Informed Care. Better Health. Lower Cost. **2/1/2015** Issue 2

CARE MANAGERS IN THE PRIMARY CARE CLINIC

Care Managers are quickly becoming one of the most critical roles in the primary care office. However, many practices are hesitant to add an additional salary to their budget. As well, there is often confusion as to what this role is and tasks they perform. Below are points to clarify the care manager role and show that it may be within your reach.

- *What is a care manager and what do they do?* A Care Manager typically is an RN who has an identified panel of high risk patients (approx.. 150 for an FTE) where they actively work to ensure this set of individuals get the care and support they need to prevent hospitalizations or ED visits. Care Management is distinct from Care Coordination.
- *What is their role in the practice?* The Care Manager is embedded as a member of the team whose function is to manage the identified panel of patients who are at high risk of hospital admission or readmission. They should not be used as a fill-in for staffing vacancies, or other office needs unless it is directly related to a patient they are working with.
- *What is the return on investment?* A study out of the Cleveland Clinic showed one patient navigator reduced the total cost of care by over $300,000 a year. Another study out of Southeastern Pennsylvania, demonstrated improved outcomes with diabetic patients. ROI is gained by incentives for reducing cost of care. These incentives will by far exceed the staffing expense.
- *What is the true cost of a care manager versus not having one in place?* By not having a care manager in place, clinics are missing out on incentives that are paid out for cost of care reductions.
- *How have smaller clinics supported this role?* This role has been supported in a number of ways by smaller clinics. Smaller clinics banding together to support a care manager has shown success. Others have found that having their clinical staff designate 3 or 4 hours out of the week to focus on the top 10 – 20 high risk patients has shown a significant reduction in those patients total cost of care.

Upcoming Meetings

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

Care Team Consortium - Friday, Feb. 27th at 8am at Clay Platte Family Medicine Clinic

KCMPA & KCMPA-ACO Board of Directors Meetings – Thursday, Mar. 5th at 6:30 PM at Metro Med.

Click here for a list of 2015 meetings

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

Follow us on LinkedIn. Subscribe to our Youtube channel.

Tobacco Cessation Support Project Update

The organization-wide tobacco cessation support project is underway. This program provides patient education and referral assistance to Missouri and Kansas Quit Lines.
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. Documents have been emailed to all ACO clinics. Patient education brochures have been ordered and will be coming to your clinic soon. This is also a great time for your staff to be trained in motivational interviewing. Please email Cindy Campbell at cindy.campbell@kcmetrophysicians.com to schedule

Diabetic Education Resource

Several KCMPA providers have asked that our Certified Diabetes Educator reach out automatically to their ACO patients who have an hgbA1c >9, forgoing the referral process. As of February Diana is pulling reports for each clinic/provider and will begin reaching out to those patients. For providers who have not made this specific request, Diana will reach out to determine your preference.

Please contact Diana at diana.rodenberg@kcmetrophysicians.com with questions.

Innovations at the Clinic

Increasing Patient Access

- A study published in the *Annals of Family Medicine* found that patients with access to evening and weekend hours have significantly lower health expenditures than those who don't.
- Patients with access to extended hours spent 10 percent less on healthcare during a two-year period than those who did not, and with no negative effects on patient mortality.
- Practices caring for patients as part of an accountable care organization, capitated contract or other risk-bearing relationship should factor these findings into their math.
- Read more at http://www.annfammed.org/content/10/5/388.full

Patient-Centered Medical Home Tips

The Daily Huddle

- The daily huddle is a critical element of effective communication in the Patient Centered Medical Home.
- The daily huddle allows the care team to briefly discuss scheduled patients and activities and identify potential needs or challenges. It allows for proactive planning to help the care team stay on task.
- The daily huddle is a very short, highly focused, consistently scheduled meeting that brings front and back office staff together and gets everyone on the same page using no more than 10 minutes.
- 2014 NCQA PCMH Guidelines requires that practices have informal daily meetings or review of daily schedules. This is typically accomplished in the form of the huddle.
- The following links show examples of huddles in action:
  http://www.youtube.com/watch?v=Wttxm7jAnb4
  http://www.youtube.com/watch?v=dJrORZEiXpo&feature=related
  https://www.youtube.com/watch?v=8Q8Cexq1fAw

TRIA Medication Management Update

Medication management services through Tria Health is a valuable resource for those patients with chronic care needs, complex medication needs, difficulty with their medication schedule, a new diagnosis requiring medication and with transitions of care. KCMPA is working with Tria Health to make the referral process easier at the clinic level. KCMPA has also begun working with area hospitals and skilled nursing facilities to improve the medication management process during transitions of care. If you have any suggestions or comments, please feel free to contact Cindy Campbell.

Care Team Consortium

This group will replace the Care Coordinator Training. It is open to all members of the care team. The objectives of this consortium will focus on 1) creating solutions to clinic based challenges 2) improving transitions of care 3) facilitation of advanced practice concepts 4) and engaging in developing the medical neighborhood. The meeting locations will alternate to areas that are convenient for clinic staff and providers to attend. Notices will be sent out prior to each meeting. For additional information, please contact Cindy Campbell at cindy.campbell@kcmetrophysicians.com

Information Technology Update

2014 Quality Reporting Update: As our ACO gears up to report on our 33 quality measures, we would like to encourage our ACO clinics to review these important tips:

1) The quality metrics data is viewable in the SQI Dashboard for all clinics. Every ACO clinic has access to this dashboard. The dashboard includes your patient list for reporting and your current percentages under each quality measure. Please let Sobia Paracha know if you're unable to login.

2) During the week of 2/16, we will be sending you a list of sample patients from the "patient ranking" file we received from CMS. We will ask each practice to run a sample audit to make sure the data for each patient on that sample list is accurate. This will help the ACO evaluate whether your data is precise before we report it to CMS.

3) The GPRO Web Interface closes on Friday, March 20, 2015 at 7pm CT.

A Note from the CEO

KCMPA originally planned for the organizations to be sustained by shared savings from CMS. As our sophistication and understanding has increased, it is apparent that shared savings won't be realized from the ACO in time to continuously sustain us. We've pursued other contracts to diversify our potential revenue. The Finance Committee also is investigating new funding sources to sustain the organization until the Kansas City market is ready to contract. Our environmental scan indicates the market will be ready in mid-2016 for 2017. New funding could come from new partnerships, membership dues, or other sources.

Guides in Practice Management: Smoking Cessation Counseling

- *How often is it covered?* Medicare Part B covers up to 8 face-to-face visits in a 12-month period. These visits must be provided by a qualified doctor or other Medicare-recognized practitioner.
- Click here for Medicare reimbursement information on tobacco use prevention and cessation counseling.