
  - Non face to face review by provider
  - Community Resource Identification
  - Referral Management
- 99496 – Patient seen within 7 days of discharge
- 99495 – Patient seen within 14 days of discharge
- RHC does not receive additional pay for TCM visit type paid at AIR payment

Chronic Care Management

"We acknowledged that the care coordination included in services such as office visits does not always describe adequately the non-face-to-face care management work involved in primary care and may not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain categories of beneficiaries"

CMS CFR 7-15-2015

Elements of Chronic Care Management

Practice Eligibility	Patient Eligibility
• Qualified EMR • Availability of electronic communication with patient and care giver • Collaboration and communication with community resources & referrals • After hours coverage • Care Plan Access • Primary Care Provider general supervision of clinical staff	• Medicare Patient (other ins also) • Two or more chronic conditions expected to last at least 12 months or until the death of the patient • At significant risk of death, acute exacerbation, decompensation, or functional decline without management • Patient Consent • CCM initiated by the primary care provider • Time tracking of at least 20 min per calendar month

99490 – 20 min (G0511 for RHCs and FQHCs)

G2058 – Add'l 20 min for max of 2 (N/A RHCs and FQHCs)

Elements of Complex Chronic Care Management

Practice Eligibility	Patient Eligibility

Practice Eligibility

- Qualified EMR
- Availability of electronic communication with patient and care giver
- Collaboration and communication with community resources & referrals
- After hours coverage
- Care Plan Access
- Primary Care Provider supervision of clinical staff

Patient Eligibility

- Medicare Patient
- Two or more chronic conditions expected to last at least 12 months or until the death of the patient
- At significant risk of death, acute exacerbation, decompensation, or functional decline without management
- Patient Consent
- CCM initiated by the primary care provider
- ***Documentation of at least 60 minutes per calendar month spent coordinating care***
  - ***With Moderate or high complexity medical decision making***

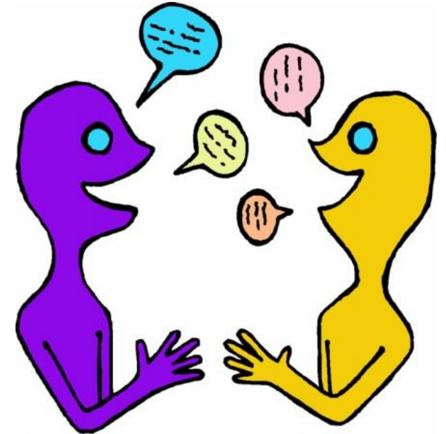
99487 – 60 min (N/A or RHCs and FQHCs)

99489 – Add'l 30 min (N/A RHCs and FQHCs)

HEALTHTECHS3

Moderate or High Complex Medical Decision Making

- Medical decision making must be done by the **provider**, in collaboration with the care coordinator, and require additional interventions and or monitoring.
- Examples of medical decision making that can meet the Complex CCM requirement may include but not limited to:
  - Medication adjustments with close monitoring
  - Ordering of tests or services to evaluate an issue
  - Close follow up for treatment changes



NOTE:

- Conversation with the provider leading to having the patient make an appointment is not moderate or high complex decision making

Elements of BHI and CoCM

Behavior Health Integration

- BHI is a team-based, collaborative approach to care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions
- Same requirements as CCM except:
  - One mental or behavior health condition
  - Care Coordinator facilitates and coordinates treatments such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation
- Must use a validated rating scale assessment
- Provide at least 20 min of coordination per calendar month

99484 – per month (G0511 for RHCs/FQHCs)

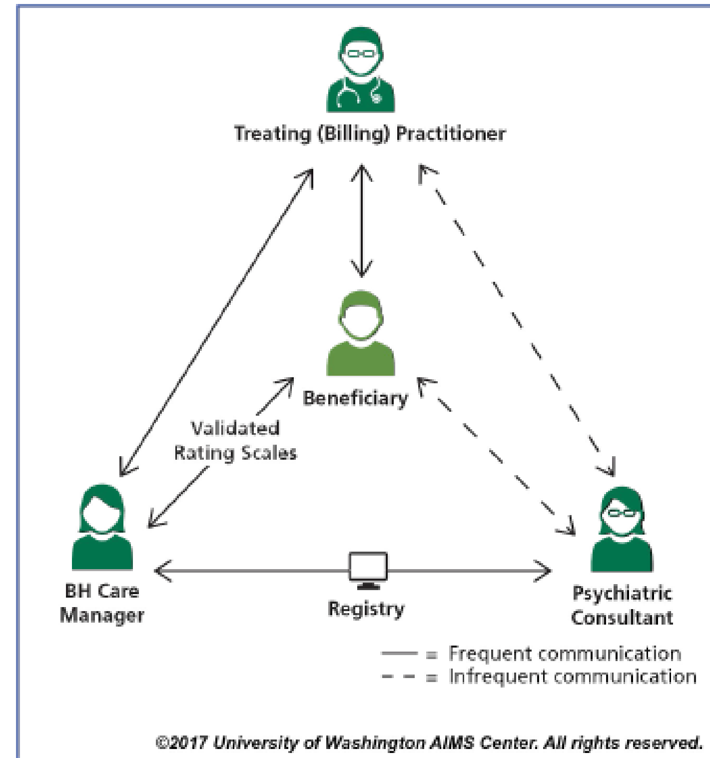
Collaborative Care Management

- CoCM is a specific model of psychiatric care provided by the primary care team consisting of PCP and behavioral care manager who work in collaboration with a psychiatric consultant
- Behavioral care manager must be a qualified health care professional with formal education or training in behavioral; health such as social work, nursing, or psychology.
- Psychiatric consultant must be a medical professional trained in psychiatry and qualified to prescribe a full range of meds
- Conduct care conferences on patients weekly
- Must use a validated rating scale assessment
- Provide at least 60 min of coordination per calendar month (70 min first time)

99492/99493/99494 – per month (G0512 for RHCs/FQHCs)

Collaborative Care Management Team

What is CoCM?
A model of behavioral health integration that enhances "usual" primary care by adding two key services: care management support for patients receiving behavioral health treatment; and regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving.



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

Remote Monitoring

Two Types:

1. Remote Patient Monitoring
2. Chronic Care Remote Physiologic Monitoring

Remote Patient Monitoring

- CPT 99091
  - Collection and interpretation of data by a physician or qualified health care professional when at least 30 minutes of professional time is dedicated to the patient per 30 day period.

Chronic Care Remote Physiologic Monitoring

- Family of Codes:
  - CPT 99453 – Initial set-up and Patient Education
  - CPT 99454 – Device supply with daily recordings each 30 days
  - CPT 99457 – Remote physiologic monitoring treatment management services

Chronic Care Remote Physiologic Monitoring

- Billing Requirements:
  - Must have patient consent / agreement for the service
  - Must be ordered by a Provider
    - For specific reason
    - Treatment plan
  - Device used must meet the FDA definition of Medical device
    - …"intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease…"
  - Data must be wirelessly synced where it can be evaluated
  - Device must be supplied for at least 16 days to be applied to the billing period

https://www.fda.gov/medical-devices/classify-your-medical-device/product-medical-

Chronic Care Remote Physiologic Monitoring

- Evaluation/Time Requirements:
  - Requires at least 20 minutes per calendar month
- What time counts:
  - Time spent in interactive communication with the patient or care giver
  - Related to the treatment plan that was established
- Who’s time counts:
  - Can be the provider OR by CLINICAL STAFF – i.e. your care coordinator

Chronic Care Remote Physiologic Monitoring

- What are we monitoring:
  - Examples include:
    - Blood pressure
    - Weight
    - Pulse / Pulse oximetry
    - Respirations / Respiratory flow rates
    - Blood Sugar

Principal Care Management (PCM)

Targeted practice to use PCM is a specialty practice:

- *"Although we did not propose any restrictions on the specialties that could bill for PCM, we expect that most of these services will be billed by specialists who are focused on managing patients with a single complex chronic condition requiring substantial care management."*
- *"We anticipate that in the majority of instances, PCM services will be billed when a single condition is of such complexity that it cannot be managed as effectively in the primary care setting, and instead requires management by another, more specialized, practitioner."*

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Principal Care Management

Designed to address those patients who have “significant resources involved in care management for a single high-risk disease or complex chronic condition”

- Elements include:
  - One serious chronic condition
  - Condition will typically be expected to last between 3 months and 1 year or until the death of the patient
  - May have led to a recent hospitalization and or place the patient at significant risk of death, acute exacerbation/decompensation or functional decline
  - Include coordination of the medical and or psychosocial care related to the single complex chronic condition
  - Minimum of at least 30 minutes per calendar month spent on care coordination

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G2064 – 30 min by provider
G2065 – 30 min by clinic staff

PCM and CCM

Expected outcome:

- "For the patient's condition to be stabilized by the treating clinician so that the overall care management for the patient's condition can be returned to the patient's primary care practitioner."

- "We anticipate that many patients will have more than one complex chronic condition. If a clinician is providing PCM services for one complex chronic condition, management of the patient's other conditions will continue to be managed by the primary care practitioner while the patient is receiving PCM services for a single complex condition."

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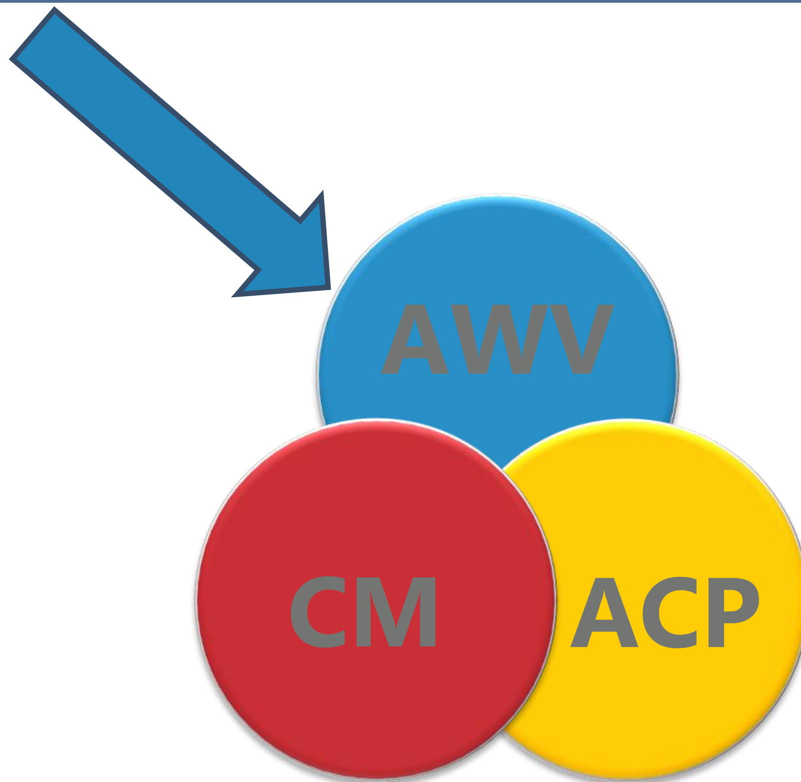
Annual Wellness Visit



Why Wellness Visits?

"The AWV will include the establishment of, or update to, the individual's medical and family history, measurement of his or her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the ***goal of health promotion*** and ***disease detection*** and ***fostering the coordination of the screening and preventive services*** that may already be covered and paid for under Medicare Part B."

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7079.pdf

Who is Eligible to Provide the AWV?

- A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Social Security Act (the Act); **or**,
- A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act); **or**,
- A ***medical professional*** (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in CFR 410.32(b)(3)(ii)) ….

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7079.pdf

Required Elements:

- Administer a Health Risk Assessment (HRA)
- Establish a list of current providers and suppliers
- Establish the beneficiary's medical/family history
- Review the beneficiary's potential risk factors for depression
- Review the beneficiary's functional ability and level of safety
- Assess height, weight, BMI, BP, other routine measures appropriate to medical history

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf

The purpose of the Annual Wellness Visit is…

To provide:

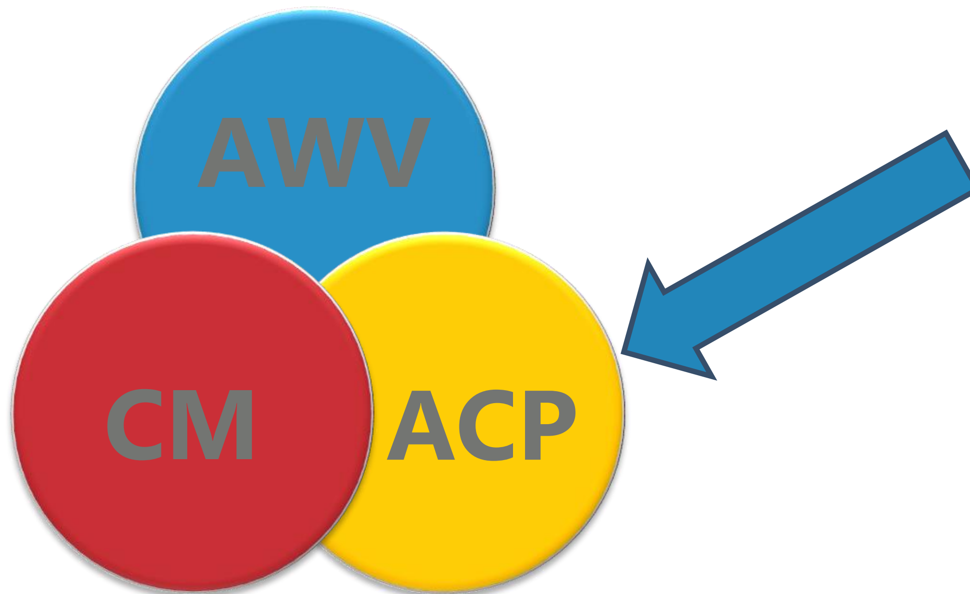
- **Personalized Prevention Plan of Care**

Individualized Prevention Plan of Care:

- Establish a written screening schedule for the beneficiary
- Establish a list of risk factors and conditions with interventions
- Provide personalized health advice and referrals to programs as appropriate
  - Community-based lifestyle interventions to reduce health risks, promote self-management, and wellness
  - Fall Prevention
  - Nutrition
  - Physical Activity
  - Tobacco-Use Cessation
  - Weight Loss

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf

Advance Care Planning



Medicare's Definition of ACP

Voluntary Advance Care Planning

- "Voluntary ACP means the face-to-face service between a physician (***or other qualified health care professional***) and the patient discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. "

MLN Matters® Number: MM9271 Related Change Request Number: 9271

Who Can Perform ACP?

"the services described by CPT codes 99497 and 99498 are appropriately provided by physicians

or using a team-based approach"

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf

Approach to the Conversation

Why ??

Voluntary Advance Care Planning

- "ACP enables Medicare beneficiaries to make important decisions that give them control over the type of care they receive and when they receive it."

MLN Matters® Number: MM9271 Related Change Request Number: 9271

Advance Care Planning & Advance Directives

Advance Care Planning = Procedure

Advance Directive = Product

99497 – 1st 30 minutes
99498 – Add'l 30 minutes

https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=3&H1=99497&M=5

Care Coordination Roles

Primary Care Provider

- Directs the overall care of the patients
- Sets expectations

RNs

- Care Coordinator/Care Manager
- Establishes the Plan of Care
- Identifies community resources
- Tracks time, documents and manages the workflow (referrals, meds, labs)

LPNs

- Contribute to the Plan of Care
- Tracks time, documents and contributes to the workflow (referrals, meds, labs)

CNAs/MAs

- Follows the Plan of Care
- Tracks time and documents
- Completes delegated tasks

Community Health Workers

- Follows the Plan of Care
- Home visits, community visits, provides feedback and insight
- Tracks time and documents

Social Workers

- Contributes to the Plan of Care
- Assists in connecting to community resources and builds relationships
- Tracks time and documents

RNs in Primary Care are Affordable and Sustainable

Transitional Care Management (TCM) ~$247.94 within 7 day visit

Transitional Care Management (TCM) ~$187.67 within 14 day visit

Chronic Care Management (CCM) ~$42.22 per patient per month

- Add'l 20 min of CCM ~37.89 (max of 2)

Complex Chronic Care Management (CCM) ~$92.39 per patient per month

- Add'l 30 min of Complex CCM ~$44.75

Behavior Health Integration (BHI) ~$48.00 per patient per month

Collaborative Care Management (CoCM) ~$126.31 per patient per month

- Add'l Collaborate Care Management (CoCM) ~$63.88 add'l 30 min

Fee for Service

RNs in Primary Care are Affordable and Sustainable

Chronic Care Remote Physiologic Monitoring (CCRPM):

- Initial Set-up and Patient Education ~$18.77
- Device supply with daily recordings ~$62.44 each month
- Remote physiologic monitoring treatment management ~$51.61 per calendar month of at least 20 min of patient and or care giver interaction

Principal Care Management (PCM):

- Provider care coordination of at least 30 minutes ~$92.03 per Calendar month
- Clinical staff care coordination of at least 30 minutes ~$39.70 per Calendar month

Annual Wellness Visit (AWV) Initial ~$172.87

Annual Wellness Visit (AWV) Subsequent ~$117.29

Advance Care Planning (ACP) ~$86.98 first 30 minutes ~76.15 Subsequent 30 minutes

Fee for Service

RNs in Primary Care are Affordable and Sustainable

Chronic Care Management (CCM) ~$66.77 per patient per month

Behavior Health Integration (BHI) ~$66.77 per patient per month

Collaborative Care Management (CoCM) ~$141.83 per patient per month

Annual Wellness Visit (AWC) ~$AIR Payment annually

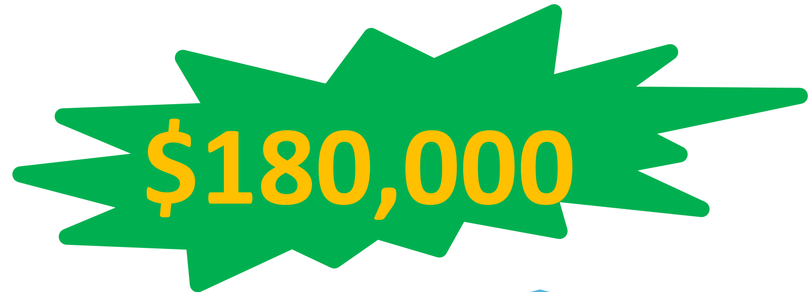
RHCs and FQHCs

Care Coordination Model: Potential Annual Revenue /Patient

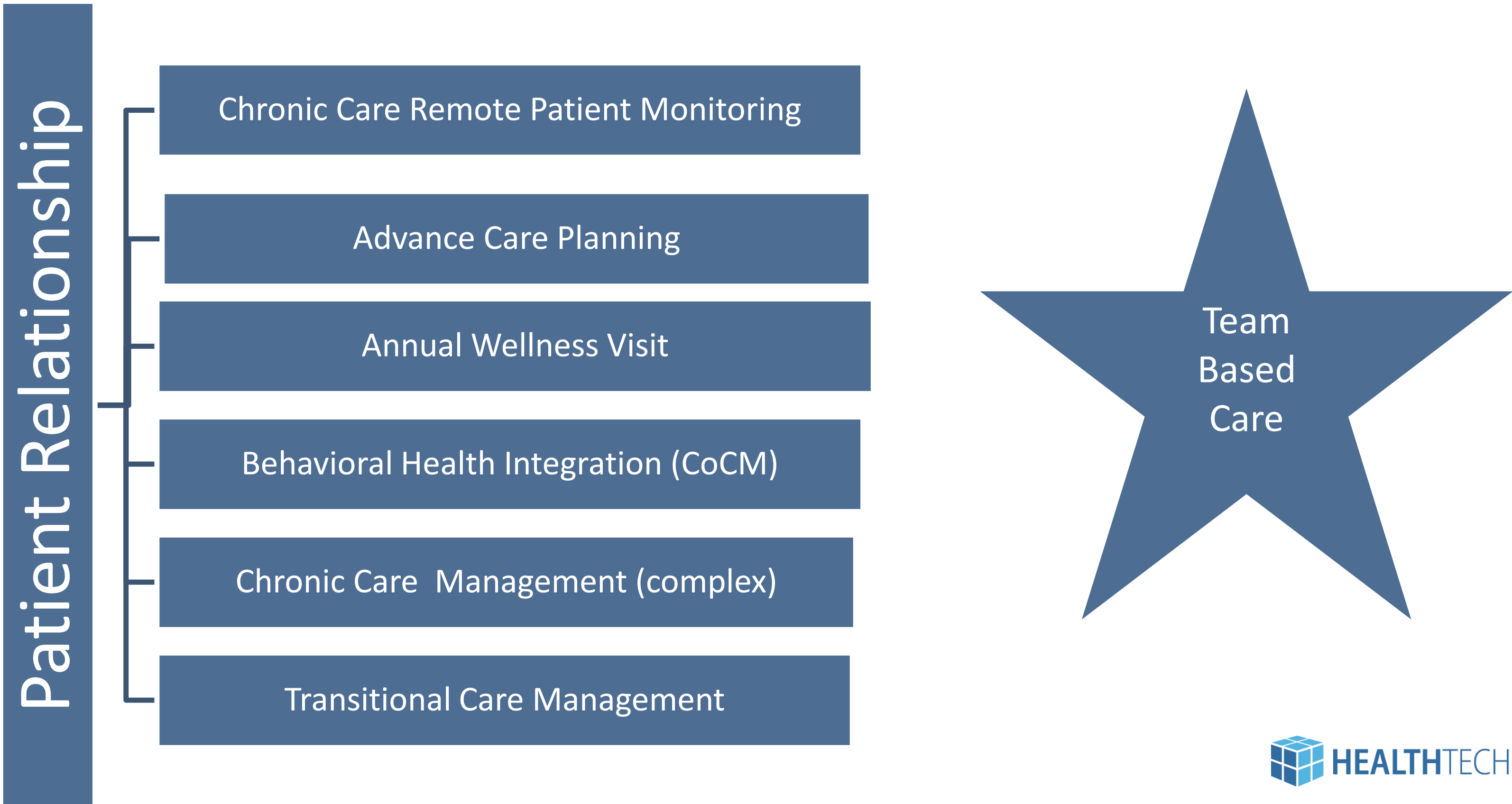
Potential Annual Revenue per Care Coordinator

$900 per Patient

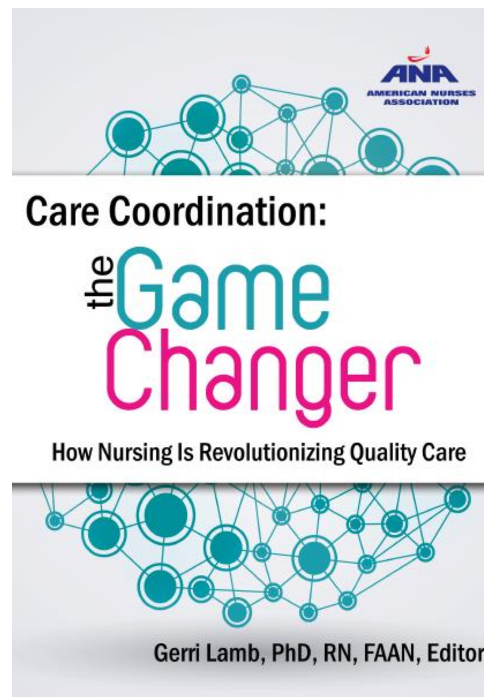
200 Patients



Building your Care Management Program

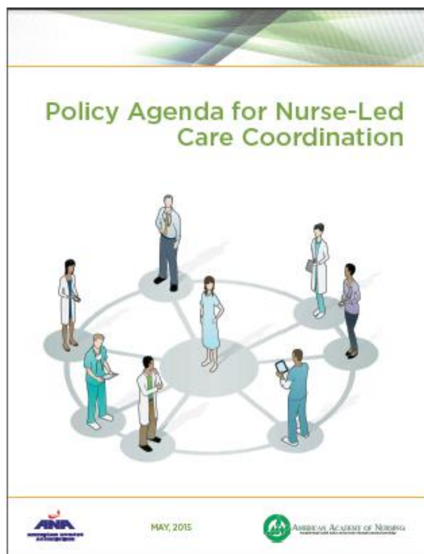


Care Coordination Resources



https://www.nursingworld.org/nurses-books/care-coordination-bundle/

ANA and AAN – Policy and Advocacy



Policy

- Policy Brief: *Policy agenda for nurse-led care coordination*. Nursing Outlook 63 (July 2015) 521-530.
- Policy Brief: *The importance of health information technology in care coordination and transitional care*. Nursing Outlook 61 (November 2013) 475–489.
- Policy Brief: *The value of nursing care coordination: A white paper of the American Nurses Association*. Nursing Outlook 61 (November 2013) 490-501.
- Policy Brief: *The Imperative for Patient, Family, and Population Interprofessional Centered Approaches to Care Coordination and Transitional Care*. Nursing Outlook 60 (September 2012) 330-333.
- ANA's Care Coordination Statement (2012): ANA Urges Recognition and Funding for Nurses' Essential Role in Patient Care Coordination

https://www.aannet.org/policy-advocacy/care-coordination

Contact Information

Faith M Jones, MSN, RN, NEA-BC

Director of Care Coordination and Lean Consulting

Faith Jones began her healthcare career in the US Navy over 35 years ago. She has worked in a variety of roles in clinical practice, education, management, administration, consulting, and healthcare compliance. Her knowledge and experience spans various settings including ambulance, clinics, hospitals, home care, and long term care. In her leadership roles she has been responsible for operational leadership for all clinical functions including multiple nursing specialties, pharmacy, laboratory, imaging, nutrition, therapies, as well as administrative functions related to quality management, case management, medical staff credentialing, staff education, and corporate compliance. She currently implements care coordination programs focusing on the Medicare population and teaches care coordination concepts nationally. She also holds a Green Belt in Healthcare and is a Certified Lean Instructor.

Email

Faith.Jones@HealthTechS3.com

Phone

(307) 272-2207

Any Questions??

Please **submit questions** via the question pane in your zoom control panel.

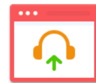
Meeting Topic: Care Coordination: Understanding the Team Based Care & Rev

Host: National Nurse Led Care Consortium (NNCC)

Invitation URL: https://zoom.us/webinar/register/WN_gNrN6fc4SDicTdDcb...

Copy URL

Participant ID: 53



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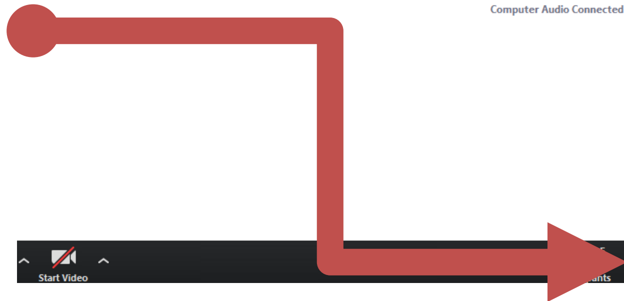

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Other NP SAN Questions?

For more information on the **Nurse Practitioner Support and Alignment Network (NP SAN)**:

- Email **Jillian Bird** at **jbird@phmc.org**
- Visit us **online at http://nurseledcare.phmc.org/programs/npsan.html**
- **Stay up to date** on the latest CE opportunities: **http://bit.ly/NPSAN_subscribe**

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Coming Up

Lunch & Learn Webinar

Profitable Partnerships: Developing the Business Case for RN Led Interventions in Primary Care

Wednesday, January 29, 2020 at 3:00 pm ET

Register Here