

Integrating Fitness into Your Practice

Your practice may already be great at talking to most patients about fitness (physical activity, healthy eating, and emotional well-being), or you may need some help figuring out how to integrate fitness discussions into patient visits. This part of the AIM-HI manual will help you think about how your office works and how you can make small changes to encourage clinicians and staff to use AIM-HI tools with patients.

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1. Assess the Environment
2. Get Started with the Tools
3. Adjust Processes and Procedures
4. Establish a Referral System
5. Maximize Reimbursement

1. Assess Your Practice's Environment

Your practice can demonstrate a commitment to fitness and facilitate patient-centered conversations about fitness by proactively setting up the physical environment to support fitness. Take a look at the way you do things now and consider making changes to better support fitness. Conducting a brief, informal assessment of your practice will help you examine where your practice is in terms of promoting fitness.

To assess how your practice does or does not support fitness, you may need to examine its policies, procedures, equipment, etc. You can accomplish this by using the following Practice Assessment Questions.

Practice Assessment Questions

1. What approaches does your practice use to encourage patients to engage in a behavior change for:

- Physical activity?
- Healthy eating?
- Emotional well-being?

Examples may include distributing educational materials, referring patients to behavior change classes, and involving support from behavior change specialists such as health educators and dietitians.

2. How does your practice environment currently promote fitness?
3. Imagine that your practice is successfully doing everything that it can do to promote fitness. How might that look?
4. What are some of the challenges to promoting fitness in your current practice routine?
5. What has worked in terms of promoting fitness in your practice? What hasn't?
6. What policies, procedures, and systems do you have in place for promoting fitness?
7. What roles and responsibilities do staff have in promoting fitness?
8. What community resources are available for patients?
9. How do you link patients to community resources?
10. What fitness promotion services and activities (with patients) does your practice document?
11. What areas would you like your practice to improve as it relates to promoting fitness?

Once you have assessed attitudes and policies related to fitness, you should look at the physical environment of the practice, to see if certain aspects facilitate or hinder patient interactions about fitness. Use the Checklist for Office Environment to see if your practice is ready to take on fitness.

Checklist for Office Environment

Does the waiting room have the following culturally appropriate materials?

- Fitness health guides or educational materials
- Fitness posters
- Fitness magazines
- Audio/video displays (optional)

Do exam rooms or adjacent areas to exam rooms have the following?

- Tape measure (for waist circumference measurements)
- Scales with a capacity of more than 300 pounds
- Scales located in private area
- Sturdy exam tables and chairs to accommodate large patients
- Gowns for people of different sizes
- Body mass index measuring tools
 - Adult BMI Chart
 - BMI-for-Age Instruction Guide
 - Growth and BMI Charts for Children and Teens Ages 2 to 20
- Fitness posters
- List of local resources

Do you have established procedures (protocols) for:

- Following the Adult Obesity Clinical Guidelines
- Distributing patient education materials
- Starting the conversation about fitness
- Documenting fitness promotion
- Following-up with patients
- Evaluating fitness promotion activities

2. Get Started with the AIM-HI Tools

After you have evaluated your practice's current physical environment and resources and considered how you might make changes to better support AIM-HI and fitness in your practice, you are ready to begin using the AIM-HI tools with patients. We recommend developing a plan for how you will implement the AIM-HI program in your office.

1. Ensure all staff and clinicians know about AIM-HI and their role in sharing the tools with patients. Holding an in-service training session will motivate staff, promote teamwork, and help formalize the protocol for delivering AIM-HI. For example, you can
 - Share information that you gathered during your practice assessment.

- Discuss the main goals of AIM-HI, how AIM-HI promotes fitness, and potential benefits to patients, staff, and the practice.
- Present and explain each of the AIM-HI tools.
- Discuss staff roles and responsibilities in implementing the intervention (see next section for more detail).

2. Decide how each tool (AIM-HI Fitness Inventory, Fitness Prescription and Journals) will be delivered to and used with patients.
3. Strategically locate AIM-HI materials (i.e., AIM-HI Fitness Inventory, Fitness Prescription pads, and Food & Activity Journals) throughout your office and make them visible to everyone. Identify ways to ensure that patients, staff, and clinicians are exposed to multiple messages about AIM-HI at different times while at the office (waiting areas and exam rooms).

Patient Scenarios

AIM-HI developed a number of instructional patient scenarios about fitness your practice can use to build skills for clinicians and staff. These scenarios provide examples of what the patient-centered conversation looks like. Use these patient-based scenario cards to orient staff to the opportunities to discuss fitness with patients and to provide an opportunity to develop and practice new skills before trying this new approach with patients. These scenarios are included in your AIM-HI Materials, separate from this practice manual.

3. Adjust Office Processes and Procedures

Consider how you might modify your current office processes to integrate AIM-HI into routine clinical procedures. Successful integration of AIM-HI into your practice routines will promote sustainability of the program, help staff think about fitness issues as a part of clinical care (not just an educational add-on), and create an environment that supports fitness. Examples of process modifications at the patient level include

- incorporating the AIM-HI Fitness Inventory into periodic screening activities,
- adding BMI and waist circumference to routine vital sign measurements,
- adding system prompts/reminders for clinicians to address fitness with patients,

- providing information to help with reimbursement, billing and coding during the visit,
- providing continuing education opportunities related to fitness for staff,
- providing regular updates and feedback to staff, and
- establishing a feedback mechanism with health clubs or weight management programs to track patients that have been referred by your office.

Next, take a moment to examine how patients flow through your office while considering each of the AIM-HI tools. See the sample Patient Flow Chart on page 9. This will help you identify opportunities where you can incorporate aspects of AIM-HI to ensure that patients are exposed to fitness promotion messages and receive adequate support from staff. Questions that you may want to consider include:

- What happens when patients enter the clinic?
- Who do patients see before seeing the clinician?
- What happens to patients when vital signs are measured?
- What information is exchanged with patients before the patient/clinician encounter?
- What happens when patients see the clinician?
- How do clinicians support fitness during the encounter?
- What services are documented, and how?
- What reminder systems and prompts are in place for clinicians to alert them of opportunities to discuss fitness?
- What happens when patients exit the clinic?

Determine specific points where you can modify your operating procedures to create opportunities to deliver AIM-HI to patients. You need teamwork to successfully integrate the AIM-HI program. Make sure each clinician and staff member understands his or her role and responsibilities for promoting fitness (see patient visit flow chart on page 9). Remember, the impact of AIM-HI tools is greatly increased by clinicians and staff reinforcing fitness promotion messages at the right moment.

- What process modifications can help staff implement AIM-HI?
- How might a patient “slip through the cracks” and miss an opportunity to discuss fitness?
- How might staff support each other?

Incorporate **systematic prompts/cues** and operating procedures to support dialogue about fitness with patients at every visit. Consider how your clinic will incorporate systematic triggers throughout the normal day-to-day practice routine that may encourage and support specific patients, clinicians, and staff to fitness discussions of.

- Prompts can include placing reminder sheets or flags in charts, identifying patients prior to their visit, getting automated alerts, and handing all patients an AIM-HI brochure at check-in.
- Weight management or lifestyle DVD’s played in the waiting room may encourage patients to talk to staff or at least ask questions signaling interest.
- Challenge patients to walk 10,000 steps with you
- Wear pedometer and use it as a prompt for discussing fitness with patients

Determine staff performance goals/expectations for implementing AIM-HI. For example, you may decide to record BMI for every patient whose height and weight are measured at your site. Identify staff responsible. (see flow chart, page 9, for example).

Incorporate systematic prompts/cues and operating procedures to support dialogue about fitness with patients during most visits. A systems and team approach will help make fitness a routine part of patient visits. Prompts can include placing reminder sheets or flags in charts, placing fitness promotion items next to stairs, etc.

Patient Visit Flow Chart

Front Office Staff:

- Hand patient AIM-HI Fitness Inventory

Patient Checks in

Nurses or Medical Assistants:

- Calculate BMI
- Measure waist circumference
- Explain why these (BMI, waist circumference) are done
- Review AIM-HI Fitness Inventory and screen issues for clinician to address
- Introduce or remind patients about AIM-HI tools

Vital signs checked

Patient meets with clinician

Clinicians:

- Refer to the Adult Obesity Clinical Guidelines
- Ask if patient is willing to discuss lifestyle changes today
- Use AIM-HI Fitness Inventory
- Discuss BMI, waist circumference
- Stay alert for opportunities to discuss fitness (e.g., when talking about chronic conditions)
- Use Fitness Prescription to help patient set goals
- Plan follow up intervals
- Ask patient to complete Fitness & Activity Journal
- Document appropriate information in charts

Patient leaves

Front Office Staff:

- Remain available to answer fitness questions or provide fitness resources
- Schedule referrals and follow up appointments

Nurses or Medical Assistants:

- Remain available to answer fitness questions

4. Establish a Referral System

Just as you have a referral system for getting patients into subspecialty care, you need a strong referral system related to fitness. For example, for patients who would benefit from additional one-on-one support, you may refer them to registered dietitians, health educators, local physical activity centers, personal trainers, walking groups, and wellness centers.

If a patient's main goal is to improve emotional well-being, you will need to focus on resources that provide access to these opportunities within your community. Remember, not all referrals will be weight-based.

Treating patients in an effective and cost-efficient manner requires a strong relationship with allied healthcare professionals. The clinician and registered dietitian should be at the core of any treatment team where improved fitness is a goal. While both members of the team understand the pathophysiology of obesity, the dietitian often sees the patient on a more regular basis throughout all stages of the obesity treatment.

The clinician assesses, diagnoses, and monitors the overall medical progress of the patient. Clinicians are usually more involved in the acute or weight change stage of obesity. **It is important to note that Centers for Disease Control and Prevention data indicate that patients are three times more likely to undertake a weight loss program if a clinician suggests that they do so.**

Dietitians assume more team responsibility during the patient's chronic or weight maintenance stage. The dietitian has primary responsibility for assessment and recommendations related to food behavior. Because of the interrelationship of physical activity to energy expenditure, the dietitian may also be involved in assessment and recommendation of activity, provided the patient is cleared for physical activity by the clinician. Additionally, the dietitian may be asked to interpret the results from the initial assessment and make appropriate, patient-matched treatment recommendations. The dietitian plays a major role in helping the patient formulate reasonable goals, which can be met using the 2005 *Dietary Guidelines for Americans*.

Healthcare professionals should work as motivators and reinforce what the other team member suggests. Most research indicates that behavior therapy and regular physical activity are necessary for long-term success. Generally, the dietitian is better positioned to conduct this follow up. Continued patient contact further ensures successful weight maintenance for the patient.

While clinicians and staff may not have all the answers or all the resources a patient needs, there is help available to support both you and your patients.

Find out what resources are available within your local community to encourage patients to explore these services. Develop your own local “Fitness A to Z” list that includes resources such as local YMCAs, fitness centers, registered dietitians, and groups such as the early morning mall walkers. Keep a copy of this list in patient rooms for reference. Below are two resources developed in cooperation with the AAFP.

Age-Friendly Fitness Locator (<http://www.icaa.cc/facilitylocator.htm>) — The International Council on Active Aging (ICAA) created a special section of its Web site as part of its relationship with the AAFP to quickly assess locations in your area for patients interested in a structured facility approach to physical activity.

Family Physician Nutrition Resource Center (<http://www.nationaldairycouncil.org/NationalDairyCouncil/FamPhyResCen/index.asp>) — This National Dairy Council resource center includes a nutrition professional locator service, supported by the American Dietetic Association and reproducible patient education tools. You can also access the American Dietetic Association (www.eatright.org) to locate a Registered Dietician by typing in your zip code.

Note that out-of-pocket costs may be a barrier for some referrals.

5. Maximize Reimbursement

As most clinicians know, Medicare and most private payers do not consider services related to obesity or weight management covered under benefit plans. Because of this, clinicians must link services to covered diagnoses such as diabetes, hyperlipidemia, metabolic syndrome or hypertension.

Likewise, clinician services aimed at helping patients to manage their health conditions through behavioral health counseling are not separately reportable and payable beyond counseling included in an evaluation and management service for a covered condition. Codes for services such as health and behavior

assessment/intervention are limited for use by non-clinician healthcare professionals. However, this does not mean that there is no reimbursement for clinician services.

When clinicians spend more than half of the face-to-face time with a patient in counseling and coordination of care activities, the level of evaluation and management service provided may be chosen based on time. Counseling is defined in CPT as discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results and/or recommended diagnostic studies,
- Prognosis,
- Risks and benefits of management (treatment) options,
- Instructions for management (treatment) and/or follow up,
- Importance of compliance with chosen management (treatment) options,
- Risk factor reduction,
- Patient and family education.

Thus, time spent discussing the potential benefits of lifestyle changes with patients, that have been identified as lessening the risks associated with or as helpful in managing their diagnosed condition, would be considered counseling.

Assume that you see a hypertensive, obese patient in follow up who has no new complaint and requires only an expanded problem-focused history and examination. Even if you documented medical decision making of moderate complexity, this would probably be reported with code 99213 based on the key components. However, if you have spent 25 minutes of face-to-face time with this patient and at least 13 minutes of that time was spent in counseling, the service may be reported as a 99214 based on time. The significance is indicated by the average Medicare allowable amounts for codes 99213 and 99214. While the national average allowable for a 99213 is \$59.50, the national average allowable for a 99214 is \$90.20. Billing based on time would result in over \$30.00 more in payment for the service than billing based on key components. Likewise, a 15 to 20 minute visit with 50% counseling will be a 99213 and a 40 minute visit (multiple problems) as a timed visit will be a 99215.

In order to report services based on time, documentation should include the approximate amount of time spent

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face-to-face with the patient, approximate amount of time spent counseling, and details of the discussion between the patient and clinician.

Example of documentation language:

"Discussed the risks associated with hypertension and obesity with patient, patient feels he does not eat excessively but has always been big boned, asked the patient to keep a diary of his diet for one week, physical activity - 2 flights of stairs twice per day and bowling once a week, patient agrees to use pedometer and record steps daily until next visit, time spent 25 min. w/counseling 15 min."

To learn more about billing based on time, see **"Time is of the Essence; Coding Based on Time for Physician Services,"** *Family Practice Management*, June 2003.

Note also that patients may be seen in follow up to clinician services by staff, incident to the clinician, for services such as recheck of blood pressure measurement. Under Medicare, incident to guidelines, these services may be reported with code 99211 as long as they are medically necessary. Such visits represent another opportunity to evaluate the patient's progress and provide educational materials to assist the patient. The national average allowed amount for code 99211 is \$20.09.

When in the course of a preventive service visit, the clinician addresses problems that require significant work beyond that of the preventive service, the work of diagnosing and managing the problem may be separately reported. The problem-focused E & M service is reported with the appropriate level of office or other outpatient services code appended with modifier 25. Separate documentation of the chief complaint, history of present illness, problem focused review of systems and examination, and plan of care may allow for easier determination of the appropriate level of service and is useful in indicating to payers the additional work of the service.

Note that counseling, anticipatory guidance and risk factor reduction are included in the preventive service. When a "significant problem" focused E & M service is provided on the same date as a preventive service, only counseling specific to the management of the problem would contribute to the level of that service. Medicare requires that the clinician deduct the amount paid for the problem-oriented service from the cost of the preventive service provided on the same date. Many private payers, but not all, pay the clinician for both services.

Group visits. You may have success scheduling group visits with patients who are working on improving fitness. In group visits, the patients teach each other and share successful strategies. Your patients may find that group visits provide emotional support and reduce any stigma they may feel. Two types of group visits are coordinated health care clinics (CHCCs) and drop-in group medical appointments (DIGMAs). See <http://www.aafp.org/fpm/20030500/66grou.html> for more detail on how to conduct group visits.

List of codes:

- 277.7** Dysmetabolic Syndrome (need diagnosis, need 3 of 5 for diagnosis)
- 278.00** Obesity, unspecified
- 278.01** Morbid Obesity (BMI 30-39.9)
- 278.02** Overweight (BMI 25-29.9)
- 414.01** Coronary Artery Disease, native coronary artery
 - 401.1** Hypertension, benign
 - 401.9** Hypertension, unspecified
 - 796.2** Elevated Blood Pressure, w/o diagnosed hypertension
 - 272.0** Pure Hypercholesterolemia
 - 272.4** Other and Unspecified Hypercholesterolemia

Example Note for Level IV (Time-based) Follow-up Visit for patient with Hypertension

CC: Hypertension F/U

HPI: Doing well on his HCTZ and lisinopril, no noted side effects, no chest pain, SOB, DOE, PND, impotence or edema noted has not increased activity trying to watch diet but still eats fast food 4 - 5 times per week

Exam: BMI 32, Weight 224, BP 138/88 P 76 T 98.4

Lungs clear to A and P

RRR without murmur – distant heart sounds

No edema

A/P: HTN – controlled on meds but drifting upward, weight up 2 more pounds, may be developing metabolic syndrome, counseling provided re: effect of physical activity on weight, blood pressure and cardiovascular risk- will begin to wear pedometer and find ways to add 2000 steps per day- hand out given

Return in 3-4 weeks fasting for cholesterol

Total visit 25 minutes – 15 counseling