KCPA Newsletter

Informed Care. Better Health. Lower Cost. **4/2015** Issue 4

CARE MANAGER'S IN THE PRIMARY CARE CLINIC

Improving Colon Cancer Screening Rates

Colorectal cancer (CRC) is both the nation's second-leading cause of cancer mortality and one of its most preventable cancers. If detected at earlier stages and ages, mortality rates would fall dramatically.

You can improve colorectal cancer screenings in your practice by using the following four essentials:

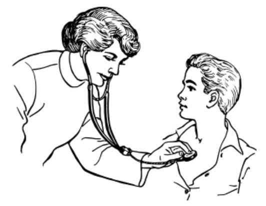
1. Recommending it to your patients is vital - Be clear that screening is important. Ask patients about their needs and preferences. The primary reason patients say they are not screened is because a doctor did not advise it.

2. Develop a screening policy - Involve your staff to make screening more effective. Engage your team in creating, supporting, and following the policy. Create a standardized course of action.

3. Track test results, and follow up with providers and patients - Create a simple tracking system that will help you follow-up as needed. Be persistent with patient reminders, you may need to remind them several times before they follow through.

4. Measure your progress to tell if you are doing as well as you think - Establish a baseline screening rate and set a goal. Seeing screening rates improve can be rewarding for your team.

For more information on colon cancer screening, click here.



Upcoming Meetings

Back Pain Protocol Info Session – Wednesday, April 22 at 5:30 PM at NKC Hospital Pavilion Prairie View Room.

IT Committee Meeting – Tuesday, May 5 at 9 AM by conference call.

ACO Board of Directors Meetings Thursday, May 7 at 6:30 PM at Metro Med.

Quality Improvement Committee Meeting – Thursday, May 21 at 6:30 by conference call.

Care Team Consortium Friday, May 29 at 8am at Northland Family Care – 9151 NE 81st Terrace #100, 64158

Click here for a list of 2015 meetings

Welcome Dietitian and Diabetes Educator

Welcome Melissa Leslie! KCMPA is very excited to announce that a new Dietitian/ Diabetes Educator has joined our team!

Melissa Leslie RD, LD has 20 years of experience as a dietitian and educator and is licensed in Kansas and Missouri. Melissa can lead group diabetes education classes, counsel one on one with diabetes patients and provide care management for uncontrolled diabetes patients. If you would like to Melissa to assist patients in your clinic, please email her.

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

Follow us on LinkedIn. Subscribe to our Youtube channel.

Innovations at the Clinic

Health Coaches Increase Patient Engagement and Chronic Disease Outcomes

Using a health coach as part of the care team has shown improvement in patient outcomes according to a recent study. With health coaching, patients showed improved hemoglobin A1c levels, LDL levels, and achieving care plan goals.

Medical Assistants (MA's) trained as health coaches is a cost-effective approach to providing the increased support patients with chronic illness need. MA's are quickly becoming an available and affordable allied health professional that can be useful in many settings.

The health coach can provide telephone support to patients as well as face-to-face. They can review care plans and goals with patients, ensure the patient is making their appointments, and assist with care coordination between the health care team. Using MA's as health coaches can open the barrier of time and resources that exists within many practices today.

For more information, visit the following links: AnnFammed.org , FiercePracticeManagement.com , and AAFP.org

Patient-Centered Medical Home Tips

Care Coordination: Referral Tracking and Follow-up

- In the medical home, an element of Care Coordination is tracking referrals to determine that the patient went to see the specialist and that the report along with any follow-up is sent back to the referring provider.
- Actively monitoring the tracking log should be assigned to someone in the clinic as a part of the care team responsibilities.
- Creating agreements between primary care and commonly used specialists will enable effective co-management of the patients care and timely sharing of patient's treatment plan and status.

Resources at your Fingertips

Please utilize the resources available to your clinic.

- Community Resource Guide
- Tria Medication Management
- Dietician and Diabetic Educator
- PCMH Facilitation assistance – contact Cindy Campbell.

Information Technology Update

KCMPA-ACO is preparing education for ACO practices on how to improve scores on the quality measures before 2015 reporting. Webinar topics will focus on understanding the definition of each measure, refining documentation, and learning the CMS scoring system to achieve shared savings.

Our data metrics vendor (Health Metrics Systems) has released a cloud-based portal as a secure, and easy way for practices to view their ACO quality measure scores. Training on the HMS system will included in the webinar series. There will be more information on these webinars in upcoming newsletters.
If you have any questions regarding the submission of your data to CMS or would like to review your percentage on any measure, please contact Sobia Paracha.

Notes from the CEO

KCMPA and Clay Platte Family Medicine Clinic will hold an informational meeting about our low back pain protocol on April 22nd at 5:30 PM in the Prairie View Room in the Health Pavilion at North Kansas City Hospital.

Clay Platte Family Medicine Clinic is piloting the protocol as we refine the referral processes and workflow that will best support the cross-specialty algorithms. Providers that are likely to receive referrals from CPFMC were invited to this first meeting, but it is open to all interested providers.

The algorithms were developed by a multi-specialty task force of KCMPA providers including primary care, radiology, pain management, orthopedics, physical medicine and rehab, physical therapy, chiropractic and behavioral health. The algorithms use current medical evidence. They were designed to improve health outcomes for patients with low back pain by closely managing progress on recommended treatments across multiple modalities and conservatively escalating care as needed.

This type of effort is not commonly done by independent groups. Having the capability to design and implement this type of protocol is the future for a clinically integrated group of providers. It's exciting to see the project coming together.

If you practice would like to be involved, contact me or Cindy Campbell, Director of Clinical Strategies.

Guides in Practice Management: Annual Wellness Visit

- The Annual Wellness Visit should be a service in which Medicare beneficiaries are routinely scheduled.
- Your clinic should have a process with a workflow in place to ensure that Medicare patients are getting scheduled for their AWV.
- An AWV will promote health and wellbeing to your Medicare patients by ensuring they are receiving preventive screenings and services.
- AWV Reimbursement ranges from $106.08 - $159.87 per patient.