Maximize Your Wellness Visits for Patients with Chronic Disease

In the eyes of a provider, wellness visits are a chance to ensure a patient's checklist is complete: vaccinations up to date, colonoscopies and mammograms scheduled, medications managed to get patients in line with evidence-based guidelines. Providers may give a perfunctory reminder to get weight down, stop smoking, cut down on alcohol and exercise regularly. The electronic medical record makes it easy to complete this standard protocol and send the patient back on their way.

In the eyes of the patient, wellness visits look like a one-stop-shop: get prescriptions refilled, schedule screenings, no deductible or no co-pay. And it only costs a half-day off work.

3 Steps to Optimize Wellness Visits

1. Make a HOPE Note standard practice
2. Train a staff member to be a health coach
3. Streamline wellness visits so that the health coach gains efficiency and productivity

But is this the optimal path to health-and-well-being for patients at risk for or with chronic disease? Unfortunately, there is little health promotion or chronic disease reversal in disease care. Disease care often leaves providers frustrated and burned out, running on the treadmill of the checklist and its administrative burdens. Patients are left on their own to tackle healing factors that come from outside the doctor's office, with little assistance on how to change behavior or deal with guilt if they cannot change. Yet eighty percent of health comes from the personal determinates of health that occur outside the medical environment - social and emotional factors, lifestyle and behaviors, mental and spiritual factors, and the physical environment. Very few health care encounters deliver treatments that address these determinants of health.

Chronic disease management requires an approach in which the whole person is considered—where the focus is not just on countering illness, but also on promoting health-and-well-being; where *healing* is as important as managing illness. Where we ask, "What matters?", and not just "What is the matter?"

How to Add Healing to an Office Visit and Beyond

From an integrative health perspective, office visits need to be more than a prescription refill. Integrative health visits provide an opportunity to invest in a patient's healing, talk about and measure risk and protective factors, and address underlying determinants of health. Providers can do this by using a Healing Oriented Practice and Environments (HOPE) Assessment and HOPE Note in addition to the SOAP Note that is standard practice in most office visits.

The physician begins a HOPE Visit by asking the patient questions about areas of their life that impact health and matter to them. This discussion reveals areas of potential action, aligning their life and health goals, so a process for improvement can be mutually agreed upon and facilitated. Follow-up support can come through a health coach, group visits, health apps, or ongoing informational resources and regular follow-up visits for progress. A team oriented around the patient's health and healing that also includes the patient and their family or friends forms the core of a truly person-centered approach.

Behavior Change Support for Chronic Diseases

More than half of all adults in the United States have at least one chronic condition such as heart disease, diabetes, high blood pressure and chronic pain from conditions such as arthritis. These conditions are among the most preventable conditions and are manageable with lifestyle changes,

evidence-based self-care and complementary approaches to healing. If health care is to deliver health-and-well-being, it must address these underlying causes of ill-health and learn to better facilitate healing.

Support for this behavior change can take many forms, but one of the most effective is health coaching. Primary care practices can add a health coach (or train an existing staff member), enabling them to continue caring for patients between doctor's visits. Health coaches support sustainable lifestyle changes through ongoing periodic check-ins either in person or by telehealth. This is especially useful for patients with chronic conditions that can't be cured with medication or conventional medical treatment. Primary Care Physicians seeking to add this into their practice should access the AMA's resource: "Implementing Health Coaching" from Thomas Bodenheimer, MD, MPH, of the UCSF Center for Excellence in Primary Care.

Top 3 Visits

1. Annual Wellness Visits
2. Diabetes Prevention Visits
3. Chronic Care Management

Properly coding for the three types of visits above can cover the cost of adding a health coach to your team or training an existing team member to be a health coach.

Health coaching offered through providers encourages patients to make and sustain healthy changes (self-care) and provides the knowledge and support they need to prevent or reduce the impact of chronic disease. It also allows them to properly integrate that behavior change with medication changes and other treatments that must be integrated into this care. Health coaches are key change agents who can help shift the U.S. healthcare system from one that is focused on reacting to disease and injury to one that also supports prevention and fosters health-and-well-being through self-healing.

RAISING HOPE MAXIMIZES PROFITS FOR YOUR PRACTICE

There is financial reward for providers who learn how to raise hope—even under fee-for-service payment. Raise your patients' hope and your bottom line by hiring health coaches to add health-and-well-being services to your practice. It's probably easier to sell that than it is to convince them that their disease care expert has become a wellness guru. By having your office business staff bill for these services under the "incident to" rules, this leaves the providers to continue their disease care services and increases productivity of the whole team.

For example, a $40/hr nurse, dietician or health educator could bill for you at these 2018 CMS rates:

Health-and-Well-Being Services	**Limiting Charge**
G0438 – Personalized Prevention Plan, initial	$192
G0439 – Personalized Prevention Plan, subsequent	$130
99490 – Chronic care management, 20 min/month, telephonic	$ 47
G0444 – Depression screen, annual	$ 20
G0442 – Alcohol screen, annual	$ 20

These are just a start. An integrative health visit and HOPE Note often identifies other conditions, service needs and codes that can be incorporated into a practice. And it can be profitable for a practice. This data come from Geoffrey Moore, M.D. of Wellcoaches Digital and Margaret Moore, CEO of Wellcoaches, a leading health coach training and certification program.

One can leverage a health-and-well-being coach or coaches into a team providing a full line of health-and-well-being services focusing on the social and emotional factors, personal behaviors, mental and spiritual factors, and the patient's environment—all factors that impact your patient's health. The most productive way to provide such visits is to do them in small groups of 4-10 participants. With full groups, the hourly revenue is impressive for allied health care workers.

G0473 – Behavioral counseling, obesity, group of 2-10, 30 min	$14 ea. x 10 = $280/hr
G0446 – Intense behavioral therapy, cardiovascular diagnosis, 30 min	$29 ea. x 10 = $580/hr
G0109 – Diabetes self-management training, group, 60 min	$16 ea. x 10 = $160/hr

Of course, providers can get in the action, using traditional outpatient evaluation and management, which can also be billed (as counseling & coordination of care)! Group visits are particularly rewarding to lead. Briefly see each patient and document the visit in the chart. EHR templates can streamline this process.

99211 – Weigh-ins, vital sign checks by a nurse	$24
99213/99214 – Can do in groups led by provider and health coach	$81/$120

In geriatric patients and persons with chronic disease or disability, it is important to evaluate physical functioning as a key aspect of quality-of-life. Such evaluations need to be done by a provider, but they're central to showing patients that you're serious about health-and-well-being services. In fact, several additional services show that your practice really cares about health-and-well-being.

97750 – Physical performance test, with report, each 15 minutes	$42
99406 – Behavior change smoking, 3-10 min	$16
99407 – Behavior change smoking, >10 min	$31
G0443 – Brief alcohol misuse counseling	$29
G0396 – Alcohol / substance use intervention, 15-30 min	$40
G0397 – Alcohol / substance use intervention, >30 min	$76
99484 – General Behavioral Health Integration Care Management	$48
G0513 – Prolonged Preventive Services, first 30 mins	$66
G0513 – Prolonged Preventive Services, >30 min	$66
96160-96161 –Health risk assessment for patient or caregiver/guardian	
X1-5 – Patient Relationship Category Modifiers	

Don't forget your paraprofessionals. Physicians and staff leave money on the table all the time because they don't know how to code properly for paraprofessionals. Paraprofessionals, like health coaches can be attached as another provider- and it all gets rolled up to enhance the RVU for the code; health coaching can also be coded that way.

Additionally, telephone services provided by a physician or other qualified health care professional who report evaluation and management (E/M) services can be billed: 99441-99443 (based on length of call).

On Oct 15, 2019, the American Medical Association approved New Category III CPT Codes for Coaching effective January 1, 2020:

0591T Health and Well-Being Coaching face-to-face; individual, initial assessment

0592T individual, follow-up session, at least 30 minutes
0593T group (two or more individuals), at least 30 minutes

Bottom Line

Under a fee-for-service payment paradigm, a well-conceived and managed health-and-well-being service line can bring in an additional $100,000 a year per provider in *profit* to a primary care practice. That's because while the payments aren't high for physicians, they are high for allied health care workers and health coaches who do most of the work under the providers supervision. In a traditional disease-care service line, a low percentage can be billed for services by practice staff. A much higher percent of health-and-well-being services can be done by practice staff allowing these workers to improve the productivity and revenue of your practice. All while addressing what the patient needs to improve their health.

Not in a fee-for-service environment? In value-based payment models, health-and-well-being service lines earn essential points for Patient-Centered Medical Home evaluations by NCQA, and provide a new angle to improve outcomes for pay-for-performance systems such as MIPS (Medicare's Merit-Based Incentive Payment System). While demonstrating these outcomes requires more than coding, having a practice that addresses and tracks what actually improves health for patients is essential.

Give your practice an ability to focus on health-and-well-being and improve quality-of-life for your patients through integrative health visits and the HOPE Note!

Example 1: Cone Family Medicine Clinic, Chapel Hill, NC

The Cone Family Medicine Clinic in Chapel Hill, NC, started implementing health education specialists (HES) and health and wellness coaches (HWC) in their practice in late 2011 / early 2012.

The payer mix was 28% Medicare, 27% uninsured, 25% Medicaid and 20% private insurance. Their preference for HES preparation was an MPH degree with certification in health education and health coaching.

The HES organized and facilitated annual wellness visits (AWV) done by the HES with preventive physical exams (PPE) done by the physician - visits which can both be billed on the same day. The HES promoted these co-visits through outreach and education, since these concepts and types of visit were new to everyone. The patients spend the majority of about 45 minutes with the HES, and a few minutes with the provider for the PPE and any medication management issues. The HES works with the patients to develop a lifestyle intervention plan, and coordinates any follow-up visits with the provider. In persons with 2 or more chronic conditions, the HES is also eligible to do telephonic follow-up support.

Cone Family Medicine found that the breakeven workload for the HES was about 3 patients per day, but was capable of seeing 6-7 patients a day depending on the size and circumstances of the patients in the practice.

Source: Chambliss ML, Lineberry SN, Evans WM, Bibeau DL. Adding health educations specialists to your practice. Fam Pract Manag. 2014 Mar-Apr;21(2):10-15.
https://www.aafp.org/fpm/2014/0300/p10.html

Example 2: University of Pittsburgh Medical Center, Pittsburgh, PA

The University of Pittsburgh Medical Center (UPMC) used the lean six sigma management model to develop a quality improvement project to better support patient engagement and health behavior change. The lean six sigma protocol has 5 steps known as DMAIC: define, measure, analyze, intervene, and control. The research team worked through the DMAIC steps to solve the operational and technical challenges with the goal of streamlining the wellness process so that it could be implemented in other UPMC facilities and improve patient outcomes through better patient engagement and behavior change.

The outcome goals were to increase the tobacco cessation rate for patients wishing to quit smoking, and to achieve ≥5% weight loss in patients who were participating in weight management. Implementation of the behavioral interventions was done by practice-based care managers (PBCM), who were dual trained as health coaches to provide telephonic support to study participants. The process was facilitated by development of electronic medical record technology that facilitated the collaboration of PBMCs with physicians.

After the proof-of-concept phase, patients who participated in this program were compared to patients who received usual care in the pre-existing tobacco cessation and weight loss programs at UPMC. Success rates for smoking cessation were about double that of usual care, and weight loss rates were comparable.

Maners RJ, Bakow E, Parkinson MD, Fischer GS, Camp GR. UPMC prescription for wellness: a quality improvement case study for supporting patient engagement and health behavior change. Am J Med Quality 2017; 33(3):274-282. http://journals.sagepub.com/doi/full/10.1177/1062860617741670