KCMPA Newsletter

Informed Care. Better Health. Lower Cost. 6/2015 Issue 6

Notes from the CEO

I've got bad news and good news.

The bad news is that KCMPA's operating capital is running very thin. We've stretched the dollars that KCMPA-ACO received from the Centers for Medicare and Medicaid Innovation Advance Payment Program as far as they can go. Without more cash by mid-August, our operations will be dramatically reduced. The good news is that we've been cultivating relationships with likely partners for many months. I'm optimistic that some of those relationships will produce sufficient operating capital for us to continue to function until we have commercial contracts in place that will bring recurring revenue to KCMPA and our members (probably 2017-2018).

It's validating that other health care entities see value in the capabilities we have built with the ACO and want to work with us to expand our reach. More good news especially for specialists who patiently waited these 2+ years while we developed the primary care based ACO, it seems like now is the right time to build on the infrastructure we've put in place for population health management and care coordination by taking those capabilities to specialty practices. I'm hopeful that all KCMPA members are eager to be involved. I think we have a window of opportunity and support from our community to develop a multi-specialty network of practices that are prepared for value-based contracts.

Here's what I think you can expect from KCMPA…

1) We plan to renew our ACO contract with the Medicare Shared Savings Program for three more years of no downside risk. That contract will go from 2016-2018.
2) We will consider adding specialists and facilities to our ACO.
3) We will connect specialty practices to the data registry and include specialty data and measures.
4) We will analyze and understand the cost of specialty care from our claims data.
5) We will pursue projects with payers, hospitals and employers that will get us closer to value-based contracts a group of practices.

This is an exciting time for KCMPA. There is a ton of opportunity for physicians who "get it." I think most KCMPA practices joined KCMPA because they "get it" on some level and want to be prepared for the next thing. I feel like we are a little ahead of our time, but while the rest of the market gets started we continue to build our capabilities and help define what the next thing is.

Upcoming Meetings

Care Team Consortium Friday, June 26th at 8:00 AM at Clay Platte Family Medicine.

IT Committee Meeting – Tuesday, July 7th at 9:00 AM by conference call.

Note the Date Change: KCMPA and KCMPA ACO Board of Directors Meetings Thursday, July 9th at 6:30 PM, location to be determined.

KCMPA Webinar Series Kickoff – Tuesday, July 21st, 12:00-1:00. More details to follow.

Quality Improvement Committee Meeting – Thursday, July 16th at 5:30 PM by conference call.

Click here for a list of 2015 meetings

Engaging Patients in Self-Care through Technology

Patient self-management represents an essential element of the chronic care model (CCM), a theoretical framework developed to guide higher-quality chronic illness management in primary care. Evidence has shown that incorporating CCM principles into practice results in favorable health outcomes. Patient engagement initiatives have led to reductions in hospital visits, decreased morbidity and mortality, and improvements in treatment adherence and quality of life associated with chronic diseases such as heart failure, ulcerative colitis, and asthma. Today, patients can self-direct their care more than ever before through the use of technology.

- Online Appointments – Many patients would prefer the convenience of scheduling their own appointments online. Studies have shown that advanced access and online scheduling reduce wait times and no show rates.

- Pre-visit Check in – Using tablets and kiosks expedite the check-in process of information gathering.

- Online Visits – Visits to physicians for routine interactions or data collection can be moved into an asynchronous, online environment creating opportunities for efficiencies.

- Remote Monitoring – Devices that monitor the physiologic consequences of disease and treatment are able to share this data via wireless connectivity, allowing the data to be captured in the patients EHR.

- Prescription Refill – Through the use of a smartphone app, patients are able to view their medications and request refills quickly and efficiently.

For more information, read the full article here.

Innovations at the Clinic

What is a Patient Centered Care Plan?

- According to the American Academy of Family Practice, a patient-centered care plan is a document to assure that care is provided in a way that is congruent with patient choices and values. A plan of care is based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for all health issues.
- The Centers for Medicare defines a care plan as, "The structure used to define the management actions for the various conditions, problems or issues. A care plan must include at a minimum the following components: problem, goal, and any instructions that the provider has given to the patient.
- Care Plan Templates: Example 1 and Example 2.

KCMPA Webinar Series

On Tuesday, July 21st KCMPA will kick off a webinar series that will be hosted the third Tuesday of each month from 12:00-1:00. The first one will cover KCMPA's strategy for the future, potential alliances and the second ACO contract. Stay tuned for more details.

Resources at your Fingertips

Please utilize the resources available to your clinic.

- Community Resource Guide
- TRIA Medication Management
- Dietician and Diabetic Educator-contact Melissa Leslie.
- PCMH Facilitation and Renewal assistance – contact Cindy Campbell.
- Smoking Cessation Materials Request– contact Kerri Craven.

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Senior Resources for Aging Well

The most comprehensive and complete book of resources for seniors, their caregivers and the respected senior industry professionals of the region. Click the above image to browse the full directory.

Member Spotlights Available

We currently have openings for Member Spotlights at the Sept 3, Nov 5, and Jan 7 Board of Directors meeting. This is a great way to share information about your practice. If you're interested contact Kerri Craven.

Patient-Centered Medical Home Tips

Performance Measurement and Quality Improvement

- In the Patient Centered Medical Home performance is reviewed on a range of measures to help it understand its care delivery system's strengths and opportunities for improvement.
- Data can come from internal sources (EHR, Registry) or external sources (health plan, CMS).
- Measures range from performance on preventive care to chronic care needs.
- The practice should have a good understanding of what their measure rates are in comparison to what their goals are.
- Performance data should include the period of measurement and the number of patients measured (numerator) compared to a patient population (denominator). Example: total diabetic patients/all patients; diabetic patients with completed hgbA1C/all diabetic patients.