“Preventive Care Visits”

PRESENTED BY:
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Transformation Coach
Our objective is to transform all safety net providers in primary care practices into NCQA 2014 Level 3 Patient Centered Medical Homes or APC models by the end of DSRIP Year 3 (March 31, 2018).

Participating practices & practitioners will be expected to meet PCMH and Meaningful Use (Stage 2), and effectively sustain this model.

AHI will be providing guidance and support while managing this project along with an administrative representative and a Physician Champion from each practice.
• Ensure all Medicaid and managed Medicaid patients receive a preventive visit, including behavioral health screenings for all patients to identify unmet needs
• Develop a timely process for assuring referrals to appropriate care
* Annual Physical Pros & Cons

**PRO**

- Importance of patient-doctor relationship
  - Dr. Allan Goroll (Massachusetts General Hospital)

**CON**

- Eliminating improves health care value
  - Dr. Ateev Mehrotra (Harvard Medical School)

Learning about the various aspects of a patient’s life is important for a doctor to understand because they affect health and well being.

- Family and work stresses
- Financial pressures
- Habits

* APA Presidential Task Force on Evidence Based Practice
Dr. Mehrotra:

• Regular checkups

• For low risk patients (e.g., healthy young adults)
  o interval > 1 year
  o yet short enough to maintain the relationship / check on health consequences.
Dr. Goroll:

• Devote time building & sustaining patient relationships using a team-based approach
  o Delegate responsibility for commoditized elements
  o Leverage interoperable electronic medical record
• The Patient Protection and Affordable Care Act (PPACA) highlights the importance of “preventive” services:
  – Health care costs have risen in the U.S. due to treating sick people instead of utilizing prevention
• The NYS Medicaid Program Physician Manual identifies primary care as “continuous in that an ongoing relationship is established with the primary care practitioner who monitors and provides coordinated care”

• An annual well visit is not just about providing preventive services
  – encourages individuals to take an active role in accurately assessing and managing their health; **consequently improve their well being and quality of life**
• Payers support the practice of preventive visits
  – Fidelis Care identifies the PCP as the one to “coordinate, provide, monitor and supervise the delivery of health care services, including the provision of health counseling and advice”
  – PCPs agree to contact Fidelis Care members who are new to the practice and perform a comprehensive evaluation within sixty (60) days from the date the member appears on the PCP’s roster
Initial comprehensive preventive medicine evaluation and management of an individual including:

- Age and gender appropriate history
- Examination
- Counseling/anticipatory guidance/risk factor reduction interventions
- Laboratory/diagnostic procedures
- New patient, CPT code(s) 99381 thru 99387
Periodic comprehensive preventive medicine reevaluation and management of an individual including

- Age and gender appropriate history
- Examination
- Counseling/anticipatory guidance/risk factor reduction interventions
- Laboratory/diagnostic procedures
- Established patient, CPT code(s) 99391 thru 99397
• Establish consistent behavioral health screening for all patients; focus on those with high-risk medical conditions:
  o Tobacco use disorder
  o Stroke
  o Myocardial infarction
  o Cancer
  o HIV
  o Chronic pain
• Screen for depression, anxiety and substance abuse disorders are recommended

○ Tools
  ✓ PHQ-9 for depression
  ✓ GAD 7 for anxiety
  ✓ Screening, Brief Intervention, and Referral to Treatment (SBIRT) for substance use
“the number of participating patients who receive preventive care screenings from participating providers to identify unmet medical or behavioral health needs from participating PCPs”
For these screenings, the preventive service codes are: 99381-99387; 99391-99397

Report of actively engaged patients must be submitted every quarter

Report must be a comprehensive patient registry that includes all patients engaged, including:

- Client ID # (CIN #)
- Date of birth
- Date of preventive visit
- First and last name
• A count of patients who meet the criteria over a 1-year measurement period.

• Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.

• Data Source – EHRs or other IT Platforms (i.e., patient registries) based on billing codes
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