Administrative and Data Tracking Training

Jodi Holtrop, PhD, MCHES
Andrea Nederveld, MD, MPH

HOPE
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Welcome!

A little about me

- 25 years working in family medicine
- Professional background as a certified health education specialist (help people make behavior changes at individual and systems level)
- Focus of work has been on helping people in primary care to achieve healthy behaviors to prevent and manage disease
- Expertise in implementation science (how to get evidence-based interventions to work in care delivery)

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Welcome!

A little about me:

- Graduated from medical school in 2000, then completed an internal medicine/pediatrics residency in 2005
- Practiced primary care medicine in Grand Junction, CO for 10 years
- Made a career shift to primary care-related research in 2015
- Interested in figuring out how issues like obesity and chronic disease management can be addressed more effectively in primary care settings
- Also interested in how social determinants of health impact health behaviors

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Introductions

Tell me about you!

- Name
- Practice
- How is it that you ended up being here today?
- What, if any, personal interest do you have in this topic?

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What are we going to talk about?
Questions to answer during our time together

- Why are we doing this project? What is it about?
- Why is the project set up like it is?
- What do I (or someone in my practice) need to do regarding data tracking? And how often do we do it?
  - Data needed to answer project (and your) questions
- What do we get paid for and how do we get paid?
  - Paid to deliver the data to the project team, paid to deliver care
- Who helps us with all this?
- What's next and when?

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Why are we doing this project?

- Obesity is a prevalent health problem with important health implications.
- Primary care is endorsed as a place where patients should get help to prevent and manage health problems, including obesity.
- Evidence-based treatments for obesity are available.
- Most primary care practices do not have the personnel, training, and resources to help patients with obesity.
- This project is to help you and your staff overcome barriers so you can help your patients with managing their weight.

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HOPE (Helping Our Patients Engage)

- The name is the overall goal:
  - To give patients and clinical teams **hope** – that something will work to support patients in developing health-promoting habits
- Supportive way to encourage health through behavior change, not just weight loss
- Continuity approach with the patient's practice team, not a "program"
- Health care provided by health care professionals

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Project Aims

Implementation Project, Funded by the **Patient Centered Outcomes Research Institute (PCORI)**

Intended to further implementation of evidence from PCORI-funded studies based on Intensive Behavioral Therapy (IBT) for Obesity

Goal: Help patients get the help they need to successfully manage weight by supporting primary care practice teams in delivering evidence-based obesity care

Aims:

1. Implement evidence-based approaches to obesity care through care delivery models.
2. Evaluate the 1) adoption, implementation and maintenance of the IBT for obesity models at the practice level and 2) reach and effectiveness of weight loss and maintenance at 6, 12 and 18 months at the patient level.
3. Determine factors associated with successful implementation including contextual factors (external environment as well as organizational, practice and patient characteristics), IBT for obesity models and their components, and implementation strategies.

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How it works

In the end: Patients get IBT for obesity delivered by your practice.

- Practice personnel pick a model to deliver the IBT with patients.
  - Individual visits | Billing clinician
  - Individual visits | Health coach
  - Group visits | Practice clinician
- Those doing the delivery get training on obesity treatment in general and with that specific model.
- Start delivering the care to patients in 2024
  - Track how it is going and patient data
- Try to get 50 (or more) patients within 18 months of enrollment
  - Get paid from the project for the data
  - Get paid by insurances/patient co-pay for care delivery

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Quick review: What is IBT for Obesity?

- IBT = Intensive Behavioral Therapy
- This consists of frequent visits/contact over at least a year; "Ideal" schedule of visits is:
  - Weekly x 4 weeks
  - Biweekly months 2 through 6
  - Monthly for months 7 through 12
- Uses the 5As approach to addressing obesity/weight management
- Focuses on diet and physical activity change through goal setting
- Emphasis on behavior change strategies including goal setting and tracking, accountability, self-management and support

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Training Recap

What is involved? 4 parts:

1. Kick-Off: Obesity and Project Overview for all interested practice staff members
2. Project-specific administrative and data tracking for those doing the data tracking and Champion
3. Clinician/health coach training in weight management for those delivering the IBT for obesity (CU eLearning)
4. Clinician/health coach training in the specific model for those delivering the IBT for obesity

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Why is the project set up like it is?

- PCORI (our funder) wants to see how study-tested interventions work in the "real world."
- We provide support and help to you, and your practice delivers the care to patients.
- To answer the questions about how it works, we need to get some data from you.

Therefore, we are partners with you in learning!

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Overview: What do I (or someone in my practice) need to do? And how often do we do it?

- Data about what you and your patients are doing (data you get and give to us); do when it occurs
  - Patients enrolled (report monthly)
  - Patients participating (report monthly)
  - Intervention delivery (report monthly)
  - Patient goals and goal achievement (check-ins, at end)
  - Patient quality of life (check-ins, at end)
- Share with project staff about how it is going (data we get about you)
  - Surveys (Pre-project, 6 months, 1 year)
  - Interviews (Pre-project, 6 months, 1 year)
- Allow us to learn from patients and watch what happens in action
  - Interviews with patients-paid, selected (around 6-9 months in)
  - Video recording encounters with patients, selected (around 6-9 months in)

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Separate Tracking – Patient Enrollment

What is this?
- Tracking which patients say yes and which say no
- What the patients are like that say yes and no

Why?
- PCORI requires us to know what degree of penetration we have with the intervention (we call this reach) of all eligible patients

Questions we need to be able to answer:
- How many patients out of how many offered are participating?
- What are the characteristics of the patients who participate versus who do not?

***Remember to put certain statements in program materials (i.e. goals for weight loss and physical activity)*

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Patient Enrollment (cont.)

WHAT: Excel document titled "HOPE Patient Enrollment"
- Let's go through the form; anything missing or would be hard to do?

HOW: Key tips
- Complete the data requested
- Add in names/MRN as you go
- Add in the other info: a) as patients are enrolled, or b) get it from the record later (but include in each monthly send)
- If you don't know, take your best guess, or leave blank

WHO: Collector; reporter
- Who is your data point person - what makes sense for your workflow?

REPORTING/SUBMISSION: How often do you turn in the data/Reporting?
- Take off patient names and MRNs! Make sure all have a study ID that remains!
- Upload monthly to Egnyte (we will provide the link for your practice)

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Separate Tracking – Patient Participation

What is this?
- Tracking which patients participate in which sessions
- Calculate how much of the intervention over how much time this happens

Why?
- PCORI requires us to report on how much patients are getting of the intervention

Questions we need to be able to answer:
- Which patients are completing what sessions/visit numbers?
- What are the characteristics of the patients who participate fully versus drop-out?

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Separate Tracking – Intervention Delivery

What is this?
- Tracking how the provider is delivering the intervention; includes key features of the intervention

Why?
- PCORI requires us to report on what intervention the patients are getting

Questions we need to be able to answer:
- Are the core components of the intervention being delivered as outlined in the proposal and to what extent?

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Patient Participation and Intervention Delivery (cont.)

WHAT: Excel document titled "HOPE Individual Patient Visit And Intervention Delivery" and "HOPE Group Patient Visit And Intervention Delivery"

- Let's go through the form; anything missing or would be hard to do?

HOW: Key tips

- Complete the data requested
- Add in names/MRN as you go; assign study ID from Patient Enrollment - make sure it matches the study ID!
- Add in the other info: a) as patients are enrolled, or b) record in medical record and retrieve from there later (but include in each monthly send)
- If you don't know, take your best guess, or leave blank

WHO: Collector; reporter

- Who does this? Person delivering intervention? Other? - what makes sense for your workflow?

REPORTING/SUBMISSION: How often do you turn in the data/Reporting?

- Take off patient names and MRNs! Make sure all have a study ID that remains and matches!
- Upload monthly to Egnyte (we will provide the link for your practice)

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Intervention Delivery – Individual Visits

What goes in the excel document?
- What patients are participating in/what they are getting
- That intervention delivery steps are happening

What goes in the medical record?
- What the patients' "results" from the visits are – for continued use with care delivery

Who does this?
- Clinician/coach as the intervention happens
- Someone(s) in the practice – data point person – gathers later and completes excel document - what makes sense for your workflow?

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Intervention Delivery – Group Visits

Set up for group sessions (by session not by patient)

What goes in the excel document?
- What patients are participating in/what they are getting
- That intervention delivery steps are happening

What goes in the medical record?
- What the patients' "results" from the visits are – for continued use with care delivery

Who does this?
- Clinician/coach as the intervention happens
- Someone(s) in the practice – data point person – gathers later and completes excel document – what makes sense for your workflow?

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Separate Tracking – In the Medical Record

What is this?
- Tracking patient background info and characteristics, health metrics, treatments applied

Why?
- PCORI requires us to report on how the intervention is affecting patients and why they may have the outcomes they have

Questions we need to be able to answer:
- Does the IBT for obesity help patients to lose weight and keep it off? What is the effect on their quality of life? What patients benefit?

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Data to be Documented in the Medical Record

HOW and WHEN
- Documented for each visit, include documentation for the patient in their own record for individual and group visits

WHAT
- Height (once at enrollment)
- Weight
- Total minutes/week physical activity since last visit
- Goal for next visit
- Goal attainment from last visit
- PROMIS/QOL (enrollment, 6 months, 12 months only)

5 A's
- Ask, Advise, Assess, Assist, Arrange – if using IBT codes (what would be helpful?)

OTHER INFO as clinically relevant and normally included for clinical care
- Comorbid conditions
- Medications (all)
- Referrals
- Resources recommended

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Key Issue to Discuss – Quality of Life

WHEN
- Ask patients upon enrollment, 6 months and end of program (about 1 year)

WHAT
- 5 questions from PROMIS Quality of Life Scales (see next slide)
- Are you already using your own QOL?
- Additional questions on health-related social needs as desired (optional)

WHERE
- In medical record (and we get it out later)

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Quality of Life Questions

1. In general, would you say your quality of life is…?
   Excellent, Very Good, Good, Fair, Poor
2. In general, how would you rate your physical health?
   Excellent, Very Good, Good, Fair, Poor
3. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?
   Completely, Mostly, Moderately, A little, Not at all
4. In general, how would you rate your mental health, including your mood and your ability to think?
   Excellent, Very Good, Good, Fair, Poor
5. In general, how would you rate your satisfaction with your social activities and relationships?
   Excellent, Very Good, Good, Fair, Poor

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Matching (i.e. Match List) – for all Enrolled Patients

MONTH	DATE	PATIENT NAME	PATIENT MRN	PATIENT STUDY ID[a]	ACCEPTED?	
January	1/4/23	Jane Smith	536000535	001	YES	
		Bob Jones	525001234	002	YES	
		Harry Potter	416010233	NA	NO	

[a]Patient study ID is consecutive numbering. We will assign a practice ID number for our analysis.

Instructions:

- Use in the monthly reports (excel)
- You will keep a listing of patient names and MRNs with the study IDs so you know who the exact patients are in your practice.
- However, we do NOT want to know patient names. Each month, remove patient names and MRNs when you send in your monthly tracking (i.e. this form). Drop off the yellow.
- Make sure to keep your own version of the list in multiple places with the names and MRNs included. This is called the match list (cross-walk). Very important!
- We need you to be able to connect the study ID to the actual patients when we do the medical record abstraction at the end.

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In Summary – what you do!

Monthly

- Submit to Egnyte (drop files) each month the following:
  - HOPE Patient Enrollment (excel)
  - Individual visits: HOPE Individual Patient Visits and Intervention Delivery (excel)
  - Group visits: HOPE Group Patient Visits and Intervention Delivery (excel)

Ongoing in the medical record – follow template (we will get it out later)

- Height (once at enrollment)
- Weight
- Total minutes/week physical activity since last visit
- Goal for next visit
- Goal attainment from last visit
- PROMIS/QOL (at specific times)

Contact your PF or Lauri Connelly if you have any questions, concerns or if you run into any trouble. We are here to help!

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Let’s Take a Break!

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Billing and Coding for Weight Management

How to get paid for what you do!

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Diagnosis Codes to Use:

- Should use two codes for all patients:
- Use E66.01 or other E66.XX code
- Use the specific z code that corresponds to the patient's BMI at that visit Z68.XX (cannot bill the z code alone)

Z68.34	Body mass index [BMI] 34.0-34.9, adult
Z68.35*	Body mass index [BMI] 35.0-35.9, adult
Z68.36*	Body mass index [BMI] 36.0-36.9, adult
Z68.37*	Body mass index [BMI] 37.0-37.9, adult
Z68.38*	Body mass index [BMI] 38.0-38.9, adult
Z68.39*	Body mass index [BMI] 39.0-39.9, adult
Z68.41*	Body mass index [BMI] 40.0-44.9, adult
Z68.42*	Body mass index [BMI] 45.0-49.9, adult
Z68.43*	Body mass index [BMI] 50.0-59.9, adult
Z68.44*	Body mass index [BMI] 60.0-69.9, adult
Z68.45*	Body mass index [BMI] 70 or greater, adult

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Individual clinician visits

- Delivered by MD/DO, PA, or NP
- Can use E&M Codes: 99212, 99213, 99214, 99215
- Diagnosis codes: Use E66.01 and then the specific z code that corresponds to the patient's BMI at that visit
- Code for comorbidities as well

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Billing clinician delivers IBT individuality

- Medicare only code: G0447
- Intensive behavioral therapy for obesity: consists of screening using BMI, dietary assessment, intensive behavioral counseling to promote sustained weight loss through high intensity interventions of diet and exercise
- Billing frequency: Up to 22 visits in 12 months, 1st month 4 weekly, biweekly months 2-6, then reassess. If 3 kg weight loss at six months, can continue monthly visits months 7-12
- Document intervention using 5As approach (ask, assess, advise, agree, assist)
- Can use 25 modifier if other dx besides obesity and also bill E&M code (but patient will have to pay co-pay for E&M if applicable)

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IBT billed "Incident to" MD/DO, PA, or NP

- An RDN or Clinical Nurse Specialist (CNS) can bill IBT "incident to" care provided by an MD/DO, PA, or NP.
- A CNS is an RN/BSN with master's level training
- Can see patients for IBT at same frequency as billing clinicians

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Non-Medicare Patients

- 99401/99402 is analogous to Medicare IBT code
- Again using 5As approach
- 99401 is for "approximately 15 minutes" - needs to be at least 7.5 minutes
- 99402 is for "approximately 30 minutes - needs to be at least 22.5 minutes
- Can also be added to E&M with 25 modifier if separate service provided for another diagnosis

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Telephone visit by billing clinicians

- 99441 – 5-10 minutes
- 99442 – 11-20 minutes
- 99443 – 21+ minutes
- G2012 – Medicare specific for telephone visit between patient and billing provider only, not another team member
- Not originating from a visit within previous 7 days and not within 24 hours of an appointment
- NOTE: these were cross-walked to E&M codes during the public health emergency, may revert to these codes (regarding reimbursement)

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Health Coach/Non-billing clinicians individual visits

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Health Coach Visits

- 0591T: Initial visit
- 0592T: Follow up visit of at least 30 minutes
- For people with a national board certification for health coaching (requires specific training and passing a standardized exam – there are several accrediting bodies)
- Providing counseling related to behavior change and weight
- Medicare does not reimburse, but possible that some Medicare Advantage plans do – would need to check with a patient's plan.

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RDN/Dietician

- 97802: Medical Nutrition Therapy, initial, individual, 15 minutes.
- Can be repeated for longer sessions (bill x 2 for 30 minutes)
- 97803: Reassessment, individual, 15 minutes
- In-person counseling on weight management and obesity
- Medicare does not reimburse for dietician care for obesity!

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Nurse visits

- Can bill 99211 for nurse visits
- Performed in-person or by video, NOT telephone only
- Record vital signs, clinical reason is documented, patients meds and "compliance level" documented, notation of clinicians previous eval and management decisions, clear identity of the provider and their credentials (the RN)
- Has been successfully used in CU Family Medicine clinics for weight prioritized visits

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Other qualified non-physician health care professionals

- 98966: 5-10 minutes
- 98967: 11-20 minutes
- Telephone visit by qualified health care professional, defined as LCSW, RN, CNS, RDN
- May need to check with individual insurance plans
- If the telephone visit ends with decision to see the billing clinician within 24 hours, code should not be reported.

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Other qualified non-physician health care professionals

- S9445
- Patient education for disease management, individual
- May need to check with individual insurance plans
- Again: RN, CNS, RD, or LCSW

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Other qualified non-physician health care professionals

- 98960
- Education and training for patient self-management by a qualified non-physician health professional using a standardized curriculum, face-to-face with the patient, 30 min
- May need to check with individual insurance plans
- Again: RN, CNS, RD, or LCSW

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Clinical Psychologist

- 96156: Health behavior assessment, or re-assessment: assessing for health behavior impact on chronic disease
- 96158: Health behavior intervention, individual, face-to-face 30 minutes
- 96159: Health behavior intervention (each additional 15 min)

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Group Sessions

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MD/DO, NP, or PA

- G0473: Group IBT for obesity, delivered by billing clinician, 30 minutes, groups of 2-10. 22 visits in 12 months, 1 x 4 weekly, biweekly months 2-6, then reassess. If 3 kg weight loss, can continue monthly visits months 7-12.
- Must be delivered by billing clinician or delivered "incident to" by a qualified non-physician health professional such as an RDN or Clinical Nurse Specialist (CNS)

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MD/DO, PA, or NP

- 99411 30 min
- 99412 60 min
- Preventive Medicine group counseling by billing professional
- May have a limit to frequency that this can be billed in some plans

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Other qualified non-physician professionals

- 98961: 30 min, 2-4 patients
- 98962: 30 min, 5-8 patients
- For patient self-management by non-physician using a standardized curriculum, group

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Non-physician qualified health professional

- S9446: Patient education on disease management, group

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Health coach (certified)

- 0593T: Group, at least 30 minutes

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RDN/Dietician

- 97804 Medical Nutrition Therapy, group, 30 min
- NOTE: Medicare does not cover for obesity, have to use the IBT code which dieticians can bill incident to a billing provider's care

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Non-physician qualified health professional

- S9452 nutrition classes, non-physician provider, per class
- S9470 Nutritional counseling, dietician visit
- Commercial plans may cover these (need to check with insurance providers if and how much)

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Behavioral Health Provider

- S9449 Weight management classes

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How to get Paid – Reimbursement for Data Collection for the Project

PROCESS

- We will send you a template for an invoice quarterly. First one will be sent in April for January-March 2024
- Review the invoice, add in your information, and have your official sign it, submit to DFMInvoice@ucdenver.edu
- You should be paid approximately 30 days after you submit your invoice
- Questions - contact:
  - Your individual PF (Liz or Margery) will coordinate with Margery Brennan who is handling all project payments; you may also correspond with a University of Colorado Dept of Family Medicine grants and contracts person

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What you get paid for

- Completion of interviews and surveys (participating)
  - If this is appropriate to the relevant time period, it will be included in the invoice for you to review and complete, your PF and project staff will also provide this information to those doing the invoice preparation
- Completion of data tracking and reporting (doing this)
  - Monthly tracking of enrollment, participation, intervention delivery
  - Medical record data collection (mid point check-in plus final project abstraction)
- Number of patients participating (recruitment goals)
  - Quarterly checks on numbers will be made – payments will be paid out yearly for meeting benchmarks for 25 and 50

If any of these are lacking for a month or more or to a lesser than needed degree, the invoice paid amount will be adjusted down accordingly

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Who helps us with all this?

- Your PF
  - Liz Bell (Elizabeth.K.Bell@cuanschutz.edu)
  - Margery Brennan (Margery.Brennan@cuanschutz.edu)
- Research project staff
  - Jodi Holtrop (leader). (Jodi.Holtrop@cuanschutz.edu)
  - Lauri Connelly (project manager overall) (Lauri.Connelly@cuanschutz.edu)
  - Chloe Glaros (interviews) (Chloe.Glaros@cuanschutz.edu)
  - Zhehui Luo (statistician) (Zluo@epi.msu.edu)
- Implementation staff
  - Seth (Erik) Kramer (physician coach) (Erik.Kramer@cuanschutz.edu)
  - Andrea Nederveld (physician coach) (Andrea.Nederveld@cuanschutz.edu)

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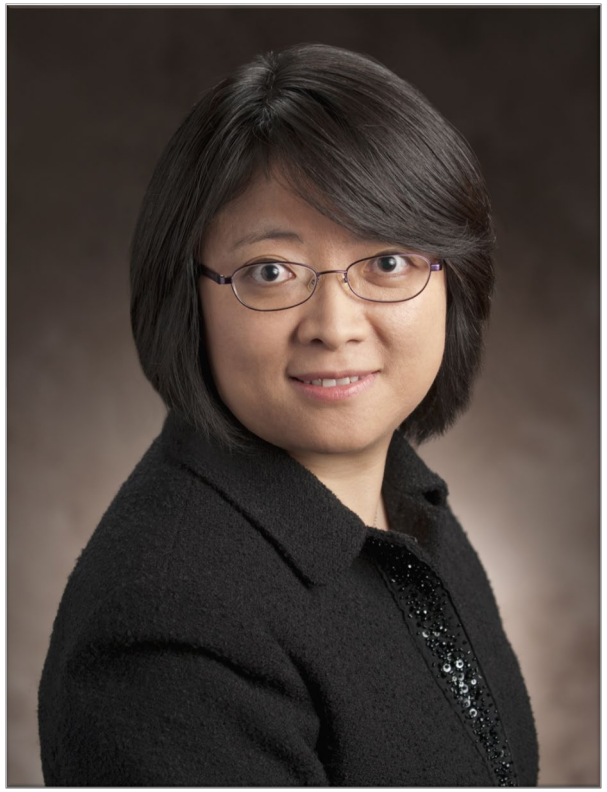
RESEARCH SUPPORT

Lauri Connelly, MS

Project Manager, Expertise in Qualitative Research

Jodi Holtrop, PhD, MCHES

Evaluation Leader, Expertise in Dissemination and Implementation Science, Qualitative Research



Zhehui Luo, PhD

Expertise in Statistics and Economics

Chloe Glaros, MPH, MSW

Expertise in Qualitative Research

IMPLEMENTATION SUPPORT

Anne Nederveld, MD, MPH

Expertise in obesity treatment and clinical practice

E. Seth Kramer, DO, MPH

Expertise in obesity treatment and clinical practice

Elizabeth Bell, BA

Practice Facilitator

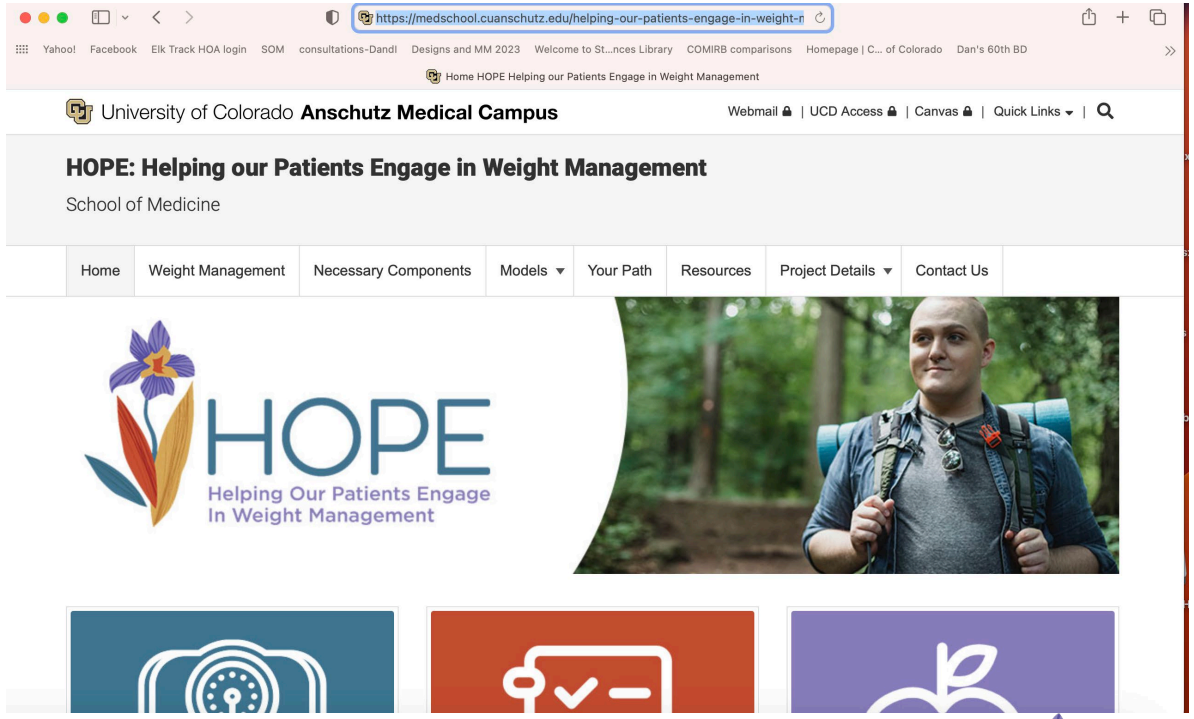
Margery Brennan, MA, CAS

Practice Facilitator

HOPE Website

https://medschool.cuanschutz.edu/helping-our-patients-engage-in-weight-management

We will be working on the website sections Under "Project Details" to include "Training" and "Data Collection & Management" to be ready for your January submissions



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Thank you!

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