BlueCross BlueShield of New Mexico

Member and Provider Engagement

Member and Provider Engagement

Learning Objectives:

- To explore the role of member engagement in quality improvement, and how Providers can work with Members to improve care delivery.
- To foster collaboration and networking among healthcare Providers, to facilitate the sharing of ideas and best practices.
- To provide education and training on quality improvement methodologies, tools, and techniques, to enable Providers to implement effective improvement initiatives.

Better Care, Better Outcomes

Better Care

- Provider Engagement
- Data-Driven Decision Making
- Evidenced-Based Practice

Member-Centered

- Care with Dignity and Respect
- Values, needs and preferences drive care
- Member as Partner

Evidence-Based

- Clinical best practices
- Member Engagement
  - Self-Management support
  - Health Literate Care

Coordinated Care

- Seamless transitions across providers, settings and time
- Meaningful and timely information exchange

Better Outcomes

- Member Engagement
- Continuous Quality Improvement

Improved outcomes leading to better health, better care and lower cost

Member and Provider Engagement: Role

- Understanding the Significance of Member Engagement
- Strategies for Effective Collaboration with Members
- Benefits of Collaborating with Members to Improve Care Delivery
- Tools and Resources to Facilitate Member Engagement
- Develop a Culture of Member Engagement

Member and Provider Engagement: Networking

- Understanding the Significance of Collaboration
- Strategies for Effective Networking among Healthcare Providers
- Facilitating the Sharing of Ideas and Best Practices
- Benefits of Collaboration and Networking in Healthcare
- Overcoming Barriers and Building a Culture of Collaboration

Member and Provider Engagement: Education

- Understanding the Significance of Education and Training
- Identify Key Quality Improvement Methodologies
- Essential Tools and Techniques for Quality Improvement
- Implementing Effective Improvement Initiatives
- Benefits of Implementing Effective Improvement Initiatives
- Overcoming Barriers and Building a Culture of Quality Improvement

BlueCross BlueShield of New Mexico

Data-Driven Decision Making

Data-Driven Decision Making

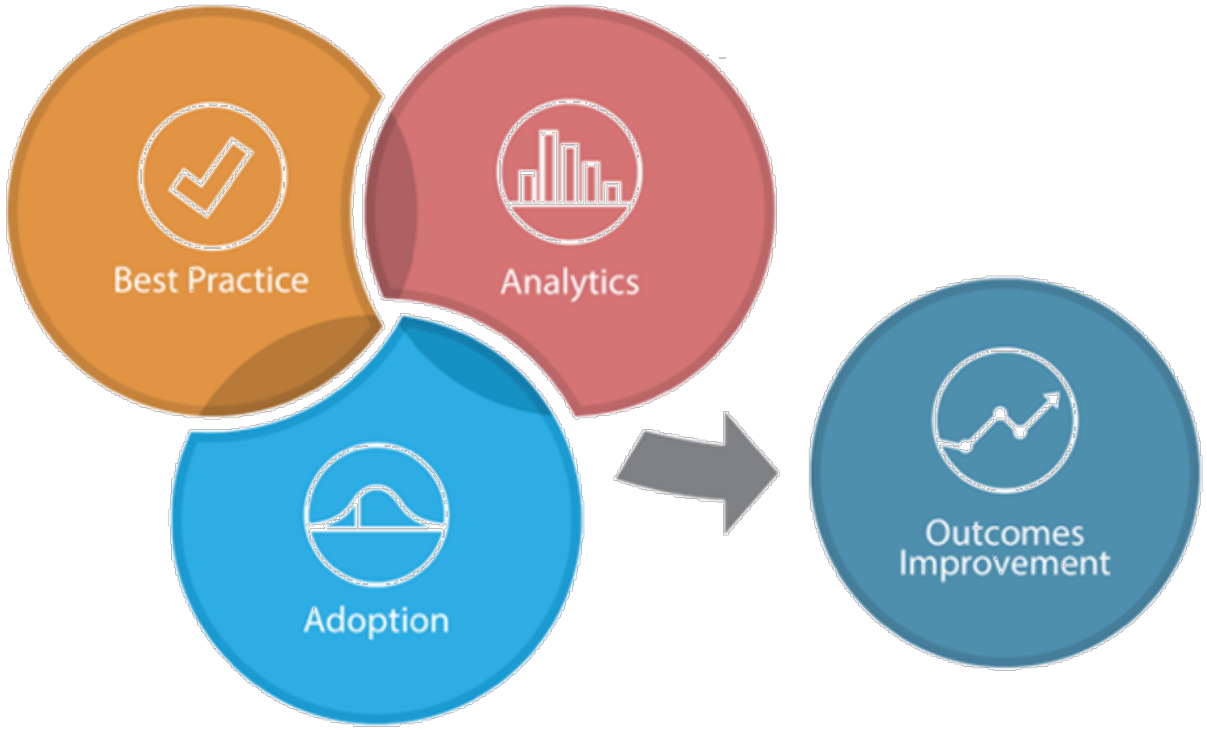
Learning Objectives:

- To identify common challenges and barriers to quality improvement and develop strategies to overcome them.
- To promote the use of data and analytics in quality improvement, and how providers can use data to drive meaningful change.
- To develop an action plan for engaging providers and members in quality improvement, to ensure that quality improvement efforts are sustained over time.
- To explore the role of technology in quality improvement, and how providers can leverage technology to improve member outcomes and streamline care delivery.

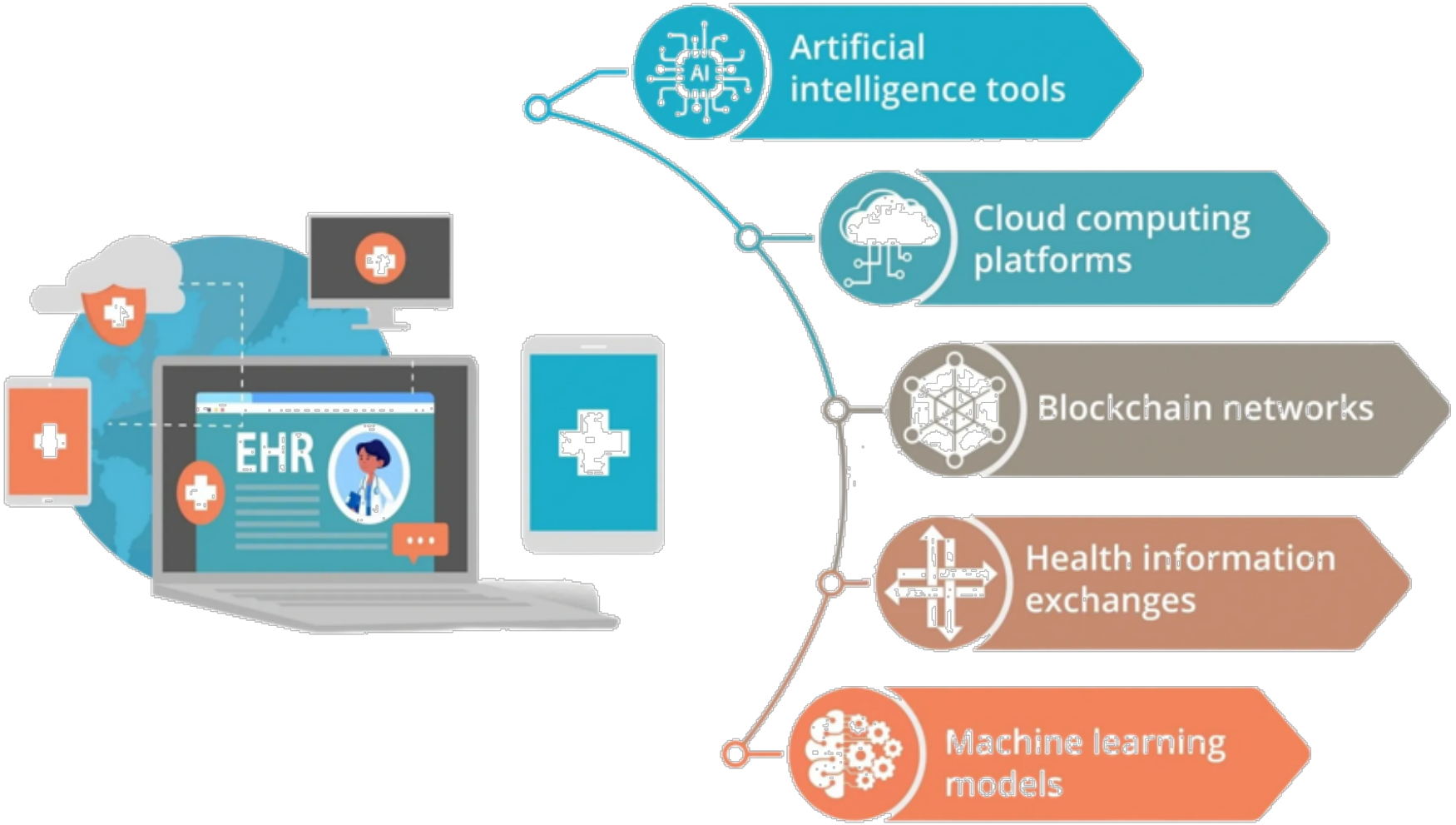
Data-Driven Decision Making: Data Analytics

Key reasons to promote the use of data and analytics in quality improvement:

- Identify areas for improvement
- Improve member/patient safety and outcomes
- Measure performance and track progress
- Evidence-based decision making
- Enhance resource allocation



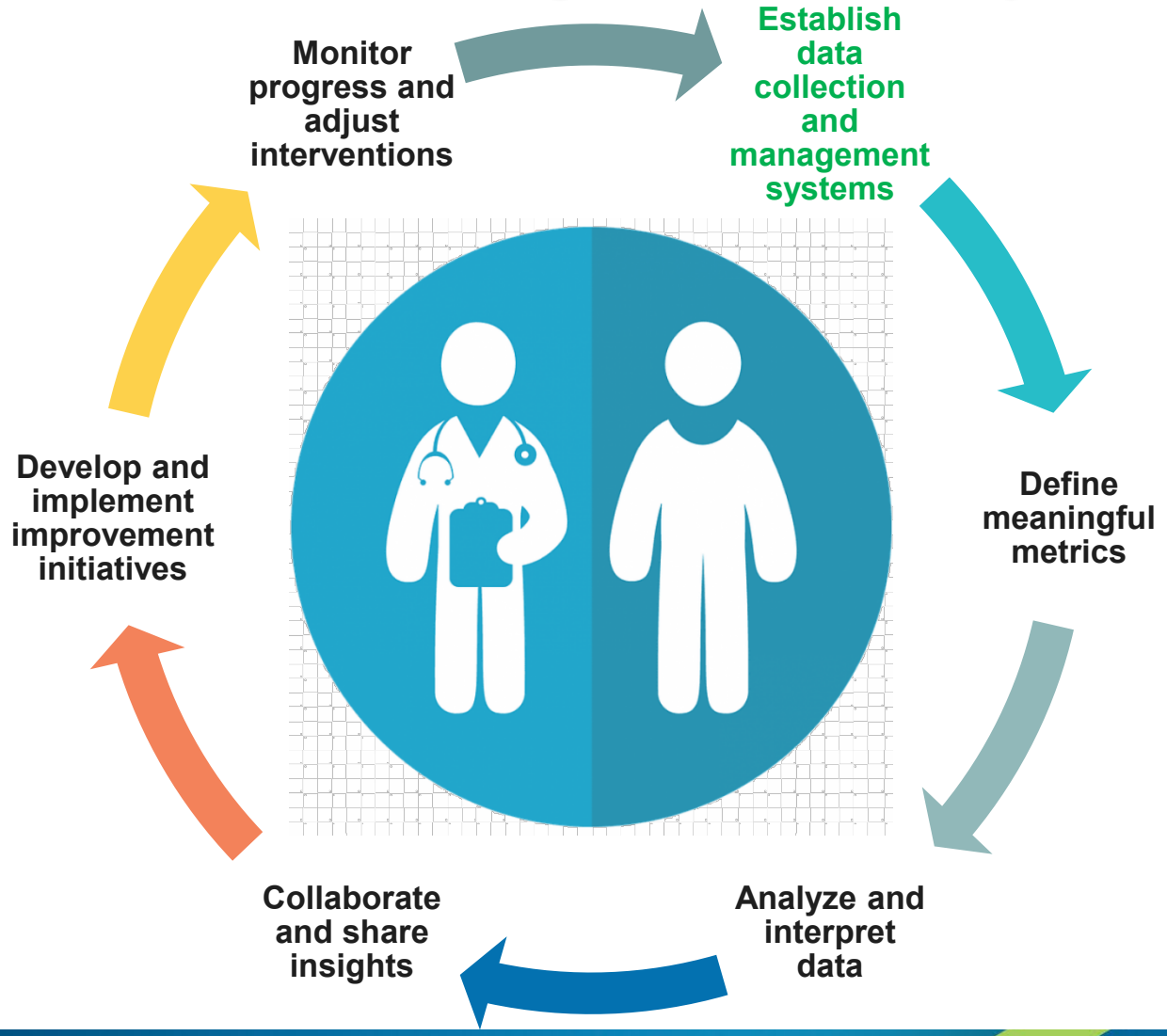
Data-Driven Decision Making: Data Analytics Technology



Data-Driven Decision Making: Healthcare Data Analytics

Data-Driven Decision Making: Data Uses

Data-Driven Decision Making: Data Analytics Application



Data-Driven Decision Making: Data Analytics Application

By promoting the use of data and analytics, providers can drive quality improvement, enhance member outcomes, and deliver more efficient and effective care.

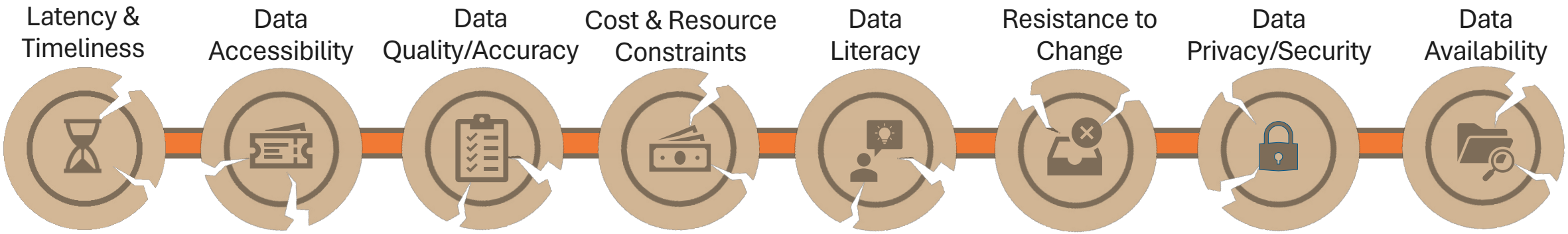
- Proactive-Preventative Wellness for our Members/Patients
- Balanced Mix of Meaningful Metrics
  - Predictable Populations and Measures
  - Trigger or Episode Based Events and Conditions
- Coordinated Planning and Response for all Patients

Data-Driven Decision Making: Technology Enhancements

Data-Driven Decision Making: Engagement

- Establish a culture of quality improvement
- Develop a quality improvement committee
- Identify and prioritize improvement opportunities
- Engage providers in quality improvement
- Engage patients in quality improvement
- Foster communication and transparency
- Provide support and resources
- Continuously evaluate and refine

Data-Driven Decision Making: Breaking Down Barriers



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Collaborative Care

Collaborative Care

Learning Objectives:

- To discuss the importance of measuring and reporting outcomes, and how Providers can use outcomes data to identify areas for improvement and track progress over time.
- To develop a framework for incorporating value-based strategies into quality improvement initiatives and identify key metrics for measuring success.
- To explore the relationship between Provider engagement and Member satisfaction, and how engaged Providers can lead to better member outcomes and higher satisfaction rates.
- To discuss the importance of member-centered care, and how Providers can incorporate member feedback into quality improvement initiatives.
- To explore the benefits of team-based care, and how Providers can collaborate with other healthcare professionals to improve care delivery and member outcomes.

Collaborative Care: Continuity & Coordination of Medical Care

Presenter:
Raman Eremia, LCPC, CPHQ, CLSSBB
Sr. Manager Quality Improvement

Collaborative Care: Continuity/Coordination of Care

What Is Collaborative Care? Why Is it Beneficial?

Collaborative care is a care model which aims to increase cooperation between a member's multiple care providers. The benefits of this model are numerous:

Improved Care Quality

Reduced Cost

Increased Coordination

Collaborative Care: Continuity/Coordination of Care

"Continuity of care is of value only to the extent that it has an impact on outcomes of care, the prevention or reduction of physical, mental, or social disabilities, the satisfaction of patients and the costs of care."

Gonella and Herman (1980)

Collaborative Care: Continuity/Coordination of Care

Continuity and coordination of medical care services is the facilitation, across transitions and settings of care, so that:

- Members receive the right care, at the right time and in the right setting,
  - Member movement across different settings: Postpartum Care
- Providers across the care continuum receive information they need to provide care that members need.
  - Member movement between Practitioners: Eye Exams for Patients with Diabetes
  - Admission and Discharge Information

Collaborative Care: Continuity/Coordination of Care

Provider satisfaction with receiving diabetic eye exam findings from eye providers.

- Do ophthalmologists and optometrists inform you of their findings after seeing patients you referred for diabetes eye exams?

Challenges & Lessons Learned

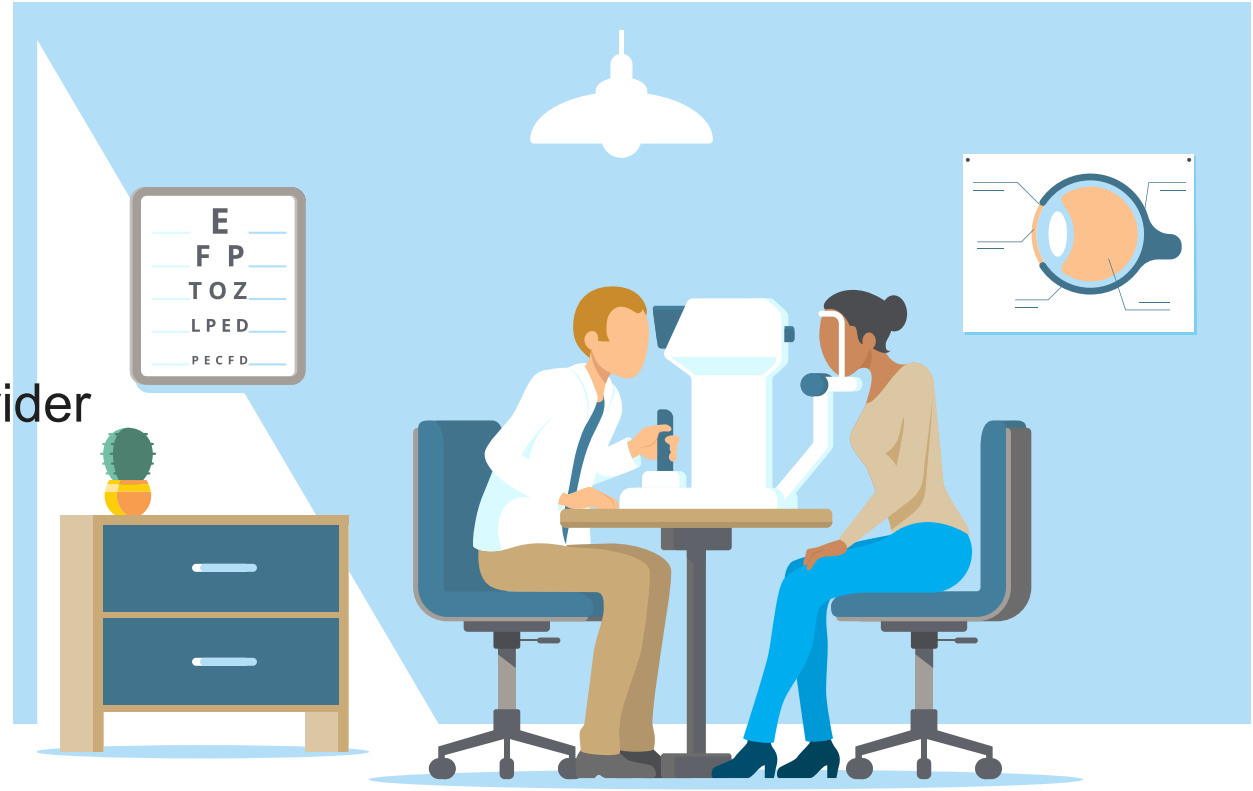
- Member Knowledge Deficit
- Limited Eye Provider access

Opportunities for Improvement

- Improve Eye Exams for Patients
- Improve eye exam findings shared with Provider

Interventions

- Member and Provider education
- Engagement Opportunities
- Increase Member Communication



Collaborative Care: Continuity/Coordination of Care

Physician satisfaction with receiving hospital discharge information.

- When your patients are admitted to a hospital, are you sent summary information after the discharge?
- When you receive hospital discharge information, does it reach your office in a timely manner?
- When you receive hospital discharge information, does it contain adequate information about medications at discharge?

Challenges & Lessons Learned

- Members provide incorrect contact information
- Discharge information not always relayed to providers
- Members may not understand discharge instructions or take prescriptions as directed.

Opportunities for Improvement

- Improve the sharing of admission and discharge information to the Provider.

Interventions

- Members Education
- Medication reconciliation upon discharge

Collaborative Care: Continuity/Coordination of Care

Member Movement Across Settings: Postpartum Care

- Timeliness of Postpartum Care (A least one visit 7 to 84 days after delivery)

Challenges & Lessons Learned

- Member knowledge deficit
- Transportation issues

Opportunities for Improvement

- Improve Timelines of Postpartum Care Visits

Interventions

- Continued enhanced care coordination
- Member education/ Targeted Texting Campaign
- Direct member outreach
- Promote Centennial Rewards
- Expand use of midwives
- Coordinate transportation services

Collaborative Care: Continuity & Coordination of Behavioral Health Care

Presenter:

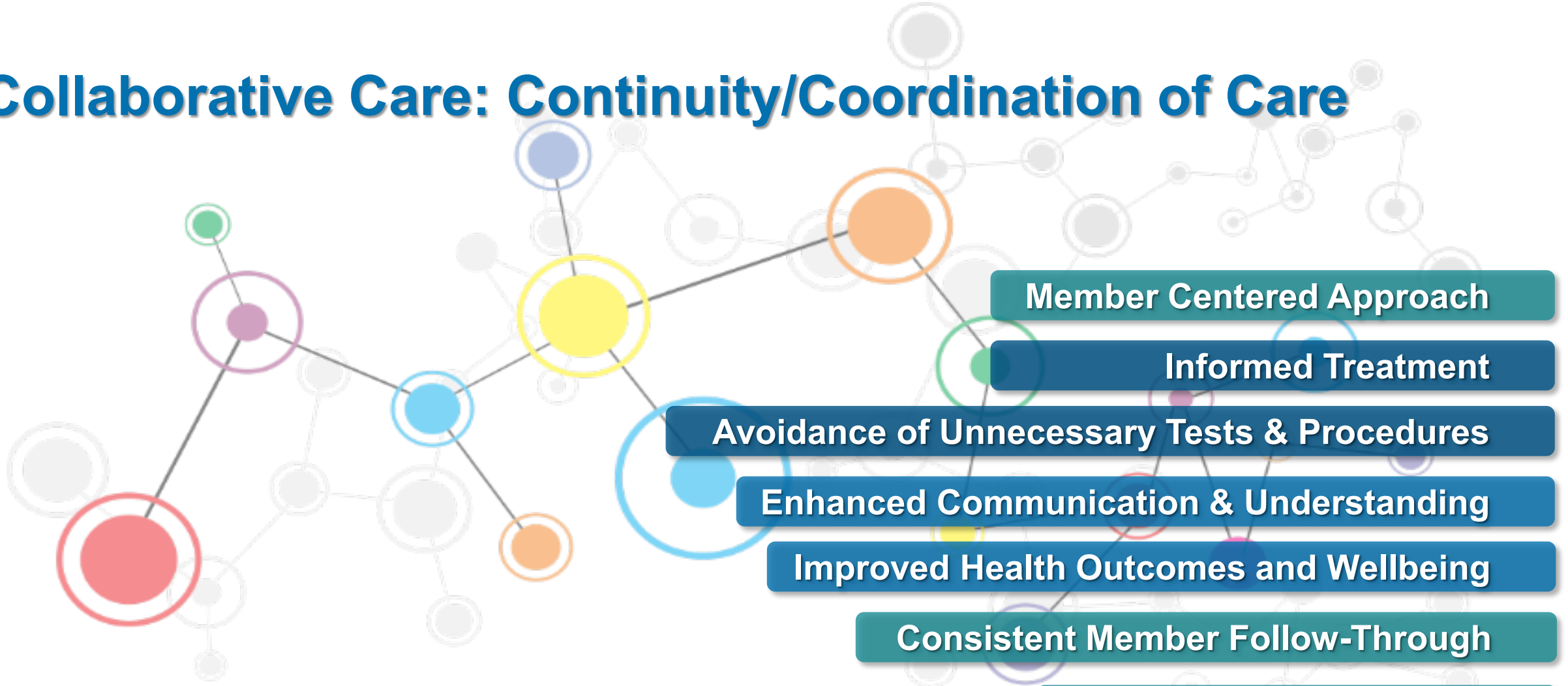
Lesley Riley, LCSW

Manager Behavioral Health Quality Improvement & Data Analysis

Collaborative Care: Continuity/Coordination of Care

- Physical Health to Physical Health
- Physical Health to Behavioral Health
- Behavioral Health to Behavioral Health
- Behavioral Health to Physical Health

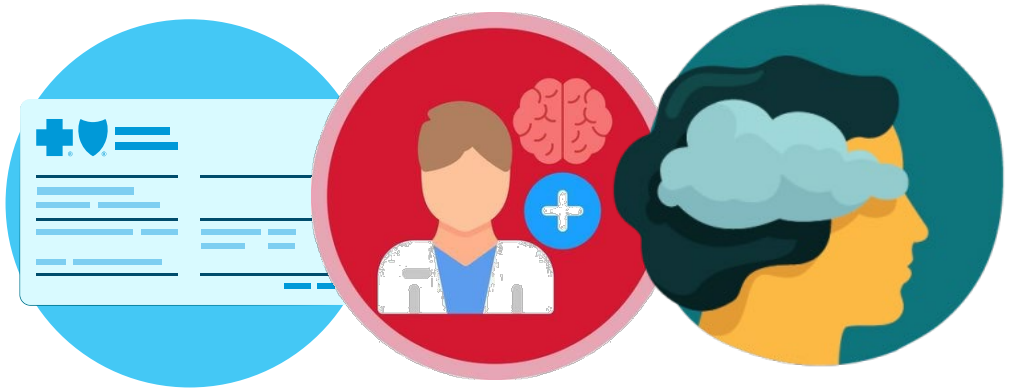
Collaborative Care: Continuity/Coordination of Care



- Member Centered Approach
- Informed Treatment
- Avoidance of Unnecessary Tests & Procedures
- Enhanced Communication & Understanding
- Improved Health Outcomes and Wellbeing
- Consistent Member Follow-Through
- Reduction in Cost for All

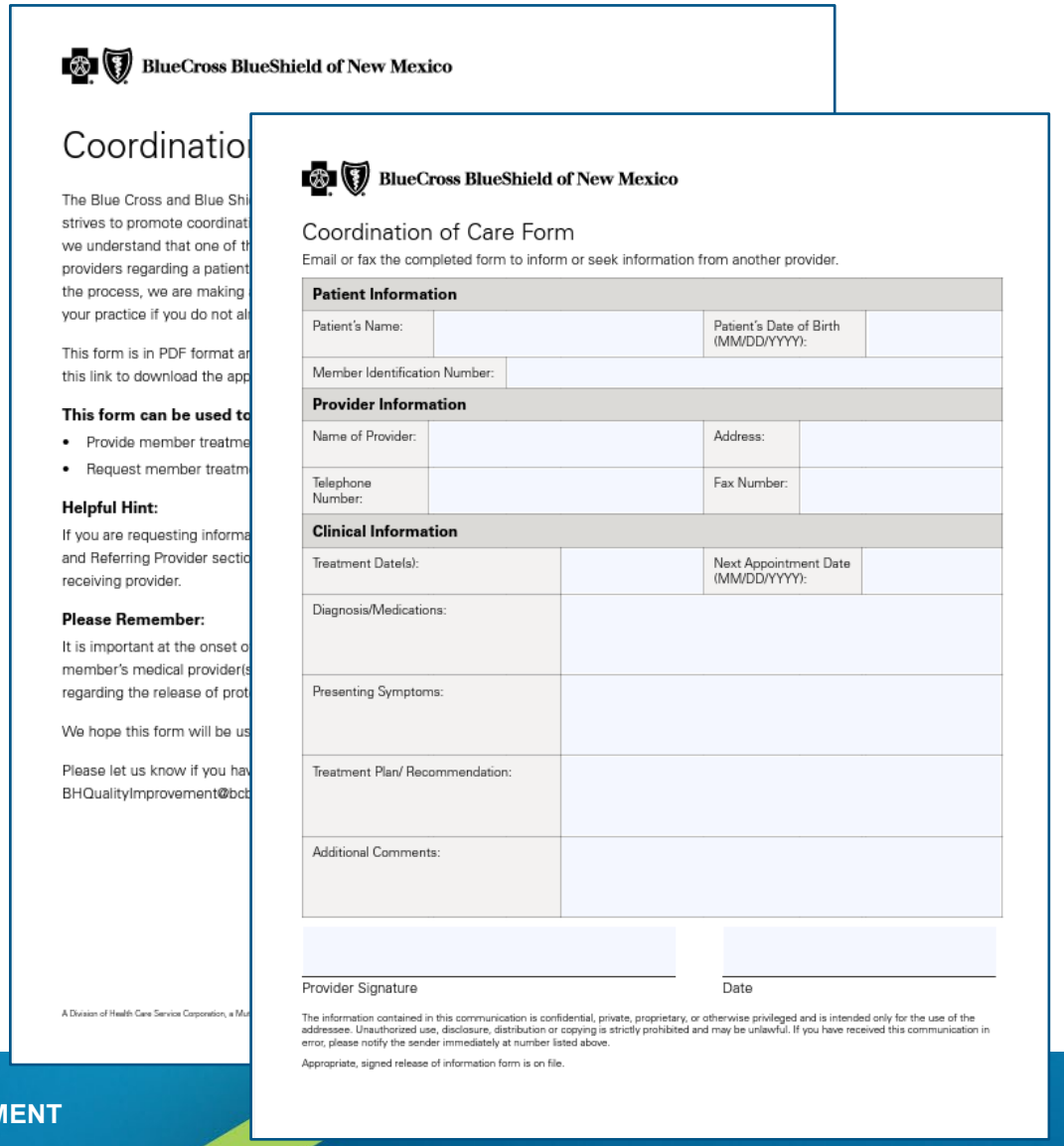
Seamless Member Experience

Collaborative Care: Behavioral Health Consultations



Behavioral Health Coordination
Medical Inpatient stays when a member with a secondary Behavioral Health diagnosis should receive a Psychiatric Consult

(CPT codes 99251-99255)



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Coordinatio

The Blue Cross and Blue Shi
strives to promote coordinat
we understand that one of t
providers regarding a patient
the process, we are making
your practice if you do not al

This form is in PDF format ar
this link to download the app

This form can be used to

- Provide member treatme
- Request member treatm

Helpful Hint:

If you are requesting informa
and Referring Provider sectio
receiving provider.

Please Remember:

It is important at the onset o
member's medical provider(s
regarding the release of prot

We hope this form will be us

Please let us know if you hav
BHQualityImprovement@bct

A Division of Health Care Service Corporation, a Mu

BlueCross BlueShield of New Mexico

Coordination of Care Form

Email or fax the completed form to inform or seek information from another provider.

Patient Information			
Patient's Name:		Patient's Date of Birth (MM/DD/YYYY):	
Member Identification Number:			
Provider Information			
Name of Provider:		Address:	
Telephone Number:		Fax Number:	
Clinical Information			
Treatment Date(s):		Next Appointment Date (MM/DD/YYYY):	
Diagnosis/Medications:			
Presenting Symptoms:			
Treatment Plan/ Recommendation:			
Additional Comments:			

Provider Signature

Date

The information contained in this communication is confidential, private, proprietary, or otherwise privileged and is intended only for the use of the addressee. Unauthorized use, disclosure, distribution or copying is strictly prohibited and may be unlawful. If you have received this communication in error, please notify the sender immediately at number listed above.

Appropriate, signed release of information form is on file.

Collaborative Care: Behavioral Health Resources

BEHAVIORAL HEALTH RESOURCES

Main Page:
https://connect.bcbsnm.com/

Behavioral Health Page:
https://connect.bcbsnm.com/behavioral-health/

Behavioral Health topics include:

- General Overview of Behavioral Health
- Depression & Depression Screening
- Anxiety
- Schizophrenia
- Loneliness
- BH Level of Care
- Bipolar and Diabetes

Member Resources

BCBSNM Connect Community Overview:

Online public forum that offers a wide-range of health information on a variety of topics.

Collaborative Care: Value Based Agreements

Presenter:
Steve DeSaulniers, MA
Manager Network Innovation & Strategy

Collaborative Care: Value Based Journey

- Assess Readiness
- Define Goals
- Engage Leadership
- Form Collaborative Partnerships
- Redesign Care Delivery
- Enhance Data Analytics
- Implement Performance Metrics
- Engage and Empower Patients
- Align Efforts to Incentives
- Educate and Train Staff
- Monitor Progress and Adapt
- Communicate and Share Success

VALUE BASED CARE

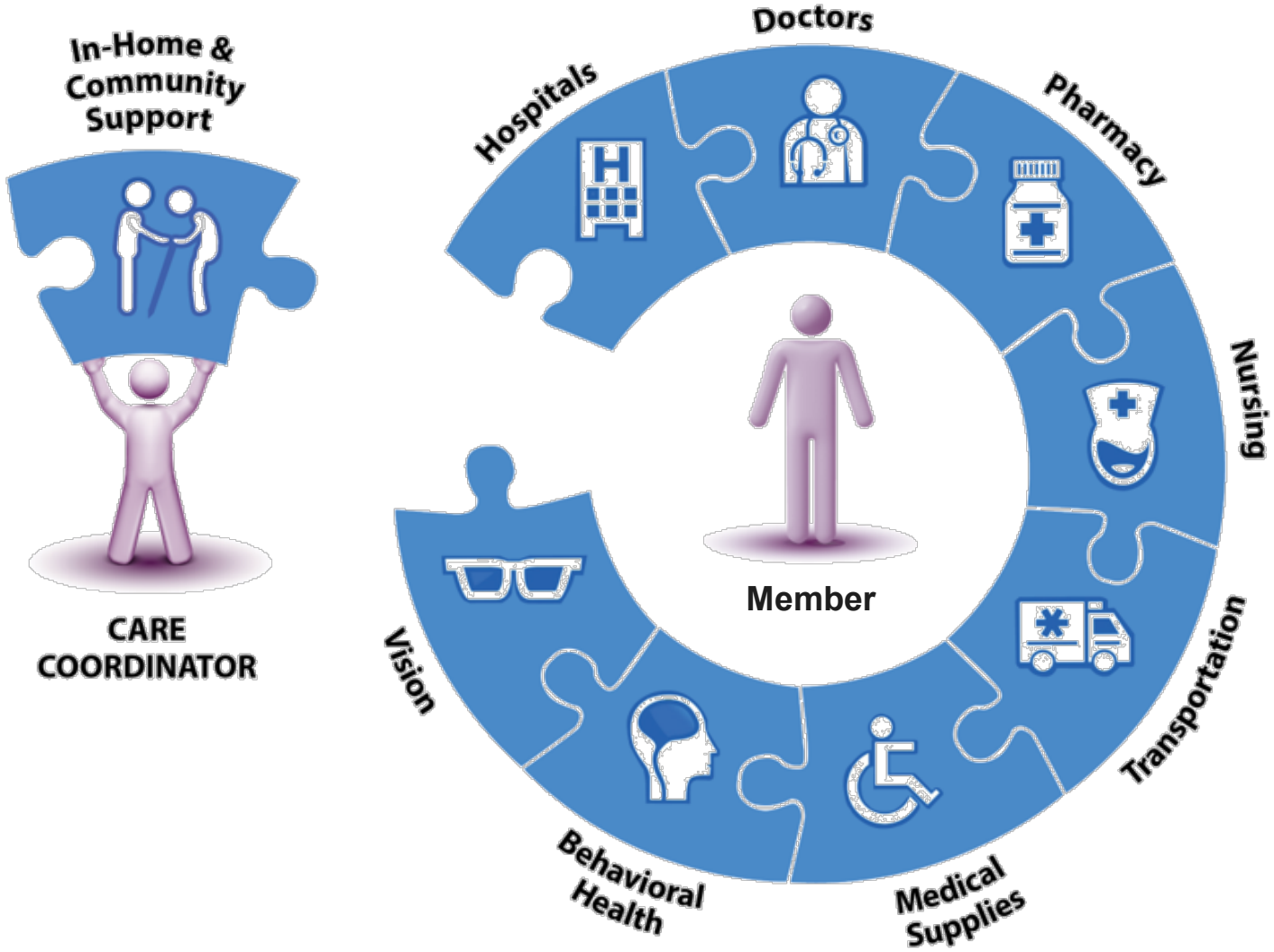
Collaborative Care: Care Coordination

Presenter:

Kadawn Evans, RN, BSN

Sr. Manager, Clinical Operations, Central Region

Collaborative Care: Care Coordination



Collaborative Care: Value of Care Coordination

- Care Programs
- Quality Programs

Primary Care Providers
Behavioral Health
Local Services & Resources

- Demographic Contact
- Clinical

Member Retention
Member Satisfaction

- Address
- Assess
- Assign

Resources
Importance of Health & Wellness

Collaborative Care: Benefits of Care Coordination

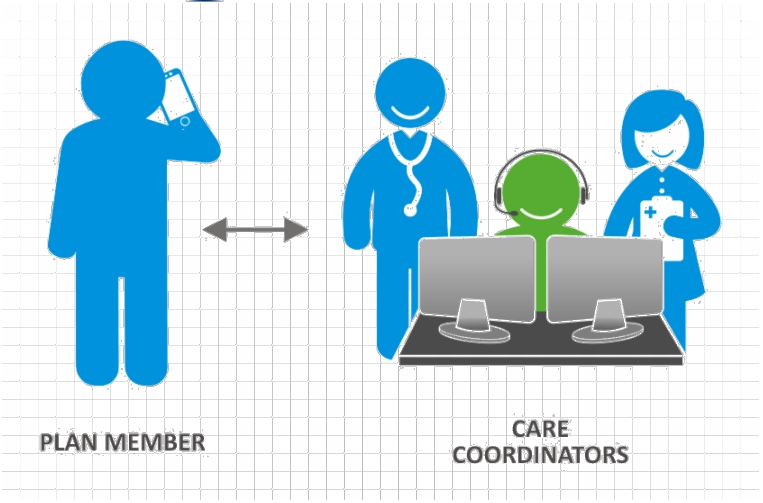
PROVIDER BENEFITS

MEMBER BENEFITS

Collaborative Care: Member Care Coordination

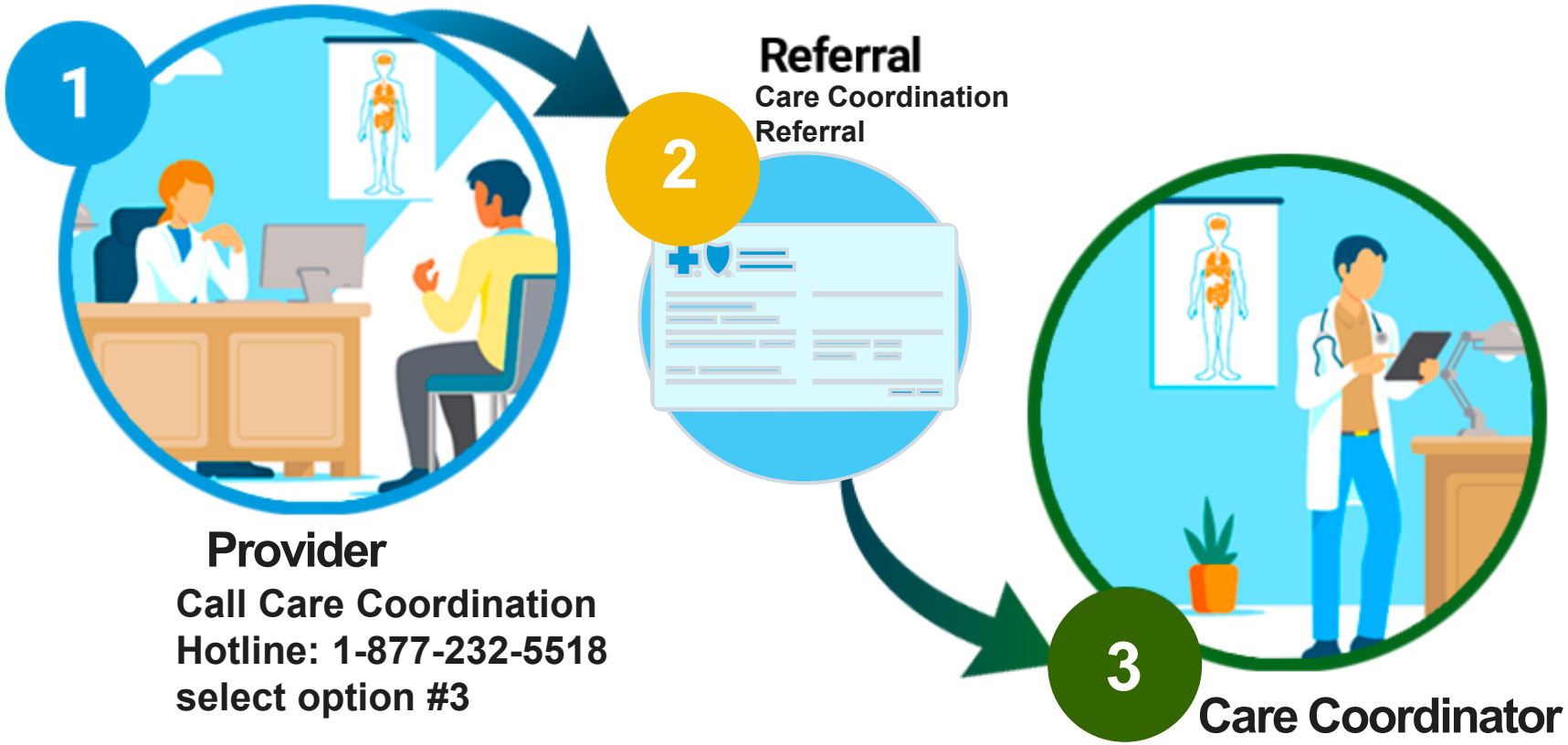
Members who can Benefit From Care Coordination

- Children
- People who live in institutional settings
- Older Adults
- Pregnant Women
- People with Disabilities
- People with Chronic Conditions
- People with Pharmacological Dependency
- People with Limited Access to Transportation
- Limited English Proficiency and Non-English Speakers
- People of Low Socioeconomic Status
- Individuals Experiencing Homelessness



Collaborative Care: Care Coordination Resources

How referrals work



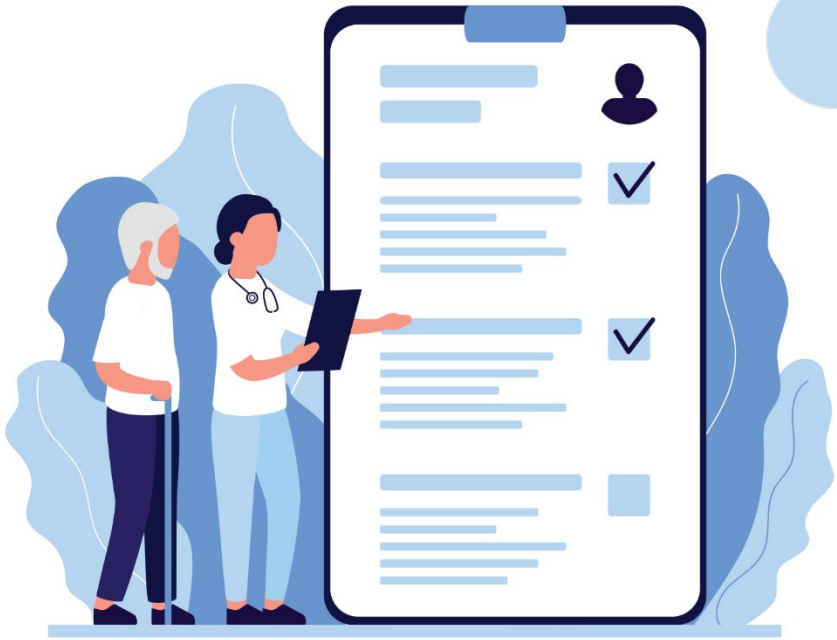
Collaborative Care: Prioritizing Care Plans

- Putting the Member's First: Optimizing Care Plans for Seamless Coordination

CARE PLAN

MEMBER PRIMARY INFORMATION			
Member Name:	Mickey Member	Gender :	M
Member DOB:	07/01/1972	Age:	51
Member Phone Number:	505-123-4567	Address:	1234 Donald Way NE
Primary Care Manager:	Emily		
Care Staff Phone Number:	505-001-0002	City, State, Zip:	ABQ, NM 87109
Medicare ID:	999-9999A	Medicaid ID:	90312345678

ELIGIBILITY DETAILS		
Eligibility	Start Date	End Date
NM MEDICAID >> Centennial Care	01/01/23	12/31/23



Collaborative Care: Special Beginnings

Presenter:

Amy Freeman, LPN

Member Care Coordinator – Special Beginnings

Collaborative Care: Special Beginnings

What: The Special Beginnings team is dedicated to improving maternal-infant health outcomes and reducing health disparities among the most vulnerable populations.

Who: Pregnancy, postpartum, and NICU Transition of care

Where: In home visits, frequent telephone touch points, and hospital settings, if indicated

When : Special Beginnings can take referrals at any point in pregnancy and up to one year postpartum.

How:

- Email: NMCNTLSpecialBeginnings@bcbsnm.com (best option)
- Phone: 1-888-421-7781
- Centennial Home Visiting Program Email: CHV@bcbsnm.com
- Special Beginnings Website Landing Page (Resource) https://www.bcbsnmcommunications.com/special_beginnings/2054953/483419.html

Collaborative Care: Member Feedback & Satisfaction

Presenter:

Jenae Avila, BSHS, MBA

Quality Management Specialist III

Collaborative Care: Member Feedback

Member Focus Groups

- Learn about innovative programs and services available to our members
- Discover the newest health plan capabilities and ways to access care
- Participating members receive an incentive
- Member feedback follow-up calls

Member Satisfaction Surveys

- BCBSNM is committed in partnering with providers to improve member outcomes and the member's experience with their health plan and providers.

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Continuous Quality Improvement

Continuous Quality Improvement

Learning Objectives:

- To showcase successful quality improvement initiatives and recognize providers who have made significant contributions to improving healthcare outcomes.
- To discuss the latest trends and developments in healthcare delivery, and how they can be leveraged to improve member outcomes.
- Explain how providers in Value Based Programs have additional incentive and tools to support Continuous Quality Improvement

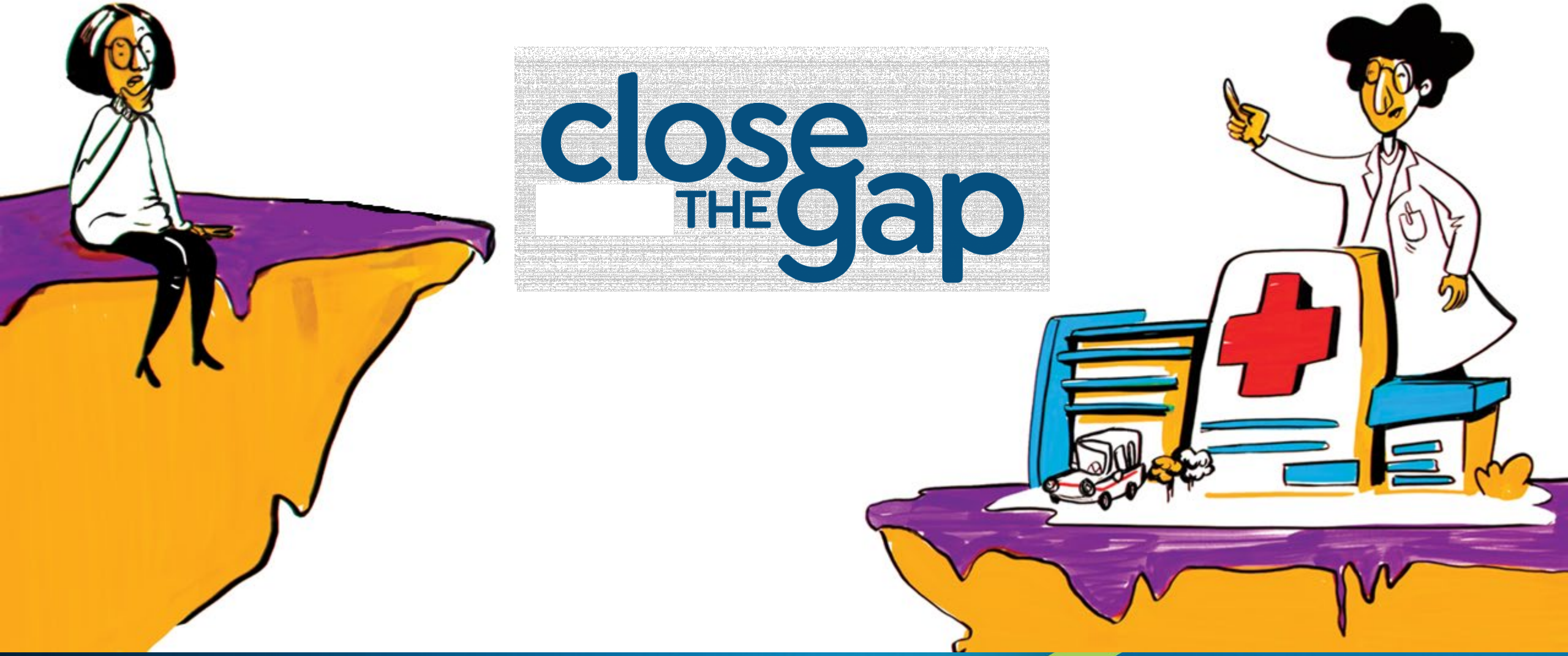
Continuous Quality Improvement: Physical Health

Presenter:

Raman Eremia, LCPC, CPHQ, CLSSBB

Sr. Manager Quality Improvement

Continuous Quality Improvement: Member Engagement



Continuous Quality Improvement: Member Engagement

- Member-Centric Approach
- Relevant Information
- Personalized Contact

- Member to Appropriate Resources
- Member to Local Care Providers
- Member to Community Resources

- Close Gaps in Care
- Assess and Address Social Determinants of Health
- Reduce Barriers

- Communication and Information Sharing
- Collaboration and Teamwork
- Integration and Continuity of Care

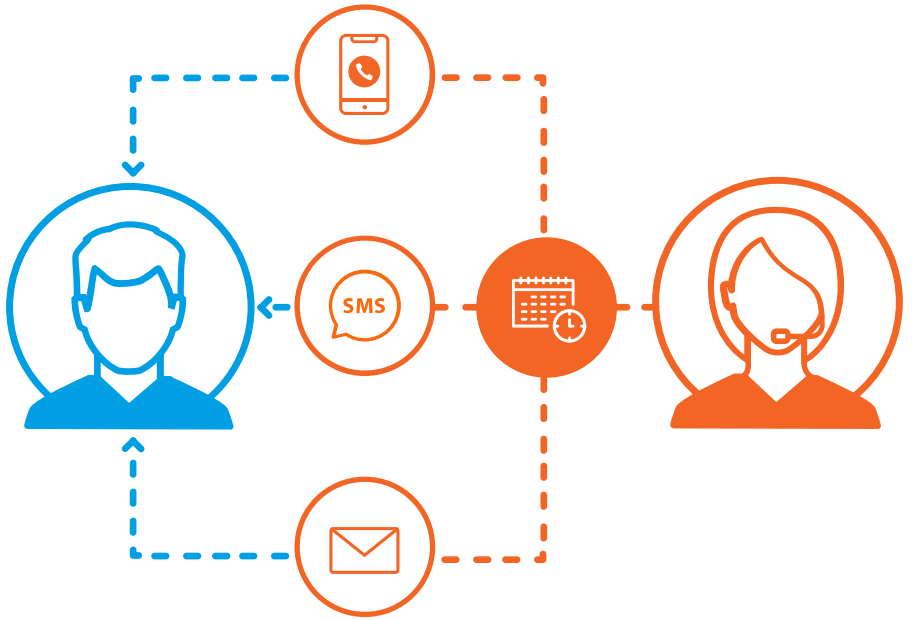
Continuous Quality Improvement: Member Interventions

BCBSNM delivers rich mobile experiences through the BCBSNM Member Feed.

- Multi-message journeys
- Timed messages that are minutes, days or months apart
- Send personalized cards discreetly without a notification
- Direct members to a specific message or the top of the member feed
- Targeted Condition Campaigns in English and Spanish

Member Communications Campaigns

- Postcard reminders and educational mailers.
- Promote Centennial Rewards
- Member Newsletter
- Social Media/Digital Advertising
- Telephonic Outreach



Continuous Quality Improvement: Member Interventions

- Home Blood Pressure Monitor Initiative
  - Condition Based, Targeted Messaging
  - Dedicated Outreach
- Condition-Based Targeted Messaging
  - Member emails based on condition/gap in care
  - Member text messaging based on condition/gap in care

Continuous Quality Improvement: Provider Interventions

- Value Based Contracts
- Supplemental Data Submission
- Opportunity/Gap List
- Outreach Assistance
- Got Shots! Partner Campaign

Continuous Quality Improvement: Behavioral Health

Presenter:
Lesley Riley, LCSW
Manager Behavioral Health Quality Improvement & Data Analysis

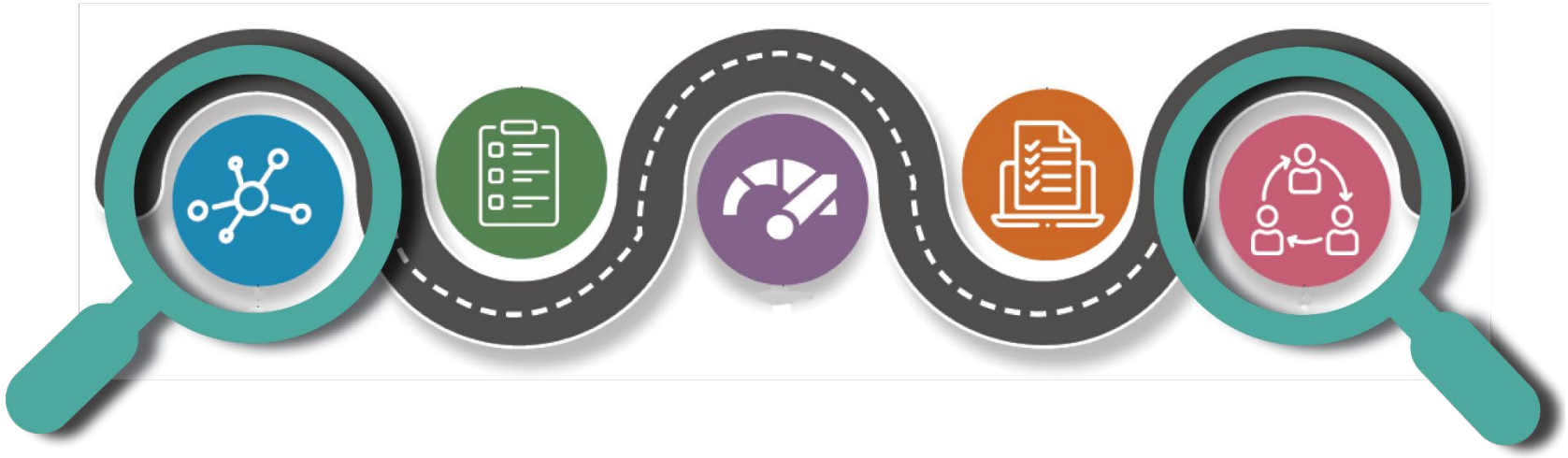
Continuous Quality Improvement: Behavioral Health

- Mental Health Follow Up Care
- Substance Use Follow Up Care
- Medication Adherence
- Diabetes Screenings for Members on Antipsychotic Medication

Continuous Quality Improvement: Member Interventions

Member-Centric Approach

- Text Messaging Initiative
- Reserved Appointment Initiative
- Home Health Test Kits
- Facility Incentive Program



Continuous Quality Improvement: Resources

Provider Resources

BCBSNM offers a three-course series on Behavioral Health, where providers can earn one CME/CEU each year, they are available online for credit after the webinar.

Online registration

- providereducation.org

Courses:

- Bipolar Disorder
- Synthetic Opioids and the Opioid Crisis
- Maternal Mental Health: Pregnancy and Postpartum

Member Resources

- BCBSNM developed a series of member videos.
    - Social media sites,
    - BCBSNM Connect site, and
    - Flyers with educational content.

Continuous Quality Improvement: Value Based Programs

Presenter:
Steve DeSaulniers, MA
Manager Network Innovation & Strategy

Continuous Quality Improvement: Value Based Programs

BCBSNM Value Based Program measures support both physical health and behavioral health in support of whole person care.

- Quality Measures Selection
- Quality of Care Measures Focus
- Quality Measure Performance Tracking and Trending

Continuous Quality Improvement: Value Based Programs

The most successful provider groups engaged in a VBP arrangements share success stories with supporting teams such as:

- Population Health Management teams
- Maintain Provider engagement with BCBSNM and Quality Improvement
- Quality Measure specification awareness
- Education for clinical staff to ensure coding accuracy
- Developing awareness of all staff levels

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Evidence-Based Practice

Evidence-Based Practice

Learning Objectives:

- To provide a platform for healthcare providers to share their experiences and best practices in quality improvement initiatives.
- To review the latest evidence-based guidelines and recommendations for improving healthcare outcomes and discuss their implications for clinical practice.
- To develop a roadmap for transitioning to a value-based care model and identify key steps for success.
- To showcase examples of providers who have successfully implemented value-based strategies and share their insights and best practices with attendees.
- To discuss value-based strategies that focus on delivering high-quality care at a lower cost and explore how Providers can implement these strategies in their practices.

Evidence Based Practice: Evidence Based Guidelines

Presenter:

Raman Eremia, LCPC, CPHQ, CLSSBB

Sr. Manager Quality Improvement

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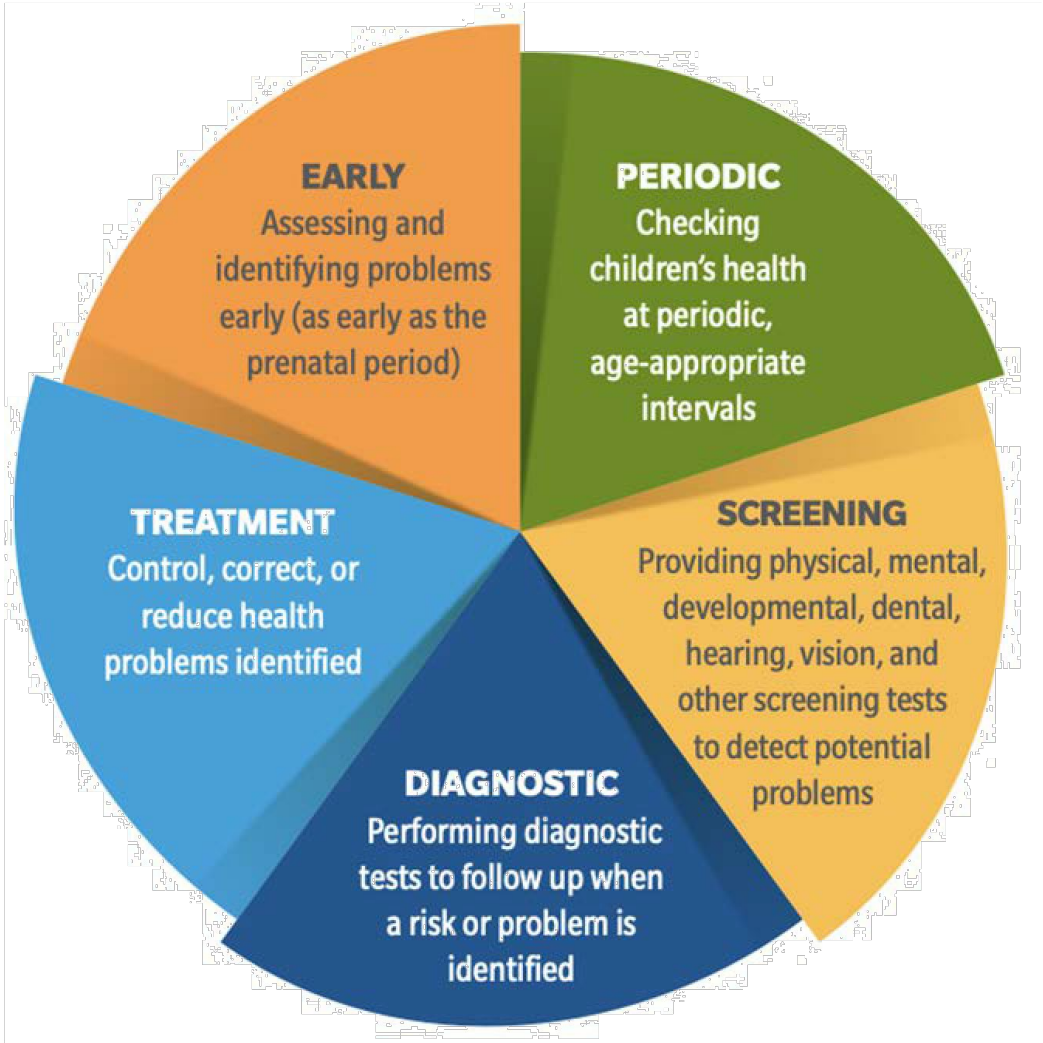
Evidence Based Practice: EPSDT



- EARLY
- PERIODIC
- SCREENING
- DIAGNOSIS
- TREATMENT

Evidence Based Practice: EPSDT Services

- Preventive Health Screenings
- Diagnosis and treatment
- Personal Care Services
- Rehabilitation Services
- Case Management
- Comprehensive unclothed physical exam
- Therapies
- Mental Health Services
- Medical Health Services
- Vision Services
- Hearing Services
- Dental Services
- Appropriate immunizations
- Laboratory tests
- Lead toxicity screening
- Health education (anticipatory guidance including child development, healthy lifestyles and accident and disease prevention)
- Developmental screenings that are part of the well-child visit
- Transportation and scheduling assistance

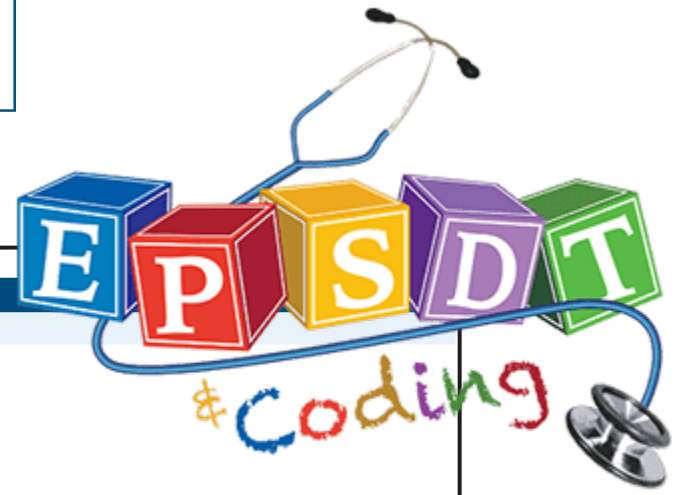
Evidence Based Practice: Provider Resources

Preventive Care Guidelines Summary
For Healthy Children

The gray shaded areas show the age that the child should get the service.

	AGE	MONTHS												YEARS														
		B	1	2	4	6	9	12	15	18	24	30	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17-21
WELL CHILD CHECKUPS & SCREENING	Newborn Screening	•																									
	History and Physical Exam	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Length, Height and Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Head Circumference	•	•	•	•	•	•	•	•	•	•																
	Developmental Screening	•					•			•		•															
	Autism Screening									•	•																
	Vision Screening	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•		•		•			•		•
	Hearing Screening	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•						•
	Body Mass Index (BMI)										•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Blood Pressure	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Anemia Test				•			•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Lead Screening							•			•	Ask child's provider if additional testing is needed.															
	Tuberculosis (TB)	Ask child's provider if TB testing is appropriate for the child.																									
	Chlamydia Test (Females)																				Sexually active females should be tested for chlamydia infection.						
	Oral Health					•	•	•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
VACCINES: CDC.GOV/VACCINES	Hepatitis B	•		•		•	Catch-up options are available. See note below.																				
	Rotavirus			•	•	•																					
	Polio (IPV)			•	•	•								•													
	Haemophilus Influenzae B (Hib)			•	•	•		•																			
	Diphtheria, Tetanus, Pertussis (DTaP)			•	•	•			•					•							•	Tdap booster at age 11. See note below.					
	Pneumococcus			•	•	•		•	Some children need the new PCV13 vaccine—ask child's provider.																		
	Measles, Mumps, Rubella (MMR)							•						•								See note below for catch-up.					
	Varicella (Chicken Pox)							•						•								See note below for catch-up.					
	Hepatitis A							•		•																	
	Meningococcus																				•					•	
	Human Papillomavirus																				•	•	3 doses				
	Influenza	Children should get a flu shot annually beginning at six months of age.																									
HEALTH ADVICE	Tobacco Use	Protect children from secondhand smoke. Discuss with child's provider how to help prevent tobacco use.																									
	Folic Acid (Vitamin B9)																				Discuss with provider need for folic acid by females of childbearing age.						
	Anticipatory Guidance	Discuss proper sleep positioning with provider.						When appropriate, discuss with child's provider how to prevent alcohol and drug use, unsafe sex, firearm injury, household accidents, and unprotected exposure to sunlight.																			
													Ask provider for advice on nutrition, physical activity, seat belt or car seat use, and family planning when child is older.													

Preventative Care Guidelines for Children Periodicity Table



COMMON CODES USED FOR EPSDT

Preventive Services*

CPT Codes:	Description
99381	New patient under one year
99382	New patient (ages 1-4 years)
99383	New patient (ages 5-11 years)
99384	New patient (ages 12-17 years)
99385	New patient (ages 18-20 years)
99391	Established patient under one year
99392	Established patient (ages 1-4 years)
99393	Established patient (ages 5-11 years)
99394	Established patient (ages 12-17 years)
99395	Established patient (ages 18-20 years)
99460	Initial care in a hospital or birthing center for normal newborn infant
99461	Initial care in other than a hospital or birthing center for normal newborn infant

*These CPT codes do not require use of a "Z" code.

Evaluation and Management Codes**

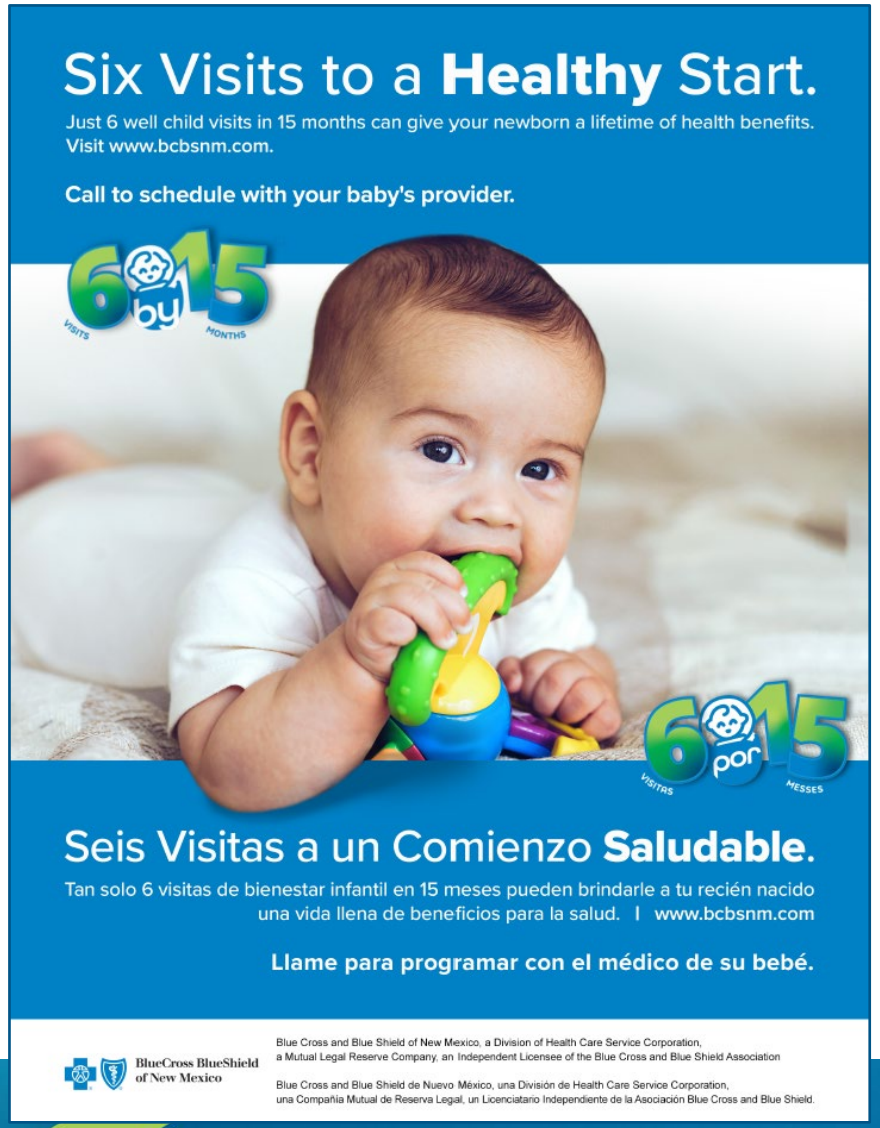
CPT Codes:	Description
99202-99205	New patient
99213-99215	Established patient

**The above CPT codes must be used in conjunction with at least one of the following "Z" diagnosis codes: Z00.0D through Z00.129, Z00.8, Z02.89 and Z76.I - Z76.2.

Evidence Based Practice: Best Practice Campaigns

Well Visit	1	2	3	4	5	6				
Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years
HepB	HepB				HepB					
		RV	RV	RV						
		DTaP	DTaP	DTaP		DTaP				DTaP
		Hib	Hib	Hib	Hib					
		PCV13	PCV13	PCV13	PCV13					
		IPV	IPV		IPV					IPV
					Influenza (Yearly)*					
					MMR					MMR
				SM	Varicella					Varicella
						HepA§				

6 by 15 VISITS MONTHS



Evidence Based Practice: Value Based Agreements

Presenter:

Steve DeSaulniers, MA

Manager Network Innovation & Strategy

Evidence Based Practice: Value Based Agreements

Physical health Provider quality targets

- Antidepressant Medication Management
- Initiation and Engagement of Alcohol or Drug Treatment
- Follow-up after Hospitalization for Mental Illness
- Follow-up after Emergency Department Visit for Mental Health

Behavioral health Provider quality targets

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Anti-psychotic Medication
- Percentage of Attributed Members who have had a PCP visit
- Registration and use of Emergency Department Information Exchange (EDIE)
- Reduction in Unnecessary Use of Emergency Department

Evidence Based Practice: Value Based Agreements

- Physical health Providers having a behavioral health provider in-house (e.g., psychiatrist, CNP/CNS with psych specialty, psychologist, clinical social worker or counselor)
  - Telehealth can support this effort
- Behavioral health Providers having a physical health provider in-house (e.g., PCP)
- Implementing the Collaborative Care Model (CoCM)
  - Resources available on CMS website such as the Medicare Learning Network; AIMS Center University of Washington; etc.)
- Formal or informal relationship between a physical health provider/group with a behavioral health provider/group for cross-referrals and collaborative care
- Member screening (e.g., PH providers administering screening tools for depression or anxiety; BH providers screening or referring to PH providers for physical health screening)

Evidence Based Practice: Value Based Agreements

- Paying for improved health outcomes or processes that lead to better health outcomes
- Close quality gaps of care – collaborative care with patients and families
- Ways to help ensure gaps of care are addressed

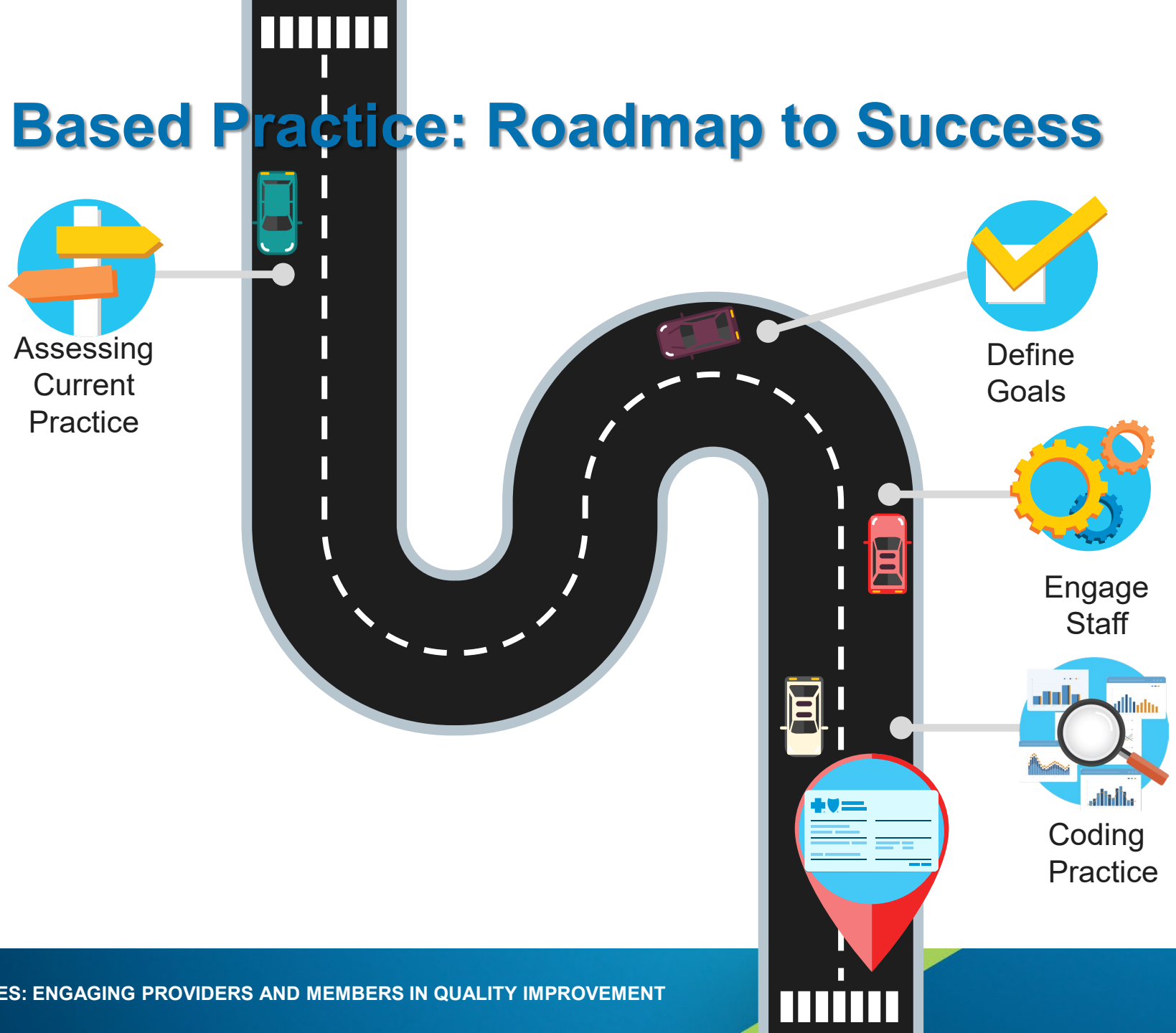
Evidence Based Practice: Roadmap to Success

Presenter:

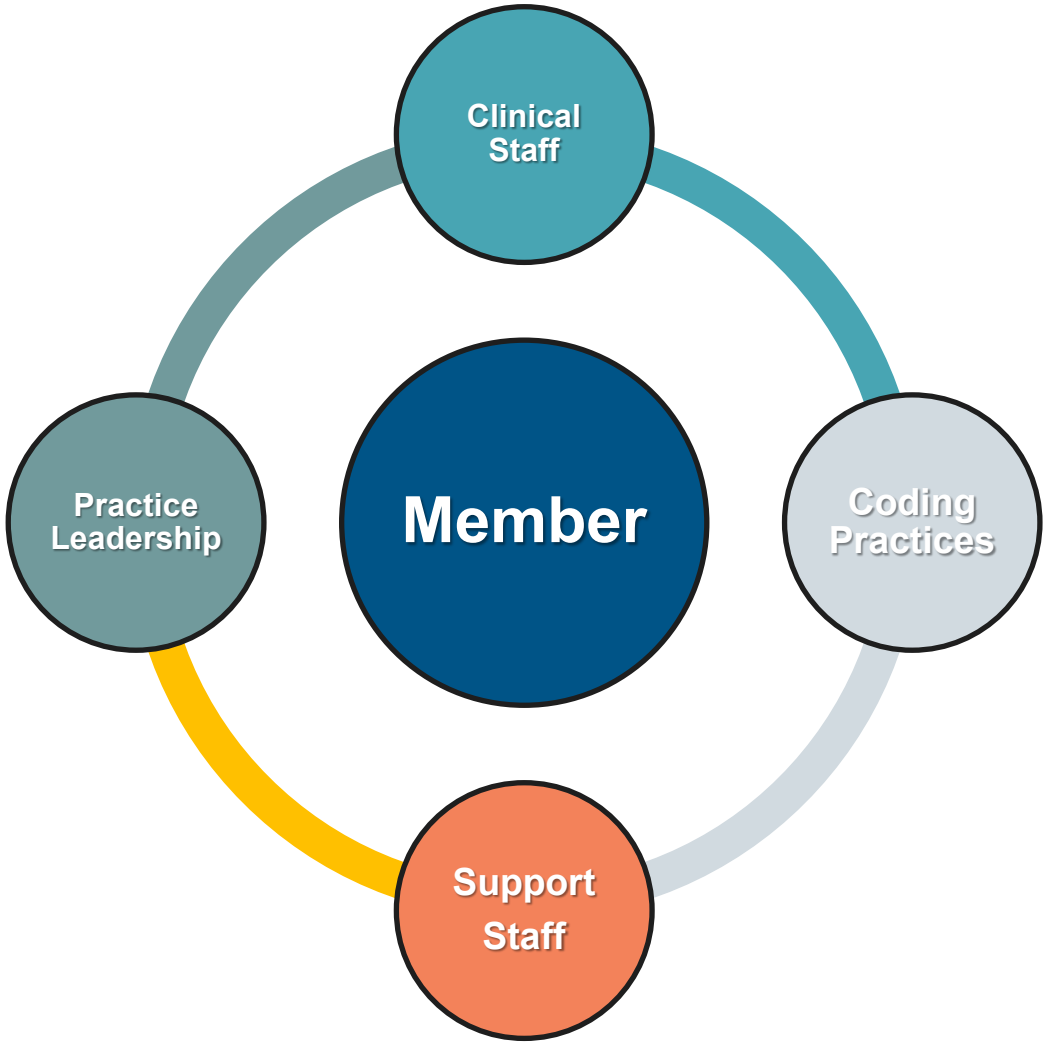
Doug Wood, RN, BSN

Clinical Practice Consultant

Evidence Based Practice: Roadmap to Success

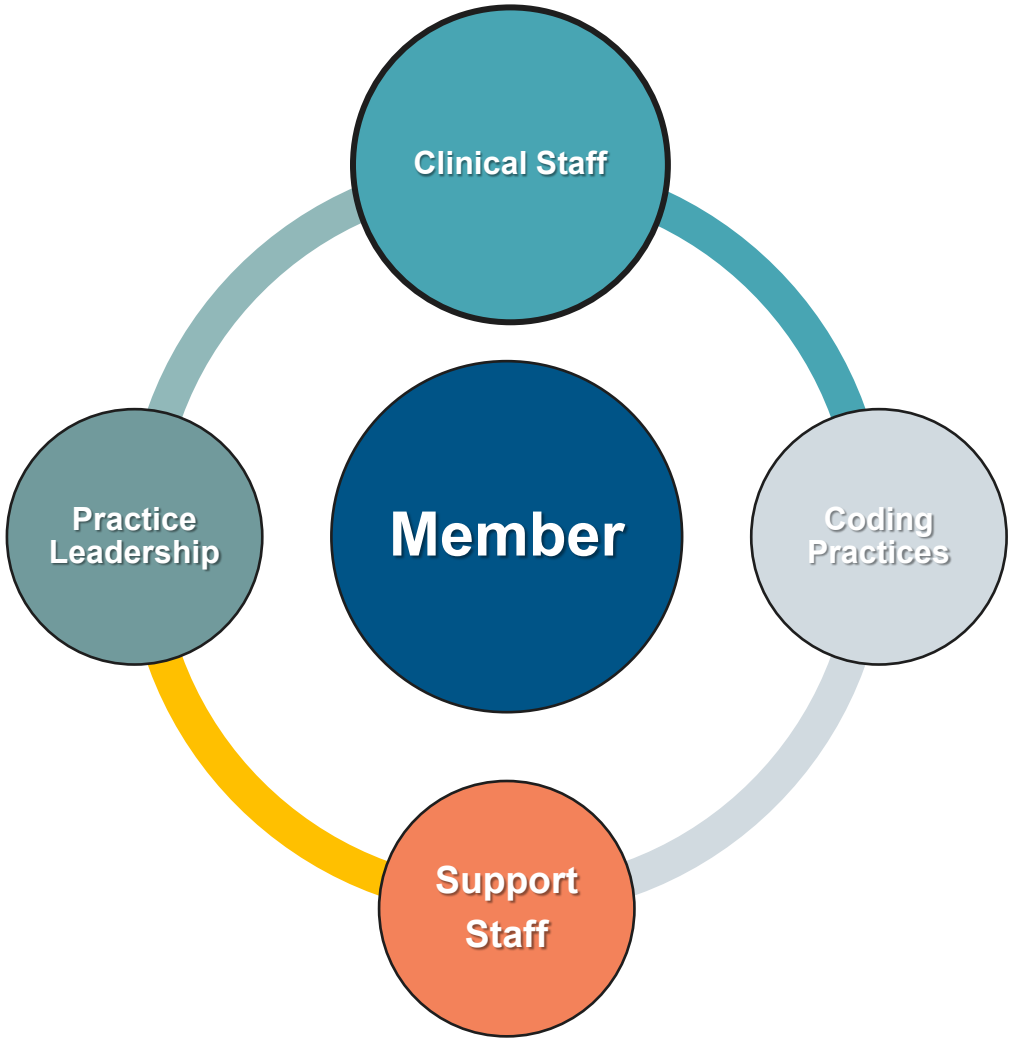


Evidence Based Practice: Assess Readiness

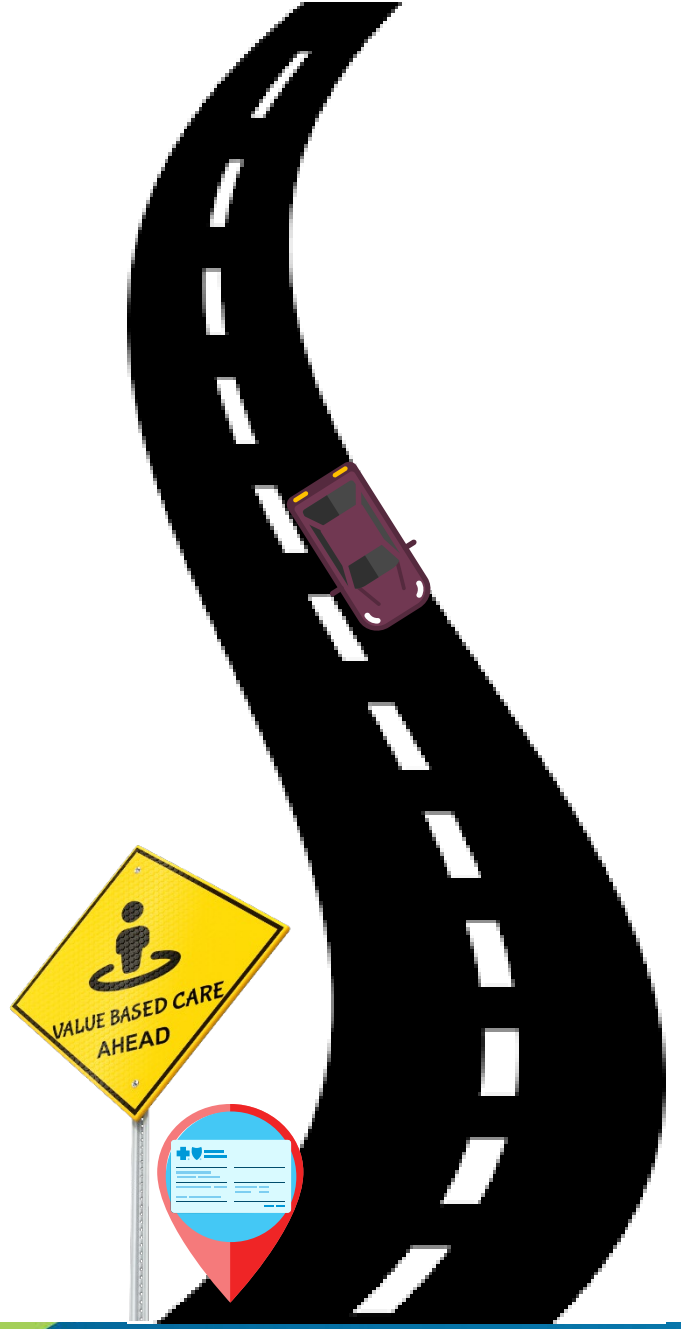


Evidence Based Practice: Define Goals

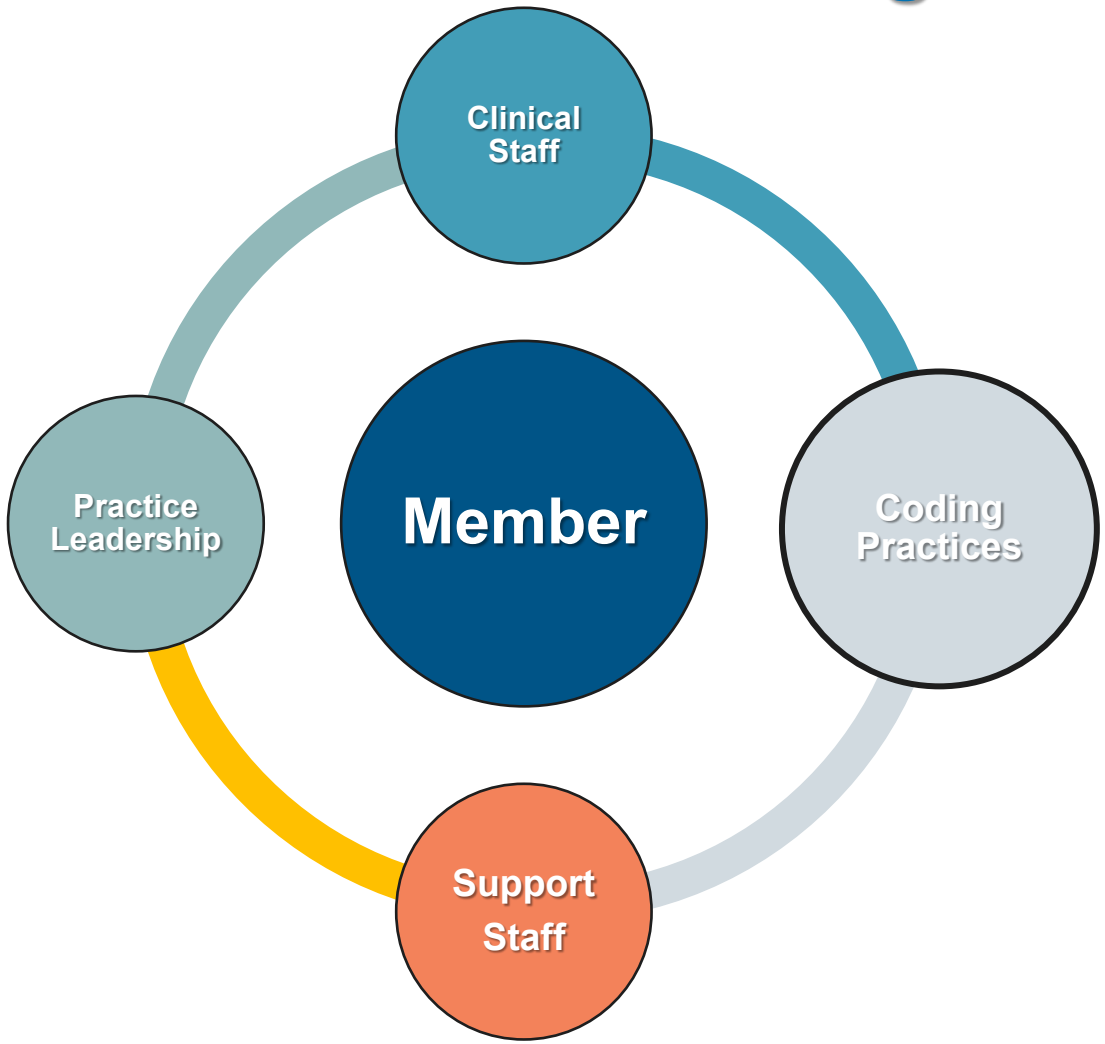
Evidence Based Practice: Clinical Staff

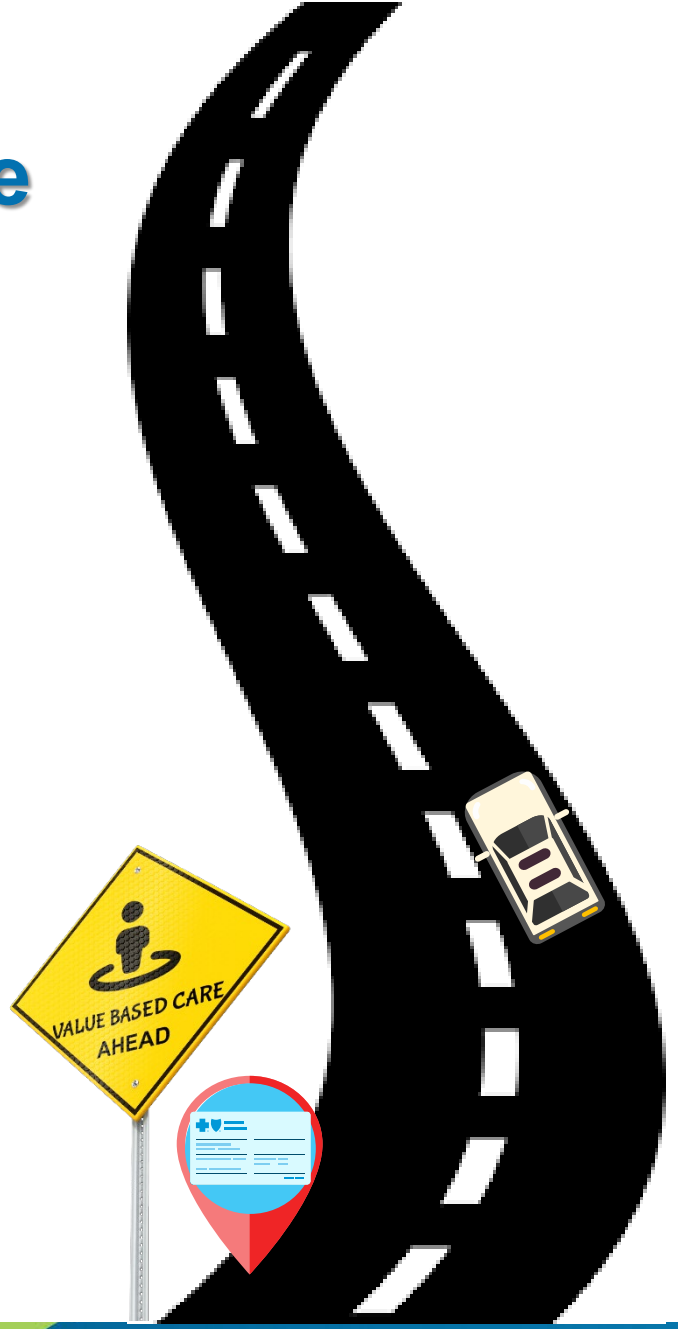


Evidence Based Practice: Support Staff



Evidence Based Practice: Coding Practice





Evidence Based Practice: Examples of Successful Implementation

Presenter:

Waynette Lopez, MSW, LCSW

Clinical Value Consultant

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Evidence Based Practice: Better Care, Better Outcomes

Value Based Strategy

- Member Centric Approach/Multi-disciplinary Team Strategy
- Promotion Health and Wellness
- Member Engagement
- Provider Engagement
- Incentives
- Coding Practices
- Data Sharing