KootenaiCareNetwork Newsletter

Annual Membership Meeting, April 5, 2018 5:30 – 7:30 p.m.

Volume 2, March 2018

WELCOME!

Kootenai Care Network launched Kootenai Accountable Care (KAC) in 2017 to participate in the Medicare Shared Savings Program (MSSP). KAC was selected as a MSSP-ACO effective January 1, 2018! Aligned with the work of Kootenai Care Network, we continue our commitment to provide patients with high-quality coordinated care, while helping to slow the growth of health care costs. To maximize our ability to be successful in these programs we have partnered with the Premier Health Solutions, Population Health Collaborative. This affords us access to more than 60 ACOs around the country to problem solve as well as evaluate successful nationally recognized population health initiatives in the context of our relationships with those people in our communities who trust us with their care.

We are influenced by numerous factors: According to Dr. David Chambers, Chairman of the Board of Directors for the Kootenai Care Network, we face:

- the increasing emphasis on publicly reported outcomes reflective;
- the rapid changes in payment focused on value-based care triangulating outcomes/quality/cost of care with overarching focus on how patients feel about the care being delivered; and
- the need for providers to be a part of something where they can collect data, understand each other across the continuum, and move the needle for health care.

In addition, we are no longer alone in North Idaho. According to Patt Richesin, President of Kootenai Care Network, KCN and KAC are strong. However, we are not immune to health care market disruption similar to that occurring around the country. We need to be mindful of the influence of all of the for-profit entrants in the ACO work or delivery disruptions through technology. These situations become an opportunity and a threat with both adding value to our work. Please join us for the April 5 Annual Membership meeting as we discuss 2017 in review and our plans for the future.

Dr. David Chambers	**Patricia Richesin**	**Dr. Karen Cabell**
Chair, Board of Directors	President	Medical Director

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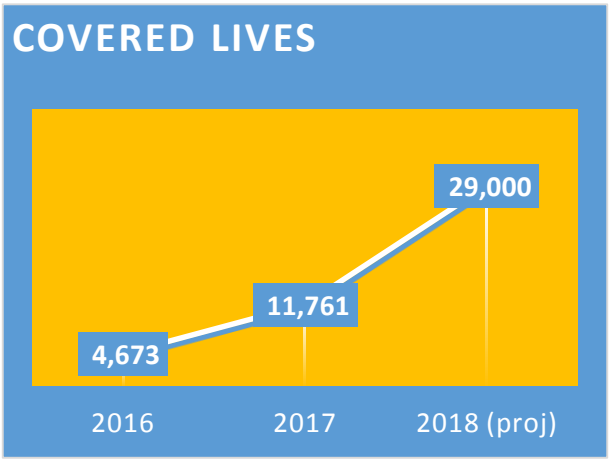
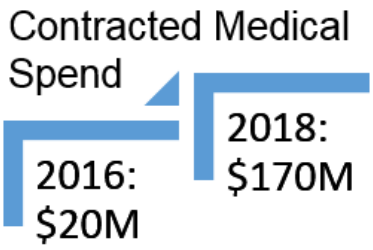
Growth and Development





In two short years, Kootenai Care Network has grown to be responsible for 5 times more covered lives. And, at more than 500 providers, we have expanded by +50% in that same period. With the addition of the Medicare ACO, we now can influence improved management of health care resources including more than $170 million in health care spend.

Quality Corner

Each month Kootenai Care Network introduces another series of quality measures on which we will be focusing. We specifically review these measures at our monthly Practice Leaders meetings. For each measure, we share information about the requirements and expected outcomes. Look for future publications in which we share outcomes across KCN and KAC.

2018 Quality Measure Communication Strategy

**Data will be validated in Lightbeam by the date of the corresponding Quality Committee*

January	February	March	April
Breast Cancer Screening (every 27 months, age 51-74)	Diabetes (DM): Hemoglobin A1c Poor Control (A1c > 9.0%, age 18-75)	Use of Imaging Studies for Low Back Pain	Medication Reconciliation Post Inpatient facility) Discharge (age ≥ 18)
Colorectal Cancer Screening (FOBT every year, Flex Sigmoidoscopy every 5 years, Colonoscopy every 10 years, age 50-75)	Diabetes (DM): Eye Exam (age 18-75)	Osteoporosis Management in Women (OMW) Who Had a Fracture (age 50-85)	Medication Therapy Management Comprehensive Medication Review
Pneumococcal Vaccination Status for Older Adults (age ≥ 65)	Diabetes, Adult: Medical Attention for Nephropathy (age 18-75)	Rheumatoid Arthritis (RA): Disease-Modifying Anti-Rheumatic Drug Therapy (age ≥ 18)	Use of High-Risk Medications in the Elderly (age ≥ 65)
Diabetes (DM): Hemoglobin A1c Poor Control (A1c > 9.0%, age 18-75)	Diabetes: Hemoglobin A1c Testing (age 18-75)	Mental Health (MH): Depression Remission at Twelve Months (age ≥ 18)	
Screening for Clinical Depression and Follow-Up Plan (age ≥ 12)	Diabetes: last BP of year <140/90	Preventive Care Visit/Comprehensive Health Assessment	
Influenza Immunization (age ≥6 mos, between 10/1/16 and 3/31/16)			

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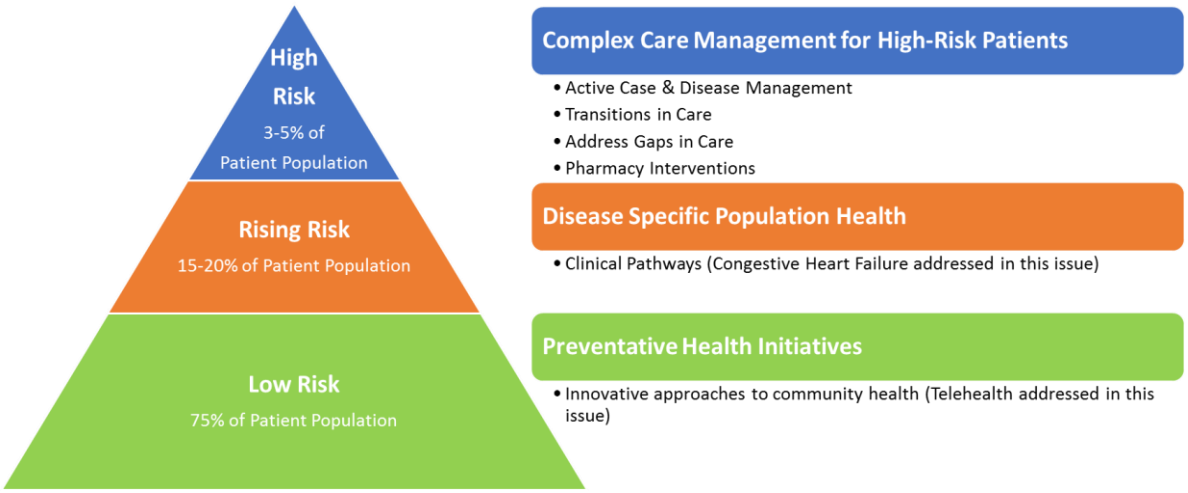
Care Management Offers Support for Patient and Caregivers



Managing chronic conditions is easier with a team of experts. With over 16 care managers across the practices within Kootenai Care Network, it's getting easier for patients with chronic conditions such as COPD, heart failure, depression, and anxiety to manage their health care. According to Toni Wells, RN Care Manager with Kootenai Care Network, "It's important for these patients to know they have a resource. People don't have to navigate this on their own. There's an entire network of people waiting to help them."

It's easy to feel overwhelmed when managing multiple health conditions. Between doctor appointments, medications, and a slew of other unfamiliar systems to navigate, feeling confused and a little lost is normal. Thankfully, a new care management program is available for those managing chronic conditions.

"We're here to assist patients and their families as they navigate the health care system and manage their care," said Toni, said. "Along with my colleagues in many of the practices, we are resources for them to reach out to so they know they're not alone." As a care manager, Toni works with a variety of patients, caregivers and health care experts within Kootenai Care Network to provide more efficient, high-quality care.

"As an advocate for patients, I work with pharmacists, primary care doctors, specialists, rehabilitation therapists, and many others to coordinate patient care," Toni said. "In the long run that helps to prevent hospital visits and decrease the overall cost of their health care."

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From the Patient's Perspective:

One patient benefitting from this new care management program is Gwen Peterson, who after an extended hospital stay, now requires home health care and multiple therapies. "I started working with Gwen and her caregiver from the day she was discharged from the hospital," Toni explained. "Together with a social worker, we were able to get Gwen health insurance and the resources she needs to work toward recovery." Today, Gwen is living in a certified family home with Rochelle Gentile and her family. There, she receives around-the-clock care for her special medical needs. Together Gwen, Rochelle, and Toni manage all aspects of Gwen's health care.

"I don't know what I would do without Toni's help and guidance," Rochelle said. "I call her frequently to keep her updated on Gwen's needs and together we come up with a plan. We've been able to prevent any further hospitalizations and reduce Gwen's pain medication. It's been wonderful to see her progression and to have an immediate resource if we need it."

"Kootenai Care Network has a process for enrolling patients in care management and would welcome the opportunity to partner with your practice," said Shelley Janke, Director of Quality and Care Management for KCN.

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Focus on Making a Difference

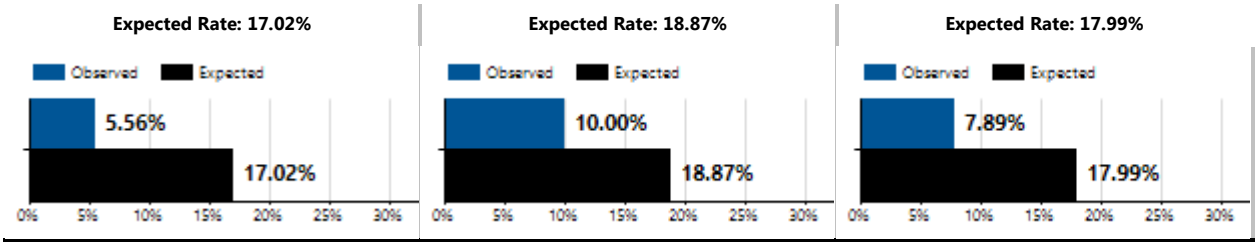
Primary Care and Specialists Improving Care Through Congestive Heart Failure Clinic

Heart Failure Clinic

Readmissions

Current Month = Feb-18 discharges
Previous 18 months = Aug-16 to Feb-18 discharges

Heart Failure Clinic Patient *Year To Date*				Non-HFC Patient *Year To Date*				Total HF Population *Year To Date*			
Readmissions	Patients	Rate	O/E	Readmissions	Patients	Rate	O/E	Readmissions	Patients	Rate	O/E
1	18	5.56%	0.33	2	20	10.00%	0.53	3	38	7.89%	0.44



Early in 2012, Kootenai Heart Clinics Northwest realized that their cardiology practice had a problem with heart failure readmissions. There wasn't adequate follow-up between the emergency room, the hospitalists, and their clinic and hence, they had no control over readmissions. In response, they developed the Heart Failure Clinic in 2013, at first focusing solely on their Coeur d'Alene patients. Within the first year, readmission numbers were down from 20% to 13-14%.

What they found was that patient teaching is vital. A nurse navigator contacts patients with heart failure diagnoses before they leave the hospital to provide discharge instructions and heart failure teaching. She establishes a rapport and a relationship with the patients so they want to return to the heart failure clinic, which they do within two to four days for consultation and testing.

The goal of the clinic is to optimize care for patients with either preserved heart failure or reduced ejection fraction, said clinic cardiologist Dr. John Everett. They make sure they're on the right medication and then educate them about their disease process, stressing the importance of diet, fluid and salt management, and the proper amount of exercise.

According to Dr. Everett, the clinic uses a holistic approach. "We see people fairly frequently," he said, "particularly early in their disease process, just to educate them

about their disease, see if their fluid balance is optimized, and try to maximize the guideline-based medications for heart failure. Then, we deal with their other problems, such as anemia and sleep apnea."

There is also a palliative care physician in the clinic who meets with patients and their families, along with the nurse practitioner or physician, and discusses the decisions they will need to make about their future. They help patients and their families make healthcare decisions in an informed way.

Coeur d'Alene Pediatrics Introduces Telehealth

Physicians from Coeur d'Alene Pediatrics began providing telehealth services in April 2017. According to pediatrician Dr. Terence Neff, they are only using telehealth with patients with chronic conditions, children where they have a very strong relationship with the families. They do not use it for initial diagnoses or treatments. The physicians utilize HIPAA-compliant software and a secure two-way video screen to see and speak with their patients. Parents use a smartphone, tablet, or regular desktop computer to interact with the physician.

"Children are excited about being involved in the program," said Connie Moering, Administrator for Coeur d'Alene Pediatrics. They think it is fun that their physician can see inside their house.

One physician in the practice works with a number of autistic children. They did not primarily consider them as a target population for telehealth, but autistic children tend to get "ramped up" when they're in the office. They're out of their comfort zone and familiar surroundings, so it causes them a great deal of anxiety. As a result, it's difficult for the parent to talk to the physician, as they're tending to their child.

"There is nothing worse for the family of an autistic child than to take them out of their routine, out of their home, into a completely sterile, scary environment," said Dr. Neff. "There's no question we're providing better care through telemedicine, instead of subjecting them to the stressors of coming into our office."

"To have the capability to be doing this in a 15-minute block of time at their convenience is absolutely tremendous for our families," said Dr. Neff. "They're not keeping their kids out of school, they are allowed to go on with their daily life with the minimal number of obstructions or complications. People are not losing wages in order to get the necessary care their kids need. The loss of income is a barrier to obtaining medical care, there's no question about it."

"Our thought process is always looking to the future, and how telehealth could be expanded even more," said Ms. Moering. "What we have done so far has been very beneficial for our patients, and the physicians enjoy it."

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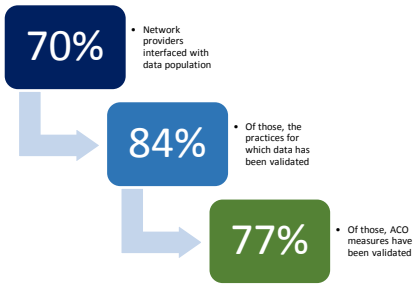
"We went into this with the stipulation that we would only provide this care if it would be equal to or greater than the care that we can provide in the office," said Dr. Neff. "We have to realize that we have to change how we practice medicine to make it work for the families also. That's been lacking in the last few years of medicine. This is just another step of trying to make it accessible to our families and eliminate barriers to obtaining care."

Practice Leaders Corner

Lightbeam Interfaces and Training



Lightbeam interfaces are progressing rapidly. Casey Meza, Director of Operations and Amy Parker, Ambulatory Service Line Specialist, introduced a comprehensive training program for practices in the use of this population health tool. "We are pleased that so many practice leaders, clinical support members and healthcare providers participated in the training sessions," said Meza. To date 214 clinical specialists have received the training. Additional training is planned so please look for announcements.

FAQ from Practices:

Will Kootenai Accountable Care conduct Medicare quality reporting for their participating practices?

YES! For 2018, KAC **will be** conducting quality reporting for all participating providers. Your practice needs to continue to work towards meeting quality outcomes but Kootenai Accountable Care will actually submit the quality outcomes at year end for all participating providers in the ACO. If your practice is preparing to report quality for 2018, you do not need to continue. Your only requirement is to report on Advancing Care Information (formerly Meaningful Use).

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Calendar

The meetings of Kootenai Care Network are open to members of the network. In some cases, schedules may be subject to change to accommodate holidays or special events.

- Board of Directors, Dr. David Chambers, Chair Meeting
  - 1st Wednesday of Month
  - Noon to 1 p.m.
- Contract and Finance Committee, Dr. Brad Brososky, Chair
  - 4th Monday of Month
  - Noon to 1 p.m.
- Shared Savings Distribution Subcommittee, Dr. Mark Borsheim, Chair
  - As scheduled
  - 5:30 p.m. to 6:30 p.m.
- Quality Committee, Dr. Robert Scoggins, Chair
  - 3rd Wednesday of Month
  - Noon to 1 p.m.
- Primary Care Service Line Collaborative, Dr. Karen Cabell, Chair
  - First Thursday of Month
  - 7 a.m. to 8 a.m.
- Health Information Technology Committee, Dr. Peter Purrington, Chair
  - 2nd Thursday of Month
  - 7 a.m. to 8 a.m.
- Membership Committee, Dr. Geoff Emry, Chair
  - Last Wednesday of Month
  - 5:30 p.m. to 6:30 p.m.
- Practice Operations
  - Practice Leaders
    - Last Wednesday of Month
    - Noon to 1 p.m.
  - Care Management Affinity Group
    - 4th Thursday of Month
    - Noon to 1 p.m.