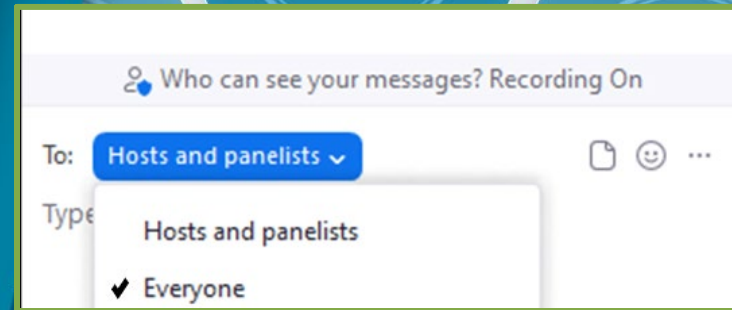
BRAIN HEALTH INTEGRATION INTO HEALTH CENTER SERVICES

Webinar 2: Care Management for Patients with/at-risk for Dementia & Leveraging Reimbursement Opportunities

Wednesday, May 17th 1-2pm ET



NATIONAL ASSOCIATION OF Community Health Centers®

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During today's session:

- **Questions:** Throughout the webinar, type your questions in the chat feature. Be sure to select "Everyone"! There will be Q&A and discussion at the end.
- **Resources:** If you have a tool or resource to share, let us know in the chat!

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

NATIONAL ASSOCIATION OF
Community Health Centers®

NACHC Quality Center

Cheryl Modica

Director,
Quality Center

Cassie Lindholm

Deputy Director,
Quality Center

Holly Nicholson

Manager, Instructional
Design & Learning

Agenda: Care Management & Leveraging Reimbursement Opportunities

Prioritizing the Aging Population and a Systems Approach to Primary Care

Cheryl Modica, PhD, MPH, BSN l NACHC

- The Aging Population
- Systems Approach to Brain Health, Evidence-Based Care

Leveraging Health Center Workflows to Support Dementia Early Detection & Reducing Risk Factors

Cassie Lindholm, MPA, PCMH CCE l NACHC

- Annual Wellness Visits
- Advance Care Planning
- Chronic Care Management

The Connection Between Hypertension and Brain Health

Meg Meador, MPH, C-PHI, CPHQ l NACHC

- Blood Pressure Measurement Best Practices
- Tools and Resources to Support Hypertension Management and Brain Health

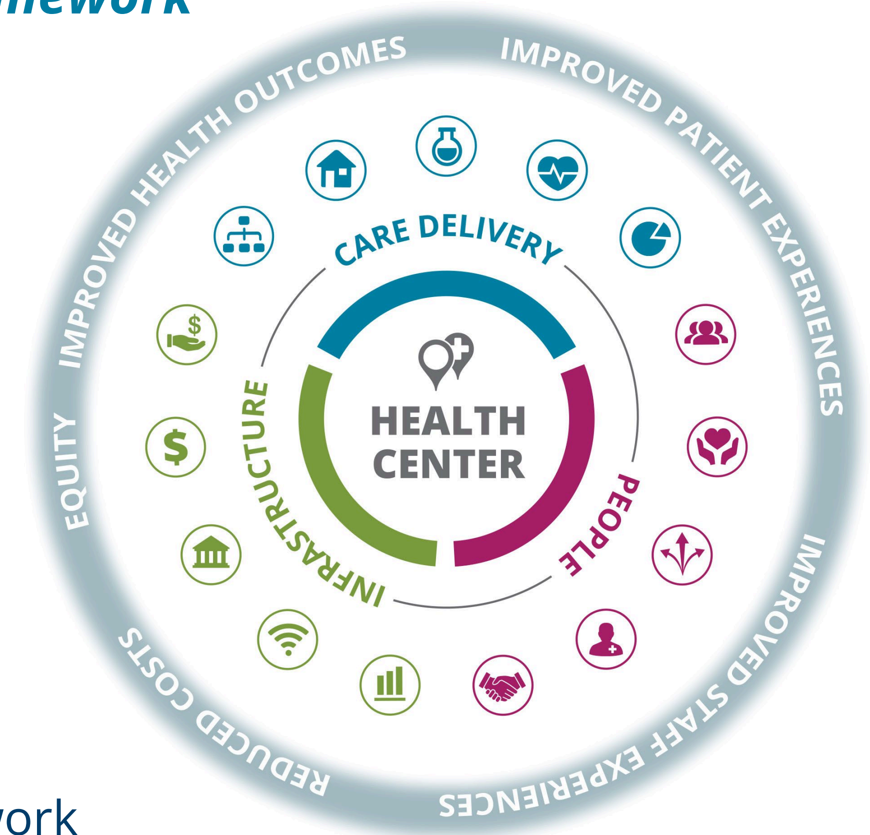
Discussion/Q&A with Speakers and Billing & Coding Expert

Lisa Messina, MPH, CPC, CPCO

The Value Transformation Framework

The Value Transformation Framework (VTF) is ***an organizing framework*** to guide health center systems change

- ***Supports change*** in many parts of the health center simultaneously
- ***Organizes and distills evidence-based interventions*** for discrete parts of the systems called ‘Change Areas’
- ***Incorporates evidence, knowledge, tools and resources*** relevant for action within different parts of the system, or Change Areas
- ***Links health center performance to the Quintuple Aim***



Download Action Guides and other Value Transformation Framework resources at bit.ly/nachcqualitycenter

Brain Health Webinar Series

Missed webinar 1? No problem!

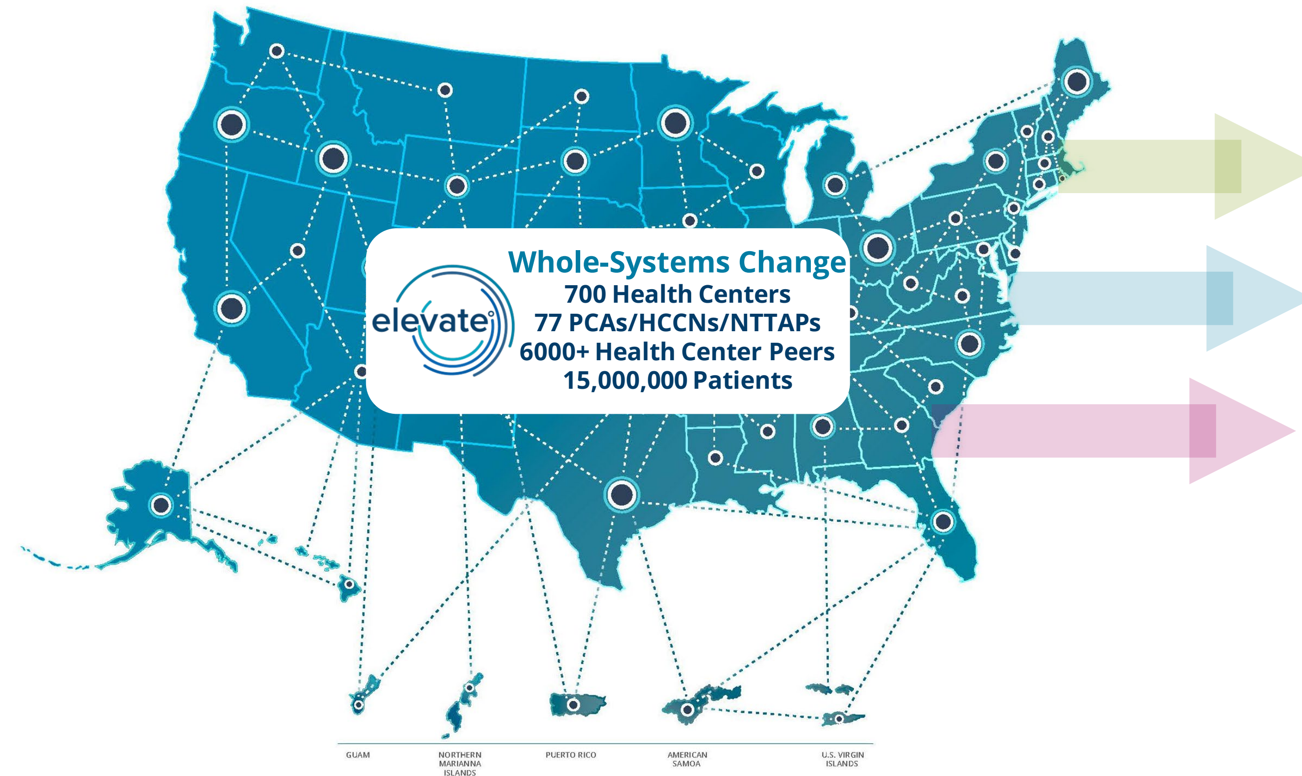
Access the slides and recording to hear from a panel of experts from the Alzheimer’s Association, the BOLD Center for Early Detection, and the University of Washington discuss:

- **Why** it is critical for health center care teams and providers to focus on dementia
- **What** can be done to identify and reduce risk factors
- **How** health centers and primary care providers can provide early detection

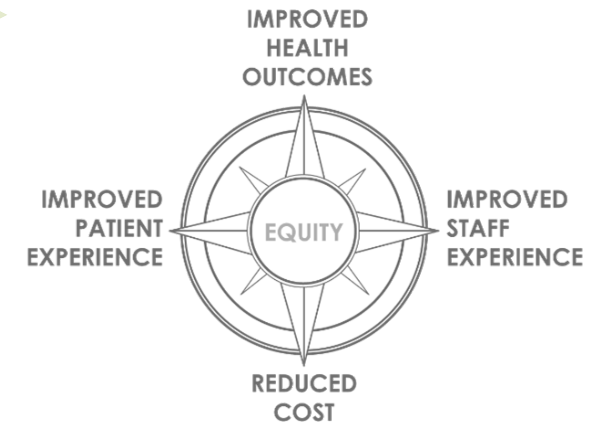
The Value Transformation Framework

Supporting a network of local and national change

Brain Health



Quintuple Aim



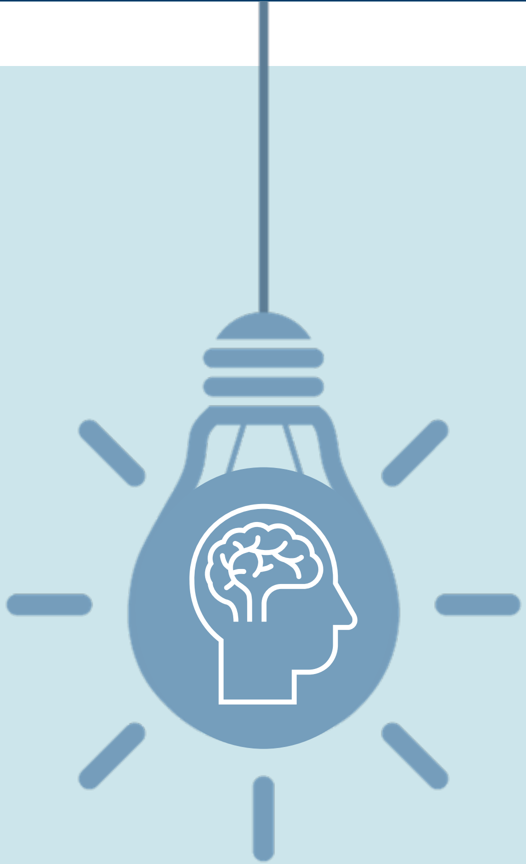
Virtual Care Models for High-Risk Patients
20 Health Centers
17 States
385 Patients

Virtual, Whole-Person Models of Diabetes Prevention & Control
6 Health Centers
3 PCAs/HCCNs
40+ Patients

Evidence-Based Interventions
Cancer Screening
Diabetes Control
HTN Control
Weight Management
HIV PrEP & nPEP

Preparing the Workforce for the Future
QI Professionals
Care Managers
Outreach Workers
Reimaging Care

The Aging Population: Is Your Health Center Prepared?



65+ years of age fastest growing health center patient population*

36% of health center patients 45+ years of age*

- 11% - 65+ years of age
- 25% - 45-64 years of age

6th leading cause of death in the United States+

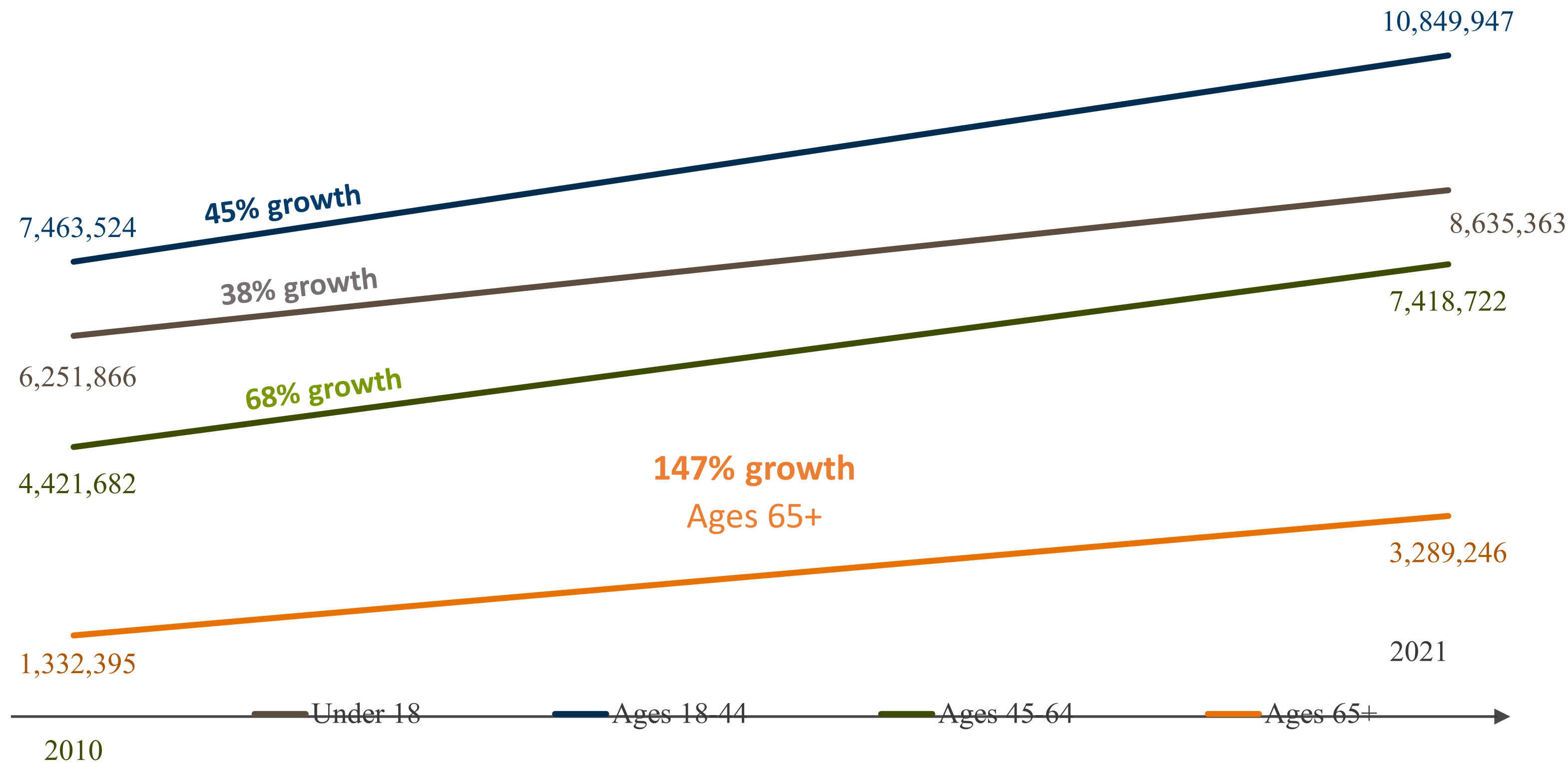
Alzheimer's kills more seniors than breast and prostate cancer combined+

Non-Hispanic Black and Hispanic older adults disproportionately more likely than White older adults to have Alzheimer's or other dementias+

* NACHC, Community Health Center Chartbook 2023. https://www.nachc.org/community-health-center-chartbook-2023/
+ Alzheimer's Association. 2023 Alzheimer's Disease Facts and Figures. Alzheimer's Dement., 19: 1598-1695. https://doi.org/10.1002/alz.13016

Health Center Patients by Age

2010 & 2021 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.



NACHC, Community Health Center Chartbook 2023. https://www.nachc.org/community-health-center-chartbook-2023/.
Source: 2010 & 2021 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS

The Aging Population: Your Health Center is Part of the Solution!

Primary care providers provide 85% of first diagnosis of dementia; provide 80% of care*

Providers and care teams:

- ✓ Can address modifiable risk factors which may slow dementia progression and modify comorbid conditions
- ✓ Address safety and incorporate advanced care planning
- ✓ Achieve cost savings and help reduce rate of hospital admissions in adults 65 years and older (1.78 greater risk of ambulatory care sensitive admissions[+])
- ✓ Generate revenue for care management and other Medicare services: Annual Wellness Visits and Advanced Care Planning

+ Phelan EA, et. al., Association of incident dementia with hospitalizations. JAMA. 2012 Jan 11;307(2):165-72. doi: 10.1001/jama.2011.1964.
*Alzheimer's Association. 2023 Alzheimer's disease facts and figures. Alzheimer's Dement., 19: 1598-1695. https://doi.org/10.1002/alz.13016

How Can the VTF Help?

1. **Drives** change and serves as an organizing framework for organizational change and QI
2. **Connects** care for the aging population to health center whole-person care
3. **Values** people and processes, with a focus on the Quintuple Aim
4. **Supports** health centers in building capacity to deliver services that offer reimbursement above and beyond FQHC Prospective Payment System (PPS)

Aging Population: Leverage the VTF and Elevate

Sample QI Workplan Activity:

1. **Incorporate** the VTF systems approach within your health center QI strategy, as an organizing approach for all age groups, including older adults
2. **Assess** health center progress in 15 areas of systems change (VTF Assessment)
3. **Join** a national learning community (Elevate) for free training and professional development opportunities
4. **Build** capacity to provide services that provide early detection and risk reduction for dementia in combination with attention to chronic conditions and social risk: Chronic Care Management (CCM) services, Annual Wellness Visits (AWV), Advanced Care Planning (ACP)
5. **Bill** code and bill for additional services (CCM, AWV, ACP)
6. **Improve** patient health outcomes and advance toward Quintuple Aim goals

Featured Speaker

Cassie Lindholm, MPA, PCMH CCE
Deputy Director, Quality Center
NACHC

Cassie serves as the Deputy Director of the Quality Center for the National Association of Community Health Centers (NACHC), where she supports the value-based transformation of health center care delivery through providing health center trainings, developing resources, and engaging with Primary Care Associations, Health Center Controlled Networks, and other health center partners to collaborate in advancement toward Quintuple Aim goals. Cassie previously served as Director of Quality at a Federally Qualified Health Center in the Upper Peninsula of Michigan. She is experienced with health center data reporting and analysis, workflow implementation, team-based care, the Patient Centered Medical Home model, alternative payment methodologies, and practice transformation processes.

Leveraging Health Center Workflows to Support Dementia Early Detection & Reducing Risk Factors

- Annual Wellness Visits

WHAT is an Annual Wellness Visit (AWV)?

Part of Medicare's suite of "Wellness Visits"

Initiative Preventative Physical Exam - IPPE

- Within 12 months of Medicare Part B enrollment
- One-time benefit. "Use it or lose it"

Initial AWV

- 12 months after IPPE OR > 12 months after Medicare Part B enrollment and IPPE never performed
- One lifetime benefit

Subsequent AWV

- 12 months after initial AWV
- One subsequent AWV per year thereafter

Tools & Resources: CMS Medicare Learning Network Medical Wellness Visits

WHAT is an Annual Wellness Visit?

Sample from full tool: Elements of an IPPE, Initial AWV, and Subsequent AWV

Workflow	CMS Required Visit Elements	Tools & Resource Options	IPPE G0402	Initial AWV G0438	Subsequent AWV G0439
Screening Questions	Perform a Health Risk Assessment (HRA): demographics, health status, psychosocial risks, behavioral risks, activities of daily living (ADL)			X	Update
	Review risk factors for depression or other mood disorders	Depression Screening	X	X	Update
	Screen for Substance Use Disorders (SUDs)	Alcohol Use Screening Tobacco Use Screening Substance Use Screening	X	X	Update

Tools & Resources: NACHC IPPE AWV Reimbursement Tip Sheet

WHY Annual Wellness Visits?

Contributes to quality care. Allows providers and care teams to gain information about the patient, including medical and family history, assess health *(including risk factors for Dementia/early detection),* and promote positive health behaviors *(Dementia risk reduction)*.

Offers reimbursement opportunity driven by extended care team.

Qualifies as an **"initiating" visit for Medicare care management services**. Care management provides additional reimbursement opportunity.

HOW to conduct an Annual Wellness Visit?

STEP 1 Compile a list of patients eligible for an AWV

STEP 2 Outreach to schedule AWV

STEP 3 Manage care team roles

STEP 4 Conduct AWV

STEP 5 Document, code, and bill for AWV

Compile a list of patients eligible for an AWV

Step 1

Step 2

Step 3

Step 4

Step 5

Initial AWV	Subsequent AWV
• Conducted 12 months after IPPE OR > 12 months after Medicare Part B enrollment and IPPE never performed • One lifetime benefit	• Conducted 12 months after initial AWV • One subsequent AWV can be conducted per year thereafter

Consider both ***empaneled*** *and* ***attributed*** *patients.*

Tools & Resources: NACHC Empanelment Action Guide

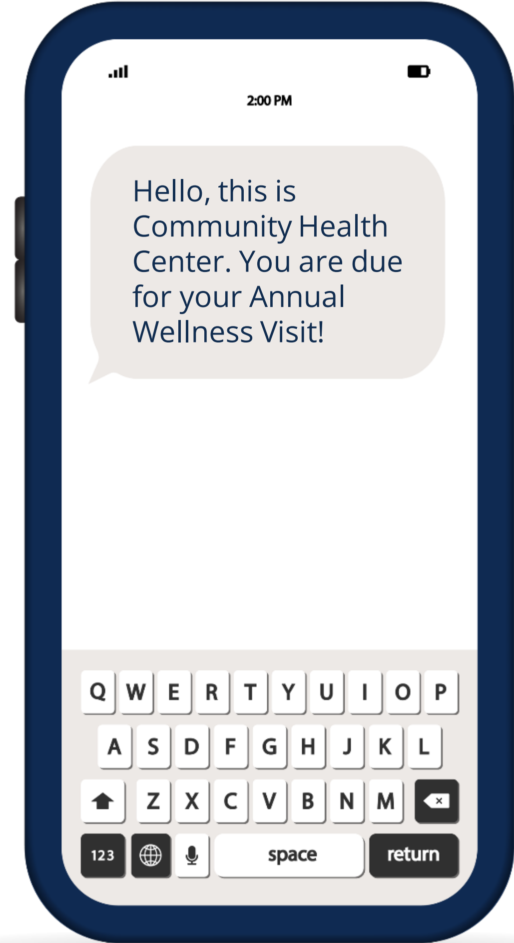
Outreach to Schedule AWV

Optimize technology to reach out to eligible patients and schedule appointments:

Phone calls

Text messages

Portal messages



Step 1
Step 2
Step 3
Step 4
Step 5

Manage Care Team Roles

Opportunity to expand care team roles!

Many AWV components can be completed by a Medical Assistant (MA), Registered Nurse (RN), Community Health Worker (CHW), or other care extenders.

Focus the provider role

to only those services that can be done by an authorized provider.

Consider completing some AWV components 'outside' of the provider scheduled visit:

- Phone or video call before provider component of the AWV
- Care team member meets with patient before provider visit
- Patient-driven processes (e.g., electronic forms, kiosks) to self-complete screenings

Conduct AWV

Meets AWV requirements for:

- ✓ Perform Health Risk Assessment
- ✓ Review patient's potential depression risk factors
- ✓ Review patient's functional level of safety
- ✓ Screen for potential substance use disorders (SUDs)

Step 1
Step 2
Step 3
Step 4
Step 5

Patient completes screening questions:

Correlation or potential correlation to Dementia risk!

- Patient self-assessment *(how does the patient rate their health)*
- Tobacco use screening
- Alcohol use screening
- Substance use screening
- Depression Screening
- Social risk screening (PRAPARE®)
- Activities of daily living (ADLs)
- Home safety

Assessing ADLs and home safety is an important benefit of early detection.

Optimize Technology and Care Team Roles:

Can be completed by an MA, nurse, CHW, or other care team member.

Complete prior to the visit via phone/video to reduce staff time needed during the visit.

Use electronic forms for patients to self-complete.

Conduct AWV

Meets AWV requirements for:

- ✓ Establish patient's medical and family history
- ✓ Review current opioid prescriptions

Step 1

Step 2

Step 3

Step 4

Step 5

Review and update the patient's history:

- Medications *(including opioids & supplements)*
- Allergies
- Medical history
- Surgical history
- Hospitalizations
- Family history

Optimize Technology and Care Team Roles:

Can be completed by an MA, nurse, CHW, or other care team member.

Complete prior to the visit via phone/video to reduce staff time needed during the visit.

Use electronic forms for patients to self-complete.

Conduct AWV

Meets AWV requirements for:

- ✓ Establish list of current providers and suppliers

Document the patient's care team members:

Establish a list of current providers who provide regular care, for example:

Include Neurologists, Geriatricians, and other Dementia care providers.

- Medical specialty providers
- Behavioral health providers
- Dental providers
- Home health

Optimize Technology and Care Team Roles:

Can be completed by an MA, nurse, CHW, or other care team member.

Complete prior to the visit via phone/video to reduce staff time needed during the visit.

Use electronic forms for patients to self-complete.

Share with patient as part of the visit summary.

Conduct AWV

Meets AWV requirements for:

✓ Establish an appropriate written screening schedule

Establish a written screening schedule:

For example, create a checklist, for the next 5-10 years (see Medicare Preventive Services Checklist), including:

- Colorectal cancer screening
- Breast cancer screening
- Immunizations

Optimize Technology and Care Team Roles:

Can be completed by an MA, nurse, CHW, or other care team member.

Complete prior to the visit via phone/video to reduce staff time needed during the visit.

Share with patient as part of the visit summary.

Conduct AWV

Meets AWV requirements for:

- ✓ Provide ACP services at the patient's discretion

ACP is an important service to many qualifying health center patients, including those with Dementia.

Offer Advance Care Planning (ACP) Services:

ACP is a discussion with the patient, family member, caregiver, or surrogate about:

- Preparing an advance directive in case an injury or illness prevents them from making health care decisions
- Future care decisions they might need to make
- How they can let others know about care preferences
- Caregiver identification

Providing ACP can be an additional billing opportunity if done a different day in a separate visit.

Optimize Technology and Care Team Roles:

Can be completed by an MA, nurse, CHW, or other care team member WITH the provider.

Offering ACP is required for AWV, *Providing* ACP can be done as a separate visit if more time is needed.

If ACP is completed, share with patient as part of the visit summary.

Conduct AWV

Meets AWV requirements for:

✓ Measure

Obtain patient measurements:

- Height
- Weight
- BMI (or waist circumference)
- Blood pressure

Correlation or potential correlation to Dementia risk!

Optimize Technology and Care Team Roles:

Can be completed by an MA, nurse, CHW, or other care team member.

During the PHE *(AWV telehealth flexibilities continue through 12/31/24)*, when the visit is conducted via telehealth, document whether measures were:

- self-reported by the patient
- visually observed
- unable to be obtained

Conduct AWV

Meets AWV requirements for:

✓ Review patient's functionable ability and level of safety

Step 1

Step 2

Step 3

Step 4

Step 5

Assess functional ability:

- Hearing impairment
- Falls risk

Traumatic brain injury is Dementia risk factor which falls risk assessment can help prevent.

Optimize Technology and Care Team Roles:

Can be completed by an MA, nurse, CHW, or other care team member.

During the PHE *(AWV telehealth flexibilities continue through 12/31/24)*, when the visit is conducted via telehealth, document whether measures were:

- self-reported by the patient
- visually observed
- unable to be obtained

Conduct AWV

Meets AWV requirements for:

✓ Detect any cognitive impairment

Step 1

Step 2

Step 3

Step 4

Step 5

Assess cognitive function:

- Assess cognitive function by direct observation, considering information from the patient, family, friends, caregivers, and others.
- Consider using a brief cognitive test; account for health disparities, chronic conditions, and other factors that contribute to increased cognitive impairment risk.

Optimize Technology and Care Team Roles:

Can be completed by an MA, nurse, CHW, or other care team member.

During the PHE *(AWV telehealth flexibilities continue through 12/31/24)*, when the visit is conducted via telehealth, document whether measures were:

- self-reported by the patient
- visually observed
- unable to be obtained

Conduct AWV

Meets AWV requirements for:

- ✓ Establish list of patient risk factors and conditions where primary, secondary, or tertiary interventions are recommended or underway

Establish a list of risk factors:

For which various interventions are recommended or already underway. **Essentially, this is the patient's diagnosis list!**

Coding Tips:

- Use this visit as an opportunity to update the patient's diagnosis list in the EHR. Remove any resolved or duplicate items and add **appropriate specificity** as needed.
- Ensure all active diagnoses are captured in documentation for the AWV and included on the claim. This allows Medicare to appropriately risk adjust attributed members each year.

Optimize Technology and Care Team Roles:

Can be completed by MD, DO, NP, PA, CNM.

Opportunity for the billing provider to review visit documentation and complete visit with patient.

Complete via telehealth (audio-only or audio and visual) or in-person.

Use EHR features or code gap reports to assist with Hierarchical Condition Category (HCC) coding.

Conduct AWV

Meets AWV requirements for:

✓ Provide patient's personalized health advice and appropriate referrals to health education or preventive counseling services or programs

Provide personalized health advice and referrals:

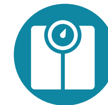
- Provide patient with personalized health advice/referrals to health education or preventive counseling services or programs.
- Include community-based lifestyle interventions to reduce health risks and promote self-management and wellness:

Fall prevention

Nutrition

Physical activity

Tobacco-use cessation


Weight loss

Cognition

Important for Dementia risk reduction.

Optimize Technology and Care Team Roles:

Can be completed by an MA, nurse, CHW, or other care team member.

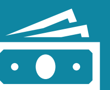
If the patient qualifies for care management, provider to discuss with patient.

Complete via telehealth (audio-only or audio and visual) or in-person.

Share with patient as part of the visit summary.

Code and Bill for AWV

- **G0438 Annual Wellness Visit (AWV) - Initial Visit**
- **G0439 Annual Wellness Visit (AWV) - Subsequent Visits**
- **FQHC bills G0468 and wellness code (above) to CMS**
- **CMS/Medicare 2023 Fee -** $251.13*
  *FHQCs reimbursed the lesser of the PPS rate or their organizational charge fee for G0468
- **No patient coinsurance** for IPPE or AWV



Tools & Resources: NACHC IPPE AWV Reimbursement Tip Sheet

Leveraging Health Center Workflows to Support Dementia Early Detection & Reducing Risk Factors

- Advance Care Planning

Advance Care Planning

ACP is an important service to many qualifying health center patients, including those with Dementia.

Advance Care Planning is a discussion between the provider/care team member and the patient, family member, caregiver, or surrogate about:

- Preparing an advance directive in case an injury or illness prevents them from making health care decisions
- Future care decisions they might need to make
- How they can let others know about care preferences
- Caregiver identification

Advance Care Planning

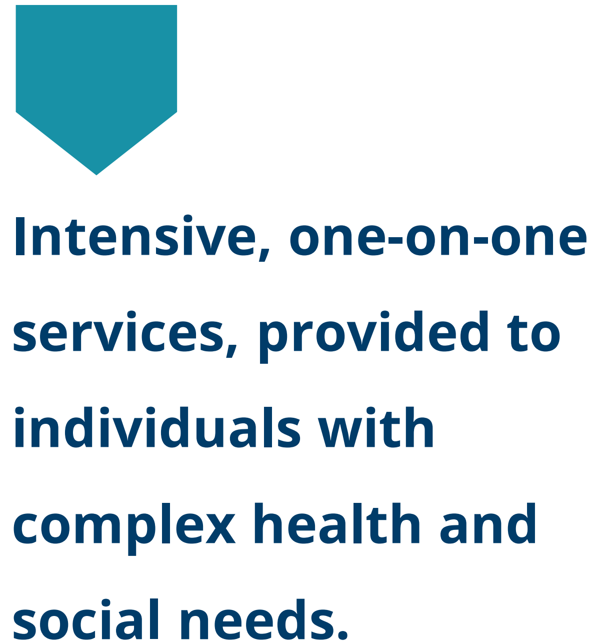
- A medically necessary, face-to-face visit reimbursable as a stand-alone qualifying visit for FQHCs.
- Services are between the provider (physician (MD/DO), PA, NP, CNM, CP, CSW) and the patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms.
- Other FQHC care team members (e.g., MA, nurse, CHW) based on state law, licensure, and scope of practice, may participate in ACP under the direct supervision of the treating and billing physician or practitioner.

What Provider Codes	Services	What FQHC bills to CMS	CMS/Medicare 2023 Fees
CPT® 99497	Advance care planning including the explanation and discussion of advances directives, by the physician or other qualified healthcare professional, first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate. Total ACP service time range is 16-45 minutes.*	G0466, new FQHC patient Or G0467, established FQHC patient	$251.13 $187.19
CPT® +99498 (reported with 99497)	Each additional 30 minutes. Total additional ACP service time range is 46-75 minutes.		(No additional payment to FQHC)
The extension of the COVID-19 PHE flexibility allows FQHCs to furnish ACP services, through December 21, 2024, using audio and visual telehealth telecommunications technology.		G2025	$98.27

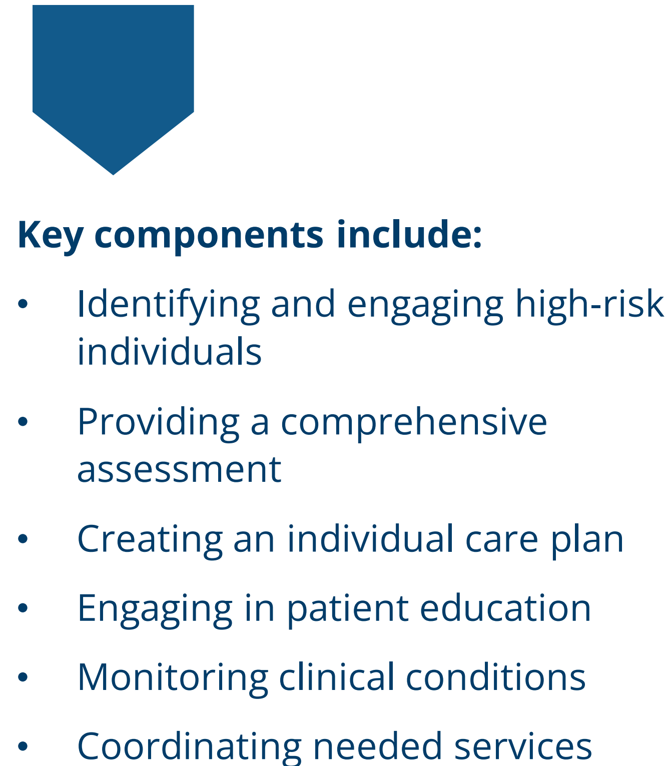
Leveraging Health Center Workflows to Support Dementia Early Detection & Reducing Risk Factors

- Chronic Care Management

WHAT is Chronic Care Management?

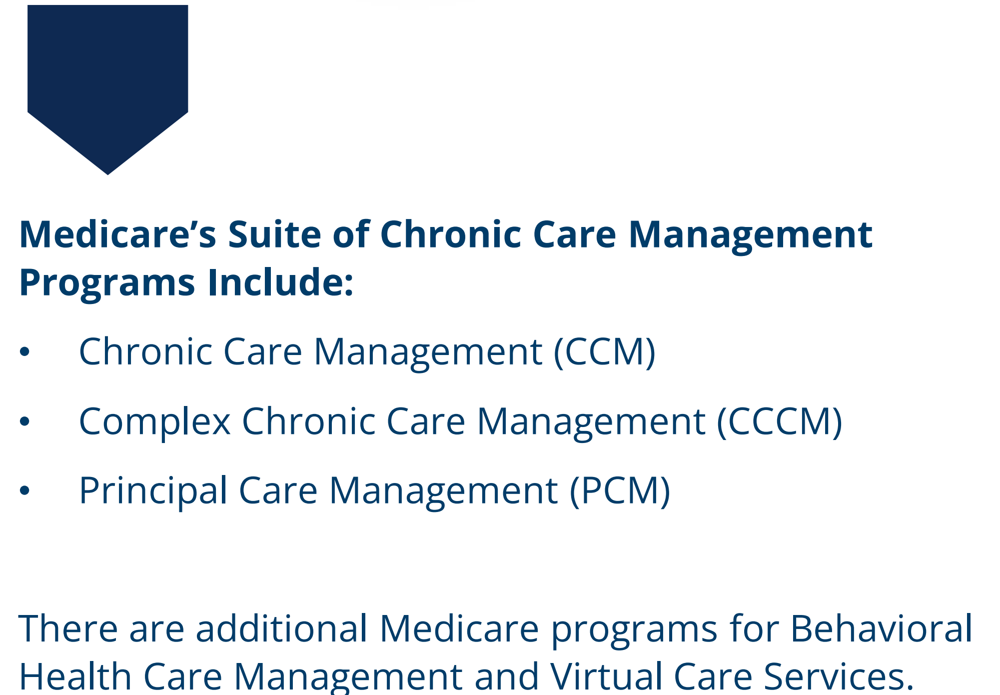


Intensive, one-on-one services, provided to individuals with complex health and social needs.



Key components include:

- Identifying and engaging high-risk individuals
- Providing a comprehensive assessment
- Creating an individual care plan
- Engaging in patient education
- Monitoring clinical conditions
- Coordinating needed services



Medicare's Suite of Chronic Care Management Programs Include:

- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)
- Principal Care Management (PCM)

There are additional Medicare programs for Behavioral Health Care Management and Virtual Care Services.

WHY Chronic Care Management?

Contributes to quality care. Allows providers and care teams to assess and monitor risk factors, *(including risk factors for Dementia/early detection)*, support patients with the management of chronic conditions *(Dementia, Hypertension, Diabetes, etc.)* and promote positive health behaviors *(Dementia risk reduction)*.

Offers reimbursement opportunity driven by extended care team.

Delivers on Quintuple Aim Goals: Improved health outcomes, improved patient experience, improved staff experience, reduced costs, and equity.

HOW to provide care management?

STEP 1 Identify or hire a care manager

STEP 2 Identify high risk patients

STEP 3 Define care manager-care team interface

STEP 4 Define services provided as part of care management

STEP 5 Enroll patients in care management

STEP 6 Create individualized care plans

STEP 7 Enhance and expand partnerships

STEP 8 Document and bill for chronic care management

STEP 9 Graduate patients from care management

STEP 10 Measure outcomes

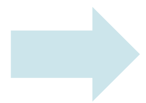
Tools & Resources: NACHC Care Management Action Guide

Identify or Hire a Care Manager

Identify staff to provide one-on-one services to high risk and highly complex patients.

An RN often serves in this role, but other members of the care team (MA, CHW, etc.) can perform many care management services within state/license requirements.

Use **empanelment data** to help determine which care teams to add care managers to, and **risk stratification data** to help determine the number of care managers needed to meet the needs of the patient population.



If your health center does not have the staffing or resources to hire/identify full-time care managers, consider formalizing care management responsibilities within current care team members' roles to provide services to a smaller number of patients.

Tools & Resources: Sample Care Manager Job Description

Identify High Risk Patients

Identify high risk patients based on:

- Risk stratification data
- CCM eligibility criteria

The target caseload for a full-time care manager varies depending on several factors and is likely to be in the range of **50-150** patients. Factors affecting caseload size include:

- Health center procedures and resources
- The care manager's experience
- The clinical and social complexity of patients
- Available social supports
- Target care management outcomes

Evaluate caseload size and manageability on an ongoing basis.

Define Care Manager – Care Team Interface

Determine how, and in what ways, the care manager and care team will work together. Including:

- How often they meet to discuss patient care details
- How they communicate in between face-to-face meetings
- Documentation expectations

Define Services Provided as Part of Care Management

Ensure comprehensive care plans support chronic disease and prevention needs, as well as mental, social, and environmental factors.

CCM services include:

- **Comprehensive assessment of medical, functional, and psychosocial needs**
- **Preventive care**
- Medication management
- **Comprehensive care plan**
- Continuity of care
- **Coordination with home-health and community-based providers**
- 24/7 access to providers or clinical staff

Also consider incorporating Transitional Care Management (TCM) services.

Tools & Resources:

- Care Management Protocol for High-Risk Patients
- NACHC TCM Reimbursement Tip Sheet

Enroll Patients in Care Management

Consider enrolling eligible patients through:

- Warm handoffs from the primary care provider (or other designated care team member) to the care manager.
- The care manager can call, email, or mail a letter indicating that their provider has recommended them for care management.
- Discuss with patients after a change in health status such as a new diagnosis, transition in care, etc.

➢ For CCM, provider must have a discussion with patient about CCM prior to enrollment (must be documented!).

➢ Obtain and document patient consent.

➢ Track enrolled patients and their assigned care manager in the EHR where other care team members can view.

Tools & Resources:

- Sample Consent Form
- Sample Internal Referral to CM Form

Create Individualized Care Plans

Working with the patient and PCP, care managers create an individualized, patient-centered care plan for each patient enrolled in care management. Each care plan goal should have explicit action items and interventions formulated with the patient and should include steps for patient engagement in self-care.

The comprehensive care plan covers all health issues with particular focus on the chronic conditions being managed. It includes the following elements:

- ✓Problem list
- ✓Expected outcome and prognosis
- ✓**Cognitive and functional assessments**
- ✓Measurable treatment goals
- ✓Symptom management
- ✓Planned interventions, including responsible individuals
- ✓Medication management
- ✓**Caregiver assessment**
- ✓Summary of advance directives
- ✓Community/social services ordered
- ✓A description of how outside services/agencies are directed/coordinated
- ✓Schedule for periodic review and, where appropriate, revision of the care plan

A copy of the care plan is shared with the patient and PCP.

Tools & Resources: Care Plan Tracking Tool

Enhance and Expand Partnerships

Connect care management patients to needed community and social resources to address social drivers of health (SDOH).

May be necessary to enhance and expand local, state, or national partnerships to have resources identified and readily available to meet patient needs.

Health Center Partnerships & Community Linkages to Care for Patients with/at-risk for Dementia

Wednesday, May 31st 1-2pm ET

Webinar 3 will focus on the importance of community linkages and partnerships in supporting health center care team members and care givers in supporting patients with/at risk for dementia, including navigating and connecting to community resources. Information on available Dementia-related resources for health centers and health center patients will also be provided.

Document and Bill for Care Management Services

CMS Care Management Services	Reimbursement Potential
Chronic Care Management (CCM), Complex Chronic Care Management (CCCM) Principal Care Management (PCM)	$77.94
Transitional Care Management (TCM)	$187.19
Psychiatric Collaborative Care Model (CoCM)	$147.07
General Behavioral Health Integration (BHI)	$77.94

Tools & Resources: NACHC CCM Reimbursement Tip Sheet

Graduate Patients

Provide care management services to patients until the patients' health goals have been reached, or until the patient has opted out of receiving care management services.

Tools & Resources: Sample Closeout Form

Measure Outcomes

The effectiveness of care management can be measured by the degree to which patients achieve care plan goals. Performance should also be measured against key clinical and quality indicators, such as:

- Performance on relevant Uniform Data Systems (UDS) measures
- Enrollment rates
- Percent of patients that reach care plan goals
- Graduation rates
- Hospital readmission rates
- Patient experience surveys
- Care Manager panel size, by program
- Enrollments and disenrollments
- Care manager completed encounters
- Percent of billed encounters

Featured Speaker

Meg Meador, MPH, C-PHI, CPHQ
Director, Clinical Integration & Education
NACHC

Margaret (Meg) Meador serves as Director of Clinical Integration & Education at the National Association of Community Health Centers. She leads several CDC-sponsored national quality improvement projects focused on improving cardiovascular outcomes with high-risk and vulnerable patients. Her research interests include chronic disease prevention, implementation science, health information technology, and innovative primary care models. She earned her BA in Human Biology from Stanford University, her MPH from UNC-Chapel Hill, and her Certificate in Public Health Informatics from Johns Hopkins University.

HYPERTENSION & BRAIN HEALTH

Elevate Forum

May 17, 2023

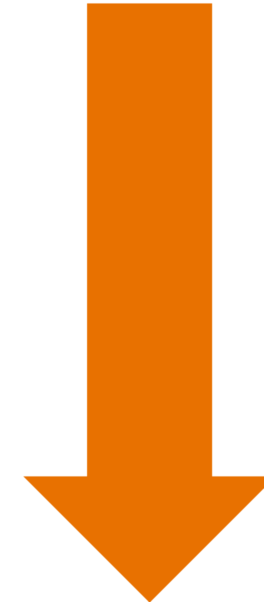
Meg Meador, MPH, C-PHI, CPHQ

mmeador@nachc.org

HYPERTENSION AND STROKE

Hypertension is the <u>most important</u> modifiable risk factor for stroke.[1]

For every 10 mm Hg reduction in systolic blood pressure…

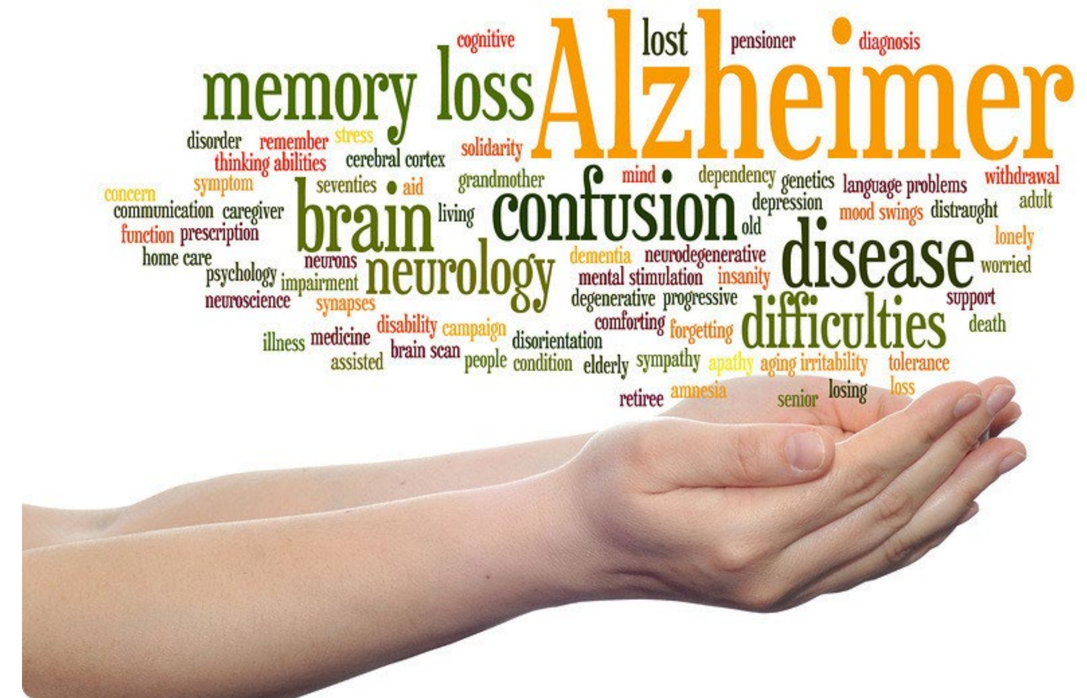


…stroke incidence is reduced by 27%.[2]

1. The importance of comorbidities in ischemic stroke: Impact of hypertension on the cerebral circulation - PMC (nih.gov)
2. Blood pressure lowering for prevention of cardiovascular disease and death: a systematic review and meta-analysis - PubMed (nih.gov)

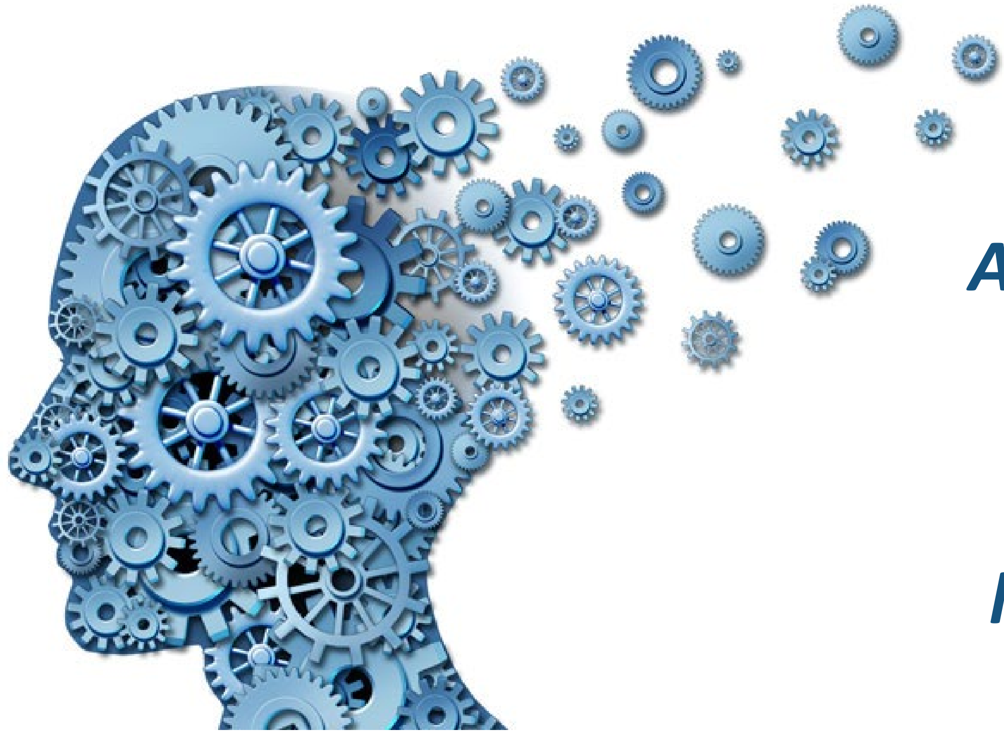
HYPERTENSION AND ALZHEIMER'S

"Hypertension affects two-thirds of people aged >60 years and significantly increases the risk of both vascular cognitive impairment and Alzheimer's disease."[3]



3. Hypertension-induced cognitive impairment: from pathophysiology to public health - PubMed (nih.gov)

HIGH BLOOD PRESSURE CONTRIBUTES TO DISPARITIES IN BRAIN HEALTH



Black persons are 2 times and Hispanic persons 1.5 times more likely to have Alzheimer's Disease and Alzheimer's Disease Related Dementias than White persons.[1]

Differences in cumulative blood pressure levels might contribute to racial differences in cognitive decline at older age.[2]

1. 2023 Alzheimer's Disease Facts and Figures - PubMed (nih.gov)
2. Association Between Blood Pressure and Later-Life Cognition Among Black and White Individuals - PubMed (nih.gov)

"BP assessment is the most common and important clinical measurement that is regularly done incorrectly."

[Accurate Blood Pressure in the Office | Circulation (ahajournals.org)]

WHAT'S THE STORY WITH BLOOD PRESSURE MEASUREMENT?

Sub-optimal BP measurement in clinical practice leads to **errors that can inappropriately alter management decisions in 20% to 45% of cases.**[1]

"Many measurement **errors can be minimized by appropriate patient preparation and standardized techniques.**[2]

Validated automated upper arm devices should be used instead of manual devices to simplify measurement and prevent observer error"[2]

1. Lancet Commission on Hypertension group position statement on the global improvement of accuracy standards for devices that measure blood pressure - PubMed (nih.gov)
2. Optimizing observer performance of clinic blood pressure mea... : Journal of Hypertension (lww.com)

COMMON ERRORS IN BP MEASUREMENT

Things we can see . . .

- Talking
- Crossed legs
- Unsupported Arm
- Unsupported Back/Feet
- Cuff is too small
- Cuff over clothing
- Unvalidated device

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COMMON ERRORS IN BP MEASUREMENT

Things we *can't* see . . .

Recent exercise

Full bladder

Recent meal ingestion, caffeine or nicotine use

White coat effect (anxiety caused by being in the presence of a doctor)

TIPS TO OBTAIN AN ACCURATE BP MEASUREMENT

- ✓ Check to see if patient needs to use the restroom.
- ✓ Check to see if patient has recently eaten, had coffee, or used nicotine.
- ✓ Allow patient to rest quietly for 5 min.
- ✓ Use a clinically validated device.
- ✓ Have the nurse or MA take the blood pressure.

TIPS TO OBTAIN AN ACCURATE BP MEASUREMENT (CONT.)

- ✓ Seat patient in a chair with back supported and feet flat on the floor.
- ✓ Ask patient to uncross legs.
- ✓ Ask patient to keep still and silent.
- ✓ Place cuff over bare arm.
- ✓ Ensure cuff fits properly.
- ✓ Position patient with arm support, cuff at heart level.

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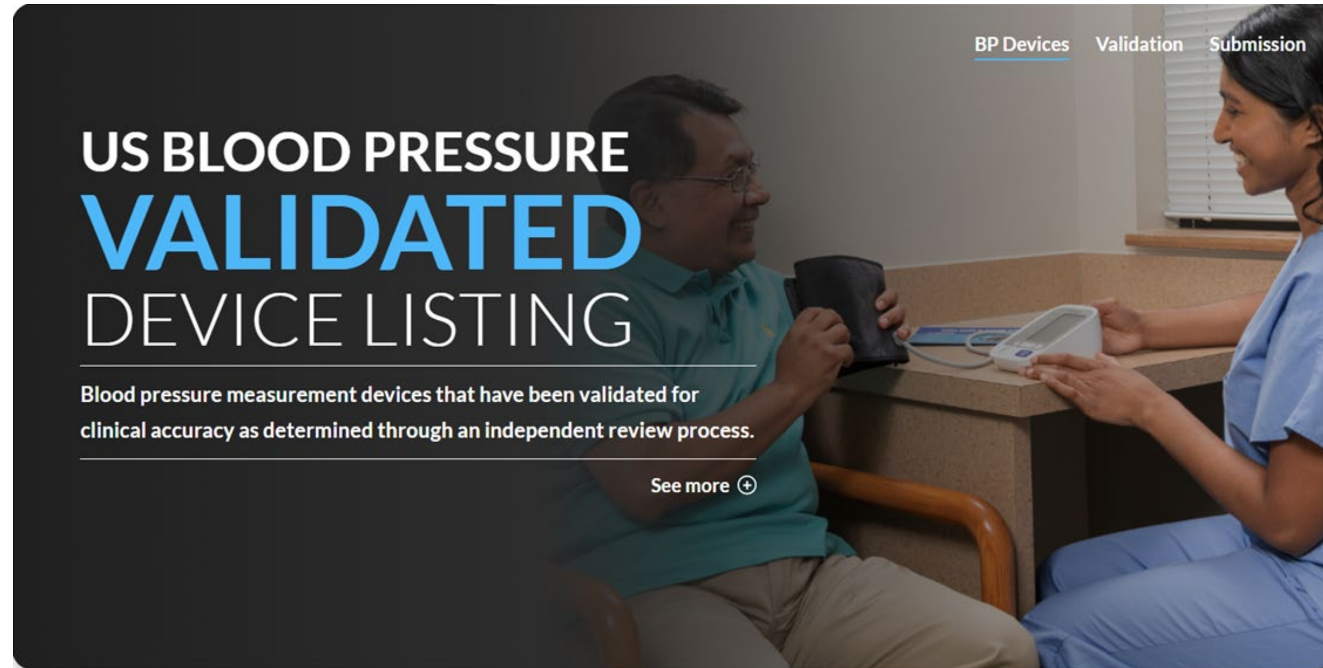
SHOCKING, BUT TRUE…

Patient Has…	Adds…*
Crossed legs	2 – 8 mm Hg
Cuff over clothing	5 – 50 mm Hg
Cuff too small	2 – 10 mm Hg
Full bladder	10+ mm Hg
Talking or active listening	10 mm Hg
Unsupported arm	10 mm Hg
Unsupported back/feet	6 mm Hg
White coat effect	Up to 26 mm Hg

**These values are not cumulative*

CLINICALLY VALIDATED DEVICES



US Blood Pressure Validated Device Listing (VDL™)

The ultimate judgment regarding whether a BP measurement device meets the requisite VDL Criteria rests with the Independent Review Committee and is not in any way determined or influenced by the AMA. The AMA does not receive funding from any device manufacturer or other third party in relation to the development of the VDL Criteria or VDL process.*

Office

Home

www.ValidateBP.org

REPEAT BP

Taking **multiple BP measurements** and calculating the **average** can help obtain a BP that **is more representative** of a patient's BP outside of the doctor's office—their "true" BP

Source: Sources of inaccuracy in the measurement of adult patients' resting blood pressure in clinical settings: a systematic review - PubMed (nih.gov)

SUMMARY

Practice Assessment: How Well Do You Measure?

Do you . . .

- ☐ Use a validated automated upper arm device to measure BP?
- ☐ Properly prepare patients before taking a BP measurement?
- ☐ Measure BP in an environment that supports appropriate patient positioning?
- ☐ Have a nurse or medical assistant take a patient’s BP?
- ☐ Take a repeat or “confirmatory” measurement if initial BP is high?

MAKE SURE PATIENTS KNOW THEIR NUMBERS AND KNOW WHAT TO DO ABOUT THEM

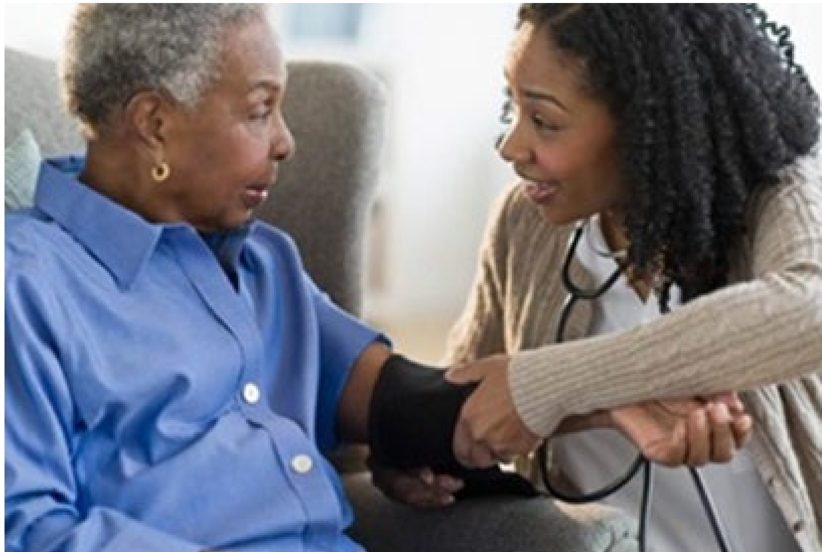
CATEGORY	SYSTOLIC (Upper #)	DIASTOLIC	WHAT YOU SHOULD DO
Normal	<120 mm Hg	<80	Enjoy your healthy lifestyle
Elevated	120 – 129 mm Hg	<80	**Live healthy:** decrease salt, increase exercise, manage your weight, stop smoking
Stage 1	130 – 139 mm Hg	80 -89	**Take 1 pill** combination therapy* and live healthy
Stage 2	140 or higher	90 or higher	**Take 1 pill** combination therapy to control high BP and live healthy

*The guidelines indicate pharmacological therapy when a person has clinical atherosclerotic cardiovascular disease, diabetes mellitus, chronic kidney disease, or an estimated 10-year cardiovascular disease risk ≥ 10%

The most current hypertension guidelines recommend combination therapy:

https://www.ahajournals.org/doi/10.1161/hyp.0000000000000065

MOST IMPACTFUL CARE TEAM ACTIVITIES TO IMPROVE BP CONTROL



1. Acting rapidly to **intensify medication** for patients with uncontrolled hypertension – *which requires accurate BP measurement!*
2. Increasing **frequency of follow-up (<4 weeks)**
3. Addressing **medication adherence**

RESOURCES

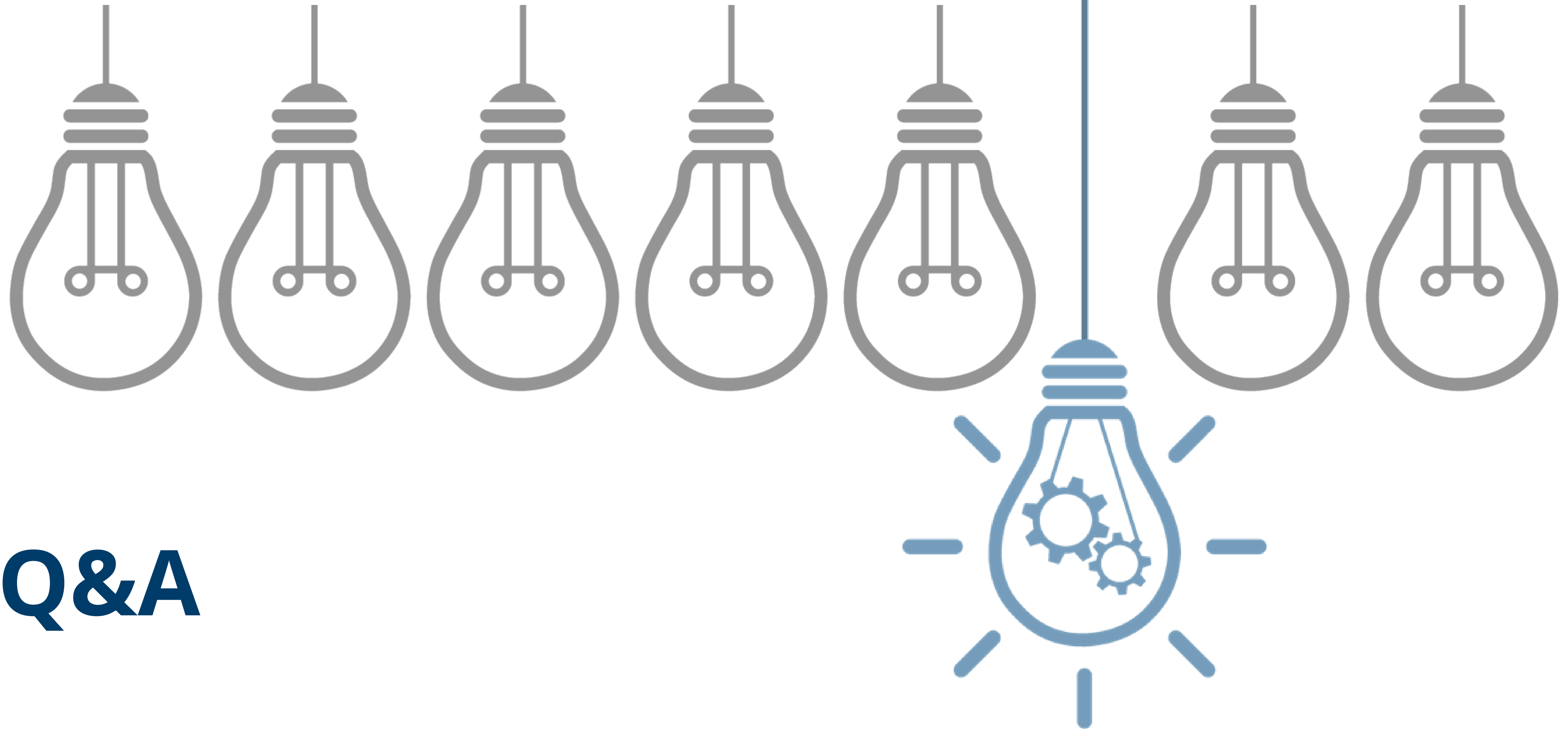
- How to measure blood pressure accurately - YouTube
- In-office BP measurement infographic (ama-assn.org)
- BP Positioning Tool | Target:BP (targetbp.org)
- BPAA-Roadmap_08252021.pdf (nachc.org)
- Three-pillars-Case-Study-1.pdf (nachc.org)
- Blood-Pressure-Control-_DYK.QT-03232023.pptx (live.com)
- AMA Hypertension Medication Treatment Protocol
- Optimizing Use of the Expanded Care Team for Hypertension and Cholesterol Management – YouTube
- SMBP-Toolkit_FINAL.pdf (nachc.org)
- Live to the Beat | Million Hearts

Billing & Coding Expert

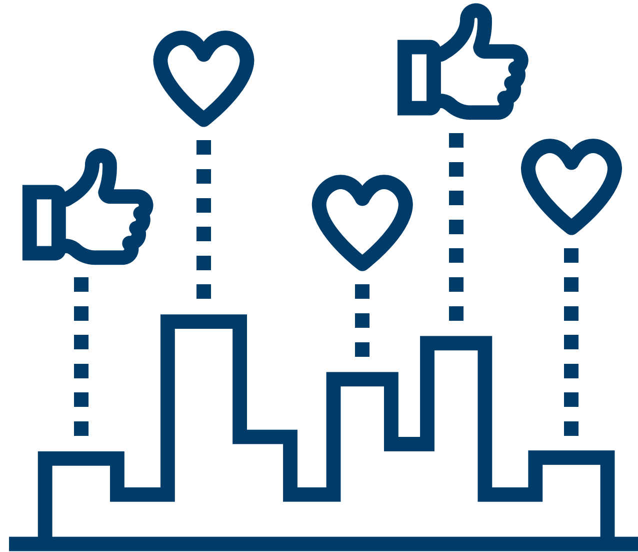
Lisa Messina, MPH, CPC, CPCO

Messina Consulting, LLC

Lisa Messina is an independent consultant and the Compliance Officer for the FQHC division of Coronis Health. Lisa has over 20 years of health care health information management and operations experience working in the inpatient, outpatient, community clinic, and physician practice arenas. She has conducted research and authored dozens of articles and blogs on coding, billing, and general compliance specific to community health centers.



Q&A



Provide Us Feedback

Brain Health Webinar Series

This 3-part webinar series is focused on the important role health centers play in dementia – early detection, reducing risk factors, care management, and effective partnerships.

Each webinar will offer health center-oriented action steps, and will feature subject matter experts in brain health, reimbursement, care management, and more!

Wednesday, May 3rd 1-2pm ET
Early Detection of Dementia & Reducing Risk Factors

Wednesday, May 17th 1-2pm ET
Care Management for Patients with/at-risk for Dementia & Leveraging Reimbursement Opportunities

Wednesday, May 31st 1-2pm ET
Health Center Partnerships & Community Linkages to care for Patients with/at-risk for Dementia

FOR MORE INFORMATION CONTACT:

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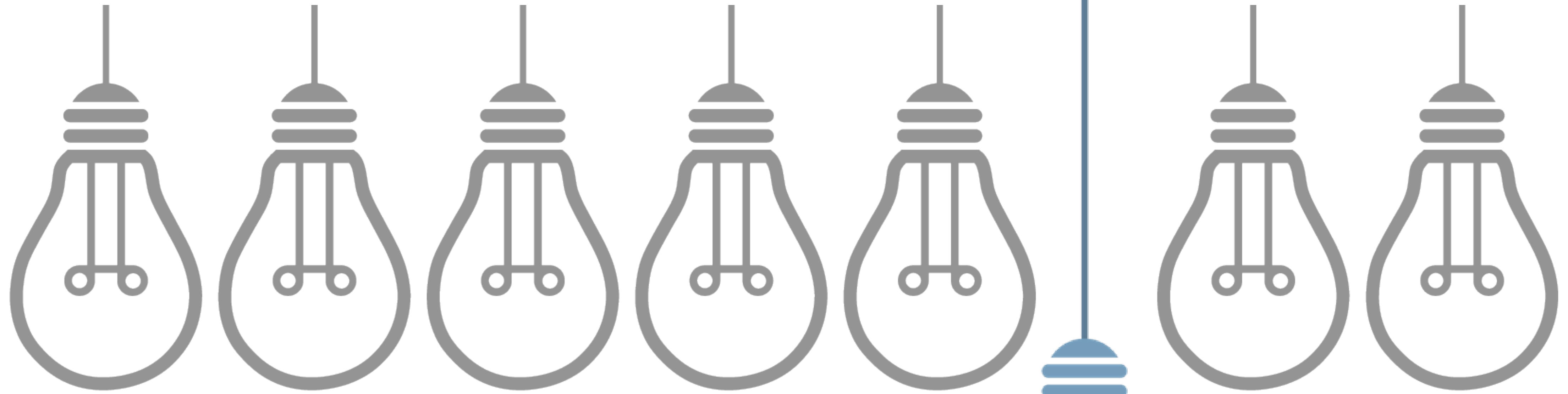
SHARE YOUR FEEDBACK

Don't forget! Let us know what you thought about today's session.

Next Webinar:

May 31, 2023
1:00 – 2:00 pm ET



Additional Slides & Resources:

Elevate National Learning Forum

National Learning Forum: Guided application of the VTF

Register https://bit.ly/2023Elevate

Assess https://reglantern.com/vtf

Ideally 3+ staff

Monthly Forum Invites are sent to registered participants

2nd Tuesday 1-2pm ET

Online Resources https://nachc.docebosaas.com/learn/signin

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Action Guides

- ✓ Empanelment
- ✓ Risk Stratification
- ✓ Models of Care
- ✓ Cancer Screening
- ✓ Diabetes
- ✓ Hypertension
- ✓ Care Management
- ✓ Patients
- ✓ Care Teams
- ✓ Leadership
- ✓ Social Drivers of Health
- ✓ Leveraging Health Center Referral Management Processes for 340B Referral Capture

Elevate National Learning Forum

Reimbursement Tips for Medicare Services

- ✓ Behavioral Health Integration
- ✓ Chronic Care Management
- ✓ Annual Wellness Visits
- ✓ Medicare Telehealth Services
- ✓ Psychiatric Collaborative Care Model
- ✓ RPM & Self-Measured Blood Pressure
- ✓ Tobacco Cessation Counseling
- ✓ Transitional Care Management
- ✓ Virtual Communication Services
- ✓ Mental Health Telecommunication Services
- ✓ Sliding Coinsurance for Care Management Services

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PAYMENT

$ Reimbursement Tips:

Payment Reimbursement Tips: FQHC Requirements for Medicare Chronic Care Management Services:

- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)

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PAYMENT

$ Reimbursement Tips:

FQHC Requirements for Medicare Transitional Care Management (TCM)

Transitional Care Management (TCM) supports the transition and coordination of services from an inpatient/acute care setting to a community setting by establishing a coordinated plan with the patient's primary care provider(s).

Program Requirements

Transitional Care Management (TCM) refers to the coordination of a Medicare patient's transition to a community setting after discharge from an acute care setting. As part of TCM, a practitioner provides or oversees the management and/or coordination of a patient's medical, psychological, and daily living needs following discharge from one of the following:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long-Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a Community Mental Health Center

Patient Eligibility & Consent

Eligible patients are those transitioning from an inpatient hospital setting (i.e., acute, psychiatric, long-term care, skilled nursing, rehabilitation, or observation status) to community setting (i.e., home, rest home, assisted living, including temporary or short-term settings such as hotel, hostel, or homeless shelter). A practitioner must obtain consent before furnishing or billing for TCM. Consent may be verbal or written but must be documented in the medical record.

Interactive Contact

Within two (2) business days of discharge date, the physician, qualified health professional (QHP), or clinical staff have direct and interactive communication with the patient (i.e., phone, in person, electronic). Contact must be more than simply scheduling a follow-up appointment and it would typically address the type(s) of services the patient had during admission, what the discharge diagnosis was, and what follow-up services they may need.

If two or more reasonable but unsuccessful attempts are made to reach the patient within two days after discharge, and all other TCM criteria are met, the service may be reported (billed). Document all contact attempts. Continue attempts to communicate until successful.

Face-to-Face Visit

Within either seven (7) or fourteen (14) days following discharge, a face-to-face visit is required. A patient whose condition warrants medical decision making (MDM) of high complexity during the service period (99496) must be seen within seven days of discharge while one whose condition warrants moderately complex decision making (99495) must be seen within fourteen days. Medication reconciliation must occur no later than the date of the face-to-face visit. Refer to the 2023 MDM table for more information for more information about medical decision making scoring.

During the COVID-19 Public Health Emergency (PHE), CMS allows TCM to be provided as an audio-visual telehealth service to a new or established patient. As it is on the CMS list of telehealth services, it would be billed for using

The Value Transformation Framework

INFRASTRUCTURE

IMPROVEMENT STRATEGY
Define vision, goals, and action steps that drive transformation and improved performance.

HEALTH INFORMATION TECHNOLOGY
Leverage health information technology to track, improve, and manage the Quintuple Aim.

POLICY
Pursue decisions, plans, and actions that help secure support and resources for health centers and expand access for under-served populations.

PAYMENT
Utilize value-based and sustainable payment methods and models to facilitate care transformation.

COST
Address the direct and indirect expense of delivering comprehensive primary care to health center patients while considering the total cost of care.

CARE DELIVERY

POPULATION HEALTH MANAGEMENT
Use data on patient populations to target interventions that advance the Quintuple Aim.

PATIENT-CENTERED MEDICAL HOME
Employ a model of care that transforms the delivery of primary care into a comprehensive, patient-centered system focused on high quality, accessible, and coordinated care.

EVIDENCE-BASED CARE
Make patient care decisions using clinical expertise and best-practice research integrated with patient values and self-care motivators.

CARE COORDINATION AND CARE MANAGEMENT
Facilitate the delivery and coordination of care for high-risk and other patient segments through targeted services, provided when and how needed.

SOCIAL DRIVERS OF HEALTH
Address the social, economic, and environmental circumstances that influence patients' health and the care they receive.

PEOPLE

PATIENTS
Intentionally and actively incorporate the patient perspective into governance, care system design, and individual care.

CARE TEAMS
Utilize groups of staff with different skills to work together to deliver and improve care, offering a wider range of services more efficiently than a provider alone.

GOVERNANCE AND LEADERSHIP
Apply position, authority, and knowledge of governing bodies (boards) and leaders to support and advance the center's transformation goals.

WORKFORCE
Leverage a trained and fully engaged staff to successfully address the health center's mission and goals, with optimal joy in work.

PARTNERSHIPS
Collaborate and partner with external stakeholders to pursue the Quintuple Aim.

15 Change Areas organized by 3 Domains:

Infrastructure: the components, including health information systems, policies, and payment structures, that build the foundation for reliable, high-quality health care

Care Delivery: the processes and proven approaches used to provide care and services to individuals and target populations, such as evidence-based care and social drivers of health

People: the stakeholders who receive, provide, and lead care at the health center, as well as partners that support the goals of high-value care

VTF Health Center Assessment

Allows health center staff to self-assess organizational progress in activities important to value transformation.

- Can be completed at the beginning of a transformation initiative to set a baseline and then repeated over time to measure improvement.
- Recommended that 3 or more health center staff complete the assessment to get a balanced perspective of organizational progress in areas of systems change.
- Health centers can electronically share their averaged score with their PCA/HCCN to help drive value transformation efforts at the state/regional level.

VTF Health Center Assessment

Assessment contains 15 questions – 1 for each Change Area.

Recently refreshed to reflect current state of value-based care.

Improvement Strategy

Define vision, goals, and action steps that drive transformation and improved performance.

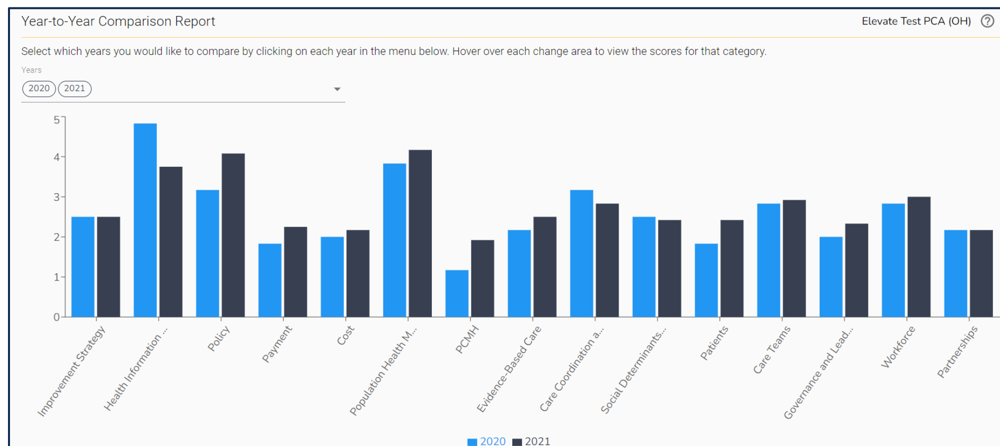
Rate your health center's level of progress in this Change Area from 1 (learning) to 5 (expert) as described in each category below. Check the level that has been fully achieved (i.e., all bullets met). For example, if your health center achieved all of Level 3 but only some of Level 4, check Level 3.

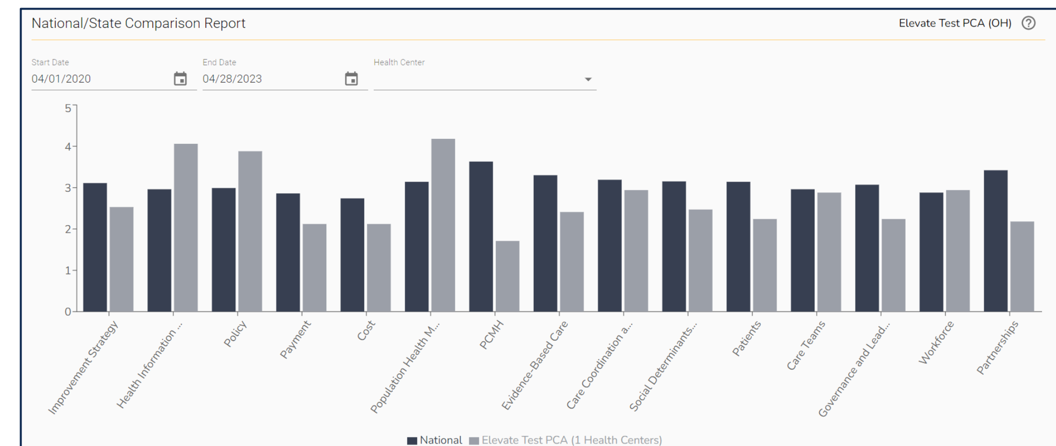
	1 - Learning	2 - Basic	3 - Applied (selected)	4 - Skilled	5 - Expert
QI Strategy	Health center is working toward implementing a QI plan that meets HRSA compliance standards.	Health center QI plan meets HRSA compliance standards. Health center QI plan involves periodic application of QI tools to make improvements (e.g., Plan, Do, Study, Act (PDSA), Failure Mode and Effects Analysis (FMEA), Root Cause Analysis (RCA), etc.).	Health center QI efforts include regular use of QI tools to make improvements (e.g., Plan, Do, Study, Act (PDSA), Failure Mode and Effects Analysis (FMEA), Root Cause Analysis (RCA), etc.) and may include application of basic components of Lean Production, Six Sigma, or other QI methods.	Health center employs a formal QI model such as the Model for Improvement, Lean Production, or Six Sigma.	Health center functions as a "learning organization" engaged in ongoing continuous quality improvement (CQI) with application of evidence-based interventions and promising practices.

VTF Health Center Assessment

PCA/HCCN functionality:

- Add and view a list of the health centers who are actively sharing VTF assessment results.
- Push a notification to health center staff to prompt them to complete a new VTF assessment.
- Download a CSV report of VTF Assessment results, including scores for each Change Area.
- Compare results from year to year, and to state/national results.





VTF PCA/HCCN Coach Assessment

Allows PCA/HCCN staff who lead transformation efforts at the state, regional, or national level to self-assess their professional skills in core competencies for quality improvement and value transformation.

Assessment contains 17 questions – 1 for each of the 15 Change Areas plus 2 coaching questions.

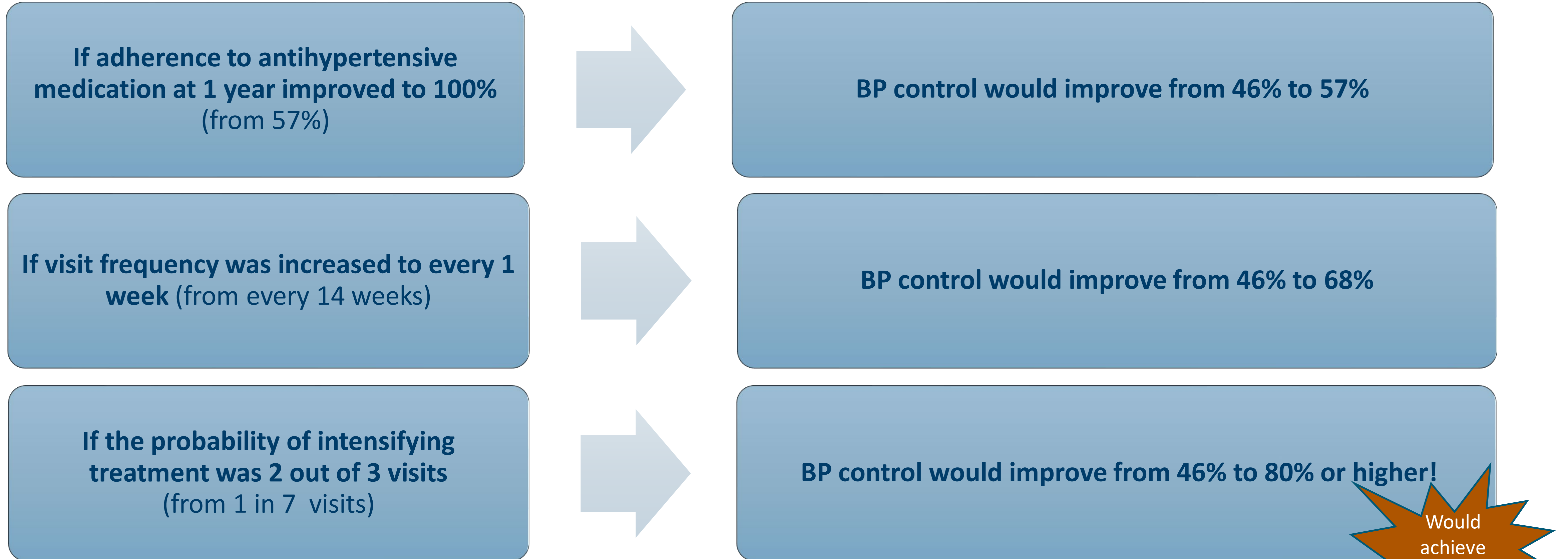
Improvement Strategy

Define vision, goals, and action steps that drive transformation and improved performance.

Rate your skill level for this change area from 1 (learning) to 5 (expert) as described in each category below. Check the level that you have fully achieved (i.e., all bullets met). For example, if you meet all the criteria in Level 3, but only some of Level 4, check Level 3.

	○ 1 - Learning	○ 2 - Basic	◉ 3 - Applied	○ 4 - Skilled	○ 5 - Expert
Improvement Scope	Coach supports health centers to work towards implementing a QI/QA plan that meets HRSA compliance standards.	Coach supports health centers to develop a QI/QA plan that meets HRSA compliance standards. Coach supports health centers to use periodic application of QI tools to make improvements (e.g., Plan, Do, Study, Act (PDSA), Failure Mode and Effects Analysis (FMEA), Root Cause Analysis (RCA), etc.).	Coach supports health centers to engage in quality planning and improvement, including regular use of QI tools or models to make improvements (e.g., Plan, Do, Study, Act (PDSA), Failure Mode and Effects Analysis (FMEA), Root Cause Analysis (RCA), etc.) and supports activities to measure, monitor, or maintain improvements.	Coach supports health centers to maintain formal quality planning structures and processes, to employ a formal QI model such as the Model for Improvement, Lean Production, or Six Sigma, and to build activities to measure, monitor, and maintain improvements into daily work.	Coach supports health centers to maintain formal planning, improvement, control, and assurance activities. Coach supports health centers to function as "learning organizations" engaged in ongoing continuous quality improvement (CQI) with application of evidence-based interventions and promising practices.
Improvement Focus	Coach supports health centers with QI efforts focused primarily on the utilization of health center services.	Coach supports health centers with QI efforts focused on quality and utilization of health center services, including clinical processes, guidelines, and standards of care, and some attention to patient satisfaction, experience, and safety.	Coach supports health centers with QI efforts expanded beyond quality, utilization, and patient satisfaction, experience, and safety to include additional operational measures.	Coach supports health centers with QI efforts expanded beyond quality, utilization, patient, and operational measures to include financial measures as part of assessing care model effectiveness.	Coach supports health centers with QI efforts focused on measures of systems-wide transformation and progress toward the Quintuple Aim (improved health outcomes, improved patient experience, improved staff experience, reduced costs, and equity).

DRIVERS OF UNCONTROLLED BLOOD PRESSURE: MODELING THREE KEY PROCESSES TO IMPROVE BP CONTROL



Bellows BK, Ruiz-Negrón N, Bibbins-Domingo K, King JB, Pletcher MJ, Moran AE, Fontil V. Clinic-based strategies to reach United States million hearts 2022 blood pressure control goals. *Circ Cardiovasc Qual Outcom* 2019;12:e005624. DOI: 10.1161/CIRCOUTCOMES.118.005624

When intensifying treatment for high blood pressure, adding a new medication class is more effective at reducing BP than increasing the dose of an existing medication – and results in fewer side effects.

Use of blood pressure lowering drugs in the prevention of cardiovascular disease: meta-analysis of 147 randomised trials in the context of expectations from prospective epidemiological studies - PubMed (nih.gov)

TREATMENT INTENSIFICATION: ADDING A NEW MEDICATION CLASS VS TITRATING DOSE

1. Most patients with uncontrolled blood pressure will need >1 medication class to reach their BP goal

2. Adding a new BP medication has 3x the BP-lowering effect of increasing the dose of an existing medication

Whelton PK, Carey RM, et al. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the prevention, detection, evaluation, and management of high blood pressure in adults. *Hypertension*. 2018;71:e13–e115.

Law M R, Morris J K, Wald N J. Use of blood pressure lowering drugs in the prevention of cardiovascular disease: meta-analysis of 147 randomised trials in the context of expectations from prospective epidemiological studies *BMJ.* 2009; 338:b1665.

GUIDELINE RECOMMENDATIONS FOR INITIATING DRUG THERAPY:
2017 ACC/AHA CLINICAL PRACTICE GUIDELINES

Recommendations for Choice of Initial Monotherapy Versus Initial Combination Drug Therapy*

COR	LOE	Recommendations
I	C-EO	1. Initiation of antihypertensive drug therapy with 2 first-line agents of different classes, either as separate agents or in a fixed-dose combination, is recommended in adults with stage 2 hypertension and an average BP more than 20/10 mm Hg above their BP target.

Whelton PK, Carey RM, et al. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the prevention, detection, evaluation, and management of high blood pressure in adults. *Hypertension*. 2018;71:e13–e115.

SIMPLIFY YOUR PILL ROUTINE

What you need to know about treating high blood pressure (BP)

Did you know? **Most people need more than one medication to keep blood pressure under control.** Fortunately, there are now "combination therapies" that have two medicines in one pill to treat high blood pressure, which is also called hypertension.

Single pill combination therapy has many advantages and it costs the same.

- **It is more effective**
- **It has fewer side effects** than high doses of one medication alone
- **It is easier** to take the medication you need to live longer

FOR MORE INFORMATION CONTACT:

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SHARE YOUR FEEDBACK

Don't forget! Let us know what you thought about today's session.

Thank you!