A Tale of Two Integration Models

SAMHSA PBHCI National Grantee Meeting
June 4-7, 2017 • Austin, TX
Disclaimer

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Outline

• North Carolina Health Care Landscape

• Western Triangle Program
  ➢ Medicare Annual Wellness Visits, Transitional Care and Chronic Care Management

• Eastern Triangle Program
  ➢ Incorporating Measurement-based Care

North Carolina Health Care Landscape

[Map of North Carolina]
**Health Home Core Components**

- Wellness Support
- SMI Integrated Care
- BH & Primary Care Provider Transformation
- Transitional Care
- Monitor Care Gaps
- Integrated Primary Care Clinic

**Population Health/Patient Centered Medical Home Elements**

- Medicare Annual Wellness Visits
- Chronic Care Management
- Transitional Care Management
Medicare Annual Wellness Visits

- Address common prevention and whole health needs that often fall through the cracks
- Provide reimbursement for care that is difficult to provide in the current primary care environment

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>Timing</th>
<th>HCPCS code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome to Medicare (IPPE) Visit</td>
<td>Within 12 months of Medicare enrollment</td>
<td>G0402</td>
</tr>
<tr>
<td>First Annual Medicare Wellness Visit</td>
<td>First MWV (&gt;12 months from IPPE visit)</td>
<td>G0438</td>
</tr>
<tr>
<td>Annual Medicare Wellness Visit</td>
<td>Subsequent MWVs</td>
<td>G0439</td>
</tr>
</tbody>
</table>

Medicare Annual Wellness Visits

Required Components of AWV

<table>
<thead>
<tr>
<th>Medical &amp; family history</th>
<th>Risk factor list</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of current medical providers</td>
<td>Functional status and safety screening</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hearing impairment</td>
</tr>
<tr>
<td></td>
<td>• Ability to perform activities of daily living</td>
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<tr>
<td></td>
<td>• Home safety</td>
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<tr>
<td>Physical assessment</td>
<td>Furnishing personalized health advice and referral to appropriate health education or preventive counseling services/ programs</td>
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<tr>
<td></td>
<td>• Weight loss</td>
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<tr>
<td></td>
<td>• Physical activity</td>
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<tr>
<td></td>
<td>• Smoking cessation</td>
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<tr>
<td></td>
<td>• Fall prevention</td>
</tr>
<tr>
<td></td>
<td>• Nutrition</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>Advanced care planning</td>
</tr>
<tr>
<td>Cognitive function assessment</td>
<td>Written Screening schedule</td>
</tr>
<tr>
<td>Depression screening</td>
<td></td>
</tr>
</tbody>
</table>


Medicare Annual Wellness Visits

- **Billing codes and payment**
  - First AWV: G0438, estimated Medicare payment $172
  - Subsequent AWV: G0439, estimated Medicare payment $111
  - Medicare will pay full amount with no co-payment for the beneficiary
  - Must also code with a diagnosis code

- **Patients may receive a mid-level visit (CPT 99213) during this same time**
  - 99213 visit may not cover same elements as AWV
  - Physicians must add modifier -25 to the service, e.g. 99213-25 to receive payment for both the AWV and mid-level office visit.
## Transitional Care

- Goal of reducing error during transitions of care
- Formalizes common steps in BH clinics
- Complex billing involving multiple team members

### Qualifying Transitions of Care for Transitional Care Management

<table>
<thead>
<tr>
<th>From: Inpatient Setting</th>
<th>To: Community Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Inpatient Acute Care Hospital</td>
<td></td>
</tr>
<tr>
<td>- Inpatient Psychiatric Hospital</td>
<td></td>
</tr>
<tr>
<td>- Long Term Care Hospital</td>
<td></td>
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<tr>
<td>- Skilled Nursing Facility</td>
<td></td>
</tr>
<tr>
<td>- Inpatient Rehabilitation Facility</td>
<td></td>
</tr>
<tr>
<td>- Hospital Outpatient Observation or Partial Hospitalization</td>
<td></td>
</tr>
<tr>
<td>- Partial Hospitalization at a Community Mental Health Center</td>
<td></td>
</tr>
<tr>
<td>- Home</td>
<td></td>
</tr>
<tr>
<td>- Domiciliary</td>
<td></td>
</tr>
<tr>
<td>- Rest Home</td>
<td></td>
</tr>
<tr>
<td>- Assisted Living</td>
<td></td>
</tr>
</tbody>
</table>

Requirements of Transitional Care Management Codes

1. Interactive communication (non-face-to-face)
2. Face-to-face visit


Chronic Care Management

- Opportunity to provide chronic care management in primary care
- Provide reimbursement for historically unreimbursed services
- Strengthen consumer involvement in care determination
Chronic Care Management Diagnoses

- Acquired Hypothyroidism
- Acute MI (Myocardial Infarction)
- Alzheimer's
- Alzheimer’s and related Dementia
- Anemia
- Asthma
- A-Fib (Atrial Fibrillation)
- BPH (Benign prostatic hyperplasia)
- Cataract
- CKD (Chronic Kidney Disease)
- COPD (chronic obstructive pulmonary disease)
- Colorectal Cancer
- Depression
- Diabetes
- Endometrial Cancer
- Female/ Male Breast Cancer
- Glaucoma
- Heart Failure
- Hip/Pelvic Fracture
- Hyperlipidemia (High Cholesterol)
- HTN (Hypertension)
- Ischemic Heart Disease
- Lung Cancer
- Osteoporosis
- Prostate Cancer
- Rheumatoid Arthritis/Osteoarthritis
- Stroke/TIA

Chronic Care Management

- Initiated at a physician visit
- Consent and Enrollment
- Standardized Care Plan
- Monthly Out-of-Pocket approx. $8 for consumer
- Multidisciplinary involvement
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Reverse Co-Location:
Case Study of Integrating Primary Care in a Mental Health Setting

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Associate Medical Director Primary Care Services WakeBrook
Objectives

- Examine a reverse co-location model of integrated care
- Identify important features of model
- Discuss generalizability and sustainability of this model

WakeBrook Primary Care Service

- **Staffing:**
  - MD/PA/NP: 1.75 FTE
  - Nurse, Office Manager
  - Peer Support Specialist, Health Educator
  - Care Coordinator
  - Monthly Volunteer Dental Clinic

- **Description of Work:**
  - Full scope outpatient family medicine office for patients with SMI
  - Coordinated and accessible care over time
  - Focus on quality improvement
  - Team based care with behavioral health
Hub and Spoke Model with Behavioral Health Teams

WB Primary Care

Primary Care Panel Size 2014-2016

Goal 750
<table>
<thead>
<tr>
<th>Prevention (Baseline 2015)</th>
<th>February 2016</th>
<th>September 2016</th>
<th>December 2016</th>
<th>PCIC Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Mammogram (Baseline 22%)</td>
<td>30</td>
<td>44.9</td>
<td>54.0</td>
<td>80</td>
</tr>
<tr>
<td>Pap (Baseline 33%)</td>
<td>25</td>
<td>37.8</td>
<td>40.0</td>
<td>82</td>
</tr>
<tr>
<td>CRC Screen (Baseline 25%)</td>
<td>30</td>
<td>36.4</td>
<td>48.0</td>
<td>72</td>
</tr>
<tr>
<td>Depression Screen (Baseline 14%)</td>
<td>66</td>
<td>83.8</td>
<td>90.0</td>
<td>61</td>
</tr>
<tr>
<td>ASA Use DM (Baseline 84%)</td>
<td>83</td>
<td>83.3</td>
<td>84.0</td>
<td>92</td>
</tr>
<tr>
<td>DM A1c &lt;8% (Baseline 67%)</td>
<td>61</td>
<td>58.9</td>
<td>73.0</td>
<td>68</td>
</tr>
<tr>
<td>DM Statin (Baseline 79%)</td>
<td>79</td>
<td>76.0</td>
<td>81.0</td>
<td>79</td>
</tr>
<tr>
<td>Fall Screen (Baseline 85%)</td>
<td>90</td>
<td>89.7</td>
<td>89.7</td>
<td>71</td>
</tr>
<tr>
<td>Pneum Shot 65+ (Baseline 57%)</td>
<td>55</td>
<td>65.5</td>
<td>89.0</td>
<td>90</td>
</tr>
<tr>
<td>Pneum Shot High Risk (Baseline 34%)</td>
<td>45</td>
<td>52.2</td>
<td>60.0</td>
<td>65</td>
</tr>
</tbody>
</table>

We continue to improve our measures!

**Other Metrics**

- **Behavioral Health Quality Indicators**
  - HIV and Hepatitis C screening
  - Tobacco Use
  - Engagement with Behavioral Health Team
- **ED Utilization**
- **Provider Experience**
- **Patient Experience**
Appendix

Resources provided by Centers for Medicare and Medicaid Services

Outreach Education for Medicare Annual Wellness

Transitional Care Outreach Education

Chronic Care Management

Transitional Care Interactive Communication Timing

- **Within 2 business days** of discharge
  - *Patient or caregiver*
  - *Telephone, electronic, etc.*
  - *2 attempts within 2 business days, if unsuccessful must continue to attempt until successful within the 30 day time frame of service*

- **Not currently being done. Look into if we should do you patients without PCP and Dr. Yu patients**

Transitional Care Interactive Communication Provider

- **Licensed clinical staff**
  - “Incident to” billing definition of clinical staff
  - Must meet state licensure and scope of practice
  - No exhaustive list, but does includes pharmacists
- **General supervision rule (Will a MD provider have to sign off?)**
  - “Incident to” rules apply, except the appropriate practitioner does not have to be physically in the same location at the time service


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Transitional Care Non-Face-to-Face Services Clinical Staff

- **Must be furnished unless determined not medically indicated**
- **Services may include**
  - Obtaining & reviewing records
  - Reviewing follow-up needs
  - Interaction with other health care professionals
  - Provider education to patient or caregiver
  - Referrals for community resources
  - Assistance in scheduling follow-up

Transitional Care Face-to-Face Requirements

CPT Code 99495
- **Moderate** medical decision making
- Within 14 calendar days of discharge

CPT Code 99496
- **High** medical decision making
- Within 7 calendar days of discharge

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Number of Possible Diagnoses and/or Management Options</th>
<th>Amount and/or Complexity of Data to Be Reviewed</th>
<th>Risk of Significant Complications, Morbidity, and/or Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

* 2 of 3 elements must be met or exceeded


Transitional Care Face-to-Face Providers

**Transitional Care Management Codes**

- **Physicians**
- **Qualified non-physician practitioners**
  - Certified nurse-midwives
  - Clinical nurse specialists
  - Nurse practitioners
  - Physician assistants

Transitional Care Face-to-Face Services Provided by Licensed Clinical Staff

- **May furnish:**
  - Communication with agencies and community services
  - Provide education to patient and caretakers to support self-management, independent living, and activities of daily living
  - Assess and support treatment regimen adherence and medication management
  - Identify community and health resources
  - Assist patient and family in accessing needed care and services


Contact

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