SMAs_Part1_20170206

Shared Medical Appointments
Part 1: Value & Return on Investment
February 2017

Karen Ten Cate
Hello and welcome to Shared Medical Appointments, Part One: Value and Return on Investment. You may have heard about Shared Medical Appointments but haven't given it much thought because you don't know the benefits for you and your patient, and want to know if the extra effort will truly be worth it. You also may be wondering how to operationalize Shared Medical Appointments, once you decide it is worth the effort. Operationalizing SMAs is covered in Part Two of this two-part series.

Welcome again. My name is Karen Ten Cate from the Quality Innovation Network National Coordinating Center and I will be your facilitator. The two objectives for this Bite Sized Learning are for physicians to see the value of investing in Shared Medical Appointments for themselves and their patients, and that physicians will see the major components of a Shared Medical Appointment and how those components could be billed.

Today's topics: Benefits to the patient, Benefits to the provider, Quality versus cost, Types of conditions for which Shared Medical Appointments would be appropriate. And namely we will look at Return On Investment from a quality, efficiency and billing perspective. Today I have two experts, Dr. Robert Schreiber and Dr. David A. Guggenheim, who will explain these topics in detail in the minutes that we have.

Dr. Robert Schreiber is Medical Director of Evidence Based Programs of the SeniorLife Department of Medicine, and Medical Director of the Healthy Living Center of Excellence in Boston. He is also a Clinical Instructor of medicine at Harvard Medical School. He served as Physician in Chief and CMO of Hebrew Senior Life in Boston, Massachusetts from 2004 to 2012. He helped to develop the strategic direction of Hebrew Senior Life Medical Group's in-home and community based services, long term care and post-acute care. We will call him Rob from this point.

Dr. David A. Guggenheim earned his Bachelor's Degree from the University of Connecticut and an MA and a Doctor in Psychology for clinical psychology from the American School of Professional Psychology in Washington, DC. He began his career at CHC Incorporated, a statewide FQHC, Federally Qualified Health Center, in Connecticut and served as Associate Chief Behavioral Health Officer. Dr. Guggenheim is trained as a coach in the Dartmouth Clinical Microsystem Approach to PI and works closely with research institutions to provide collaborative treatment for chronic pain and addiction. He led a team in the development of his organization's shared medical visits for patients living with diabetes and other chronic health conditions. He is also a Geiger Gibson Capstone Fellowship graduate and regularly presents to healthcare teams about integrated mental health and primary care service delivery, and the delivery of care to LGBTQ populations. In his recent role as Chief Mental Health Officer at

Callen-Lorde in New York City, Dr. Guggenheim works to expand access to integrated LGBTQ sensitive in affirming integrated primary and mental health services. From this point on we will refer to Dr. Guggenheim as Dave.

I'm going to turn it over now to Dave.

Dr. David A. Guggenheim:
Thank you Karen. So what is an SMA? Shared Medical Appointments or SMAs are an alternative to the standard individual outpatient medical appointment. They typically include an E&M visit with each patient, as well as an educational or counseling component done as a group. SMAs can be used for care and ongoing follow-up of a chronic or behavioral condition and would be an effective and efficient way to deliver Diabetes Self-Management Education or DSME in primary care, especially in FQHCs and RHCs where group DSMT is not specifically billable to Medicare.

SMAs typically consist of staff formed groups of about ten to twelve patients who have common conditions such a Type II diabetes, hypertension, depression or COPD. Newer Medicare covered services that may be appropriate to offer as SMAs include alcohol misuse counseling, smoking or tobacco cessation, cardiac risk reduction counseling, and intensive behavioral counseling for obesity. And we'll go into greater detail about some of those.

So some of the benefits to patients. SMAs have been used for many years and are often used for chronic medical conditions. Many include motivational interviewing, and sometimes this is a part of the behavioral health component led by a social worker or psychologist. There is evidence of improvement in mental health outcomes as a result of group participation, not only for SMAs but group therapy in general. This may be because group members get a chance to get to interact with one another. They gain support from one another and sort of network with people who are similar.

And there's quite a bit of research supporting the use of SMAs in practice. For example, in one study researchers used monthly two-hour SMAs with a multi-disciplinary team. The team included nurse educator, dietician, pharmacist and a behavioral therapist. In the study all participants had elevated A1C levels and the control group's care was managed as usual by their PCP. The SMA patients had more of a reduction in A1C than the usual care group. They had lower hospitalization admission rates and reported more self-efficacy related to balancing food intake and glucose levels. They were also better able to treat hypoglycemia and manage their blood glucose when they were ill.

In another study authors conducted a randomized controlled trial over five years and found that participants in the SMA group had an increase in knowledge of diabetes care versus a decrease in the control group; so they were more knowledgeable about care for their diabetes. The SMA group showed an increase in problem solving abilities versus the control group. In the SMA group overall, the A1C was maintained while in the control group the A1C levels actually increased. On a quality of life measure participants rated a higher quality of life in the SMA

group after participation versus a decrease in the control group So you can see here these are many benefits to SMAs.

And one last study that I'll discuss; in 2007 researchers also found that Shared Medical Appointments foster more trust in a patient's physician and helped physicians meeting ADA standards.

So when we look at all the research that I've just discussed we know that group visits are associated with decreased emergency department utilization, improved quality of life, improved self-efficacy, increased adherence and increased knowledge.

Dr. Robert Schreiber
Thank you, Dave, for explaining the benefits to the patient and what I'll now take on is the benefits to the provider of doing SMAs.

So the benefits to the provider are many. Think about the number of times a day or a week or a month you repeat a lot of the same recommendations or education. This can be greatly reduced when you group patients together. It actually gives you more flexibility in the schedule because you are seeing ten to twelve patients at a time; possibly freeing up more time to dealing with individual cases that need more of your attention. It also allows you to spend more face to face time with patients in that group without increasing the time you spend in your practice setting. Much of the time you already have the expertise needed within you and your medical staff, so no new hiring is needed. Further, doing group visits allows you to reduce overhead costs, decreases patient wait times, and usually results in higher patient satisfaction rates.

Now I'd like to discuss other value propositions of SMAs to providers. You have them listed in front of you. The first I'll be talking about is patient activation. Studies have shown that SMAs enhance patient ownership for their own health and health behaviors. We'll be discussing the impact on health outcomes and costs a little later in the presentation.

The second value proposition involves improving quality measures tied to incentive payments. When you are able to show improvement in key measures that you choose, such as blood pressure control or A1C control, this may factor into positive payment adjustments in the following year, given the new payment changes that are happening now involving MACRA and MIPS. Payment adjustments can be as high as four percent in the first year in 2019 where incentives are being paid out. If you don't plan to make improvements, your payments could actually go down by four percent just in that first year.

Another value proposition of SMAs involves decreasing re-admissions. By having improved clinical measures this will likely mean fewer re-admissions to your local hospital, and they will certainly be appreciative of that.

And lastly the value proposition of improving population health is an important one. SMAs are a great way for your practice to make substantial progress in improving the health status of your entire patient population. Given the fact that payments will be valued based in the coming years

as I just mentioned, it makes sense to start developing approaches that will improve the overall outcomes for your practice at this time.

Benefits to your practice. SMAs have been used for many years and they promote coordination among healthcare team members, including your allied health professionals. We know that 86% of the nation's healthcare costs are related to chronic health conditions, and SMAs are useful in addressing these chronic conditions. Group visits have been shown to be effective at helping patients change their health related behaviors, and an SMA can include more than the doctor charging for their time. For example, a psychologist or a licensed social worker could bill for the behavioral health component of the group visit if there is one. And as you can see listed here, and as Dave had mentioned, this applies to almost any chronic health condition.

Other potential conditions for SMAs are listed below. Here are some of the common chronic conditions that likely permeate the patient panels in your practice, and which Shared Medical Appointments could be used for. These are involving both physical and mental conditions, and include a number of behaviors that are associated with them. Insomnia, depression, anxiety, as well as cognitive impairment are some of these. But in addition Shared Medical Appointments can be used for well child visits, prenatal care, or really any common or costly chronic condition. I'm going to turn this over now to Dave.

Dr. David A. Guggenheim
Thanks Rob. So in this slide we have an example of a shared medical visit that I actually ran in practice. In this SMA we identified about thirty-five patients who were eligible and ended up with about twenty to twenty-five patients coming to the session. Sessions were for two hours though the provider again is only part of the first hour. The patients met with a nurse, a medical assistant, and were screened by a behavioral health provider for depression as needed based on what we prepared in our chart review.

As patients arrive, the nutritionist begins their session with the patients and speaks about managing diabetes and healthy eating. This was followed by an information and discussion session with the medical provider. We also had a behavioral health provider, a social worker, who was able to use motivational interviewing techniques and smart goal setting with the group. In some groups we had a dental provider run part of the session discussing diabetes and oral hygiene. All groups are run interactively. Patients are not being lectured, but instead part of the program and able to speak with one another and their providers. Some groups are able to set shared goals such as exercising twice per week.

On the next slide we see components and their value. In two hours, ten to twelve patients participate in individual follow-up medical visits by their provider and also get in an interactive group focused on lifestyle behavior change by an educator; which might be a nurse, a dietician, a social worker, or other allied health team member depending on the condition and the issue that you're addressing. This allows for high quality care and education in the same encounter, but the provider does not have to be present for the education component; two distinct components in practice and for billing purposes.

Dr. Robert Schreiber
So now we'll talk about the Return on Investment of an Engaged Patient; and in particular avoidable hospitalizations.

This graph shows the odds of hospital use after one year, stratified by Patient Activation Level which is measured by the Validated Patient Activation Measure developed by Judy Hibbard. The more activated a patient is to care for themselves, the less likely they are to show up at the hospital. Patients with the lowest activation scores at baseline had a 62% greater likelihood of having an avoidable hospitalization compared to the most activated group, one year later, again after controlling for baseline demographics and chronic conditions. Two years later the difference between the least and most activated groups was 40%, while three years later the difference was still 30%. So to be clear, those patients with the lowest activation scores often have poorer health and quality outcomes, as well as higher costs.

In this study there was also a Return On Investment of an engaged patient involving the development of new chronic diseases. This was a second finding which was perhaps even more intriguing. After controlling for baseline chronic conditions and demographic characteristics, patients at the lowest activation level at baseline were 25% more likely to develop a new chronic disease in the next calendar year compared to patients at the highest activation level. The same analysis two years after baseline showed a 31% difference between the lowest and highest activation groups. Three years after baseline the difference was still 21%.

Dr. David A. Guggenheim
Thanks Rob. As Rob mentioned, patient activation and engagement pays off.

Now I'm going to talk a bit about return on investment. This chart shows you how you would calculate the reimbursement for an SMA using E&M codes for each patient, and then the DSMT group code of G0109 for the educator who is part of an accredited or recognized DSME program billing Medicare. These rates are based on the 2017 CMS Fee Schedule, but we took liberty to round so we have zeros on the end for example purposes. We assume you schedule about twelve to fourteen patients – again that may vary – and end up with about ten at the visit. The patients are there about two hours but the physician or mid-level would be spending just one hour. The educator would use the other hour for DSMT or whichever other education or behavior program you are doing. The E&M visits billed by the physician or mid-level would be 99214, at roughly $100 per patient. The reimbursement for educating ten patients would be $300 per hour, and for the medical visit for ten patients about $1,000 per hour, for a grand total of $1,300 for two hours. If you want to take this collective payment back at the hourly rate, it's about $650 an hour.

On the right side we can see the total hourly payment rate of a physician doing traditional one-on-one visits; $300 per hour. Even if you do not have a billable DSMT program, or you are having your staff teach on some other condition that is not billable, you still come out ahead by doing SMAs and billing only for the E&M visits; $1,000 per hour versus $300 per hour. If you are in an FQHC this is something to consider since accredited DSMT programs are not allowed to bill for DSMT as a group.

Here's a recap of the bottom line based on the previous slide. Also, you may see improved patient activation as Rob mentioned. You may see increased medication adherence, primary care utilization, increased patient satisfaction scores, and improved quality incentive payments in the following year.

Here is a similar example but with a behavioral health provider instead of an educator. So your E&M visits remain the same; then you could have a licensed social worker, psychologist or psychiatrist do a behavioral health intervention with the group and bill using 96153, which puts you at $200 per hour for ten patients just for the behavioral health intervention. So your grand total is $1,200. Again, this is ten times the payment per hour of sticking with one-on-one visits.

So setup costs. Here is a chart to help you break down your setup costs. Basically you want to record which staff are going to do what, how long that will take, and estimate your labor. Then if you already have a room large enough, decide if there is any cost related to using that room for two hours every month or two. If you have to build on the room or rent the room, that would cost you a bit that you'd want to add on. Then you have the minimal cost of supplies and forms. You are probably already spending money on consent forms and some educational handouts for these patient one-on-ones, so you may not have any additional costs to figure in. If you are making the education more robust than it has previously been, you may have one-time costs to supply your educator with visuals such as food models or a wounded foot model to discuss foot care for diabetes for instance.

In terms of time frame, the time frame is typically two hours and includes a private triage RN. Then the moderator opens the appointment with housekeeping items, sets the tone; the provider comes into the group and possibly pulls patients out during their other parts to have one-on-one time. The educator comes in for a behavior change education piece; then wrap-up, action planning and reminders for the next group visit.

In Part 2 of this series we will explain the planning and execution of SMAs in great detail.

Dr. Robert Schreiber
Thanks Dave. So now that we've demonstrated the value of doing group visits, let's talk a little bit more about the billing aspects. No additional CMS code exists to really denote these medical visits done in a group format. And so performing these services in groups does not really affect coding, billing or reimbursement per patient. Any applicable E&M code may be used. Medicare has actually disseminated general policy statements in support of reimbursement of group medical visits, but there is a regional variation. Other insurers, especially commercial insurers, may have policies for reimbursement of group visits, so these programs could be done with commercial insurers if in fact they support these types of approaches. I think what's important however is that you always should check with your Medicare Administrative Contractor, or MAC, to make sure you and they are interpreting the billing the same way, and if they know that you are doing group visits it might prevent them from doing an audit when they see multiple E&M and lifestyle codes being billed that same day.

So common billing practices. Let's review that. It's really important that you document clearly with two distinct parts. There needs to be an E&M code, and usually 99213 or 99214 are the ones that we use. And it's really important to emphasize the medical management component. There is a short list of education services that can be billed for the education part: diabetes self-management, teaching by an accredited, recognized diabetes self-management education program, medical nutrition therapy or MNT by a registered dietician, or intensive behavioral treatment or IBT for cardiovascular disease. Check with your Medicare Administrative Contractor to see if they will accept claims for the intensive behavioral therapy for cardiovascular disease done as a group. The CMS policy is not 100% clear about this point involving groups with cardiovascular disease. We've included the reference that describes the IBT for cardiovascular disease policy at the end of this presentation.

So there are medical and behavioral codes that need to be included. We talked about the E&M level based on complexity; again 99213 and 214 were the ones that I mentioned, but you could use any other the E&M codes from 99212, especially if it's a very short visit and you don't do much medical management, up to something very complex as the 99215. If you're a psychologist, psychiatrist, social worker or psychiatric nurse practitioner you may be able to use the CPT code 96153.

So let's talk about more of the lifestyle and education group billing. The procedure code that should be billed by an educator or the facility in which SMAs are furnished such as a provider's practice or hospital clinic will be discussed at this point. It's really important, for example, if you're billing on behalf of the educator that the DSMT can be billed by a registered dietician or a podiatrist or a psychologist in addition to the traditional medical practitioners. For example, a clinical nurse specialist that's doing education can also bill for the lifestyle education component. Be sure however that the NPI number of the educator, or the NPI number of the lifestyle behavior change program is different than the NPI number of the medical provider; such as the mid-level or physician doing the E&M visit on the claim.

It's also important to note that in Federally Qualified Health Centers and RHCs that this group education and lifestyle management are not separately billed for additional payment on Medicare claims. So MNT and DSMT teaching will not be able to be billed separately. So a Federally Qualified Health Center that's seeing shared medical appointments as an efficient, effective way to deliver medical care and education is really only able to bill for ten patient encounters versus one for the doctor's hour of time; and it does not allow you to bill for the education portion at this time.

However, as Dave mentioned, there's a significant ten to one return on that time spent. Now that does not include the costs associated with doing this, but nevertheless is fairly significant so it's still a value for FQHCs to do this.

So let's talk now about the lifestyle education codes and rates. And as you see on the slide, we have the different codes on the first column and the time that these codes require for the unit to be billed; as well as the service and then the reimbursement. The highlighted rows are the group codes for DSMT, MNT, and IBT for cardiovascular disease that you could potentially use as an

education component of the shared medical appointment. Note that you would never use DSMT and MNT on the same day, as those are not billable per Medicare. You have to use one or the other.

Also notice: if you're going to use these in your own hourly rate calculations, some of these are thirty minute codes and some are fifteen minute codes; so you would need to multiply these dollar values up to determine the hourly rate for reimbursement. These dollar values that you see in the last column in 2017 are from the National Payment Amount on the CMS fee schedule for that year, so your local value might vary slightly.

Karen Ten Cate
Thank you Rob and Dave. This wraps up Shared Medical Appointments, Part 1; Value and Return on Investment. Check out the references on the next slide if you want to read more. If you have a burning question for Dr. Guggenheim or Dr. Schreiber, they graciously made their emails available here.

On the references slide, note the Eisenstat Reference from 2012 is an online book you can use to further educate and prepare yourself for implementing Shared Medical Appointments.

Thank you so much for participating in this bite sized learning. We hope you found Shared Medical Appointments, Part 1 useful to your practice. We value your feedback, so please take a few moments to click on the Survey Monkey link in the slides that are accompanying this recording and let us know what you think. If you have a question or comment that you'd like to email us directly, please use this email link here: QINNCC@area-d.hcqis.org. And don't forget, Shared Medical Appointments, Part 2: Operationalizing.