CONNECTED CARE PARTNERS

# CONNECTIONS

## Ready, Set, Go...

This month, Connected Care Partners will enter into its first value-based agreement with the NMHS health plan. This initiative provides us the opportunity to demonstrate value through clinical integration. Value-based delivery is a commonly used term; in essence, it involves improving the quality of care while reducing excessive utilization of non-value added services.

Over the past year, we have identified key clinical quality metrics that will help us improve the care we deliver to our patients. These include:

- Diabetic A1c monitoring
- Diabetic eye exam
- Colorectal screenings
- Mammogram
- Diabetic nephropathy assessment

In addition, we will try to improve efficiency in these areas:

- Reduce inappropriate emergency room utilization
- Improve generic prescription utilization
- Reduce duplicative and excessive imaging with a particular focus on low back pain
- Reduce inappropriate hospital admissions and readmissions
- Appropriate use of post-acute care services like rehabilitation and therapy

Improvement in these key indicators will help us achieve success in 2018.

So what do each of us need to do in helping accomplish our goals? The Connected Care Partners Board of Directors has also approved these five areas of engagement that will be required for Connected Care Partners members:

1. Patient-Centered Medical Home (PCMH) Readiness Assessment survey completion or PCMH certification for Primary Care Providers
2. Participate in a plan to have capacity to serve patients 24 hours/day by Dec. 31, 2018

3. Identification of a provider champion for each group to disseminate Connected Care Partners related information
4. Participation in Quality and Efficiency Review with Connected Care Partners Outcomes Manager
5. Endorsement and promotion of population health managers to identified patients

We will be providing more details about these requirements in the coming weeks. Thank you for being a part of north Mississippi's first active clinically integrated network. It is going to be an exciting year.

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## Primary Care Collaborative Committee Update

The Primary Care Collaborative (PCC) is an integral component of Connected Care Partners. The PCC has developed initiatives that will bring value to providers and assist the network in giving the best patient - and family-centered care to the people of this region. Some of the initiatives the Collaborative is focused on include:

- **Provider Portal:** A Provider Portal has been developed that is available to Connected Care Partners providers only. This provider portal includes Centricity Read Only access, SCM Read Only access, Up To Date, CME calendar, network information and educational resources. Please contact Alison Gilbert (alallen1@nmhs.net) or Robin Hicks (rahicks@nmhs.net) for more information on how to enroll in the portal or call (662) 377-7811.
- **PCC Newsletter:** The newsletter will be focused on the interest and communication needs of advanced practice clinicians and physicians. The content will include a variety of topics, including specialists and PCP education, best practice sharing, metric communication, CIN updates and leadership messaging.
- **Patient Centered Medical Home (PCMH) Integration:** PCMH is the foundation of a clinically integrated network. We know that some in the network are PCMH certified by NCQA. This year, we want to work toward increasing certification across the network. In addition, we will focus on establishing principles in all primary care practices to help them with transformation to key population health based principles. The team will be collaborating with key members of the ACO and CIN to ensure a continuity of workflow changes.
- **Integration of Mental Health Initiatives:** The PCC is working to integrate mental health initiatives into primary care in an effort to better meet the needs of our patients. The patient-centered care model provides whole person care which includes focus on physical, behavioral and psychosocial elements of the people served. We will be sharing more in the coming months about our journey.

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## NMHS Wellness Visits

The NMHS health plan wellness visit was implemented as a new benefit for NMHS employees and spouses in 2017. We ended the year with over 85% participation. There will be a few changes and added benefits in 2018:

- Employees and spouses may complete their visits from November 1, 2017-October 31, 2018.
- Members may have up to three free consults with a registered dietitian.
- High risk members will be linked to a Population Health nurse for additional support.

The ultimate goal is to provide strategies to help employees/spouses improve their overall health by focusing on prevention of illness and learning personalized approaches to manage chronic disease. Your involvement with the beneficiaries is one that will be invaluable in the success of the NMHS wellness program. For more information call Sarah Hammock, RN, BSN, at (662) 377-3268 or email shammock@nmhs.net.

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## Clinical Efficiency

As Connected Care Partners continues to evolve, in 2018 we installed a new committee that will focus on Clinical Efficiency across our CIN. This committee will be co-chaired by Drs. Brad Crosswhite and Joe Johnsey. The focus will be on tackling key drivers of high-cost, low-quality health care. This will include a renewed emphasis on reducing readmission rates along with ensuring appropriate ED utilization, encouraging in-network utilization for all post-acute services, and focusing on pharmacy benefits management for alignment of best practices and increased generic utilization across the health plan members. This work strategically aligns with North Mississippi Health Services ACO efforts. This committee will meet in early January, and we will begin to share best practices across the CIN. Watch for more information to come!

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## Seeing Patients Back for Hospital Follow-up Appointments

Effective earlier this month, patients admitted to NMMC-Tupelo are being scheduled a follow-up appointment with their primary care provider prior to discharge. The appointment time is placed on their discharge summary and communicated by the nurse at the time of discharge. Please help the network in this endeavor. Consider ensuring that your schedule has one or more open slots daily to allow for transitional care appointments to see patients back in a timely fashion.

This effort should help reduce the likelihood of readmission and allow the

primary care provider to see the patient in a timely manner. Primary care coordination during transitions is an important component of Connected Care Partners' efforts to improve value to patients and reduce unnecessary utilization of services.

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