<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>7:30-8:00AM</td>
<td>Registration and Continental Breakfast</td>
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<tr>
<td>8:00-8:05AM</td>
<td>Opening Remarks</td>
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<tr>
<td>8:05-9:05AM</td>
<td>Plenary</td>
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<tr>
<td>8:05-9:05AM</td>
<td>Create a Professional Life You Love</td>
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<tr>
<td>8:05-9:05AM</td>
<td>Camille Rapacz</td>
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<tr>
<td>8:05-9:05AM</td>
<td>Professional Development Coach</td>
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<tr>
<td>8:05-9:05AM</td>
<td>Ballroom</td>
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<tr>
<td>8:05-9:05AM</td>
<td>Most people say they work because they have to, not because they're excited to do it. Is it any wonder that more than 50% of people surveyed say they're unhappy in their jobs? You don’t have to stay on this hamster wheel, running fast and getting nowhere. You have more control over your professional life than you think; you even have the power to create one that you love.</td>
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<tr>
<td>8:05-9:05AM</td>
<td>Objectives: Participants will be able to identify the current state of our connection, satisfaction, and engagement with work. Define what it means to do work that you love and is it even possible for everyone. Describe steps you can take right now to work towards the fourth aim of the Quadruple Aim, improving the work life of health care providers, clinicians and staff.</td>
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<tr>
<td>9:05-9:20AM</td>
<td>Breakout Transition</td>
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<tr>
<td>9:20-10:05AM</td>
<td>Breakout #1</td>
</tr>
<tr>
<td>9:20-10:05AM</td>
<td>A Team-Based Diabetes Care Management</td>
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<td>9:20-10:05AM</td>
<td>Glenn Madrid, MD FAAFP</td>
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<td>9:20-10:05AM</td>
<td>Western Colorado Physicians Group (WCPG)</td>
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<tr>
<td>9:20-10:05AM</td>
<td>Ballroom</td>
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<tr>
<td>9:20-10:05AM</td>
<td>B Empowering Employees through Accelerated Engagement</td>
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<td>9:20-10:05AM</td>
<td>Kim Brown, MHA, BA, RT(R), CPHIMS</td>
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<tr>
<td>9:20-10:05AM</td>
<td>Rae Sanchez, BHA, MSA</td>
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<td>9:20-10:05AM</td>
<td>Rocky Mountain Health Plans</td>
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<tr>
<td>9:20-10:05AM</td>
<td>Parlor</td>
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<td>9:20-10:05AM</td>
<td>In this session, participants will engage with members of the RMHP Practice Transformation Team on how to build a positive team culture. Presenters will share specific examples of how to motivate staff, drive engagement and achieve a higher level of meaningful work. Accelerate your practice’s effectiveness through the power of some of the team building strategies shared during this session.</td>
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<tr>
<td>9:20-10:05AM</td>
<td>Objectives: Identify strategies aimed at building a strong team based culture for reducing turnover. Describe specific tools and strategies that can be deployed in your practice which accelerate employee engagement</td>
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<tr>
<td>9:20-10:05AM</td>
<td>C Grant Writing</td>
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<tr>
<td>9:20-10:05AM</td>
<td>Melanie Hall</td>
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<tr>
<td>9:20-10:05AM</td>
<td>PIC Place</td>
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<tr>
<td>9:20-10:05AM</td>
<td>Kokopelli</td>
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<tr>
<td>9:20-10:05AM</td>
<td>Explore opportunities to diversify your funding sources through this introductory session on how funding through grants can add financial sustainability to your practices operations, capital improvements or program expansions.</td>
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<tr>
<td>9:20-10:05AM</td>
<td>Objectives: Participants will be able to identify grant sources and evaluate them, define what is needed to write a successful proposal and explain the full cost of &quot;free money.&quot;</td>
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### RMHP Attribution Reports

**Annie Schudy, BSN, BA, RN**  
*Rocky Mountain Health Plans*  
*Aspen*

In this session, we will be reviewing elements in the RMHP attribution reports. We will look at different use cases, as well as discuss the differences between reports and attribution methodologies used. This will be an opportunity to see a demonstration of how to use the reports, as well as to explore your practice’s reports. Be sure to bring your laptop so you can access your reports. There will be RMHP staff members available to answer specific questions.  
**Objectives:** Review key elements included in all RMHP attribution reports. Apply use cases to your practice’s reports. Understand difference in attribution methodologies.

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<tr>
<th>Time</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>10:05-10:20AM</td>
<td>Break</td>
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</table>
| Roundtables 10:20-11:20AM | KPI Discussion; Heath Neighborhood 1 and 2 and ED Visits PKPY  
This session provides the opportunity to discuss best practices and ways to implement effective strategies based upon your role within the practice. |
| 11:20-11:35AM | Breakout Transition                     |

### Breakout #2  
**11:35-12:20PM**

#### A

**Physician Reimbursement in a Value-based World**  
**Jeffrey Milburn, MBA, CMPE**  
*MGMA Healthcare Consulting Group*  
*Ballroom*

In this session, participants will explore opportunities to develop and evaluate value-based physician compensation plans. With the shift from fee-for-service to value based payment models, physician reimbursement should be reevaluated. This session will assist practices with knowing when to move toward a value based reimbursement system and provide the opportunity to discuss various value-based compensation options.  
**Objectives:** Describe the process of developing and evaluating a physician compensation plan. Identify the various value-based incentive options and the selection and implementation processes. List the steps necessary for approving and implementing a new compensation plan.

#### B

**Sustaining Behavioral Health Integration**  
**Lori Raney, MD**  
*Health Management Associates*  
*Parlor*

**Objectives:** Identify the opportunities for fee-for-service billing in Colorado, including 6 Medicaid BH visits annually. List the key therapy codes suited for short term care in the primary care setting. Recognize the key components of documentation compliance. Comprehend the value opportunities in demonstrating outcomes based on effective care.

#### C

**Take Back Your Work Day**  
**Camille Rapacz**  
*Professional Development Coach*  
*Kokopelli*

Whether you want to break out of a rut, bring more meaning to your work, or become the leader you’re meant to be, this workshop will give you the boost you need. In this session, you’ll work individually to create your own unique plan. This is not about productivity or time management. This approach is all about you.  
**Objectives:** Discover the greatest opportunities for improving work life experience. Identify how a professional targeted plan can impact your satisfaction at work and highlight focus areas for success.
<table>
<thead>
<tr>
<th>Column</th>
<th>Session Title</th>
<th>Presenters</th>
<th>Location/Room</th>
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<tbody>
<tr>
<td><strong>D</strong></td>
<td>Clinical Quality Measure (CQM) Buzz session: Diabetes and Depression</td>
<td>Kimberly Brown, MHA, BA, RT(R), CPHIMS</td>
<td>Rocky Mountain Health Plans, Aspen</td>
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<td>Doug Bolton, MSN, RN</td>
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<td>In this buzz session, participants will dive into measure specifications, learn tips and tricks and explore unique attributes on CMS 2 Depression Screening and Follow up and CMS 122 Diabetes A1c Poor Control. <strong>Objectives:</strong> Develop and explore a deeper understanding of measures CMS 2 Depression Screening and Follow Up and CMS 122 Diabetes A1c Poor Control. Identify resources such as clinical recommendation statements, practice guidelines and measure specifications on CMS 2 and CMS 122.</td>
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<tr>
<th><strong>12:20-1:20PM</strong></th>
<th>Lunch</th>
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<tbody>
<tr>
<td><strong>A</strong></td>
<td>Managing Depression – an Innovative Approach</td>
</tr>
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<td></td>
<td>Jules Rosen, MD</td>
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<td><strong>Objectives:</strong> Define phases of depression and measurement based care. Formulate potential new pathways to work with patients with depression.</td>
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</table>

| **B**            | Last Call: Recognizing Patterns in Alcohol Use Disorder | Ryan Jackman, MD | St. Mary’s Family Medicine Residency, Parlor |
|                  | Jessica Stephen Premo PhD, LMFT                                           |
|                  | **Objectives:** Discuss the risks and costs associated with different patterns of alcohol use. Examine your clinic’s practices for identifying and intervening with alcohol use. Identify points at which effective treatment practices, including referral, can be implemented to improve treatment of alcohol use. |

| **C**            | Quality Improvement (QI) 101: Train the Trainer | Sara Jordan, BS, MS | Rocky Mountain Health Plans, Kokopelli |
|                  |                                                                                     |                                           |
|                  | **Objectives:** Identify the purpose of the Model for Improvement/Plan-Do-Study-Act (PDSA) cycles, fishbone diagrams, and process mapping. Discuss and share best practices for successful coaching with these quality improvement tools |

| **D**            | Practical Tips on Effective Communication and Persuasive Messaging | Bronte Smith, BS, MHA | Rocky Mountain Health Plans, Aspen |
|                  |                                                                                     |                                           |
|                  | **Objectives:** Participants will be able to identify barriers to effectively communicate with all levels of staff and will be provided applicable messaging tools to take back to their practice. |

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<tr>
<th><strong>2:05-2:20PM</strong></th>
<th>Breakout Transition</th>
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<tbody>
<tr>
<td><strong>Breakout #3</strong></td>
<td>1:20-2:05PM</td>
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</table>

| **A**            | Managing Depression – an Innovative Approach | Michelle Hoy, MA, LPC, CAC III | Mind Springs Health, Ballroom |
|                  | Jules Rosen, MD                                           |                                           |
|                  | **Objectives:** Define phases of depression and measurement based care. Formulate potential new pathways to work with patients with depression. |

| **B**            | Last Call: Recognizing Patterns in Alcohol Use Disorder | Ryan Jackman, MD | St. Mary’s Family Medicine Residency, Parlor |
|                  | Jessica Stephen Premo PhD, LMFT                                           |
|                  | **Objectives:** Discuss the risks and costs associated with different patterns of alcohol use. Examine your clinic’s practices for identifying and intervening with alcohol use. Identify points at which effective treatment practices, including referral, can be implemented to improve treatment of alcohol use. |

| **C**            | Quality Improvement (QI) 101: Train the Trainer | Sara Jordan, BS, MS | Rocky Mountain Health Plans, Kokopelli |
|                  |                                                                                     |                                           |
|                  | **Objectives:** Identify the purpose of the Model for Improvement/Plan-Do-Study-Act (PDSA) cycles, fishbone diagrams, and process mapping. Discuss and share best practices for successful coaching with these quality improvement tools |

| **D**            | Practical Tips on Effective Communication and Persuasive Messaging | Bronte Smith, BS, MHA | Rocky Mountain Health Plans, Aspen |
|                  |                                                                                     |                                           |
|                  | **Objectives:** Participants will be able to identify barriers to effectively communicate with all levels of staff and will be provided applicable messaging tools to take back to their practice. |
**Feed-forward**

**Ballroom**

**Objectives:** Identify topics from today’s sessions that you would like to implement within your practice. Gain insight from your fellow participants on how you might go about implementing your selected change plan.

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**Roundtables**

2:50-3:45PM

**Ballroom**

Participants will choose three of the following roundtables to attend for small group discussion and rotate between tables for cycles of 15-minute discussion.

<table>
<thead>
<tr>
<th>Table#</th>
<th>Topic</th>
<th>Discussion Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Building Your Quality Improvement Vision</td>
<td>Barbara Bishop, BA, MA</td>
</tr>
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<td>Rocky Mountain Health Plans</td>
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<tr>
<td>2</td>
<td>Value of Coding Certification</td>
<td>Kellie Yocom, CPC, COSC</td>
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<td>Vail-Summit Orthopaedics &amp; Neurosurgery</td>
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<tr>
<td>3</td>
<td>Virtual Staff Meetings</td>
<td>Kristi Hall, MA, BS, CCM</td>
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<td>Rocky Mountain Health Plans</td>
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<td>4</td>
<td>Practical Tips for Increasing Behavioral Health Engagement through Primary Care</td>
<td>Alexandra Hulst, PhD, LMFT</td>
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<td>Rocky Mountain Health Plans</td>
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<td>5</td>
<td>Key Performance Indicators (KPIs)</td>
<td>Rae Sanchez, BHA, MSA</td>
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<td>Rocky Mountain Health Plans</td>
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<tr>
<td>6</td>
<td>CQM Buzz Session Follow up</td>
<td>Kimberley Brown, MHA, BA, RT(R), CPHIMS</td>
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<td>Doug Bolton, MSN, RN</td>
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<td>Rocky Mountain Health Plans</td>
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<td>7</td>
<td>Communicating with the C Suite</td>
<td>Kevin Fitzgerald, MD</td>
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<td>Rocky Mountain Health Plans</td>
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<tr>
<td>8</td>
<td>Q&amp;A with RMHP Care Management</td>
<td>Kila Watkins, RN</td>
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<td>Rocky Mountain Health Plans</td>
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<tr>
<td>9</td>
<td>Physician Reimbursement in a Value-based World</td>
<td>Jeffrey Milburn, MBA, CMPE</td>
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<td></td>
<td>MGMA Healthcare Consulting Group</td>
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3:45-3:50PM

**Closing Remarks**

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Colorado Medical Society through Rocky Mountain Health Plans. Rocky Mountain Health Plans is accredited by the Colorado Medical Society to provide continuing medical education for physicians.

Rocky Mountain Health Plans designates this live activity for a maximum of **5.75 AMA PRA Category 1 Credit(s)™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**Financial Disclosure:**

- Glenn Madrid, MD FAAFP discloses that he is a Medical Director at VaxCare Corporation; medical advocate advancing availability of vaccines to practices and patients in Colorado.
CREATE A PROFESSIONAL LIFE YOU LOVE

Your work, your life, your way.

Camille Rapacz
Professional Development Coach
WHY ME?

The hats I’ve worn:
- Project manager
- Project portfolio manager
- Consultant
- Performance improvement (lean) coach
- Manager
- Director
- Trainer
- Coach
THE PLAN

- What’s happening with our work and life
- What it means to love your work
- How to make the change you want
WHOSE STORY IS THIS?

- 51% of Americans are neither engaged or disengaged “they’re just there” (Gallup)
- 16% are actively engaged, “love your job” (Gallup and ADP Research)
- 84% “just coming to work” (ADP Research Institute)
- 50% of paid vacation forfeited in 2017 54% feel able to “check out” on vacation (Glassdoor)
- 40% gained weight 25% had access to wellness benefits, 63% didn’t use them (Career Builder)

Adam Grant, Organizational Psychologist, Professor at Wharton School:

*The majority of people will say “Work is something they do because they have to, not because they’re excited to do it”.*
THE SHOULD VS. REALITY

Your job
- Be engaged at work
- Be more efficient
- Be a good leader
- Run a tight ship (stay on budget)
- Live the company values
- Ensure your team delivers

Your reality
- Pulled in different directions
- Too much busy work and firefighting
- Good people are moving on
- Priorities change too fast
- Struggling to be seen and heard
- No room to try your big ideas
- Bringing work home (literally and emotionally)
Love Takes Effort
Love Gives Back

It’s about what you do
How you do it, and
Who it’s all for
The change you want is within reach, it’s all up to you, here’s how you make it happen.

5 Steps To Create A Professional Life You Love
1 KNOW WHERE YOU STAND

*It Starts With You, All of You*

- Take personal inventory
- Observe what’s happening now and what effect it has on you
  - Energy
  - Fulfillment
- Think bigger than just work
- Gather the data
- No judgment, just honest answers
2 DETERMINE WHERE YOU WANT TO GO

Give Yourself Permission to Think Big

- State your preferences
- Envision your no limits ideal state
- Create a picture that inspires you
- Let go of the need to be practical or realistic
- If doesn’t have to be achievable, just knowable

Bold moves require bold ideas.

.camillerapacz.com
A Simple Plan Will Take You Far

- Decide what to improve (Priority Goal)
- Decide what to enhance (Balance Goal)
- Pick a start date
- Plan for a 4-week pursuit
- Commit to 20 minutes a day
- Schedule it
**Uncover your Purpose and Motivations**

- Ask why 5 times
  - Each time go a layer deeper
- Why does your Priority Goal matter?
- Be selfish
- No need to be altruistic about everything you do.
- A better you is better for everyone.

*When your why is the driving force behind your actions you become unstoppable.*
The Right System Can Take You Anywhere

- Set your daily intention
- Write it down (handwriting matters)
- Track your progress
- Note what gets in your way
- Adjust and improve
- Make small moves (20 minutes a day)
- Make this you a priority
- Do it daily

You don’t need more willpower or discipline, you need a better system.
CHOOSE YOU.
START NOW.

- You have everything you need.
- You know everything you need to know.
- You have enough time.
- You have the skills.
- All you need to do is choose.

Thank You!

Camille Rapacz
Professional Development Coach
camillerapacz.com
Your Guide to Creating a Professional Life you Love

This guide walks you through the first and most powerful steps for pursuing a professional life you love. These steps are powerful because they build your foundation and are likely your very first steps. And starting is the most important thing you can do so don't underestimate how significant this work can be.

There's no quick fix but this guide will get you started by providing you with clear and simple steps. For some of you this guide will take you far enough. For others, you'll find that this is just the tip of the iceberg and you want to learn more, be more, and take things to the next level. Either way, don't hesitate to contact me at camille@camillerapacz.com with any questions.

Note that this guide is designed to be printed and completed by handwriting your answers. Let the power of handwriting begin!

**Step 1: Know Where You Stand**

A. Take Personal Inventory

Rate each of the following 4 areas of your life on a scale of 1-10

- 1 = extremely dissatisfied or feel hopeless
- 10 = extremely satisfied, joyful

**Physical Health**

This is more than your physical appearance; this is about your health. Can you do the physical activities you want to do? Do you stay current on health checkups? Do those checkups go well? Do you feel your habits support a healthy lifestyle?

**Mental and Emotional Well-Being**

This is about how well you enjoy life and your ability to deal with stress and difficult moments in life. Your spirituality (whatever that means to you) may also be part of this as you consider the role of this in your overall sense of well-being.

**Social, Leisure, Fun and People**

This is about spending time doing things that bring you joy and recharge your batteries as well as key relationships with loved ones. Do spend enough time in these activities? This may include vacations, weekend time, time spent with loved ones, being outdoors, reading your favorite books, spending time alone, etc.

**Work / Career**

This is your “job”, the work you do on a daily basis as well as the direction your career is headed. Job and career aren't necessarily the same thing as it's possible to feel satisfied with the work you do but not satisfied with your career progression, or vice versa. Weigh both ideas together. It's also common for people to not have a clear career direction in which case this would cause your score to be lower.
B. Observe Your Activities

List activities you’ve engaged in over the past week or two. Include at least one activity from each of the four areas of life as defined in the previous exercise. Next, describe what was involved in the activity (where were you, what tools or devices did you use, how many people, etc.). Finally, rate your level of energy and fulfillment for each activity by indicating L, M, or H for a low, medium or high. Here are some descriptions of low and high energy and fulfillment.

**Energy**

High Energy = you’re fully engaged, get into a state of flow, could keep doing this all day

Medium Energy = you’re not aware of your energy level, you feel average, not up or down

Low Energy = you’re bored, feel tired, can’t wait for this activity to be over

**Fulfillment**

High Fulfillment = you’re learning, feeling renewed, contributing to someone else’s learning, the activity is meaningful and will add value to others

Medium Fulfillment = this activity isn’t completely fulfilling but also not worthless, there is some value but there’s definitely room for improvement

Low Fulfillment = the outcome isn’t that interesting, you didn’t learn much, you don’t feel the outcome is contributing to anything or anyone in a meaningful way

<table>
<thead>
<tr>
<th>Activity</th>
<th>What’s Involved</th>
<th>Energy</th>
<th>Fulfillment</th>
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Step 2: Determine Where You Want to Go

A. Describe your preferences for each of the four areas from Step 1.

Consider what’s going on in each area right now and ask yourself what you would prefer it to be like. This is a way to think about how you could make a shift or a tweak that would make this area more to your liking.

Here’s an example:

- Let’s say you scored Work / Career on the low end because you’ve been feeling frustrated and like you’re perpetually behind in your work. Your preference might be to feel like you accomplished what you set out to do at least 3 days a week. And if you know at least one thing that could help you feel more accomplished you might also state that you prefer to stop doing email at home.

The level of specificity you use for your preferences is up to you. If you can only describe the way you prefer to feel that’s a good starting point. But if you can define a specific thing that would create that feeling that’s even better.

Preferences
Describe what’s happening now and what your preference is for each area below.

Physical Health
Mental and Emotional Well-Being

Social, Leisure, Fun and People
B. Describe your vision for the no limits ideal state of each of the four areas from Step 1.

Consider a world where there are no limits or barriers to achieving your ideal state for each of these four areas of your life. Don't hold back; use your full imagination to create a vision for each area. This is no place for worrying about what's realistic or achievable, this is an exercise in thinking and dreaming big.

Here's an example:

- **For social, leisure, fun and people you could think about your bucket list of places you want to go, people you want to spend time with, and adventures you want to experience.** Maybe you want to try skydiving, take your entire family on a cruise around the world, or go on safari (or all of the above)! This should also include describing how much time or how often you do these things, who you do them with, and in what way. Do you stay at 5 star hotels or prefer Airbnbs, do you take mini vacations once a month or just really big ones 2 times a year, or both? Go all in here and describe all aspects of your ideal way to have fun and spend time with your loved ones.

Go ahead and get carried away on this one and describe as much detail as you can. What do you see, smell, hear, who's with you, what are you eating, what are you wearing, what are you doing?
No Limits Ideal State

Physical Health

Mental and Emotional Well-Being
Social, Leisure, Fun and People

Work / Career
Step 3: Make a Simple Plan

A. Priority Goal (One Improvement)

Review where you are and what you want as you defined it in Steps 1 and 2. What's the one thing you want to improve that would make a meaningful difference to you? This is about you taking charge of you and making something better. This could be about a skill you want to hone, a relationship you want to build, or a mindset you want to improve.

Use the work you’ve done so far to generate your best goal. Look for themes in your personal inventory and activity observations. Keep it simple but make sure it aligns to what you've stated as your preferences and no limits ideal state.

It's impossible to know if you've chosen the right goal until you start working on it. So don't get stuck here trying to create the perfect goal. If you do start working on your goal and find it's not right, you can come back to this work and create a new goal.

And if you ever find yourself questioning your goal be sure to check in with yourself and ask whether you're just trying to avoid doing some hard work. There will be times when this goal gets tough but if it's anchored to your why keep going. Don't hesitate to start just because you're not sure the goal is right, start so you can find out if it's right.

My One Thing to Improve = Priority Goal


B. Balance Goal (One Enhancement)

What’s the one thing that's working in your favor that you've been neglecting or not leveraging to your advantage? It's easy to forget about what works as the negative thoughts and emotions can be very strong. Find the one thing that's working. This could be one of your most energizing and fulfilling activities, or maybe it’s something new that you haven't done it a while and didn't show up in your activity observations.

The key is to tap into your strengths and build upon them. This will give you fuel to work on the improvement work as it gives you confidence and brings you positive results.

My One Thing to Enhance = Balance Goal


C. Identify the Work

Plan to pursue your Improvement and Enhancement goals for the next four weeks. Brainstorm a list of tasks to do to achieve those goals. This list will not be all inclusive of everything you need to do. Just capture what comes to mind right now and that will be your starting point.

Priority Goal (Improve) – Tasks I Can Identify Now

Balance Goal (Enhance) – Tasks I Can Identify Now
D. Choose a Start Date and Commit

Choose a start date and write this date along with a commitment statement to yourself. State what this commitment means, why this work is important, how you plan to show up and engage with your why. This should be a powerful and inspiring statement.

E. Schedule It

You may be wondering how you’re going to get it all done because you’re already so busy. And the best answer I have for you is that you have plenty of time if you choose to. You can make great progress in just 20-minutes a day and that’s where you’ll start. The work you will do every day should be ridiculously small. And if you can only do this 2 or 3 days a week that’s okay too. The idea is to just start and not let time or other obligations get in your way. Set yourself up for success by making this work so small at the start that you can easily make it work.

Another way to set yourself up for success is to do this at the same time every day so you start to create a routine or habit around working on what matters to you. Schedule the time in your calendar just as you would any other important appointment.
Step 4: Connect to Your Reason Why

A. Ask yourself why 5 times

Why did you choose the Priority Goal (One Improvement) you did in Step 3A? What makes it important? Why does it matter? To get to the truest reason why you’ll ask yourself why 5 times, each time going another level deeper.

Your why is powerful but your true why lives deep inside you and we don’t often take the time to explore it. But once you know it you can align yourself to it and this will make the path clearer, the hard work worth doing and each day will have more meaning and purpose. Most importantly, a strong why keeps you on the right path and your path is everything.

Go as far as you can to find deeper levels of why. If you get stuck and can’t come up with Why #5 don’t push too hard. You can come back to this later and see if something comes to you. Or, it might be that you got to your deepest reason why without asking why 5 times. Either way, continue to challenge yourself to have the most meaningful why you can. You’ll know it’s the one because it will be so powerful that it will make you feel unstoppable.

My Why

Why #1: Why did you create the Priority Goal you did in the step 3A? Why is it important to you? What will you gain?

<table>
<thead>
<tr>
<th>Why</th>
<th>Why</th>
<th>Why</th>
<th>Why</th>
<th>Why</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Why #2: Why is your Why #1 important to you? What will you gain?

<table>
<thead>
<tr>
<th>Why</th>
<th>Why</th>
<th>Why</th>
<th>Why</th>
<th>Why</th>
</tr>
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<tbody>
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</tbody>
</table>

© 2019 Breakthrough 2 Excellence, LLC
Why #3: Why is your Why #2 important to you? What will you gain?

Why #4: Why is your Why #3 important to you? What will you gain?

Why #5: Why is your Why #4 important to you? What will you gain?
Step 5: Create a System for Success

This is the linchpin for creating a professional life you love. You aren't lacking in discipline or motivation, you don't need more willpower or a perfect plan, and you don't need more answers. You need a system that supports doing what matters to you and your system starts here.

Your system is something you'll develop and strengthen over time. The stronger your system the easier it is to do what matters to you. And, at the end of the day, all that matters is that you are on the path to a professional life you love, the one that will support you living the life you've envisioned for yourself.

A. Create Your System

   Step 1: Get a journal, notebook or planner
   This should be something you can write in. If you're hesitating because you like to do things electronically and this feels like extra work, then take a little leap of faith with me and try it.

   There is science about how our brains respond to handwriting vs. typing and it shows that learning improves with handwriting. Your system is all about learning so handwriting will help you maximize the benefits. Handwriting will also help you slow your thinking and reflect on what's important while also keeping you away from the distractions of your computer. Plus, the idea of using a new tool for your new system has power in itself.

   Step 2: Set your intention at the start of each day (do this before you check email).
   - Write down your Priority Goal (Improvement) and your Balance Goal (Enhancement)
   - Next, write down what you plan to do today to work toward those goals

   If you struggle to do this first thing every day try set reminders using post-its on your computer screen or other key location, or by setting electronic reminders. Don't rely on your discipline or memory to do this every day. Make it as easy as possible to remember to do this. This should only take 2-3 minutes each morning.

   Step 3: Schedule 20 minutes in your calendar with a reminder.
   This is when you'll work on your Priority Goal. If it's not scheduled, it's not a priority.

   If your goal is something you can do as part of another activity you already have scheduled then just set an intention for what you'll do during that time instead of scheduling the 20-minutes.

   Step 4: Take notes about how it went each day.
   Did you do what you planned to do? If so, how did it go and what did you learn? If not, what got in your way and how will you mitigate that for next time? You can do this ideally at the end of each day or, take time in the morning just before you write your intention for the day to reflect on how things went yesterday. This should take you just a minute or two each day.

   Step 5: Reflect and adjust.
   Look for trends and seek to understand what's preventing you from doing what matters to you and sticking with your goal and your plan. Then make adjustments so you get better every week. Again, make small moves here, only taking on minor adjustments each time. This is how you build a strong system for success.
Know that you won't use your system consistently so prepare yourself for the imperfection of starting a new routine. Just set reminders for yourself, be kind to yourself, and start building up your routine slowly. It's okay to start with just a couple days a week and build from there if you have to.

If you already have a system or routine of planning your day and it works for you then take the elements from this that you don't have and incorporate them into your own. The key is to make sure you are setting your intentions each day by stating what you'll do to work toward your goal, then making your goal a priority, learning, and adjusting.

B. Repeat the steps in this guide every 6 months

This process becomes more powerful the more you use it. Your personal inventory scores will change, your vision will change, and your goals will definitely change. The more you work toward your vision the clearer the picture gets so you'll want to keep at it and see what you learn and how much you advance as you go. But mostly, you want to enjoy the journey and that happens when your journey is on the path that you created in pursuit of a professional life and whole life you love.

_Congratulations!_

You've taken your first steps to creating a professional life you love!

While these steps look simple on paper that doesn't mean they're easy. The work you've done here is something to be celebrated! And if you find it's hard to stick with it, that just means you're human. Keep moving forward.

If you have any questions about this guide or if you're interested in what it would take to stop settling, take things to the next level and unapologetically pursue a professional life you love I'd be honored to talk to you about what that could look like for you.

Email me at camille@camillerapacz.com.
Glenn Madrid, MD FAAFP
Western Colorado Physicians Group
A division of Primary Care Partners

Carol Schlageck
Chief Transformation Officer
Primary Care Partners
Objectives

- Review the clinical aspects of diabetes management
- Understand how Western Colorado Physicians Group uses team-based care in the management of Type 2 diabetes mellitus
- Reflect on patient stories and best practices as it pertains to managing diabetes in a team-based care setting.
Type 2 diabetes mellitus

- Incidence in US; 6-13%
- More personal care resources are spent on diabetes mellitus than any other condition
- Type 2 diabetes accounts for 90% of diabetes
Initial evaluation (based on symptoms-polydipsia, polyuria, asymptomatic laboratory finding)

- History and physical
- Nutrition, weight history, exercise/physical activity, cardiovascular risk factor evaluation including
- Hypertension, obesity, hyperlipidemia, smoking, family history
Initial laboratory evaluation

- HgA1c
- Lipid panel
- Liver function test (fatty liver disease)
- Urine albumin excretion
- Serum creatinine
Routine follow up visits, typically every 3-6 months

- Limited history and physical examination
- HgA1c
- Blood pressure
- Foot exam
- Urine albumin excretion
- Cardiovascular risk factor review
Foot exam

- Skin integrity
- Screening for peripheral vascular disease
- Monofilament examination
Foot exam- prophylactic care

- Avoid barefoot
- Wash and check feet daily (both dorsal and especially plantar surfaces)
- Appropriate toenail care
- Good fitting sock (change daily) and appropriate shoes (snug but not tight)
Urinary albumin excretion (spot urine)

- Perform at least yearly
- Must have at least 2 abnormal tests to diagnose elevation
- Fever, exercise, congestive heart failure, poor glycemic control may cause transient elevation
Increased Albumin Excretion; definition

- Normal- <30 mg / day
- Moderately increased albuminuria (microalbuminuria)- 30-300 mg / day
- Severe increased albuminuria- >300 mg / day
Cardiovascular Risk Factors

- Blood pressure
- Lipids
- Smoking
- Obesity
- Sedentary lifestyle

High risk may benefit from aspirin, ACEI/ARB, statins
Co-Morbidity evaluation

- Dental examination yearly
- Oncologic risk increased; liver, pancreas, endometrium, colon, breast, bladder
Longitudinal management

- HgA1c goal
  - < 6.5, intensive
  - < 7.0, usual
  - < 8.0, older and dependent on co-morbid conditions
- Non pharmacologic; diet, exercise, weight reduction
- Pharmacologic; Metformin preferred first line
Disease course

- Worsening Beta-cell function
- Decreased insulin excretion
- Increased insulin resistance
- Decreased lifestyle compliance
Risk Factor Reduction

- Smoking cessation
- Aspirin therapy; especially for secondary prevention (Clopidogrel for aspirin allergic)
- Blood pressure control
- Lipid management
- Vaccinations; influenza, pneumococcal, hepatitis b (19-59 years of age)
Morbidity

- Macrovascular disease (atherosclerosis)
- Microvascular disease (retinopathy, neuropathy, nephropathy)
- Interventions can limit end organ damage
Reference

- Up-to-Date: Overview of Medical Care in Adults with Diabetes Mellitus
Team-Based Care in the Management of Diabetes at Western Colorado Physicians Group

- Physician
- Physician’s Assistant
- Medical Assistant(s)
- Care Coordinators
- Pharmacist
- Behavioral Health Specialist
- Front Office Staff
Office Visit - every 3-6 months

- POC HgA1c
- POC urinalysis and A:C (usually every 6 months)
- Cardiovascular examination
- Foot examination
- PHQ2/PHQ9
- Prescription refills as appropriate (refills on diabetes medication 6 months or less)
Office Visit Follow Up

- Phone call or letter follow up on labs as appropriate
- Generate task to contact patient for follow visit at 3 or 6 months (phone call or letter)
Practice and Patient Specific Best Practices utilizing Health Information Technology in the Team-Based Care Setting
Eagle Dream Health

- Real-time Point of Care Population Health Management System that overlays with our Allscripts electronic health record system
- Embedded registries for chronic conditions
- Care Management system including gaps in care and tracking longitudinal and episodic care
Condition Specific Registries with Drill Down Capabilities
Patient Specific Data including gaps in care and risk scores both HCC and ACG

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOB</th>
<th>MRN</th>
<th>GENDER</th>
<th>GAPS IN CARE</th>
<th>PROBLEMS</th>
<th>ACU RISK SCORE</th>
<th>ENROLLED IN CARE MANAGEMENT</th>
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<td>Male</td>
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<td>Susan, 60 yrs</td>
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<td>Michael, 78 yrs</td>
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<td>Robert, 68 yrs</td>
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<td>38</td>
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</table>
Metric Monitoring
Quarterly Reviews

HgbA1c

Population: Age 18-75 years, Diagnosis: Diabetes, A1C greater than 9% done
Met When: HgbA1c resulted and greater than 9%

30th < 35.9%
70th < 9.09%
Lower is Better

Provider A, Provider B, Provider C, Provider D, Provider E, Provider F, Provider G, Provider H, Provider I, Provider J, Provider K, Provider L, Provider M
Metric Outcomes

Western Colorado Physician Group

CMS-122/NQF-0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Practice Total:

<table>
<thead>
<tr>
<th>CQM Date</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Practice Rate</th>
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</thead>
<tbody>
<tr>
<td>12/31/2018</td>
<td>80</td>
<td>719</td>
<td>11.13%</td>
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<tr>
<td>9/30/2018</td>
<td>86</td>
<td>604</td>
<td>14.24%</td>
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<tr>
<td>6/30/2018</td>
<td>97</td>
<td>577</td>
<td>16.81%</td>
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<tr>
<td>3/31/2018</td>
<td>151</td>
<td>460</td>
<td>32.83%</td>
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<tr>
<td>12/31/2017</td>
<td>66</td>
<td>623</td>
<td>10.59%</td>
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<tr>
<td>12/31/2016</td>
<td>119</td>
<td>694</td>
<td>17.15%</td>
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</tbody>
</table>
Questions or Comments?

Thank You!
Empowering Employees through Accelerated Engagement

Kim Brown & Rae Sanchez

June 14, 2019
Objectives

• Identify strategies aimed at building a strong team based culture for reducing turnover.

• Describe specific tools and strategies that can be deployed in your practice which accelerate employee engagement.
Impact of Employee Engagement

Who’s Sinking Your Boat?

Employee Engagement
## Turnover Rates

The above employee turnover rate figures are provided by [CompData Surveys](https://www.compdatasurveys.com).

<table>
<thead>
<tr>
<th>Industry</th>
<th>Turnover Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banking and Finance</td>
<td>18.1%</td>
</tr>
<tr>
<td>Healthcare</td>
<td>19.9%</td>
</tr>
<tr>
<td>Hospitality</td>
<td>28.6%</td>
</tr>
<tr>
<td>Insurance</td>
<td>12.2%</td>
</tr>
<tr>
<td>Manufacturing and Distribution</td>
<td>16.0%</td>
</tr>
<tr>
<td>Not-For-Profit</td>
<td>15.7%</td>
</tr>
<tr>
<td>Services</td>
<td>16.8%</td>
</tr>
<tr>
<td>Utilities</td>
<td>8.8%</td>
</tr>
</tbody>
</table>
Good News!

The 4 Areas of Leadership

Goal Setting

Communication

Trust

Accountability
Building Blocks of Recognition

1. *Day-to-day recognition*  
   - frequent, specific and timely

2. *Above-and-beyond recognition*  
   - focus on value, impact and make it personal

3. *Career recognition*  
   - more than just a retirement party!

4. *Celebration events*  
   - just because. . . .

RMHP Recognition Strategies
Connecting

- **Create a shared space**
- **Weekly “Ops” meeting**
- **Monthly 1:1 with Manager**
- **Quarterly 1:1 with Director**

First Day At Work
Employee/Team Member Recognition

1. Bravo! Awards
2. Shout Outs
Annual Retreat
Fun Committee

Low Cost Strategies
When all else fails. . . . .
Start with Why

How Great Leaders Inspire Us

- Simon Sinek -

GRANTS
MELANIE HALL, EXECUTIVE DIRECTOR
THE PIC PLACE
Your experience with grants?
Grants have been a part of my professional career for the last 20 years

Program Director for various nonprofits

Executive Director of Montrose Community Foundation

Primary Grant Writer and Grants Management Person for The PIC Place

Learned a lot through the years!
Overview of the session:

IDENTIFY AND EVALUATE GRANT OPPORTUNITIES

KNOW WHAT IS NEEDED FOR A SUCCESSFUL PROPOSAL
OVERVIEW OF THE PROCESS

1. Demonstrate need
2. Offer a solution
3. Prove that you can meet that need
4. Receive funding
5. Report that need was met
Biggest Trap: Seek money first without a strategic plan
- Grants are a resource; not a goal
- Know who you are first! (structure of organization)
- Once you have a plan, it becomes easier to find the grants you need
- Places to search for grants (formal and informal channels)
Primary Types of Grants

**CAPITAL**
- Bricks and Mortar
- Equipment or Capital Expenditures
- Usually One-Time Funding
- Easier to Obtain
- Often Requires Local Donor Support
- Funders Specific to Capital

**OPERATIONS**
- Operations or Program Support/Expansion
- DO NOT Start a New Program just for the sake of funding
- Takes Into Account All Funding Sources (Diverse Funding Portfolio)
- Funding the Copy Machine
- Colorado Common Grant Application
Where do grants come from?

No, not from leprechauns

- Private Foundations
- Family Foundations
- Public Foundations
- Community Foundations
- Corporations with Charitable Arms
- Family Foundations
- Government

FUNDERS ARE INVESTORS: ROI
IT IS THERE JOB TO GIVE AWAY MONEY
ELEMENTS OF SUCCESSFUL PROPOSAL

- Aligns with funders granting areas of focus
  - Program Officer (Let them give you advice before money!)
  - Mission Statement
  - Succinct History of Organization
  - Story of Your Impact
  - Compliance Statements/Policy (Inclusiveness)
  - Letters of Support
  - Match = Your Own Skin in the Game
  - Strong Financial Statements (audit)
  - Evidence of Need (data)
  - The Solution
  - Uses Funder’s “Language” in Narrative
  - Proofread Application
NO SUCH THING AS FREE MONEY Seriously!
Know what you are getting into first

- Grants Management: TIME
- Deliverables
- Timeline
- Multi-Year Commitment
- Data Collection
- Financial Reporting
- Sustaining After Funding
- Coaching Sessions
- Learning Collaborative
Questions?

TIME FOR DISCUSSION
Attribution Reports

Reports that show basic utilization and total cost of care on a risk adjusted basis for practices every month.
Types of Attribution Reports

**RMHP Masters Practice Summary Report**
- CHP+
- Medicare
- Medicare/Medicaid
- Commercial
- RMHP PRIME

**RMHP PRIME* Practice Summary Report**
- RMHP PRIME

**RMHP CPC+* Track 1 and 2 Practice Summary Report**
- CHP+
- Medicare
- Medicare/Medicaid
- Commercial

* PRIME and CPC+ Reports also include monthly practice specific payment summaries.
What’s In the Reports
## Five Tabs on All Reports

<table>
<thead>
<tr>
<th>Tab Type</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Practice Summary</td>
<td>Practice level cost and utilization data, risk score and run charts</td>
</tr>
<tr>
<td>Patient Summary</td>
<td>Patient’s name, # of visits broken down by type, total cost per patient, patient level risk scores</td>
</tr>
<tr>
<td>Patient Detail</td>
<td>Patient demographic information, cost break down per patient, detailed encounter information, diagnoses, medications</td>
</tr>
<tr>
<td>Assigned But Not Attributed (ABNA)</td>
<td>Patient’s name, # of visits broken down by type, total cost per patient, patient level risk score</td>
</tr>
<tr>
<td>ABNA Detail</td>
<td>Patient demographic information, cost break down per patient, detailed encounter information, diagnoses, medications</td>
</tr>
</tbody>
</table>
Practice Summary Report

Practice

015

Some data contained in this report has been modified for presentation purposes. Member names, ids, contact information, and provider names are not real.

Attribution and risk score are based on claims incurred and paid from 4/1/14-6/30/15. Membership is per RMHP data as active on 6/16/15.

Monthly Patient Count and Risk Score for Practice:

<table>
<thead>
<tr>
<th>RMHP Insured</th>
<th>0.765</th>
</tr>
</thead>
</table>

Count of patients: 184
Average risk score: 0.765

Patients Cost of Care Summary:

Total cost of care for attributed RMHP patients included in this report:

- Emergency Hospital: $77,074
- Inpatient Hospital: $396,917
- Outpatient Hospital: $328,515
- Pharmacy: $218,273
- Physician Services - Primary Care: $9,878
- ABNA Services: $32,281
Some data contained in this report has been modified for presentation purposes. Member names, IDs, contact information, and provider attribution and risk score are based on claims incurred and paid from 4/1/14-6/30/15. Membership is per RMHP data as active on 6/16/15.

MASTERS Monthly Patient Count and Risk Score for Practice:

<table>
<thead>
<tr>
<th></th>
<th>RMHP Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count of patients</td>
<td>184</td>
</tr>
<tr>
<td>Average risk score</td>
<td>0.765</td>
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</table>

MASTERS Total Patients Cost of Care Summary:

<table>
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<th>Cost Category</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Emergency Hospital</td>
<td>$77,074</td>
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<tr>
<td>Inpatient Hospital</td>
<td>$396,917</td>
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<tr>
<td>Outpatient Hospital</td>
<td>$328,515</td>
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<tr>
<td>Pharmacy</td>
<td>$218,273</td>
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<tr>
<td>Physician Services - Primary Care</td>
<td>$9,878</td>
</tr>
<tr>
<td>Physician Services - Specialist Care</td>
<td>$276,704</td>
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<tr>
<td>All Else</td>
<td>$147,652</td>
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<td>Grand Total</td>
<td>$1,455,013</td>
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Utilization for attributed RMHP insured patients included in this report

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<th>All of RMHP Masters</th>
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<td></td>
<td>Count</td>
<td>Per Member</td>
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<tr>
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<tr>
<td>Avg Total Cost per Member</td>
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<td></td>
</tr>
<tr>
<td>PMPM Cost Per Member</td>
<td><strong>$607.01</strong></td>
<td></td>
</tr>
</tbody>
</table>
Average Total Cost Per Member

- Total cost of care for members over the 15 month review period divided by the count of members.

- Example: You have $1,455,013 cost of care for 184 members - average total cost for this month’s attribution is $7,907.68 per member.

✓ $1,455,013 total cost/184 members = $7,907.68 per member
PMPM Cost per Member

- Cost of care for members over the review period divided by the total count of months enrolled during the prior 15 months (where each member has an actual count of between 1 and 15)

- Example: You have $1,455,013 in cost of care for 184 members over the prior 15 months and those members have been enrolled in RMHP for a total of 2397 months then the per member per month cost is $607.01. (2397/184 = average 13.03 months)

$1,455,013/ *2397 months = $607.01 PMPM

*184 members x 13.03 months average per patient = 2397 months
Hierarchical Conditional Categorical (HCC) Risk Score

CMS-HCC Medicare risk adjustment methodology

- Prospective scoring calculated by taking member demographics (age, gender) and the first three diagnoses found on each processed medical claim (not pharmacy)
- The methodology looks at all the diagnoses and determines which ones it cares about (like cancer codes), excludes the rest (like sprained ankle).
- Adjusts for demographics (and older person with cancer might be rated higher for cancer than a younger person with the same cancer)
- A score of 1.0 on the HCC scale would be the cost of an “average” Medicare client (nationally).
Chronic Illness & Disability Payment System (CDPS) Risk Score

CDPS Medicaid risk adjustment methodology

- Prospective scoring calculated by taking member demographics (age, gender, disability status) and the first four diagnoses found on each processed medical claim and national drug codes (NDCs) from pharmacy claims
- The methodology looks at all the diagnoses and determines which ones it cares about (like cancer codes), excludes the rest (like sprained ankle).
- Adjusts it for demographics (and older person with cancer might be rated higher for cancer than a younger person with the same cancer), and disability status.
- The last step performed is to normalize based on average cost the results across the three separate population groups of adults, disabled’s and child populations.
- A score of 1.0 on the CDPS scale would be the cost of an “average” Medicaid adult client (nationally).
Run Charts

All – Program average for attributed patients

You – Raw or unadjusted performance of a practice

You Norm – Factors in diagnostic and demographic complexities

The “your norm” adjusts the practices results up or down based on the variance in risk scores. For example if the practice’s risk score is 50% higher than the all risk score, the actual practice’s ER result is decreased 50% to make a normalized result.
Practice Summary *tab* -Charts

Charts:
- **You** = This Practice
- **All** = All of RMHP Masters
- **YouNorm** = This practice as normalized using risk score

**Average Risk Score**

**Average ER Visits Per 1000 Members**

**Average IP Visits Per 1000 Members**

**Average IP Readmits Visits Per 1000 Members**
# Patient Summary

Highlight a row to populate a patient’s detail in the next tab.

<table>
<thead>
<tr>
<th>RMHP ID</th>
<th>Patient Last</th>
<th>TIN</th>
<th>Suf</th>
<th>Provider</th>
<th>Type</th>
<th>Total ($)</th>
<th># ER Vis</th>
<th># IP Adm</th>
<th># Readm</th>
<th>Rx Scrp</th>
<th>HCC Sco</th>
<th>Practice Ra</th>
<th>Trend</th>
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RMHP Attribution Methodology

RMHP Attribution = There is a relationship between the patient and the provider (based on a claim or a patient choice form).

- Patients are attributed to the practice where the member had the most primary care visits during the 15 month look back period.
  - Based on 9 digit TIN has the most instances in the look back period.
  - Then determine the specific provider (12 digit provider ID) If there is a tie for attribution it is then made to the one with the most recent service.

- Only certain types of providers have patients attributed to them - Family Practice, Internal Medicine, OB/GYN.
# Patient Detail tab

## Patient Details

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<th>Attribute</th>
<th>Value</th>
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<td>Date of Birth</td>
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</tr>
<tr>
<td>Gender</td>
<td></td>
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<tr>
<td>Race</td>
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<td>Ethnicity</td>
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<td>Phone</td>
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<td>Email</td>
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<td>DOB</td>
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## Risk Adjustment

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<tr>
<td>Inpatient Hospital</td>
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</tr>
<tr>
<td>Outpatient Hospital</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
</tr>
<tr>
<td>Physician Primary Care</td>
<td></td>
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<tr>
<td>Physician Specialty Care</td>
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## Claims Info

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<tr>
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<td>OP Claims</td>
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## Office Visit Claims Info

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## NH Diagnosis Info

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## Rx Drug Info

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<tbody>
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## Chronic Diagnosis Info

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<tbody>
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## Provider Info

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</thead>
<tbody>
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</tbody>
</table>

## Other Info

- **Note:** Additional information may be present in the document, such as notes about medical conditions or treatments.
Chronic Diagnosis

- The Chronic Diagnosis section of the Masters Report has NOTHING to do with the risk scoring methodology.

- It is RMHP looking in the claims history, not limited to the 15 month review period, for these 9 particular diagnoses and noting them on the report.

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<th>Type</th>
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<td>Asthma</td>
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<td>CHF</td>
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<td>COPD</td>
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<tr>
<td>CVD</td>
</tr>
<tr>
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<tr>
<td>Hypertension</td>
</tr>
<tr>
<td>Obesity</td>
</tr>
<tr>
<td>Tobacco Use</td>
</tr>
</tbody>
</table>
Assigned But Not Attributed tab

These are RMHP patients that are assigned to your practice or assigned to a provider in your practice.

- **Assignment** = A patient is assigned to a provider, but there has not been a relationship created (there are no claims for the PCP). These are patients potentially could become your patients.

- **Attribution** = There is a relationship between the patient and the provider (based on a claim or a patient choice form).
Assigned But Not Attributed tab

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<th>Patient Last Name, First, MI</th>
<th>CPC Attribution</th>
<th>Type</th>
<th>Total $</th>
<th># ER Visits</th>
<th># IP Adm</th>
<th># Readmit</th>
<th>Rx Scripts</th>
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<td>Member 192</td>
<td>Other provider</td>
<td>Commercial</td>
<td>5725</td>
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<td>0</td>
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<td>M0204</td>
<td>Member 204</td>
<td>Unattributed</td>
<td>Medicare</td>
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<td>Member 205</td>
<td>Unattributed</td>
<td>Medicare</td>
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<td>M0206</td>
<td>Member 206</td>
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<td>Member 207</td>
<td>Other provider</td>
<td>Commercial</td>
<td>137</td>
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<td>M0208</td>
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<td>M0209</td>
<td>Member 209</td>
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<td>8393</td>
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<td>M0210</td>
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</tbody>
</table>
ABNA Detail tab

RWHP Patient Detail Report For Those Assigned But Not CPC Attributed
Report for: This Practice
As of August 2015

<table>
<thead>
<tr>
<th>RWHP ID</th>
<th>Patient Last Name, First, MI</th>
<th>CPC Attribution</th>
<th>Total $</th>
<th>1 ER Visit</th>
<th>1 IP Visit</th>
<th>1 Readmit</th>
<th>HCC Score</th>
<th>Practice Baseline</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOB7?</td>
<td>Member 267</td>
<td>Unattributed</td>
<td>$2,537</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.666</td>
<td>III</td>
</tr>
</tbody>
</table>

**Contact Info for Member 267**
- Address: PO Box 100, Monrove, GA 0401
- Home Phone: 370-720-3100
- Work Phone: 9271568
- Email: me@google.com
- Gender: M
- DOB: 9271568
- Age as of today: 54

**ER Claims Info for Member 267**
- Count: 0
- Details: None

**IP Claims Info for Member 267**
- Count: 0
- Details: None

**OP Claims Info for Member 267**
- Count: 2
- Details: 12/02/2014 at Some Hospital, ICD-10: D42.10 (DISPL SCL LUMBAR DISC W/O MYELOPATHY)
  2/27/2015 at Some Hospital, ICD-10: D27.20 (ORGANIC SLEEP APNEA UNSPECIFIED)

**Office Visit Claims Info for Member 267**
- Count: 0
- Details: None

**MH Diagnosis Info for Member 267**
- Count: 0
- Details: None

**Rx Drug Info for Member 267**
- Count: 4
- Details: DOXYCYCLINE MONOIC 100 MG, CAP
  HYDROCODONE-ACETAMINOPHEN 5-325
  HYDROCODONE-ACETAMINOPH 5MG-325
  LIDOCAINE 5% (700MG)

**Chronic Diagnosis Info for Member 267**
- Count: 0
- Details: None

**Risk Adjustment**
- Initial Enrollment Date: 7/2014
- Current Product Type: Medicaid
- Ad Category: AWIC

**Total Cost Info for Member 267**
- Emergency Hospital: $0 0%
- Inpatient Hospital: $0 0%
- Outpatient Hospital: $12,536 66%
- Pharmacy: $302 13%
- Physician - Primary Care: $0 0%
- Physician - Specialist Care: $692 12%
- Other: $677 7%
- Total: $2,537 100%
RAE (State) Attribution Methodology

RAE (State Attribution) = All Members are attributed in the RAE regardless of if there is a relationship with a provider or not

1. Auto- attribution – Utilization: based on claims history
2. Auto – attribution - Family Connection
3. Auto- attribution - Proximity
4. Member Contact with the Health First Colorado Enrollment Broker
And we’re off…

Now it’s your turn!
Sign into your account

https://rmhpcommunity.account.box.com/login
Click on - Report Name, Year and Month

<table>
<thead>
<tr>
<th>Report Name</th>
<th>Date</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaps in Care Reports</td>
<td>Jan 11, 2018</td>
<td>Kendra Peters</td>
</tr>
<tr>
<td>Masters Monthly Attribution Reports</td>
<td>Jun 3, 2019</td>
<td>Jennifer Waltersch...</td>
</tr>
<tr>
<td>Medicaid ACC-RCCO Care Management Analysis Tools (CMA...)</td>
<td>Jun 2, 2017</td>
<td>Kendra Peters</td>
</tr>
<tr>
<td>Name</td>
<td>Updated</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>Dec 29, 2017</td>
<td>Jennifer Waltersch...</td>
</tr>
<tr>
<td>2018</td>
<td>Dec 31, 2018</td>
<td>Jennifer Waltersch...</td>
</tr>
<tr>
<td>2019</td>
<td>Jun 3, 2019</td>
<td>Jennifer Waltersch...</td>
</tr>
<tr>
<td>SMG-Mancos - 201905 report.xlsm</td>
<td>Jun 3, 2019</td>
<td>Jennifer Waltersch...</td>
</tr>
</tbody>
</table>
Download Report
Enable Editing and Content

PROTECTED VIEW  Be careful—files from the Internet can contain viruses. Unless you need to edit, it's safer to stay in Protected View.

SECURITY WARNING  Macros have been disabled.
Microsoft Excel ro-Enabled Works
Use Cases

Sort by:

- Total Cost
- ER Visits
- Inpatient Admits
- Inpatient Re-admits
- Number of Prescriptions
- Risk Scores (consider this is only claims data, no SDOH information)
Questions?
As the Regional Accountable Entity (RAE) for Region 1, Rocky Mountain Health Plans (RMHP) is committed to meeting specific key performance indicators (KPIs) to help improve our Members’ health.

RAE Key Performance Indicators

**Understanding Key Performance Indicators**

Key performance indicators, or KPIs, are designed to assess the functioning of the overall system to support population health. Each RAE has KPIs they strive to meet. KPIs are based upon paid claims and encounters and offer RAES the opportunity to earn back withheld PMPM for reaching certain performance targets as a region. Those performance thresholds are set by the Colorado Department of Health Care Policy and Financing.

You can find the KPIs for 2018-19 on the back of this flyer.

**How KPI Payments Work**

RAEs will have $4.00 withheld from their total administrative PMPM payment. They are then able to earn back some or all of that amount by meeting the performance thresholds. The withheld funds are spread equally among all KPIs for 2018-2019; no indicator is worth more than another. KPI performance is evaluated using twelve rolling months of data and will be paid to the RAE on a quarterly basis. Unused KPI funds will be placed into a pool of funds available for additional performance measures or for participation in state and federal initiatives that align with the goals of the Accountable Care Collaborative.

**Measuring KPI Performance**

KPI performance is measured using Truven (IBM Watson). Truven is a data analytics portal that contains population and performance information. To request access to Truven, please contact Nicole Konkoly at nicole.konkoly@rmhp.org.

**How RMHP Can Help**

RMHP can support your practice by offering:

- Free consultative services (Business Acumen & Integrated Behavioral Health)
- Advanced practice conferences
- Practice Transformation programs
- PCMH recognition assistance

**RAE Glossary of Terms**

**Key Performance Indicators (KPIs):** measures designed to assess the overall performance of the ACC program and RAES and reward RAES for improvement of health outcomes, access to care, quality of services, cost savings, and regional delivery system as a whole

**Primary Care Medical Provider (PCMP):** a primary care provider who serves as the medical home for attributed Health First Colorado Members and partners with their RAE to coordinate the health needs of their Members

**PCMP Practice Site:** a single brick and mortar physical location where services are delivered to Members under a single Medicaid billing provider identification number

**Regional Accountable Entity (RAE):** Colorado has seven Regional Accountable Entities that are part of ACC program. RMHP is the RAE for Region 1, which includes Western Colorado and Larimer County.

**RAE Member:** an individual who qualifies for Health First Colorado and is enrolled with a Regional Accountable Entity

---

RMHP is the RAE for Region 1

- 22 counties with a population of 910,852
- 142,263 RAE Members (excluding ~35,000 RMHP Prime Members)
- 197 unique PCMP sites
## KPIs for FY 2018-2019

<table>
<thead>
<tr>
<th>KPI</th>
<th>Description</th>
<th>Focus or Baseline</th>
<th>Tier 1 Payment</th>
<th>Tier 2 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potentially Avoidable Costs (PAC)</td>
<td>Compares a standard cost of an episode of care to actual costs.</td>
<td>RMHP focus: Diabetes, SUD, Anxiety &amp; Depression</td>
<td>$0.428 PMPM</td>
<td>$0.571 PMPM</td>
</tr>
<tr>
<td>Emergency Department Visits</td>
<td>Number of ED visits, per 1,000 Members per year (PKPY) risk-adjusted.</td>
<td>Region 1 baseline: 597.431 (ER Risk Adjusted/Actual ER Visits PKPY)</td>
<td>$0.428 PMPM</td>
<td>$0.571 PMPM</td>
</tr>
<tr>
<td>Behavioral Health Engagement</td>
<td>Percentage of Members that access BH services.</td>
<td>Region 1 baseline: .829%</td>
<td>$0.428 PMPM</td>
<td>$0.571 PMPM</td>
</tr>
<tr>
<td>Well Visits</td>
<td>Percent of Members who receive a well visit during 12-month evaluation period.</td>
<td>Region 1 baseline: 31.32%</td>
<td>$0.428 PMPM</td>
<td>$0.571 PMPM</td>
</tr>
<tr>
<td>Prenatal Engagement</td>
<td>Percent of deliveries where a woman received prenatal care during pregnancy</td>
<td>Region 1 baseline: 60.19%</td>
<td>$0.428 PMPM</td>
<td>$0.571 PMPM</td>
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<tr>
<td>Dental Visit</td>
<td>Percent of Members who received professional dental services.</td>
<td>Region 1 baseline: 33.38%</td>
<td>$0.428 PMPM</td>
<td>$0.571 PMPM</td>
</tr>
<tr>
<td>Health Neighborhood</td>
<td><strong>Part 1: Care Compacts (25%)</strong> Percentage of PCMPs that have an effective care compact with a specialty provider within a 12-month rolling evaluation period.</td>
<td>N/A</td>
<td>$0.143 PMPM</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Part 2: PCMP-Specialty Referrals (75%)</strong> Percentage of Members who had an outpatient visit with a specialist who saw a PCMP within 60 days and obtained a referral for the specialty services</td>
<td>Region 1 baseline: 2.098%</td>
<td>$0.321 PMPM</td>
<td>$0.428 PMPM</td>
</tr>
</tbody>
</table>

- **Level 1 Performance Improvement:** 1% - 5% improvement from baseline (75% incentive payment)
- **Level 2 Performance Improvement:** > 5% improvement from baseline (100% incentive payment)

### References


At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Emergency Department visits.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Emergency Department Visits per Thousand Member Months per Year (PKPY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Number of emergency department visits per thousand Members per year (PKPY), risk adjusted</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of actual ED visits PKPY (# of ED visits/# Member months * 12,000)</td>
</tr>
<tr>
<td>Denominator</td>
<td>Members will be counted in the denominator if they are enrolled in the ACC any month in the rolling 12 month evaluation period; to normalize this measure the denominator is measured in terms of Member months (PKPY). The PKPY is then risk adjusted using a RAE risk weight.</td>
</tr>
<tr>
<td>Notes</td>
<td>An ED visit will be counted in the numerator if it does not result in an inpatient admission. The per-thousand member months per-year rate is risk adjusted using Vercend’s Diagnostic Cost Group software, which calculates a raw cost risk score and an aggregated diagnostic cost grouper per Member. Raw cost risk scores are then converted into an ED visit risk weight by RAE region.</td>
</tr>
<tr>
<td>Measure Specifications</td>
<td>Please refer to the Department of Health Care Policy and Financing’s KPI Methodology document for the full measure specifications.</td>
</tr>
<tr>
<td>Resources</td>
<td>Return Visits to the ED</td>
</tr>
<tr>
<td>KPI Baseline and Targets</td>
<td>RAE Region 1 Baseline</td>
</tr>
<tr>
<td>Data Source</td>
<td>Calculated by IBM Watson using fee-for-service claims; data is reported monthly for a rolling 12-month period</td>
</tr>
</tbody>
</table>

**Practice Interventions for Improvement**

- Reduce unnecessary ED utilization
  1. Track ED utilization to identify frequent users and trends that may be contributing to unnecessary ED use in your practice.
  2. Based on utilization trends, develop strategies to address the factors contributing to unnecessary ED visits.
    - Common reasons for utilization stem from a lack of patient education on the appropriate use of the ED and lack of patient awareness on options to consult providers first. One strategy to reduce inappropriate ED use is to implement more patient education in these areas.
    - Underlying social or behavioral health issues may also contribute to unnecessary ED utilization. Identifying these conditions and addressing them with a behavioral health provider would potentially reduce further inappropriate ED use.
- Ensure patient risk is reflected as accurately as possible
  1. Patient diagnoses are up-to-date
  2. Conditions are coded correctly and to the highest level of specificity

**Tips for Using Data**

- Using the data analytics portal, review the list of members who have visited the ED to determine frequency and nature of the visits; using this data, identify trends that would inform strategies for reducing ED visits.
- Using an internal tracking mechanism (e.g., a registry), track ED follow-ups to ensure there is an opportunity to address an individual patient’s underlying reasons for inappropriate ED use, thus reducing frequency of visits in the future.
At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Health Neighborhood.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Health Neighborhood Part 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Percentage of RAE PCMPs with new/renewed care compacts in effect with specialty care providers, that adhere to the Colorado Medical Society’s Primary Care Compacts criteria.</td>
</tr>
<tr>
<td>Numerator</td>
<td>PCMPs in the denominator who have at least one primary care/specialty care compacts in place within the 12 month rolling evaluation period</td>
</tr>
<tr>
<td>Denominator</td>
<td>PCMPs that are contracted with a RAE during the last month of the 12-month evaluation period</td>
</tr>
<tr>
<td>Notes</td>
<td>The Health Neighborhood is a composite measure made up of two parts. Part 1 accounts for 25% of the performance rate for this KPI. This component is calculated manually by the State and is paid out annually. Due to manual calculation, this component will not be displayed in the Data Analytics Portal. Note that the denominator for FY Quarter 4 expands to require at least two care compacts in effect, one being with behavioral health.</td>
</tr>
<tr>
<td>Measure Specifications</td>
<td>Please refer to the Department of Health Care Policy and Financing’s <a href="#">KPI Methodology</a> document for the full measure specifications.</td>
</tr>
<tr>
<td>Resources</td>
<td></td>
</tr>
<tr>
<td><a href="#">CO Medical Society Care Compact Guidelines</a></td>
<td><a href="#">Care Compact Examples</a></td>
</tr>
</tbody>
</table>

**KPI Baseline and Targets**

| Quarter 1: 25%+ of PCMP network has 1+ executed care compacts in place (Eval. Period: July 1, 2018-Sept. 30, 2018) Region final submission: 35.8% | Quarter 3: 75%+ of PCMP network has 1+ executed care compacts in place (Eval. Period Jan. 1, 2019-March 31, 2019) Region final submission: TBD |
| Quarter 2: 50%+ of PCMP network has 1+ executed care compacts in place (Eval period: Oct. 1, 2018-Dec.31, 2018) Region Final Submission: 51.5% | Quarter 4: 50% of PCMP network has 2+ executed care compacts in place — 1 must be with behavioral health (Eval. Period April 1, 209-June 30, 2019) |

**Data Source**

RAEs will submit to the State a detailed list that includes the number of new/renewed compacts, PCMP and specialist names, and the signed date of the compacts.

**Practice Interventions for Improvement**

1. Identify high volume/high cost specialists with which to engage in care compact development.
2. Collaborate with the specialty practice when creating care compacts, ensuring that both parties’ needs are represented in the agreement and that the document promotes meaningful care coordination.
3. Ensure that the care compacts adhere to the criteria required by the State, using guidelines from the Colorado Medical Society.
4. Establish a mechanism for renewing care compacts at least annually, revising as needed.

**Tips for Using Data**

- Using payer data (e.g. specialty visits in the IBM Watson Data Analytics Portal) identify high volume or high cost specialists that your practice refers patients to, in order to select specialty practices to engage with in care compact discussions
- Track referrals using a registry or review care coordination process measures such as “closing the referral loop” to monitor referrals and the success of the care compact
# KPI: HEALTH NEIGHBORHOOD PART 2

At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Health Neighborhood.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Health Neighborhood Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Percentage of members who had an outpatient visit with a specialist who saw a PCMP within 60 days prior to the specialist visit and included a referring PCMP on the claim</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of specialty claims in the denominator with at least one PCMP visit within 60 days prior to the specialty visit and a referring PCMP listed on the specialty claim</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of specialty claims for Members enrolled in the ACC as of the end of the rolling 12 month evaluation period (multiple specialist visits on a single date of service will be counted once in the denominator)</td>
</tr>
<tr>
<td><strong>Exclusion</strong></td>
<td>Members who were enrolled in any physical health managed plan for more than 3 months anytime during the evaluation period are excluded from the denominator.</td>
</tr>
<tr>
<td><strong>Notes</strong></td>
<td>The Health Neighborhood is a composite measure made up of two parts. Part 2 accounts for 75% of the performance rate for this KPI. This portion of the Health Neighborhood KPI is calculated monthly and paid out quarterly.</td>
</tr>
<tr>
<td><strong>Measure Specifications</strong></td>
<td>Please refer to the Department of Health Care Policy and Financing’s KPI Methodology document for the full measure specifications. Value code sets can be found here under the “Performance measurement” section.</td>
</tr>
<tr>
<td><strong>Resources</strong></td>
<td>Detailed Coding Criteria (page 26), Instructions for Referring Claim Submissions, Improving Referral Management</td>
</tr>
<tr>
<td><strong>KPI Baseline and Targets</strong></td>
<td>RAE Region 1 Baseline SFY 17-18 performance for members with full Medicaid residing in each RAE Region: 2.098% Level 1 Target: 1% -5% decrease below baseline Level 2 Target: &gt; 5% decrease below baseline</td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>Calculated by IBM Watson Health using only claims submitted through the MMIS (interChange); data is available in the Data Analytics Portal</td>
</tr>
<tr>
<td><strong>Practice Interventions for Improvement</strong></td>
<td>• Complete patient education and shared decision before referral to determine if the referral is the patient’s preference; this reduces likelihood of no-shows and creates access for more appropriate specialty visits • Determine if the referral is clinically appropriate, or can it be handled in primary care • Make the appointment for the patient, in order to monitor the timeliness of the appointment • Complete pre-work to optimize efficient appointment scheduling; care compacts are a good channel for outlining appropriate pre-work specific to the specialist • Work with specialty providers to ensure they are including the referring PCMP on the claim</td>
</tr>
<tr>
<td><strong>Tips for Using Data</strong></td>
<td>• Using the IBM Watson Data Analytics Portal for this measure, identify trends for individual specialists (e.g. is it a scheduling issue, lack of indication of the referring PCMP on the claim) and address issues accordingly • Using an internal referral tracking mechanism (e.g. a registry), track referrals to ensure the visits are completed at the initially scheduled time (i.e. if the patient reschedules, visit may fall outside of KPI timeframe; if they no-show, will need to determine barriers to completing the visit and ensure proper coordination of care for the condition referred for</td>
</tr>
</tbody>
</table>
Advanced Practice Conference
Provider Compensation with a Value Based Component

Jeffrey B. Milburn, MBA, CMPE
June 14, 2019
Program Outline

• Introduction
• Program Objectives
• Compensation Plan Foundations
• Trends in Compensation Plans
• Value Based Incentives
• Incentive Plan Development
• Jeffrey B. Milburn, MBA, CMPE
  – Over 30 years of medical practice management and consulting experience
  – Contributing author to *RVUs: Applications for Medical Practices* 2nd Edition
  – Co-author of *Strategies for Value Based Physician Compensation*
  – MBA Northeastern University, Boston
  – BSBA Denver University
  – CMPE Certified Medical Practice Executive
  – Past member MGMA Board of Directors, Finance Chair
  – Past member and chair MGMA Survey Advisory Committee and Financial Management Society
Herding Cats?
How Do You Herd Cats?

Answer......“Move Their Food”

Anonymous Medical Director

The Challenge......

Recruit
Retain
Motivate
Participation
Program Objectives

- Understand basic **plan structures**
- Be familiar with current **trends** and options
- Understanding **incentive plan components**
- **Integrating** a value based incentive component into a compensation plan
Compensation Plan Foundations
Moving Parts

physician

growth

primary care

salaries

specialists
Basic Plan Themes

- Salary / Base Guaranty / Shift Based
- Equal Sharing (of profits and/or losses)
- Part Equal or Base and Part Productivity
- Productivity on Various Metrics
- Productivity less Allocated Expenses
- Plus Optional Options
  - Value Added Incentive Components
Plan Complexity

Base Salary ................................ Expense Allocation

ADMINISTRATIVE COMPLEXITY

+ 

OPTIONS
Salaries / Base Guaranty

- Understandable
- Easy to administer
- New physicians
- Part time physicians
- Easy to benchmark
- Employed physicians
  - Integrated Systems
  - Non-Shareholders
- Support shift rate MDs
  - Hospitalists
  - Emergency MDs
- Doesn’t support productivity
- Add quality incentives
Equal Profit Sharing

Positives

• Early private practice model
• Understandable
• Easy to administer
• Low producers 😊
• Single specialty with compatible…
  – Workloads & production
  – Resource utilization
• Quality incentive options

Negatives

• Limited IDS applicability
• Minimal productivity incentive
• Doesn’t mature well
• High producers 😞
• Multi-specialty issues
  – Primary care vs. surg/med specialists
Part Equal Part Production

- Hybrid methodology – some combination of equal sharing and productivity based profit sharing
- Transition from sharing to production
- The higher the equal share, the greater the support for lower producers
  - Example: 70% equal 30% productivity
- The higher the productivity based component, the greater the support for high producers
  - Example: 40% equal 60% productivity
Production

• Primarily based on individual productivity
• Productivity metrics
  – Charges
  – Collections
  – Work RVUs (wRVU)
  – Time
  – Patient visits
• Data requirements
Production - Charges

• Pros
  – Easy to measure
  – Understandable
  – Internal Benchmarking
  – Single specialty groups

• Cons
  – External Benchmarking Limited
    • No consistency in charge setting methodology
  – Multi-specialty differences
  – Fees vary by market
  – Can be manipulated
  – Usually not cost-based
Production - Collections

- **Pros**
  - Relates to cash available
  - Easy to measure
  - Understandable
  - Better benchmarks

- **Cons**
  - Payer mix - not payer blind
    - Option: Consolidate collections and allocate
  - Depends on business office and contracting effectiveness
  - Benchmarking issues
Production – Time

• Shift Based Compensation
  – Hospitalists, Emergency Departments
    • Hospital based specialties
  – Productivity subject to patient demand
  – Evening, weekend, holiday rates
  – Example: EM MD mean annual comp = $320,000
    weeks worked per year = 48 x 5 = 240 days
    $320,000 / 240 = $1,333 day (shift)
  – Incentives possible

• Limited benchmarks

• Available Time vs. Actual Time
Production - Encounters

- Single specialty practices
- Small to medium size groups
- Profits / pro rata share of encounters = comp $
- Operating profits / pro rata share of encounters less expense allocation = comp $
- Define encounters – office, hospital, procedures
- Benchmarks available
- Incentive payments applicable
Production - Work RVUs

• Pros
  – Measurable and “understandable”
  – **Payer mix blind**
  – Good benchmarks – National Standards
  – Growing utilization by groups
  – Measure productivity across specialties
  – Assign value by specialty from benchmarks
  – Periodic review and updates

• Cons
  – **More complex to administer**
  – Subject to CMS changes
Expense Allocation

• Tracks individual physician collections and deducts expenses allocated to the physician.

• Multiple methods and combinations of methods for expense allocation
  – Allocation based on % of collections
  – Equal share of expenses
  – Hybrid equal share and % of collections
  – Direct cost of resource usage

• Administrative complexity is high
Multiple Plan Components

“One model doesn’t always fit all”

• Possible plan components…..
  1. Primary plan for majority of physicians
     Productivity
  2. New physician plan
     Salary to productivity transition
     One to three years
  3. Part-time physicians
     Permanent or optional duration
     Retirement transition
  4. Wild cards…..
Wild Cards

• Set up option in the plan for a component addressing physicians who don’t fit in the primary plan.

• Examples:
  – Hospital physician needed to fill scope of services but patient demand won’t support. Salary
  – Extra physicians needed to cover specialty call that patient demand won’t cover.
  – Special deals
  – Legacy deals
  – Non-shareholder track
Stacked Compensation Model

• Individual physician compensation may consist of multiple parts:
  – Base guaranty +
  – Production incentive +
  – Non-production incentives +
  – NPP supervision stipend +
  – Part time medical director +
  – Committee participation

• = Total Compensation
Compensation Trends
Compensation Trends

• Salary to production
• Production to wRVUs
• Less cost accounting
• Volume (FFS) to Quality
• Pay for “extras”
  – Call pay
  – Committee
  – Leadership
  – Supervision
• Alternative Payment
• **Individual to group culture**
Trends Continued

• **Private practice to system employment**
  – Loss of ancillary income

• **Primary Care to specialty to sub-specialty**

• **Smaller to larger practice size**
  – Increased ancillary income (except hospital)

• **Risk**
  – Capitation (Decapitation)
  – Population management
Compensation Plan Incentives
Incentives

- Part of Primary Compensation Plan
  - Private Practice 5% to 10%
  - IDS 10% to 20%
- Pay for Performance (P4P or $4P)
- Value = Cost + Quality
  - Reduce cost
  - Increase quality
  - Cost of improving quality
Incentives - Objectives

• Incentive Factors - Goals and Objectives
  – Improve patient satisfaction
  – Improve **clinical quality**
  – **Reduce costs** – practice and/or payer
  – Change physician behaviors
  – Participate in payer initiatives
  – Address organizational strategic goals
  – Culture change – **individual to group focus**
Incentives - Funding

• Where’s the money?

• Source of Funds
  – Internal
    • Private practice
    • Integrated Delivery System / Hospital
  – External
    • Payer programs
    • Government programs
  – Additive
  – Withhold from MDs
Incentives - Measures

• Incentive Factors – Measures
  – Easily measured (objective)
    • Clinical quality, utilization, panel size
  – Behavior measurements (subjective)
    • Based on opinions and observations – supportable?
    • Patient and peer satisfaction surveys
  – Data issues
    • Source – trustworthy?
    • Accurate
    • Acceptable to physicians
    • Understandable – report methodology
    • Frequency – status feedback
Incentives – Targets & Rewards

• Targets
  – Emphasize objective over subjective
  – **Reasonable and attainable**
  – Align with goals and objectives
  – Multiple targets – **not excessive**
  – Flexible – periodic review and recalibration

• Rewards
  – **Allocation** – individual and group
  – Meaningful
  – Frequent
  – Cash and other options – additional benefits
Incentives - Concerns

Physician Concerns

Physicians support concept of...

- Quality care and outcomes
- Coordination of care
- Lower costs

...but worry about their compensation

- “Fair” compensation
- Meet personal expenses
- Quality and value not always easy to define or measure
- FFS is usually a direct line to productivity - understandable
Incentives - Concerns

• Different payers different metrics = confusion
• Multiple comp plans in organization
• **Patient compliance**
  – Physicians fire non-compliant patients - immunizations
• Patient acuity
• Patient attribution
• Comp plan complexity – forget KISS
• Risk management – **decapitation**
• Risk allocation
Incentives Impact MD Comp $

• Identify and assess plan component cash flows
  – Start up costs
  – Ongoing costs
  – Timing of expenses and revenue
  – Allocation of costs
    • Individual
    • Practice
    • System
    • Payer
Incentive Implementation

• Understand the…
  – Source of funds
  – Scope of services
  – Physician motivation opportunities
  – Risk and reward potential

• **Infrastructure is critical**
  – Internal and external data sources
  – Staffing support and management

• Build from P4P

• Evaluation and evolution
  – Start slow and build
# Incentive Mix and Phase In

<table>
<thead>
<tr>
<th>Year</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction</td>
<td>75%</td>
<td>50%</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>Citizenship</td>
<td>25%</td>
<td>20%</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>Clinical A</td>
<td>0</td>
<td>10%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Clinical B</td>
<td>0</td>
<td>10%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Clinical C</td>
<td>0</td>
<td>10%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Clinical D</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>30%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Model Options with Incentives

- Salary + P4P
- Productivity + P4P
- Salary + Prod + P4P
- Prod + P4P + Other

Legend:
- Other
- P4P
- Production
- Salary
Incentives-Final Points

• Physicians are critical to the process
• P4P methodology will support transition
• Move from an individual to a group culture
• FFS isn’t going away quickly
• Payer or source of funds will drive compensation methodology
• Continuous evaluation and evolution
• Value will be defined at various levels from individual to practice
Questions?
Contact Information

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Colorado Springs, CO 80906
jmilburn@jmilburn.com

719.375.3158
Value-Based Team Oriented Compensation Plan Example

**Family Medicine (w/o OB):**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Doc A</th>
<th>Doc B</th>
<th>Doc C</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Determine market median compensation per work relative value unit (wRVU) value for each specialty</td>
<td>$ 40.00</td>
<td>$ 40.00</td>
<td>$ 40.00</td>
<td>median compensation/wRVU</td>
</tr>
<tr>
<td>2</td>
<td>Assign compensation per wRVU for practice at 90% of market median</td>
<td>$ 36.00</td>
<td>$ 36.00</td>
<td>$ 36.00</td>
<td>assigned compensation/wRVU</td>
</tr>
<tr>
<td>3</td>
<td>Determine “draw” and “compensation credit” based on production</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actual wRVUs during compensation period</td>
<td>$ 4,500</td>
<td>$ 3,700</td>
<td>$ 3,900</td>
<td>physician annual wRVUs</td>
</tr>
<tr>
<td></td>
<td>Actual wRVUs during compensation period X assigned compensation per wRVU</td>
<td>$ 162,000</td>
<td>$ 133,200</td>
<td>$ 140,400</td>
<td>$ 435,600</td>
</tr>
<tr>
<td></td>
<td>Step 4 Amount used for monthly (or bi-weekly) draw</td>
<td>$ 162,000</td>
<td>$ 133,200</td>
<td>$ 140,400</td>
<td>compensation credit based on produ</td>
</tr>
<tr>
<td>5</td>
<td>Determine each physician percent of total wRVU production</td>
<td>37%</td>
<td>31%</td>
<td>32%</td>
<td>100%</td>
</tr>
<tr>
<td>6</td>
<td>Assign value-based compensation based on performance and production</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Example: Additional $2 per wRVU for performance on quality, cost and patient satisfaction measures (total of $6 per wRVU possible)</td>
<td>$ 9,000</td>
<td>$ 7,800</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quality ($2 per wRVU of physician production when quality targets met)</td>
<td>$ 9,000</td>
<td>$ 7,800</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cost management ($2 per wRVU of physician production when cost management targets met)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Satisfaction ($2 per wRVU of physician production when satisfaction targets met)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Production plus value-based compensation (Step 4 + Step 6)</td>
<td>$ 180,000</td>
<td>$ 140,600</td>
<td>$ 156,000</td>
<td>$ 476,600</td>
</tr>
<tr>
<td>8</td>
<td>Determine compensation pool based on practice financial metrics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Practice net collections</td>
<td>$ 2,050,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Less practice total operating expenses (including physician draw + value-based compensation pool) and reserves</td>
<td></td>
<td>$ 1,931,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Practice net income (available for additional compensation)</td>
<td>$ 118,400</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Physician-owned practices — allocate practice net income based on physician % of wRVU production (to ensure budget neutrality)</td>
<td>$ 44,033</td>
<td>$ 36,205</td>
<td>$ 38,162</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total compensation per physician in physician-owned practice (Step 7 + Step 9)</td>
<td>$ 224,033</td>
<td>$ 176,805</td>
<td>$ 194,162</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Calculations may be inexact due to rounding and other variables

Sustaining Behavioral Health Integration

LORI RANEY, MD
PRINCIPAL

WWW.HEALTHMANAGEMENT.COM
LEARNING OBJECTIVES

+ Understand the opportunities for FFS billing in CO including 6 Medicaid BH visits annually
+ List the key therapy codes suited for short term care in the primary care setting
+ Recognize the evidence-based brief interventions commonly used in primary care settings
+ Recognize the key components of documentation compliance
+ Comprehend the value opportunities in demonstrating outcomes based on effective care
FEE FOR SERVICE: WHAT DO WE HAVE TROUBLE BILLING FOR?

- Brief interventions
- Stress/no diagnosis
- Huddles
- Hallway conversations/consultations
- Warm hand-offs
- Curbside consultations with psychiatric consultants
- Phone calls to patients
- Repeating measurement scales
- Interdisciplinary team meetings
- Registry management

**Payment approaches are necessary for these services that do not work in a typical FFS environment. “What works can’t be coded.”**
BILLING OPPORTUNITIES

- Complexity Coding
- Traditional Therapy Codes
- Screening/Measurement-based Care Codes
- Value Based Payment
- New Codes for Collaborative Care
  (Medicare/Aetna only for now)
MEDICAL NECESSITY | DEFINITION

✓ Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. Is provided in accordance with generally accepted professional standards for health care in the United States;

✓ Is clinically appropriate in terms of type, frequency, extent, site, and duration;

✓ Is delivered in the most appropriate setting(s) required by the client's condition.
Minimum: The following are required as minimum documentation for providing that service:

- Date of Service (DOS)
- Start and end time/duration of session (total face-to-face with patient)
- Session setting/place of service
- Mode of treatment (face-to-face, telephone, video)
- Provider’s dated signature, degree, title/position
- Separate progress note for each service
A unit of time is attained when the mid-point if passed. For example, 30 minutes is attained when 16 minutes have elapsed.

**Time Stamping:**
- 90832 - **16-37** minutes
- 90834 – 38-52 minutes
- 90837 – 53+
• Mix of Medicare, Medicaid, Commercial?
• What does each payer pay for or not?
• What staff (with and without licensure) can bill?
• How much will you be reimbursed for each code?
• Why was a claim denied?
• How do I get credentialed (empaneled) with payer?
<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT Code</th>
<th>Medicaid FFS Rate</th>
<th>Commercial/ Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Evaluation</td>
<td>90791</td>
<td>$106.05</td>
<td>*</td>
</tr>
<tr>
<td>Psychotherapy 30 min</td>
<td>90832</td>
<td>$55.13</td>
<td>*</td>
</tr>
<tr>
<td>Psychotherapy 45 min</td>
<td>90834</td>
<td>$88.87</td>
<td>*</td>
</tr>
<tr>
<td>Psychotherapy 60 min</td>
<td>90837</td>
<td>$100.80</td>
<td>*</td>
</tr>
<tr>
<td>Family psychotherapy w/o patient</td>
<td>90846</td>
<td>$57.00</td>
<td>*</td>
</tr>
<tr>
<td>Family psychotherapy with patient</td>
<td>90847</td>
<td>$59.00</td>
<td>*</td>
</tr>
</tbody>
</table>

- State fiscal year – July to June
• Know the rules for the RAE
• Different address for billing
• Can see sessions in MCD portal
• Fiscal year July 1 – June 30th
• Treatment plan required
• Track outcomes to determine level of care needed

• Demonstrate ongoing value to the payer by making the extra effort!
Service Content

- The reason for the visit. Chief complaint/presenting concern(s) or problem(s)
- Referral source
- Psychiatric diagnostic interview examination elements
- HPI, past psych tx, SUD hx, medical diagnoses, family history MI
- Review of psychosocial, family, and treatment history
- Mental status exam
- Diagnostic formulation
- Plan for next contact(s) including any follow-up or coordination needed with 3rd parties and disposition

Can be brief (30 minutes) and added to over time
• Evidence-based Brief Interventions proven to work in the Primary Care Setting

- Motivational Interviewing
- Distress Tolerance Skills
- Behavioral Activation
- Problem Solving Therapy
- Solution Focused Brief Therapy
• The reason for the visit. What was the intended goal or agenda? How does the service relate to the treatment/service plan?

• Description of the service

• The therapeutic intervention(s) utilized and the individual’s response to the intervention(s)

• How did the service impact the individual’s progress towards goals/objectives?

• Plan for next contact(s) including any follow-up or coordination needed with 3rd parties
The requirements for this type of note have four parts/requirements that we use to make documentation simple and compliant. This documentation can be short and often done concurrently with the patient and during a warm hand off.

**Diagnosis:** patient referred by primary care provider for depression follow-up

**Assessment of symptoms:** patient scored a 14 on the PHQ9, reports difficulty sleeping and concentrating as most prominent symptoms

**Clinical Intervention:** utilized behavioral activation to establish short term goal of XX to begin care and engage patient into treatment

**Plan:** patient provided with follow up phone appointment (1-2 days) on XX and follow up visit on XXX (within the week) to begin care for depression and PHQ9 reduction
• **D:** Mr. Jones reports his depression is better since his visit 2 weeks ago. His PHQ-9 score has dropped from 14 to 11 with continued endorsement of low mood, fatigue, difficulty sleeping and difficulty concentrating. He denies any suicidal ideation. Did a session of behavioral activation and set a goal to visit his daughter this weekend

• **A:** Major Depression, improving

• **P:** Follow-up on BA goal next week; Follow-up with PCP on antidepressant; FU with me in 2 weeks.
A Tipping Point for Measurement-Based Care

John C. Fortney, Ph.D., Jürgen Unützer, M.D., M.P.H., Glenda Wrenn, M.D., M.S.H.P., Jeffrey M. Pyne, M.D.,
G. Richard Smith, M.D., Michael Schoenbaum, Ph.D., Henry T. Harbin, M.D.

Objective: Measurement-based care involves the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. This literature review examined the theoretical and empirical support for measurement-based care.

Methods: Articles were identified through search strategies in PubMed and Google Scholar. Additional citations in the references of retrieved articles were identified, and experts assembled for a focus group conducted by the Kennedy Forum were consulted.

Results: Fifty-one relevant articles were reviewed. There are numerous brief structured symptom rating scales that have strong psychometric properties. Virtually all randomized controlled trials with frequent and timely feedback of patient-reported symptoms to the provider during the medication management and psychotherapy encounters significantly improved outcomes. Ineffective approaches included one-time screening, assessing symptoms infrequently, and feeding back outcomes to providers outside the context of the clinical encounter. In addition to the empirical evidence about efficacy, there is mounting evidence from large-scale pragmatic trials and clinical demonstration projects that measurement-based care is feasible to implement on a large scale and is highly acceptable to patients and providers.

Conclusions: In addition to the primary gains of measurement-based care for individual patients, there are also potential secondary and tertiary gains to be made when individual patient data are aggregated. Specifically, aggregated symptom rating scale data can be used for professional development at the provider level and for quality improvement at the clinic level and to inform payers about the value of mental health services delivered at the health care system level.

Psychiatric Services 2016; 00:1–10; doi: 10.1176/appi.ps.201500439
Care That Is Measured Gets Better

- HAM-D 50% or <8
- Paroxetine and mirtazapine
- Greater response
- Shorter time to response
- More treatment adjustments (44 vs 23)
- Higher doses antidepressants
- Similar drop out, side effects

Screening and Measurement of Symptoms

96127
Brief emotional/behavioral health risk assessment

- PHQ9, GAD7, Vanderbilt, SCARED, etc.
- Commercial, sometimes limited due to “bundling” criteria by payer
- Bill code up to 4x/year for up to 4 screening tools per visit
- Recommended Depression every annual visit age 11+

96160
Patient focused health risk assessment

- PHQ9, etc. except Medicaid. Interchangeable with 96127, basically the same rate.

96161
Care-giver focused health risk assessment

- For example: post partum depression
- Unless Medicaid (see later)

96110
Peds Screenings

- Can bill 96127 in addition if both performed at same visit.
- Developmental – 1 unit billed on a single visit, 1 per year, $17.67
- Autism – 2 screens total between 18 and 24 months, $17.67

Health Management Associates
ONGOING MEASUREMENT OF PROGRESS: MEASUREMENT BASED CARE (MBC)

- 96127 – approximately $10
  - Repeat measurement up to 4x/year typically, although, may be some variation between payers, can do use any of the following:
    - PHQ9
    - GAD7
    - SCARED
    - Vanderbilt
    - AUDIT-C
  - **Scenario:** the PHQ9 is administered during screening for depression and then monthly for up to 3 months to track progress and adjust treatment for patients not improving.
Medicaid: G Codes

- For teen depression screening and Post Partum Depression, screen and bill for mom up to three times, once a year only for teen depression screening up to age 21 (although recommended every visit) and adults, includes counseling, referral and follow-up
  - G8431: positive screen for depression - $29.68
  - G8510: negative screen for depression - $10.70
Alcohol Treatment

+ Screening:
  + Medicaid: H0049
    + Negative screen for substance use, 1 per day, 2 per state fiscal year (July 1-June 30) - $10.70
  + Other Payers: 96127 or 96160; can use psychotherapy code like 90832 for counseling

+ Treatment: SBIRT
  + 99408 – positive substance use screen with intervention, 15-30 minutes - $31.39
  + 99409 – positive substance use screen with intervention, 30+ minutes - $64.26
Higher Complexity or time based:

- 99213 – 15 minutes
- 99214 – 30 minutes
- 99215 – 45 minutes
SCENARIO

Dr. Begay sees a patient for a 15 minute routine blood pressure check and depression follow-up (typically billed as 99213 if all is stable) She notices a repeat of the PHQ9 score is now elevated at 14. She calls the BHP to the exam room, steps out and the BHP completes a brief assessment. Dr. Begay returns to the exam room and they discuss depression treatment. There are now 2 problems being addressed - 1 old and one new, 30 minutes was spent with the patient and a 99214 was billed.
HEALTH BEHAVIORAL ASSESSMENT AND INTERVENTION (HBAI)

- Not Paid in Colorado
- Includes 96150-155
- Psychologists (some now allow LCSW)
- Developed by CMS in 2002 to support determining the biological, psychological, and social factors affecting the patient’s physical health and any treatment problems, and related interventions by psychologists.
Common H Codes in PC; reimbursed by the RAE, not state MCD - Negotiate!

+ **H0023**: outreach and engagement, can be in person or by phone, peer and up, can be used to prevent or address a BH problem

+ **H0025**: psychoeducation for prevention/reduce risk, delivered prior to onset of BH problem

+ **H0031**: brief assessment, no MSE, bachelors degree, intern and up

+ **H2011**: crisis per 15 minutes

+ **H0002**: alcohol and drug screen

+ **T1017**: targeted case management

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0004</td>
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<td>$22.77</td>
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<td>$11.88</td>
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<td>T1017</td>
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<td>H0025</td>
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<td>$23.04</td>
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</tbody>
</table>

Health Management Associates
THE COLLABORATIVE CARE MODEL

**Effective Collaboration**

**PRACTICE SUPPORT**

Informed, Activated Patient

PCP supported by Behavioral Health Care Manager

Measurement-based Treat to Target

Psychiatric Consultation

Caseload-focused Registry review

Training
Codes and Reimbursement for CoCM

- 99492 (Initial month, CoCM) - $161
- 99493 (Subsequent month, CoCM) - $129
- 99494 (Add’l 30 mins, CoCM) - $69
- 99484 – other models of BHI - $48
- G0512 – FQHCs $135/month

**Codes Cover:**

- Outreach and engagement by BH Provider or Care Manager
- Initial assessment of the patient, including administration of validated rating scales
- Entering patient data in a registry and tracking patient follow-up and progress
- Participation in weekly caseload review with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
TIME STAMPING – PER MONTH

- Minutes spent talking to patient (in person or phone)
- Minutes spent talking to the PCP
- Minutes spent talking to the psychiatric consultant
- Minutes spent coordinating care
- Minutes spent documenting anything or scoring
- Minutes spent reviewing charts/documentation
- Minutes spent talking to referral source
- ETC! Get it all
CONSIDERATIONS FOR SUSTAINABILITY

- Staffing mix
- Productivity/Volume
- Payer mix
- Direct Revenue
- Indirect Revenue
- Coding
- Contracting
- Optimization (concurrent doc)
- Back end-denials
- Dashboard development
- Even if you have a grant
- Attach code to workflow
### BILLING GRID BY PAYER

<table>
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<tr>
<th>Payers</th>
<th>90791</th>
<th>90832</th>
<th>90834</th>
<th>90837</th>
<th>90853</th>
<th>96150</th>
<th>96151</th>
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</table>

Raney L, Lasky G: Chapter 8, Financing Integrated Care, in Integrated Care: A Guide to Effective Implementation, APPI 2017, courtesy Virna Little
# Financial Modeling Workbook

**Total Reimbursement**

<table>
<thead>
<tr>
<th>Monthly Case Rate Reimbursement</th>
<th>Billable Individual Services Reimbursement</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$102,026.70</td>
<td>$958,126.04</td>
<td>$1,060,153.74</td>
</tr>
</tbody>
</table>

**Total Cost**

<table>
<thead>
<tr>
<th>Personnel</th>
<th>FTE</th>
<th>Salary Cost Per FTE</th>
<th>Fringe Benefits % of Salary</th>
<th>Fringe Benefits Cost</th>
<th>Personnel Subtotal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Manager</td>
<td>2.40</td>
<td>$156,000.00</td>
<td>24.0%</td>
<td>$37,440.00</td>
<td>$193,440.00</td>
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<tr>
<td>Psychiatric Consultant</td>
<td>0.70</td>
<td>$42,000.00</td>
<td>15.0%</td>
<td>$6,300.00</td>
<td>$48,300.00</td>
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<tr>
<td>Subtotal: Personnel Cost</td>
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<td>$198,400.00</td>
<td></td>
<td>$43,740.00</td>
<td>$242,140.00</td>
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</tbody>
</table>

**Organizational Overhead**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>35.0%</td>
<td>$84,609.00</td>
</tr>
</tbody>
</table>

**Total Cost: Personnel + Overhead**

<table>
<thead>
<tr>
<th>Personnel + Overhead</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$326,749.00</td>
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</table>

**Net Impact**

<table>
<thead>
<tr>
<th>Total Reimbursement</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,060,153.74</td>
<td>$326,749.00</td>
</tr>
<tr>
<td></td>
<td>$133,804.54</td>
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</tbody>
</table>

---

https://aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook
• Constantly moving target between insurers and medical boards and state and federal government
• No two states are alike – Medicaid pays in CO
• Rural vs not – Medicare
• Home as originating site
• Equal pay issue for the Tele vs in person
• Commercial can do or not unless forced through legislation
• Parity – Colorado OK
• Consent and co-pays apply
• FQHC and Medicare distant provider billing limitations
• Instate or across state lines
• Special modifiers you add to CPT codes

• 50 state report – American Telemedicine report
• Resources – Colorado Medicaid Telemedicine Reimbursement Manual
### Potential economic impact of integrated medical-behavioral healthcare

Updated projections for 2017

January 2018

Stephen P. Melick, FSA, MAAA
Douglas T. Norris, FSA, MAAA, PhD
Jordan Paulus, FSA, MAAA
Katharine Matthews, ASA, MAAA
Alexandra Weaver, ASA, MAAA
Stoddard Davenport

<table>
<thead>
<tr>
<th>BODY SYSTEM (CONDITION)</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>BENIGN/IN SITU/UNCERTAIN NEOPLASM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARDIORESPIRATORY ARREST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEREBROVASCULAR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COGNITIVE DISORDERS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIABETES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EARS, NOSE, AND THROAT</td>
<td></td>
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<tr>
<td>EYES</td>
<td>$789</td>
<td>$2,182</td>
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<tr>
<td>GASTROINTESTINAL</td>
<td>$1,132</td>
<td>$2,595</td>
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<tr>
<td>GENITAL SYSTEM</td>
<td>$889</td>
<td>$2,066</td>
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<tr>
<td>HEART</td>
<td>$1,375</td>
<td>$2,867</td>
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<tr>
<td>HEMATOLOGICAL</td>
<td>$1,906</td>
<td>$4,034</td>
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<tr>
<td>LIVER</td>
<td>$1,784</td>
<td>$3,444</td>
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<tr>
<td>LUNG</td>
<td>$990</td>
<td>$2,568</td>
</tr>
<tr>
<td>MALIGNANT NEOPLASM</td>
<td>$2,569</td>
<td>$4,278</td>
</tr>
<tr>
<td>MUSCULO SKELTAL AND CONNECTIVE TISSUE</td>
<td>$931</td>
<td>$2,181</td>
</tr>
<tr>
<td>NEUROLOGICAL</td>
<td>$1,982</td>
<td>$3,177</td>
</tr>
<tr>
<td>NUTRITIONAL AND METABOLIC</td>
<td>$1,095</td>
<td>$2,583</td>
</tr>
<tr>
<td>PREGNANCY-RELATED</td>
<td>$1,540</td>
<td>$2,242</td>
</tr>
<tr>
<td>SKIN AND SUBCUTANEOUS</td>
<td>$804</td>
<td>$2,379</td>
</tr>
<tr>
<td>URINARY SYSTEM</td>
<td>$1,449</td>
<td>$3,217</td>
</tr>
<tr>
<td>VASCULAR</td>
<td>$2,428</td>
<td>$4,533</td>
</tr>
<tr>
<td><strong>TOTAL (INCLUDING THOSE WITHOUT ANY MEDICAL CONDITIONS)</strong></td>
<td><strong>$494</strong></td>
<td><strong>$1,708</strong></td>
</tr>
</tbody>
</table>

Potential calculated savings with IC $175 billion
FEE-FOR-SERVICE
– What we know
– It’s safe and secure
– Non-alignment of incentives for integration

APMs/VALUE-BASED PAYMENT
– The unknown
– Opportunities for rewards, but more uncertainty
CASH FLOW IN FFS VS. A VALUE-BASED ENVIRONMENT

Fee-for-Service World

• Provider performs a service and receives payment for it in a quantifiable period of time (30 – 90 days)
• Reimbursement is certain if billing requirements are met
• Steady cash flow throughout the year
• Traditionally no payment for care coordination, integration, quality

Value-Based Payment World

• Provider performs a service and may receive a FFS payment for some portion of the service
• Payments based on contract performance (managing total cost of care and quality measures) are received after the measurement period, and cannot be quantified at the time service is rendered
  • Some payments may be PMPM
• Uncertain cash flow with delays from time service delivered
• Providers/systems rewarded for quality and metrics that integrated care addresses
  • Alignment of incentives around achieving better outcomes
### COMMON PERFORMANCE MEASURES FOR ACOs, VALUE-BASED PAYMENT

#### Process Metrics
- Percent of patients screened for depression
- Percent with follow-up with therapist within 2 weeks
- Percent not improving that received case review
- Percent not improving referred to specialty BH

#### Outcome Metrics
- Percent with 50% reduction PHQ-9 – Clinical Response at 6 and 12 months
- Percent reaching remission (PHQ-9 < 5 ) at 6 and 12 month

#### Experience
- patient and provider

#### Functional
- work, school, homelessness

#### Utilization/Cost
- ED visits, 30 day readmits, med/surg/ICU, overall cost

---

**Source:** Lori E. Raney et al, *Integrated Care: A Guide to Effective Implementation*; American Psychiatric Association Press; 2017
## EXAMPLE VBP METRICS - WASHINGTON

<table>
<thead>
<tr>
<th>Task</th>
<th>VBP Target</th>
<th>Fidelity Measure</th>
<th>% Payment Returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematic Follow-up</td>
<td>1. Maintain minimum monthly caseload</td>
<td>At least one follow-up with the BHP in each 4 week period</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>2. &gt; 50% of caseload receives &gt;2 visits with BHP per month</td>
<td>Same as above</td>
<td>5%</td>
</tr>
<tr>
<td>Measurement-based Care</td>
<td>Not incentivized</td>
<td>At least on PHQ9 in each 4 week period</td>
<td>0</td>
</tr>
<tr>
<td>Stepped Care</td>
<td>3. BHP reviewed &gt;50% of their caseloads with psychiatrist</td>
<td>At least one psychiatric consultation of the care in each 4 week period</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>4. Registry documents current psychiatric medication for &gt;75% of the caseload</td>
<td>NA</td>
<td>5%</td>
</tr>
</tbody>
</table>
When P4P arrangements were in place, median time to depression treatment response was reduced by half.
BUILD A RELATIONSHIP

+ The future is about value based payment and other alternative payment models.
+ A relationship build on trust will allow you to advocate for specific incentives based on what you know you are good at.
+ Ask questions, be a good partner, and avoid “seeing what happens”
+ Loss of trust will cost you far more in the future.
LORI RANEY
Principal
lraney@healthmanagement.com
Values Alignment

Step 1 – Identify your top values

A. Circle the values in the list below that are most important to you. You aren’t limited to only the values on this list so feel free to use your own values that don’t appear here.

Accountability  
Accuracy  
Achievement  
Adventurousness  
Altruism  
Ambition  
Assertiveness  
Balance  
Being the best  
Belonging  
Boldness  
Calmmess  
Carefulness  
Challenge  
Cheerfulness  
Clear-mindedness  
Commitment  
Community  
Compassion  
Competitiveness  
Consistency  
Contentment  
Continuous  
Improvement  
Contribution  
Control  
Cooperation  
Correctness  
Courage  
Courtesy  
Creativity  
Curiosity  
Decisiveness  
Democratic  
Dependability  
Determination

Diligence  
Discipline  
Discretion  
Diversity  
Dynamism  
Economy  
Education  
Effectiveness  
Efficiency  
Elegance  
Empathy  
Enthusiasm  
Environmentalism  
Equality Excellence  
Excitement  
Expertise  
Exploration  
Expressiveness  
Faith  
Family-oriented  
Fidelity  
Fitness  
Focus  
Freedom  
Fun  
Generosity  
Goodness  
Grace  
Growth  
Happiness  
Hard Work  
Health  
Helping Society  
Holiness  
Honesty  
Honor  
Humility  
Humor  
Independence  
Ingenuity  
Innovation  
Inquisitiveness  
Insightfulness  
Intelligence  
Intellectual Status  
Intuition  
Joy  
Justice  
Leadership  
Legacy  
Love  
Loyalty  
Making a difference  
Mastery  
Merit  
Obedience  
Openness  
Order  
Originality  
Patriotism  
Perfection  
Perseverance  
Positivity  
Practicality  
Preparedness  
Professionalism  
Prudence  
Quality-orientation  
Reliability  
Resourcefulness  
Restraint  
Results-oriented  
Rigor  
Security  
Self-actualization  
Self-control  
Selflessness  
Self-reliance  
Sensitivity  
Serenity  
Service  
Shrewdness  
Simplicity  
Soundness  
Spontaneity  
Stability  
Strategic  
Strength  
Structure  
Success  
Support  
Teamwork  
Temperance  
Thankfulness  
Thoroughness  
Thoughtfulness  
Timeliness  
Tolerance  
Traditionalism  
Trustworthiness  
Truth-seeking  
Understanding  
Uniqueness  
Unity  
Usefulness  
Vision  
Vitality
B. Narrow the list.
- Narrow your list down to a maximum of 10 values.
- Group together similar values to narrow the list.
- Write your values in the table below assigning a letter to each value.

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
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</table>

C. Identify your top 3.
Use the grid below to identify your top 3 through a comparison process.
- Ignore the shaded cells, they will remain unused.
- For all the non-shaded cells, compare the 2 values that the letters represent and choose which value is more important.
- Write the letter of the most important value in the cell.
- For example, if A represents honesty and B represents resiliency, you would write B in the cell to show that you value resiliency over honesty.
Tally your results:
Count how many times you wrote “A” in the grid above and write that number in the table below. Repeat for each letter.

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</tbody>
</table>

The highest number in the table above indicates your most important value. List your top 3 values in order according to the scores in the table above.

#1 Value ____________________________
#2 Value ____________________________
#3 Value ____________________________

Pause Here
Step 2 – Assess Alignment with your Values

List various activities you've done in the past week and rate the level of alignment that activity has to each of your top 3 values.

- **L** = Low: Very little to no alignment
- **M** = Medium: Mediocre alignment or aligns about half of the time
- **H** = High: Very aligned or aligns well most of the time

Activity: ______________________________________________________________________________________

Value #1: _______ Value #2: _______ Value #3: _______

Activity: ______________________________________________________________________________________

Value #1: _______ Value #2: _______ Value #3: _______

Activity: ______________________________________________________________________________________

Value #1: _______ Value #2: _______ Value #3: _______

Activity: ______________________________________________________________________________________

Value #1: _______ Value #2: _______ Value #3: _______

Activity: ______________________________________________________________________________________

Value #1: _______ Value #2: _______ Value #3: _______

Activity: ______________________________________________________________________________________

Value #1: _______ Value #2: _______ Value #3: _______

Activity: ______________________________________________________________________________________

Value #1: _______ Value #2: _______ Value #3: _______

Activity: ______________________________________________________________________________________

Value #1: _______ Value #2: _______ Value #3: _______

Activity: ______________________________________________________________________________________

Value #1: _______ Value #2: _______ Value #3: _______

Activity: ______________________________________________________________________________________

Value #1: _______ Value #2: _______ Value #3: _______

Pauses Here
Step 3 – Improve Alignment to your Values

List your two lowest scoring activities.

List your one lowest scoring value.

Brainstorm ideas for how you can improve the alignment of your values to your activities.

What did you learn or discover in this exercise?

What one action will you take to improve the alignment of activities to your values and when?
Objectives

• Develop and explore a deeper understanding of measures CMS 2 Depression Screening and Follow Up and CMS 122 Diabetes A1c Poor Control.

• Identify resources such as clinical recommendation statements, practice guidelines and measure specifications on CMS 2 and CMS 122.
Test Your Knowledge
Depression Screening and Follow Up

1. What is the age criteria for this measure?

2. A patient is actively being treated for depression and schedules an appointment with his/her physician. Does this patient qualify for the measure? Y/N

3. A practice has completed a PHQ-2 screening with a patient and the result of the screen was negative for depression. Is this patient counted in the numerator? Y/N
Depression Screening and Follow Up

Colorado’s suicide rate of 19.1 per 100,000 residents (2012) is the nation’s sixth highest. Despite concerted efforts, the state has not been able to lower this rate.

A higher percentage of Coloradans living in rural and frontier communities commit suicide than those in more urban counties.

Source: Colorado Health Institute
# Depression Screening and Follow Up

## Measure Name

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Screening for Clinical Depression and Follow-Up Plan (CMS 2/NQF 418)</th>
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<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.</td>
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<tr>
<td><strong>Exclusions/Exceptions</strong></td>
<td>Patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder / Patient refuses to participate OR Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status, OR, situations where the patient’s functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools.</td>
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<tr>
<td>PRIME CQM Y5 MLR = 64%</td>
<td>PRIME CQM Y5 MLR = 64%</td>
<td>RAE (70th %)</td>
<td>KPI BH KPI</td>
</tr>
<tr>
<td>Y6 MLR = 70%</td>
<td>Y6 MLR = 70%</td>
<td>42.31%</td>
<td>RMHP Programs Practice driven</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SIM none</td>
</tr>
</tbody>
</table>

### KPI Call Out

Follow-up After a Positive Depression Screen: % of members engaged in mental health service within 30 days of screening positive for depression within a Primary Care Setting.

### Practice Workflow

1. Identify a standardized/validated screening tool such as the PHQ-2, PHQ-9, PHQ-A, etc.
2. Develop a practice workflow for administration of the screening tool.
3. Develop office protocols that support clinical guidelines inclusive of follow-up, treatment, maintenance, dx criteria, etc.
4. Review and analyze data

### Did ya know?

- Standardized depression screening tools should be normalized and validated for the age appropriate patient population in which they are used and must be documented in the medical record.
- The screening and encounter must occur on the same date.
- The depression screening must be reviewed and addressed in the office by the provider, filing the code, on the date of the encounter.

### Say whattttt?

- This measure actually has nothing to do with depression.
- This is a preventive measure, so every patient, at least once per year, should be screened. This includes patients that only come for acute visits.
- Almost anything counts as a follow up (referrals, medications, additional screenings, suicide assessments, etc.)
- Billing may play a role in how this measure is captured so consider including them on the QI team.
- Parents cannot fill out their child’s screener — have the parent work on other paperwork.

### Why care?

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. While Primary Care Providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients (Boter, 2010, p. 948).
Test Your Knowledge
Diabetes A1c Poor Control

1. What is the age criteria for this measure?

2. A patient with Diabetes is seen by their provider 3 times during the measurement year. The patient is considered “in control” and the provider does not order an A1c test to be done. Is this patient in the numerator? Y/N

3. Are patients with gestational diabetes, or secondary diabetes due to another condition, included in the denominator of this measure? Y/N
Diabetes A1c Poor Control

**Fast Facts on Diabetes**

- 30.3 million people have diabetes
  - (9.4% of the U.S. population)

- **Diagnosed**
  - 23.1 million people

- **Undiagnosed**
  - 7.2 million
  - (23.8% of people with diabetes are undiagnosed)

Source: [American Diabetes Association](https://www.american.diabetes)
# Diabetes A1c Poor Control

## Measure Name

<table>
<thead>
<tr>
<th>Description</th>
<th>Diabetes: Hemoglobin A1c Poor Control (NQF 59/CMS 122)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c &gt; 9.0% during the measurement period (a lower rate indicates better control).</td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td>Patients whose most recent HbA1c level (performed during the measurement period) is &gt; 9.0% (greater than 9.0%).</td>
</tr>
<tr>
<td>Denominator</td>
<td>Patients 18-75 years of age with diabetes with a visit during the measurement period.</td>
</tr>
<tr>
<td>Exclusions/Exceptions</td>
<td>Exclude patients who were in hospice care during the measurement year. NOTE: Patient is numerator compliant if most recent HbA1c level &gt;9.0%, the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement period. Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included.</td>
</tr>
</tbody>
</table>

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<td>Y5 MLR 23.5%</td>
<td>PRIME HEDIS</td>
<td>RAE &amp; CPC+ (70th %)</td>
</tr>
<tr>
<td>Y6 MLR 19.5%</td>
<td></td>
<td></td>
<td>27.27%</td>
</tr>
<tr>
<td>KPI</td>
<td>PAC</td>
<td>RMHP Programs</td>
<td>Practice driven</td>
</tr>
<tr>
<td>SIM</td>
<td>N/A</td>
<td></td>
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</tr>
</tbody>
</table>

## KPI Call Out

Potentially Avoidable Costs: Diabetes is an “episode of focus” in RMHP’s strategy to reduce avoidable costs. The PAC measure is calculated using Prometheus software and is largely focused on both Diabetes and Substance Use Disorder diagnoses.

## Practice Workflow

1. Develop a practice workflow for chronic care management of identified Diabetes patients to include Hemoglobin A1c testing.
2. Develop office protocols that support clinical guidelines inclusive of follow-up, treatment, maintenance, dx criteria, etc.
3. Consider pre-visit planning with these patients.
4. Review and analyze data

## Did ya know? Tips/Tricks

- A missing A1c test during the measurement year will result in the patient being numerator compliant.
- In certain situations a Point-of-Care lab result will NOT satisfy this measure.
- Consider developing care compacts with Endocrinologists that may be managing your Diabetic patients to ensure getting lab results.

## Say whattttt? Odd Things

- This is an INVERSE measure — lower performance is better.
- The most recent A1c test is the one this measure will look at for numerator compliance or non-compliance.
- Average medical expenditures for people with diagnosed diabetes were about $13,700 per year ([2017 CDC Diabetes Statistics Report](#)).

## Why care?

In 2012, diabetes cost the U.S. an estimated $245 billion: $176 billion in direct medical costs and $69 billion in reduced productivity. As the seventh leading cause of death in the U.S., diabetes kills approximately 75,000 people a year (CDC FastStats 2015). A diagnosis of diabetes indicates that a patient has high levels of sugar in the blood due to insulin deficiency or insulin resistance. A patient with a Hemoglobin A1c of greater than 9% would indicate poor control. People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney failure, amputation of toes, feet or legs, and premature death. (CDC Fact Sheet 2014).
PY 2020 Measure Updates

**CMS 2: Screening for Depression and Follow-up Plan**

- Version 9.1
- The depression screen can now be completed on the date of the encounter or up to 14 days prior to the date of the encounter

**CMS 122: Diabetes Hemoglobin A1c Poor Control**

- Version 9.4
- There are now additional denominator exclusions:
  - *Exclude patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.*
  - *Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.*
<table>
<thead>
<tr>
<th><strong>Measure Name</strong></th>
<th><strong>Body Mass Index (BMI Screening and Follow-Up Plan (CMS 69/NQF 0421)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous 12 months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous 12 months of the current encounter. Normal Parameters: Age 18 year and older BMI =&gt; 18.5 and &lt; 25 kg/m2</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Patients with a documented BMI during the encounter or during the previous 12 months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the 12 months of the current encounter.</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>All patients 18 and older on the date of the encounter with at least one eligible encounter during the measurement period.</td>
</tr>
<tr>
<td><strong>Exclusions/Exceptions</strong></td>
<td>Exclusions: Patients who are pregnant, patients receiving palliative care, patients who refuse measurement of height and/or weight or refuse to follow up. Exceptions: Patients with a documented medical reason and patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.</td>
</tr>
<tr>
<td><strong>Fun Links</strong></td>
<td><strong>Measurement Specifications</strong></td>
</tr>
<tr>
<td><strong>Program Suites &amp; Targets</strong></td>
<td>PRIME CQM</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
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<tr>
<td><strong>KPI Call Out</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Practice Workflow</strong></td>
<td>1. Verify your practice documentation workflow supports measurement for BMI Screening and Follow-up plan when appropriate. 2. Build a registry or tracking system to support tracking Follow-Up with out of range patients. 3. Verify your practice’s ability to capture and report data. 4. Review and analyze data.</td>
</tr>
<tr>
<td><strong>Did ya know?</strong></td>
<td><strong>Tips/Tricks</strong></td>
</tr>
</tbody>
</table>
Say whatttt?
Odd Things

- There is no diagnosis associated with this measure
- BMI is not a direct measure of adiposity and as a consequence it can over- or underestimate adiposity
- Out of normal parameter measures of BMI also includes being underweight. Normal Parameters: BMI=>18.5 and < 25
- Screening for BMI and follow-up is critical to closing the gap of BMI and diabetes risk, and contributes to quality goals of population health and cost reduction.

Why care?

- Hales et al (2017), report that the prevalence of obesity among adults and youth of the United States was 39.8% and 18.5% respectively, from 2015-2016. More than a third of U.S adults have a BMI >= 30 kg/m2; substantially at increased risk for diabetes and cardiovascular disease.
- Colorado is ranked as having the healthiest BMI out of 51 states, however the measure went from 6% in 1990 to 22.6% in 2017.
- Colorado Obesity Ranking

Fun graphs:

Notes:
<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Cervical Cancer Screening (CMS 124/NQF 0032)</th>
</tr>
</thead>
</table>
| **Description** | Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:  
* Women age 21-64 who had cervical cytology performed every 3 years  
* Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years |
| **Initial Patient Population** | Women 23-64 years of age with a visit during the measurement period |
| **Numerator** | Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:  
- Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test  
- Cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement period or the four years prior to the measurement period for women who are at least 30 years old at the time of the test |
| **Denominator** | IPP |
| **Exclusions/Exceptions** | Women who had a hysterectomy with no residual cervix or a congenital absence of cervix. Exclude patients whose hospice care overlaps the measurement period. |
| **Fun Links** |  |
|  | Measurement Specifications | Colorado Cancer Coalition | Cervical Cancer Screening Recommendation Summary |
| **Program Suites & Targets** | PRIME CQM N/A | PRIME HEDIS N/A | RAE RAE- 47.76% | CPC+ N/A | RMHP Programs Practice Driven |
| **Practice Workflow** | 1. Verify your practice documentation workflow supports measurement for cervical cancer screening when appropriate  
2. Develop a ‘gaps in care’ report to identify patients needing a cervical cancer screening  
3. Develop a recall system to remind patients when their annual wellness visit is due  
4. Verify your practice’s ability to capture and report data  
5. Verify your workflow includes the technical documentation requirements for screening and follow up to support the data capture for cervical cancer screening. |
| **Did ya know?** |  |
| **Tips/Tricks** |  |
| **Say whattttt?** |  |
| **Odd Things** |  |
| **Why care?** |  |

**Fun graphs:**
Notes:
**Measure Name**  | **Closing the Referral Loop (CMS 50)**
---|---
**Description**  | Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

**Numerator**  | Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred.

**Denominator**  | Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period.

**Exclusions/Exceptions**  | None

**Fun Links**

<table>
<thead>
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<th>Program Suites &amp; Targets</th>
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<th>Safety Net Medical Home</th>
<th>Workflow – Process Map</th>
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<td>N/A</td>
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<tr>
<td>RAE &amp; CPC+</td>
<td>63.79%</td>
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<td>Practice driven</td>
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**KPI Call Out**

Care Compacts: This is a composite measure focused on the relationship between PCMP’s and specialty care providers. There are 2 components to this KPI. 1) Percentage of RAE PCMP’s with Colorado Medical Society Care Compacts in effect with specialty care providers. 2) Percentage of members who had an outpatient visit with a specialist who saw a PCMP within 60 days prior to the specialist visit and included a referring PCMP on the claim.

**Practice Workflow**

1. Develop a standardized workflow for referral management including roles and responsibilities of both the primary and specialty practice. Use care compacts to outline duties.
2. Office protocols should exist for ensuring that patients follow through with appointments when referred out as well as documenting and closing the referral loop when appropriate correspondence is received from the specialists.
3. Use HIT or other Information Systems within the practice to track and close referrals.
4. Review and analyze data

**Did ya know?**

- Patients referred to another practice that do not show up for their scheduled appointment will not satisfy this measure. Practices should consider including no-show policies in executed care compacts to ensure appropriate communication.
- In some EHR’s a workaround to “closing the loop” when patients do not show or refuse to schedule, is to scan a template into the EHR to attach to the referral that has a standardized message on it related to the patient not completing the referral.

**Say whattttt?**

- There is no clinical recommendation statement for this measure.
- This measure is looking at “provider to provider” reports; meaning, it applies to both specialists and primary care providers.

**Why care?**

In a study of physician satisfaction with the outpatient referral process, Gandhi et al. (2000) found that 68% of specialists reported receiving no information from the primary care provider prior to referral visits, and 25% of primary care providers had still not received any information from specialists 4 weeks after referral visits. In a 2006 report to Congress, MedPAC found that care coordination programs improved quality of care for patients, reduced hospitalizations, and improved adherence to evidence-based care guidelines, especially among patients with diabetes and CHD.
Fun graphs:

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<tr>
<td>KPI Call Out</td>
<td>Follow-up After a Positive Depression Screen: % of members engaged in mental health service within 30 days of screening positive for depression within a Primary Care Setting.</td>
<td></td>
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**Practice Workflow**
1. Identify a standardized/validated screening tool such as the PHQ-2, PHQ-9, PHQ-A, etc.
2. Develop a practice workflow for administration of the screening tool.
3. Develop office protocols that support clinical guidelines inclusive of follow-up, treatment, maintenance, dx criteria, etc.
4. Review and analyze data

**Did ya know? Tips/Tricks**
- Standardized depression screening tools should be normalized and validated for the age appropriate patient population in which they are used and must be documented in the medical record.
- The screening and encounter must occur on the same date.
- The depression screening must be reviewed and addressed in the office by the provider, filing the code, on the date of the encounter.

**Say whattttt? Odd Things**
- This measure actually has nothing to do with depression.
- This is a preventive measure, so every patient, at least once per year, should be screened. This includes patients that only come for acute visits.
- Almost anything counts as a follow up (referrals, medications, additional screenings, suicide assessments, etc.)
- Billing may play a role in how this measure is captured so consider including them on the QI team.
- Parents cannot fill out their child’s screener – have the parent work on other paperwork.

**Why care?**
Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. While Primary Care Providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients (Borner, 2010, p. 948).
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<tr>
<td>PRIME CQM</td>
<td>Y5 MLR 23.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Y6 MLR 19.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRIME HEDIS</td>
<td>Y4 MLR 29.23%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>RAE &amp; CPC+ (70th %)</td>
<td>27.27%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>KPI PAC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RMHP Programs</td>
<td>Practice driven</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIM</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**KPI Call Out**

Potentially Avoidable Costs: Diabetes is an “episode of focus” in RMHP’s strategy to reduce avoidable costs. The PAC measure is calculated using Prometheus software and is largely focused on both Diabetes and Substance Use Disorder diagnoses.

**Practice Workflow**

1. Develop a practice workflow for chronic care management of identified Diabetes patients to include Hemoglobin A1c testing.
2. Develop office protocols that support clinical guidelines inclusive of follow-up, treatment, maintenance, dx criteria, etc.
3. Consider pre-visit planning with these patients.
4. Review and analyze data

**Did ya know?**

- A missing A1c test during the measurement year will result in the patient being numerator compliant.
- In certain situations a Point-of-Care lab result will NOT satisfy this measure.
- Consider developing care compacts with Endocrinologists that may be managing your Diabetic patients to ensure getting lab results.

**Say whattttt?**

- This is an INVERSE measure – lower performance is better.
- The most recent A1c test is the one this measure will look at for numerator compliance or non-compliance.
- Average medical expenditures for people with diagnosed diabetes were about $13,700 per year (2017 CDC Diabetes Statistics Report).

**Odd Things**

In 2012, diabetes cost the U.S. an estimated $245 billion: $176 billion in direct medical costs and $69 billion in reduced productivity. As the seventh leading cause of death in the U.S., diabetes kills approximately 75,000 people a year (CDC FastStats 2015). A diagnosis of diabetes indicates that a patient has high levels of sugar in the blood due to insulin deficiency or insulin resistance. A patient with a Hemoglobin A1c of greater than 9% would indicate poor control. People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney failure, amputation of toes, feet or legs, and premature death. (CDC Fact Sheet 2014).
Fun graphs:

CMS-122/NQF-0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Notes:
<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Tobacco Use: Screening and Cessation Intervention (CMS 138/NQF 0028)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: (see Numerator and Denominator for population descriptions).</td>
</tr>
<tr>
<td><strong>Initial Patient Population</strong></td>
<td>All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Population 1: Patients who were screened for tobacco use at least once within 24 months. Population 2: Patients who received tobacco cessation intervention. Population 3: Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.</td>
</tr>
<tr>
<td><strong>Exclusions/Exceptions</strong></td>
<td>Population 1: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason). Population 2: Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason). Population 3: Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (e.g., limited life expectancy, other medical reason).</td>
</tr>
<tr>
<td><strong>Fun Links</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measurement Specifications</td>
</tr>
<tr>
<td><strong>Program Suites &amp; Targets</strong></td>
<td>PRIME CQM</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>KPI Call Out</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Practice Workflow</strong></td>
<td>1. Verify your practice documentation workflow supports measurement for tobacco use and cessation intervention when appropriate. 2. Build a registry or tracking system to support tracking. 3. Verify your practice’s ability to capture and report data. 4. Verify your workflow includes the technical documentation requirements for screening and follow up to support the data capture for tobacco use.</td>
</tr>
<tr>
<td><strong>Did ya know?</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **Tips/Tricks** | The rates simplified:
A: Screened
Initial Patient Population
B: Intervention
Positive Screen
C: Screened + Intervention
Initial Patient Population
- Tobacco Use - Includes any type of tobacco (cigarettes, cigars, smokeless tobacco, etc.).
- Tobacco Cessation Intervention - Includes brief counseling (3 minutes or less), and/or pharmacotherapy – Note: Concepts aligned with brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone). |
are included in the value set for the numerator. Other concepts such as written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies are not included in the value set and do not qualify for the numerator.

- If tobacco use status of a patient is unknown, the patient does not meet the screening component required to be counted in the numerator and should be considered a measure failure. Instances where tobacco use status of "unknown" is recorded include: 1) the patient was not screened; or 2) the patient was screened and the patient (or caregiver) was unable to provide a definitive answer.

**Say whattttt? Odd Things**
- The measure does not currently capture e-cigarette usage as either tobacco use or as a cessation aid. E-cigarettes (such as vapes) contain nicotine but do not contain or burn tobacco.
- For RMHP Programs, we only track rate C, but rates A and B must be submitted.

**Why care?**
- Tobacco use is the leading cause of preventable disease, disability, and death in the United States (CDC, 2019).
- Each year, the United States spends nearly $170 billion on medical care to treat smoking-related disease in adults (CDC, 2019).
- [Colorado Quit Line](#)

**Billing Considerations**
- The following CPT codes can be submitted for tobacco cessation intervention:
  - 99406 Smoking and tobacco cessation counseling visit for the symptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes.
  - 99407 Intensive, greater than 10 minutes
- These counseling services must be submitted with appropriate diagnosis coding to support medical necessity. The claim and documented encounter should include tobacco use status and confirmed tobacco-related diseases, as appropriate.

**Fun graphs:**

![Graph 1](#)

![Graph 2](#)

**Notes:**
<table>
<thead>
<tr>
<th><strong>Measure Name</strong></th>
<th><strong>Well Child Visits (NQF 1392 and NQF 1516)</strong></th>
</tr>
</thead>
</table>
| **Description**  | NQF 1392: Percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life.  
NQF 1516: Percentage of children 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement year. |
| **Numerator**    | NQF 1392: Children who received the following number of well-child visits with a PCP during their first 15 months of life – N1: No well-child visits; N2: One well-child visit; N3: Two well-child visits; N4: Three well-child visits; N5: Four well-child visits; N6: Five well-child visits; N7: Six or more well-child visits.  
NQF 1516: Children who received at least one well-child visit with a PCP during the measurement year. |
| **Denominator**  | NQF 1392: Children 15 months old during the measurement year.  
NQF 1516: Children 3 to 6 years of age during the measurement year. |
| **Exclusions/Exceptions** | None |
| **Fun Links** |  |
| **Program Suites & Targets** | PRIME CQM | RMHP HEDIS FOCUS | RAE & CPC+ | KPI | RMHP Programs | SIM |
| | N/A | Medicaid/CHP+ | 56% | 48.55%* | Practice driven | N/A |
| **KPI Call Out** | Non-incentivized measure for KPI’s but is used to demonstrate performance in the RAE. The state baseline is 48.55. We reach target 1 at a 1-4% improvement, and target 2 at 5% or more improvement. |
| **Practice Workflow** | 1. Develop a practice workflow for implementing well-child visits including patient recall.  
2. Develop office protocols and adopt a practice guideline that supports clinical guidelines in screening and management of well-child visits.  
3. Consider family planning with these patients.  
4. Review and analyze data |
| **Did ya know?** |  |
| **Tips/Tricks** | • Accurate and appropriate coding seems to be a large barrier to capturing the data that supports this measure.  
• See the resource [here](#) for tips on coding well-care visits for children and adolescents. |
| **Say whattttt?** |  |
| **Odd Things** | • See the Bright Futures Recommendations for Preventive Pediatric Health Care [here](#).  
• Bright Futures recommends autism screening at 18 and 24 months of age, cholesterol screening between nine and 11 years of age, an annual screening for high blood pressure beginning at three years of age – none of which are included in the AAFP list of recommended preventive services for children. |
| **Why care?** | The 2011/2012 National Survey of Children’s Health showed that an estimated 11 million children 0 to 17 years of age did not have any preventive medical care visits in the past year (Child and Adolescent Health Measurement Initiative [CAHMI], n.d.). Studies show that children with delayed development who receive early intervention are more likely to graduate high school, hold a job, live independently and avoid teen pregnancy, delinquency and violent crimes — representing a saved cost to society of between $30,000 and $100,000 per child (Glascoe & Shapiro, 2007). |
**Fun graphs:**

**We only have Dino-Peds actively reporting on this measure right now**

**Notes:**
Phase-Based Care
An Innovative Approach to Mental Health Care

Jules Rosen; MD
Michelle Hoy; LPC, CAC III
David Hayden; LPC, CAC III,
Sharon Raggio; LPC LMFT MBA
• **Increasing demands for care**
  - ACA resulted in 40% higher Medicaid recipients in CO

• **Care delivered in “silos”**
  - Typically poor coordination between meds and therapy

• **Long wait time to access psychiatry**
  - Annecdotal: 7 to 12 weeks, longer for Medicaid and Rural

• **Therapists with large caseloads see returning patients routinely**
Implication of Inadequate Access and Engagement

- Patient suffering
- Family distress
- Financial loss
- Over-use of hospital emergency departments
- Increased morbidity
- Suicides
Core Values

- Access
- Engagement
- Person-centered
- Cost-effective
- Promote good patient outcomes
- Promote staff satisfaction
Principle of Phase-based care

- Mental illness has phases (for most people)
- During “acute” phase: resources need to be evidence-based, intensity appropriate, and timely
  - Monthly “therapy” visits are not evidence-based
- USE VALID RATING INSTRUMENTS AS GUIDE TREATMENT INTENSITY OVER TIME
- Coordinate treatment efforts of ALL team members
- When symptoms improve, treatment plan changes to meet the reduced intensity.
Points of Agreement

- Treatment works for different people at different times
  - Medication
  - Psychotherapy
  - Peer Support
  - Mindfulness
  - Pet Therapy
  - Equine Therapy
  - Groups
  - “Happy Hour”
  - OTHER
- Treatment per patient preference and needs AND our capacity
- The right TX at the right time = best clinical and financial outcomes
- Evidence-based and Person-centered drive process
Phases of Depression

- 6-12 weeks
- 6-9 Months
- 1 year

(Kupfer et al, 1991, J Clin Psychiatry)
### Every Touch Has MEANING

Improved reduction in depressive symptoms

<table>
<thead>
<tr>
<th>Additional Visit (6 weeks)</th>
<th>Antidepressant</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>56%</td>
<td>51%</td>
</tr>
<tr>
<td>2</td>
<td>70%</td>
<td>79%</td>
</tr>
</tbody>
</table>

The credentials of the “toucher” does not matter!!!

6 Week RCTs; 15 with 6 visits; 19 without 5 visits, 7 with 4 visits
Therapeutic Effect is Cumulative. No Effect on Completion Rates (59 – 63%).
Efficacy of Treatments and Controls for Depression (N=10,310)
Measuring Care Matters

B. Estimated Mean Time to Remission

- Teaching hospital
- Adult outpatients with moderate to severe major depression
- Pharmacotherapy restricted to paroxetine or mirtazapine in both groups

Challenges

- Long wait-times to engage in treatment
- Once engaged, treatment intensity not matched to symptom severity
- Staff resources are not managed to prioritize care to the most highly symptomatic patients
- Appointments scheduled according to provider schedules rather than patient need
  - symptom severity should guide treatment intensity over time
Solutions: Phase-based Care

- Illness severity presents with “phases” for most patients
- Medication and non-medication approaches can be equally effective when coordinated through an integrated team approach
- Quantitative assessment of symptom severity longitudinally with rating instruments improves outcomes
The Culture Change

- Therapists and medical providers have “routines” for managing stable patients
  - “My patients have the right to see me once per month”
  - Sometimes fueled by State regulation requiring routine visits or discharge
- Fully integrated care of medical and non-medical teams not the norm
  - Some exceptions like ACT team
- Use of valid rating instruments not universally accepted across medical and especially non-medical team members
- Universal response to Phase-based Care: “You will have to double our staff”
Developing Phase-based Clinics

- Use of mathematical algorithms and scalable database to manage patient flow and staff allocations
  - Algorithms used to incremental shift clinic from “routine” to Phase based
- Single, multi-disciplinary care plan modified as symptoms change
- Treatment team of physicians, APNs, therapists, case managers and peers
  - Meet weekly to review PHQ 9 scores, resource utilization
Developing Phase-based Clinics
cont.

- Patients can choose evidence-based treatment modalities
  - psychotherapy, medications, groups, peer support, case management
- Scheduled appointments as well as weekly walk-in options
- The PHQ 9 depression rating scale is completed at each visit to assess progress or lack of progress.
Rapid Recovery Clinic for Depression

- Initially met 4 hours per week plus one hour team meeting
  - Now 8 hours per week and 2 providers and 4 therapists
- Patient can have scheduled appointment or walk-in
- Appointment frequency and duration based on patient need
- Valid rating instrument: PHQ-9
- Patients review their measurements with team
- Assumptions of staffing model created by team members
  - how many therapy / med management sessions will you need to treat this depression?
- Weekly team meetings review all new and acute patients
Weekly Team Meeting
Rapid Recovery Dashboard 12/30/2018

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Pts.</td>
<td>142</td>
<td>Days to appt.</td>
<td>4.5</td>
<td>Ave. therapy hrs. / client (acute)</td>
</tr>
<tr>
<td>Acute Phase</td>
<td>78</td>
<td>Days to provider</td>
<td>3.9</td>
<td>Average # Provider Hours per client, (acute)</td>
</tr>
<tr>
<td>% drop out (wk 6)</td>
<td>13</td>
<td>Ave PHQ init</td>
<td>20.3</td>
<td>Average # Peer hours per client, (acute)</td>
</tr>
<tr>
<td>Total pts. (15 mths)</td>
<td>182</td>
<td>Ave. PHQ wk 12</td>
<td>12.0</td>
<td>Ave. CM hrs / pt. (acute)</td>
</tr>
</tbody>
</table>
Summary of Clinical Outcomes

• Acute Phase for Depression: PHQ 9 of >10
  o “Recovery” means out of acute phase; different from remission
• Week 6 and 12: 63% and 78% no longer in acute phase
  o STAR D data of routine care time to remission:
    16% and 33% at weeks 6 and 12
• Time to engagement with full treatment team: 4 days
  o Anecdotal time nationwide > 7 weeks
Resources Utilization

- 4 hours per week of clinic time (recently expanded)
- 8 hours of provider time (2 providers)
- 12 hours of therapy (3 therapists)
- 4 hrs. of CM, MCM, and Peer
- Admit 6-8 new patients per week plus 8 – 12 scheduled f/u
- Typically 15 – 20 walk-ins
Creating Model: Group Exercise

- How many new patients/year?
- How long for initial evaluation?
- % going on to therapy (acute)?
- % needing medication (acute)?

- Average provider time (acute)?
- Average therapist time (acute)?
- Average CM (acute)?
- Average Group utilization (acute)?
Phase-based Care Video
LAST CALL

RECOGNIZING PATTERNS OF ALCOHOL USE DISORDER

Dr. Ryan Jackman
Jessica Stephen Premo, PhD, LMFT
DISCLOSURES

Both Ryan Jackman, MD and Jessica Stephen Premo, PhD work at St. Mary’s Integrated Addiction Medicine Program which operates a HRSA RCORP Grant for Improving Addiction Services (particularly for Opioid Use Disorder) in Western Colorado.

Dr. Jackman serves as a consultant for the SAMHSA Opioid Response Network.
OBJECTIVES

AT THE END OF THIS PRESENTATION PARTICIPANTS WILL BE ABLE TO:

• DISCUSS THE RISKS AND COSTS ASSOCIATED WITH DIFFERENT PATTERNS OF ALCOHOL USE

• EXAMINE HIS OR HER CLINIC’S PRACTICES FOR IDENTIFYING AND INTERVENING WITH ALCOHOL USE

• IDENTIFY POINTS AT WHICH EFFECTIVE TREATMENT PRACTICES, INCLUDING REFERRAL, CAN BE IMPLEMENTED TO IMPROVE TREATMENT OF ALCOHOL USE
ALCOHOL USE FACTS

88,000 alcohol-related DEATHS per year (2006-2010)

WHAT IS A STANDARD DRINK?
- 12 fl oz of beer
- 8 fl oz of wine
- 5 fl oz of spirits

$249 BILLION
Cost of excessive alcohol use in the U.S. in 2010

Workplace productivity: $179 billion
Medical expenses: $28 billion
Criminal justice: $25 billion
Motor vehicle collisions: $13 billion

EXCESSIVE DRINKING

WOMEN
- Binge drinking is having 4 or more drinks in one occasion
- Heavy drinking is having 8 or more drinks per week

MEN
- Binge drinking is having 5 or more drinks in one occasion
- Heavy drinking is having 15 or more drinks per week

UNDERAGE DRINKING IS RISKY DRINKING in 2016 ages 12 to 20
- 19.3% (7.3 Mil) reported alcohol use
- 12.1% (4.5 Mil) were binge drinkers
- 2.8% (1 Mil) were heavy drinkers

ALCOHOL USE AGE 21 OR OLDER in 2016
- 55.8% (129 Mil) reported alcohol use
- 6.2% (60 Mil) were binge drinkers
- 6.6% (15 Mil) were heavy drinkers

## Patterns of Alcohol Use

<table>
<thead>
<tr>
<th>Drinking pattern</th>
<th>AUD Criteria</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinent/Low Risk</td>
<td>Less than NIAAA limits</td>
<td>None</td>
</tr>
<tr>
<td>At-Risk Drinking</td>
<td>Above NIAAA daily limits 1-7 days per week</td>
<td>0-2 dependence only</td>
</tr>
<tr>
<td>Harmful Drinking</td>
<td>Episodic to daily</td>
<td>0-2 dependence</td>
</tr>
<tr>
<td></td>
<td>0-1 abuse</td>
<td></td>
</tr>
<tr>
<td>Dependent Drinking</td>
<td>Daily or near-daily, 5-10 drinks per day</td>
<td>3-5 dependence 0-1 abuse</td>
</tr>
<tr>
<td>Chronic Dependence</td>
<td>Daily or near-daily, 10+ drinks per day</td>
<td>6-7 dependence 2-4 abuse</td>
</tr>
</tbody>
</table>
## Costs of Excessive Alcohol Consumption by State

<table>
<thead>
<tr>
<th>Location</th>
<th>Total Cost ($)</th>
<th>Cost per drink ($)</th>
<th>Cost per capita ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>3,724,300,000</td>
<td>2.27</td>
<td>779</td>
</tr>
<tr>
<td>Alaska</td>
<td>827,200,000</td>
<td>2.25</td>
<td>1,165</td>
</tr>
<tr>
<td>Colorado</td>
<td>5,056,500,000</td>
<td>2.14</td>
<td>1,005</td>
</tr>
<tr>
<td>Michigan</td>
<td>8,161,700,000</td>
<td>2.10</td>
<td>826</td>
</tr>
<tr>
<td>Minnesota</td>
<td>3,886,400,000</td>
<td>1.74</td>
<td>733</td>
</tr>
<tr>
<td>North Dakota</td>
<td>487,600,000</td>
<td>1.40</td>
<td>725</td>
</tr>
<tr>
<td>Texas</td>
<td>18,820,600,000</td>
<td>1.99</td>
<td>748</td>
</tr>
<tr>
<td>Utah</td>
<td>1,636,100,000</td>
<td>2.74</td>
<td>592</td>
</tr>
<tr>
<td>Vermont</td>
<td>513,000,000</td>
<td>1.66</td>
<td>820</td>
</tr>
<tr>
<td>Virginia</td>
<td>6,126,000,000</td>
<td>2.06</td>
<td>766</td>
</tr>
<tr>
<td>Washington</td>
<td>5,805,100,000</td>
<td>2.23</td>
<td>863</td>
</tr>
<tr>
<td>West Virginia</td>
<td>1,334,900,000</td>
<td>2.20</td>
<td>720</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>4,452,900,000</td>
<td>1.62</td>
<td>783</td>
</tr>
<tr>
<td>Wyoming</td>
<td>593,100,000</td>
<td>2.33</td>
<td>1,052</td>
</tr>
</tbody>
</table>
Economic costs

- Excessive alcohol consumption cost the United States $249 billion in 2010. This cost amounts to about $2.05 per drink, or about $807 per person.

- Costs due to excessive drinking largely resulted from losses in workplace productivity (72% of the total cost), health care expenses (11%), and other costs due to a combination of criminal justice expenses, motor vehicle crash costs, and property damage.

- Excessive alcohol use cost states and DC a median of $3.5 billion in 2010, ranging from $488 million in North Dakota to $35 billion in California.

- Binge drinking, defined as consuming 4 or more drinks per occasion for women or 5 or more drinks per occasion for men, was responsible for about three-quarters (77%) of the cost of excessive alcohol use in all states and DC.

- About $2 of every $5 of the economic costs of excessive alcohol use were paid by federal, state, and local governments.
ALCOHOL USE IN THE U.S.

Alcohol Initiates

PAST YEAR, 2015 - 2017, 12+

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>12 - 17</td>
<td>2.4M</td>
<td>2.3M</td>
<td>2.3M</td>
<td>2.2M</td>
<td>2.2M</td>
<td>2.4M</td>
</tr>
<tr>
<td>18 - 25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 or Older</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Alcohol Use Disorder

PAST YEAR, 2015 - 2017, 12+

<table>
<thead>
<tr>
<th>AUD</th>
<th>2015: 15.7M</th>
<th>2016: 15.1M</th>
<th>2017: 14.4 M</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 - 17</td>
<td>0.6M</td>
<td>0.5M</td>
<td>0.4M</td>
</tr>
<tr>
<td>18 - 25</td>
<td>11.3M</td>
<td>10.9M</td>
<td>10.6M</td>
</tr>
<tr>
<td>26 or Older</td>
<td>10.8%</td>
<td>10.6%</td>
<td>10.5%</td>
</tr>
</tbody>
</table>

See tables 7.29, 7.31, and 7.32 in the 2017 NSDUH detailed tables for additional information.

+ Difference between this estimate and the 2017 estimate is statistically significant at the 0.05 level.
SCREENING: WHO

RECOMMENDATIONS:

- CENTERS FOR MEDICARE AND MEDICAID SERVICES
- U.S. PREVENTIVE SERVICES TASK FORCE
- SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
- AMERICAN ACADEMY OF PEDIATRICS
WHAT IS “ONE” DRINK?!?
**AUDIT-C**

Please circle the answer that is correct for you.

<table>
<thead>
<tr>
<th>1. How often do you have a drink containing alcohol?</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never (0)</td>
<td></td>
</tr>
<tr>
<td>Monthly or less (1)</td>
<td></td>
</tr>
<tr>
<td>Two to four times a month (2)</td>
<td></td>
</tr>
<tr>
<td>Two to three times per week (3)</td>
<td></td>
</tr>
<tr>
<td>Four or more times a week (4)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 or 2 (0)</td>
<td>10</td>
</tr>
<tr>
<td>3 or 4 (1)</td>
<td>3</td>
</tr>
<tr>
<td>5 or 6 (2)</td>
<td>5</td>
</tr>
<tr>
<td>7 to 9 (3)</td>
<td>9</td>
</tr>
<tr>
<td>10 or more (4)</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. How often do you have six or more drinks on one occasion?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Never (0)</td>
<td>0</td>
</tr>
<tr>
<td>Less than Monthly (1)</td>
<td>1</td>
</tr>
<tr>
<td>Monthly (2)</td>
<td>2</td>
</tr>
<tr>
<td>Two to three times per week (3)</td>
<td>3</td>
</tr>
<tr>
<td>Four or more times a week (4)</td>
<td>4</td>
</tr>
</tbody>
</table>

**TOTAL SCORE**
Add the number for each question to get your total score.

Maximum score is 12. A score of ≥ 4 identifies 86% of men who report drinking above recommended levels or meets criteria for alcohol use disorders. A score of > 2 identifies 84% of women who report hazardous drinking or alcohol use disorders.

**SCREENING: HOW**

- AUDIT/AUDIT-C
- ASSIST
- TAPS
- CAGE
- TWEAK
- PREGNANCY: 5 P’S
- ADOLESCENTS: CRAFFT
- OLDER ADULTS: MAST-G
SCREENING: WHEN

- HIGH BLOOD PRESSURE
- DIABETES
- ACID REFLUX
- ED FOLLOW-UP
- ACCIDENTS
## ALCOHOL BIOMARKERS AND HOW TO USE THEM

<table>
<thead>
<tr>
<th></th>
<th>Sens/Spec %</th>
<th>Time to Return to Normal</th>
<th>To Know</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>GGT</td>
<td>Sens: 34-85 Spec: 11-95</td>
<td>2-4 weeks</td>
<td>5 drinks/day for several weeks. Best in 30-60 y/o. More specific than AST/ALT. Risk of false positives.</td>
<td>$95, 8hrs</td>
</tr>
</tbody>
</table>
| AST/ALT | AST Sens: 15-69 Spec 47-68  
ALT Sens: 18-58 Spec: 50-57 | 2-4 weeks              | Requires heavy drinking for several weeks. | CMP $127 LFT $69.75, 4-8hrs |
| MCV   | Sens: 34-89 Spec 26-95 | Months                   | Requires heavy drinking for several months                            | CBC        |
### Alcohol Biomarkers and How to Use Them

<table>
<thead>
<tr>
<th>Biomarker</th>
<th>Sens/Spec %</th>
<th>Time to Return to Normal</th>
<th>To Know</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>EtG/EtS</td>
<td>Sens: 76-91 Spec: 77-92</td>
<td>1-3 days</td>
<td>Direct biomarker. Also good at monitoring abstinence. Other EtOH containing products can cause +.</td>
<td>$90, 1-4 days</td>
</tr>
<tr>
<td>PEth</td>
<td>Sens: 94.5 Spec: 100</td>
<td>2-4 weeks</td>
<td>3-4 drinks/day. Linear dose response. More research needed.</td>
<td>$145, 2-4 days</td>
</tr>
<tr>
<td>Carbohydrate-Deficient Transferrin (CDT)</td>
<td>Sens: 39-94 Spec: 82-100</td>
<td>2-3 weeks</td>
<td>5 drinks/day for 2 weeks. Good for relapse to heavy drinking only.</td>
<td>$211 (ARUP) 1-8 days</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Drinking pattern</th>
<th>AUD Criteria</th>
<th>Disability</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abstinent/Low Risk</strong></td>
<td>Less than NIAAA limits</td>
<td>None</td>
<td>Health promotion/primary prevention</td>
</tr>
<tr>
<td><strong>At-Risk Drinking</strong></td>
<td>Above NIAAA daily limits 1-7 days per week</td>
<td>0-2 dependence only</td>
<td>None</td>
</tr>
<tr>
<td><strong>Harmful Drinking</strong></td>
<td>Episodic to daily</td>
<td>0-2 dependence 0-1 abuse</td>
<td>Limited</td>
</tr>
<tr>
<td><strong>Dependent Drinking</strong></td>
<td>Daily or near-daily, 5-10 drinks per day</td>
<td>3-5 dependence 0-1 abuse</td>
<td>Mild to moderate</td>
</tr>
<tr>
<td><strong>Chronic Dependence</strong></td>
<td>Daily or near-daily, 10+ drinks per day</td>
<td>6-7 dependence 2-4 abuse</td>
<td>Moderate to severe</td>
</tr>
</tbody>
</table>
BRIEF INTERVENTION

MOTIVATIONAL INTERVIEWING:
1. BUILD RAPPORT AND RAISE THE SUBJECT
2. PROVIDE FEEDBACK
3. BUILD READINESS TO CHANGE
4. NEGOTIATE A PLAN FOR CHANGE

FIVE A’S: ASSESS, ADVISE, AGREE, ASSIST & ARRANGE

OTHER INTERVENTIONS: SLEEP HYGIENE, SMOKING CESSATION, SMART GOALS

WHO?
ALCOHOL USE DISORDER (DSM V CRITERIA)
AT LEAST TWO OF THE FOLLOWING IN THE PAST 12 MONTHS. MILD (2-3), MODERATE (4-5), SEVERE (>6)

- Larger amounts of alcohol
- Unsuccessful efforts to cut down
- A great deal of time is spent in obtaining, using, or recovering
- Cravings, strong urge to use
- Recurrent failures to fulfill major obligations
- Giving up important activities to use
- Continued use despite having persistent social/interpersonal problems
- Recurrent use despite danger
- Recurrent use despite knowledge of physical/psych consequences.
- Tolerance
- Withdrawal

ADDICTION-FOCUSED BEHAVIORAL THERAPY

STEPWISE APPROACH:

• SAFETY PLANNING AND HARM REDUCTION
• RELAPSE PREVENTION
• INVOLVEMENT WITH SELF-HELP (AA/NA) OR INCREASE IN OTHER SUPPORTS
• PSYCHOSOCIAL INTERVENTION
• MINDFULNESS SKILLS
• TRAUMA-FOCUSED-COGNITIVE BEHAVIORAL THERAPY
• ACCEPTANCE & COMMITMENT THERAPY
• DIALECTICAL BEHAVIORAL THERAPY
• COMPLEMENTARY WELLNESS

WHO?
**PHARMACOTHERAPY – SEE SHEET**

**Table: Medications for outpatient alcohol detoxification**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Example Regimen</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clonidine</td>
<td>25-100 mg q8h x 4 doses, then 25-50 mg q6h x 8 doses OR 50 mg q6-12h (day 1), 25 mg q6h (day 2), 25 mg q12h (day 3), then 25 mg at bedtime (day 4) OR 50 mg bid may repeat up to 300 mg daily. Reduce to sustained (FDA approved regimen)</td>
<td>Long-acting – associated with fewer breakthrough or rebound symptoms. Self-tapering. May have lower abuse potential than disulfpram.</td>
</tr>
<tr>
<td>Diazepam</td>
<td>10-30 mg q6h x 6 doses, then 10-15 mg q6h x 6 doses OR 10 mg q6h every 8 hours (day 1), then 5 mg q6h x 6 doses daily as needed (FDA approved regimen)</td>
<td>Long-acting – associated with fewer breakthrough or rebound symptoms. Self-tapering. Relatively free of sedating action.</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>2-4 mg q6h x 6 doses, then 1-2 mg q6h x 6 doses OR 2 mg TID x 3 days, then 2 mg BID or q6h OR 4 with 1-2 mg breakthrough dose available up to 3 breakthrough doses/day</td>
<td>Shorter-acting – associated with more breakthrough or rebound symptoms than clonidine or disulfpram. May consider clonidine/diazepam or lorazepam when prolonged sedation is not a concern.</td>
</tr>
<tr>
<td>Oxazepam</td>
<td>30 mg q6h (day 1), 30 mg q6h (day 2), 20 mg q12h (day 3), then 5 mg q6h at bedtime (day 4) OR 15-50 mg q6h-8 doses (FDA approved regimen)</td>
<td>Shorter-acting – associated with more breakthrough or rebound symptoms than clonidine or disulfpram. May consider clonidine/diazepam or lorazepam when prolonged sedation is a concern.</td>
</tr>
</tbody>
</table>

**Table: Medications for maintaining abstinence from alcohol**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosing</th>
<th>Contraindications</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naltrexone</td>
<td>50 mg daily</td>
<td>Opioid use (patient should carry an alert for emergency personnel), acute hepatitis or liver failure</td>
<td>May be started while patient in still drinking. Reduces cravings; helps prevent relapse to heavy drinking. Can be combined with acamprosate once abstinence is achieved. DM formulation available (150 mg DM q4 weeks)</td>
</tr>
<tr>
<td>Acamprosate</td>
<td>666 mg TID 333 mg TID (G/C 30-50 ml/min)</td>
<td>Severe renal impairment (G/C ≥ 30 ml/min)</td>
<td>For patients who are abstinent. May be better than naltrexone for maintaining abstinence. Helps prevent relapse to heavy drinking.</td>
</tr>
</tbody>
</table>

**Second Line:**

| Disulfpradine | Initial: 500 mg daily x 1-2 weeks Maintenance: 250 mg daily | Use of alcohol or ethanol-containing medications, metronidazole, severe musculoskeletal dis/amenorrhoea, psychosis | For patient who are abstinence (minimum 12 hours since last drink). Does not reduce cravings. Requires a motivated patient. Poorly tolerated. Reduces heavy drinking days: Poorly tolerated. Tolerance occurring naltrexone to potentiate final little difference in outcomes. |
| Topiramate | Initial: 25-50 mg daily with slow titration up to 150 mg BID Taper when discontinued | Taper when discontinued |
| Buprenorphine | Initial: 5 mg TID x 3 days, then 10 mg TID Taper when discontinued | Mixed results in studies; may improve chance of abstinence. |

**Additional information that have some case report/trial data include:**

- Ondansetron 4 mg/kg BID
- Gabapentin higher doses (1800 mg/daily and greater) had better outcomes
- Naltrexone 200 mg daily (for 3-5 days)
- N-acetyl cysteine may be beneficial for patients with depression and alcoholism
- Varenicline patients who were trying to quit smoking self-reported less drinking

---

**Additional Table:**

<table>
<thead>
<tr>
<th>Antidepressants</th>
<th>200 mg q6h (day 1), 200 mg q6h (day 2), 200 mg q6h (day 3), 100 mg q6h (day 4)</th>
<th>Consider when a benzodiazepine is not desirable. Watch for drug-drug interactions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gemfibrozil</td>
<td>Don’t forget folic acid and a multivitamin. Some case reports have also used a gabapentin taper over 5-7 days for outpatient alcohol detoxification.</td>
<td></td>
</tr>
</tbody>
</table>
QUESTIONS

Contact
Ryan Jackman
ryan.jackman@sclhealth.org

Jessica Stephen Premo
Jessica.Stephenpremo@sclhealth.org

Clinic 970-298-3801
Outpatient alcohol detoxification criteria:
- CIWA score of up to 15 without symptoms of delirium tremens or seizures ([http://my.ireta.org/sites/ireta.sitesquad.net/files/CIWA-Ar.pdf](http://my.ireta.org/sites/ireta.sitesquad.net/files/CIWA-Ar.pdf))
- Able to commit to daily medical visits
- Responsible close contact available to stay with patient throughout the detoxification period
- No unstable medical condition, not pregnant, psychotic or suicidal
- No concurrent withdrawal from other substances
- No history of delirium tremens or alcohol withdrawal seizures
- Age less than 60 years

### Medications for outpatient alcohol detoxification

<table>
<thead>
<tr>
<th>Medication</th>
<th>Example Regimen</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlordiazepoxide</td>
<td>25-100 mg q6 hours x 4 doses, then 25-50 mg q6 hours x 8 doses OR 50 mg q6-12 hours (day 1), 25 mg q6 hours (day 2), 25 mg q12 hours (day 3), then 25 mg at bedtime (day 4) OR 50-100 mg per dose may repeat up to 300 mg/day. Reduce as tolerated (FDA approved regimen)</td>
<td>• Long-acting – associated with fewer breakthrough or rebound symptoms • “Self-tapering” • May have a lower abuse potential than diazepam</td>
</tr>
<tr>
<td>Diazepam</td>
<td>10-20 mg q6 hours x 4 doses, then 5-10 mg q6 hours x 8 doses OR 10 mg q6-8 hours (day 1), then 5 mg q6-8 hours daily as needed (FDA approved regimen)</td>
<td>• Long-acting – associated with fewer breakthrough or rebound symptoms • “Self-tapering” • Relative fast onset of action</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>2-4 mg q6 hours x 8 doses, then 1-2 mg q6 hours x 8 doses OR 2 mg TID x 3 days, then 2 mg BID on day 4 with 1-2 mg breakthrough doses available (up to 3 breakthrough doses/day)</td>
<td>• Shorter-acting – associated with more breakthrough or rebound symptoms then chlordiazepoxide or diazepam • May consider over chlordiazepoxide or diazepam when prolonged sedation is a concern</td>
</tr>
<tr>
<td>Oxazepam</td>
<td>30 mg q6 hours (day 1), 30 mg q8 hours (day 2), 30 mg q12 hours (day 3), then 30 mg at bedtime (day 4) OR 15-30 mg q6-8 hours (FDA approved regimen)</td>
<td>• Shorter-acting – associated with more breakthrough or rebound symptoms then chlordiazepoxide or diazepam • May consider over chlordiazepoxide or diazepam when prolonged sedation is a concern • May have lower abuse potential then diazepam or lorazepam</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>200 mg q6 hours (day 1), 200 mg q8 hours (day 2), 200 mg q12 hours (day 3), then 200 mg daily (for 1-2 days)</td>
<td>• Consider when a benzodiazepine is not desirable • Watch for drug-drug interactions</td>
</tr>
</tbody>
</table>

- Don’t forget thiamine, folic acid and a multivitamin
- Some case reports have also used a gabapentin taper over 5-7 days for outpatient alcohol detoxification
**Medications for maintaining abstinence from alcohol**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosing</th>
<th>Contraindications</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Line</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naltrexone</td>
<td>50 mg daily</td>
<td>Opioid use (patient should carry an alert for emergency personnel); acute hepatitis or liver failure</td>
<td>• May be started while patient is still drinking&lt;br&gt;• Reduces cravings; helps prevent relapse to heavy drinking&lt;br&gt;• Can be combined with acamprosate once abstinence is achieved&lt;br&gt;• IM formulation available (380 mg IM q4 weeks)</td>
</tr>
<tr>
<td>Acamprosate</td>
<td>666 mg TID&lt;br&gt;333 mg TID (CrCl 30-50 ml/min)</td>
<td>Severe renal impairment (CrCl &lt; 30 ml/min)</td>
<td>• For patients who are abstinent&lt;br&gt;• May be better than naltrexone for maintaining abstinence&lt;br&gt;• Helps prevent relapse to heavy drinking</td>
</tr>
<tr>
<td><strong>Second Line</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disulfiram</td>
<td>Initial: 500 mg daily x 1-2 weeks&lt;br&gt;Maintenance: 250 mg daily</td>
<td>Use of alcohol or ethanol-containing medications, metronidazole, severe myocardial disease/coronary occlusion, psychosis</td>
<td>• For patient who are abstinent (minimum 12 hours since last drink)&lt;br&gt;• Does not reduce cravings&lt;br&gt;• Requires a motivated patient&lt;br&gt;• Poorly tolerated</td>
</tr>
<tr>
<td>Topiramate</td>
<td>Initial: 25-50 mg daily with slow titration up to 150 mg BID&lt;br&gt;Taper when discontinued</td>
<td></td>
<td>• Reduces heavy drinking days&lt;br&gt;• Poorly tolerated&lt;br&gt;• Trials comparing naltrexone to topiramate found little difference in outcomes</td>
</tr>
<tr>
<td>Baclofen</td>
<td>Initial: 5 mg TID x 3 days, then 10 mg TID&lt;br&gt;Taper when discontinued</td>
<td></td>
<td>• Mixed results in studies, may improve chance of abstinence</td>
</tr>
</tbody>
</table>

Additional medications that have some case report/series data include:
- Ondansetron 4 mcg/kg BID
- Gabapentin higher doses (1800 mg/day and greater) had better outcomes
- SSRIs (fluoxetine, sertraline) maybe beneficial for patients with depression and alcoholism
- Varenclire patients who were trying to quit smoking self-reported less drinking
References:

Quality Improvement 101: Train the Trainer

Advanced Practice Conference

June 14, 2019
Objectives

- Understand the purpose of the Model for Improvement, process mapping, and fishbone diagrams

- Learn and share best practices for coaching others with these quality improvement (QI) tools
The Work of Improvement

- Quality Improvement needs to be the way we do things, not an added task or responsibility.

- It is a priority, not an intrusion on “real jobs”.

- “Without change there is no innovation, creativity, or incentive for improvement. Those who initiate change will have a better opportunity to manage the change that is inevitable.” – William Pollard
Quality Improvement Tools

- Model for Improvement
- Process Mapping
- Swimlane
- Fishbone Diagrams
- Run Charts
The Model for Improvement

- A method to test a change and assess its impact
- Breaks down change into manageable, bite-sized, time-limited chunks
- Minimizes risks and expenditures of time and money

What changes can we make that will result in an improvement?

How will we know the change is an improvement?

What are we trying to accomplish?

**Source:** IHI – The model for improvement is adapted from Deming’s work and developed by Associates in Process Improvement
Aim Statements include:

- What are we trying to accomplish?
- Why is it important?
- Who is the specific target population?
- When will this be completed?
- How will this be carried out?
- What is our measurable SMART goal?
Aim Statement Examples

- By August 15, 2019, we will create a protocol/action plan that allows better care for our Asthmatic patient population.

- We will reduce the average wait time (non-value added time) from its current baseline of 32 minutes by 50% to 16 minutes, by August 2019.

**Case Study:** We will improve our Hemoglobin A1c CQM for all patients in our practice; by August 31, 2019 we will decrease the percentage of patients with a Hemoglobin A1C greater than 9% or not measured during the prior year from 45% to 35%.
“Plan” for Measurement

How will we know that a change is an improvement?

- How will the data be used?
- What are the data sources?
- Do you have baseline data?
- Who is responsible for actually collecting the data?
- How often and how long will the data be collected?

Case Study: # patients not meeting measure, # of patients recalled and seen, # of patients tested at visit
DO: Piloting Your Solution

- Begin by making sure that people understand why a change is needed, and how to implement the solution to be piloted.

- Carry out the test - DO IT!

- Monitor the progress

- Make sure the data you’ll need to evaluate success is collected.

- Tip - Effective communication is especially important during change.

**Case Study:** Implement reminder system; outreach to poorly controlled or not tested patients; enroll patients in care management.
Study

- Analyze your results by using your Aim Statement from the Plan and data gathered from the Do.

- Complete analysis of the data.

- In hindsight, what are the pro’s and your solution?

- Do you believe this change can be sustained?

- Summarize and reflect on what was learned.

**Case Study:** Did patient outreach increase measure compliance? How many patients >9% were enrolled in care management?
Act: The Next Steps

- Reflect on your plan and the outcomes.
- Adapt, Abandon or Adopt based on the analysis of the collected input and information.
- Prepare and plan for the next test.

Case Study: Develop a registry, coordinate care management.
Act: The Next Steps

**If the change you piloted was successful:**

- Celebrate your success!
- Take whatever steps are necessary to formalize the change and sustain your accomplishment
- Communicate accomplishments internally and externally

**If the change you piloted didn’t work out as intended:**

- Share the results
- Use the lessons learned to develop a new
- Begin another PDSA cycle
**Aim:** By August 31, 2019 we will decrease the percentage of patients with a Hemoglobin A1C greater than 9% or not measured during the prior year from 45% to 35%.

**Cycle 1:** Validate the data

**Cycle 2:** Identify patients with care gaps and conduct recalls

**Cycle 3:** Implement pre-visit planning process

**Cycle 4:** Develop standing orders

**Cycle 5:** Regular monitoring and follow-up

**Introduce Diabetes HgA1C measure**
Process Mapping

Process Maps help us understand how a process works and understand how a process is done.

• To study a process for improvement

• To communicate to others how a process is done

• When better communication is needed between people
Steps to Process Mapping

• Focus on one process at a time and understand that process

• Describe a process as it works today (current state)

• Identify gaps, brainstorm, and create new workflows to close gaps

• Once you achieve the end ideal end results, create a written work flow that can be used for training new staff
# Common Process Map Symbols

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Process" /></td>
<td><strong>Process</strong> represents a step or activity in your process.</td>
</tr>
<tr>
<td><img src="image" alt="Terminal points" /></td>
<td><strong>Terminal points</strong> indicate the starting or ending points of a process.</td>
</tr>
<tr>
<td><img src="image" alt="Delay" /></td>
<td><strong>Delay</strong> represents a waiting period where no value-added activity takes place.</td>
</tr>
<tr>
<td><img src="image" alt="Decision" /></td>
<td><strong>Decision</strong> indicates a point where the outcome of a decision dictates the next step. There can be multiple outcomes, but often there are just two - yes and no.</td>
</tr>
<tr>
<td><img src="image" alt="Document" /></td>
<td><strong>Document</strong> represents a step that requires or results in a document.</td>
</tr>
<tr>
<td><img src="image" alt="Kaizen bursts" /></td>
<td><strong>Kaizen bursts</strong> indicate improvement opportunities.</td>
</tr>
<tr>
<td><img src="image" alt="Preparation" /></td>
<td><strong>Preparation</strong> indicates an action that helps prepare for the next step in the process.</td>
</tr>
<tr>
<td><img src="image" alt="Manual operation" /></td>
<td><strong>Manual operation</strong> indicates an operation or adjustment to the process that can be made manually.</td>
</tr>
</tbody>
</table>
Connectors

Solid lines are used to connect the flowchart symbols.

Dotted lines indicate an alternate process.

Arrow on both ends indicates that the process flow can move in either direction between the two steps.

Arrow on one end indicates the direction of the process flow.
Example 1

Patient Roomed

Patient over 65?

NO

Patient Eligible for Vaccine

Patient NOT Eligible

Patient is a smoker?

NO

YES

YES

NO
Daily Huddle – Current state

- 7:45 Start
- Discuss dress code
- Discuss vacation schedule
- Discuss new patients
- Discuss anticipated needs
- 8:07 Finish

Revised Daily Huddle

- 7:45 Start
- Discuss staff assignment
- Discuss available appts
- Discuss new patients
- Discuss anticipated needs
- 7:58 Finish
Swimlane
Fishbone Diagram – Cause and Effect

- Root Cause Analysis identifies underlying factors or causes of an unwanted event
- Helps categorize and organize thoughts
- Maps out causes and effects
Fishbone Example

Emergency Department/Hospital Utilization

Problem: ED and Hospitalization Rates are increasing. Why? What’s the effect? What are some solutions?

FISHBONE DIAGRAM

Causes

Effect

Unnecessary utilization of the ED
Leaving the Practice in Action

Problem: ED and Hospitalization Rates are increasing. Why? What’s the effect? What are some solutions?

- Solutions that I can implement in my practice tomorrow:
  - How can we measure this?

- Solutions that I can implement in my practice in 6 months:
  - How can we measure this?

- Solutions that I can implement within the next year:
  - How can we measure this?
Sharing Best Practices

- What has your practice experienced with QI tools?

- What QI tools is your practice currently using?

- Share a success story involving using a QI tool.
Exercise – Process Mapping
Resources

Fishbone Exercise:
IHI http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx
Go Lean Six Sigma https://goleansixsigma.com/cause-and-effect-diagram/

Model for Improvement:
IHI http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Process Mapping:
Questions

Sara Jordan, Quality Improvement Advisor, RMHP
Email: Sara.Jordan@rmhp.org
PRACTICAL TIPS ON EFFECTIVE COMMUNICATION
AND PERSUASIVE MESSAGING

BRONTE SMITH, MHA
ROCKY MOUNTAIN HEALTH PLAN
KEY POINTS

- Develop strategies that can enhance team-based care in resistance to change
- Identify barriers to effectively communicate
- Provide applicable tools to take back to your practice
- “Crafting Your Message” activity
WHAT IS PERSUASIVE MESSAGING?

- Compel Your Audience
- Focus on the Listener
- Communicate the WHY

BENEFITS OF A PERSUASIVE MESSAGE

- Improve staff buy-in
- Open difficult discussions with leadership for system/workflow changes
- Alleviate confusion
- Understand purpose behind change proposal

EFFECTIVE COMMUNICATION BETWEEN PROVIDERS AND STAFF

- Improves the understanding of wider vision for the organization
- Promotes the idea of integrated care
- Direct influence on quality of working relationships

WE'RE ALL IN THIS TOGETHER

- Engaging all levels of employees to provide suggestions for change
- Understand different perspectives
- Physician “Champion”
- Transparency on progress toward the change

WORKPLACE COMMUNICATION:
DID YOU KNOW?

15% Of employees say their companies are doing a good job of fostering communication throughout the organization.

20% Say they had a clear line of sight between their tasks and organizational goals.

40% Of employees share their ideas for improving their roles/job performance just a few times a year or less.

69% Of managers report feeling uncomfortable communicating with employees in general.

BARRIERS TO EFFECTIVELY COMMUNICATING IN REGARD TO CHANGE

Uncertainty
- Lack of Experience
- Extra Work/Overload
- Fear in Contribution
- Capacity/ Bandwidth
- Uncertainty
LET’S FIX THE PROBLEM

Understand your Audience → Craft the Message → Motivational Interviewing
Step 1: Understanding Your Audience
HOW CAN YOU APPEAL TO THEIR SELF-INTEREST
WHAT DO YOU WANT THEM TO THINK?
HOW DO YOU WANT THEM TO FEEL?
Step 2: Crafting the Message
ELEMENTS OF CRAFTING YOUR MESSAGE

PROBLEM  SOLUTION  ASK  URGENCY
Problem:
- What is the problem that needs to be addressed?
- What is the problem and how does it align with your audience’s values?
Solution:
- What could be done, needs to be done, and is being done?
- Describes what you or others can do to overcome the problem
ASK MESSAGE

- Ask:
  - Specific thing you want people to do.
  - Next steps & call to action
URGENCY MESSAGE

Urgency

- Why action is needed now
- Helps audience understand the “so what?”
- What will the world look like if your audience does what you want them to do?

Step 3: Motivational Interviewing
MOTIVATIONAL INTERVIEWING TOOLS

- **Core Principles:**
  - Express Sympathy
  - Roll with resistance
  - Develop discrepancy
  - Support self-efficacy

- **OARS:**
  - Open-Ended Questions
  - Affirmations
  - Reflective Listening
  - Summarize
<table>
<thead>
<tr>
<th>Strategies</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Open-Ended Questions</strong></td>
<td>Often starts with “how” or “what” or “describe”</td>
<td>• How would you like things to be different?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Can you describe that experience?</td>
</tr>
<tr>
<td><strong>Affirmations</strong></td>
<td>Must be done sincerely and acknowledge difficulties</td>
<td>• You handled yourself really well in that situation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• That’s a good suggestion.</td>
</tr>
<tr>
<td><strong>Reflective Listening</strong></td>
<td>Shows you have interest and respect for what they have to say</td>
<td>• It sounds like that strategy was effective for you</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Please say more….</td>
</tr>
<tr>
<td><strong>Summarize</strong></td>
<td>Reinforces what has been said</td>
<td>• Let me see if I understand this so far…</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Here’s what I’ve heard. Tell me if I’ve missed anything</td>
</tr>
</tbody>
</table>

MOTIVATIONAL INTERVIEWING

**INCREASES:**
- Positive treatment outcomes
- Engagement and retention
- Staff recruitment, satisfaction, retention

**DECREASES:**
- Staff burn out
- Confrontations
- Patient no shows/drop outs

WHERE TO SHARE THE PERSUASIVE MESSAGE

<table>
<thead>
<tr>
<th>DO’s</th>
<th>DON’Ts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Leadership/Staff Meetings</td>
<td>• Sending an email</td>
</tr>
<tr>
<td>• 1:1 with management</td>
<td>• Rushed conversation</td>
</tr>
<tr>
<td>• Open/Shared workspace</td>
<td></td>
</tr>
</tbody>
</table>

PRACTICE THE TOOL

Now it's your turn!
 ABOUT THIS ACTIVITY

- **Time**: 15 Minutes
- **Purpose**: Developing Your Persuasive Message

- **Learning Objectives**: By the end of this session, participants will be able to...
  - *Describe why messaging is important*
  - *Craft a message that will promote change*
  - *Utilize strategies to open difficult discussions*
**EXAMPLE OF EACH MESSAGE FOR TOOL**

- **PROBLEM:** A recent staff survey was conducted to assess the workplace environment. The results indicated staff members felt they were lacking leadership support and experience a negative culture in their current role.

- **SOLUTION:** We need to improve leadership support, build better relationships, and provide training for effective communication among staff if we want to improve job satisfaction.
EXAMPLE OF EACH MESSAGE FOR TOOL

- **ASK**: Now is a time for significant cultural change. By providing funding for employee retreats, employees can enhance their working relationships and interact with leadership.

- **URGENCY**: Staff members feel undervalued and are not satisfied. It is costly to replace high-performing employees, so let’s remedy the problem and get back to work!
DISCUSSION
# Persuasive Messaging

Understanding strategies that can improve effective communication that promotes team-based care

## Elements of Crafting Your Message

<table>
<thead>
<tr>
<th><strong>Problem</strong></th>
<th><strong>Solution</strong></th>
<th><strong>Ask</strong></th>
<th><strong>Urgency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>What needs to be addressed?</td>
<td>What can be done?</td>
<td>Next steps and call to action!</td>
<td>Why is action needed now?</td>
</tr>
</tbody>
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CRAFTING YOUR PERSUASIVE MESSAGE

Take a few minutes to think about something you would like to see change in your practice. This could be a specific workflow, process, culture change, etc that may present some resistance from leadership or other staff members. Consider the Persuasive Messaging strategy and take the steps to craft a compelling message got your audience of choice (leadership, provider, specialist, clinician, front desk staff). Pair up and present your message. Solicit feedback and discuss barriers/successes in creating your message.

Understanding Your Audience:

1. Who is the **audience** for this particular message?

2. What might appeal to their **direct self-interest**? (What’s in it for them and why should they care?)

3. What do you want your audience to **think or understand** about your issue?

4. How do you want them to **feel** about what you have said?

5. What do you want your listener to **do** after they hear your message?

Craft Your Message:

**PROBLEM:**

**SOLUTION:**

**ASK:**

**URGENCY:**

FEED FORWARD

INSTRUCTIONS

• **Topic.** Think of an area in which you would like to improve. Pick one behavior that you would like to change. This change should make a significant positive impact in your life. Describe it simply: e.g., “I want to be a better listener.” To stimulate your thinking, here are some examples of areas for improvement: delegation, meeting management, time management, giving feedback, negotiating budgets, getting buy-in, communicating better, getting others to take ownership.

• **Rounds.** This exercise is conducted in rounds (i.e., we will repeat it a few times).

• **Pairs.** Find a partner for the first round. If possible, start with someone with whom you are reasonably comfortable.

• **Ask for feed forward.** Share this desired behavior change with your partner, and ask for feed forward, i.e., “I want to be a better listener. Do you have any ideas?”
  o Ask for two suggestions for the future that might help you achieve this positive change.
  o If you have worked together in the past, you are not allowed to talk about the past, only offer ideas about the future.
  o Listen to the suggestions and take notes. You may not comment on the ideas in any way. Just say “thank you”.
  o Asking for and receiving the feed forward should take about a minute.

• **Switch.** The partners switch roles. Again, asking for and receiving the feed forward should take about a minute.

• **Repeat.** Find another participant and keep repeating the process until the exercise is stopped.
FEED FORWARD

State the improvement you want to make:

___________________________________________________________________________

Two suggestions from 1st partner:
1.___________________________________________________________________________
2.___________________________________________________________________________

Two suggestions from 2nd partner:
1.___________________________________________________________________________
2.___________________________________________________________________________

Two suggestions from 3rd partner:
1.___________________________________________________________________________
2.___________________________________________________________________________

Two suggestions from 4th partner:
1.___________________________________________________________________________
2.___________________________________________________________________________

Two suggestions from 5th partner:
1.___________________________________________________________________________
2.___________________________________________________________________________

Two suggestions from 6th partner:
1.___________________________________________________________________________
2.___________________________________________________________________________

State your Action Plan:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________