



Introduction

Kootenai Care Network is a forward thinking organization supported by Kootenai Health to actively engage in health care transformation and optimization. Through the establishment of shared clinical criteria, data analytics, and provider to provider decision making the goals for the “Triple Aim” can be realized. The term “Triple Aim” refers to the simultaneous pursuit of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care.

For us it is all about communication within the medical community, among independent and employed providers, and between primary care and specialty services, to make sure that patients are getting the benefit of all of the resources within our community. We have engaged over 500 providers in the network who are sharing care data, looking at best practices, analyzing where there may be gaps in care, and establishing chronic care management teams to engage nurses and other providers with people who need assistance with their long-term medical needs.

The structure of the medical payment climate is changing and our medical community needs to be prepared for these changes. The agenda of the governmental payers and the commercial payers is quickly advancing to value-based care. Translating all of this, clinical, operational, and financial expectations, into work is challenging and we think Kootenai Care Network is in a great position to partner with you for success.

Our intention is that this new health care delivery system will become the norm, and that we will be capable of constant improvement and analysis of the way we are delivering care. We appreciate all of you being a part of this transformation.



Dr. David Chambers
Chair, Board of Directors



Patricia Richesin
President



Dr. Karen Cabell
Medical Director



Your Colleagues in Kootenai Care Network Have Been Busy

So much is occurring within Kootenai Care Network and onsite in various practices throughout the network. This summer we created Kootenai Accountable Care in preparation for our application to participate in the Medicare Shared Savings Program as an accountable care organization. In response to the escalating engagement between primary care and specialty services in creating clinical pathways for some of the conditions most dramatically affecting our patients, the Primary Care Service Line Collaborative was created. And, at the recent Kootenai Care Network Strategic Planning session held on October 4, 2017, your colleagues reported on activities occurring real time in practices throughout the community. Allow us to share some of this work:

Primary Care Service Line Collaborative

Earlier this year, Dr. David Chambers, Kootenai Care Network Board Chair, Dr. Karen Cabell, Kootenai Care Network Medical Director, and Patricia Richesin, Kootenai Care Network President met with local medical practices to gauge their interest in joining other providers to apply to become a Medicare Accountable Care Organization (ACO). The overarching response was that most of them had interest, but not a lot of time.

"We queried the primary care practices," Dr. Cabell, an expert in transforming care, said. "What would be best? What would work to become an ACO, or what would be the best mechanism to support your practice to move to value-based care?" They came up with the concept of creating a primary care service line that relies on the dyad leadership model between the physicians and their administrative partners.

"The providers want to know what they can do to be successful," Dr. Cabell said. "So much of what a clinically integrated network is trying to accomplish relies heavily on the work of the primary care providers." It requires providers to act as a cohesive unit across the patients served, and engage in much more meaningful ways with specialists to smooth the path for patients to improved clinical outcomes while managing the overall cost of care.



The structure of the primary care service line is for each brick and mortar primary care location to send a provider and practice leader (clinical and operational dyad partnership) to a monthly meeting to participate in conversations to move health care delivery forward in our community. Each dyad partner has a specific role. The providers drive the clinical inputs linking those to the operational requirements of their practice necessary to do the work. These practice representatives will take the learnings from those meetings back to their clinics, and share them with other providers and staff.

Changes in healthcare feel like daily bombardments of requirements at the practice level. “This work can be very isolating,” said Shelley Janke, Director of Quality and Care Management for Kootenai Care Network. The work of the network is to engage providers and offer support by building up resources to let them know that they are not alone. Providers are looking ahead to how health care will be practiced and asking how do I get to where I want to be from where I am today?

In each newsletter we will feature outcomes from the Primary Care Service Line Collaborative. For this first newsletter, allow us to introduce you to the discussion of Chronic Obstructive Pulmonary Disease.

Primary Care and Specialists Improving Care Through Clinical Pathways

At the first Primary Care Service Line Collaborative meeting in September, Dr. Robert Scoggins hosted a conversation about Chronic Obstructive Pulmonary Disease (COPD), where providers described how they manage their COPD patients. We discussed topics including how to diagnose and treat chronic stable COPD, how to follow a patient if they are admitted to the hospital, various triggers for requesting a co-management consult with a pulmonary physician, and when it's time to involve palliative care. These conversations are designed to ensure more uniform, evidenced based treatment of various diseases and mutually understood expectations of all care to be delivered in our community.



COPD Clinical Pathway

Clinical Pathway:

- *Compact for care expectations across specialties and settings of care for specific conditions*
 - **Primary Care Provider:** Diagnosis, Treatment, Surveillance, When and how to refer, what to expect once you refer
 - **Specialist:** What is expected prior to and with the referral, when do they co- manage and what do they co- manage
- **Goal:** Consistent standardized care following evidence based guidelines leading to better patient outcomes and less ER and inpatient utilization for chronic conditions



COPD Clinical Pathway

- KCN Quality Committee Developed and Approved July 2017
- Rolled out to Primary Care Service Line Meeting in September 2017

Patient Centered Medical Home Initiatives

One of the goals of Kootenai Care Network is to assist every primary care office to become a NCQA recognized Patient Centered Medical Home. Among the challenges in advancing Patient Centered Medical Home (PCMH) is understanding what it means for everyone in the practice to be working at the top of their license and at the top of their responsibilities within their function on the team.

PCMH often is viewed as yet another tactic to organize care. In fact, the basis of PCMH rests with initiatives of the Institute for Healthcare Improvement (IHI). It is strengthened



further through reform efforts linking PCMH to outcomes for Medicaid in numerous states as well as CMS funding from Medicaid and Medicare made available for a cornerstone of PCMH, chronic disease management.

Chronic disease management is strengthened in the network through the deployment of the population health analytics tool, Lightbeam. Interfacing with each electronic health record in the network, Lightbeam enables us to reach into practices and extract data points out of every chart and generate a dashboard for every provider that shows the care opportunities for each patient. The data aggregated in Lightbeam will help practices accomplish the PCMH 2017 standards of Knowing and Managing Your Patients, Care Management and Support, Care Coordination and Care Transition and Performance Measure and Quality Improvement.

Shelley Janke, Director of Quality and Care Management, said the network will use the data collected through Lightbeam to better understand the healthcare needs of the population.

- 1) What healthcare issues are challenging patients the most?
- 2) How can providers best manage high-risk patients and engage them in chronic care management?
- 3) How can we enhance referral management and improve documentation and communication between providers to better coordinate care for the patient?
- 4) How can we understand the needs of the highest risk patients?

From data, we can determine if providers are attaining the goals that have been established. We can monitor the outcomes of patients, not just treat them. And as quality metrics among network members improve and measurably better patient care is established, the network is able to engage in value-based contracting with both payers and employers.

At a recent Kootenai Care Network meeting, Dr. David Chambers shared the journey of Ironwood Family Practice in advancing Patient Centered Medical Home. This dashboard is reflective of the ways in which this practice maps its progress and provides perspective on success.



Ironwood Family Practice Patient Centered Medical Home Journey

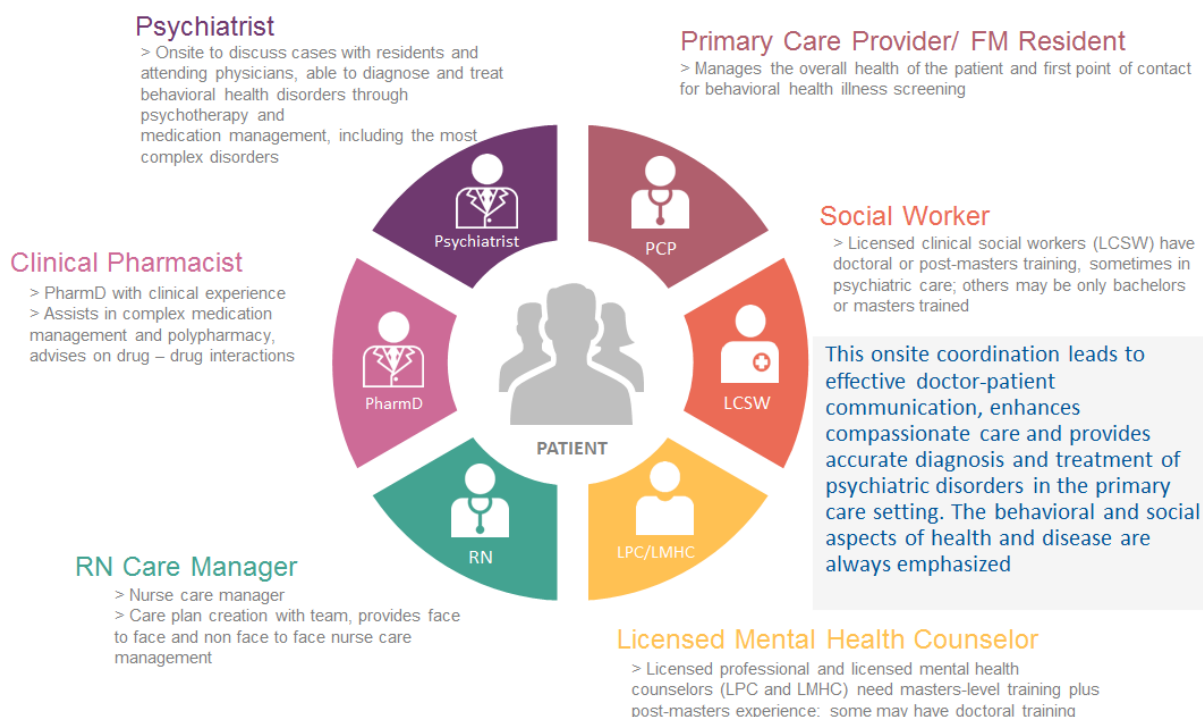


Standard	Title	Points		Standard	Title	Points	
		Possible	Our Score			Possible	Our Score
PCMH 1	Patient-Centered Access			PCMH 4	Care Mgmt & Support		
A	Patient Centered Appointment Access	4.5	4.5	A	Identify Patients for Care Management	4	3
B	24/7 Access to Clinical Advice	3.5	3.5	B	Care Planning & Self-Care Support	4	3
C	Electronic Access	2	2	C	Medication Management	4	3
	Subtotal	10	10	D	Use Electronic Prescribing	3	3
PCMH 2	Team-Based Care			E	Support Self-Care & Shared Decisions	5	3.75
A	Continuity	3	1.5		Subtotal	20	15.75
B	Medical Home Responsibilities	2.5	2.5	PCMH 5	Care Coordination & Transitions		
C	Culturally & Linguistically Appropriate Svcs	2.5	1.875	A	Test Tracking & Follow-up	6	6
D	The Practice Team	4	2	B	Referral Tracking & Follow-up	6	3
	Subtotal	12	7.875	C	Coordinate Care Transitions	6	3
PCMH 3	Population Health Management				Subtotal	18	12
A	Patient Information	3	2.25	PCMH 6	Performance Measurement & QI		
B	Clinical Data	4	4	A	Measure Clinical Quality Performance	3	3
C	Comprehensive Health Assessment	4	4	B	Measure Resource Use & Care Coord	3	1.5
D	Use Data for Population Management	5	5	C	Measure Patient/Family Experience	4	1
E	Implement Evidence-Based Decision Supp	4	1	D	Implement Continuous QI	4	2
	Subtotal	20	16.25	E	Demonstrate Continuous QI	3	2.25
	Level 1 = 35-59 pts			F	Report Performance	3	2.25
	Level 2 = 60-84 pts			G	Use Certified EHR Technology	0	0
	Level 3 = 85-100 pts				Subtotal	20	12
					Our Total Score		73.875



In upcoming issues, we will be exploring other initiatives currently in place for our community. Exploring each of these allows us to understand opportunities for other practices either in establishing similar programs or by leveraging those already in place. Look for more information on the following:

Integrated Behavioral Health Kootenai Clinic FM Residency





Coeur d'Alene Pediatrics Telehealth Appointments

Current program

- Began in April 2017
- Three physicians piloted the program
- Targeted Medicaid population (they are paying on par for telehealth visits)
- Targeted appointments are for patients on behavioral health medication who are stable
- Use Chiron platform which has an interface with our scheduling system (Greenway's Intergy)



Expanded program

- More providers will be offering Telehealth Services
- Plan to offer acute onsite visits with patients at Children's Village
 - Will expand the types of appointments provided through telehealth
 - Will have a Certified Medical Assistant onsite
 - Will have electronic stethoscope, electronic otoscope, and throat and urine tests onsite

Benefits of Program

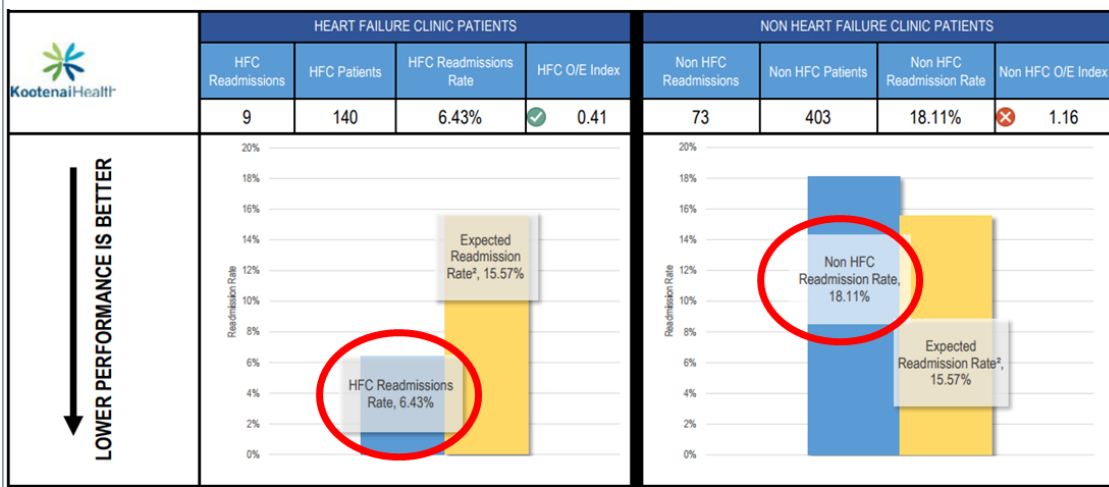
- Telehealth Services has increased patient access and satisfaction
- No monetary gain for telehealth appointments, but does offer enhanced convenience for parents

Heart Failure Clinic

Model:

- Multi-disciplinary team approach using evidence based care guidelines with specialty nurse navigation, cardiologists, NP's and palliative care

Results: Readmission rate of 6.43% vs. 18.11% (usual care)





Practice Leaders Corner

What is a QRUR, and what does it mean to my practice?

Physicians who are immersed in caring for their patients and running their practices don't have much time left to keep up with the details of a payment system that is shifting from traditional fee-for-service payment based on volume to one that is focused on quality and value. But it's worth taking the time to understand the Quality and Resource Use Report (QRUR), and why you should care about it.

The Centers for Medicare & Medicaid Services (CMS) provides practices with an annual QRUR. This is one of the Medicare report cards for your practice. The QRUR shows how your payments under Medicare Part B fee-for-service (FFS) will be adjusted, based on the quality and cost of care that you provide to your Medicare patients. Data is reported by taxpayer identification number (TIN); this is how CMS identifies a practice and its patients.

The QRUR is important. It indicates how physicians will fare under Medicare's Value-Based Payment Modifier (VBPM) program. The VBPM program adjusts your Medicare payment based on quality and cost, or resource use. Under the VBPM, physicians with high quality and cost scores could be eligible for a bonus to their Medicare reimbursement. On the other hand, physicians with low scores could face penalties that decrease their Medicare reimbursement. Performance is compared to benchmarks of similar peer groups.

As Medicare moves from a system that rewards volume of service to one that rewards quality and efficiency, physicians will need to prepare themselves for success in this new world. The QRUR is an excellent resource to navigate this transition, as it shows where you are doing well and where you need to improve. Reviewing your practice's QRUR can provide you with important information that can help you maximize payments now, and in the future.

For more information, visit <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-Sample-MedPractice-A.pdf> and <http://www.aafp.org/practice-management/regulatory/qrur.html>



Sample Information from QRUR Report

ABOUT THIS REPORT FROM MEDICARE

The 2015 Annual Quality and Resource Use Report (QRUR) shows how your group or solo practice, as identified by its Medicare-enrolled Taxpayer Identification Number (TIN), performed in calendar year 2015 on the quality and cost measures used to calculate the Value-Based Payment Modifier (Value Modifier) for 2017.

In 2017, the Value Modifier will apply to all physicians in groups with two or more eligible professionals and to physicians who are solo practitioners who bill under the Medicare Physician Fee Schedule. It will not apply to eligible professionals who are not physicians.

The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at the discretion of the Centers for Medicare & Medicaid Services (CMS), including, but not limited to, circumstances in which an error is discovered.

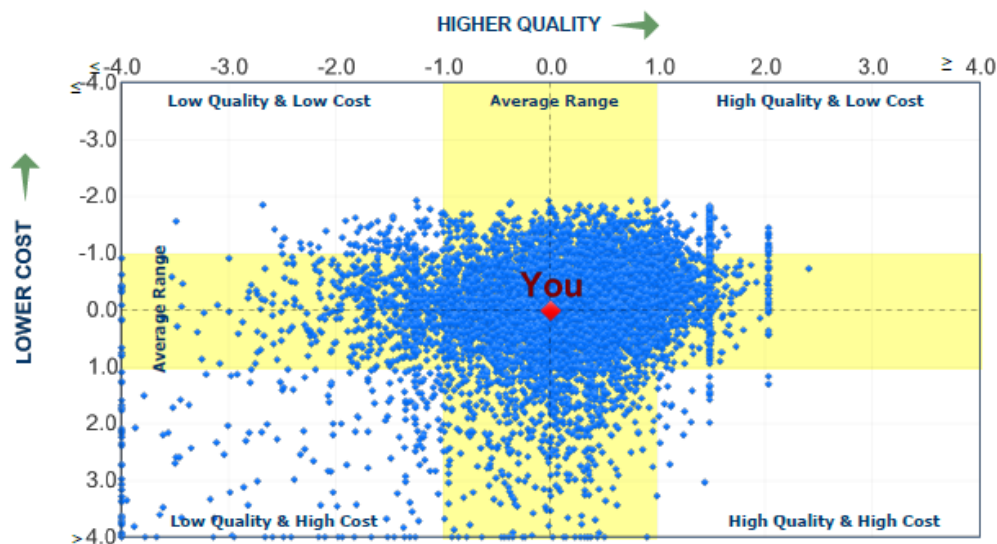
YOUR TIN'S 2017 VALUE MODIFIER

Average Quality, Average Cost = Neutral Adjustment (0.0%)

Your TIN's overall performance was determined to be average on quality measures and average on cost measures.

This means that the Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for physicians billing under your TIN in 2017 will result in a neutral adjustment, meaning no adjustment (0.0%).

The scatter plot below shows how your TIN ("You" diamond) compares to a representative sample of other TINs on the Quality and Cost Composite scores used to calculate the 2017 Value Modifier.



Note: The scatter plot shows performance among a representative sample of all TINs with Quality and Cost Composite Scores reflecting standard deviations from the mean for each Composite Score.



Lightbeam Training

Casey Meza, Director of Operations and Amy Parker, Ambulatory Service Line Specialist, will be introducing the comprehensive training program for practices in the use of Lightbeam. “Having spent the past few months validating the data and testing the various modules, we are ready to begin the process of educating practices in how to use the tool”, says Meza. She continued, “The real work begins at the practice level and we wanted to ensure that we maximized that experience before meeting with each group.” The training schedules will be built collaboratively with the practices and will be published in the next few weeks.

Kootenai Care Network Board of Directors

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- Todd Hoopman, MD
- Brad Brososky, MD
- Beth Martin, MD
- Tom Nickol, MD
- Jon Ness, Kootenai Health, CEO
- Walt Fairfax, MD, Kootenai Health, CMO
- Kimberly Webb, Kootenai Health, CFO

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- Walt Fairfax, MD, Kootenai Health, CMO
- Kimberly Webb, Kootenai Health, CFO
- Paul Anderson, Medicare Beneficiary



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
 - 2nd Monday of Month
 - 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.



Your Network

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