The background of the entire page is a photograph of two hands holding white puzzle pieces. A semi-transparent network of white lines and dots is overlaid on the image. A large blue rounded rectangle is positioned in the upper center, containing the title text in white.

# User Guide: Risk Stratification Tool and Chronic Conditions Financial Calculator

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# TABLE OF CONTENTS

<b>Introduction</b>	<b>4</b>
What is Population Health Management?	4
Principles and Components of Population Health Management	5
What Does Population Health Management Have to Do with Value-based Payment Arrangements (VBPs?)	6
How Can the Care Transitions Network Risk Stratification Tool and Chronic Conditions Financial Calculator Help Us Prepare for VBPs?	6
How Can We Use the Care Transitions Network Risk Stratification Tool and Chronic Conditions Financial Calculator Data?	7
<b>About the Risk Stratification Tool</b>	<b>8</b>
Entering Data into the Raw Data Tab	8
Entering Data into the Risk Level Tab	9
Viewing the Transformed Data Tab	12
Analyzing Your Data- Using the Summary Data Tab	12
Risk Stratification Tool Data Dictionary	13
<b>About the Chronic Conditions Financial Calculator Tool</b>	<b>14</b>
Entering Data into the Raw Data Tab	14
Viewing the Transformed Data	15
Analyzing Your Data — Using the Summary Data	15
Chronic Conditions Financial Calculator Data Dictionary	16

## INTRODUCTION

Payments for health care services are quickly shifting from a volume-oriented, fee-for-service method of reimbursement, to value-based payments that reward organizations for delivering care that is both high quality and cost-effective. An essential skill that you, as a behavioral health organization, must develop to succeed in such business environments is the ability to analyze data about your patient populations and ensure that patients get the intervention that is most appropriate. The Care Transitions Network offers two tools to help members take a population health management approach to both clinical care and business operations, and determine their value based on patient outcomes and cost to payers. Together, these tools — the **Risk Stratification Tool and Chronic Conditions Financial Calculator** — highlight service utilization and costs related to your patient populations, and help answer the following questions:



Which patients need our attention?



How can we support my staff to reduce risk for targeted populations?



What is our quantifiable value?

Before diving into the tools, however, it is important to understand the underlying concept of population health management, which is the first step toward preparing for value-based payment arrangements (VBPs).

### What is Population Health Management?

Population health management refers to improving and maintaining the health of your entire patient population across the full continuum of care — from low-risk, generally healthy individuals to high-risk individuals with one or more chronic conditions who are much more likely to use the emergency department or have a hospital admission.

Population Health Management entails aggregating patient data and analyzing that data into a single, actionable patient record, so administrators and clinicians can identify opportunities to improve both clinical and financial outcomes. Aggregate patient data can be stratified according to many different variables, such as primary and secondary diagnosis, risk level according to structured assessment tools such as the PHQ-9 for depression or social determinants of health.

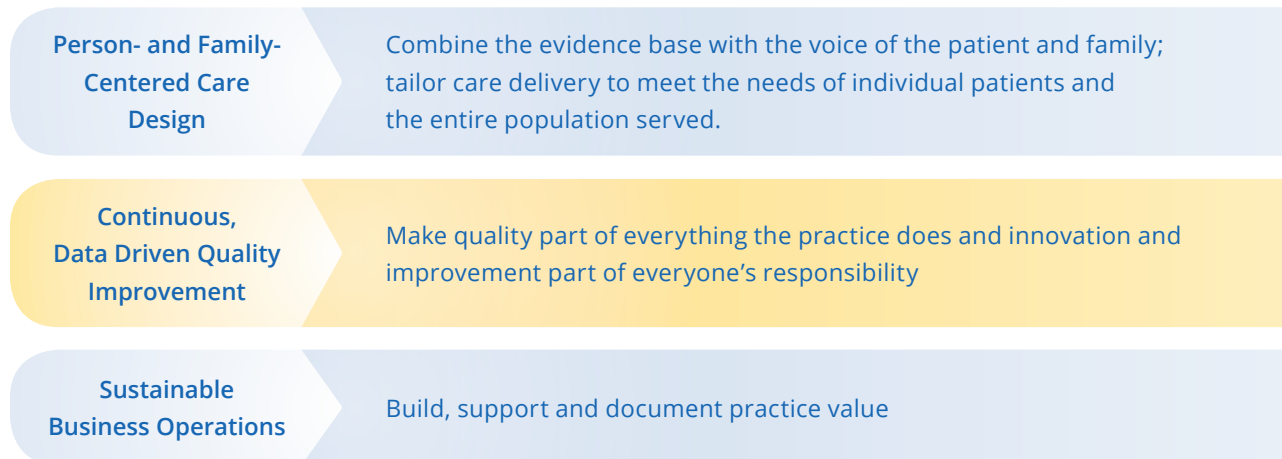
Using population-level data helps identify broad trends and prompts thinking around how your practice can improve patient experience and health outcomes, and reduce costs. For example, a behavioral health practice may examine its population-level data and find that only a few of its patients who are diagnosed with schizophrenia are prescribed long-acting injectable (LAI) medication, an intervention that can help stabilize their condition and reduce the risk of re-hospitalization. This information might prompt administrators to determine whether there are any barriers to LAI use (e.g., Are clinicians comfortable discussing LAIs as an option with

#### Population Health Management

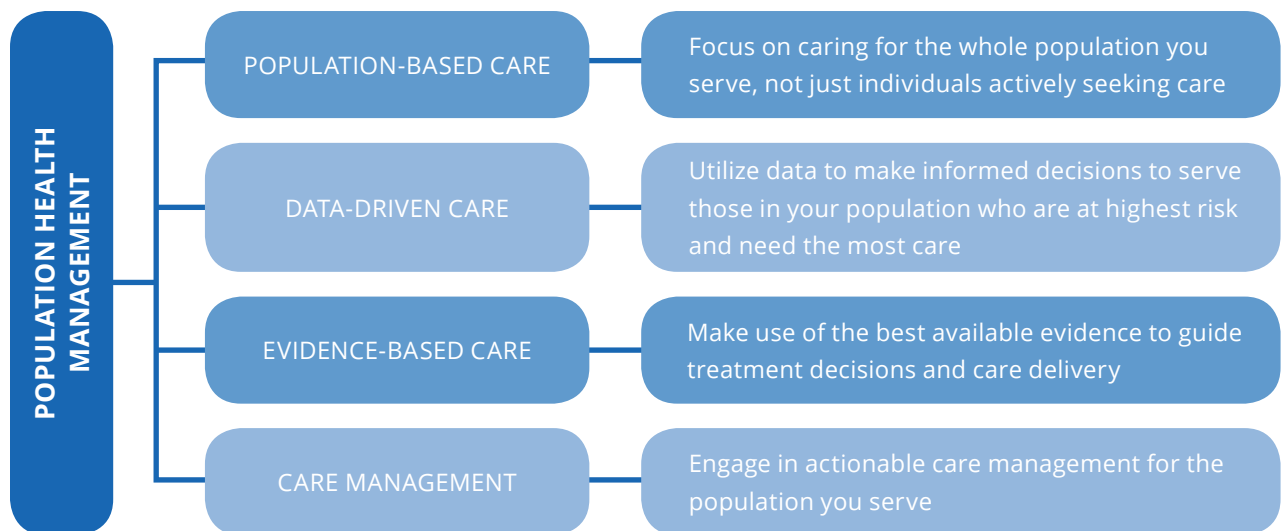
- ▶ Improves care coordination
- ▶ Improves services penetration
- ▶ Informs care provisions
- ▶ Provides clinical decision support
- ▶ Provides a means to see how quality metrics are linked to cost

their patients? Are patients hesitant to try LAIs?). Practice leadership can then identify the root causes of these barriers and implement interventions to address them.

Population Health Management is integrated into all three Transforming Clinical Practices Initiative (TCPI) drivers of transformation. Practice leadership can then identify the root causes of these barriers and implement interventions to address them.



## Principles and Components of Population Health Management



Population Health Management depends upon:

1. Team consensus on relevant data points
2. A data registry to stratify the risk of your population(s)
3. Team proficiency with quality improvement tools to respond to data trends
4. Continuous quality improvement policies/procedures to benchmark progress and sustain outcomes over time

## What Does Population Health Management Have to Do with Value-Based Payments (VBPs)?

VBP arrangements incentivize health care providers to provide effective, efficient care, and bring together information on the quality of health care, including patient outcomes and health status, with data on the dollars spent. VBPs also provide incentives for providers to focus on managing health system utilization to improve care and identify and reward the best-performing providers.

Participating in VBPs, therefore, requires Population Health Management, including stratifying patient populations by risk. If an organization cannot identify and manage its highest risk populations and track improvement at the population level over time, it will not be able to demonstrate value to payers.

## How Can the Care Transitions Network Risk Stratification Tool and Chronic Conditions Financial Calculator Help Us Prepare for VBPs?

The New York State Department of Health has defined five chronic mental health conditions that lead to episodes of care: schizophrenia, substance use disorder, bipolar disorder, depression, anxiety, and stress. The Chronic Conditions Financial Calculator can show how much your organization is paid on average for a client diagnosed with each chronic condition episode.

The **Risk Stratification Tool** and **Chronic Conditions Financial Calculator** help members take a population health management approach to both clinical care and business operations, and determine their value as defined by patient health outcomes and cost of care. Together, they highlight the populations you serve based on the New York State guidance on chronic behavioral health conditions and will answer the following questions:

1. What patients need our attention?
2. How can we support staff to reduce risk for targeted populations?
3. What is our quantifiable value?

Data can be exported from your electronic health record (EHR) or electronic medical record (EMR) system and imported into the tools' Excel templates. These data come from your patient population, and are specific to your organization. You can then use the data in these tools to work through your [VBP Strategic Planning Guide](#) and inform strategic decision-making.

### New York State Episodes of Care

- ▶ Schizophrenia
- ▶ Substance Use Disorder
- ▶ Bipolar Disorder
- ▶ Depression
- ▶ Anxiety
- ▶ Stress



The Care Transitions Network will continue to improve the utility of these tools for enrolled organizations. We value your input in this process and encourage you to send any feedback to [CareTransitions@theNationalCouncil.org](mailto:CareTransitions@theNationalCouncil.org)

## How Can We Use the Care Transitions Network Risk Stratification Tool and Chronic Conditions Financial Calculator Data?

The Care Transitions Network's tools offer enrolled organizations easy access to aggregated, practice-level data for clinical decision-making and continuous quality improvement. Of course, accessing population-level data is not enough to facilitate practice transformation. The transformation process depends upon nurturing a culture of quality improvement, which starts with practice leadership and should involve everyone on your team — not just the staff who work on quality improvement, assurance or compliance! The Care Transitions Network can support your entire team to use the Risk Stratification Tool and Chronic Conditions Financial Calculator to more easily identify population-level trends and strengthen systems of care.

### ADDITIONAL CARE TRANSITIONS NETWORK RESOURCES:

- ▶ Webinar: [November "Data Jam" webinar: Using Data to Stratify Risk and Reduce Re-hospitalization](#)
- ▶ Webinar: [December "Data Jam" webinar: Using Data to Stratify Risk](#)
- ▶ Webinar: [Population Health and Risk Stratification: The First Steps toward Value-based Payments](#)



Available at: [www.CareTransitionsNetwork.org](http://www.CareTransitionsNetwork.org)

Questions? Contact: [CareTransitions@TheNationalCouncil.org](mailto:CareTransitions@TheNationalCouncil.org)

## ABOUT THE RISK STRATIFICATION TOOL

The Care Transitions Network's Risk Stratification Tool is an Excel workbook that enables providers to stratify risk, identify trends, and track outcomes over time at the population level. This tool is meant to prompt questions among administrators, supervisors, and clinicians. (Note: You can still use the tool even if you do not have all of your data and/or do not have data in all of the data entry fields!)

For example, you could stratify by diagnosis and look at all your patients who are diagnosed with schizophrenia. Of these high-risk patients, you can then see who is receiving LAI medication and who is enrolled in a health home. You can use the tool to identify your highest risk patients and discuss strategies with your team to enhance health home enrollment and use of LAIs in this population. You may customize this tool to suit your needs. For example, you could enter specific provider data to examine trends among patients who are served by specific providers.

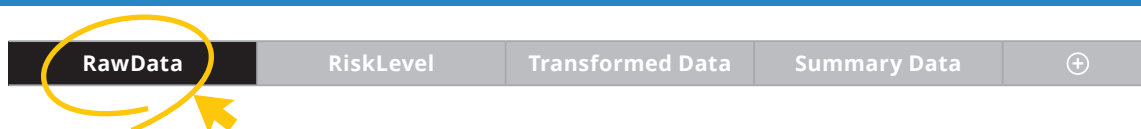
### Entering Data into the Raw Data Tab

The Risk Stratification Workbook is used to examine the levels of risk in your client population. To use it properly, you will need client data for the past three months from your EHR/EMR/other data repository. For example: If Client A was seen at the clinic on 8/15/2016, 9/25/2016, and 11/25/2016, only export data associated with the 11/25/2016 appointment. Some data can be exported from an EHR/EMR or other data repository system, other data will need to be hand-entered. It is important to follow the format defined in the data dictionary when entering all data regardless of source.

If the exported format does not match the necessary format as defined by the Data Dictionary, or you cannot easily export the data from your EHR/EMR, you can hand enter into any field.

To begin entering data, navigate to the "RawData" tab, Figure 1.

Figure 1. Navigating to the Raw Data tab



Clicking on the Raw Data tab will look like Figure 2, below.

Figure 2. Raw Data Tab, with Example Data

FROM EHR										Hand-entered		calculated from 'risk level calculation'	
Patient Record Number	Age	Gender	Last Visit Date	Primary Payer	Primary Diagnosis (ICD 10 Code)	Secondary Diagnosis (ICD10 Code)	Comorbid 1 (ICD10 Code)	Comorbid 2 (ICD10 Code)	Health Home	LAI/ Clozapine	Status	Intervention	Risk Category
#	#	M/F/T	##/##/####	text	###.###/NULL	###.###/NULL	###.###/NULL	###.###/NULL	y/n	y/n/na	active/ inactive		high/low
1	63	F	9/12/2016	Medicaid Managed Care	F41.9	NULL	E66.9	E10.8	Y	N/A	active		
7	49	F	9/28/2016	Medicare Advantage Plans	F20.0	F42	F1027	E10.9	N	N/A	active		
12	60	F	9/28/2016	Medicare Advantage Plans	F33.9	F17.201	F1027	J45.909	N	N/A	active		
51	48	F	9/15/2016	Medicaid Managed Care	F39	NULL	F1027	J45.909	N	N/A	active		
70	49	F	9/29/2016	Commercial - CHP, APG, NPI	F20.0	F60.9	J44.9	E10.8	N	N/A	inactive		
71	48	M	9/22/2016	Medicaid Managed Care	F41.1	F42	G43.909	E10.9	Y	Y	inactive		
74	54	F	9/27/2016	Medicare Advantage Plans	F25.1	NULL	E78.0	J44.9	Y	N	inactive		
121	57	F	9/27/2016	Commercial - CHP, APG, NPI	F41.9	NULL	G43.909	E10.8	N	Y	active		
133	54	F	9/26/2016	Medicare Advantage Plans	F29	F40.10	E66.9	E10.9	N	N	active		
149	46	M	9/15/2016	Medicare Advantage Plans	F31.9	NULL	G43.909	J45.909	N	N	active		
160	30	F	9/29/2016	Medicaid Managed Care	F20.9	NULL	E66.9	J44.9	N	N/A	active		
168	60	F	9/8/2016	Medicaid Managed Care	F41.9	NULL	G9340	F10951	Y	N/A	inactive		
182	37	M	9/14/2016	Medicaid Managed Care	F40.01	NULL	E78.0	F1027	Y	N/A	inactive		

Enter data into the “RawData” sheet on the Excel workbook for Columns A-M. Columns A-I can be exported from your EHR/EMR; however, Columns J-M will need to be hand-entered. To understand the correct format for data entry please refer to the Data Dictionary. If the exported format does not match the necessary format as defined by the Data Dictionary, or you cannot easily export the data from your EHR/EMR, you can hand-enter into any field.

DO NOT enter data into the “Risk Category” field (Column N) — it will automatically calculate risk based on other entered fields.

Use the column headings, Figure 3, to identify the correct data field. Use the notation under the column heading to quickly identify the correct format for the data value. For example, Last Visit Date should appear as ##/##/#### or 01/05/2017. Text fields have no character limit.

**Figure 3. Column Headings for Raw Data Tab**

Patient Record Number	Age	Gender	Last Visit Date	Primary Payer	Primary Diagnosis (ICD 10 Code)	Secondary Diagnosis (ICD10 Code)	Comorbid 1 (ICD10 Code)	Comorbid 2 (ICD10 Code)	Health Home	LAI/ Clozapine	Status	Intervention
#	#	M/F/T	##/##/####	text	###.###/NULL	###.###/NULL	###.###/NULL	###.###/NULL	y/n	y/n/na	active/ inactive	text

## Entering Data into the Risk Level Tab

Once you have entered your data into the Raw Data sheet, you have the option of entering additional information about client risk level under the “RiskLevel” tab, Figure 4.

**Figure 4. Navigating to the Risk Level Tab**



**Figure 5. Column A, Auto-populated**

A	B	C
Patient Number	IP Admit in Past 30 Days	30-Day Readmission in Past Year
1	Y	
7	N	
12	Y	
51		
70		
...		

Column A, Patient Number, will auto-populate from the Raw Data tab, so there is no need to enter any data into Column A.

Columns B-AB should be manually entered after referencing the client chart. These fields will be used to calculate either a High or Low risk status based on an algorithm. Similar to the “RawData” tab, use the column headings (Figure 6) to identify the correct data field. Use the notation under the column heading to quickly identify the correct format for the data value. All data fields are Y/N, except for “Number of not well controlled chronic diseases not previously noted.”

**Figure 6. Column Headings for Risk Level Tab**

			Substance, actively using, new sober, motivated to change (alcohol, narcotics, benzodiazepines, other)	Mental health diagnosis that is severe, persistent, and uncontrolled (schizophrenia, major depression, bipolar, debilitating anxiety, other)	Number of not well controlled chronic disease, not previously noted	
Psychosocial Risk 1	Psychosocial Risk 2	Psychosocial 3				Fall Risk
Y/N	Y/N	Y/N	Y/N	Y/N	#	Y/N

### Risk Level Tab Data Dictionary

Risk level is defined as High or Low based on best practices from algorithms used to identify risk from across the country (see appendix A).

**Table 1. Data Dictionary for Risk Level**

Data Field	Definition	Data Entry
Inpatient (IP) admit in the past 30 Days	Answer "Y" if the client was admitted to the hospital in the past 30 days	Y/N
30-day readmission in the past year	Answer "Y" if the client was readmitted to the hospital within 30 days of any discharge within the past year	Y/N
2 + IP admits in the past 6 months	Answer "Y" if the client had 2 or more hospital admissions in the past 6 months	Y/N
2 + ED visits in the past 6 months	Answer "Y" if the client had 2 or more emergency department visits in the past 6 months	Y/N
High risk of IP admit/ED visit in the next 6 months	Answer "Y" if the client is at high risk of a hospital admission or emergency department visit in the next 6 months	Y/N
High risk of significant decline in functional status/need for long-term care in the next 6 months	Answer "Y" if the client is at high risk for a significant decline in functional status/need for long-term care in the next 6 months	Y/N
Coronary Artery Disease (CAD)	Answer "Y" if the client has poorly controlled CAD	Y/N
Chronic Heart Failure (CHF)	Answer "Y" if the client has poorly controlled CHF	Y/N
Diabetes	Answer "Y" if the client has poorly controlled diabetes	Y/N
Chronic Obstructive Pulmonary Disorder (COPD)	Answer "Y" if the client has poorly controlled COPD	Y/N
End-stage Disease	Answer "Y" if the client has any other poorly controlled end-stage disease	Y/N
8+ active prescriptions or recent change in high risk meds	Answer "Y" if the client has 8+ active prescriptions or recent change in high risk medications	Y/N

Data Field	Definition	Data Entry
Disengagement	Answer “Y” if the client is disengaged, defined as: inadequate follow-up with PCP, not following care plan, or recurring specialty care without coordination	Y/N
Disability	Answer “Y” if the client has a significant disability (physical/mental/learning) impacting reasons for referral	Y/N
Psychosocial Risk 1	Answer “Y” if the client has a psychosocial risk factor which prevents adequate management of high risk diseases (e.g., language/literacy, safety, homeless, poor supports, food insecurity, undocumented legal status)	Y/N
Psychosocial Risk 2	Answer “Y” if the client has a psychosocial risk factor which prevents adequate management of high risk diseases (e.g., language/literacy, safety, homeless, poor supports, food insecurity, undocumented legal status)	Y/N
Psychosocial Risk 3	Answer “Y” if the client has a psychosocial risk factor which prevents adequate management of high risk diseases (e.g., language/literacy, safety, homeless, poor supports, food insecurity, undocumented legal status)	Y/N
Substance Abuse	Answer “Y” if the client is actively using, newly sober, or motivated to change (using: alcohol, narcotics, benzodiazepines, or other substance)	Y/N
Mental Health Diagnosis	Answer “Y” if the client has a mental health diagnosis that is severe, persistent, and uncontrolled (e.g., schizophrenia, major depression, bipolar, debilitating anxiety)	Y/N
Number of not well controlled chronic disease, not previously noted	Enter the number of chronic disease not previously noted above	Number
Fall Risk	Answer “Y” if the client is at risk of falls	Y/N
Impaired activities of daily living (ADLs)	Answer “Y” if the client has impaired ADLs	Y/N
Impaired Ambulation	Answer “Y” if the client has impaired ambulation	Y/N
Impaired Judgement	Answer “Y” if the client has impaired judgement	Y/N
Difficulty getting to appointments	Answer “Y” if the client has difficulty getting to appointments	Y/N
Substance Abuse	Answer “Y” if the client is unable to follow a medicine regime	Y/N

## Calculating Risk

Risk is automatically calculated based on information entered in the “RiskLevel” tab. Calculated risk level will appear in the “Transformed Data” tab in Column K.

## Viewing the Transformed Data Tab

Once you have entered all the data into the “RawData” and “RiskLevel” tabs, you can navigate to the Transformed Data tab (Figure 7) to see the risk calculation, as well as each client’s episode according to New York State (see Figure 8 for an example).

**Figure 7. Navigating to the Transformed Data Tab**



**Figure 8. Example Transformed Data**

Patient Record Number	Age	Gender	Last Visit Date	Primary Payer	Primary Diagnosis	Secondary Diagnosis	comorbid 1	comorbid 2	Status	Risk level	Health Home	LA/clozapine
1	45-64	F	9/12/2016	Medicaid Managed Care	Anxiety & Depression	NULL	Obesity	Diabetes	active	Low	Y	N/A
7	45-64	F	9/28/2016	Medicare Advantage Plans	Schizophrenia	Anxiety & Depression	Alcohol Abuse	Diabetes	active	Low	N	N/A
12	45-64	F	9/28/2016	Medicare Advantage Plans	Anxiety & Depression	Other	Alcohol Abuse	Asthma	active	High	N	N/A
51	45-64	F	9/15/2016	Medicaid Managed Care	Anxiety & Depression	NULL	Alcohol Abuse	Asthma	active	Low	N	N/A
70	45-64	F	9/29/2016	Commercial - CHP, APG, NPI	Schizophrenia	Other	COPD	Diabetes	inactive	High	N	N/A
71	45-64	M	9/22/2016	Medicaid Managed Care	Anxiety & Depression	Anxiety & Depression	Migraine	Diabetes	inactive	Low	Y	Y
74	45-64	F	9/27/2016	Medicare Advantage Plans	Schizophrenia	NULL	Hypercholesterolemia	COPD	inactive	Low	Y	N
121	45-64	F	9/27/2016	Commercial - CHP, APG, NPI	Anxiety & Depression	NULL	Migraine	Diabetes	active	Low	N	Y

## Analyzing Your Data — Using the Summary Data Tab

Several analytic tables have been created so you can stratify your client population by risk. To view these tables, navigate to the Summary Data tab after you populated the raw data fields, Figure 9.

**Figure 9. Navigating to the Summary Data Tab**



## Risk Stratification Tool Data Dictionary

The Risk Stratification Tool contains the following fields:

Field Name	Column	Definition	Format	Source
Patient Record Number	A	Unique client identifier	Number	EHR/EMR
Age	B	Age of client	Number	EHR/EMR
Gender	C	Gender of client	Male, Female, or Other M, F, or O	EHR/EMR
Last Visit Date	D	Date of last visit of the client	MM/DD/YYYY	EHR/EMR
Primary Payer	E	Primary payer for the client (e.g., Medicare, Medicaid Managed Care)	Text	EHR/EMR
Primary Diagnosis	F	Primary Mental Health Diagnosis	ICD – 10 Code	EHR/EMR
Secondary Diagnosis	G	Secondary Mental Health Diagnosis	ICD – 10 Code	EHR/EMR
Comorbid 1	H	Comorbid Condition	ICD – 10 Code	EHR/EMR
Comorbid 2	I	Comorbid Condition	ICD – 10 Code	EHR/EMR
Health Home	J	Health Home enrollment status	Y or N	EHR/EMR
Long-acting Injectable (LAI)/ Clozapine	K	LAI or clozapine use	Y, N, or NA	Manual Entry
Status	L	Determine based on last visit date if the client is active or inactive	Active or Inactive	Manual Entry
Intervention	L	Note if the client is using any intervention	Text	Manual Entry

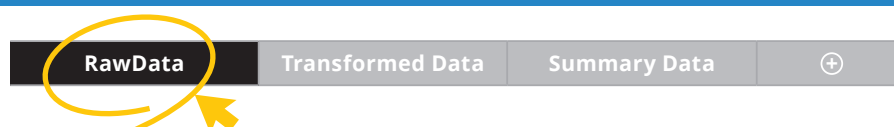
# ABOUT THE CHRONIC CONDITIONS FINANCIAL CALCULATOR TOOL

The Financial Calculator Tool uses the same data from the Risk Stratification Tool, with the addition of a procedure code for each client interaction. In preparation for importing data into the tool, you will need to export each unique client encounter from the past six months from your EHR/EMR. You may have multiple lines of data for each client.

## Entering Data into the Raw Data Tab

Data exported from your EHR/EMR are entered into the Raw Data tab, Figure 9.

Figure 9. Navigating to the Raw Data Tab



It is important to follow the format defined in the Data Dictionary when entering all data, regardless of source.

If the exported format does not match the necessary format as defined by the Data Dictionary, or you cannot easily export the data from your EHR/EMR you can hand enter any field. See Figure 10 for an example of a populated "Raw Data" tab.

Columns A-O can be exported from your EHR/EMR. If that field does not exist in your EHR/EMR, you can hand enter the data. Look to the second row to determine acceptable data formats, Figure 10. If you are hand entering data, be sure the format matches the acceptable fields.

Figure 10. Example of Raw Data Tab

Client_ID_No	Age	Gender	Visit_Date	Primary_Payer	Primary_Dx	Secondary_Dx	Tertiary_Dx	Dx4	Dx5	Dx6	Dx7	Dx8	procedure_code	modifier1_description
####		M	mm/dd/yy	Medicaid Medicaid Managed Care Medicare Medicare Advantage Plans Commercial Insurance Commercial - CHP, APG, NPI Non-Billable by LRI Other Contracts/ Sliding Scale Agreements	###.###	###.###	###.###	###.###	###.###	###.###	###.###	###.###	#####	Nurse Practitioner Add On Psychiatrist Add on Language other than English 20 min 30% reduction Telepsychiatry Mental Health NULL
1	63	F	7/26/2016	Medicaid Managed Care	F41.9	NULL	NULL	NULL	NULL	NULL	NULL	NULL	90834	NULL
1	63	F	8/23/2016	Medicaid Managed Care	F41.9	NULL	NULL	NULL	NULL	NULL	NULL	NULL	99214	Nurse Practitioner Add On
1	63	F	8/23/2016	Medicaid Managed Care	F41.9	NULL	NULL	NULL	NULL	NULL	NULL	NULL	99214	Nurse Practitioner Add On
1	63	F	9/12/2016	Medicaid Managed Care	F41.9	NULL	NULL	NULL	NULL	NULL	NULL	NULL	90834	NULL
4	49	F	8/2/2016	Medicaid Managed Care	F31.81	F43.10	F60.3	M19.90	F60.3	M79.7	K21.9	M32.9	99214	NULL
4	49	F	8/10/2016	Medicaid Managed Care	F31.81	F43.10	F60.3	M19.90	F60.3	M79.7	K21.9	M32.9	90834	NULL
7	49	F	7/14/2016	Medicare Advantage Plans	F20.0	F42.9	NULL	NULL	NULL	NULL	NULL	NULL	90834	NULL
7	49	F	7/25/2016	Medicare Advantage Plans	F20.0	F42.9	NULL	NULL	NULL	NULL	NULL	NULL	99214	Psychiatrist Add on
7	49	F	8/22/2016	Medicare Advantage Plans	F20.0	F42.9	NULL	NULL	NULL	NULL	NULL	NULL	90834	NULL
7	49	F	9/28/2016	Medicare Advantage Plans	F20.0	F42.9	NULL	NULL	NULL	NULL	NULL	NULL	99214	Psychiatrist Add on
12	60	F	7/20/2016	Medicare Advantage Plans	F33.9	F17.201	NULL	NULL	NULL	NULL	NULL	NULL	90834	NULL
12	60	F	8/2/2016	Medicare Advantage Plans	F33.9	F17.201	NULL	NULL	NULL	NULL	NULL	NULL	99214	Psychiatrist Add on
12	60	F	8/24/2016	Medicare Advantage Plans	F33.9	F17.201	NULL	NULL	NULL	NULL	NULL	NULL	90834	NULL

## Viewing the Transformed Data

Once you have imported data into the “RawData” tab, you may view the results by clicking on the “Transformed Data” tab, Figure 11.

**Figure 11. Navigating to the Transformed Data Tab**



The “Transformed Data” tab will display the primary diagnosis as well as associated CPT codes and modifiers. Where applicable, the cost with the associated CPT code will appear, as in Figure 12. You will need to undergo some additional manual data entry on this tab in Column B “First Record for Client?” This will be a “yes” or “no.”

**Figure 12. Example of Transformed Data**

Client_ID	First Reco	Age	Gender	Primary Payer	Primary Diagnosis	Comorbid ICD10 Code	Comorbid Condition	CPT Code + modifier	CPT Category	Cost
1	yes	45-64	F	Medicaid Managed Care	Depression & Anxi	no comorbid condition	no comorbid condition	90834NULL	Therapy	117.4
1	no	45-64	F	Medicaid Managed Care	Depression & Anxi	no comorbid condition	no comorbid condition	99214Nurse Practitioner	Psychiatric	
1	no	45-64	F	Medicaid Managed Care	Depression & Anxi	no comorbid condition	no comorbid condition	99214Nurse Practitioner	Psychiatric	
1	no	45-64	F	Medicaid Managed Care	Depression & Anxi	no comorbid condition	no comorbid condition	90834NULL	Therapy	117.4
4	yes	45-64	F	Medicaid Managed Care	Bipolar	no comorbid condition	no comorbid condition	99214NULL	Psychiatric	130
4	no	45-64	F	Medicaid Managed Care	Bipolar	no comorbid condition	no comorbid condition	90834NULL	Therapy	117.4
7	yes	45-64	F	Medicare Advantage Plan	Other	no comorbid condition	no comorbid condition	90834NULL	Therapy	117.4

## Analyzing Your Data — Using the Summary Data

Once you have reviewed the transformed data you can navigate to the “Summary Data” tab, Figure 13.

**Figure 13. Navigating to the Summary Data Tab**



This tab contains the five chronic episodes as defined by New York State, as well as the number of individuals, the average number of interactions per individual, and the average cost per individual for the three-month period. Additional summary data tables appear to the right of this original table, Figure 14.

Figure 14. Example Summary Data Tables

Primary BH Diagnosis	Number of individuals	Avg interactions per individual	Average charges per individual	Types of interaction					
				Psychiatric	Therapy	Case Management	Injection	Health Monitoring	Crisis
Schizophrenia	45	7.5	\$783	71	238	0	7	14	2
Depression & Anxiety	794	6.1	\$678	756	3893	43	4	53	59
Substance Use Disorder	1	9.0	\$939	1	8	0	0	0	0
Bipolar	160	7.1	\$740	238	814	3	2	29	20
Stress	167	6.3	\$706	138	848	13	3	9	25
Other	637	5.8	\$633	509	2987	27	11	11	66

You may use these data to investigate average charges per client for each chronic episode.

## Chronic Conditions Financial Calculator Data Dictionary

Field Name	Column	Definition	Format	Source
Client_ID_No	A	Unique client identifier	Number	EHR
Age	B	Age of client	Number	EHR
Gender	C	Gender of client	M/F/T	EHR
Visit_Date	D	Date of interaction	MM/DD/YYYY	EHR
Primary Payer	E	Primary payer: Medicaid, Medicaid Managed Care, Medicare, Medicare Advantage Plans, Commercial Insurance, Commercial — CHP, APG, NPI, Non Billable by LRI, Other Contracts/Sliding Scale Agreements	Text	EHR
Primary_Dx	F	Primary diagnosis	ICD – 10 Code	EHR
Secondary_Dx	G	Secondary diagnosis	ICD – 10 Code	EHR
Tertiary_Dx	H	Tertiary diagnosis	ICD – 10 Code	EHR
Dx4	I	Comorbid Condition	ICD – 10 Code	EHR
Dx5	J	Comorbid condition	ICD – 10 Code	EHR
Dx6	K	Comorbid condition	ICD – 10 Code	EHR
Dx7	L	Comorbid condition	ICD – 10 Code	EHR
Dx8	M	Comorbid condition	ICD – 10 Code	EHR

Field Name	Column	Definition	Format	Source
Procedure_code	N	CPT code	Number	EHR
Modifier1_description	O	Modifier code, if applicable: Nurse practitioner add on, psychiatrist add on, language other than English, 20 minutes 30% reduction, telepsychiatry, mental health, NULL	Text	EHR

#### HAVE QUESTIONS?

Contact us at

[CareTransitions@theNationalCouncil.org](mailto:CareTransitions@theNationalCouncil.org)

Or your practice coach.

