

From Motivation to Results: Approaching Chronic Pain with Holistic Treatment and Quantifiable Outcomes

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SPEAKER INFO



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SPEAKER INFO



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OBJECTIVES

Ascertain best practices for data tracking and treatment options that ensure patients receive high quality-care that keeps them safe and helps them regain function for their daily lives.

Understand how data can be leveraged to reinforce compliance with national regulations for treating pain

Articulate key metrics that can be measured and benchmarked to facilitate shared community success for safely managing pain.

THE OPIOID EPIDEMIC

THE IMPACT OF THE OPIOID CRISIS IN INDIANA

THE OPIOID EPIDEMIC

\$78.5B Economic burden of prescription opioid misuse

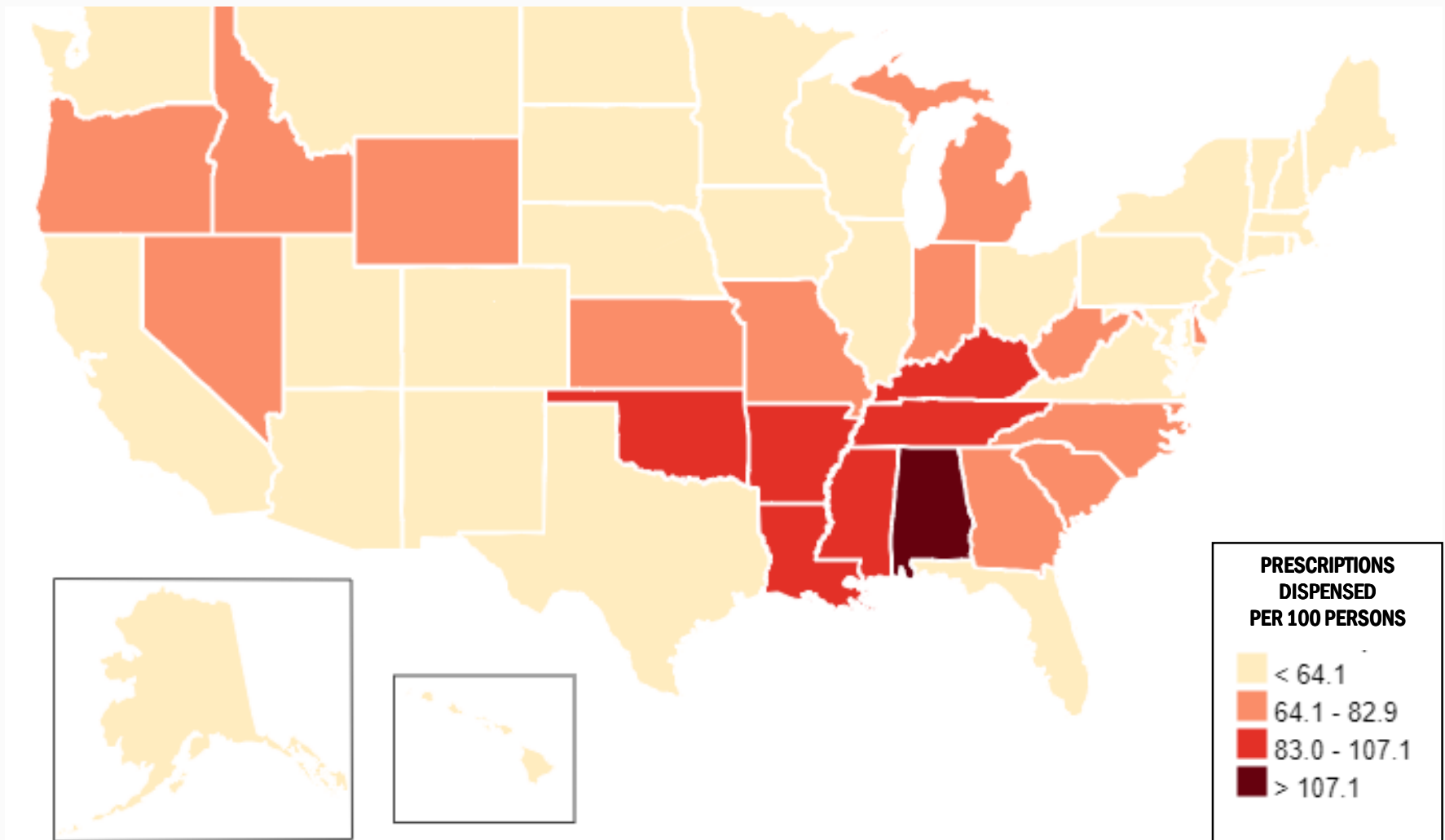
4 in 5 new heroin users started out misusing prescription painkillers

175+ Americans die every day from unintentional drug overdoses

63,000+ American overdose fatalities annually

THE OPIOID EPIDEMIC

2017 STATE PRESCRIBING RATE

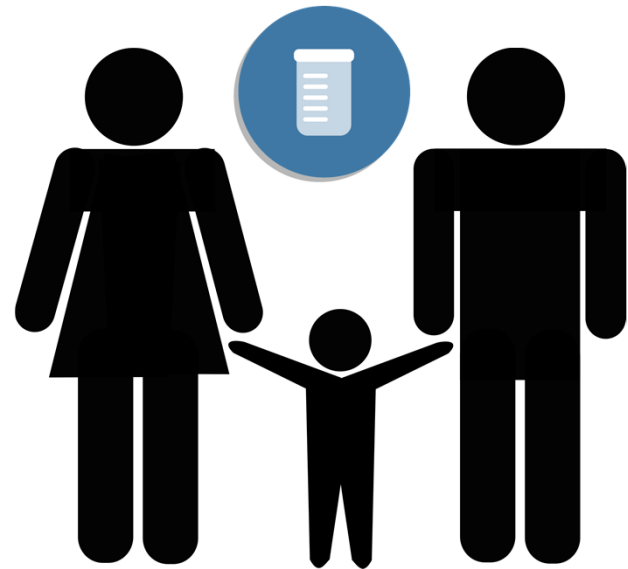


THE NUMBERS

- Enough opioids are prescribed in the U.S. each year to keep every man, woman and child in the country medicated around the clock for one month
- In 2015, 2.7M Americans suffered from opioid dependence or addiction

AT RISK POPULATIONS

- Individuals aged 45-64
- Individuals on Medicaid and others living in poverty or with low-income



CHRONIC PAIN

A man with short brown hair, wearing a light blue V-neck sweater, is sitting on a light-colored tufted sofa. He is looking off to the right with a thoughtful or pained expression, his right hand resting against his face. The background is a bright, out-of-focus window with greenery outside. The overall tone is soft and contemplative.

WHAT IS CHRONIC PAIN?

Any pain lasting longer than 3 months

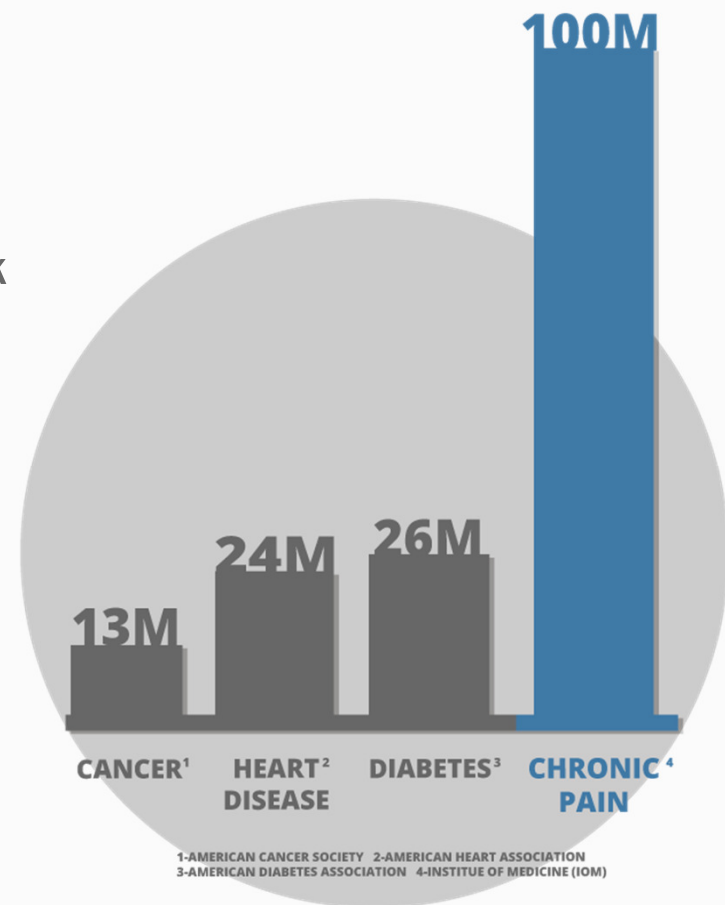
CHRONIC PAIN IN THE U.S.

100 Million - Americans suffer from chronic pain each year¹

#1 Reason - Pain is the primary reason that Americans enter the healthcare system

Psychological Distress - Adults with lower back pain are 4 times more likely to experience serious psychological distress compared to those without lower back pain

4 Types of Pain - The 4 most common types of pain are low back, migraine, neck, and facial pain

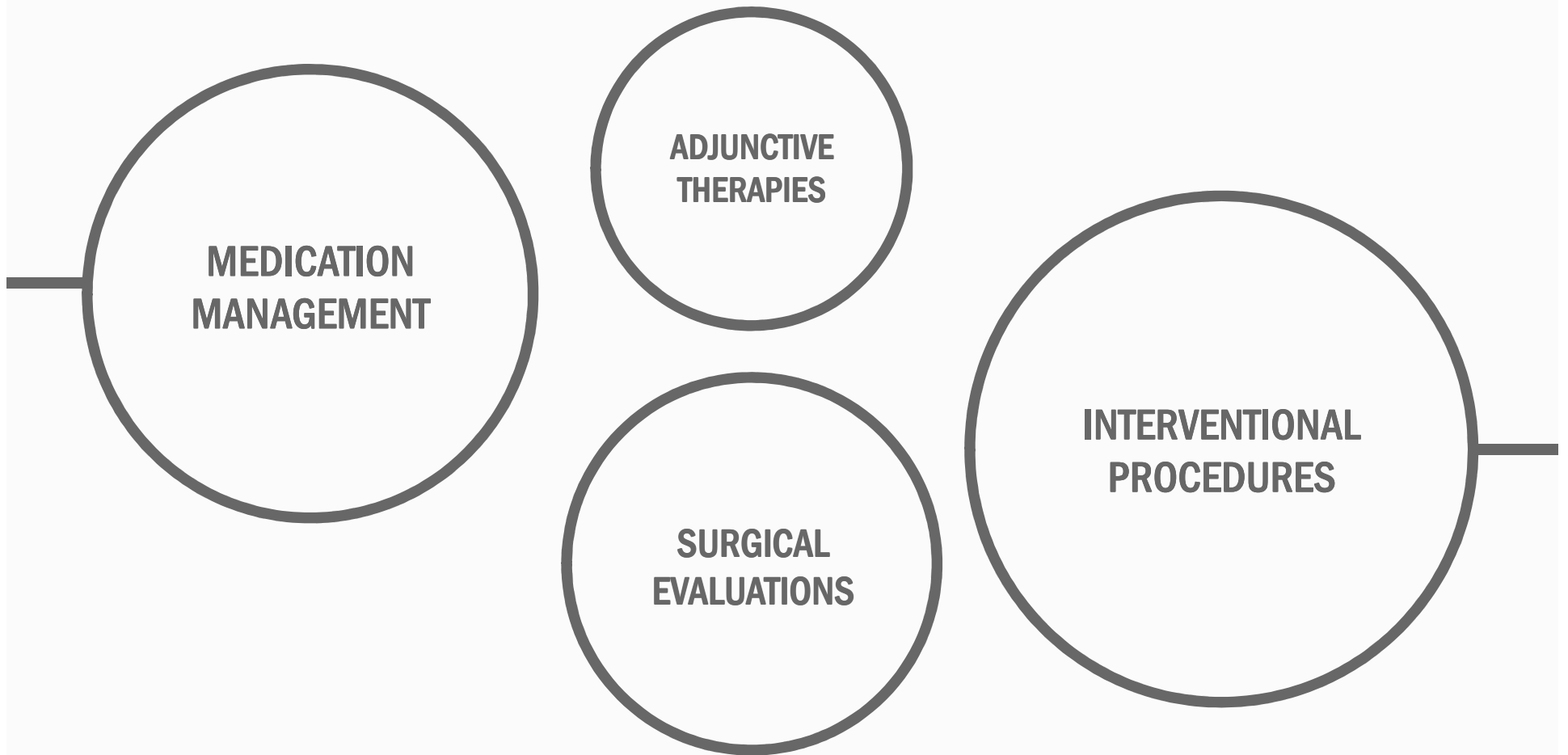


CDC GUIDELINES

1. Opioids are not first-line therapy
2. Establish goals for pain and function
3. Discuss risks and benefits
4. Use immediate-release opioids when starting
5. Use the lowest effective dose
6. Prescribe short durations for acute pain
7. Evaluate benefit and harm frequently
8. Use strategies to mitigate risk
9. Review PDMP data
10. Use urine drug testing
11. Avoid concurrent opioid and benzodiazepine prescribing
12. Offer treatment for opioid use disorder

<https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>

BALANCED & RESPONSIBLE CARE



THE ROLE OF PSYCHOLOGY IN PAIN MANAGEMENT

FIRST WE MUST UNDERSTAND

- According to the institute of Medicine, At least 100 Million adults in the united states suffer from Chronic Pain
 - American Academy of Pain Medicine: Chronic Pain affects more Americans than These combined...
 - Diabetes
 - Heart Disease
 - Cancer
- Pain is useful
- Chronic Pain is complex
- Medical Treatments And Psychological Treatments are important
- I will not talk you out of your pain



A photograph of two medical professionals in white lab coats. The person on the left is holding a clipboard and a pen, looking down at it. The person on the right is partially visible, also in a white coat. The background is bright and out of focus, suggesting a clinical or hospital environment.

WHY IS PSYCHOLOGY IMPORTANT?

Let's do a little exercise

WHAT IS PAIN? LET'S BREAK IT DOWN...

International Association for the Study of Pain

- “An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.”
- Pain is emotional as well as sensory

Primary vs Secondary Pain

- Primary pain – arises from illness, injury or damage to the body or nervous system
- Secondary Pain – the mind’s reaction to primary pain but often far more intense and longer lasting



ACUTE → CHRONIC PAIN

A CONCEPTUAL MODEL OF THE TRANSITION FROM ACUTE TO CHRONIC PAIN (GATCHEL, 1991)

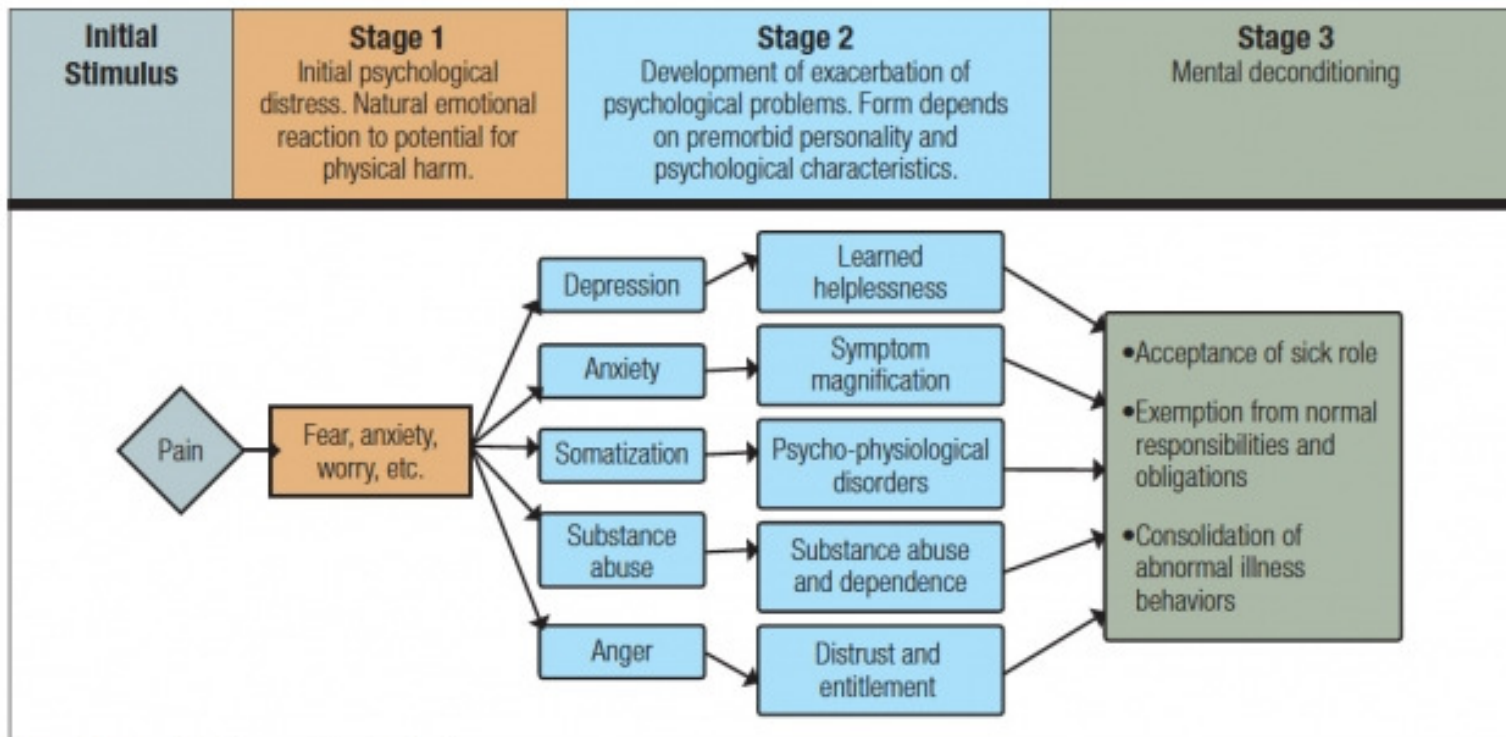


Figure. The transition from acute to chronic pain.



THE NUMBERS: PREVALENCE RATES OF PSYCHOLOGICAL DISTRESS

CHRONIC PAIN

- Major Depressive Disorder
 - 30-54%
- Substance Use Disorder
 - Current: 15-28%
 - Lifetime: 23-41%
- Anxiety
 - 16.5-28.8%
- Personality Disorders
 - 31-81%

GENERAL POPULATION

- Major Depressive Disorder
 - 5-17%
- Substance Use Disorder
 - Lifetime: 16.7%
- Anxiety
 - 19.1%
- Personality Disorders
 - 9.1%



COGNITIVE FACTORS OF PAIN

- Beliefs about pain
- Beliefs about Controllability
- Self-Efficacy
- Catastrophizing
- Coping

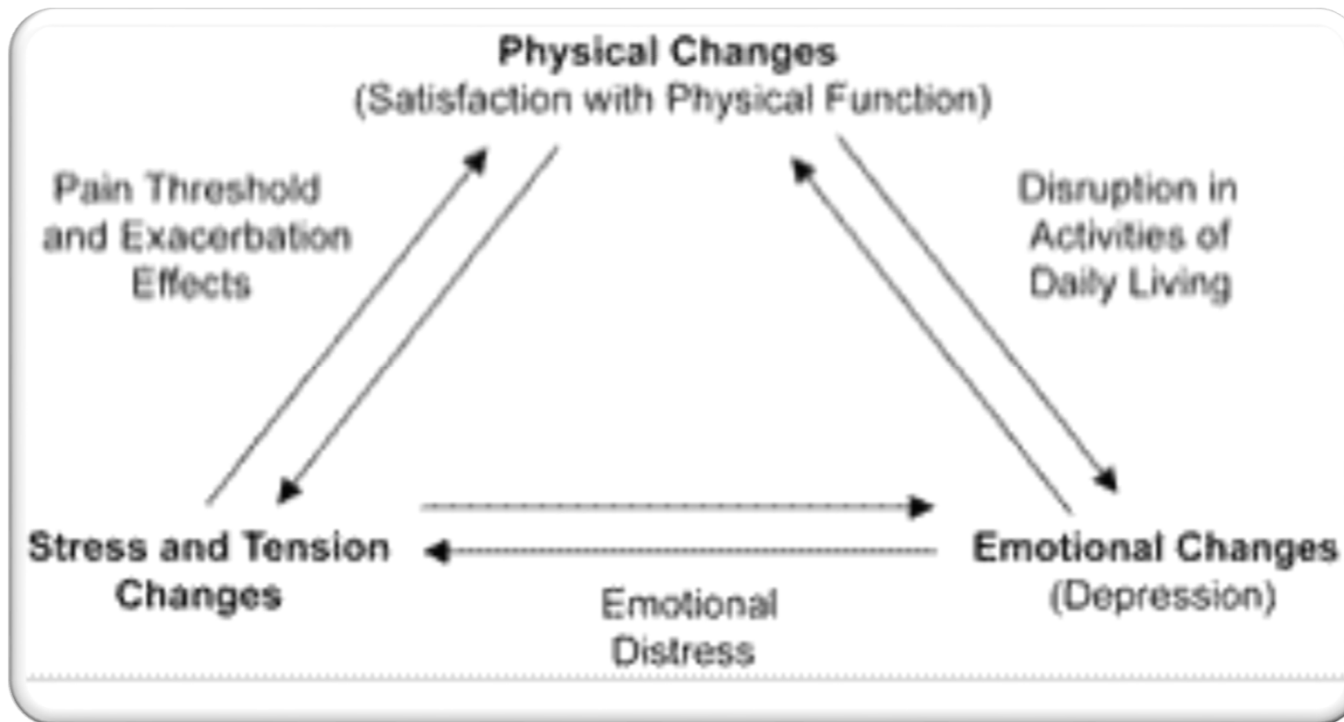


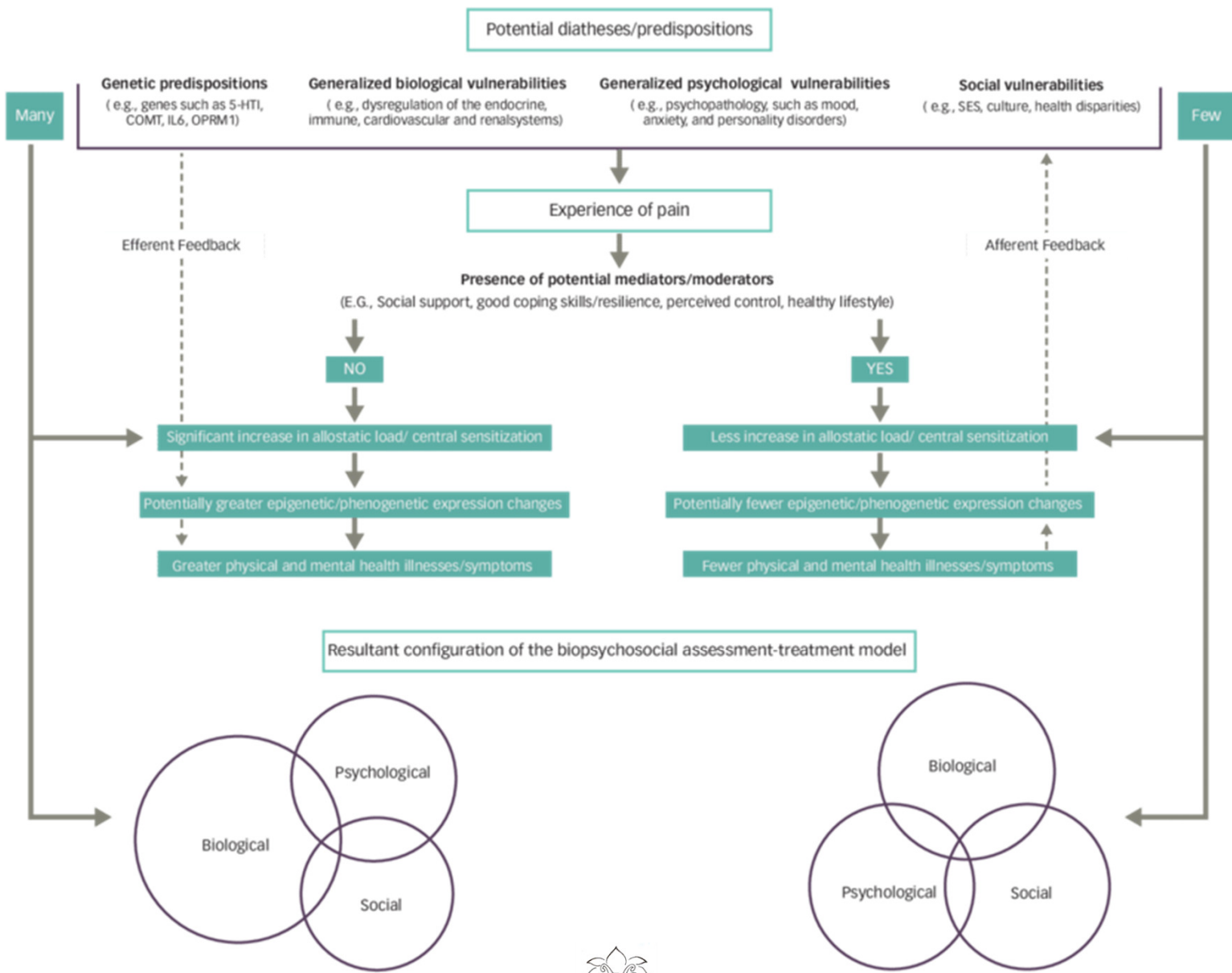
AFFECTIVE FACTORS OF PAIN

- Depression
- Anxiety
- Post Traumatic Stress Disorder (PTSD)
- Anger



MAYER & GATCHEL (1988)





WHAT DOES THIS MEAN?

- As pain becomes more chronic in nature, psychological variables play an increasingly important role in the maintenance of pain behavior and suffering.
- Psychopathology is a significant concomitant of chronic pain.
- The Biopsychosocial model has long proven to be the most heuristic approach to better understanding the complex interaction among the biological, psychological and Social factors that contribute to chronic pain
- Therapeutic and interdisciplinary pain programs have been developed due to the biopsychosocial model, which has shown to be cost effective in addition to effective overall in treatment



TALK TO ME...

Remember the Exercise in the Beginning?

TREATMENT APPROACHES AND METHODS

- Motivational Interviewing
- Cognitive Behavioral Therapy
- Acceptance and Commitment Therapy
- Exposure Therapy
- Group Therapy

NOT DISCUSSED TODAY BUT ALSO EFFECTIVE...

- Biofeedback Training
- Hypnosis



MOTIVATIONAL INTERVIEWING (MI)

FIVE PRINCIPLES OF MI

- Expressing Empathy
- Developing Discrepancy
- Avoiding Argumentation
- Rolling with Resistance/Dealing with Discord
- Supporting Self-Efficacy



MOTIVATIONAL INTERVIEWING (MI)

Examples of questions that may evoke self-motivational statements in individual with pain problems:

- **PROBLEM RECOGNITION**

- Have things gotten better or worse in the past six months?
- What are you now doing to cope with your pain problem? Is it working?
- What do you miss most about your life before the pain problem?

- **CONCERN**

- What concerns you most about the pain problem?



MOTIVATIONAL INTERVIEWING

Examples of questions that may evoke self-motivational statements in individual with pain problems:

- **INTENTION TO CHANGE**

- How would you like your life to be different?
- If you received treatment here, how would you know it was working?

- **OPTIMISM**

- What area of your life has not been touched by the pain problem?
- What evidence do you have that you can succeed here?
- What will make (decreasing meds, engaging in exercise program) easier for you?
- What aspects of your life do you feel the most control over?



COGNITIVE BEHAVIORAL THERAPY (CBT)

- Problem Oriented
- Educational (teaches self-management, problem solving, coping, and communication skills)
- Collaborative (patient and HC Provider work together)
- Makes use of in-clinic and in-home practice to consolidate skills and identify problem areas
- Encourages expression of feelings, then control of feelings that impair rehabilitation
- Addresses the relationship among thoughts, feelings, behavior, and physiology
- Anticipates setbacks and lapse and teaches patients how to deal with these



GOALS OF COGNITIVE BEHAVIORAL THERAPY

- Reconceptualization of patients' views of their problems from overwhelming to manageable (combat demoralization)
- Convince patients that skills necessary for responding to problems more adaptively are included in treatment (enhance outcome efficacy)
- Reconceptualization of patients' views of themselves, from passive, reactive, and helpless to active resourceful and competent (foster self-efficacy)
- Ensure that patients learn how to monitor their thoughts, feelings, behaviors, and physiology, and learn interrelationships among these (break up automatic, maladaptive patterns)



GOALS OF COGNITIVE BEHAVIORAL THERAPY

- Teach patients how and when to use adaptive overt and covert behaviors required for adaptive response to problems associated with chronic pain (skills training and use)
- Encourage patients to attribute success to their own efforts (self-attribution)
- Anticipate problems and discuss these, as well as ways to deal with them (facilitate maintenance and generalization)

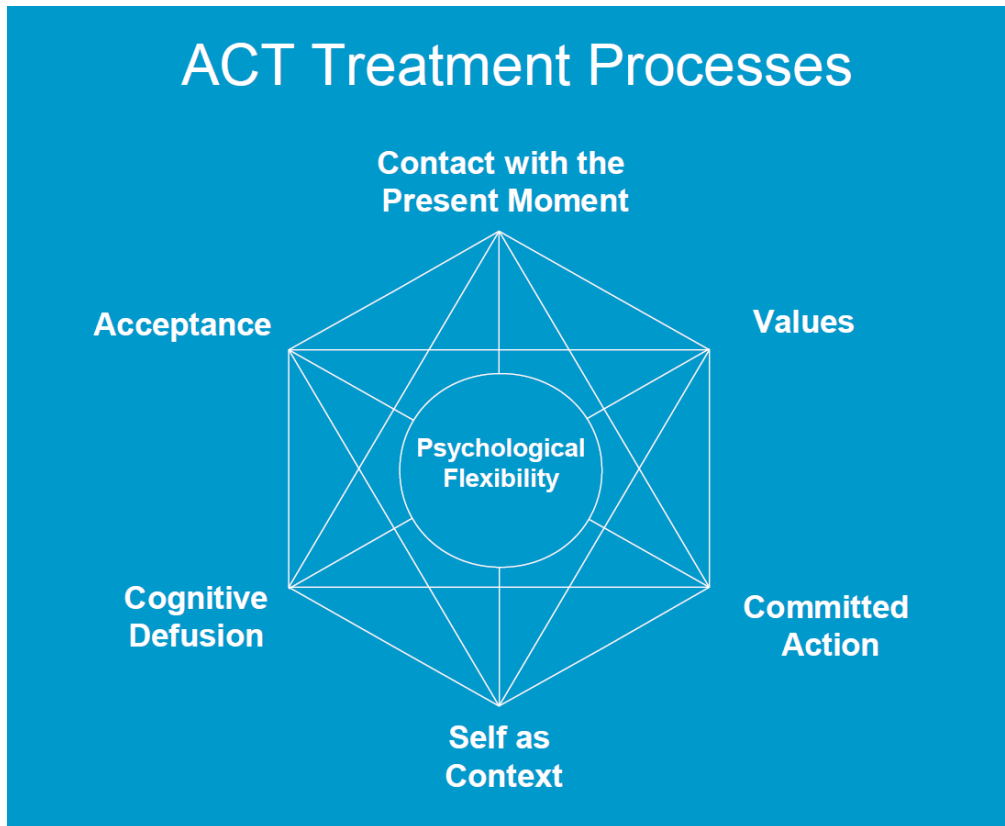


ACCEPTANCE & COMMITMENT THERAPY (ACT)

- **BASIC PREMISE:** By accepting and learning to live with pain, one can limit the control it exerts over his or her life.
- **ESSENCE OF THERAPY:** This therapy guides individuals to change their expectations from the elimination of pain to living as well as possible with pain.
 - Through metaphors and experiential exercises, individuals learn the futility of control-oriented strategies and the benefits of acceptance-oriented strategies in response to negative internal experiences such as pain and discomfort.
 - Individuals are encouraged to explore their personal values and set goals consistent with those values in order to improve overall quality of life and functioning.



ACCEPTANCE & COMMITMENT THERAPY (ACT)



EXPERIENCE THOUGHTS & FEELINGS

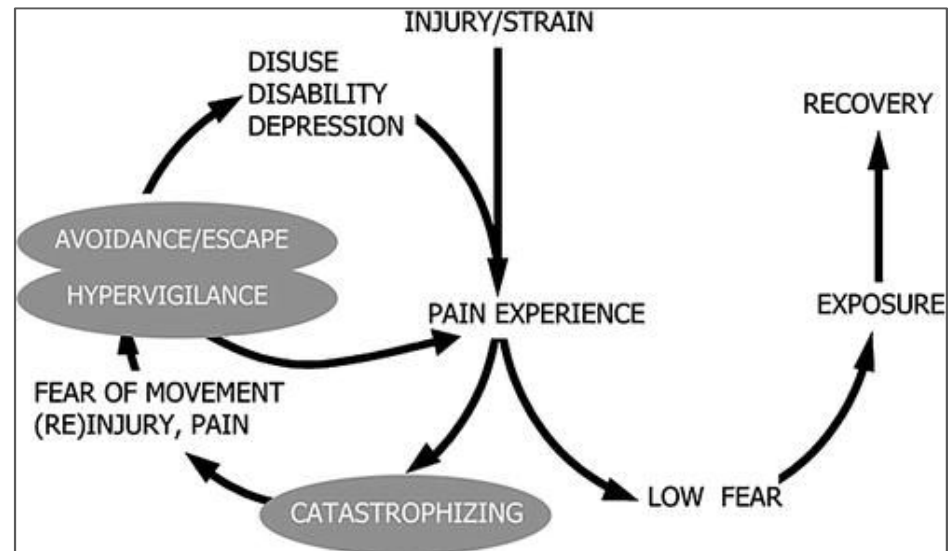
- Detect
 - Know a thought or feeling is present
- Register the content
 - Understand the message of the experience
- Believe/heed
 - Take it as true
- Fuse
 - Contact it as the only experience present



EXPOSURE THERAPY

FEAR AVOIDANCE MODEL OF EXAGGERATED PAIN PERCEPTION

- Fear of Pain
- Fear that Physical Activity will cause (re) injury when pain increases
- Approach/avoidance



GROUP THERAPY

FOUR MAJOR GOALS

1. Teaching pain coping skills
 2. Educating patients about their pain or disease
 3. Proving social support
 4. Teaching mindfulness – and Acceptance- based strategies
- Specific Goal is important in determining the basic format and structure of the group, the types of patients treated, and the level of training required by the group therapist



GROUP THERAPY

TYPES OF GROUP THERAPY

- Coping Skills Training Group
- Patient Education Group
- Social Support Group

SHORT TERM

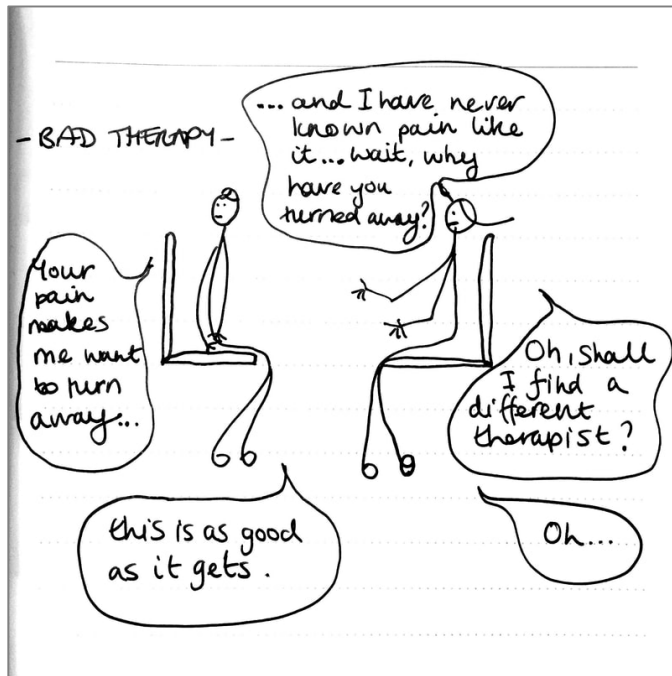
- 8-10 Weeks

NOT EVERYONE IS APPROPRIATE FOR GROUP

- Most appropriate patients are those that accept the fact that their pain is likely to persist, and who are open and willing to learn new pain management skills



BUT...DOES IT WORK?



RESEARCH CONSISTENTLY SHOWS:

- Reduction of psychological symptoms resulted in association with pain reduction
- There is good evidence from trial and evaluations of programs to indicate that psychological treatments are efficacious and effective
- Future research should refine the formulation of pain and attempt to make explicit links between the process of therapy and outcomes



USING DATA TO MITIGATE RISK, ENSURE COMPLIANCE, & PROVIDE BALANCED CARE



**Pain Treatment
Agreement**

**Compliance
Management List**

UTOX

Key Accountability Tools

CENTRALIZED COMPLIANCE MANAGEMENT LIST

- Automatic search of CML when enter a NP referral
- Supports PMG's key business and clinical processes

We see you have previously been seen at our [Davie Community Hospital](#) facility. We encourage you to call that facility to reschedule. Do you need the phone number for that facility? Phone: [812-254-2952](#)

Q CML Results

Name	Physician	DOB	Location	Reason	Date Added	Notes
Patient	Dr. Name	01/01/2001	Medical Center	NNCP (Medication Management)	12/10/2014	violated at MCHS also

No Patient Found

Patient is entered into Referral Log . . .

Referral Log

Referral Date:
Month:

Pt. First:
Pt. Last:

Pt. DOB:
Pt. Zip Code:

+ Add Referring Physician

Q Search Referrals

Work Queue

10 records per page

Search:

Last Action:

COMPLIANCE MANAGEMENT LIST BENCHMARKING

Exception Reporting	Goal	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	PMG AVG
% Wrong Site Procedure	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% Infection Rate	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% Admissions Following Surgery	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% Pts. with Dural Puncture	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% Death / Overdose	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% Pts w ED Visits ¹	1.0%	0.6%	0.0%	0.6%	0.0%	0.7%	0.0%	0.0%	3.7%	2.4%	0.0%	0.0%	0.0%	2.1%

Non-Compliance Metrics	Goal	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	PMG AVG
% Pt Encounters Non-Compliant due to Medication Management	2.0%	1.3%	1.2%	1.1%	0.0%	0.7%	0.0%	0.0%	2.8%	2.4%	1.0%	0.0%	0.0%	1.6%
% Pt Encounters Non-Compliant due to Attendance	2.0%	3.8%	2.5%	0.0%	1.1%	0.0%	0.0%	0.0%	0.0%	0.8%	1.0%	4.3%	0.0%	1.2%
% Pt Encounters Non-Compliant due to Behavior	0.5%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	1.6%	1.0%	0.9%	0.0%	0.4%

Customer Satisfaction	Goal	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	PMG AVG
Clinic Survey Score	90.0%	100%	95%	100%	80%	83%	100%	100%	100%	100%	100%	94%	100%	--
Clinic Survey Sample Size	--	17	18	12	10	29	8	30	20	30	3	18	10	--
Procedure Survey Score	90.0%	100%	94%	96%	100%	100%	--	100%	100%	100%	100%	94%	100%	--
Procedure Survey Sample Size	--	16	15	35	16	10	0	13	7	10	16	16	6	--

**Electronic
Chart Audit**

**Prescription &
Procedure
Benchmarking**

Key Quality Tools

Chart Audit Application: Patient Safety

Risk Management Metrics

PTA

PMP checked

SOAPP (*preferred NP tool*)

ORT

UDS

Was Naloxone offered with opiate prescription?

History of overdose in last 1 year?

Risk Management Metrics notes:

CHART AUDIT APPLICATION: PRESCRIPTION METRICS

Provider Metrics

Brand Name (generic): [Prescription not listed?](#) Dose Frequency Ordered PRN ?

Record rationale for opioid prescription:

Rationale not found:

Current MED Preferred Calculator: https://www.ohiopmp.gov/MED_Calculator.aspx
<https://www.easycalculation.com/medical/opioid-conversion-calculator.php>

Within the last year was

If the patient was opiate naive, did provider initiate an opiate at the NP visit?

High Risk Medication Prescribed? Opiate + Benzo* ? An opiate prescribed when history of Suboxone (Bupenorphine) ?

CHART AUDIT SUMMARY

	Goal	Q1 18	Q2 18	Q3 18	Q4 18	PMG AVG Q4 18
Charts Audited						
Total Encounters		1653	1456	1558	1553	883
Charts Audited		16	33	32	31	32.61
% Encounters Audited		0.97%	2.27%	2.05%	2%	3.69%
Staff Metrics						
PTA % Complete	> 96%	93.75%	87.88%	87.5%	90.32%	94.19%
PMP % Complete	> 96%	100%	100%	100%	100%	99.44%
Risk Tool % Complete	> 96%	100%	100%	87.5%	96.77%	98.87%
% High Risk Patients		25%	6.06%	17.86%	20%	20.24%
UDS % Complete	> 96%	71.43%	66.67%	87.5%	85.71%	90.38%
Prescription Metrics						
% Patients on Opiate		43.75%	45.45%	25%	22.58%	49.48%
Was naloxone offered with opiate Rx?		0%	0%	0%	0%	0.16%
Average MED		20	18	28	26	27
Max MED†		34	45	60	60	210†
% Opiate Pts w/ MED >= 80	< 4%	0%	0%	0%	0%	1.96%
% Opiate Pts w/ Specialty Meds Prescribed		14.29%	0%	0%	0%	3.43%
% Opiate Pts w/ Opiate + Benzo	< 2%	0%	0%	0%	0%	4.08%
% High Risk Pts Prescribed Opiates		6.25%	3.03%	0%	6.67%	8.98%
† Max MED is highest reported MED across all locations.						



OUTCOME & BENCHMARKING REPORTING

Exception Reporting	Goal	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	PMG AVG
% Wrong Site Procedure	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% Infection Rate	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% Admissions Following Surgery	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% Pts. with Dural Puncture	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% Death / Overdose	0.0%	0.3%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% Pts w ED Visits ¹	1.0%	2.4%	2.6%	2.1%	0.2%	1.5%	1.1%	0.1%	0.4%	0.4%	0.2%	0.6%	0.7%	2.1%
Meet or exceed goal = green. Miss goal = red.														
¹ ED Visits 2% or less = green. 2% - 4% = yellow. >4% = red.														
Non-Compliance Metrics	Goal	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	PMG AVG
% Pt Encounters Non-Compliant due to Medication Management	2.0%	14.3%	7.0%	4.0%	0.9%	1.1%	1.4%	1.2%	1.0%	0.8%	0.8%	0.5%	1.6%	1.6%
% Pt Encounters Non-Compliant due to Attendance	2.0%	0.6%	2.2%	1.4%	0.2%	0.0%	0.7%	0.8%	0.0%	0.0%	0.2%	0.0%	0.0%	1.2%
% Pt Encounters Non-Compliant due to Behavior	0.5%	2.7%	2.2%	1.2%	0.2%	0.1%	0.4%	0.1%	0.0%	0.5%	0.0%	0.2%	0.0%	0.4%

PROCEDURE OUTCOME & BENCHMARK REPORTING

Procedures	Count	%Total Procedures Facility	%Total Procedures PMG
Epidural Steroid Injection	292	33.4%	14.1%
Medial Branch Block	247	28.3%	22%
Sacroiliac Joint Injection	58	6.6%	8.2%
Joint Injections: Shoulder, Knee, Hip, Bursa, Ankle	56	6.4%	6.1%
Radiofrequency Ablation	56	6.4%	15.4%
Other Diagnostic	50	5.7%	3.8%
Other Therapeutic	38	4.3%	6.3%
<i>Caudal Epidural</i>	25	2.9%	2.6%
<i>Facet Injection</i>	15	1.7%	8.3%
<i>Nerve root / TFESI</i>	14	1.6%	10.8%
<i>Lumbar Sympathetic block</i>	12	1.4%	0.7%
<i>Intercostal Nerve Block</i>	5	0.6%	0.3%
<i>Ganglion Impar</i>	3	0.3%	0.3%
<i>Stellate Ganglion Block</i>	2	0.2%	0.1%
<i>Stimulator Trial, Implant, or Revision</i>	1	0.1%	0.4%
<i>Dorsal Ramus Block</i>	0	0%	0.5%
<i>Occipital Nerve Block: Greater, Lesser, Third</i>	0	0%	0.3%
Grand Total	874	100%	100.2%
Cumulative ESI Rating*	331	37.9%	27.5%

PROCEDURE OUTCOME & BENCHMARK REPORTING

Procedures	Minor Improvement	Moderate Improvement	Significant Improvement	Mod / Sig Improvement	PMG AVG Mod / Sig
Epidural Steroid Injection	24%	33%	43%	76%	77%
Medial Branch Block	16%	24%	60%	84%	86%
Sacroiliac Joint Injection	26%	26%	48%	74%	82%
Joint Injections: Shoulder, Knee, Hip, Bursa, Ankle	27%	36%	38%	73%	82%
Radiofrequency Ablation	13%	20%	68%	88%	89%
Other Diagnostic	14%	22%	64%	86%	83%
Other Therapeutic	13%	45%	42%	87%	75%
Caudal Epidural	52%	24%	24%	48%	81%
Facet Injection	33%	33%	33%	67%	82%
Nerve root / TFESI	43%	36%	21%	57%	81%
Lumbar Sympathetic block	67%	25%	8%	33%	56%
Intercostal Nerve Block	0%	60%	40%	100%	79%
Ganglion Impar	33%	0%	67%	67%	71%
Stellate Ganglion Block	100%	0%	0%	0%	68%
Stimulator Trial, Implant, or Revision	0%	100%	0%	100%	89%
Dorsal Ramus Block	--	--	--	--	80%
Occipital Nerve Block: Greater, Lesser, Third	--	--	--	--	81%
Grand Total	22%	29%	49%	78%	83%
Cumulative ESI Rating*	27%	32%	40%	73%	79%

Facility Dashboard

**Physician PpH
Benchmarking**

**Operations Financial
Review**

Key Efficiency Tools

FACILITY DASHBOARD



Stats Breakdown (prior week)

	NP Scheduled	NP Seen	Follow-Up Seen	Procedures Seen	Same Day Cx / Ns	Total Encounters	Scheduled / Day	Worked Hrs	Encounters / Hour
Monday	4	4	27	--	9	31	40	6.75	4.6
Tuesday	7	5	23	--	8	28	36	7.08	4
Wednesday	2	6	26	--	5	32	37	7.17	4.5
Thursday	--	--	--	11	3	11	14	5.33	2.1
Friday	7	8	26	--	2	34	36	6.53	5.2

CX/NS (prior month)

Clinic
136 **25%**
 Procedure
18 **16%**

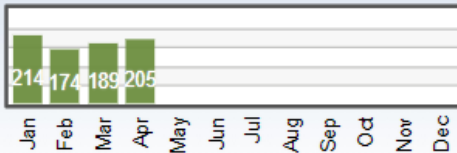
Patients / Hour

(prior week)

4.1

YTD: 15.8

Monthly Referrals



Patients in Queue

16

Pending Paperwork

3

New Patient Wait Time

Time (Days)

0

Effective Time Out

(prior month)

6 (n = 6)

Physician Efficiency (worked hours prior week)

Dr. Name **4.14** Patients per hour YTD: **3.71**

Physician Procedure Ratio (prior week)

Dr. Name **8%** YTD: **18%**

PHYSICIAN PpH BENCHMARKING

Q4 2017 Physician Comparison

Include Extenders Exclude Extenders

Physician Comparison - Patients per Hour

Includes all locations for each provider

Goal = 4 patients per hour

(Excluding Extenders)

Physician	Q1 2017 Patients per Hour	Q2 2017 Patients per Hour	Q3 2017 Patients per Hour	Q4 2017 Patients per Hour	
PMG AVG	3.5	3.5	3.4	3.3	
	4.5	4.8	4.8	4.8	
	5.1	4.1	3.9	4.7	
	4.4	4.4	4.5	4.4	
	3.9	4.2	4.4	4.2	
	3.8	3.9	4.1	4.1	
	4.4	4.5	4.3	4.0	
	3.8	4.2	4.1	4.0	
	4.1	4.0	4.1	3.9	GOAL = 4.0
Dr. Name	2.4	3.4	3.8	3.9	
	--	1.5	2.2	3.6	
	3.3	3.4	3.5	3.6	

OPERATIONS FINANCIAL REVIEW

- **Physician Specific Procedure Quality Scores**
- **Physician Specific Exception / CML / Patient Satisfaction Scores**
- **Physician Comparison: Patient Encounters by Doctor (clinic, procedure, PpH, Procedure Ratio)**
- **Physician Comparison: PpH (current Q + prior 3 Q)**
- **Stats Service Report**
- **Financial Analysis (current revenue comparison with income support)**

Outpatient
EMR
Physician Education

Key Communication Tools

Prior Authorizations

**Appropriate
Documentation**

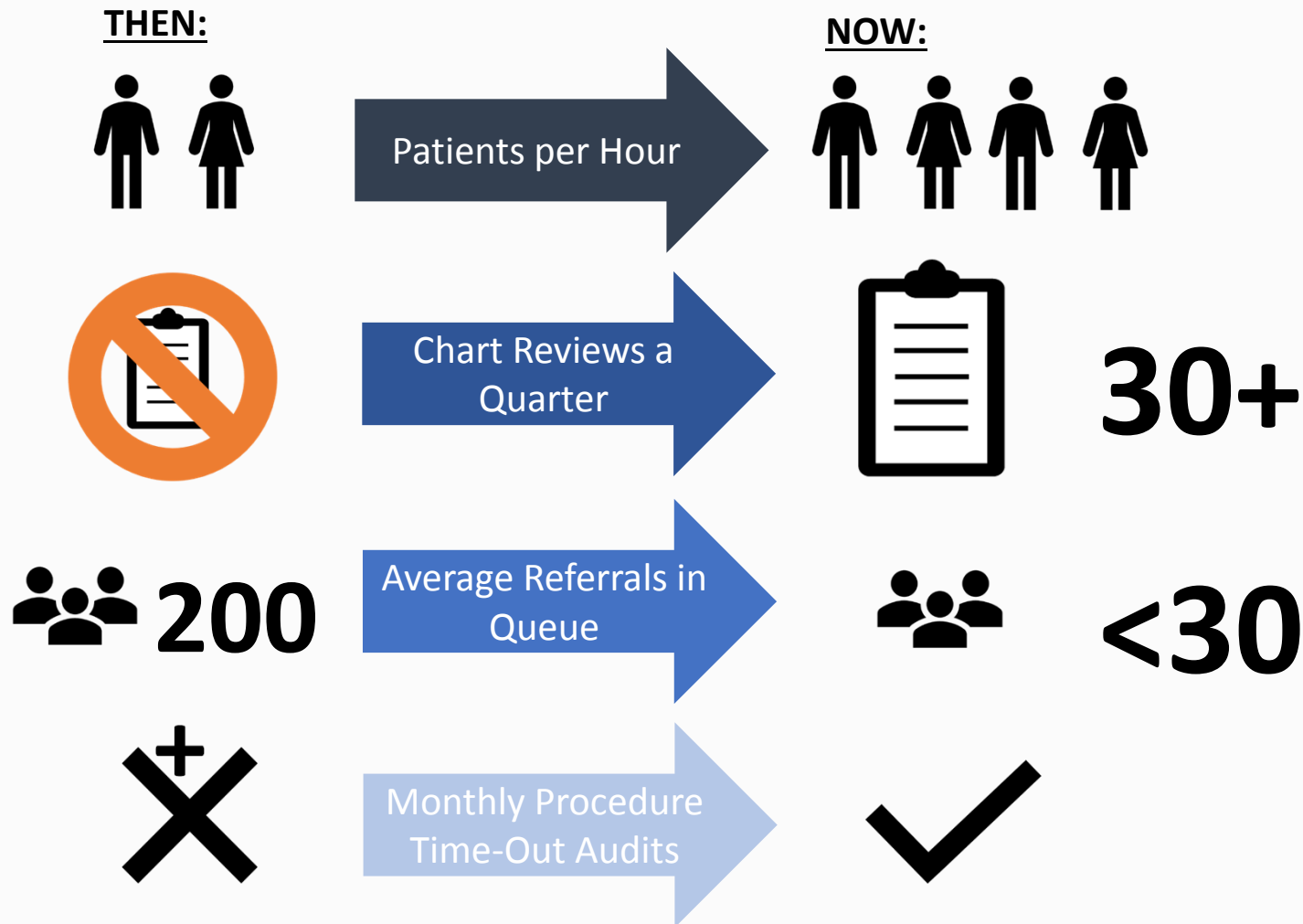
Financial Opportunity

FINANCIAL BENCHMARK REPORT

	1st Quarter 2017	2nd Quarter 2017	3rd Quarter 2017	4th Quarter 2017	Endor 2016 Consolidated	PMG 2016 Consolidated	Management Agreement 2016
Encounters							
Clinic Visits	1239	1898	1925	2067	1524		
Procedures	252	490	431	448	633		
Total Encounters	1491	2388	2356	2515	2157		
Clinic Visits % of Encounters	83%	79%	82%	82%	71%	74%	75%
Procedures % of Encounters	17%	21%	18%	18%	29%	26%	25%
Charge Analysis							
Gross Revenue per Encounter	\$343.55	\$545.67	\$435.14	\$465.70	\$1,731.78	\$963.01	\$798.63
Net Revenue per Encounter	\$113.37	\$242.99	\$202.94	\$227.55	\$513.91	\$328.83	\$261.91
Net Revenue % to Charge	33%	45%	47%	49%	30%	34%	33%
Cost Analysis							
Compensation % of GR	49%	17%	18%	17%	9%	9%	8%
Compensation % of NR	149%	38%	40%	35%	30%	26%	25%
Compensation % of Total Cost	68%	55%	60%	53%	29%	40%	47%
Compensation \$ per Encounter	\$168.77	\$93.26	\$80.40	\$79.87	\$152.78	\$86.62	\$65.07
Benefits % of Compensation	16%	26%	15%	22%	23%	30%	31%
Non-Wage Related % of NR	46%	21%	20%	23%	66%	32%	21%
Total Expense % of NR	219%	69%	66%	66%	102%	66%	51%
Profitability Analysis							
Net Operating Margin	-119%	31%	34%	34%	-2%	34%	47%

n = 10

THE RESULTS OF USING DATA TO MANAGE PROVIDERS AND PATIENTS



QUESTIONS?

RESOURCES

Centers for Disease Control and Prevention (2017). CDC guideline for prescribing opioids for chronic pain. Retrieved from <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>

Next Level Recovery Indiana (2018). 2017 Opioid Prescriptions per 100 residents. Retrieved from <http://www.in.gov/recovery/1054.htm>

Griffith, L.J. (2008). Why Psychotherapy Helps the Patient in Chronic Pain. *Psychiatry*, 5(12), 20-27.

Jamison, R.N. & Edwards, R. R. (2012). Integrating Pain Management in Clinical Practice. *Journal of Clinical Psychology in Medical Settings*, 19(1), 49-64.

McCracken, L. (2015). *ACT for Chronic Pain*. New York, NY: Context Press.

Turk, D.c. & Gatchel, R.J. (Eds.). (2018). *Psychological approaches to pain management: a practitioner's handbook*. New York, NY: The Guilford Press.