Better Choices, Better Health® South Dakota Referrals Model Policy

Rationale

A Chronic Disease Self-Management Program (CDSMP) is an evidenced-based, community-led intervention that helps individuals with chronic conditions learn to manage and improve their health. Workshop participants focus on challenges that are common to individuals living with any physical and mental health condition(s). Sessions are co-led by two Stanford University trained lay leaders, who typically have chronic conditions themselves.

Workshops are highly participative; with the mutual success and support participants receive, they gain confidence in their ability to manage their health and maintain active, fulfilling lives. Self-management skills covered in the curriculum include goal setting, problem solving, relaxation/stress management, fitness/exercise, eating well, appropriate use of medications, and others.[1]

CDSMP and Patient Education: What is the Difference?

Similarly, CDSMP and patient education both focus on behavior change of the person to support better health outcomes. CDSMP, not disease or condition specific, is offered in a group setting and is usually peer led. The program premise is to empower participants to take charge of their life, focus on increasing self-efficacy, and support problem solving and decision making while building skills to manage quality of life.

In contrast, patient education classes provide information to increase knowledge on a specific disease. The setting is lecture based and participants are expected to take the information learned and apply it to their specific chronic disease (i.e. diabetes, arthritis, hypertension). The classes may involve some technical learning (i.e. self-checking of blood sugar and blood pressure levels); it is taught by healthcare professionals and supports specific expectations such as lowering blood sugar or blood pressure numbers.

CDSMP workshops will not conflict with existing patient education programs or treatment. CDSMP is designed to enhance regular treatment and disease-specific education, such as Better Breathers, cardiac rehabilitation or diabetes prevention and self-management.

Why Chronic Disease Self-Management?

Chronic disease self-management skills and strategies can positively impact many South Dakotans and lessen the disparity in prevalence of chronic disease and related risk factors. In South Dakota (SD), the leading causes of death for adults are chronic diseases (i.e. heart disease, cancer, cerebrovascular diseases, chronic lower respiratory disease, and diabetes mellitus). Chronic diseases and related risk factors impact racial/ethnic groups in the state differently. In SD, eight and a half percent (8.5%) of white adults are diabetic. Nearly twice as many (15.6%) American Indians have diabetes.[2] Likewise, risk factors for chronic disease – including obesity and tobacco

consumption – disproportionately impact American Indians. According to 2015 data in SD, 29.1% of whites and 35.1% of American Indians in SD are obese.[3]

A 2016 report by Trust for America's Health states that one in three children will develop type 2 diabetes in their lifetime, and one in four young adults are not healthy enough to join the military. An investment of $10 per person in proven, evidence-based community prevention programs (i.e. increase physical activity, improve nutrition, and reduce tobacco use) could save the country more than $16 billion annually – a $5.60 to $1 return.[4]

Why Are Provider Referrals Important?
Many patients want and expect their providers to talk to them about their health status, including chronic disease education. Most patients are open to their providers' advice. Studies show that successful participation in CDSMP is linked to a provider referral. In fact, several of the most highly attended Better Choices, Better Health® (BCBH) South Dakota workshops were where the participants were prompted by a patient portal notification or provider-generated letter. Healthcare providers have the skills to assess chronic conditions, educate on their adverse health effects over time, develop trust and rapport with patients, and sustain follow-up with patients.

Implementing a referral policy provides the capacity to not only identify patients who have a chronic condition, but remind providers to refer these patients to CDSMP. BCBH is the name of the CDSMP program in SD. This referral process increases the likelihood that healthcare providers will consistently assess patient's chronic disease(s) and advise and/or refer these patients to community resources such as BCBH.

According to the Centers for Medicare & Medicaid Services CMS data from 2011, 28% of Medicare beneficiaries have a diagnosis of diabetes, yet the American Association of Diabetes Educators (AADE) estimates that only 1.5% of eligible Medicare beneficiaries have used their Diabetes Self-Management Benefit.[5] In a pre-survey of BCBH program participants, when asked what type of health insurance they have, 57% indicate Medicare.

Participants may select more than one option*:

Health Insurance	Number of Participants
Medicare	211
Medicaid	41
Veterans benefits	18
Private insurance (employer or purchased)	147
Other	45
None	10

*Data from 367 BCBH participants (August 2015 – August 2016).

Overall, chronic disease decreases quality of life, has a negative economic impact, and increases the need for health care services. SD's aging population also contributes to this chronic disease problem. In 2013, approximately 15% of the SD population was 65 years or older, with another 26% between 45-64 years.[6] In 2013,

84.3% of the population older than 50 had at least one chronic condition.[7] Providers need to show continued support and encouragement for all adults to utilize Better Choices, Better Health® SD as a proven option for better health outcomes which align with the Triple Aim goals for healthcare systems.[8]

An official referral is not required for participants to attend a BCBH workshop, but research shows that a recommendation from a healthcare provider may be the most influential factor on whether people attend a self-management education (SME) workshop. An abstract presented at an American College of Rheumatology meeting found that people who received a provider recommendation were almost 28 times more likely to attend a SME course than those that did not.[9] A referral may also come from those who work closely with patients and clients in other dimensions of their health management such as health coach, public health nurse, pharmacist, physical therapist, occupational therapist, speech therapist, social worker, or faith community nurse. A participant may also self-refer because they have an interest in learning skills to help them gain the confidence they need to better manage their health and increase their quality of life.

Policy Guidelines

These guidelines were created to assist all healthcare professionals (i.e. physicians, social workers, nurses, etc.) to embed a referral process within their organization for patients and/or clients who might benefit from attending a BCBH workshop. This policy can be used as a tool for healthcare providers, partners, and collaborators to establish systems change and implement chronic disease self-management into routine clinical care, community-based prevention, and health promotion models.

These guidelines focus on three aspects of systems change:

1. Healthcare provider reminder systems (Electronic Health Record prompts)
2. Provider education
3. Patient education

The first step to creating a healthcare facility that supports chronic disease self-management for all patients who need it is to utilize this model policy in its entirety or adapt the policy. A self-management referral policy can include a few or all of the major components listed below:

1. Given indisputable research and evidence that self-management helps individuals with chronic conditions learn how to manage and improve their health, it is our responsibility as healthcare professionals at [Organization] to address the devastating consequences of chronic diseases and help our patients/clients manage these diseases.
2. [Organization] is committed to providing its healthcare providers, nurses, therapists, and other staff with evidence-based and practical information that they need to successfully integrate self-management referral activities into their practices.
3. [Organization's] leadership endorses the referral process to Better Choices, Better Health® SD.

4. [Organization] will assemble a multidisciplinary team to promote, implement, and evaluate the program.
5. [Organization] will identify a "Provider Champion" to lead the effort.
6. [Organization] will conduct an assessment of existing chronic disease programs and services to determine what is available and any barriers that might prevent effective implementation.
7. [Organization] will set measurable referral policy implementation goals.
8. [Organization] will establish quality improvement measures to support and meet the implementation goals.
9. [Organization] will designate a department or individuals responsible for consults and referrals for patients with chronic conditions.
10. [Organization] will assess the current Electronic Health Record system and modify as needed to effectively document BCBH referrals and interventions.
11. [Organization] will customize their Electronic Health Record to include mandatory fields related to chronic disease with automated prompts and drop-down lists.
12. [Organization] will provide staff training and technical assistance to develop systems for referral, follow-up, and billing with clients.
13. [Organization] will evaluate the impact of BCBH workshops for their patients/clients.
14. [Organization] will identify staff to be trained as lay leaders to lead BCBH workshops.
15. [Organization] will maintain engagement of patients, clients, and stakeholders.
16. [Organization] will provide patient education materials, resources, and referral forms for BCBH.
17. [Organization] will provide meeting space for BCBH sessions.
18. [Organization] will complete health behavior and assessment interventions with patients and seek reimbursement for these services.
19. [Organization] will promote BCBH workshops for their patients.
20. [Organization] will include the BCBH website and logo on social media venues.
21. [Organization] will collaborate with BCBH staff to provide bidirectional information with providers.

Implementation

The following section includes recommendations and best practices for implementation. Training and support services are available from BCBH staff to assist organizations with implementation. Contact 1.888.484.3800 or betterchoicesbetterhealth@sdstate.edu.

Electronic Health Record

The Electronic Health Record (EHR) can be used to identify patients who may be eligible for BCBH. Provider reminders can be generated in the EHR such as:

1. Setting up diagnosis codes (new or existing conditions) that will cue a BCBH referral.
2. Utilizing a retrospective approach to conduct an EHR query using the following criteria:
    - Age 18 years or older
    - Diagnosis of chronic disease(s) or conditions including, but not limited to: cancer, diabetes, pain, anxiety, obesity, hypertension, COPD, depression, stroke, arthritis

   From this queried report, generate a list of potential eligible participants. Use the list to contact patients to inform them about the program, why they are eligible, and how to enroll in a workshop.
3. Utilizing BCBH scripted language when making contact with the patient. This assures messaging is consistent.[10]
4. Flagging the EHR to remind healthcare staff to follow up with the patient about the referral at the next visit or other appropriate point of contact.

Patient Portal Systems

Utilize patient portal systems to communicate upcoming BCBH workshops to patients, including a link to register. Patients who have registered in the portal can be invited to sign up for BCBH. Be cognizant of HIPAA compliance. The email must be generalized enough to avoid divulging any disease-specific or other medical information to the reader in the event the inbox recipient is not the intended party. Cast a wide net and send a general message such as, "Dear Mr. Smith, you may be interested to learn more about the Better Choices, Better Health® program." Also be sure to encourage the reader to share the program information with family and friends.

Utilize patient email notification systems to send messages, reminders, and appropriate information about managing chronic diseases and attending BCBH workshops. This should be a secure email if sent to a specific patient for a specific diagnosis.

BCBH Promotional Materials

Order materials to distribute to your patients/clients from the BCBH website: http://goodandhealthysd.org/communities/betterchoicesbetterhealth/resources/.
Available materials include:

- Prescription pads
- Rack Cards
- Infographics
- Health system specific information sheet

BCBH Referral Process

Contact the Better Choices, Better Health® SD program via email at betterchoices.betterhealth@sdstate.edu if you are interested in referring your patients.

Sample Workflows
Additional workflows can be provided by BCBH staff upon request.

Compliance

Healthcare organizations are looking for programs that meet the Triple Aim[8] goals of better health, better care, and lower healthcare costs. By utilizing the Stanford CDSME model, it is anticipated that participants who complete a BCBH workshop will experience improvement in all of these areas, further solidifying the need for strong healthcare organization partnerships that will drive BCBH to scale. The curriculum and process of the CDSM program is different from traditional healthcare. It is a resource that both complements and extends an opportunity for its participants to become empowered self-managers. Healthcare organizations can also utilize CDSM programs to assist in meeting patient-centered medical home requirements of high quality, comprehensive, coordinated care.

Medicare Payment Reform – Medicare Access & CHIP Reauthorization Act (MACRA)

The MACRA rule includes the following performance category related to self-management. Healthcare organizations could achieve these objectives through partnering with the BCBH program.

Beneficiary Engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms:

- Care Coordination:
  - Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following:
    - Maintain formal (referral) links to community-based chronic disease self-management support programs with the potential for bidirectional flow of information; and/or
    - Provide a guide to available community resources
- Beneficiary Engagement:
  - Use tools to assist patients in assessing their need for support with self-management (e.g., the Patient Activation Measure or How's My Health)
  - Provide peer-led support for self-management
  - Provide condition-specific chronic disease self-management support programs or coaching, or link patients to those programs in the community (i.e. Diabetes Self-Management Program)
  - Provide self-management materials at an appropriate literacy level and in an appropriate language

Accountable Care Organizations

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other healthcare providers, who come together voluntarily to give coordinated, high quality care that focuses on the whole patient. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. Providers participating in ACOs are incentivized to collaborate to provide the best system of clinical care and to partner with appropriate health and non-health-related

organizations in their communities to improve the health of their patient population. If the ACO is successful in improving care while lowering costs, it will share in the savings that it achieves. BCBH may help ACOs by providing self-management tools to patients enrolled in workshops.

Medicaid Health Home Requirements

CMS requires six core services be provided as appropriate to all enrolled health home recipients. Core services are actions that are specific to the patient, are included in their care plan, and typically exceed the standard actions performed for other patients. Self-management is included in the following core services:

- Health Promotion: encourage and support healthy ideas and concepts to motivate recipients to adopt healthy behaviors and enable recipients to self-manage their health
- Referrals to Community and Social Support Services: help recipients overcome access or service barriers, increase self-management skills, and improve overall health

Bundled Payment for Care Improvement

The Bundled Payments for Care Improvement (BPCI) initiative is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost. BCBH may help healthcare organizations participating in BPCI by providing self-management tools to patients enrolled in workshops.

Medicare Advantage

One of the Centers for Medicare & Medicaid Services' (CMS) most important strategic goals is to improve the quality of care and general health status for Medicare beneficiaries. CMS publishes the Part C and D Star Ratings each year to measure quality in Medicare Advantage (MA) and Prescription Drug Plans (PDPs or Part D plans), assist beneficiaries in finding the best plan for them, and determine MA Quality Bonus Payments. Moreover, the ratings support the efforts of CMS to improve the level of accountability for the care provided by physicians, hospitals, and other providers. By having beneficiaries participate in BCBH, Medicare Advantage plans may expect individuals to have improved health outcomes, therefore potentially elevating the plan's star rating.

Hospital Readmission Penalties (Hospital Readmission Reduction Program)

The Hospital Readmission Reduction Program requires CMS to reduce payments to hospitals with excess readmissions for applicable conditions within 30 days of discharge. Depending upon the patient acuity at discharge, BCBH may offer self-management support to help with their transition back to their home and daily life.

Community Health Needs Assessments (CHNA)

In order to comply with federal tax-exemption requirements in the Affordable Care Act, a tax-exempt hospital facility must:

- Conduct a community health needs assessment every three years
- Adopt an implementation strategy to meet the community health needs identified through the assessment
- Report how it is addressing the needs identified

Hospitals in South Dakota are including the BCBH program as a key implementation strategy to improve community health.

Reimbursement for CDSMP through Health Behavior Assessment & Intervention (HBAI):

Purpose

- Service intended to identify and address the psychological, behavioral, emotional, cognitive, and social factors important to treatment and management of physical health problems
- HBAI is expected to support the consumer in building the skills necessary to overcome the non-mental health perceived barriers to self-management of chronic disease(s)

Coverage

- Covered benefit under Medicare Part B program and South Dakota Medicaid
- As a required benefit under Original Medicare, all Medicare Advantage plans must also cover HBAI services

Codes

- 96150 – Initial HBAI Assessment to determine participant's barriers and limitations for disease self-management
- 96152 – Additional one-on-one time conducted with a participant to address barriers
- 96153 – Participation in group sessions

Limits

- Services are billed in 15-minute unit increments
- The initial HBAI Assessment would be expected to be completed in one hour (four units)
- Time billed using codes 96152 and 96153 accumulate toward a 15-hour calendar year threshold limit per beneficiary

Eligibility

- Patient must have an underlying physical illness or injury
- Must be non-psychiatric factors impacting person's ability to manage chronic disease
- Patient must have a referral from a healthcare provider: physician, nurse practitioner, physician assistant, clinical psychologist

Final Statement

By implementing this model policy in its entirety or choosing to tailor this policy to your needs, you are taking a great first step in encouraging your patients to manage their chronic disease(s). Together through strategy, commitment, and action, we can impact the burden of chronic disease.

Definition of Terms

Self-management: management of or by oneself; the taking of responsibility for one's own behavior and well-being

Self-efficacy: one's belief in one's ability to succeed in specific situations or accomplish a task

Resources

Better Choices, Better Health® (BCBH) South Dakota
http://www.betterchoicesbetterhealthsd.org

National Council on Aging Roadmap to Community-Integrated Health Care:
https://www.ncoa.org/center-for-healthy-aging/roadmap

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