PCMH User Group Highlights 2/22/18

Slides from presentations are attached to email and on website (slides and highlights under PCMH User Group)

PLEASE REVIEW SLIDES AS THEY ARE NOT REPEATED BELOW – just highlights

The format is a little different this time; instead of just a summary, below is a transcript of the meeting. Lori Boctor spoke most of the time; Sandy Stimson from BCBSM answered a couple of questions and Kris Elliott, NPO, answered one.

(LORI) Good Afternoon everybody I am Lori Boctor. I'm with BCBSM. Just to give you a little background about me I'm not a clinical person, I'm a lay person. I've been with the Blues thirty-two years. I actually have been in various areas within Blue Cross; I have worked for various Blues plans, one was Michigan and the other one was Illinois. What I thought we would do - I want to be very informal and I want you guys feel free to ask me questions. My presentation is five pages, I want to be interactive.

I'm here today to try and ease your mind and answer any questions that you have relative to the provider delivery care management program as well as any PDCM billing questions.

I'm going to talk today about Provider Delivered Care Management and Blue Distinction Total Care.

So, what is Provider Delivered Care Management? A program that BCBSM started in 2012. It is our care management program within the company that allows our members to receive care management services from you guys at no cost share.

Blue Distinction Total Care is a mandate that came down from the Blue Cross and Blue Shield Association that says if you have a Care Management program in place currently and you have members that have coverage through another Blue Cross Blue Shield plan from another state, we want to allow those members to also receive care management. BDTC is the acronym for Blue Distinction Total Care; it is for the hosted members and I know there's a lot of issues with BDTC program.

At a high level, the 12 different procedure codes that are eligible for reimbursement on the Provider Delivered Care Management side as well as the Blue Distinction Total Care program side.

The first code is the G9001, Initiation of Care Management. Typically, the very first visit that person has ever had.

The next code is G9002, which is a follow up visit with your patient and the office setting.

The next codes are the education and training and they are the 98961 and 98962. How many of you guys do a group visit? These are the codes that would be utilized if you're doing something within a group setting and the only difference in the nomenclature of those two codes for the number of patients that are going to be within that group setting.

Our next three codes are the telephone assessment procedures and they are 98966, 98967 and 98968. Those three codes are when you are reaching out to your patient and talking to them via phone call. The only difference in the nomenclature is the number of minutes that you may be on that phone with that patient.

So now I'm going to ask you a question.

If the first call of the day with that patient is five minutes and then you do a follow up call later on that day with that patient for forty-five minutes - can you bill two codes for that same day? Can you bill a 98966 and a

98968?

No, very good, you are right. You have to add up in total amount of time that you talk to your patient and bill the appropriate code based on the time limit. We do get asked the question a lot of "what happens if we spend more than thirty minutes talking on the phone with that patient, how can we get compensated for our time"?

So, what we have recommended and have stated since the beginning, if you're spending more than thirty minutes on the phone with your patient as a follow up you really should be bringing that patient into your office because then you can bill a G9002.

The next two are the Care Coordination Codes, 99487 and 99489. These two codes are billed when you are reaching out to the medical neighborhood on behalf of your patient, perhaps calling that Meals on Wheels service, or DME service or you're calling a physician's office to get medical records.

Those two codes are based on minutes as well and they are what we call a monthly code and they are the most underutilized codes because you have to find a way to track the amount of time that you spend during that month reaching out to the medical neighborhood.

- *Question: What is the minimum, it says first hour, but what if you only have fifteen minutes?*

It is actually fifty one percent, so it would be thirty-one minutes. So, if you are reaching out to the medical neighborhood for that month, if you spend thirty-one minutes talking on the problem you can bill 99487. Each additional thirty minutes, so it will be an additional 16 minutes, is when you can use quantity billing. And we do have a chart in the full presentation as well as in the billing guidelines that show you how you can bill those two codes.

- *Question: Does the patient have to have a G9001 in order to do this, or are we expected to do it after they have been enrolled in care management?*

The answer to that is no. The reason being, we know that not every single patient that you have is going to require a G9001, which is the initiation of the Care Management. You have some folks for example, who are managed diabetic, they may not be a hot mess to require the initiation code of Care Management (G9001), but you are still managing that patient. They are a managed diabetic. OK, that managed diabetic may not be a hot mess to require the initiation of care management (G9001), but you're still managing that patient. So, if you bring that patient in, you can actually bill G9002 because you are managing that patient.

It's not a requirement of the Provider Delivered Care Management program or the BDTC program that G9001 has to be completed before any of the other codes are billed.

- *Question: Can you bill any of these codes with tele-health visits?*

Yes, you can however, BCBSM shared the telephone code with the Tele-health policy. If you're practice is doing telehealth, yes you can those three codes as part of tele health or if you're also doing PDCM or BDTC you can bill those three codes. Keep in mind for telehealth, it is a separate policy and not part of the PDCM or BDTC program.

- *Question: The next question that I get a lot is: "what about if I'm doing transition of care?" and "Can I bill a telephone code if I'm doing transition of care?"*

You can however, it does have to be a separate and distinct service from the transition of care, but you can't bill a telephone code if you're calling that patient to schedule an appointment.

- *Question: For clarification, if I make a TCM call, review the hospital summary, get their meds, get the patient on the phone, discuss their discharge, then send them up front to make an appointment, none of these codes would cover it?*

That is correct, because there's a lot of criteria that goes into TCM codes to bill them. They're not part of the PDCM or BDTC program. But we do get asked the question at least weekly, "so if I am billing a TCM code, the 99496 or 99495, can I also bill telephone codes or one of the other PDCM codes?" You can if you are doing a

separate and distinct service, separate from the TCM, if you are reaching out separate and distinct, you can bill a telephone code.

- *Question: I am under the impression BCBSM only covers the TCM for high complexity as opposed to moderate complexity, so if you are reaching out to your patient to talk about their discharge or med rec, can you bill a telephone code?*

Yes, you can, in that instance, and just so you guys are all aware - as of January 1, 2018 we did start paying for the other TCM code 99495, that is why I am quoting both of them right now.

- *Question: In the last billing summary that we received, it mentioned we have to have patient consent for us to reach out to them for a phone call. How does that work into this since they didn't tell us it was OK to call them after the hospitalization?*

So, this is how we explain it. If you have a patient who has been part of your office for a year and you've been working with that patient, that patient comes in and they sign up fifty forms right up front. We utilize that information as part of the patient consent. Now I do know that there was a record article that was published in January that talked about federal employee program or FEP members. For their care management program, it requires that the doctor actually sign the form, it is not relating to PDCM, it is relating to something separate the FEP is doing. If you have the patient sign that form that's what we will utilize as a patient consent.

The last code that we have is S0257 which is the counseling and discussion regarding the end of the life or advance care planning.

Sorry about that we have two more codes I skipped. G9007 which is the Coordinated care fee and conference, this is you as the care manager talking to the physicians about the patient, whether it's good, bad or changing meds.

And then the other code G9008 is a physician enrollment fee, to get that doctor engaged in the PDCM program. They can bill this code one time per patient per lifetime and receive a payment of about fifty dollars. So, one thing I do want to point out that G9008 is a physician only code and what I mean by that is it really should be billed only by the physician. Are there any physician assistants in the room?

I know that PAs sometimes as well as the CNP's may act as a physician on behalf of that patient. What we have said continuously is if you are a you a PA or CNP you can continue to bill under your rendering physician NPO - you don't have to utilize your own NPI. The reason is because the PA and CNP are receiving a reduced amount for reimbursement, 85% vs 100% of our maximum payment.

- *Question: Clarification please, that seems to be an exception relative to PA rendering of service that isn't necessarily supervised by the physician but they're having it billed as though it is supervised by the physician.*

It's my understanding that a physician does oversee the PA and that physician would be discussing with the PA, that's why we say that they can bill under the physician NPI.

- *Question: Can the G9008 be billed by the physician without a G9001?*

The physician is initiating care management but you're going to be doing something right? Maybe not as a G9001, but maybe a medical neighborhood phone call to the patient, then yes and again keep in mind the G9001 is not required to bill any of the other codes. I know in the very beginning and I don't know if you guys have been here since 2012, but in the very beginning, we didn't feel that it had to be done but it was recommended highly that a G9001 be conducted first. But as the program has progressed, we have also learned from you that not every single patient is going to require that.

So, any other questions about the procedure code?

- *Question: If the physician says call the patient and discusses her blood pressure could the G9008 code be billed?*

You are going to engage that patient in care management, right?

- *Question: Yes, but what if you're only going to call once or twice?*

You can still bill the telephone codes; if you're not going to engage the patient in the care management program, you can bill a phone call if you are reaching out to that patient.

You know this is my understanding, this is what happened in my doctor's office: I am a Blue Cross employee and I have provider delivered care management as a benefit. I'm not a hot mess however there are things that I can work on so when I went in for my yearly physical the Dr. said "You know Lori we have this program" and I said I know what program is, and she said we think you could benefit from it, so I'm going to bring in my care manager and she's going to talk to you and then you know maybe there's something that you might want to work on. One of the things was weight loss. I was pre-diabetic I needed to lose weight. And after talking with her, at first, I was standoffish because I did not want to be bothered but for my own benefit and for my health I needed to be bothered. So as a result, I enrolled in provider deliver care management and I do receive phone calls about once every two months to say: Hey, how you are doing, when are you coming back in and we need to check your blood. That is my understanding of how the handoff may be between the patient, the physician, and the care manager.

- *Question: When I'm sitting calling my patients and doing my transition of care template and they say this was just overnight and I really don't want a follow-up appointment, so then my TCM goes away and I bill a telephone call right?*

Yes, you are correct.

All right, so now I'm going to go on to our favorite topic, which is eligibility. At BCBSM, we have two different operating systems. One is called MOS, it stands for the Michigan Operating System. This eligibility is for our in-state non-national members; for example, BCBS Michigan employees are on the MOS system. Our group numbers typically start with 007 and they have five digits after that. The other one is NASCO. NASCO is much easier and it is for our national employers who have plants outside of the state of Michigan, for example Ford, GM or Chrysler. NASCO is much easier to look at and understand whether or not a member has the PDCM benefit.

MOS on the other hand, when you go in through WebDenis, and it's a MOS platform it takes you to something called benefit explainer. How many of you are familiar with it? It can be a little challenging to try and understand under the current status whether or not that member has the benefit. In an ideal world, it should say covered or not covered. But it's not an ideal world, we haven't devoted a lot of time to WebDenis and hopefully moving in the near future we will be. However, there is some good news and the good news is the majority of our groups, whether they are Michigan local groups or national NASCO group, are now participating in the PDCM Program. There are only about fourteen groups that are not, two of the largest however happen to be MBT, which is the automotive retirees, and FCA which is Fiat/Chrysler. Those two large groups are not participating in the PDCM program for the commercial business.

The Blue Cross Medicare Advantage PPO. is also participating in PDCM, but there are four groups that don't, and I will send Kris the group numbers by the way because on WebDenis it does not say anything about PDCM. We have to go by CMS rules and it just says you have to highlight the basic benefits.

The four groups, two of them happen to be the largest, MPSERS, which is the public-school retirees, around fifty-nine thousand. URMBT, which is the automotive retirees that have a Medicare Advantage PPO, BCBSM retirees and Accident Fund retirees. Just as a point of clarification, MPSERS members who are under 65 (non Medicare) or those who don't have the Medicare Plus Blue PPO are eligible for the PDCM program. The group exclusion applies to the Medicare Advantage population only.

I think I kind of went through this, but one thing I do want to point out you guys have a lot of federal employees here in this area. FEP is included in PDCM. However, those patients are not included on your PDMC Patient list. The reason why they are not on your list is the federal government does not allow us to have the membership information, so as a result we can't attribute a patient to your practice. The other thing is the federal employee has never had to pay into Social Security, so you can have a retired federal employee who is eighty-five years old but on the straight up PPO product and no Medicare. Or you could have a FEP Employee,

a retiree, who is sixty-six years old but decided they wanted to enroll in Medicare Part A and Part B. It does cost them over a thousand dollars a month which I'm not sure why they would do that, but somebody might. So, if you have an FEP member whether it's an active employee or a retiree and they're not in Medicare and they can benefit from provider delivered care management, please reach out to them. So now you're probably thinking: how do I know an FEP employee, how would I have any idea about that? They have a unique identifier on their ID card. Their unique identifier always starts with the letter R as in Robert. Now moving towards the future, we are trying to get these patients on the list, but we all know that the list is only as good as the day it is produced.

OK. So, you know there's no program that go smoothly, right, every program has issues. And PDCM has had many issues this past year. One of the issues had to do with the National NASCO groups. When you went in and checked WebDenis to see if they had the benefit, it wasn't showing. But in fact, that patient was on the list or that patient does have the benefit. We have since corrected it.

The other issue was that Michigan Public School retirees. MPSERS patients, under sixty-five population, not Medicare Advantage enrolled, are included in PDCM. But those folk's benefits were neve loaded to the system until the end of December. And the result was if claims were submitted they were rejected as not a benefit, right? So, we are in the process of readjusting all of those claims that were rejected previously I don't know if anybody experienced that. Under sixty-five MPSERS are eligible, over sixty-five MAPPO. are not.

And then lastly, the telephone coach procedure codes 98966, 98967 and 98968. They were being denied requesting a modifier because those three codes are shared with telemedicine policy. Telemedicine you don't have to have a modifier for any of the phone codes only for the virtual visits. So that was the system issue it was fixed December and the majority of the claims have been reprocessed.

How many of you guys are rendering services to the hosted members?

So, for the Blue Distinction Total Care program. It is, for lack of a better word, a hot mess.

Each plan set up their care management programs differently. As an example, for BCBSM, the way we set up the BDTC program or value-based program was based on claims. Providers would have to submit a claim using the same 12 procedure codes. We are one of five plans that are doing a claim-based payment. All the other plans are doing a per member per month reimbursement.

Some plans, which are Anthem and HCSC, don't pay for any telephone services whether it's that telephone call to the patient or a call to the medical neighborhood, they flat out reject them corporately. We're trying to figure out a way to make you guys whole for those eligible members for claims were rejected.

Many Blues programs implemented a program by allowing one procedure code to be billed per month. Whereas Michigan says if you bill G9002 or 98966 or S0257 and whether it's five times that month if you're seeing that patient you can bill it as many times as you are seeing that patient. Other plans didn't do it that way our plans are, only allowing one code a month to be billed.

- *Question: How many plans are we talking about?*

The majority of the hosted plans only allow one code.

The other thing is if you are billing any kind of on-going care coordination G9002, 98966 and 98947 within that same month, you have to separate the claim. You can't bill all three codes on one claim form, even though they may have been different dates of service, that is how some of the other plans have set it up. And then, for the G9001, when billing it you can include other medical services such as a 99124 on same claim form but you can't include the G9008, that would have to be billed separately. And again, this is only for BDTC, not in Michigan.

- *Question: How many of you are seeing where claims are being paid for and they're taking a co-payment, co-insurance or deductible, and there is no cost share associated with these services?*

So, what we have found is a hosted member may not have a value-based program benefit and again there's no way to verify that. But that plan may pay for one of the 12 codes. They're paying that code based on their regular benefit which is applying a co-payment, cost share or deductible. It's wrong because there is no cost

share associated with the 12 codes, that was a mandate from the association. Again, we're trying to figure out a way to make you guys whole, but nothing has been finalized yet.

- *Question: For sharing the telephone calls with this program how does the system know not to apply cost share on telephone calls associated with the program when the same telephone codes are used outside of the program?*

So, it is my understanding the way it works and I'm not a system guru, it is going to look for that virtual code as far as telemedicine policy and pay the phone code at 100%.

Have you experienced for Michigan members, telephone codes that have been applied to the deductible or co-insurance? I know that I haven't been made aware other than I know that last year claims rejected, requesting a modifier.

Because of all of these highlighted issues with BDTC, we did publish something back in October or November of last year that said we understand if you don't want to render services anymore because you're not getting paid right and it's not fair to you, it's not fair to the practice, not fair to the patients and it's not fair to the people that have to do the work. We have recommended that practices no longer render services until we can get it worked out, however, I know that practices treat every patient the same so if your practice is doing that continue to bill them. And the reason why I say that is because eventually we're going to be able to make you whole.

Because we told each and every one of you for almost a year about the hosted members and oh yes render services, do the care management, it is then hard to sit up here and say sorry about your luck you know. Anthem and HCSC which are the two largest conglomerates Blues plans don't pay for any phone codes. The phone code is of the most utilized code that we have. It's not fair that a Care Manager reached out to a patient and said "Hey, how you doing this month is there anything that we need to talk about" but then the practice billed it and BCBSM doesn't pay. There is a lot of discussion that's been going on and I am here to say that yes, we are going to make it some way, somehow, we just haven't figured out yet to get you guys whole. We've been working with the association very heavily as well as the Anthem plan and HCSC plan to try to get the issues resolved.

Any questions about BDTC?

- *Question: How long should we leave the monies in accounts receivable, waiting for that reimbursement?*

I don't know what the answer is to that, we have been working on it for almost a year. You do not have to re-bill the claims if you have already billed the claims and they have been rejected. I get a monthly claims report and I keep a tab because that's the only way that I can identify issues as well. And I do keep a tab of the hosted member issues specifically.

- *Question: Will the hosted members be included in the 3% touchpoint?*

So, for 2018, hosted members will be included in the numerator. They will not be included in the denominator, which is only going to benefit you. For 2019 and moving on they will not be included in the numerator nor will they be included in the denominator. We've given fair warning there will be, using information posted on our collaboration site, for 2019 and forward hosted will not be included.

- *Question: Can we use the med-rec code, while doing TCM, or if we can't use when do we use it to capture that data?*

(SANDY) The med-rec code applies the cost share; the member will be responsible for their co-pay or deductible for that. It originally became a benefit with Medicare Advantage; when you billed it, you received reimbursement of ten dollars and then on the commercial side they made that from a non-payable code to a payable code but nothing in reference to waiving any member liability.

- *Question: Can we bill as a care encounter along with another code that doesn't allow payment of it anyway?*

You could, just like a regular category 2 as long as your system will allow that claim to come through with that zero to be identified. For the Value based reimbursement for 2018 we are going to include the Med-rec code. If it is billed and shows up on our analysis, it would be carried as 3% of that touchpoint, as well as your TCM code.

- *Question: Should they be billed together?*

- *Question: If there is no fee associated with the code, do we get credit toward the 3%?*

If it is a paid claim, we will count it toward the 3% touchpoint, I will take the question back regarding if there is no fee associated with the code, will you get credit toward the 3%.

- *Question: The med-rec counts for 2018, do we know about 2019?*

It will count for 2019, for Medicare Advantage members. Whether or not they would be counted in the numerator as well as perhaps in the denominator so, for 2018 they will not be counted in the numerator. However, in 2019 they will be counted in the numerator as well as the denominator, so in 2018 they're not going to be counted, 2019 they will be. Then just so you guys are aware, commercial members are going to be counted in the numerator and denominator for 2018 as well as 2019.

- *Question: We've got a nutritionist who is joining our care management team, so she is a registered dietician, but cannot be a lead care manager. So, can she exclusively see the patient, do I ever need to see the patient for care management service, can she bill if she has done everything with that patient?*

So, her question is she has a dietitian. She wants to know whether or not that dietician can explicitly see that patient and Bill G9002, the phone codes, group education, care coordination codes, etc. The answer to that would be yes because she is part of the team, you and she are going to be talking at some point about the patient. She can bill if she is doing group education and training, she can do telephone codes, because she is part of that care team.

One thing I want to just mention as a point of clarification, how many of you have medical assistants? We get questions all the time about medical assistants, they can be part of the care team, however the only thing that a medical assistant can do under the BCBSM billing guidelines is the care coordination within the medical neighborhood, 99487 and 99489 codes. MAs cannot bill for patient interaction.

- *Question: Do they have to have training to bill for the care coordination within the medical neighborhood?*

For Blue Cross what we require is the person who will be the lead care manager, they have to go through the training through the Care Management Resource Center. For an MA, what we recommend everything is that on the Care management resource center we have a PowerPoint and there are some break out testing that they can do, which is part of the Care Management Resource center, so it is recommended that, yes, they go through that aspect. Coordinating care in the medical neighborhood is time specific, you have to figure out a way to keep track of your time. They are typically billed at the end of the month, your last reach-outs to the medical neighborhood would be your date of service.

So, for the 99487 codes, it pays $90.24 and the 99489 pays $45.31, keep in mind that 99489 is quantity.

- *Question: What are the required elements of a PDCM visit in terms of what has to be covered in the visit?*

It is in the billing guidelines, for example the G9001, would have to be conducted by the lead care manager, contacts must add up to at least 30 minutes of discussion with the member, and that thirty minutes discussion must include some sort of face-to-face encounter.

Moving on to G9002, there are certain requirements for that, is billable if any of the qualified, approved PDCM or BDTC care team discussions must be focused on the content relating to the patient individualized care plan.

Typically, we don't need see a G9001 and G9002 being done on the same day, but we know it can occur.

The G9002 is a quantity-based procedure code, so if you're spending 1 minute to 45 minutes with the patient, you only bill G9002, and you want to indicate quantity of one. If you're spending 45 minutes to 76 minutes with a patient you would bill G9002 and indicate quantity of 2, etc. You would have to add up the total amount of time that the lead care manager and maybe other team members to deal with that patient on that day.

So, if you have the dietician, she spent 30 minutes with a patient and the Pharmacist that spent 45 minutes with the patient. You would add up to total time and on the total amount of time and you would bill the G9002 and state in the appropriate quantity. You would not bill two G9002 codes on the same day. The first one that comes in will be paid and the second comes in will reject as a duplicate.

- *Question: Regarding 99487, if two people from the practice make calls all throughout the month, can they be combined?*

Yes, but you must add up the total time. So as far as quantity of time things, everybody's got a different system of tracking these. In tracking the time, you do need to include time and what was talked about.

- *Question: Can the 99487 and 99489 codes be billed along with the G9001?*

Yes, but keep in mind with hosted members, you have to separate everything out.

- *Question: How about with TCM codes? TCM codes eliminates any Care Management codes for that thirty days, is that correct?*

That question comes up a lot. If your practice is doing CCM, you bill any of the 12 PDCM codes as long as it is a distinct and separate service from criteria for the TCM codes.

- *Question: Can a Medical Assistant bill for the TCM codes?*

(SANDY) BCBSM follows CMS guidelines and there is a FAQ out there that would indicate that if the physician is overseeing that MA and the content it is ok, but the physician would have to sign off. TCM has to be done by a clinical person it cannot be done by a front desk person.

- *Question: I believe you said this before, but TCM doesn't count toward the 3% or 4% touchpoint goals, correct?*

For the VBR we are counting the 12 procedure codes that I just went through, for 2018 and 2019 we are also counting the transition of care codes, 99495 and 99496 and the 111F (med rec) code.

But I do have a question I have to take and that is that if you bill the med rec code with a zero or bill with 1 penny, and there is no payment, will you still get credit for it?

- *Question: So, the TCM codes are counting toward your 3% goal?*

Yes.

- *Question: What if they only have the TCM code, but no other touch point?*

You have to have 2 touches to get credit for the 3% goal.

To let you know regarding the hosted issues, we have been back and forth on this, and I have stood up for you. I have said that it is not fair, we have been saying for a year, if you render services you will get paid, we have a new program! And we all know that that did not work how it was supposed to.

Just from listening to care managers and physicians and physician organizations. I know how difficult it is to get somebody engaged in the program, and without you doing what you do every single day we would not have a successful business. We would not have success in the PDCM program and I can tell you our customers want to

see their return on investment, it's all about money, how much money they spend on health care. So, my role, amongst other things, is to try and ease your mind made things easier. I know we can make them complicated. But just know that we are trying to make it easier for everybody because we need this a program to succeed, especially because a lot of the larger national accounts are down quite a bit and they want to see how this program benefiting their members.

- *Question: Are there any studies that show what we are doing is working? You know to have these patients come back, and seeing somebody else and you know actually spending more insurance money, are there any studies to show what are we saving, how are we benefiting, what do we see as the benefit of the patients are there any?*

I don't think that we have done a study per say, except for the MIPCT one, and that did show that it did save money, I don't know how much per member per month. and again, the members are key, they do want to see that they are saving money. The question to ask is if I'm spending three hundred dollars a year for this provider delivered care management program on 10 members, how much is that saving me from that person going to the emergency room or being admitted inpatient. So, I do foresee that a study is something that will be done because we do have to show actual savings.

(KRIS) NPO was asked that question months ago, and I did a very thorough search. There are studies that show PCMH lowers costs, but I could not find anything specific to this type of Care Management. Many of the studies concluded that the more oversight there was, including PCMH, led to savings. But the payers are paying for it so that would indicate there are savings they are seeing.

(LORI) And I think you know, like I mentioned earlier, the majority of our groups are now included in the program so there's going to be a lot more customer focus. We are forming a work group and NPO is a member. Hopefully moving forward it'll be easier to meet that number.

So, like I said we have to work collaboratively together. You know I'm always a great listening ear, I may not always have all the answers but if you do have a question and Kris knows how to get a hold of me, please feel free to reach out to me directly. And I'll do what I can to get you the appropriate answer.

I hope that you walk out of here with a little bit more knowledge and a little bit more ease.

2018 meetings dates and topics:

- **Wed, 4/25/18** Practice sharing: Please be prepared to share.
  - Specialist Referral Process - what does your practice do? What works? What doesn't? Some questions to start discussion:
    - Are patients scheduled before they leave your office?
    - Does your office hand patients referral info and do patients know what they are supposed to do?
    - Does your practice have expectations such as "patient will hear from specialist office in a week"?
    - Do specialists notify your office of appointment dates?
    - How does your office track and monitor outstanding referrals?
    - Does your office have a designated referral specialist?
  - How is your practice handling the 10.5 capability requirement of a screening tool for community resource needs?
- **Tuesday, 6/19/18**
- **Tuesday, 8/21/18**
- **Wed, 9/26/18**
- **Thursday, 10/25/18**
- **Thursday, 11/29/18**