Benefits of Preventive Services in Chronic Disease Management

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Objectives

• Examine preventative service processes related to billing regulations and organizational implementation

• Understand the impact of chronic disease management to patients’ quality of life

• Determine potential resource allocations to support organizational goals related to population health management

• Identify potential revenue sources through accurate billing of preventive services
Medicare: Changing the Landscape

From

• Nine individuals under 65 contributed to each person over the age of 65.

• 19,000,000 enrolled in Medicare in 1967

To

• Five individuals under 65 who contribute to each person over the age of 65.

• Nearly 58 million enrolled in Medicare as of February of 2017

Source: CMS
Per Capita Costs Comparison

United States per capita healthcare spending is more than twice the average of other developed countries

**Healthcare Costs per Capita (Dollars)**

- Italy: $3,077
- U.K.: $3,235
- Japan: $3,713
- Australia: $3,866
- France: $4,124
- Canada: $4,351
- Germany: $4,819
- Sweden: $4,904
- Switzerland: $6,325
- United States: $8,713
- OECD Average: $3,453

**Source:** Organization for Economic Cooperation and Development, OECD Health Statistics 2015, November 2015. Compiled by PGPF.

**Note:** Data are for 2013 or latest available. Chart uses purchasing power parities to convert data into U.S. dollars.

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International Comparison of Spending on Health, 1980–2012

Average spending on health per capita ($US PPP)

Total health expenditures as percent of GDP

Note: PPP = Purchasing power parity.
Source: Commonwealth Fund, based on OECD Health Data 2014.
# Quality Comparisons Worldwide

## Exhibit 9. Select Population Health Outcomes and Risk Factors

<table>
<thead>
<tr>
<th>Country</th>
<th>Life exp. at birth, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Infant mortality, per 1,000 live births, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Percent of pop. age 65+ with two or more chronic conditions, 2014&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Obesity rate (BMI&gt;30), 2013&lt;sup&gt;a,c&lt;/sup&gt;</th>
<th>Percent of pop. (age 15+) who are daily smokers, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Percent of pop. age 65+</th>
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<td>54</td>
<td>28.3&lt;sup&gt;e&lt;/sup&gt;</td>
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<td>14.4</td>
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<td>4.8&lt;sup&gt;e&lt;/sup&gt;</td>
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<td>28.3</td>
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<sup>a</sup> Source: OECD Health Data 2015.

<sup>b</sup> Includes: hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014.

<sup>c</sup> DEN, FR, NETH, NOR, SVE, and SWIZ based on self-reported data; all other countries based on measured data.

<sup>d</sup> 2012.  
<sup>e</sup> 2011.
Growth of Health Care Costs

Obesity and Diabetes Epidemic

- Correlation between Obesity and Diabetes
- Epidemic Trend over the last 30+ Years
Obesity Trends* Among U.S. Adults
BRFSS, 1990, 2000, 2010

(*BMI ≥30, or about 30 lbs. overweight for 5’4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1990, 2000, 2010

- In 1990, 10 states had a prevalence of obesity less than 10% and no state had prevalence equal to or greater than 15%.

- By 2000, no state had a prevalence of obesity less than 10%, 23 states had a prevalence between 20–24%, and no state had prevalence equal to or greater than 25%.

- In 2010, no state had a prevalence of obesity less than 20%. 36 states had a prevalence equal to or greater than 25%; 12 of these states had a prevalence equal to or greater than 30%.
Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among U.S. Adults Aged 18 Years or older

Obesity (BMI $\geq 30$ kg/m$^2$)

- 1994
- 2000
- 2010

Diabetes

- 1994
- 2000
- 2010

International Health Institute - Triple Aim

- Improve Health
- Lower Costs
- Better Care
Medicare Spending

• 94% of Medicare spending is on seniors with 2 or more chronic conditions
• 52% of Medicare spending is on seniors with 6 or more chronic conditions, which is 14% of the people
• 6% of Medicare spending is on seniors with less than 2 chronic conditions which is 32% of the people
• 19% of total Medicare spending is on people less than 65, which are 18% of the total people on Medicare
Movement to Value-Based Care

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

2016:
- All Medicare FFS: 85%
- FFS linked to quality: 30%
- Alternative payment models: 30%

2018:
- All Medicare FFS: 90%
- FFS linked to quality: 50%
- Alternative payment models: 50%

Source: CMS
Value-Based Programs

Value-Based Programs

Source: CMS
Focus Area: Preventative Services
Welcome to Medicare
Initial Preventive Physical Exam

Introductory visit to the Medicare Part B program ("Welcome to Medicare")

Not a “routine physical checkup”

Source: CMS
Initial Preventive Physical Exam

Frequency

• Once in the first 12 months of enrolling in Medicare

Eligibility

Source: CMS
Initial Preventative Physical Exam – Why is it Important?

• Provides the Clinician and Patient the opportunity to establish a plan of care to support their health

• Increases Patient and Caregiver engagement in their health plan and overall well being

• Opportune time to provide preventative and screening services to proactively manage care
Annual Wellness Visit
Annual Wellness Visit

Used to develop/update personalized prevention plan

A preventive visit – not routine yearly exam

Source: CMS
Annual Wellness Visit

Frequency

• Covered once every 12 months
  • Medicare will look to verify that at least 11 full calendar months have passed since last AWV

Eligibility

• Patients with Part B coverage for more than 12 months
• Have not received an IPPE or AWV service within last 12 months
• IPPE and the AWV cannot be combined into a single visit

Source: CMS
Annual Wellness Visit – Why is it Important?

- Improves Patient satisfaction and the ability to care for themselves
- Helps Patient take responsibility for their own care
- Provides Clinician and Patient the opportunity to establish a plan of care for the Patient’s chronic illnesses and health care needs
Annual Wellness Visit

- Marketing and Education of AWV
  - Providers
  - Patients
  - Staff

- Develop workflow and assess additional resources needed
  - Wellness Nurse

- How to get patients in?
  - Dual visits
  - Cold calling
  - Birthday cards
  - Mail letters
Chronic Care Management
Chronic Care Management

Care coordination and care management for a beneficiary with multiple chronic conditions

Requires the use of a certified EHR or other electronic technology

Source: CMS
Chronic Care Management

Frequency

• At least 20 minutes of clinical staff time

Eligibility

• Patient must have two or more chronic conditions expected to last at least 12 months, or until death

Source: CMS
Chronic Care Management – Why is it Important?

• Supports active management of Patient’s care plan on a regular basis

• Provides coordinated care across multiple health care resources

• Provides an avenue for active communication and coordinated care
Chronic Care Management

- Comprehensive care management and coordination
- MDH Certified Health Care Home
- Create a comprehensive care plan
- 24/7 access to address urgent needs
- Communication between visits — monthly check-in
- Community Care Team — link them to community resources
Transitional Care Management
Transitional Care Management

Coordination and Management of care for the first 30 days following an inpatient stay to support transition back into the community setting

Source: CMS
Transitional Care Management – Why is it Important?

- Provides opportunity for Clinician support following discharge from a care episode in an inpatient hospital setting
- Reduces potential for re-admission or complications from acute care episodes
- Supports transition of Patient into community setting
Transitional Care Management

• Already doing but not formalized and was not billing appropriately

• Opportunity to assess patients who may benefit from CCM

• Community Care Team — link them to community resources

• Track and monitor patients — avoid preventable readmissions
Additional Services
Additional Preventative Health Services

- Annual Depression Screening
- Annual Alcohol Misuse Screening
- Annual face-to-face Interventional Behavior Therapy for Cardiovascular Disease
- Diabetes Outpatient Self-Management Training
- Medical Nutrition Therapy
- Smoking and Tobacco Use Cessation Counseling
- Advance Care Planning

Source: CMS
Opportunities

• Improve patient care delivery and quality of care

• Improve health outcomes

• Improve financial performance
Challenges

• Change
  • Staff, Providers and Patients
  • Documentation and Billing
  • Learning Curve

• Resources
  • Staff, Time, EHR and Data Analytics
Questions?

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Thank You!

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