Michigan Institute for Care Management & Transformation

Self-Management Support Training

Welcome!

MICMT

Michigan Institute for Care Management & Transformation

HOUSE KEEPING

Today's Agenda

- Introduction
- Self-Management
- Chronic Illness and Self-Management
- Motivational Interviewing
- Team Based Care and Self-Management
- Action Planning and Problem Solving
- Billing and Sustainability

Introduction

Learning Objectives:

- Describe Michigan Institute for Care Management and Transformation goals and resources available for physician office team members
- Apply behavior change to personal goals

Michigan Institute for Care Management and Transformation (MICMT)

- *Who we 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

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
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- Nicole Rockey, PharmD
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- Cindy Stevens
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- Julie Wolf
  - Administrative Assistant Sr.

MICMT Statewide Self-Management Support Course Post Test and Evaluation

Logistics:

- The MICMT SMS Statewide Post Test and evaluation is web based
- A web link to the SMS Post Test and evaluation will be sent to you via the e-mail you provided during registration
- 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 SMS Course Post test “Pass” status
  - For Questions contact: **micmt-requests@med.umich.edu**

Statewide Self-Management Support (SMS) Course Completion

Successful Completion of the SMS course includes:

1. Completion of the self-study modules

2. Completion of the 1 day in-person

3. Complete the Michigan Institute for Care Management and Transformation (MICMT) SMS 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

4. Complete a 30 minute Practice Phone Session

Statewide Self-Management Support (SMS) Course Completion

*Please note:

- You will have **5 business days** to complete the Statewide Self-Management Support Post Test and evaluation
- You will need to complete a 30 minute practice session with the SMS course trainer following your successful (pass status)completion of the post test. An email will be sent to you within 1-2 weeks of completing the SMS post test enabling you to schedule the practice session.
- You will receive a certificate (Nursing CE, Social Work CE, or certificate of completion) following the 30 minute practice session

Introductions:

- What type of patient do you enjoy working with?
- What type of patient do you find challenging?

INTROSPECTION EXERCISE

Activity #1*

Looking at our own attempts at behavior change

Self-Management

Learning Objectives:

- Define Self-Management
- Describe Self-Management Support
- Define the 5A's Behavior Change Model

Looking Through a New Lens:

Standard Approach	Self-Management Support Approach
• Focused on fixing the problem	• Focused on the patient's concerns and perspectives
• Paternalistic relationship	• Egalitarian partnership
• Confront, warn, persuade	• Emphasizes 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 developed

Video

- https://www.youtube.com/watch?v=0z65EppMfHk

Self-Management

"The individual's ability to manage the symptoms, treatment, physical and social consequences and lifestyle changes inherent in living with a chronic condition."

Barlow et al, Patient Educ Couns 2002;48:177

The 6 principles of Self-Management
The Flinders Model

- Knowledge of one's condition
- Follow a care plan
- Actively share in decision-making
- Monitor and manage signs and symptoms
- Manage impact on physical, emotional and social life
- Adopt lifestyles that promote health

https://www.flindersprogram.com.au/

What is self-management support?

According to Bodenheimer et al., "Self-management support involves:

collaboratively helping patients and their families acquire the skills and confidence to manage their chronic illness, providing self-management tools (e.g., blood pressure cuffs, glucometers, and referrals to community resources), and routinely assessing problems and accomplishments"

https://pdfs.semanticscholar.org/930c/f3266a05746c3cd49cb1fd15d7ed534f3ef2.pdf

Self-management programs focus on preparing people with chronic conditions for the 99% of the time they live outside of the health care system

https://www.integration.samhsa.gov/about-us/CDSM_January_Webinar.pdf

Professionals are experts in **diseases**

Patients are experts about **their own lives**

https://healthydebate.ca/opinions/patients-as-experts

The risk of equating “lived experience “ with patient expertise, Frank Gavin 2/13/19

Chronic Illness and Self-Management

The patients we are serving…

Learning Objective:

- Describe chronic illness care and the relationship to Self-Management

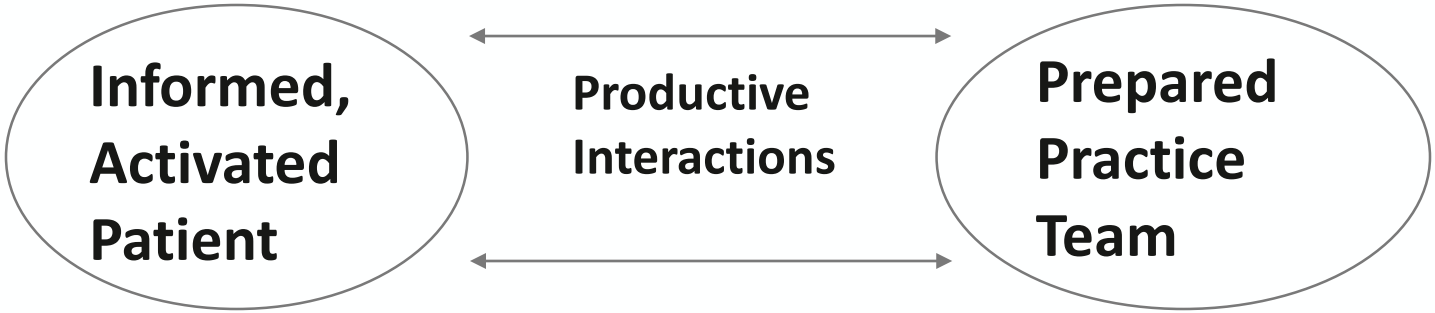
https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm

What Patients with Chronic Illnesses Need

- A “continuous healing relationship” with a care team and practice system organized to meet their needs for:
  - Effective Treatment (clinical, behavioral, supportive)
  - Information and support for their self-management
  - Systematic follow-up and assessment tailored to clinical severity
  - More intensive management for those not meeting targets
  - Coordination of care across settings and professionals

Wagner, E., MD Redesigning Chronic Illness Care: The Chronic Care Model, accessed through http://www.improvingchroniccare.org/index.php?p=Presentations_&_Slides&s=397

What distinguishes good chronic illness care from usual care?



http://www.improvingchroniccare.org/index.php?p=Presentations_&_Slides&s=397

What characterizes an “informed, activated” patient?

Informed, Activated Patient

Patient understands the disease process, and realizes his/her role as the daily self manager. Family and caregivers are engaged in the patient’s self-management. The provider is viewed as a guide on the side, not the sage on the stage!

http://www.improvingchroniccare.org/index.php?p=Presentations_&_Slides&s=397

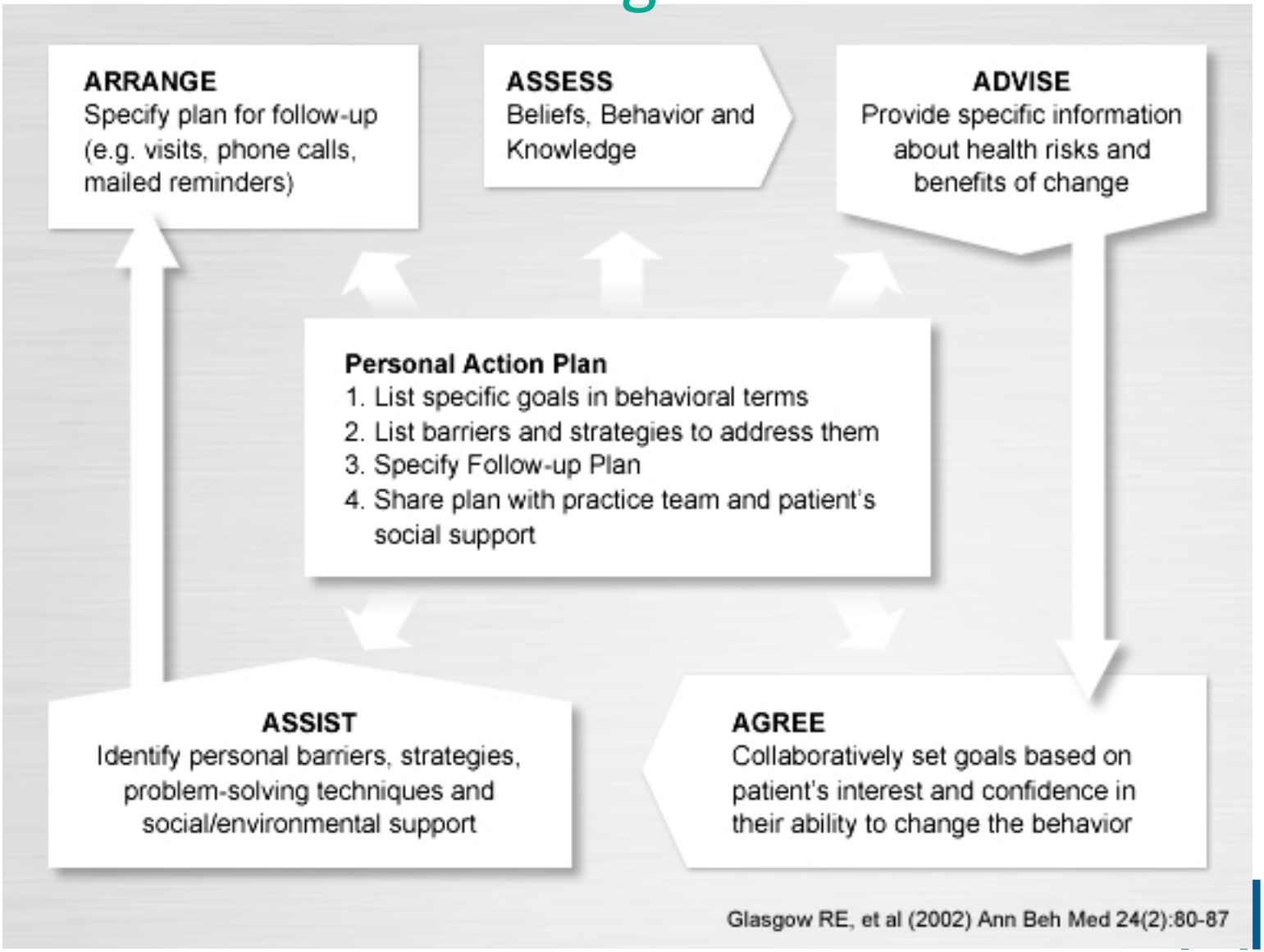
"Copyright 1996-2018 The MacColl Center. The Improving Chronic Illness Care program is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Group Health's MacColl Center for Health Care Innovation".

What characterizes a “prepared” practice team?

At the time of the visit, they have the patient information, decision support, people, equipment, and time required to deliver evidence-based clinical management and self-management support

http://www.improvingchroniccare.org/index.php?p=Presentations_&_Slides&s=397
"Copyright 1996-2018 The MacColl Center. The Improving Chronic Illness Care program is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Group Health's MacColl Center for Health Care Innovation".

The 5 As of Self-Management Behavior Change



“Self-Management is inevitable”

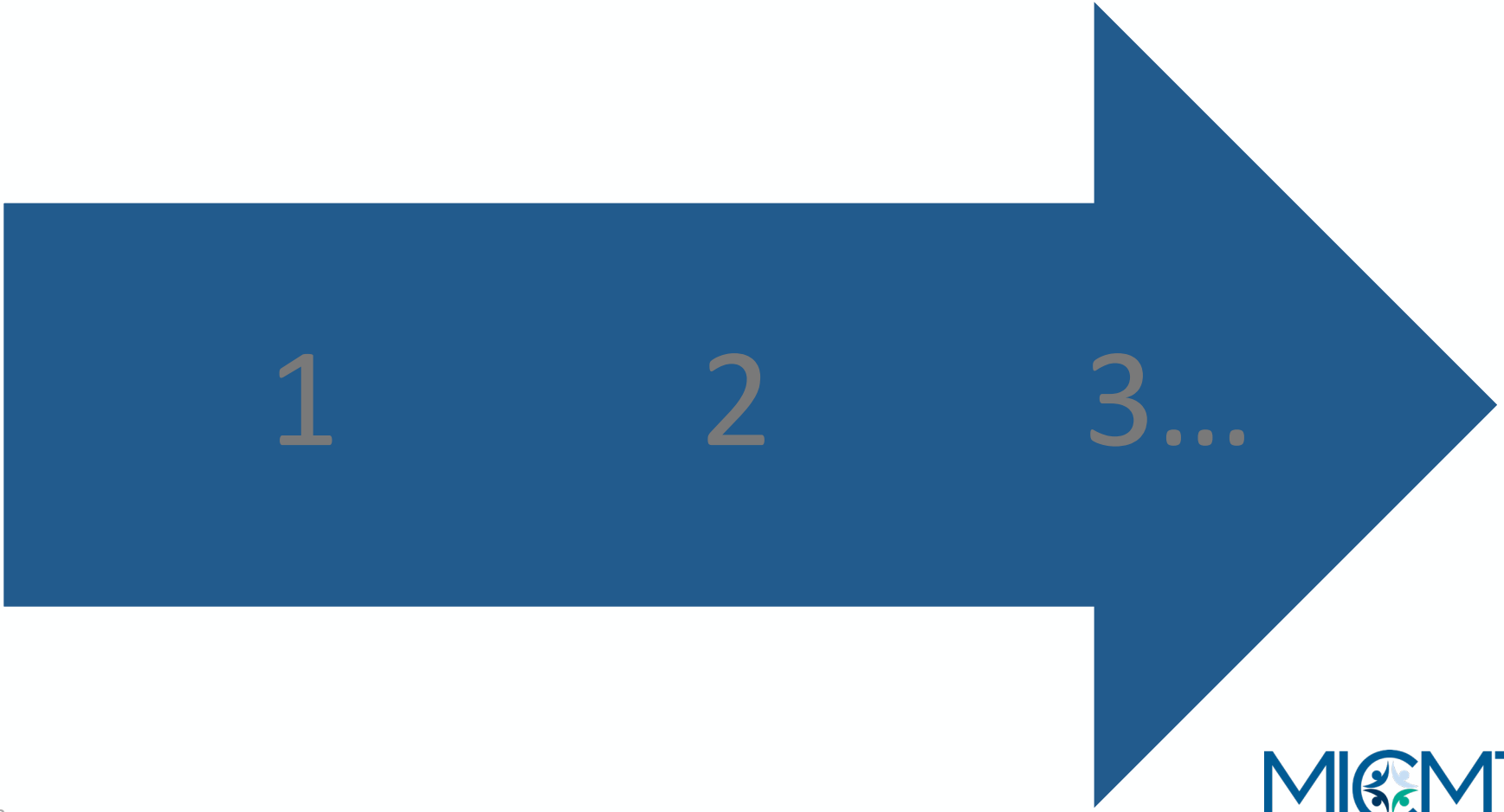
T. Bodenheimer, MD

Motivational Interviewing

Having conversations with patients…

Ruler Line Up

Activity #2



Learning Objectives:

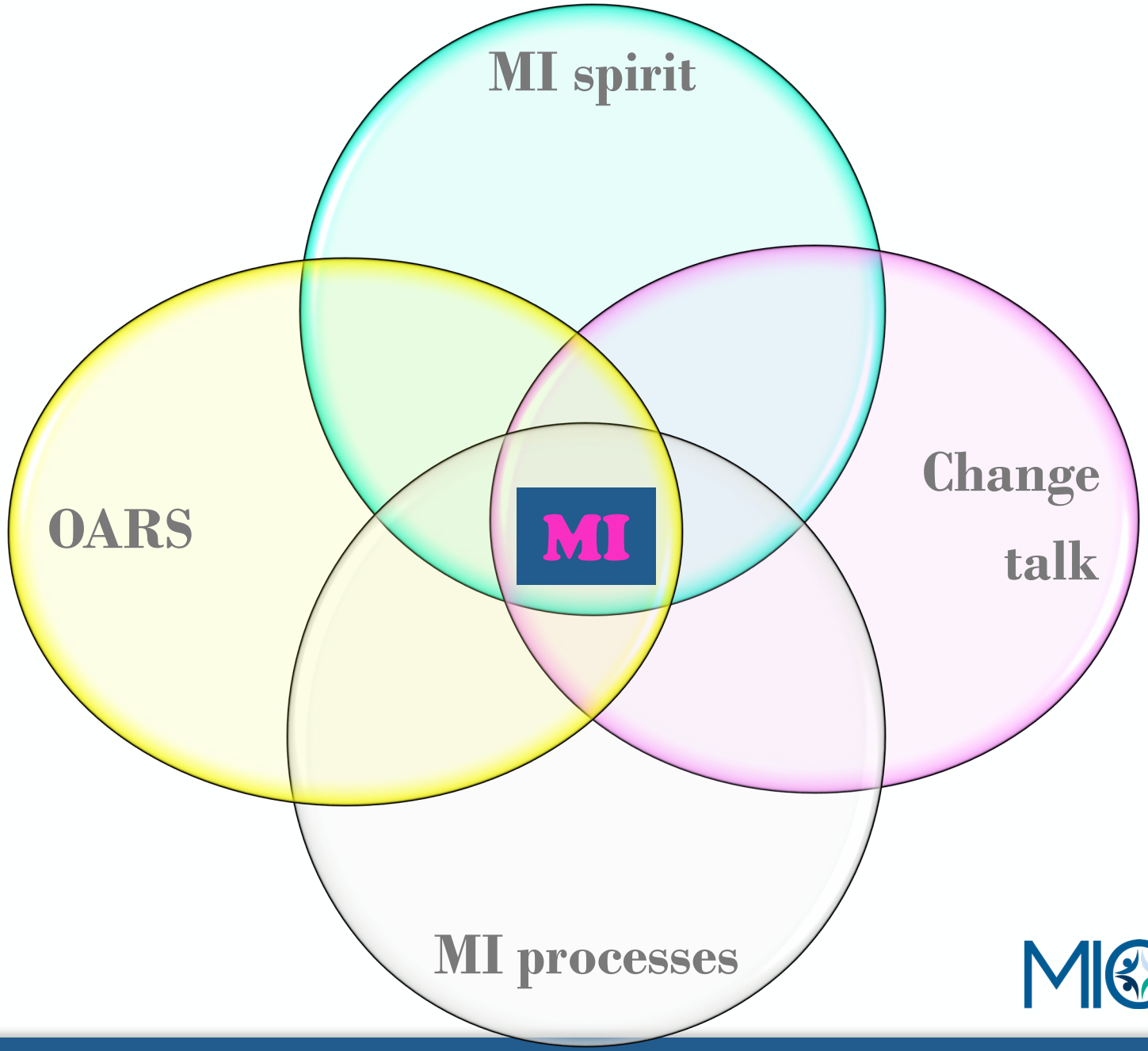
- Provide an understanding of the MI spirit
- Illustrate how strategies and applications of MI can support patient self-management

Motivational Interviewing:

A collaborative conversation style for strengthening a person's own motivations and commitment to change

Person centered counseling style for addressing the common problems of ambivalence about change

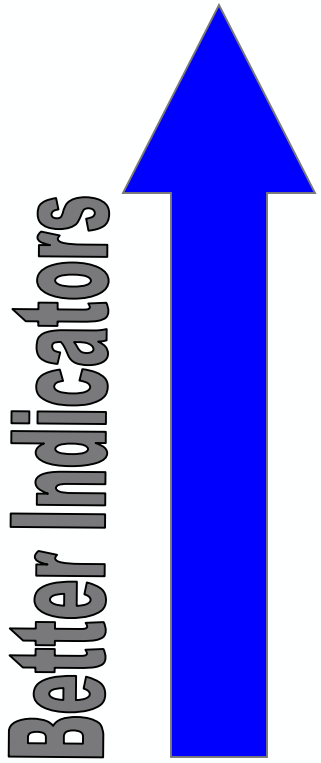
Miller and Rollnick 2013



- Partnership
- Acceptance
- Compassion
- Evocation

Why don’t people just do what they should?

Knowledge ≠ Behavior Change



Behavior

Intention

Knowledge

Remember that what people **know** may not determine what they **do**.

Example:

Motivational Interviewing and Behavior Change

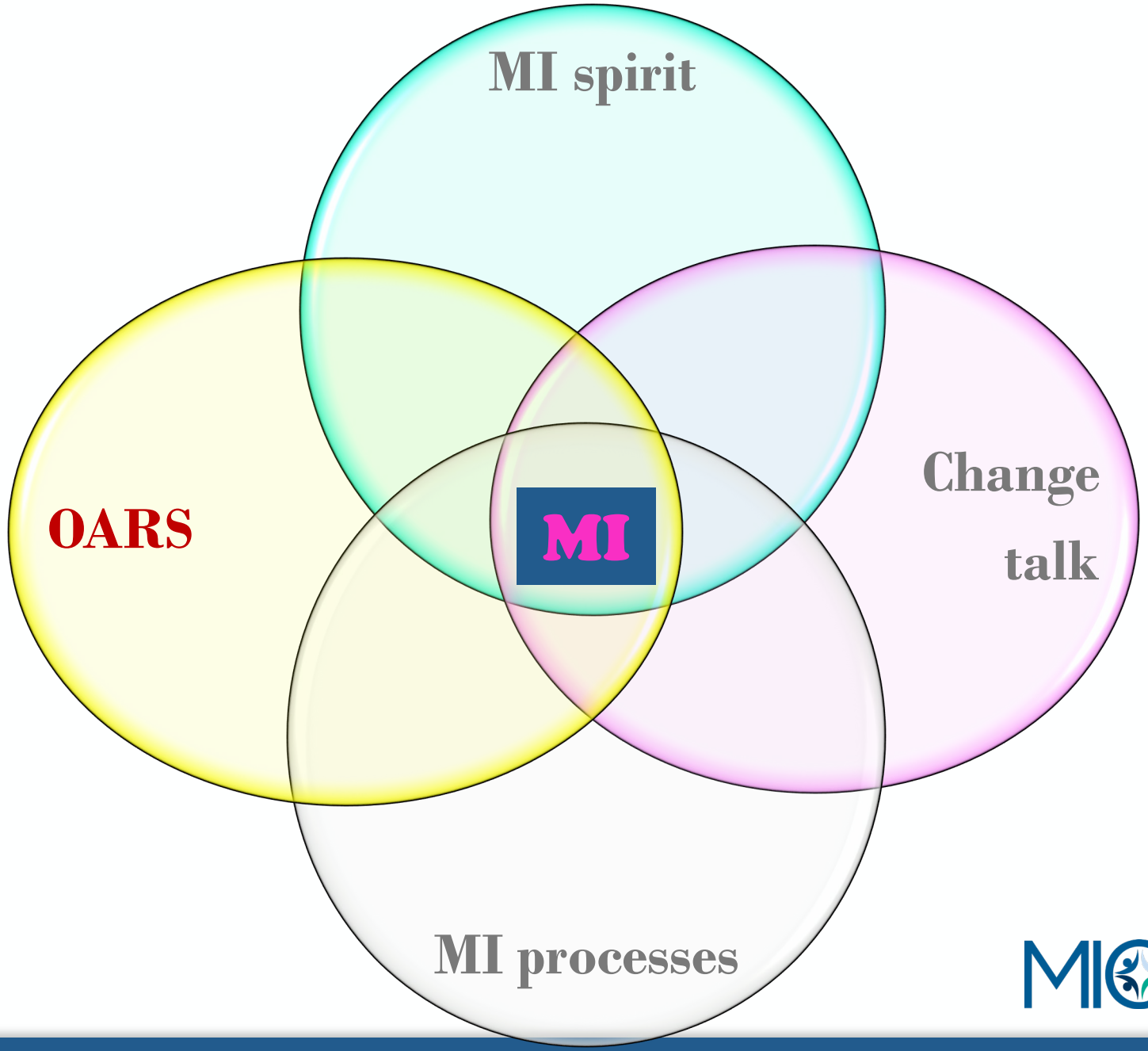
- **R** Resist the “Righting Reflex”
- **U** Understand your patient’s motivations
- **L** Listen to your patient
- **E** Empower your patient

Roll with Resistance

- Resistance is what happens when we expect or push for change when the patient is not ready for that change.
- Resistance often stems from fear of change

How we as providers respond to patient resistance is a big determining factor in the outcome of our interaction with that patient and the ability to help the patient move toward behavior change.

https://health.mo.gov/living/healthcondiseases/chronic/wisewoman/pdf/MIRollingwithResistance.pdf



MI Interviewing Strategies/Skills

- **O**pen ended questions
- **A**ffirmations
- **R**eflections
- **S**ummaries

OARS

Activity #3*

Open Ended Questions Activity…..

Asking Questions

- Many patients have never been asked how they *feel* about their health or what *they* would like to change.
- Asking questions can also help us understand why a patient may not be making progress
- Questions help in the engagement process

Explore --- Offer --- Explore

- **Explore** – ask what the patient knows, has heard, or would like to know
  - "When it comes to diabetes, what would be most helpful to know more about?"
- **Offer** - offer information in a neutral, nonjudgmental manner
  - "Research suggests…"
  - "What we generally recommend is…"
- **Explore** – ask about thoughts, feelings, and reactions
  - "What do you think about this information?"
  - "Based on these ideas for healthy eating, what could you see yourself doing?"

OARS

Affirmations

In order to encourage and support the client during the change process, the MI provider frequently affirms the patient in the form of statements of appreciation or understanding ~e.g. – "It took courage to do that." "You have a lot of great ideas on how to move forward."

- *“If you treat an individual as he is, he will stay as he is, but if you treat him as if he were what he ought to be and could be, he will become what he ought to be and could be.”*

- - Johann Wolfgang von Goethe

OARS

Reflections:

- An active process (the provider decides what to reflect or ignore, what to emphasize, preferentially reflecting change talk)
- Statements rather than questions
- Mirror meaning of a preceding statement(s)

Reflections

- Help with letting our patients know we are listening to them
- Help us understand if we're on the right track in listening to our patients
- Help our patients move forward in their thought process
- Help patients look at their ambivalence

Simple Reflections

"I've been taking my medication but my depression is getting worse"

- **Repeat** – repeating an element of what the speaker said.
- **Rephrase –** staying close to what the speaker has said with some rephrasing and synonyms

- "You've been more depressed lately."
- "So your sadness is getting worse and you don't know why."

Complex Reflections

I've been taking my medication but my depression is getting worse"

- **Reflect feeling –** Emphasizing the emotional dimension through feeling statements
- **Double-sided (reflect both sides of a patient's ambivalence)**

- "It's scary not to be able to understand your depressed feelings."
- "You're worried about your depression getting worse and you're looking for ways to manage your symptoms"

Reflections Activity

- One thing that I like about myself is that….
- One thing you should know about me is….
- One thing about myself I'd like to change is…..

Activity #5*

Reflections Practice

- “I really hate pricking my finger!”
- “I’m not going to stop eating steak no matter what!”
- “Well, I do drink most days, but not that much really.”
- “I’m usually the rock of the family, and even at work, but now this!”
- “I wouldn’t say that I miss many days, (of medication) but it’s not always so easy.”
- “I really want to lose weight, but I hate exercising!”

OARS

Summaries

- Show that the provider has been listening
- Link material together and can help emphasize certain points
- Can reinforce “change talk”
- Help to end talking points without losing material or end a session

Seek first to understand
before
seeking to be understood

Franklin Covey https://www.franklincovey.com/the-7-habits/habit-5.html

"What people really need is a good listening to."

Mary Lou Casey

55% of communication is non-verbal

38% is tone

7% is words

https://www.psychologytoday.com/us/blog/beyond-words/201109/is-nonverbal-communication-numbers-game

Video – TV example

- https://www.youtube.com/watch?v=4VOubVB4CTU

2 Reflections to every question

Q - **“Tell me what you typically eat at dinner.”**

“Usually some kind of meat, maybe a potato and a vegetable.”

R - **“Vegetables are included in your dinners.”**

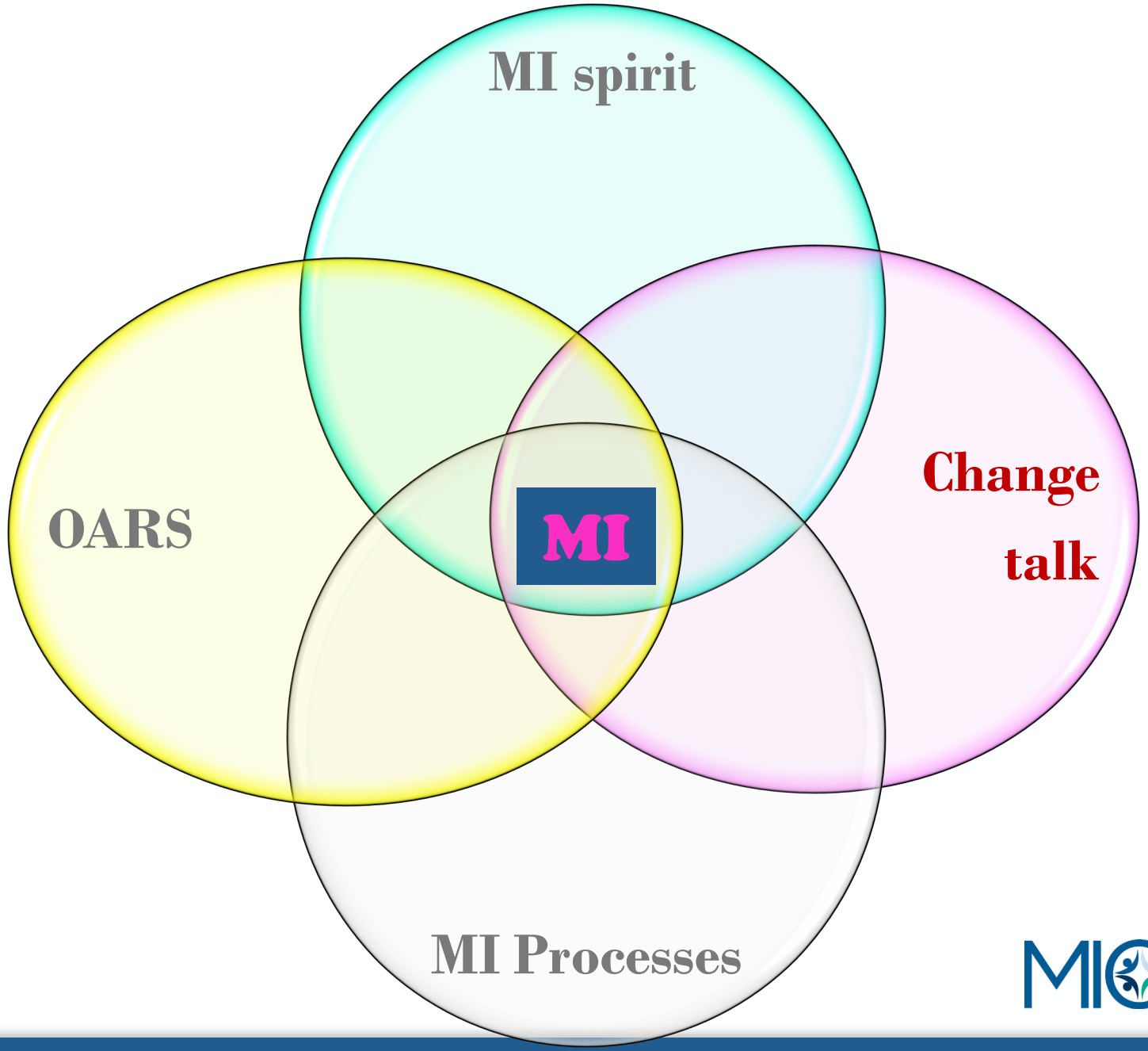
“Yes, I know they’re important.”

R - **“Healthy eating is important to you.”**

Activity #6

Virginia Reel

Activity……



Guiding Through Change Talk

Activity #7

Change Talk: Any patient speech that favors movement toward a particular change goal

Sustain Talk: Any patient speech that favors status quo rather than a movement toward a change goal

Change Talk

DARN C

- **Desire** "I really want to fit into my old clothes."
- **Ability** "I could maybe not have a cigarette right when I wake up."
- **Reasons (to, not to)** "It would be better for my husband too if we ate better."
- **Need** "The doctor said if I don't start taking my insulin, my diabetes could get a lot worse."
- **Commitment** "I'm going to buy a scale on my way home from here."

Responding to Change Talk

- **Reflection** – "You don't like the way this makes you feel sometimes, *and* you're looking for ways you might change things."
- **Elaboration** – "What other concerns have you had about…? What other things have people told you about this? Tell me more about…"
- **Summarizing** – "Let me see if I've got it so far…"(summarize client statements, including ambivalence)
- **Affirming** – "; that sounds like a good idea"
- **Clarifying Ambivalence** – explore both sides (e.g., "what do you like about drinking… what is the other side, things you don't like?")
- **Clarify Values** – helps move beyond ambivalence, important aspects of tipping the decisional balance in favor of change "your children are really important to you"

Enhancing Patient Confidence

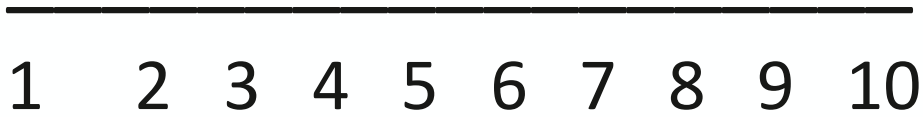
- **Evocative Questions** – First steps? How might you…?
- **Confidence Ruler** – How confident are you that you can start on this goal tomorrow from 0-10?
- **Review Past Successes** – Other times in your life where you made up your mind about something and did it…
- **Elicit Personal Strengths and Supports** – What strengths do you have that will help you succeed in changing?

  In an ideal world, what would you like to be able to say about yourself?
- **Hypothetical Change** – Suppose you made a change and are looking back on it now. How did it happen? What would you tell or say to someone else in this situation?

Readiness Ruler:

Using a scale to determine:

- Importance
- Readiness
- Confidence

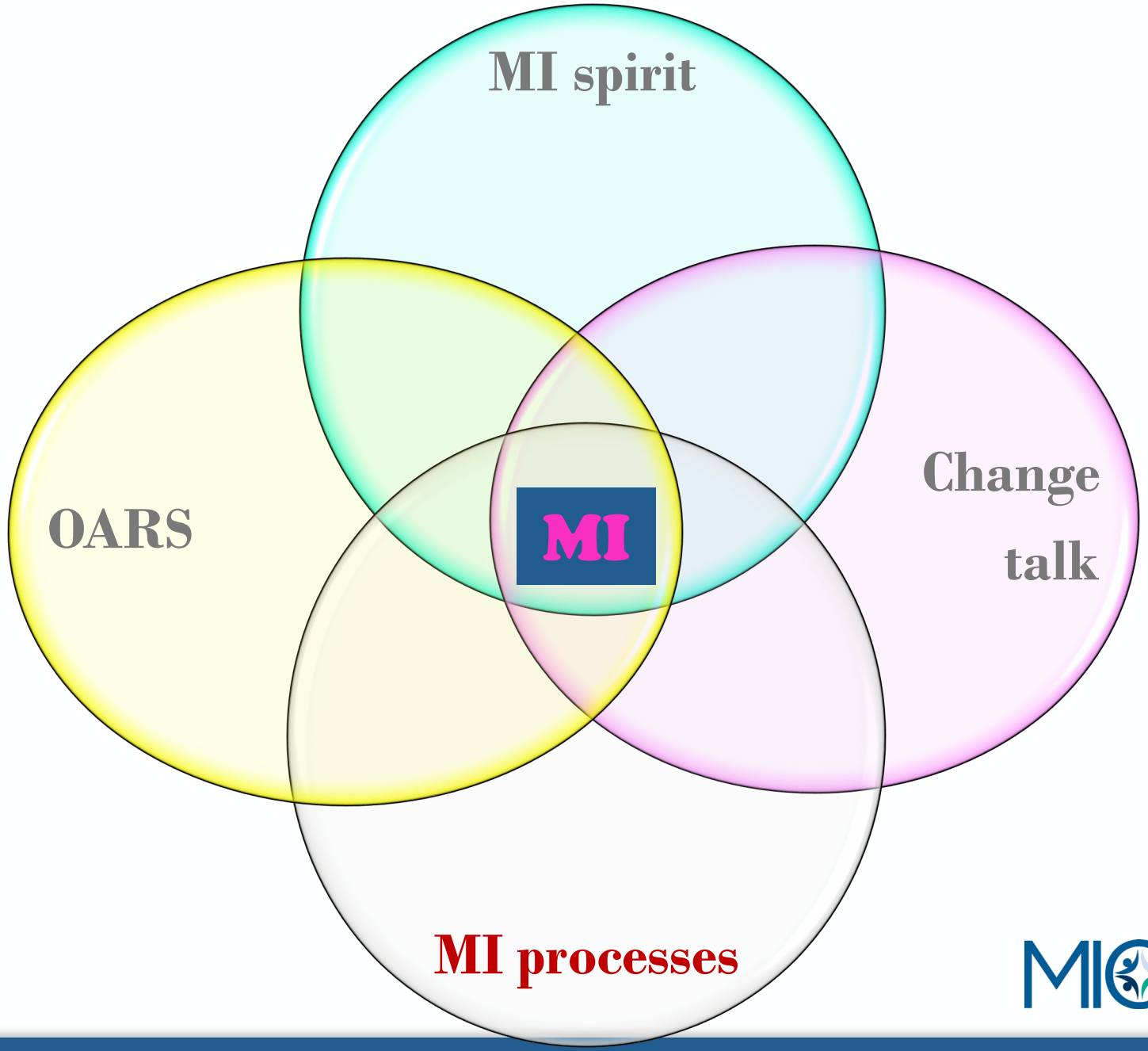


Video Examples

Activity #8*

https://www.youtube.com/watch?v=_VlvanBFkvI

https://www.youtube.com/watch?v=67I6g1I7Zao



4 Broad Processes of MI

1. Engaging
2. Focusing
3. Evoking
4. Planning

Processes of MI

1. Engaging

- **Appropriate introduction and rapport building**
  - Introduction of self and role
  - Establish agenda (“Dr. Smith asked me to talk with you about your diabetes.”)
  - Set a timeframe (“We have about 15 minutes to talk today.”)
  - Ask permission (“Dr. Smith asked me to talk with you today about your diabetes. Is it okay if we spend the next 15 minutes together?”)

Processes of MI

2. Focusing

- Clarifying a particular goal or direction for change

Bubble Sheet for Agenda Mapping

What would you like to focus on?

Processes of MI

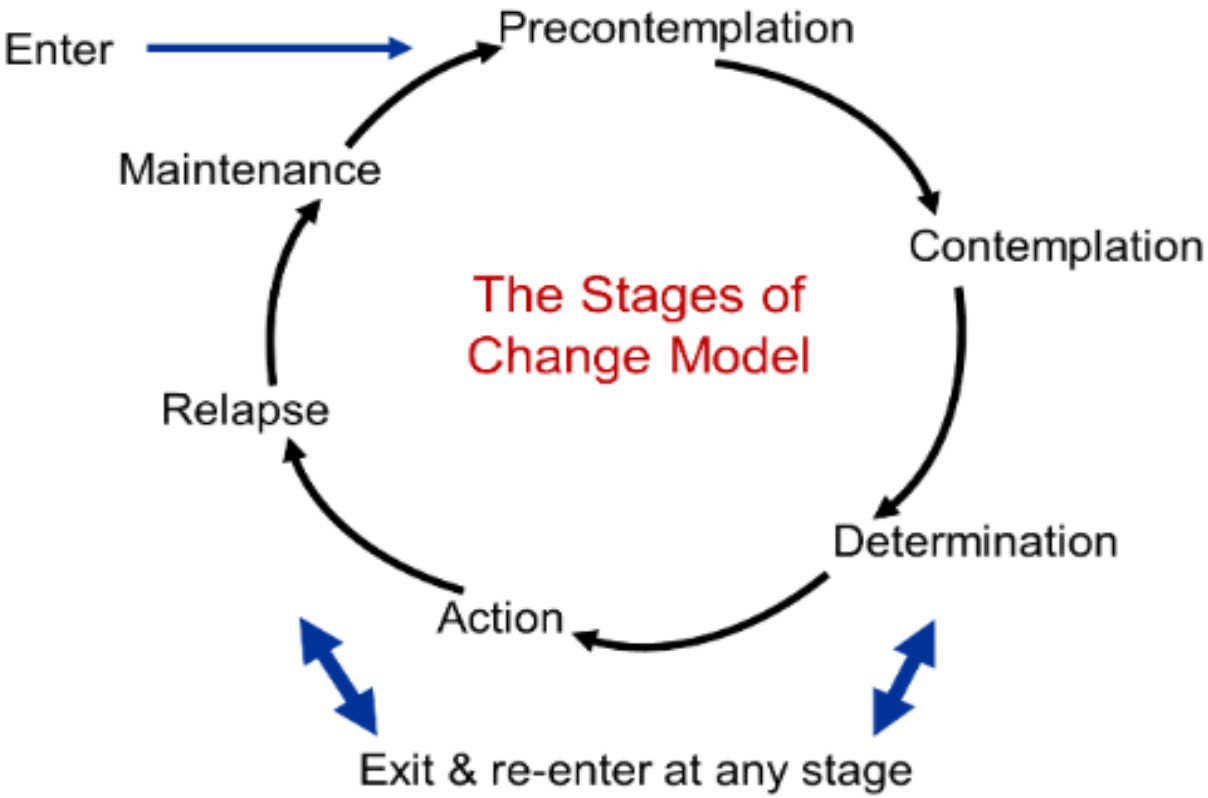
3. Evoking

- Drawing out patient's own ideas and reasons for change
  - "What are some reasons you chose this goal to work on?"
  - "What would be some benefits if you made this change?"
  - "How do you see your life being different if you decide to make this change?"
- Assess readiness and confidence

4. Planning

- Collaboratively developing a specific change plan that a patient is willing to implement
- Use SMART

Stages of Behavior Change: Transtheoretical model



http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories6.html

Stages of Change

Stage	Patient Characteristic/Behavior
• Pre-contemplation	• Not thinking about making a change
• Contemplation	• Ambivalence about making a change
• Preparation	• Decision made to change in the near future
• Action	• Taking definite action to change (<6 months)
• Maintenance	• Making an effort to maintain new behavior over time (>6 months)
• Relapse	• Return to old behavior can occur at any stage causing feelings of disappointment, and frustration, focus on why - triggers

Planned Visits

- How often do you see your patients?
  Ex. A patient with diabetes with an appointment every 3 months.
- How can you support self-management goals during a planned visit?

Team Based Care and Self-Management Support

Learning Objective:

- Define and relate team based care to self-management support

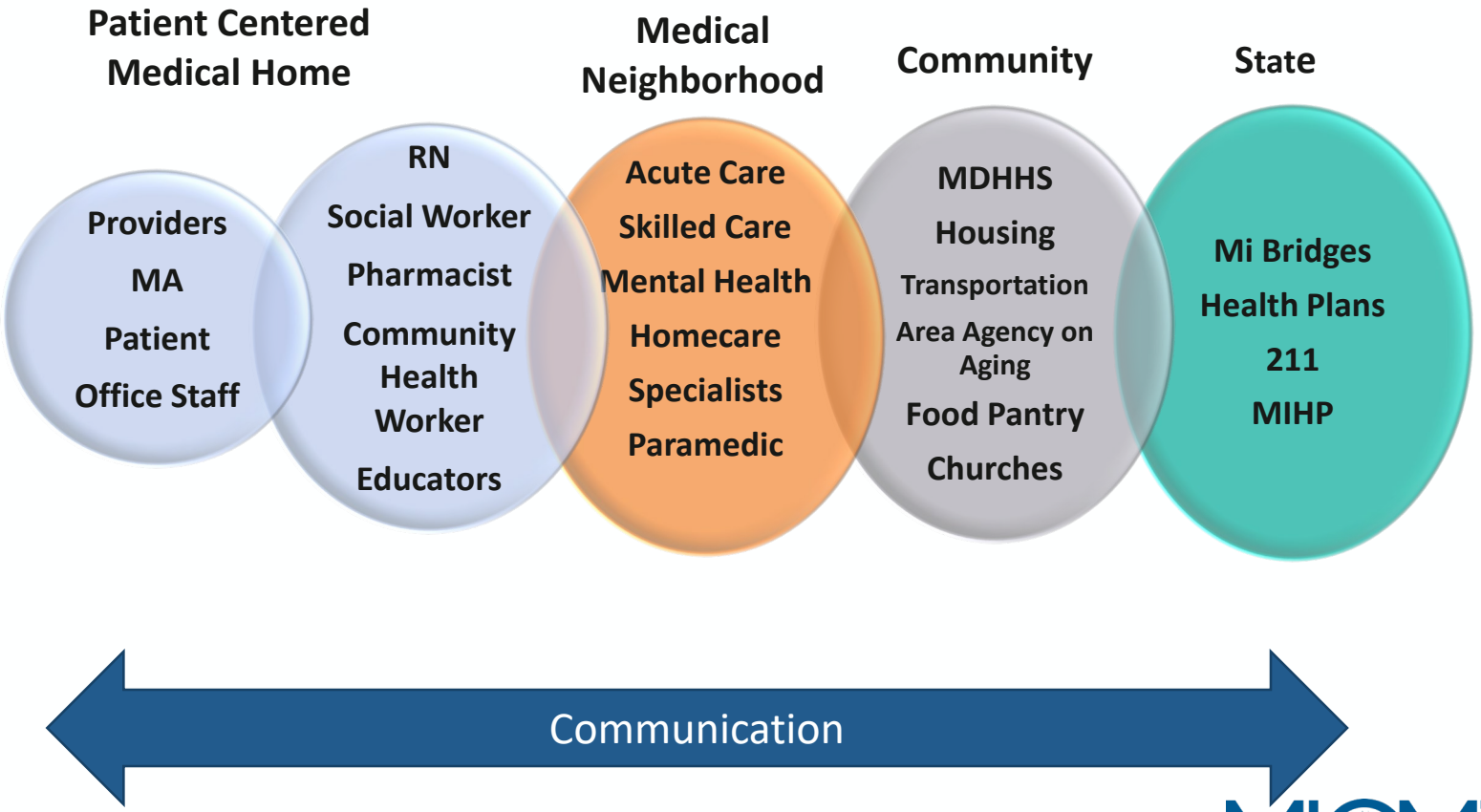
Team Based Care and Self-Management Support

2 or more healthcare staff….

- working toward shared goals within and across settings to achieve coordinated, high-quality care
- utilizing specific skills and roles within the practice to help patients toward self-management
  - MA, health coach, community health worker, care coordinator calling patient to check on action plan
  - Pharmacist addressing medication management
  - Behavioral health staff working with patients on psychosocial issues

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

Who is on the Team?



Health Coaching

- Once a goal is established, how do we follow up and continuing working with our patient?
  - Give support, “how did you do with walking around the block this week?”
  - Address barriers/challenges, “you weren’t able to walk this week, tell me about what got in the way”
  - Increase confidence, “you’ve done well with accomplishing your goal this week, you’re moving toward better management of your diabetes”

- Who can make these calls on the Care Team?

Action Planning and Problem Solving

Learning Objectives:

- Define an action plan
- Describe the use of brief action planning
- Understand how problem solving can be helpful in addressing barriers to care planning

Health Behavior Change

- Progress not perfection
- Guiding –

  "I can help you to solve this for yourself."

Know WHEN to call your provider office and HOW

Even when the office is closed

Ex: Asthma Action Plan

GO! (GREEN Zone) Use these controller medicines every day

You have *ALL* of these:

- ✓ Breathing is easy
- ✓ No cough or wheeze
- ✓ Sleep well at night
- ✓ Able to exercise
- ✓ Peak flow is 80% of personal best (= ____)

Personal best = ____

Asthma, Allergy and GERD/Acid Reflux Medicines	How much to take & when to take it

▸ **If asthma with exercise:**

WATCH OUT! (YELLOW Zone) Keep using Green Zone medicines and ADD this quick-relief medicine

You have *ANY* of these:

- ✓ First sign of a cold
- ✓ Cough or wheeze
- ✓ Tight chest
- ✓ Wake at night
- ✓ Peak flow is 60% to 80% of personal best (____ to ____)

	Asthma Rescue Medicine	How much to take
First:		

Next:

- ▸ If not breathing better after 2 treatments, 20 minutes apart, GO TO RED ZONE.
- ▸
- ▸ If breathing better, take treatments every 4 to 6 hours as needed for up to 2 days.

Call the doctor:

- ▸ If at any time, quick-relief medicine does not last for 4 hours, OR
- ▸ If quick-relief medicine is needed more than 2 times a week.

DANGER! (RED Zone) Use these emergency medicines AND get medical help NOW!

You have *ANY* of these:

- ✓ Medicine not helping
- ✓ Breathing hard, fast
- ✓ Nose opens wide
- ✓ Can't walk or talk well
- ✓ Ribs suck in
- ✓ Peak flow less than 60% of personal best (< ____)

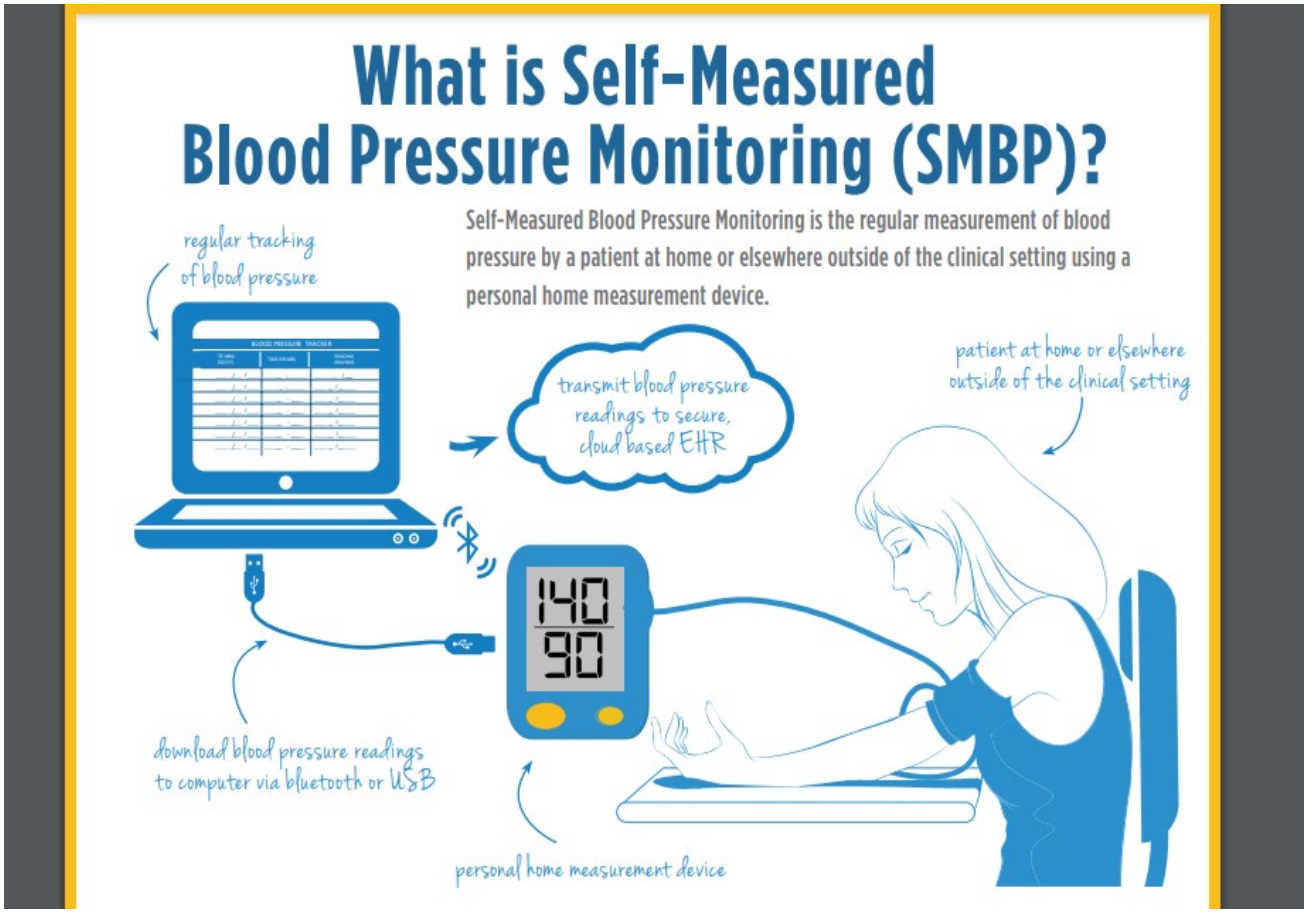
	Asthma Rescue Medicine	How much to take
First:		

Next:

- ▸ Wait 15 minutes to see if the treatment(s) have helped.
- ▸ If not breathing better, GO TO THE EMERGENCY DEPARTMENT OR CALL 9-1-1.
- ▸ If breathing better, keep taking treatments every 4 to 6 hours and CALL THE DOCTOR FOR AN APPOINTMENT TODAY!
- ▸ Make an appointment with your doctor within 2 days of an ER visit or hospitalization.

https://getasthmahelp.org/images/aim-action-plan-adult-revised-3-2019.jpg

Self - Monitoring



Brief Action Planning

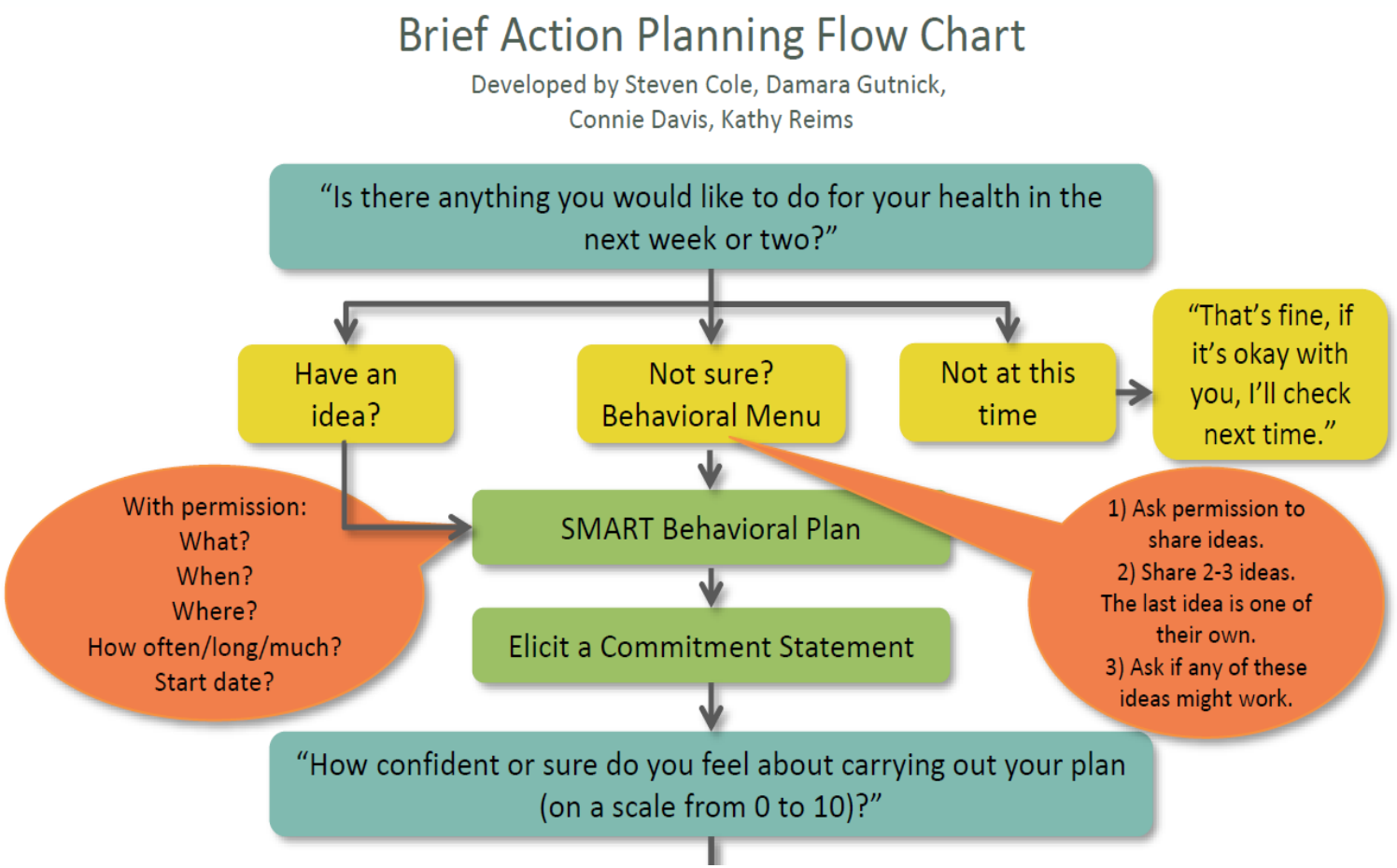
- A structured conversation to help people make concrete action plans
- Person centered approach
- Based on the principles and practice of Motivational Interviewing

3 Questions of Brief Action Planning

- "What, if anything, would you like to do for your health in the next week or two?"
- "How confident or sure do you feel about carrying out your plan (on a scale from 0-10)?"
- "Would it be helpful to set up a time to check up on your plan?"

Brief Action Planning

Activity #9*



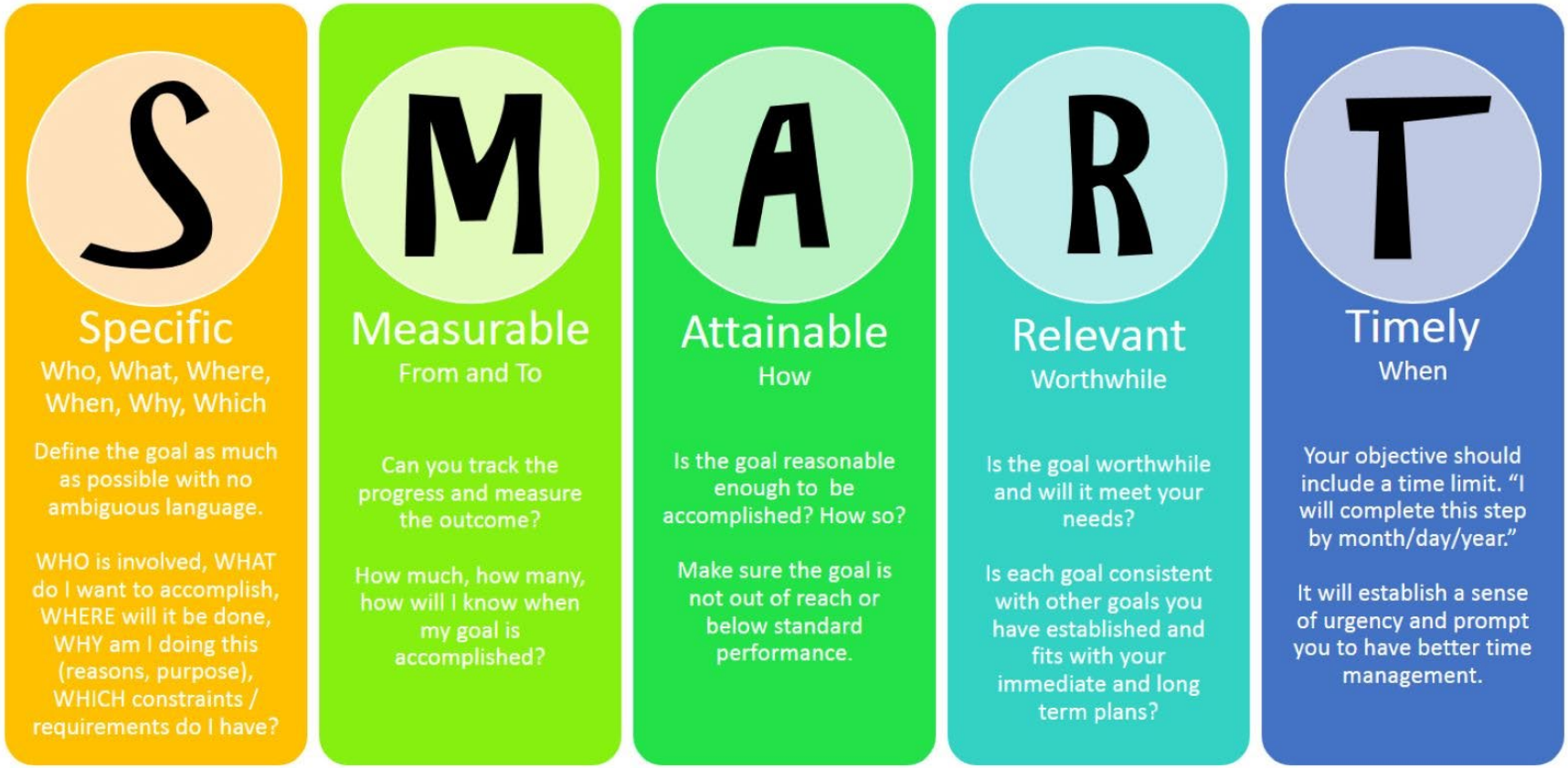
Parts of an Action Plan:

Something **YOU** **want or decide to do**

- Achievable
- Action Specific
- Answers the questions:
  - What?
  - How much?
  - When?
  - How often?

Confidence of 7 or more

SMART Goals



Teach Back Video

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

Teach back

- Teach back is not a test of a patient's knowledge. It's a test of how well you explained the concept.
- Chunk and Check
- Clarify and check again
- Use the show-me method
- Ask open ended questions
- Ask the patient to explain back using their own words

https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool5.html

Teach Back Video

- https://vimeo.com/48471644

Ask – Tell – Ask

- https://vimeo.com/85555368

Action Plan Completed:

Activity 10*

What if my patient hasn’t followed his/her action plan?

Barriers to Self Management

Review from Self-Study Curriculum

- Social Determinants of Health
- Health Literacy
- Physical Barriers

Problem Solving

"We cannot direct the wind but we can adjust the sails."

The Problem

Problems represent a discrepancy between your current state (what is) and your desired state (what I want). This discrepancy is a problem because of the existence of various obstacles that block the path when trying to reach your goals.

The Solution:

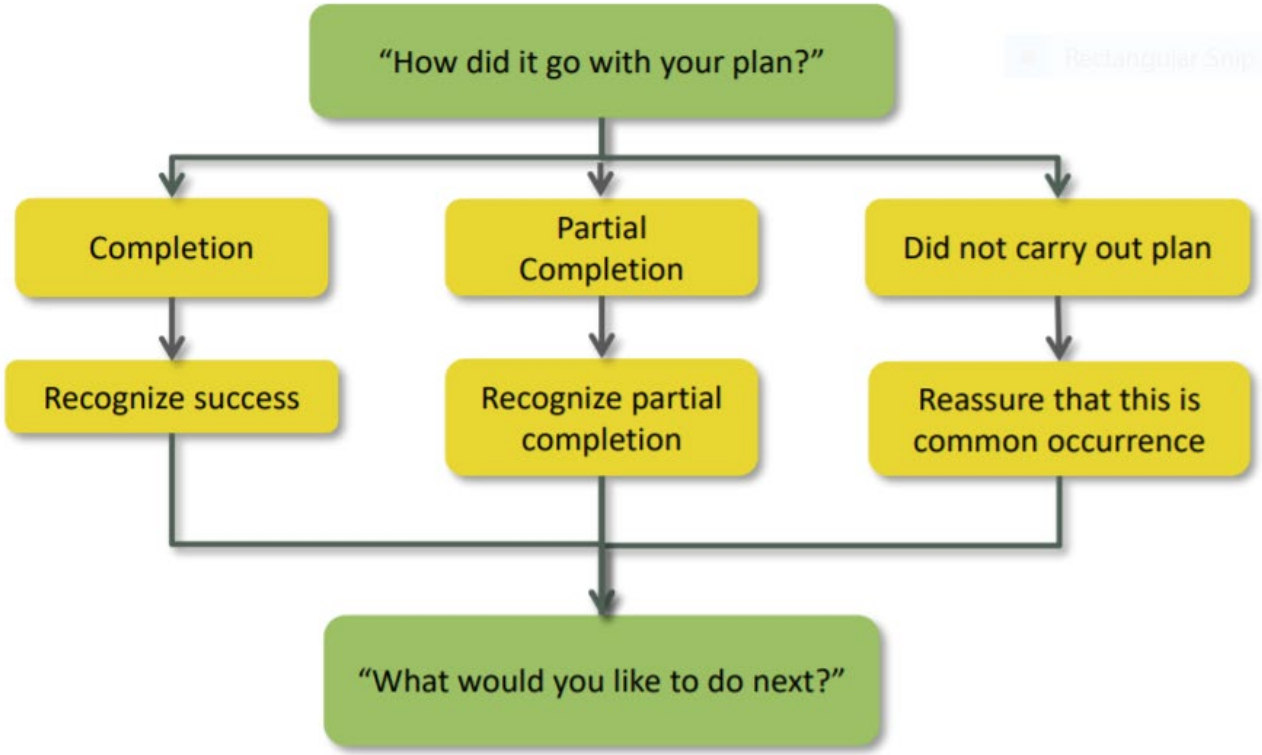
A solution is a person's attempt to change that nature of the situation so that it no longer represents a problem (obstacles are overcome) or changes a negative reaction to situations that cannot be changed.

Steps of Problem Solving

1. Define the problem and explore the problem, (who, what, where, when, how)
2. Define the goal
3. Generating solutions (brainstorming)
4. Decision making (pros and cons, decisional balance)
5. Decide on a solution
6. Implement the solution
7. Evaluate the outcome

ACTION PLAN FOLLOW UP

Checking on the Brief Action Plan



www.centreCMI.ca

Follow-Up with Action Planning

Discuss Action Plans and Goals with supportive reminders:

- Check often with new actions plans (remember to use the care team as appropriate)
- Decrease frequency as behavior is more secure
- Introduce problem solving as needed
- Change goals if appropriate

Goal is for patients to conduct BAP on their own

Case Study – Jim

Activity #11A & B*

Sustainability and Billing

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

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

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
  - Improving performance on payer quality / utilization programs *(i.e. earning incentive money and being financially sustainable)*

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)**

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 31 to 75 minutes 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 after initial 75 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)

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.

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

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

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.

G9007 – Team Conference

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

Phone Service Codes – 98966, 98967,98968

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

Incentive Programs for Care Management:

BCBSM

- Value Based Reimbursement (i.e. increase on every E&M code and PDCM code)
  - Up to 150% available
  - In 2019:
    - 5% of this is VBR for the billing codes for having 2 touches on 3% of the population
    - 6% is for Quality and Outcomes, focusing on A1c, BP, IP utilization, and ED utilization
- 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.

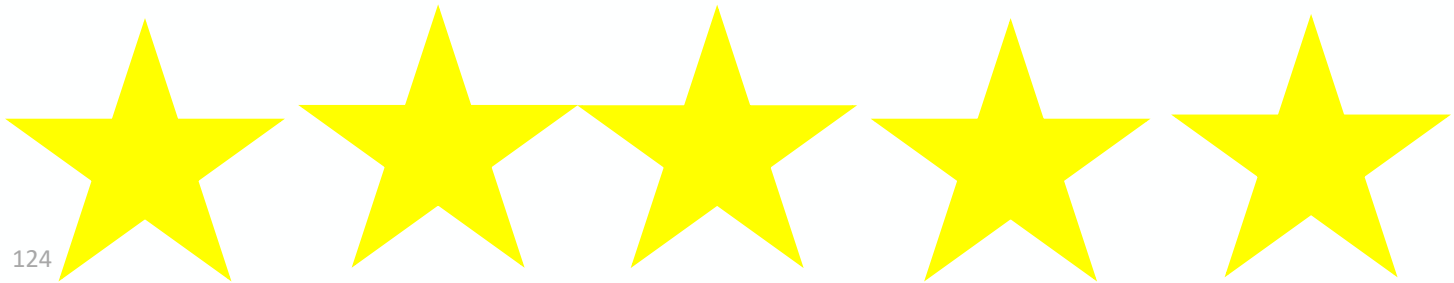
Activity / Billing Progress Reports

- 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.

Common Outcomes Goals

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



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.

Sustainability Model

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!

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.

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.

Billing Examples

Before we start… Activity #12

- 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

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.

Identify the billing code: G9007, G9001

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.

Identify the billing code: G9002, G9008

Note how this is different from the G9001!

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

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

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

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 billing code: S0257
* Note: this code allows for phone visit and meeting may be with the patient, care giver, or family member.

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.

- 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

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

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

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
- 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

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.

FINAL STEP of Training: Activity#13*

- Review Activity 13 in your folder.
- An email will be sent to you enabling you to make an appointment with the trainer
- Complete the 30 minute practice session (if you are unable to make your appointment time, please email Sarah Fraley svoor@med.umich.edu to re-schedule).
- After completing the practice session, you will be considered as having completed the course.

MICMT Statewide Self-Management Support Course Post Test and Evaluation

Logistics:

- The MICMT SMS Statewide Post Test and evaluation is web based
- A web link to the SMS Post Test and evaluation will be sent to you via the e-mail you provided during registration
- 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**

Statewide Self-Management Support (SMS) Course Completion

*Please note:

- You will have **5 business days** to complete the Statewide Self-Management Support Post Test and evaluation
- You will need to complete a 30 minute practice session with the SMS course trainer following your successful (pass status)completion of the post test. An email will be sent to you within 1-2 weeks of completing the SMS post test enabling you to schedule the practice session.
- You will receive a certificate (Nursing CE, Social Work CE, or certificate of completion) following the 30 minute practice session

Statewide Self-Management Support (SMS) Course Completion

*Please note that you will have **5 business days** to complete with a “Pass” score on the Statewide Self-Management Support Post Test and evaluation in order to receive a certificate (CE, certificate of completion)

THANK YOU!!

http://www.youtube.com/watch?v=Pwe-pA6TaZk

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