CCHP
NCTRC Webinar: The Synergy Between Care Coordination and Telehealth
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Remote CART Captioning via Zoom

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>> MARY DEVANY: We'll give everybody just another minute to get everybody connected in to the session.

>> Recording in progress.

>> MARY DEVANY: Hello, everyone. My name is Mary. I welcome you to the latest presentation of the national consortium of telehealth resource centers webinar series.

These webinars are designed to provide timely information and demonstrations to support and guide the development of our telehealth program.

These webinars are presented on the 3rd Thursday of every month. Next slide.

As you can see, there are 14HRSA funded telehealth resource centers across the country. There are 12 regional centers which you see defined by the colors on the map.

And then there are two national centers. One that is focused on technology, the telehealth technology assessment center, and one on policy, the center for connected health policy.

These -- these are located throughout the country and each serves as focal points for advancing the effective use of telehealth and supporting access to telehealth services to rural and underserved communities.

A few tips before we get started. Your audio has been muted. Please use the Q&A function of Zoom -- of our Zoom platform to ask your questions.

The questions will be answered at the end of the presentation. I will -- will monitor as things go along and we'll make sure we get Faith those questions.

Today's webinar is being recorded and you will be able to access today's and past webinars on the national telehealth resource center's YouTube channel.

Today's webinar is hosted by GP track, and it is my pleasure to now introduce to you Faith Jones.

She is going to give us some wonderful information, and I'm excited to have her introduce herself and tell you a little bit about the organization and kick off the session. Thank you. Faith?

>> FAITH JONES: Thank you so much. Let me go ahead and get my screen shared for you and we can go ahead and get started. I appreciate that introduction.

So we are going to talk -- my name is Faith Jones, and I am the director of care coordination at health techS3. I work a lot with Lean. And likely as we figured out, this space is starting to encroach also into telehealth.

So being able to do a lot more things with telehealth and with remote physiological monitoring and all of those pieces.

Today, I'm going to talk about that intersection a little bit because sometimes, I think we are really good at healthcare about starting programs that are siloed and I'd like to help people to connect the dots, so to speak, so that we don't silo our programs and we look at the synergy that we can accomplish when we bring some of these programs together.

So I'm going to share a little bit of information and knowledge and experiences that I've had in some of these areas already.

So these are just today's objectives, just to kind of give you a quick look at them. I'm not going to actually go over them in detail but we're going to jump right into the session.

Okay, so first of all, what makes us healthy? What makes us healthy? Of course, it's important that we have access to healthcare.

And access to healthcare actually accounts for 10 percent, research shows, 10 percent of what makes us healthy.

But I will tell you that's where we spend the majority of our money. So we are looking at many of you enrolled, say it a couple of times, but many of you heard of the triple aim.

Better health for the population, better care for individuals and lower cost through improvements. These are the kind of programs we're going to be talking about with care coordination and with telehealth that really does target in on those improvements that actually do lower cost.

Because we're targeting particularly around telehealth, as you can see on our little man figure, the person figure over to the left, that really, what makes us healthy, at least half of it is our own health behaviors or lack of health behaviors. Those are the things that care coordinators can work with patients because these are long-term relationships that we get in to with patients and figuring those pieces out.

Just keep that in the forefront of our brain that we have destiny over or own health.

And as we're looking at care coordination in particular, everybody does care coordination.

I actually found a quote in a Florence Nightingale journal that actually did talk about care coordination. She didn't use those words but when I read it I laughed to myself and said we've been doing care coordination particularly in nursing since the beginning of nursing.

But one of the things that are different now is two things. Now, it's now a reimbursable model, so that's cool. But two, it's really putting in that structure to be incredibly proactive in our care coordination, and that is health promotion.

That is exactly what health promotion is. And keeping in mind that the health of a person is absolutely what they believe it is.

We can't tell somebody that -- what to believe around health.

We need to understand what it is they're beliefs are around health because that's the only way we're going to get them to focus on those healthy behaviors.

We can't just tell them what to do. That doesn't work.

And most importantly, we need to make sure we're engaging patients because you can know what? Our healthcare system is pretty siloed and it's very complicated and patients are getting information from all sources.

So having that care coordinator or that one person that they can count on that they can rely on, that they have that one touch point, that one contact point, is really key.

And that is typically being done now in primary care practices. I'm going to say typically because I'm going to talk about some other model said. But typically this is truly being done in primary care.

Because even when somebody sees two or three physicians they don't always know about each other. So sometimes, patients can get information that's actually conflicting, and they can get information from one specialist that maybe contradicts another specialist.

So having that single point of contact, that's what is important. So patients don't get confused if they get so many messages being thrown at them. What they tend to do is give up. Right? I don't know who to believe. Therefore, I'm not going to do anything different.

So that's the point. When we can have consistent messaging with patients we can engage patients. They want to be accountable for their care. They want to know what it is they're supposed to do. But they need to have that streamlined and not being told ten or 15 things all at once. None of us can do that.

I like to say multi-tasking is not our friend. Pick one thing and work on that. And once we got that as a good, solid habit, now you can do a second one. But don't tell someone to do ten things. That's where care coordination comes into play.

And typically, lots of people can be care coordinators. Okay? But typically, I do work a lot with registered nurses who are care coordinators. Why is that? Because they really do come with a skill set, the underlying knowledge to do care coordination because it is a standard. In the scopes and standards of practices for the nurse association, it is a standard of care, a standard of practice that we actually do care coordination.

And there was an outline of competencies that go around this. So these competencies, you can expect every RN, registered nurses to have.

I'm not going to read through all this but I want to point out the theme of all of these. One, organizing a plan. Organizing, that's key. We're going to talk about that in a minute. But also, it's that collaborating with the consumer, with the patient. Right? To help them.

We're not doing things to patients. Not doing things for patients. We truly are doing things with patients. So look at all this collaborative kinds of language. That's super important that we keep that in the forefront, that we're collaborating with them to help them manage their care.

We're actually looking out for the care that they have in their own self-care and helping them to achieve their goals. Right? Their referred goals. So it's really important that that's kind of what we're looking at.

And we want to make sure that we understand all of the options and all of the things that are out there around this.

So these are really important pieces, and I like to set that foundation as we kind of move forward.

When I talk about care coordination in general, I like to talk about it as the trifecta. Right? [Chuckling].

So we have three different aspects to care coordination, and these are all aspects that I use in care coordination because they're all reimbursable. They're all reimbursable, team-based care areas that has continued to develop. So these are acronyms. But we're talking about care management, the CM. AWV and advanced care planning.

So I want to -- that's a quick little, short piece. But here is a very busy slide.

I know it breaks all the rules for PowerPoint 101. But I do like to show it on purpose because this really gives you some context around care coordination and the growth and development of it.

And every single one of these modalities that I have are service lines. However you want to refer to them, that I have outlined here is reimbursable service. Here's some cool stuff. Starting with Medicare -- this is Medicare's growth and development. But let me tell you, more and more private insurance companies are following suit, if not all, but pieces and parts of some of these as well as there are nor and more state Medicaid programs that are starting to follow suit and do the same program.

The good news around that is when they're doing the program the same way, we can have one process.

And that's a really important piece because we want to make sure that we have one process that we can manage various kinds of patients in.

So it all started back in 2011.

Remember, I said care coordination's been around since flow, who has celebrated her 201st anniversary of her birth. I guess you can't say birthday when they're already deceased. But it's been around. But it has only become a care coordinated, reimbursable modalities starting 2011.

And CMS, centers for Medicare and Medicaid services has continued to expand. This 2013, this is a bunch of alphabet soup. I'll say the words for you, not that you need to remember them all. But in 2013, we did transitional care management.

That's the care management model of managing a patient 30 days post discharge. And then in 15, chronic care management.

That's my favorite. That really is a baseline program. We'll go into a little bit more detail on that one as we go forward. 2016, they took the modalities and actually made them reimbursable for health centers. And they also started paying for advanced care planning visits. And when I say paid for, I want to make this really clear. We're doing this under a team-based approach to care.

What does that mean? It means people in the practice other than the providers are doing these services, and they are getting billed under the practice billed under the provider.

So it's a really important piece. And you can see we started doing complex CCM and behavioral health integration in 17, followed suit in 18 with rural health clinic withes and federally qualified health centers. 2019 is when it first started on the -- the name was chronic care remote physiological monitoring or CCRPM.

And then in 2020, you can see we expanded some of those roles in addition to then putting in principal care management as a visible modality which is a care coordination model designed for specialty practices.

We'll talk mostly in the primary care world. But just to let you know, there is a specialty care practice model out there as well.

And then we added additional units to the CCRPM so that can be billed.

And then in 2021, added additional billing codes to some of the existing -- and this is where just this year, we changed the words from chronic care remote physiological monitoring to simply remote monitoring because people sent in their comments that you can do remote physiological monitoring for conditions other than chronic care. That's a quick run down of all of the modalities that are reimbursable through Medicare and some others, which is super exciting.

Why are we doing this and why do they keep growing? Programs and paying for more CPT codes and more modalities? Because it's working.

This comes out of the code of federal register in November of 2019 as they were publishing the final rules for 2020.

And at that time they actually had some amount of time, right? We talked about ACP went into effect in 2016. But TCM in 13, CCM in 14. So somewhere from three to six years. And they kind of looked at, over that course of time, how many people, how many Medicare patients have received this combination of services and what were the outcomes.

Well, 3 million unique beneficiaries, unique patients. That might sound like a lot of patients, and it is. But we still have a lot of growth because that only represents about 9 percent of the care fee for service population. But it's a good number to take a look at.

They studied them based on cohorts. They did a little bit of comparison. And they did see that it reduced readmission rates. It lowered mortality in this particular population. And it decreased healthcare costs.

So can you see the triple aim in that? Absolutely. It's working. That's why they keep expanding it.

Let me tell you a little bit about what it is. We'll talk about chronic care management. I'm not going to go into detail in all the programs. But I think it's important to understand the structure of this particular one because as I said, this is a really great foundational program to have in place.

And if you have this foundational program in place of all those other ones build on top of it.

I don't want us to thinking about a program here and a program over here and a program over here. I talked about us making sure we can truly connect the dots and that we can build one program where everyone knows what's going on.

And you're going to see how telehealth fits into that as well. Using HEMR. Electronically communicating with patients and care givers. Doesn't mean they're required to electronically commune can with them but you have to be able to electronically communicate with them and community resources and referrals, after hours coverage. That often trips people off.

Do I have to be on call? No. But many clinics in particular are attached to hospitals or at least affiliated with hospitals so it's really easy to come into some agreements as to who is going to answer the phone after hours if a patient wants to call after hours and talk to a person. Those an easy, easy things, not big hurdles.

Care planning. This is interesting because one, having access to the -- but doing care planning in ambulatory care in actual physician offices or in provider offices is not actually the norm. But when we do that with patients and we identify their goals and we work with them on their goals, that's how we see all of these great benefits that come along with that.

So they are the primary care provider's patient. CCM is typically a primary care provider. Service whereas PCM, principal care management is a specialty.

Medicare is where it started, as I said.

But see my little parentheses? Other insurances are also paying for it. So excited about that.

So we have -- patients with two or more chronic conditions that are expected to last 12 or more months, they're at some risk. Maybe up to and including death. That's all it takes. People ask me is the a magic list of all of those care coordination eligible diagnoses? No, there isn't. This is up to the provider.

Any condition that if you don't management it puts them at risking and expected to last 12 months or until the death of the patient. There is no magic list out there. So really exciting.

It does take patient consent. I often have people saying to me, oh, I wish we didn't have to get consent and that makes me go why? Why do you want to have to get consent? Because really, is the consent word scary? Just think about patient agreement. I -- you can't do care coordination behind their back. They have to be engaged.

It's all about that patient engagement that we talked about. It's an important piece that they have to want this service and they have to be engaged in it. And when it's presented to patients that way, they actually do quite well.

CCM initiated by the primary care provider. If you have a really great care coordinator in your office setting they can help if the patients that would qualify. But it is important that the primary care provider does inform the patient that they have these chronic conditions.

And there's time tracking. We'll talk more that more at the end. That's what makes this billable. We do this in billable months. And a month is considered qualified if you have more than 20 minutes of care coordination for that month. I wanted to go over that as a quick review.

Some of you on this webinar might not have understood those pieces.

So what's the purpose? What's the purpose of care coordination?

It really is about getting organized, as I talked about in the picture of all the papers getting thrown at the patient. And sure, care coordination you do have to track time. And lots of times where you're calling patients.

But it is way, way more than that.

So I want to make sure that we understand that proactive approach. And how do we determine what's important?

It's about what's important to the patient.

And what is right for this patient. Absolutely care coordination is a patient-centered -- absolutely patient-centered care. They are at the center of everything we do.

And this is one of the definitions that comes out of the institute of medicine. An older definition but still tried and true definition around patient centered care. What I like about this definition is really talked about ensuring that the patient's values guide all clinical decisions.

So how do we ensure that the patient's value guide all clinical decisions? We have to ask them, what are their values? What's important to them. What is it that they want to be working on.

That's the part that I think is really key.

I have another really important piece that I like to point out there. One of the research pieces has shown that care coordination really is helping to prevent burn out.

And you're like what? Yes, we all know that marly in our primary care providers, burn out is a huge, huge concern.

And so using the team based approach to care and actually having lots of people participate in that care and putting that together as a team, that is really an area where we can prevent burn out. So I can give you a reference to an article here that really talks about this. And again it talks about extending the role of nurses and other clinical staff to perform at the highest level of their training and their education.

And we already know that it's a standard for registered nurses to do care coordination, let them practice at that level, and get reimbursed for it as a practice. So that's kind of what we're talking about.

Okay. So what do we like to start with care coordination? We want to start with research. Right? So what's the purpose of the visit? Why were they here? Review those last notes. When is the next visit scheduled. Review any labs, lab reports. Did we request a consult? Do we have that report? What's going on?

As we're getting ready to set somebody up for a particular visit it's always a great idea to call the patient. If they're part of your care coordination program you can track time for this. But call the patient and ask them what are their expectations at this appointment?

Sometimes, they're, like, I don't know. I was just told to come back. I have no idea what they're going to do. Okay. So we need to set the stage so that people understand what's the expectation.

And if we're not providing people with some information so that they can set their own expectations and then communicate them -- because uncommunicated expectations is a really huge issue. That's where we get lots of dissatisfaction. So it's really important that we understand what the patient's expectations are of a visit, of any visit. So we need to figure that out.

So when we're making these follow-up appointments and we're calling and we're figuring these pieces out, and we understand what's the plan? What's the plan of that appointment, this is where a care coordinator can have that very first, huh, is this appointment be an appointment that we do by telehealth?

Based on what we're going to do at the appointment, what the patient's expectations of that appointment this might be a great appointment to start with with telehealth.

As we know, telehealth has gained lots of attention and lots of people like it because -- but in some ways they were forced to have a telehealth visit or no visit during the pandemic.

But we can capitalize on that in some ways. We can really kind of optimize that.

And in the future, maybe somebody who hasn't had a telehealth visit yet, this is a great way for us to start introducing telehealth visits and working with patients. Our care coordinators have relationships with these patients.

If you have a care coordination program in place in your clinic this is how you can start going down that road.

So maybe you've identified at this particular visit, hey, this would be a great visit for us to do by telehealth, Mrs. Jones. Can we set a telehealth visit versus you having to come in to the clinic

or drive an hour? Or you got to know about your patients. So all of these kinds of things. And that may be great.

So let's assume that your patient has said yes, we want a telehealth visit and that's great. And we're going to be talking a little bit about technology.

So right now, we're going to be a little bit under the premise that we're doing these telehealth with the patient at home.

The originating site being the patient's home.

So keep this in mind that during the pandemic, that is an absolutely approved, originating site is for the patient to be at home.

Currently, once the public health emergency is truly, quote-unquote, over, if nothing else changes, then we go back to the originating site of the patient's home is not considered appropriate. But we're going to talk at the end.

There's lots of legislation out there and I have every faith that something will be passed to maintain the patient's home being an originating site into the future.

But that's kind of what we're working with as we go forward here.

It all starts with connections. You can't do telehealth without connections. So we definitely want to make sure we're looking at does the patient have Wi-Fi? Are we using cellular service? Do we need to use a hot spot? So connection is huge.

And then lights, camera, action, as they say.

We'll need to be looking at do they have a camera? Do they have a camera on their web -- whatever they're going to be using, whether it's a laptop or a smart phone or a tablet or whatever that is.

Or are you provider that? So that's another thing to be thinking about. Right? What is that piece of technology? Where is it coming from? And doing those sound checks. So do they have speakers? Are they loud enough? Are they going to be able to hear them? Do they know where the volume is? Do they have a microphone. Never people have never really talked into a computer until recently, I guess you can say. And they just assume oh, I can have speakers so I can hear people so they might be able to hear me. We got to double check. Let's make sure there really is a microphone and does it come across nice and clearly? There are privacy issues maybe. Maybe a headset would be better if they live in a house with lots of people and they don't want to have everybody hear what it is the provider is saying to do them.

Maybe a headset is more appropriate. So making sure we've double checked all these things. Make no assumptions.

But at the same time, I don't want you to make an assumption that just because they're older they can't do telehealth.

Grandmas and great grandmas are a fast growing demographic on Facebook. Please don't count them out. We want to make sure they have all of these things. Don't make assumptions.

Pulling it all together. Does your patient have everything they need for a successful telehealth visit? Maybe the answer is yes. That's awesome, you're ready to go. But would this patient -- maybe they've never done one before. Maybe haven't done much with technology. That makes them anxious all by itself let alone the visit.

Would the patient be better served if they had somebody in the home during the visit or helping them? Maybe the answer to that is yes but you're thinking who would that be? Who could that person be?

Well, care coordination model there's lots of creative model said out there and the key to success is to be creative and also to be looking at your patient population and figuring out what that means for your patient population.

So one of the care coordination models that's out there is obviously just having one RN, whatever, care coordinator, and that's it. Yes, that care coordinator can go out and make a home visit. They can get things settled and help people get connected. Make sure everything is cool with that.

Or you can have care coordination teams. I work with several clinics who use this methodology where they partner with either community paramedics or community health workers around the country. Community paramedic programs have been pretty successful. But one of the issues that has kind of blocked some of them is there's really no fundic for them.

So many of them were successful because they were getting grant money and they've done lots of things the community. But when the money goes away, they can't maintain the program.

We've been able to be successful with some of our care coordination programs by bringing these particular programs in under the clinic and using them to assist in tracking time and doing those kinds of things in to the care coordination program which is a billable modality.

So be thinking about that if you're in an area where well, we had as community health program. The grant ran out. Can't do it anymore. But man, it was helpful when we had it. This is a way to bring it back in a sustainable way. Maybe it's a partnership. They're doing that on their own and having that kind of happen.

Remember, you may be thinking a home visit? Can we bill for that? The answer is no. You're not billing for a home visit. But what you're doing is you're tracking time. Remember I said all care coordination modalities happen under this time tracking?

So absolutely, you track time traditionally when you're calling the patient, take talking to the patient. When you're researching would this be a good visit for telehealth, all of that, time trackable. All of those chart research. Because sometimes, we forget the regulations say time spent with or on behalf of the patient.

We oftentimes forget about all of this behind the scenes stuff we do for the patient.

Assessing and scheduling that appointment, the conversation about what you expect out of the visit, this would be a great telehealth visit, what do you think, that's all time trackable.

Driving to the patient's home and being able to set up that telehealth piece, that's all time trackable as we're setting up the telehealth.

I also want to point out here, as we do more and more remote physiologic monitoring, so RPM, that remote physiological monitoring is a care coordination modality but it also falls under that telehealth world.

This is a place where we start to share that connection which is also super exciting because remote physiological monitoring is done in a time tracking way, usually with a care coordinator in the clinic.

When you have those people that can go out, set these systems up so that patients can take that blood pressure every day, it automatically connects, not fumbling with the technology we can get that blood pressure reading, the weight reading every single day in the office on our website that we have connected with for those devices, that is really key.

And patients will be way more compliant in doing those things if they're not frustrated with the technology.

So that's another area where care coordination and telehealth really do intersect.

And that's another reason why if you have, for example, community health workers or community paramedics or even your care coordinators going to the home and troubleshooting all of those, that's time trackable.

So I want to make sure that we understand that.

So now you have this patient who has decided they're going to have a great telehealth visit. You got somebody out in the home. You really need to manage expectations.

Managing expectations is key.

When they come in to the office, they are seeing a whole waiting room full of people. They're not seeing that in the telehealth world so they may think you have all the time in the world.

So another key factor to having that community health worker, paramedic or the care coordinator, being dur during the appointment is helpful.

They're a part of the appointment and listening. Maybe not. Maybe just for tech support. And making sure that afterwards there's some time to discuss what was said at the appointment or next steps or what needs to happen next because if you don't do that, we don't keep them on track, you're going to mess up quite frankly, the schedule that is back at the office.

And it's really important that we treat the telehealth visit just like we treat the in-person visit. So it needs to be managed on that provider's schedule.

So it's important that you're making sure that, hey, maybe you have somebody back at the office that you can text to say, we're set, we're ready. Are you on time? What time are you

logging in, those kinds of things so that you have those pieces that are ready to go, letting you -- giving you information when you're in the office.

You can look around and know whether or not the provider is on time. You know whether or not there's something crazy going on.

You don't know that, right? You want to make sure that you have that connection when you're out in the home so that you can keep that going with that patient.

And so making sure -- because if we can make sure we keep things on track for patients and we meet patients and we meet providers' expectations and their satisfaction with the system, as that goes up, we are getting rid of those frustrations and though inefficiencies with the technology or any of those pieces as those decrease, we truly have a telehealth visit that looks exactly like it would have looked when they were in the office.

So that's really our key. We really want to make sure we're doing the best piece.

So you might be thinking to yourself, man, who has time for all this? Well, that's why care coordinators and practices, this is another duty as assigned, they're actually hired care coordinator. This is their job. They actually have the time to plan.

They're tracking all that time. That's how it gets reimbursed. That's a really big deal.

So it is an important piece to make sure that as you're doing care coordination, particularly as you're bringing in telehealth and you're making those kind of work together, that we have this particular person who it is their job to make sure this happens.

So I'm going to run through right now a couple of, oh, pretty quickly. I'm not going to go through them in detail, but some of the reimbursement models.

This is for 2021. These are the national averages, the fee schedule that anyone can go and pull them down yourself. This is what Medicare is reimbursing.

Medicare sets that reimbursement average and then there's up and down on that based on things in your region. Right?

So keeping that in mind.

But with these CPT codes, we talk about care coordination, No. 1 being the annual wellness visit which is that health promotion visit. Your care coordinator can do that. And guess what?

This has always been a telehealth service since it started being a service. It got on the telehealth approved list pretty quickly. Advanced care planning definitely got put on the list within a year.

These are telehealth services that once you get your patients set up and doing well with technology, maybe you don't have to go to the home anymore, and maybe they're so good at it, they're, like, yup, I'm going to do this by telehealth. You could be at the office, they could be at home. Life would be great. You can see the reimbursements are really good in those areas.

And then CCM or chronic care management, that's the one we've been talking about kind of in detail as I like to talk about that foundational kind of program. This is where you are tracking time.

And you can have those partners tracking time with you, working with all of those pieces online so for the first 20 minutes, it's reimbursed at $38.89 for the month. You wait until the end of the month and you say, how much time did I spend? I you get to bill that. If you spent 40 minutes you get to bill one 38.89's and then one of the 35.65's. If you spent an hour, you can do one and then two. It doesn't matter if you spent more time on that on general care coordination. There's a max.

There's something called complex chronic care management which gets you higher reimbursement and gets you more time.

And that is when we have medical decision-making. Your patient's super complex and you're doing some of the pieces along with that.

But that happens in about 10 percent of our population in any given month has been my experience for most of the people I work with.

So you can see there's some reimbursement there. And you might be thinking wow that's a lot of work for $38. Hold that thought.

I know we didn't talk about behavioral health but these are also the same kinds of modalities I just wanted to show you this. If patients meet these criteria they can have all of these service lines. One or two or three, or whatever it is.

We took talk about the remote physiologic coordination. It uses technology which makes it cross that bridge between telehealth and care coordination. So if you can't double dip you can only count your minutes in one place or the other, but you can have a CCM patient you you're doing major care coordination on. We would be well served if we could monitor your blood pressure or weight for a few months.

You get them set up on remote physiologic monitoring. These are other modalities that go along with that. They likely won't be on it for life. But the goal really is that they are CCM for life.

You can see how we can go back ask forth and utilize our services along these areas.

And so you can see that 20 minutes or more the reimbursement for that, and additional 20 minutes, there's a reimbursement for that. Set up in education, there's reimbursement for that.

And then you can also get reimbursed for every month that they are using your device.

Here's the caveat. Provided they use the device for at least 16 days in that month. And why is that important? Because sometimes, people forget that's why putting it in that care coordination model and making sure they're not frustrated with the technology and that you've had people out there and troubleshooting and making sure that the equipment works and took away all those frustrations, that's when you're going to get compliance because if they only took their blood pressure 12 or 14 times.

Then you can't bill for the device even though the device was in their house the whole time. 16 days or more for chronic conditions.

And then of course looking at if you are a rural health clinic, it's all the same processes, but you do get reimbursed differently and you have different codes. So I wanted to throw those out there.

O cay. I started with this trifecta. So putting this together for doing an annual wellness visit on someone once a year, spending 30 minutes which often times it's more than that but I'm ballparking it and just a CCM program. We haven't introduced any of the ort programs. Just CCM for the most part and we're doing that billing over 12 months. Some of those months might be complex. They may have additional factors other times. So that's how I come up with $600 is what that one patient brings to your practice over the course of a year.

Again you might be thinking $600 over the course of a year? Is that worth it? Let me tell you when it becomes worth it.

Because that is about $800 per patient and we have find from the productivity side of the world using an RN communication working combo, you can manage 300 patients. That brings $244,000 to your practice. Is it worth it? Absolutely, it's worth it.

I sometimes have people say to me where can't afford to hire an RN in my practice. Well you saw that arrow in the beginning and you saw how many programs just keep adding and adding and adding and growing in the health promotion world.

That's where it's going. Add on top of that the telehealth components and all of those resources. I'm here to tell you that you can afford not to hire a care coordinator. And finding one who has some savvy in the tech world because it is going to be the wave of the future and it is already here. The future is now. So that is exactly where we're going as we move forward now.

So I did want to remember at the beginning I talked a little bit about the fact that we have legislation that's out there.

There's a few pieces of legislation that's out there. I just -- I'm highlighting this piece of legislation just to have you be aware of it.

I don't know if any of you follow legislation closely. I do. It's kind of my world.

I do a lot of these pieces.

So this is a great site. Maybe you know about it already. Maybe you don't. But it's just Congress.gov. And I put the actual link at the bottom of the slides which yes, you'll have access to the slides. That's always a question we get. So I picked this one out. And it is the connect for health act of 2021. And of course, connect is an acronym, which don't you love that? So it is that entire piece where we talk about connecting people and using technology.

Actually, the T stands for technology and not for telehealth, believe it or not. So it is a broader bill.

But in this bill, you can look it up for yourself, read all the language that's in there.

It has garnered quite a bit of bipartisan support which is another reason why I highlighted this particular bill.

You can see if -- when you go online how many Republicans have cosponsored, how many democrats have co-sponsored it. It's straight across the board so far.

They're getting more and more co-sponsors. It has been introduced. Hasn't gone further than that yet. But it's looking like it's something that will be going forward.

Three main things are a part of this particular piece of legislation and that is having the home of the patient be the originating site.

Those of you from an rural health clinic during the pandemic, public health emergency you are allowed to be a distance site provider, meaning you can do telehealth from your office with the patient at home.

This actually solidifies that. This piece of legislation actually solidifies that into the future even after the PHE which is going to be super helpful, especially in our rural community.

I personally live in a rural community so super helpful in our rural communities as well.

And then the third piece is it takes away those -- the geographic restrictions. It does a lot of other pieces, but those are the three pieces that from a care coordination and telehealth synergy and bringing these pieces together, those are going to be key areas for us as we move forward.

So I wanted to share this piece of legislation with you just so you knew it was out there, just to be informed so that you know it's out there so you can see other pieces.

Now, I've heard of other pieces of legislation that other people are looking at doing and moving forward. But this is the one that I think so far from what I could research, was the furthest down the path. Let's put it that way. So I just wanted to share that with you as well.

Okay. So this is me. And so again, there's my phone number, cell phone. It's a cell phone so you can call or text. Leave a message if you do call because I don't always have time to answer at the moment. And sometimes if I don't know the number I'll let it go to voice mail first. I know you probably do that too because I don't need more warranty information. I don't know about you.

That's one of the things out there. This is also my email address, faith.jones@healthtechS3.com. If you have questions about care coordination in general or about how you can implement care coordination and telehealth, I'd love to reach out to you.

I have been in this world for quite some time.

So with that, I'm going to stop sharing my slides, and we can move to any questions.

>> MARY DEVANY: And there are a couple of questions that have come across, Faith. First of all, thank you. Wonderful presentation. Very engaging, and I appreciate all the knowledge that you shared.

I love the -- I appreciate the idea of being creative and understanding that it may take a little bit of a different thought, different mindset than maybe what we may have had in the past.

So the first question is, you know, are there restrictions on eligible providers to be able to bill for these services?

>> FAITH JONES: I think I know the answer to this question. I mean, I think I know the question. The restriction on eligible providers, yes.

So you must -- the restriction is, you must actually be someone who can bill Medicare in an office setting. So we're talking about physicians.

So this is the part of the physician fee schedule. Okay? So keep that in mind. The physician fee schedule.

These aren't hospitals. We're not at an inpatient setting. Not even an outpatient setting of a hospital. We are focusing on that clinic setting.

We're talking about physicians, nurse practitioners, clinical nurse specialists, certified nurse midwives and PAs.

Those are kind of the main billing specialists. So I actually had somebody ask me whether or not a podiatrist can do this under PCM. What a great question because how incredibly great that would be. But the answer is no because they do not fall into the category of being a physician.

Remember, these are all services that typically an RN is doing in the clinic but it doesn't get billed under the RN. It gets billed under the primary care provider of that patient.

That's why that general supervision, yes they need to tell the patient, they need to do those kinds of things.

And I saw occupational therapist and physical therapist -- not for -- you can bill for telehealth at the moment as you know, but not for chronic care management. It's really -- even any of the principal care management is really that provider modality because you really are looking at all of the medical care for that patient and figuring that out and bringing all those pieces together.

But hopefully, a good care coordinator would know that you as a physical or occupational therapist does telehealth and can engage you in a telehealth where they from the primary care side actually sets it up. Great partnership, lots of ways to be creative.

But care coordinator is not available for people outside of providers.

>> MARY DEVANY: And I think this -- this kind of stays with the same theme. Can an LPN serve and be billable?

>> FAITH JONES: Yes, they can serve as a care coordinator in an office. But here's where you need to be careful.

You need to be looking at your scope of practice in your state. In many states, not all -- so that's why you need to look-in many states, LPN's are not allowed to initiate a plan of care.

And do be a -- to do CCM, it's important that you initiate that plan of care with the patient. That's important. What is the patient's goals? What does the care plan look like? If in your state your scope of practice says you can contribute to the plan of care, you can gather information for the plan of care but you may not create, independently create a plan of care, then you are going to need to have an RN or the provider create that plan of care and then can you manage the stuff after that? Absolutely.

But do not work outside of your scope of practice. And the care planning piece is the piece that gets a lot of LPNs a little stuck. So that's -- but you can do it. Be creative. You can find other people to help you with that actually developing the plan of care with the patient. And then yes, you can absolutely contribute and do some of that care coordination. Hopefully, that's helpful.

>> MARY DEVANY: Another question here. Do you have to have a formal CCM program established to bill for time on a monthly basis? Or can you literally just submit the CPT codes of course with documentation of time, and get reimbursed by Medicare for this work by a billable provider?

>> FAITH JONES: If you are doing all those elements, you have a formalized program. There's no such thing as a certified program or anything along those lines. You can start your own program. Absolutely. You just start your program. So that means you need to make sure you have a consent that meets all the regulations of that and the patient agrees to the program, that you do a care plan, and that you have that, that you have a way to track time and that you understand what you're doing with all of these pieces, that you're being proactive and you're working --

Once you get all that going, yeah, you just submit on a bill at the end of the month.

You look at all your documentation. There's no such thing as a certified program or anything along those lines. You just want to make sure that you have met all the regulations, billing that CPT code says hey Medicare, I have a consent, the patient is an established patient of ours, that this provider is seeing this patient. It's an established patient.

I've spent the time. I have a care plan. And the patient has a copy of their care plan and this is what we're doing.

I have a way to electronically communicate with patients if they choose to. I have a way to electronically communicate with community resources if they choose to.

When you use that CPT code you are committing that yes, I meet all those elements. And that's all it takes.

>> MARY DEVANY: Wonderful. Wonderful. So how do you see the emerging CMS hospital-at-home program fitting in with the RPM telehealth program?

>> FAITH JONES: I actually have only read the cursory stuff around that. So I -- I'm not probably good at being able to answer that. But let me tell you one piece that I can answer is anything you're doing with Medicare, if Medicare believes -- if they are and they believe -- that they are paying for a block of time, then you can't track time during that same time. Okay?

I know that probably sounded confusing.

For example, if you have a CCM program in your office and the patient comes in for an office visit, during the time of that office visit you're billing for the office visit. You can't track time as care coordination because you're not doing care coordination. You're providing an office visit. So depending -- I don't know all the rules yet and where it's going to go.

But depending on how this hospital-at-home piece is getting paid for, if Medicare believes they're paying for the full 24 hours, you certainly can help and you can do all those pieces, but you won't be able to track time during that same time.

And bill for that separately, just like even if you have a CCM patient in your practice, they get hospitalized, sure, you can check on them while they're in the hospital, but you can't track time while they're hospitalized because Medicare is paying for 24 hours of that time.

So it's really going to have to be a wait and see in my mind until these regulations are final eased and we determine -- and Medicare says out loud we're paying for this service for this patient to be at home.

We believe we're paying for a 24-hour service.

So if they're paying for a 24-hour service, you won't be able to track time.

So that's -- and that's all I know right now. I don't know all the details about it. So that's what we'll have to be watching for in our regulations.

>> MARY DEVANY: Wonderful. So I think this is something I think you mentioned earlier on, and I think somebody is looking for some clarification. What is a green belt in healthcare?

>> FAITH JONES: Yeah. So that is Lean. So I do lean training and I teach Lean. And Lean is an improvement methodology for quality improvement, and there are white, yellow, green and black belts in lean. And it goes along with being a novice, white belt. Yellow belt is competent lean. And green belt is proficient and black belt is expert. I have not finished all of my work yet to be a black belt although I'm in the process and will probably have that done soon. But I am a green belt meaning I am proficient and can teach lean trainings. Yeah, great question. Thanks.

>> MARY DEVANY: Great. Couple other questions here. I'm just checking time here to see where we are.

So this also -- these two questions kind of are also around the billing side of it, as often is the question. Can a podiatrist bill for a remote physiologic management. Evidently there are special insoles that upload to a platform, different pressure changes, temperature changes, compliance and activity. Would that be billable as remote physiologic monitoring or management?

>> FAITH JONES: That is a great question that I have to tell you I have not looked up. I'm really sorry that I have not looked that piece up. But that would beef something we'd need to double check in the regulations.

They say provider in the regulation. And so my guess -- off the top of my cuff guess, it's a solid maybe. Sorry. [Chuckling].

I don't know that piece. I really only did the research on CCM and PCM because those have been pieces that have come to me quite often.

But not the are emote physiologic monitoring. Yeah, sorry.

>> MARY DEVANY: No, there's always some that are -- don't know.

>> FAITH JONES: I don't know that one.

>> MARY DEVANY: Yes. The other question we have here is if you think more of the perspective of behavioral management, can a therapist serve as a CCM? What about a licensed social worker who are independent practitioners?

>> FAITH JONES: So from a behavioral health integration piece, the answer -- the quick answer to that is no. So as a licensed clinical social worker, you can bill for visits, absolutely. And so it's great, you know, to have part of your practice, right, working with care coordinators in primary care.

But remember, it's not always, but the intent is that behavioral health integration really is from that primary care mode so that that care coordinator can make sure that -- and now we have integrated behavioral health and behavioral health integration are not the same thing.

So they are two different things. Integrated behavioral health is where you have your licensed clinical social workers, clinical psychologist in the actual practice of a primary care practice which is of course where would be perfect in all worlds and we're not lucky to have those resources.

But when you have that, it's your primary care is billing the BHI care coordination, and that care coordinator is working with the licensed clinical social worker to make sure the patient gets to their appointment, is following up and following through and doing time tracking.

But when they come to the appointment you get to bill for the appointment. So the good news about working with care coordinator as a licensed clinical social worker, I know mane tend to do all their own double checking. Are you coming to their appointment to keep people on track.

You can give all that then to a care coordinator on primary care and say keep this person on track for me and you can spend more time doing more and more billable visits.

But you can't bill under your number, you can't bill BHI, the 99484 which is the CPT code for that.

>> MARY DEVANY: Great. Thank you. Well, looks like we covered all of the questions. And we are at that time to wrap up. Faith, thank you so very, very much for your information today.

I think we are going to see more and more of this integration and synergy around telehealth and CCM I think is just going to continue to grow and grow as a component of what we do.

So thank you for sharing your knowledge and your experience with that.

Just a reminder that our next -- or next webinar series is going to be on July 15th, and it's going to be hosted by the California telehealth resource center. So the topic will be shared here

shortly.  You'll be getting additional information coming up.  But just know that it is coming and that we are glad that you joined us.  Next slide.

And also, please, this is really important for us.  Your opinion about this -- this webinar and the webinar series in general is really important to us.  So please take a few minutes.  That's all it would take is just a couple minutes to give your evaluation, share your comments on the webinar.  It's extremely helpful to us, and we do greatly appreciate that.

Next slide.

And that is the end of the slides.  So thank you all for coming today.  Please, join us again next time for the next -- the next webinar with the national consortium of telehealth resource centers.

And Faith, thank you very much.

>> FAITH JONES:  You're welcome.  Thank you so much.  Buh-bye.

[End of event].