COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

MEETING PATIENTS WHERE THEY ARE : IMPROVEMENTS IN A CHRONIC CARE MANAGEMENT PROGRAM IN A RURAL FQHC

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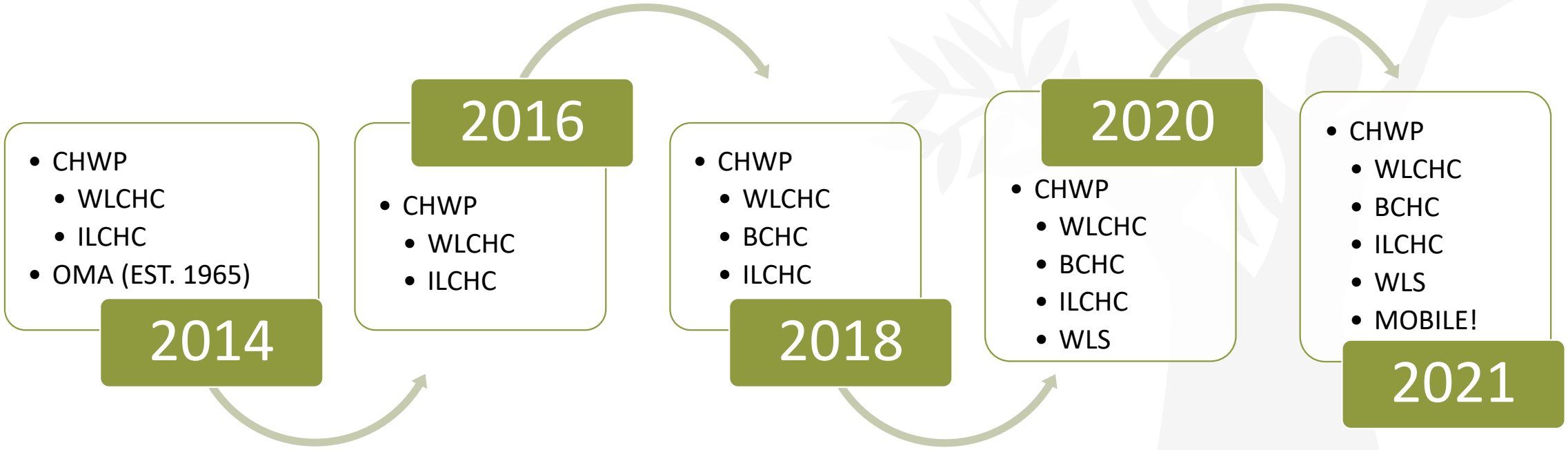
Overview

- Objectives
- CHWP Overview
- COVID-19 Impact
- Questions

Objectives

1. Describe what are Medicare covered Chronic Care Management services
2. Describe ways to engage different populations using non-traditional methods
3. Learn about specific improvements in diabetes care, anticoagulation control, and patient outreach at a rural Federally Qualified Health Center (FQHC)

CHWP History - Timeline

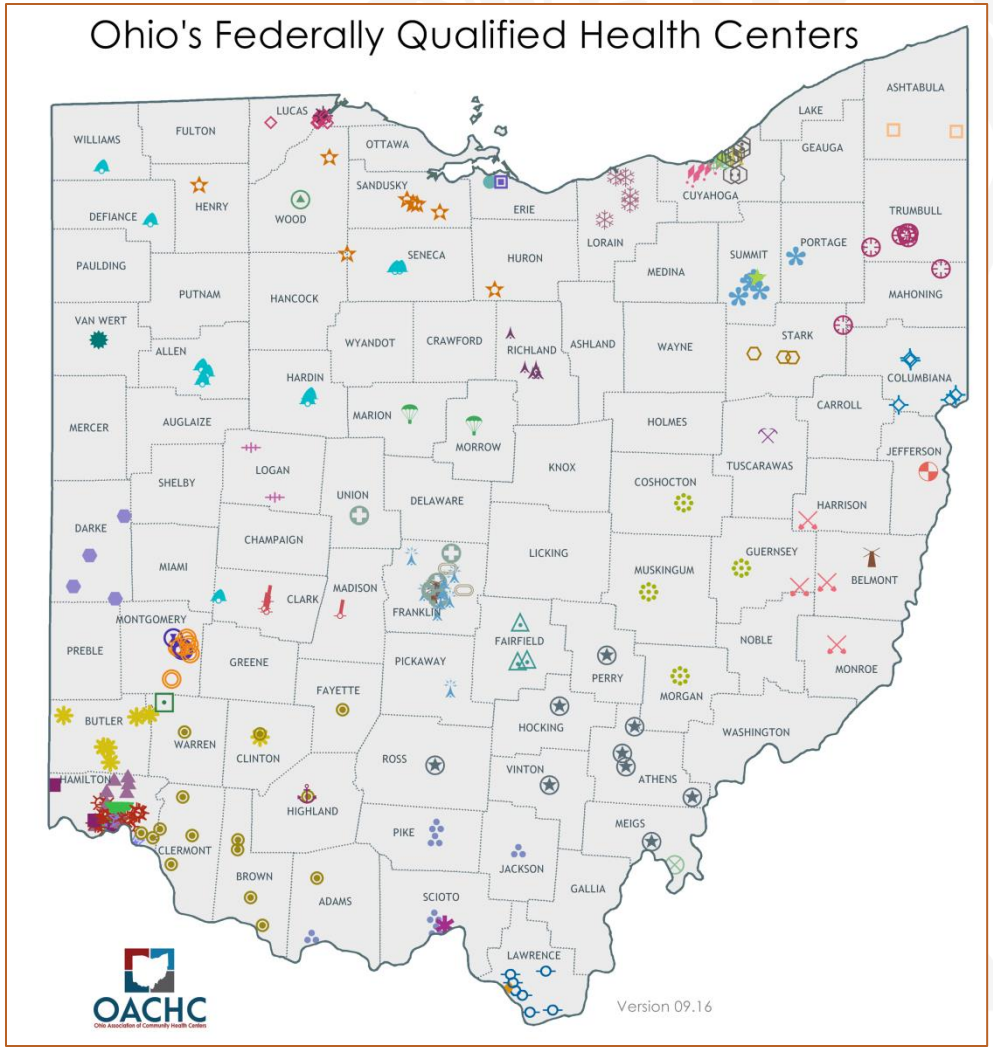


Health Centers Impact & Growth

1,400 Health Centers in the US
10,400 sites

50 Ohio CHCs

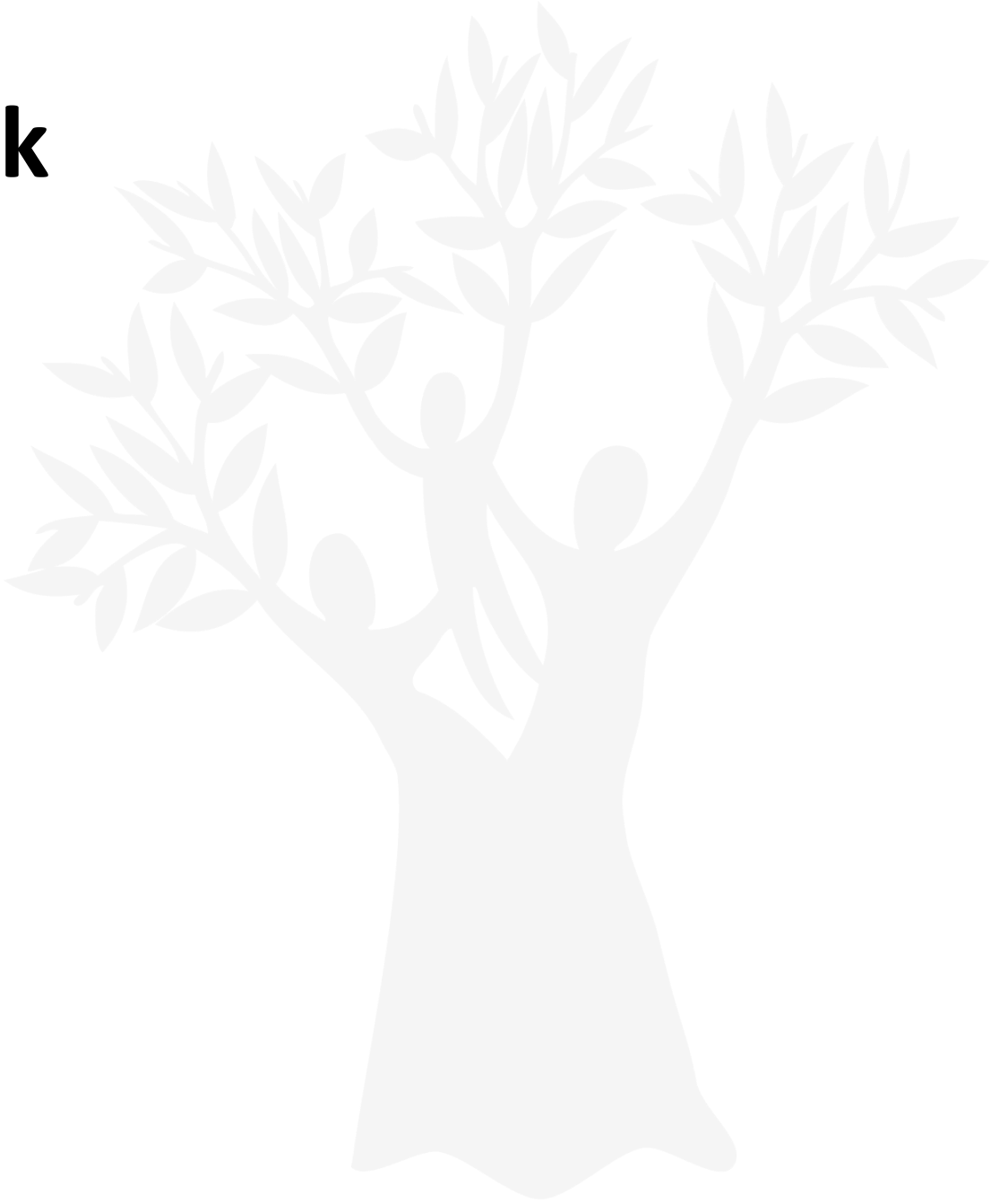
270 Site Locations



How Health Centers Work

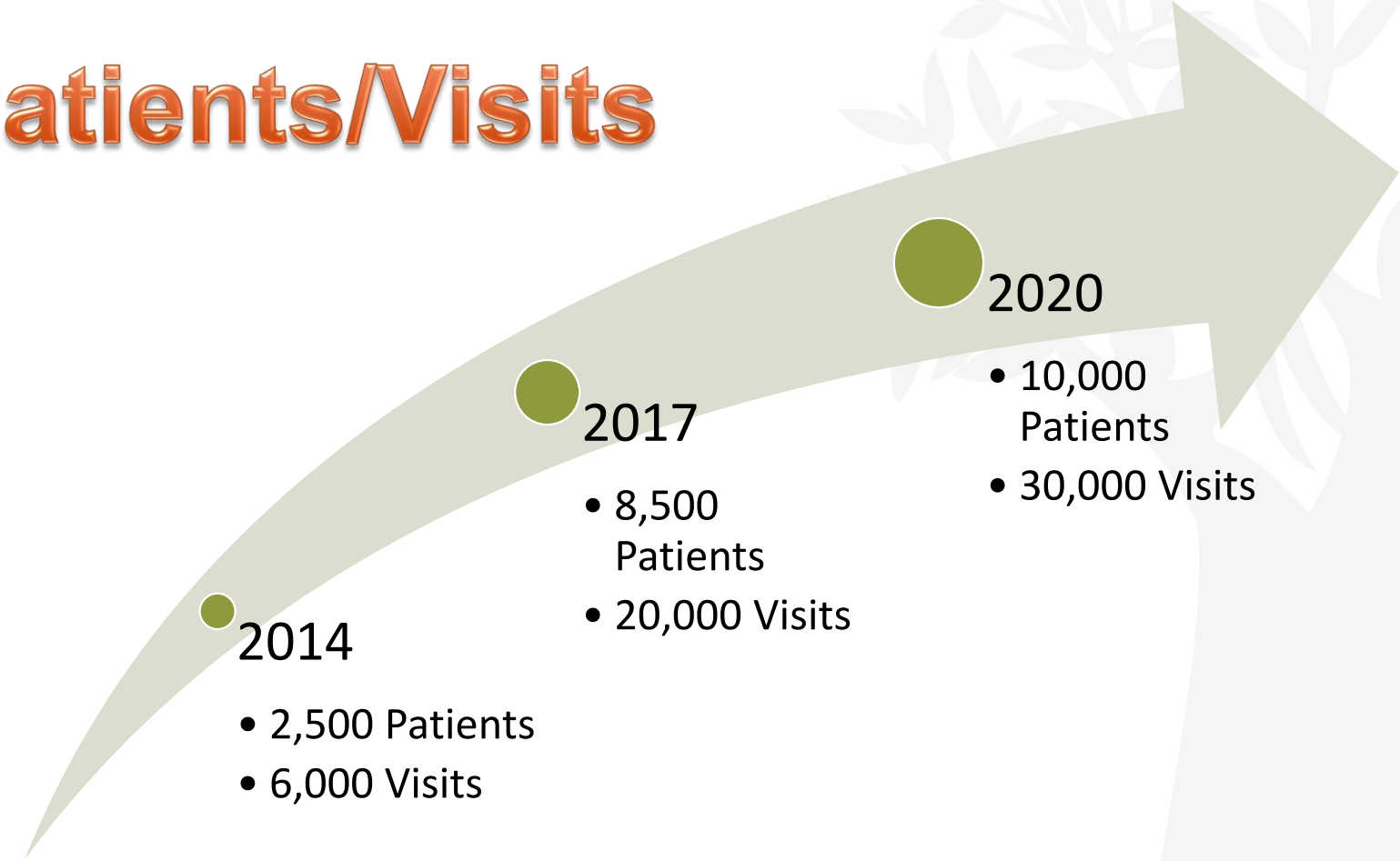
Operate on the following resources:

- Grants
- Medicaid
- Medicare
- Private Insurance
- Patient Fees
- Other resources



CHWP Growth

Patients/Visits



CHWP Mission – Vision - Values

Mission:

To provide quality, whole-person, patient-centered medical care to anyone and everyone in our community.

Vision:

To change lives within our community by eliminating barriers and providing a standard of healthcare that improves the well-being of the whole person.

Values:

Be welcoming

Listen with heart

Educate patients

Serve with excellence

Share best practices

Eliminate barriers

Develop relationships

B-L-E-S-S-E-D

More About CHWP

- Multi-center FQHC with embedded medical and behavioral health services
  - Team based care delivery
  - Chronic Care Management services are part of Population Health Department
    - RN educators
      - Diabetes Education, Anticoagulation, Chronic Care Management, Medicare Annual Wellness Visits (AWV)
    - Dietitian
    - Clinical pharmacists
      - Anticoagulation, Pharmacogenomics, Comprehensive Medication Management, Diabetes Education
    - Outreach coordinator

How Did COVID Affect Us?

- Ohio declared state of emergency on *March 9, 2020*
- In the following weeks schools, restaurants, gyms, and many other public venues closed
  - CHWP visit volume decreased by approximately 40%
  - Restricted healthy patients to AM and symptomatic patients to PM
  - At risk patients asked to postpone routine appointments
  - Required a lot of phone calls/manual labor to notify patients

Telehealth- Pre-COVID

Outreach

- CCM programs telephonically reached out to enrolled high risk patients
- Identified by PCP during transitions of care, population health screens, etc
- Ensured point person for coordinating care

Barriers

- Labor intensive
- Subsidized phones ran out of minutes by end of month

CHWP CCM Telehealth Response

Identified Needs:

- Increased outreach to vulnerable populations
- Follow up with patients seen for COVID symptoms
- Provide quality care for patients whom visits were postponed

Telehealth:

- April 2020:
  - Telehealth visits remotely through video/audio feed
  - Trialed texting program to reach large numbers of patients effectively

CHWP CCM Program Response- Text

Identifying High-Risk Patient Populations

- Follow up text messages to patients seen in-office for COVID symptoms
- Patients that had appointments postponed
- Medicare patients with 2 or more chronic conditions

- Utilized "cold" blast texts
  - Converted approximately 12% of these messages into active CCM patients

CCM: What is the Goal?

The goal of every CHWP Chronic Care Management program is to serve our patients by creating a partnership and providing individualized care to promote living successfully with chronic illnesses.

Medicare CCM: What is It?

CMS defines Chronic care management as:

"A care coordination services done outside of the regular office visit for patients with 2 or more chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline."

Medicare CCM Program: Enrollment Requirements

- Two or more chronic conditions expected to last at least 12 months (or until the death of the patient)
- Patient consent (verbal or signed)
- Personalized care plan in a certified EHR and a copy provided to patient
- 24/7 patient access to a member of the care team for urgent needs
- Enhanced non-face-to-face communication between patient and care team

Eligibility

Eligible Patients

- Patient has 2 or more qualifying chronic health conditions
  - (Examples include but not limited to the following: Alzheimer's disease and related dementia, Arthritis (osteoarthritis and rheumatoid), Asthma, Atrial fibrillation, Autism spectrum disorders, Cancer, Cardiovascular Disease, Chronic Obstructive Pulmonary Disease, Depression, Diabetes, Hypertension, Infectious diseases such as HIV/AIDS
- Patient has been seen by their PCP in last 12 months
- Patient is not receiving CCM services from another provider

Exceptions

The following cannot be billed at the same time/month as CCM:

- Home health care supervision (HCPCS G0181)
- Hospice care supervision (HCPCS G0182)
- Certain ESRD services (CPT 90951-90970)
- Cannot receive TOC and CCM simultaneously

Comprehensive Care Plan

A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and identification of the individuals responsible for each intervention
- Medication management
- Community/social services ordered
- A description of how services of agencies and specialists outside the practice are directed/coordinated
- Schedule for periodic review and, when applicable, revision of the care plan

Text Messaging Patients

Check-in text messages sent twice weekly. Questions are meant to initiate conversation

General check-in questions

- How are you feeling today (1-10 scale)?
- Do you need any of your medications refilled?
- Do you need help coordinating any of your appointments?
- Monthly/Seasonal topics:
  - Ex: sun protection, dehydration awareness

Disease state based message examples

- Diabetes
  - Recent trends in blood glucose values
  - Proper foot care
  - Sick day management
- Heart failure
  - Recent weight changes
- Hypertension
  - DASH diet reminders
  - Recent trends in measurements

Text Messaging Patients

- Overall response
  - 97% of patients respond to a message
- Interesting findings
  - Satisfaction improved over having to call clinic, especially during high call volume due to COVID
  - Enjoy having text to reference for instructions
  - Patients with difficulty hearing especially thankful

Text Messaging Patients

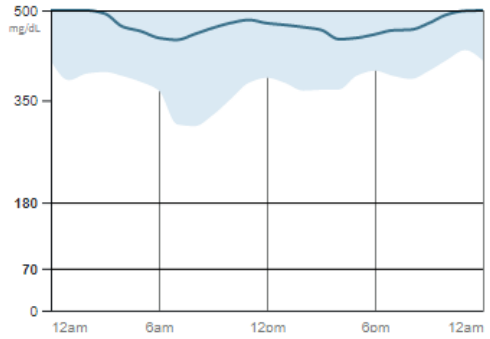
- Other findings
  - “Same Day” virtual/telehealth visits
    - New onset symptoms triaged more quickly
    - Patients willing to text about a symptom before having to call and wait on hold
    - Smoking Cessation visits on demand
  - Remote Patient Monitoring
    - Body weight, blood sugars, blood pressure
    - Automatic feed for continuous glucose monitors
      - Can monitor and proactively reach out to patient who has readings out of range

Example Cases

February 19, 2020 – **March 3, 2020**

FreeStyle LibreLink

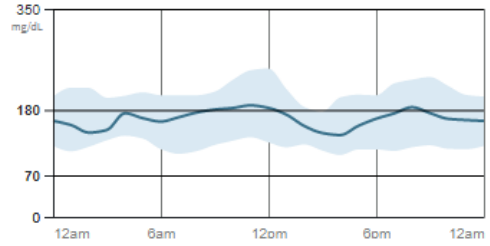
456	100%	0
mg/dL Average Glucose	Days of Data	Hypo Events



June 24, 2020 – **July 7, 2020**

FreeStyle LibreLink

166	100%	0
mg/dL Average Glucose	Days of Data	Hypo Events

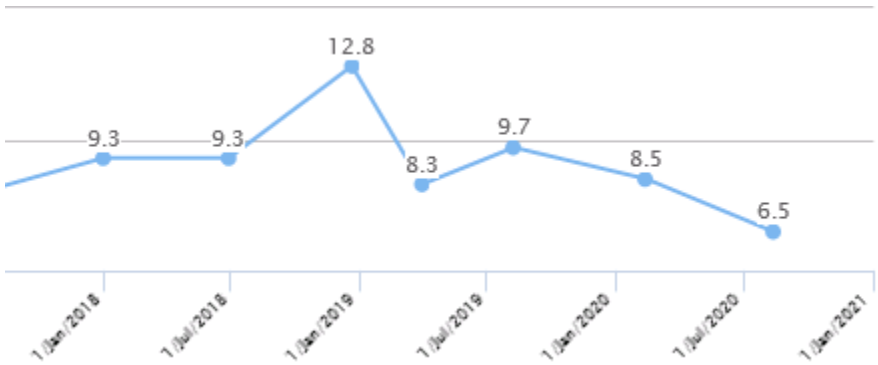


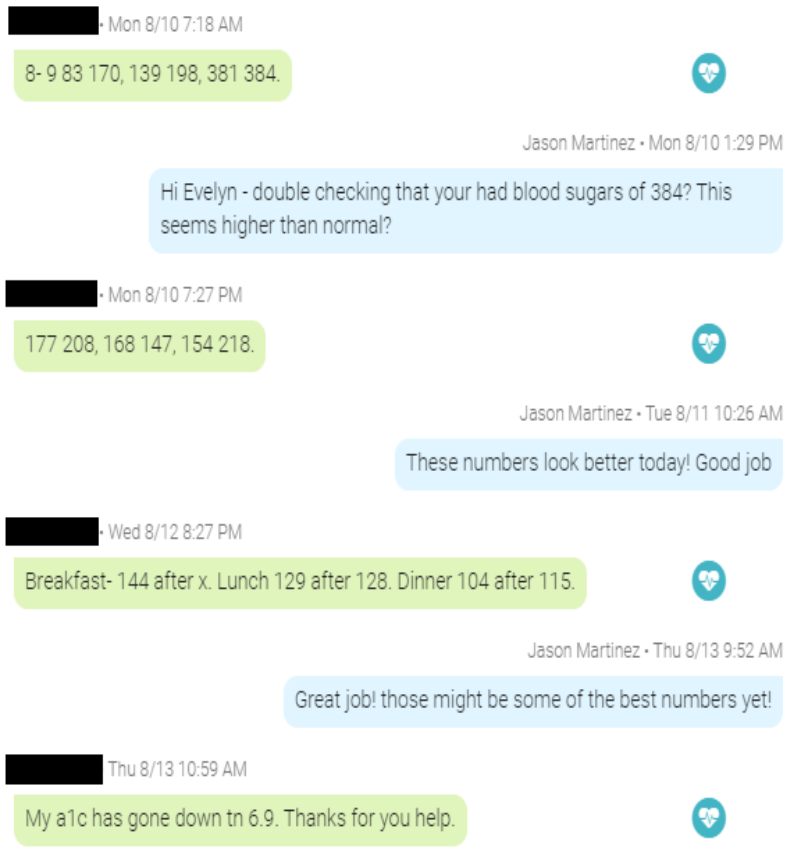
Example Cases

- 55 yo male with transient housing
  - Frequently no shows medical and behavioral health visits
  - Reached out to patient through “cold” text and signed up
  - Became trusting of nurse and one day sent message regarding concerns about safety in current housing situation
  - Stated that for months he felt unsafe to call and voice his concerns over roommate hearing

Example Cases

- 72 yo female with long standing diabetes
- Sends readings daily
  - Can offer real-time feedback
- A1C improvement



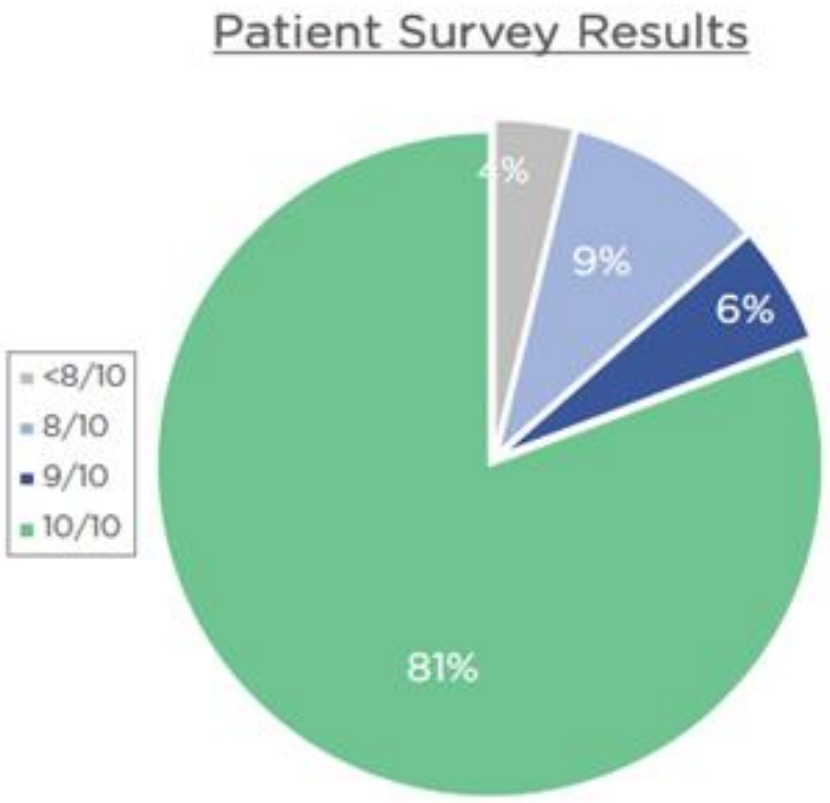


Patient Feedback

- Impactful communication
  - Patients recognize “who” is texting them
  - Sending pictures of food choices, blood sugar logs, etc.

- Comments
  - “It makes me more mindful, because I know someone is checking in with me”
  - “I like the feeling that someone cares”
  - “This helps me feel like I’m not alone in my health care situation”
  - “It's so nice to be able to send a text when something is happening. This helps for things not to be forgotten.”
  - "Keeping me on task with monitoring my vitals routinely. Words of encouragement to be more active!”
  - "I've never gotten this much help before. I find it very helpful to be able to have almost instant contact, and it helps get things done quickly. VERY satisfied."

Patient Feedback



Patient Participants = 63

Recordable Responses = 52

Avg. Satisfaction Score = 9.3

Note: Recordable Response = patient provided quantifiable measure of satisfaction

"…..I love being only a message away."

"I do appreciate your service, checking up on me! I don't take my blood pressure on a regular basis, so I appreciate that as well as your help getting appointments and answering my questions! Sometimes it just makes my day hearing from you, someone who cares!

"I love the fast response to questions , genuine interest in my well being , continue ongoing support !! :)"

Billing

Who Can Bill?

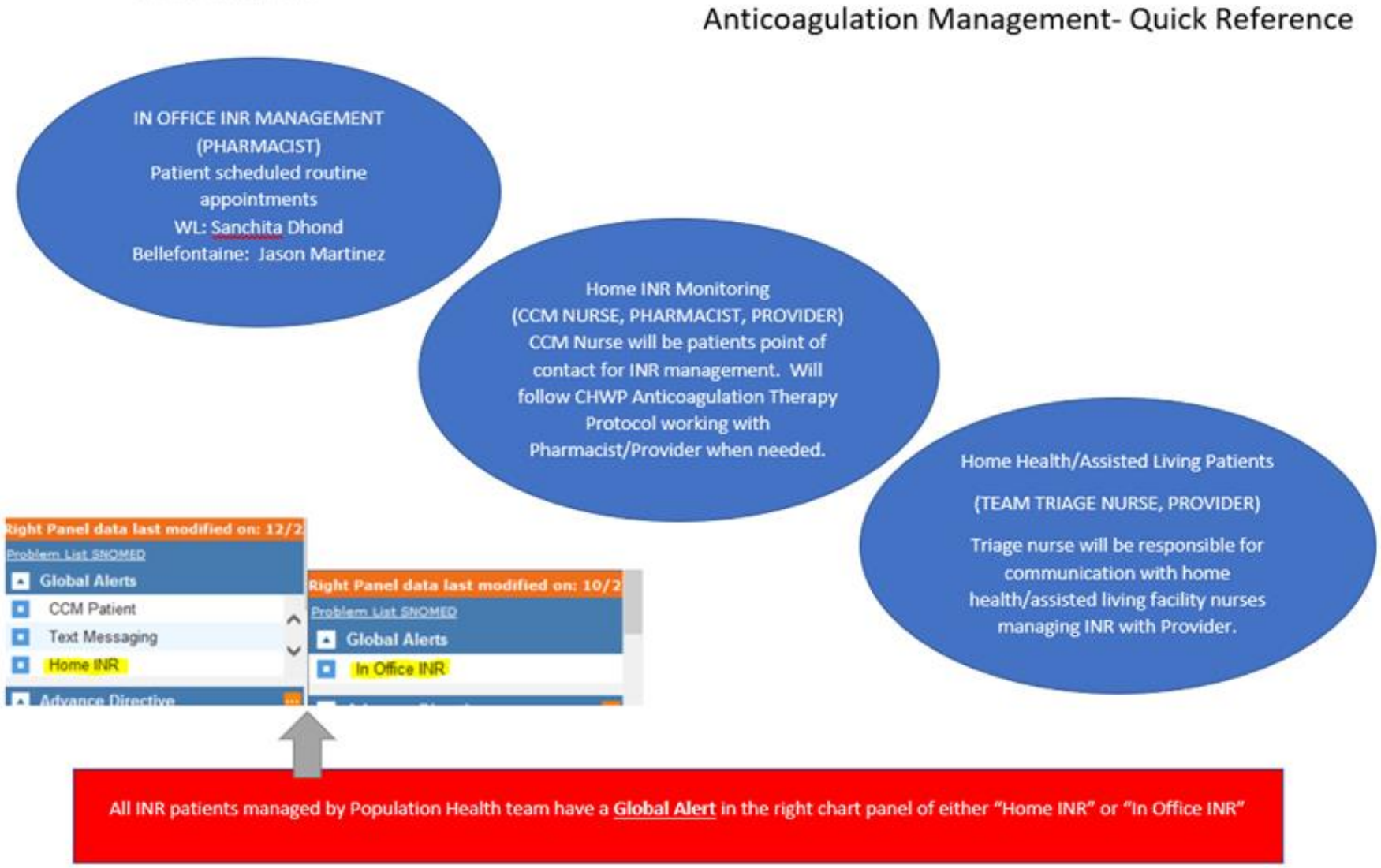
- Physicians
- Certified Nurse Midwives
- Clinical Nurse Specialists
- Nurse Practitioners
- Physician Assistants

When Can Bill?

- CPT 99490 is a billable service when 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

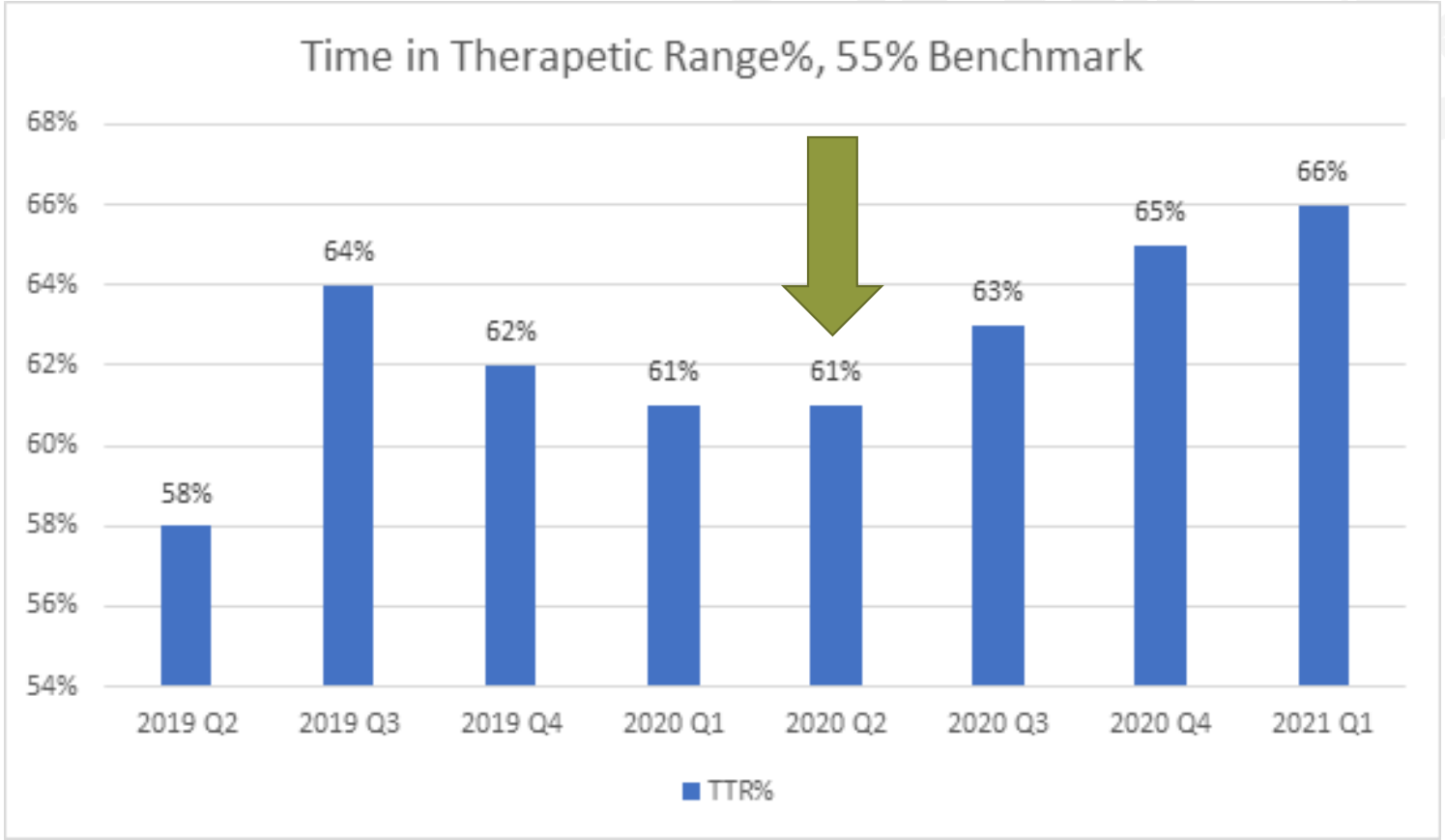
Anticoagulation Management Service (AMS)

CHWP offers
3 different options for our patients to choose from to for AMS. This allows the patient to choose what best fits their personal needs.

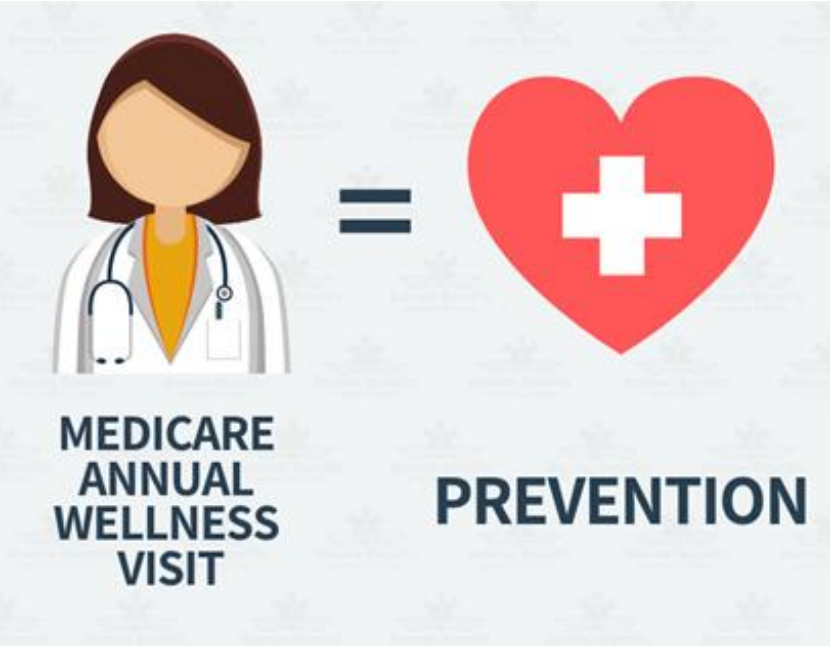


Anticoagulation Management Service (AMS) Statistics

- >400 INRs/quarter for approximately 60 patients
- Management by provider is included in this calculation (70% if removed)



Medicare Annual Wellness Visits (AWV)



The **Medicare wellness** exam, or **Annual Wellness Visit** (AWV,) provides an **annual** opportunity for **Medicare** beneficiaries to create or update their personalized prevention plan. This exam is part of an effort by **Medicare** to encourage seniors to be proactive about their health and engage more in preventive health services.

Requirements of AWV

There are 11 requirements of AWV that each have their own elements involved

1. HRA- Health Risk Assessment
2. Establish patient's medical and family history
3. Establish a list of providers and suppliers
4. Vital signs
5. Cognitive screening
6. Depression Screening
7. Functional ability and level of safety
8. Establish screening schedule for 5-10 years
9. List of risk factors/conditions for which primary, secondary or tertiary interventions are recommended or underway (immunizations, diagnostic imaging, behavioral health, ect.)
10. Furnish appropriate personalized health advise/referrals
11. Furnish at the patient's discretion advance care planning service

Medicare Covered Preventative Services

- Advance Care Planning (ACP) as an Optional AWV Element
- Alcohol Misuse Screening and Counseling
- Annual Wellness Visit (AWV)
- Bone Mass Measurements
- Cardiovascular Disease Screening
- Colorectal Cancer Screening
- Counseling to Prevent Tobacco Use
- Depression Screening
- Diabetes Screening
- Diabetes Self-Management Training (DSMT)
- Flu, Pneumococcal, and Hepatitis B Shots and their administration
- Glaucoma Screening
- Hepatitis B Screening
- Hepatitis C Screening
- Human Immunodeficiency Virus (HIV) Screening
- Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD)
- IBT for Obesity
- Initial Preventive Physical Examination (IPPE)
- Lung Cancer Screening
- Medical Nutrition Therapy (MNT)
- Medicare Diabetes Prevention Program
- Prostate Cancer Screening
- Screening for Cervical Cancer with Human Papillomavirus (HPV) Tests
- Screening for Sexually Transmitted Infections (STIs) and
- High Intensity Behavioral Counseling (HIBC) to Prevent STIs
- Screening Mammography
- Screening Pap Tests
- Screening Pelvic Examination (includes a clinical breast examination)
- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

Benefits of AWV

- **Keeping our patients as healthy as possible—** As health care moves from volume- to value-based models, the AWV addresses gaps in care and enhances the quality of care delivered. A personalized prevention plan created for the Medicare beneficiary is a way to improve patient engagement and promote preventive health care.
- **Empowering patients with resources** — It is said that "information is power." When completed successfully, the knowledge provided to patients during the annual wellness visit should enable them to take an active role in their health and treatment plan.
- **Providing patients with prevention services** — The visit is a chance for providers to recommend further treatments that can aid in proactive healthcare planning.
- **Establishing confidence in their providers** — With the level of communication that the Medicare annual wellness visit necessitates, patients work closely with their healthcare team, often achieving better rates of compliance and treatment adherence because they have a clearer understanding of health goals.

Questions?

Contact Information

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