KCMPA E-Newsletter

Informed Care. Better Health. Lower Cost. 1/1/2015 Issue 1

New Year, New Faces & Renewed Focus

Happy New Year! With the New Year comes new and exciting goals for our organization!

Introducing Cindy Campbell, BSN, RN, MBA, CPHQ
Director of Clinical Strategies

Cindy replaces Ally McCoy and comes to us with a background in leadership and practice transformation. She comes from TransforMED, a subsidiary of the American Academy of Family Practice, where she coached practices across the country as they transformed to a Patient Centered Medical Home and employed techniques of advanced primary care.

Sobia Paracha, MPH, Implementation Manager now has a new title as **Director of Technical Operations**. Sobia's new title is more befitting to her current role at KCMPA.

Monthly E-Newsletter

KCMPA developed this e-newsletter to give practices an overview of current projects and initiatives. The e-newsletter provides information on population health management, tips on achieving a Patient-Centered Medical Home, community resource information, and other news that may be helpful as we continue to improve on our clinical quality and cost efficiency goals across the KCMPA network.

Tobacco Cessation Project

Cindy is introducing an organization-wide tobacco cessation program that provides patient education and referral assistance to the Missouri and Kansas Quit Line. These state programs are free to the patient and clinics, offering 24 hour coaching, a comprehensive quit plan, educational materials, and smartphone apps. For Missouri's Quit Line click here, for Kansas click here.

Upcoming Meetings

Care Coordinator Meeting – Friday, Jan. 30th, 10AM to 3 PM at Metro Med

Finance Committee Meeting – Thursday, Feb. 5th at 5:30 PM at Metro Med.

KCMPA Board of Directors Meeting – Thursday, Feb. 5th, at 6:30 PM at Metro Med.

KCMPA-ACO Board of Directors Meeting – Thursday, Feb. 5th at 7:30 PM at Metro Med.

Quality Improvement Committee Meeting – Thursday, Feb. 19th at 6:30 by conference call.

Click here for a list of 2015 meetings

Email Cindy Campbell at cindy.campbell@kcmetrophysicians.com if you would like additional information.

Patient-Center Medical Home Support

Cindy is available to work with those clinics that have achieved PCMH status to help continue enhancing their status. She is also available to work with those clinics that are looking to be a PCMH, which also includes specialty care clinics. Please contact Cindy for more information.

Diabetic Education Resource

- The registered dietitian/certified diabetes educator services are available for clinic or in home visits. We will also continue to register patients for the ALRT Health-e-Connect (HeC) remote monitoring program through January 31.
- This program is designed to help improve blood glucose control for KCMPA-ACO patients with diabetes who have A1C's above 9 and are taking insulin. If your practice would like to refer a patient for RD/CDE services and/or the ALRT HeC program, click here for the referral form or go the KCMPA-ACO website. The completed form can be sent by either email or fax to 816.388.9369. The RD/CDE will then contact the patient to schedule.
- Please contact Diana at diana.rodenberg@kcmetrophysicians.com with questions.

Innovations at the Clinic

Focus on High Cost Patients

- 5% of patients account for 50% of all health-care expenditures.
- These 5% of patients are those with complex health and social needs.
- By focusing on the top 14 frequent flyers of the emergency department, Ann Arbor Health System saved $1 million.
- Identifying high cost patients and utilizing care managers to work directly with this group of patients is becoming an essential role within the primary care practice.
- Read more at http://kaiserhealthnews.org/news/one-percent-of-costliest-patients/

Patient-Centered Medical Home Tips

The Care Team

- Managing patient care is a team effort that involves clinical and non-clinical staff interacting with patients and working as a team to achieve stated objectives.
- The care team extends far beyond the provider and into the community, especially for those with chronic healthcare needs.
- Team based care means that the practice is utilizing the entire care team in their approach to addressing patient needs.
- **Points to consider:** Am I working to the top of my license or training? Am I performing activities in which others on the care team can do? Does everyone know what their role is in caring for the diabetic patient or any other chronic illness? Who are you utilizing as part of the care team outside of the clinic to help your patients?
- Click here for more information.

Community Resources

Incorporating community resources as part of the care team is an important part of building the healthcare neighborhood. Community-based agencies can encourage self-management and improve access to care for many patient populations. KCMPA has compiled a list of key community resources that includes nutrition, mental health, transportation, and more. We will continue to build this resource guide and share it our partners.

TRIA Medication Management

Medication management services are available through Tria Health at no cost to the practice or patient. This is a valuable resource for those patients with chronic care needs, complex medication needs, difficulty with their medication schedule, or a new diagnosis requiring medication. The referral form can be obtained here or at www.kcmetrophysicians.com.

Information Technology Update

KCMPA how has a YouTube channel where we post informational and educational videos on various clinical topics. You can use these videos as a training tool for your staff and care teams. You may access those videos here: Youtube Channel.

LACIE Update: KCMPA's connection to the regional Lewis And Clark Health Information Exchange (LACIE) has been upgraded. Data from area hospitals available to your practice via LACIE is more valuable than ever. If your practice has not yet connected to the KCMPA Data Network and LACIE, contact Sobia Paracha at sobia.paracha@kcmetrophysicians.com to get started. KCMPA's Data Network has a bright future. Make sure your practice does not miss out.

A Note from the CEO

KCMPA is applying for the federal Transforming Clinical Practice Initiative as a Practice Transformation Network. If our application is successful, KCMPA will receive funding to assist specialty practices in adapting to value based contracts. This grant is a perfect opportunity to take what we've learned with our ACO and Medicare Advantage contracts and share it with specialists. Our grant will make the case that by awarding KCMPA CMS has a chance to achieve real transformation in an entire medical market. Awardees will be announced in April.

Please visit our website for more information or to contact KCMPA.

Follow us on LinkedIn.

Guides in Practice Management: Chronic Care Management Codes – CPT code 99490

- Payment of $42.50 PMPM began January 1, 2015.
- Requires at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month to patients.
- Criteria includes multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.
- Requires a comprehensive care plan established, implemented, revised, or monitored.
- For additional resources and information, please visit our website.