Advance Care Planning Process & Reimbursement Opportunities

HEALTHTECH S³
strategy solutions support

Building Leaders – Transforming Hospitals – Improving Care
## Who We Are

### Our Company
Formerly known as Brim Healthcare we have a 45 year track record of delivering superior clinical & operating results for our clients.

### Our Team
Our Executive Team has experience in managing hospitals from multi-billion $ healthcare systems to community hospitals.

### Our Mission
We believe that the combination of People, Process & Technology transforms healthcare & provides the required results.

## Management
- Turnaround Strategy
- Financial
- Operations
- Corporate Compliance
- Board Development

## Consulting
- Regulatory Compliance and Accreditation Preparation
- Lean Process Improvement
- CHNA

## Placement
- Executive Recruiting
- Interim Executive Placements
- Mid-level and Specialty Placements

## Technology
- Gaffey Revenue Cycle Management
- CrossTX Population Health Platform
- Optimum Productivity

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Faith M Jones, MSN, RN, NEA-BC
Director of Care Coordination and Lean Consulting

Faith Jones began her healthcare career in the US Navy over 30 years ago. She has worked in a variety of roles in clinical practice, education, management, administration, consulting, and healthcare compliance. Her knowledge and experience spans various settings including ambulance, clinics, hospitals, home care, and long term care. In her leadership roles she has been responsible for operational leadership for all clinical functions including multiple nursing specialties, pharmacy, laboratory, imaging, nutrition, therapies, as well as administrative functions related to quality management, case management, medical staff credentialing, staff education, and corporate compliance.
3-Part Series

• Welcome
• 3 part series on Care Coordination in Primary Care
  – Overview of Population Health in Primary Care: A Look at Financial Impacts – July 26, 2016
  – Chronic Care Management Program and Tools – August 23, 2016
  – Advance Care Planning Process and Reimbursement Opportunities – Today

Recording Available at:
http://www.healthtechs3.com/category/past-webinars/
Population Health: Stages

**Healthy/No Disease**
- Prevention measures
- Wellness Incentives
- Health Education
- Health education: classes, pamphlets, services
- Health Screenings
- Early symptom identification and personal management

**Termial Illness**

**Healthy/No Disease**
- Palliative
- Advanced Directives
- Arrange Hospice care
- Execute personal wishes
“Our goal is to recognize the trend toward practice transformation and overall improved quality of care, while preventing unwanted and unnecessary care”

CMS CFR 11-12-2014
Why Wellness Visits?

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

The ABC’s of the Annual Wellness Visit

Required Elements:

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

The ABC’s of the Annual Wellness Visit

Individualized Prevention Plan of Care:

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

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

Vol. 80 Wednesday, No. 135 July 15, 2015, P 226
Roles in Wellness Visits

Who is Eligible to Provide the AWV?

• A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Social Security Act (the Act); or,

• A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act); or,

• A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in CFR 410.32(b)(3)(ii)) ....

Welcome to Medicare Initial Preventative Physical Exam (IPPE)
(Your Medicare deductible is waived for this visit)

Cost: FREE
Coverage: Once per lifetime
- When it occurs within 12 months of the effective date of your initial Medicare Part B coverage.

Purpose:
- A review of your health, education and counseling about preventative services, and referrals for other care if needed.

Performed by:
- Physician, physician’s assistant or nurse practitioner

Please note:
- When making your appointment, please let us know that you would like to schedule your "Welcome to Medicare physical exam".
- You may be billed and responsible for co-pay if treating an illness (acute or chronic) or injury in the same visit.
- Medications are not refillable or prescribed in this exam.

NEW! Annual Wellness Visit
(Your Medicare deductible is waived for this visit)

Cost: FREE
Coverage: Annually
- When it occurs at least 12 months after you received an Initial Preventative Physical Exam
- When you have been covered by Medicare Part B for more than 12 months starting January 1, 2011.

Purpose:
- To develop or update a personalized prevention plan based on your current health and risk factors.
- Click here to see what will be discussed/reviewed with you in this visit

Performed by:
- Registered Nurse (RN)

Please note:
- When making your appointment, please let us know that you would like to schedule your "Yearly Wellness Visit".
- You may be billed and responsible for co-pay if treating an illness (acute or chronic) or injury in the same visit.
- Medications are not refillable or prescribed in this exam.

Annual Physical Exam

Cost: Co-Pay
Coverage: Annually
- You will be billed and responsible for 20% of the Medicare approved amount and the Part B deductible applies.

Purpose:
- For medically necessary services including evaluation and management of an illness (acute or chronic) or injury.
- Medication management.

Performed by:
- Physician, physician’s assistant or nurse practitioner

Please note:
- For the most up-to-date Medicare plan coverage, please visit www.medicare.gov
- Medications may be refilled or prescribed in this exam.

http://mayoclinichealthsystem.org/~/media/Local%20Files/Austin/Documents/MedicareVisits.pdf
Patient Self Determination Act

In 1990, the Patient Self-Determination Act was passed to preserve patient autonomy regarding end-of-life medical decision-making.

ADVANCE CARE PLANNING IS MORE THAN THE QUESTION......

Do you have a living will or advance directive?

http://journals.lww.com/jncqjournal/Abstract/publishahead/Improving_the_Advance_Directive_Request_and.99663.aspx
What is Advance Care Planning?

“Advance care planning is about planning for the ‘what ifs’ that may occur across the entire lifespan.” — Joanne Lynn, MD

“Denial about death does a disservice of not dealing with life-review and life-closure issues that some people would choose to do if they were thinking about dying as part of this last phase.” — Judith Peres, MSW

“Is not the logical conclusion of healthy aging a ‘good’ death? Is not this an important part of public health work?” — Myra Christopher

When it comes to end-of-life care, one conversation can make all the difference.

**Consider the Facts**

- 90% of people say that talking with their loved ones about end-of-life care is important. *but*
- 27% have actually done so.

- 80% of people say that if seriously ill, they would want to talk to their doctor about end-of-life care. *but*
- 7% report having had an end-of-life conversation with their doctor.

- 60% of people say that making sure their family is not burdened by tough decisions is "extremely important." *but*
- 56% have not communicated their end-of-life wishes.
Reimbursement for the Conversation

• Advance Care Planning (ACP)
  – Effective January 1, 2016
  • CPT code 99497 and 99498
Who Can Perform ACP?

“the services described by CPT codes 99497 and 99498 are appropriately provided by physicians or using a team-based approach”

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf
**CPT Code 99497** - Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.

**CPT Code 99498** - each additional 30 minutes (List separately in addition to code for primary procedure)

[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf)
Reimbursement Rate

CPT Code 99497 - $85.93
(National Average)

CPT Code 99498 - $74.83
(National Average)

Advance Care Planning & Advance Directives

Advance Care Planning = Process

Advance Directive = Product
How To Die In America: Welcome To La Crosse, Wisconsin

(1) Conversations and relationships matter.
(2) Innovation in end-of-life care requires highly personalized local solutions
(3) While the end-of life advance directive document is standardized, the process for each patient and family will be unique and intimate.
(4) Accessibility of records.

Improving the Advance Directive Request and Retrieval Process in Critical Access Hospitals

Honoring the Patient’s Wishes

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[http://journals.lww.com/jncqjournal/Abstract/publishahead/Improving_the_Advance_Directive_Request_and.99663.aspx](http://journals.lww.com/jncqjournal/Abstract/publishahead/Improving_the_Advance_Directive_Request_and.99663.aspx)
KSAs for the Conversation

“Atul Gawande’s book ‘Being Mortal’ highlights how modern scientific capability has profoundly altered the course of human life. People live longer and better than at any other time in history. But scientific advances have turned the processes of aging and dying into medical experiences, matters to be managed by health care professionals. And we in the medical world have proved alarmingly unprepared for it.”

Atul Gawande
Free Resources

Your Conversation Starter Kit

When it comes to end-of-life care, talking matters.

Institute for Healthcare Improvement

the conversation project

CREATED BY THE CONVERSATION PROJECT AND THE INSTITUTE FOR HEALTHCARE IMPROVEMENT

http://theconversationproject.org/starter-kit/intro/
Certification Programs

http://www.gundersenhealth.org/respecting-choices
RN Care Coordination Model:
Potential Annual Revenue/CCM Patient

$117 + $511 + $85 = $713
Care Coordination Productivity for ONE RN

Each Patient
AWV = 1 Hour
ACP = 0.5 - 1 hour
CCM = 4 hours
Total = 5.5 - 6 hours

200 Patient Practice
5.5 - 6 hours x200 =
1100 – 1200 hours /year
Care Coordination Revenue for ONE RN

$713 per patient \times 200 \text{ patients} = $142,600 Annually
Upcoming Events

September 30, 2016: Overview and Key Elements of Population Health Management

In order to understand population health, one must determine how the term is defined. Is there a difference between care management, public health and population health? This webinar will explore such differences, and how each can contribute to improving health and wellness among vulnerable populations.

October 7, 2016: Community Health Needs Assessment: Setting Priorities

Setting priorities for improving community health is one of the requirements for completion of a Community Health Needs Assessment. Who should be involved in determining priorities? How do you get the right people to the table? What criteria should you use for choosing priorities?

Visit our Website

http://www.healthtechs3.com/webinars/
THANK YOU!

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