Vital Sounds
A Newsletter for Health Care Professionals and Facilities
KaMMCO
Kansas Medical Mutual Insurance Company
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Doctors Quality Reporting Network Eases Quality Reporting to CMS

Time is slipping away for healthcare providers to meet the requirements of the Merit-Based Incentive Payment System (MIPS) for 2017. The Kansas Health Information Network (KHIN) is uniquely positioned to work with physicians to streamline reporting for practices.

KHIN has launched the new Doctors Quality Reporting Network, a service that can ease the burden associated with quality reporting through a qualified clinical data registry (QCDR). KHIN applied to be a QCDR because the KHIN exchange already has much of the data necessary for reporting quality measures, advancing care information and improvement activities for our physician practices.

The Doctors Quality Reporting Network is CMS-approved to submit data for 21 Electronic Clinical Quality Measures (eCQMs). The measures, certified by the National Quality Care Association and ONC, are standardized and intended to provide reliable indicators of high quality patient care. The metrics cover management of chronic diseases, preventive care screening, use of appropriate medications and overall cost of care reductions. The indicators are required elements of the Centers for Medicare and Medicaid Services' Quality Payment Programs initiated this year.

What you need to know to have KHIN prepare and submit your 2017 quality reports to the registry:

- KHIN will report for the first 250 physicians/healthcare providers who inquire.
- Physicians/healthcare providers must be sharing data with KHIN in order to participate.
- Physicians/healthcare providers should determine which measures to report on for 2017.
  Download the Doctor's Quality Reporting Network
- Interested parties who would like to learn more or begin the process should contact Laura McCrary, Ed.D, KHIN Executive Director

Step 1 is an introductory call to discuss obtaining a patient list from the eligible clinician or group for the reporting period of Jan 1 – current. The patient list includes anyone who has had an office visit since Jan. 1. Doctors Quality Reporting Network will then run the quality measures for either one physician or the practice. When the reports are ready, an interactive webinar will be scheduled to review the report and determine next steps, including submission of 2017 measures to CMS by the Doctors Quality Reporting Network.

If you choose to have the Doctors Quality Reporting Network submit the eCQM quality measures on your behalf, you will receive a purchase order for the QCDR service fee of $285/per submission, which includes the KaMMCO Health Solutions dashboards. There is a reduced fee if your practice has already purchased the dashboards.

Please contact Dr. Laura McCrary for more information.

Cyber Insurance Coverage and Resources: A Priceless KaMMCO Member Benefit

As a KaMMCO member, your Cyber Security Insurance (CSI) provides basic coverage for network security and privacy violations, both online and offline media, asset protection for recovery or replacement of data, reasonable costs for legal, public relations, credit monitoring, etc., expenses resulting from extortion, and income loss or interruption due to a terrorist attack.

In August, KaMMCO encouraged members to check out its updated and expanded cyber-security resources, complete an online survey, and be entered into a drawing for a $50 gift card. Our winner is Kay Kelly, a clinical social worker at Heritage Mental Health Clinic, Topeka.

Kay explored the updated resources for how to avoid a cyber-attack and conducted a risk assessment of her organization. She analyzed what she believed to be the greatest threat to her organization and has made steps to upgrade online security, including utilizing a new IT company that has more training in HIPPA requirements.

Members seeking a better understanding of the coverage and how it can save time and money when an incident occurs should check out available resources at www.kammco.com/Insurance/Cyber-Security-Insurance.aspx.

New KMS President takes office

Rob Gibbs, MD

One of the highlights of the 2017 Kansas Medical Society Annual Meeting on Sept. 9, was the installation of the new KMS President, Rob Gibbs, MD, a radiologist from Parsons. He will serve a two-year term.

During his installation speech, Dr. Gibbs discussed two key issues which may affect Kansas physicians in the coming years: the opioid addiction crisis and physician burnout. Dr. Gibbs also cast a positive vision for the future saying, "I see a bright future for our profession and the residents and students who will follow. I deeply believe that through hard work and leadership today we will accomplish great things tomorrow."

Tips from the Trenches: Claims Update

By Cristy Anderson, JD
KaMMCO Vice President Claims

Specialty: Physician Emergency Services

Procedure: This 25 year-old female presented to the ER with complaints of inability to speak, dizziness, inability to see or focus her eyes, inability to think or reason, involuntary urination, vomiting, confusion, pain and discomfort. The patient had received chiropractic care earlier in the day. Immediately following her chiropractic manipulation, the patient developed a headache, dizziness, and began vomiting. It was noted the patient's left pupil was dilated. EMS was called and the patient was assessed to be oriented to person, place and time and her neurological examination was normal. The patient reported that her husband was home with flu-like symptons. Our insured's physical exam was essentially normal other than the patient's general behavior was atypical. Our insured also ordered a CTA of the head/neck to rule out dissection. The neck CTA was inadvertantly not performed but the CTA of the brain was normal. A CT of the head and neck was performed based on an earlier physician order and it was also read as normal. The patient was discharged. The following evening she presented to another ER where stroke was ultimately diagnosed.

Allegations: The Plaintiff alleges our insured physician was negligent in that he failed to provide an accurate and thorough medical screening examination for stroke; failed to stabilize and treat the stroke; failed to consult with a neurologist; and failed to transfer the patient to a tertiary or other medical care facility equipped to treat stroke.

Resolution: This claim was settled by our insured, the ER physician and the hospital for a reasonable amount below primary policy limits. The chiropractor continued to defend his care.

Cost of Defense: $139,156

Risk Management Tips:

- Confirm that tests ordered are actually performed, evaluated and reported on. In this case, even after reading the report, our insured was under the impression that the study included both head and neck because that was the order.
- Do not let suspected mental health issues and atypical behavior cloud your judgment when examining and assessing the patient.
- Take care when writing orders, especially handwritten orders. Here, the provider ordered "CT neck/head" when "CT of head and neck" might have been more clearly understood by the clerk that entered the order.

Opioid Use Disorder and Addiction Treatment

Part 2: The difficulties of substance abuse treatment and recovery

By Shane D. Hudson, MS, LCP, LCAC
Central Kansas Foundation
Vice President of Clinical Operations

Physical drug dependence can occur without the presence of addiction. Many people are physically dependent on medications they are prescribed for mental and physical illnesses. Would you say all of these individuals are addicted? No, because diagnosing addiction requires that there is continued use of the substance despite negative effects and chaos occurring as a result of the continued use (i.e. continued use despite harm).

There are medications that people are prescribed and take in order to successfully treat an illness and add balance to their level of functioning. There also are substances that may start by having a positive impact on an individual, but then the negative impact begins to outweigh the positive impact. While some will be able to easily say they want to stop the substance and do so, others will struggle with this due to their own neurobiology.

The reward pathway in the brain is how we experience pleasure and feel "good" overall. This pathway lights up and dopamine is released as we think about the things we enjoy, and participate in the things we enjoy. Those without the disease of addiction operate within a realm of feeling "okay" on average, also referred to as the hedonic tone. For those with the disease of addiction, the hedonic tone is negatively altered as a component of the reward pathway. The addicted brain does not feel "okay" on average in the same way that the non-addicted brain feels. It feels less than okay. And, when the brain lights up as a response to reward, the peak of the pleasure experienced is not quite as high as in the non-addicted brain. When an external chemical (i.e. drugs or alcohol) is added to the existing chemical properties of the addicted brain, the individual might then start to feel "okay". After feeling "okay" for maybe the first time ever, there will be an inclination to continue to feel "okay", and then to feeling good, feeling great, and then to never wanting to return to a bland existence felt prior to the introduction of the external chemical.

Kansas facts related to opioid addiction[1]

Opioid-related hospital stays

- Kansas ranks 46th out of 50 states in the rate of opioid-related hospital stays.
- Kansas reported 104.3 stays per 100,000 population; the nationwide average was 224.6.
- Kansas demonstrates the greatest *decrease* in opioid-related hospital stays across the nation: a reduction of 18% between 2009 and 2014.
- Kansas is the only state that demonstrated a substantial *decrease* in the rate of opioid-related hospital inpatient stays between 2009 and 2014.

Opioid-related ED visits

- Kansas ranks 46th out of 50 states in the rate of opioid-related ED visits.
- Kansas had 81.8 visits per 100,000 population, well below the average of 177.7.
- Kansas reported an 11.4% *increase* in its rate of opioid-related ED visits between 2009 and 2014; the national average was a 65.5% *increase.*

1 Weiss AJ (Truven Health Analytic), Elixhauser A (AHRQ), Barrett ML (M.L. Barrett, Inc.), Steiner CA (AHRQ), Bailey MK (Truven Health Analytics), O'Malley L (Truven Health Analytics). Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009–2014. HCUP Statistical Brief #219. December 2016. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.pdf.

As the brain begins to adjust to the presence of the chemical, it expects the chemical as a regular part of its makeup. The undoing of this process takes work, even by the most motivated individual. Change is challenging for anyone, especially someone with substance addiction. While motivation is necessary, it does not necessarily make recovery easier. Despite the challenge, recovery is possible and occurs for many individuals.

If we are to assist more individuals in finding their path to recovery, we must realize that addiction is greater than any one drug. Addiction is a disease of the brain, which is treatable. For any other organ in our body, we would not tell the patient not to get sick in the first place or to stop being sick. We would find the most successful way to treat the patient's illness. Research indicates the most effective treatment for substance use disorder is medication assisted treatment (MAT), outpatient addiction treatment, and ongoing recovery support.

If you missed Part 1 of this article, "The substance abuse epidemic and potential treatment," you can read it here: http://www.kammco.com/Newsletter/2017/9/Opioid-Use-Disorder-and-Addiction-Treatment.aspx For more information about MATs, including drug facts and becoming a prescriber, go to www.samhsa.gov/medication-assisted-treatment.

KaMMCO Continues to Reward Loyal Members

In 2014, the KaMMCO Board of Directors established the KaMMCO Loyalty Award to recognize members for past loyalty and to encourage commitment into the future.

It's amazing to consider that in three short years, more than 1,500 KaMMCO members have benefited with more than $3.7 million distributed in Loyalty Awards. We believe rewarding members is a sound business decision which encourages continued loyalty and member retention. In addition, it recognizes the contribution KaMMCO members have made to the financial success of their mutual insurance company.

We appreciate the loyalty our members have shown to KaMMCO and hope to continue those positive relationships moving forward.

Kansas Practice Transformation Network (PTN) Annual Learning Event Scheduled for October 18

The Kansas PTN's Annual Learning Event, hosted by Kansas Healthcare Collaborative (KHC), is scheduled for Wednesday, October 18 at Rolling Hills Zoo/Conference Center in Salina. The day-long program is available at no charge for Kansas PTN participating practices.

The event features practice transformation testimonials from Coffeyville Regional Medical Center, WesleyCare Family Medicine, and Family Health Care Clinic of Lindsborg. Keynote presentations will be delivered by nationally recognized speakers, including: Tom Evans, MD, President and CEO, Compass PTN; Justin Moore, MD, Health ICT; Patricia Meier, MD, Regional Director, Center for Medicare and Medicaid Services; and Kady Reese, MPH, CPHQ, Compass PTN. Additional presentations will feature Eric Cook-Wiens, KHC Data and Measurement Manager, and KHC's team of Quality Improvement Advisors.

All members of a practice's healthcare team eager to focus on the quality of care in their organization are welcome to attend, including providers, nurses, group practice administrators, practice managers, quality improvement managers, and information and technology support staff.

To register, visit www.khconline.org. Lunch is included in the registration. The complete agenda can be found here.

Practices not currently participating members of Kansas PTN may receive more information by contacting Rosanne Rutkowski, Program Director, at 785-235-0763 or rrutkowski@khconline.org.

The event has been approved for continuing education credits.

Unexpected Death of a Physician

By Yolanda Sims, JD, MHA
KaMMCO Loss Prevention and Risk Management Advisor

In the event of an untimely death of a physician, what is your protocol for reaching out to patients? A physician/patient relationship is personal in nature and when a physician dies, patients should receive a notice that acknowledges the physician's place in their lives. The plan for reaching out to patients after the death of a physician is similar to closing a practice. The sooner you act, the better.

Also, in some instances, there may be challenging circumstances that require a collaborative effort to help minimize disruption in the continuity of care. For example, the death of a solo practitioner may result in the local medical community or local hospital working together to refill prescriptions, schedule appointments or even help facilitate the transfer of medical records to a new treating physician. Keep in mind, this may be a difficult time for patients as they process the news and many will have questions. Reassure them their records can be transferred to a provider of their choice after you receive a signed authorization form.

Your protocol after the death of a physician should include the following steps:

- Send a brief letter to all active patients acknowledging the death of their physician. In the letter, advise patients where their medical records will be stored, how to access them and include an authorization form for patients seeking to transfer care.
- In addition, send an email message to patients whose email address you have. Include the same message you have in the printed letter. Post the same message on the practice website.
- Consider placing an advertisement in a prominent local newspaper to inform inactive patients.
- Identify peers in the medical community that are willing to assist in the event of an untimely death. This may only be necessary for a small practice or solo practitioner.
- Provide notice to The Kansas Board of Healing Arts regarding the location of patient records after the termination of active practice within 30 days as required by K.A.R. 100-24-3. This task is typically completed by the spouse or executor/administrator of the deceased physician's estate.

When the Insurance Company Says "No" to Treatment Recommendations

By Connie Dyke Christian, MBA, CPHRM
Facility Risk Management & Patient Safety Advisor

Recently a provider requested information on appropriate documentation in the patient's medical record when a pre-authorization for recommended treatment has been denied by the health insurance company. As providers you may also encounter this dilemma or one where the patient is underinsured and simply cannot afford the recommended diagnostic test, treatment, medication or procedure. There are several elements to consider when addressing this patient issue. Talking with the patient about the payment issue creates a partnership and shared decision making in moving forward and determining an alternative plan for continued care. Document the conversation and plan.

In the case of a health insurance denial, the patient may ask the provider to contact the insurance company to request an exception based on the medical necessity of the test, treatment, medication or procedure. Documentation of the conversation with the health insurance representative or a copy of written correspondence may be placed in the patient's medical record for future reference.

When the patient refuses a test, treatment, medication or procedure due to cost and an alternative at standard of care is not available, setting up payment arrangements for the recommended plan may assist the patient. In some cases, referring the patient to a safety net clinic may provide a means to the desired treatment plan. If the patient is unable or unwilling to pursue the recommended treatment options, continuing to work with the patient through an altered treatment plan and the rationale for the choices made in the plan should be documented. Discussions regarding risks and both expected and unexpected outcomes also should be included in the documentation in the patient's medical record.

Prior authorizations and sorting through payment issues is time consuming and frustrating for both the provider and patient. Working through an alternative treatment plan also can be frustrating and time consuming; however, documenting the discussions and plans may prove invaluable should they be required for future reference when care decisions may be questioned.

Sniffle or Sneeze? No Antibiotics, Please

Antibiotic resistance is one of the world's most pressing public health problems. Think you know the facts about antibiotics and antibiotic resistance? Test your knowledge by taking the CDC's quiz: http://1.usa.gov/1xan4ui

U.S. Antibiotic Awareness Week will be observed Nov. 13-19, 2017. The KDHE's Healthcare-Associated Infections and Antimicrobial Resistance Program will offer an educational webinar on antibiotic stewardship for Kansas healthcare providers on Thursday, Nov. 16, from 12 to 1 p.m. and repeated from 5:30 to 6:30 p.m. Registration information for this free learning session will be available soon. For more information, contact Bryna Stacey, director, KDHE HAI/AR Program, bryna.stacey@ks.gov or Michele Clark, program director, Kansas Healthcare Collaborative, mclark@khconline.org.

Mobile Integrated Healthcare working to reduce ER visits and hospital stays

By Toni Dixon, Director of Communications
Kansas Healthcare Collaborative

"People don't realize how important it is to know your patient, to see them in the home and to learn what the barriers are," said Tammy Church, RN. "One encounter can't tell you the whole story."

Through a 2016 grant awarded to the Cheyenne County Clinic in St. Francis, Ks, Church and the EMS director, Reid Raile, began the mobile integrated healthcare service, working with high risk patients at risk for complication or admission. Church had two goals - to help patients stay safely in their homes and to reduce the number of avoidable emergency room and hospital visits.

"There are so many barriers to care that you can identify if you visit a patient's home. But first," Church said, "you've got to earn their trust. I go in with the education, we come up with a care plan and set up a routine."

Church has worked with about 40 patients. Typically they start with frequent home visits and then transition to semi-monthly or monthly home visits. Eventually they may only require a follow-up phone call to ensure that their care plan is being followed.

Church evaluates their needs, making sure that patients understand why they are taking each medication and the way it is intended to be taken. "Medication education is such a huge piece of the pie."

However, her work to assist high risk patients goes beyond monitoring prescriptions. It may include assessment for dementia or making sure a patient understands the appropriate technique for their breathing treatments. She may be helping veterans who have trouble getting their medications or assessing a person's fall. She looks for fire alarms and carbon monoxide testers, too. "Sometimes going in with a fresh set of eyes can make a difference," she added.

Her services are valuable for patients' mental health, too. "People who don't get a lot of visitors look forward to the visit," she said.

Church also accesses other services in the community such as scheduling a housekeeper, doctor or physical therapy appointments or arranging transportation through the community van. Patients who are able to stay at home but are nearing the end of life can turn to Church for assistance in hospice care. All of these efforts reduce the need for frequent clinic or emergency room visits, as well as admissions to hospitals and long term care facilities.

Patients come to Church through provider referrals from the clinic, when discharged from the hospital or through Home Health Services. Cheyenne County Clinic offers the mobile integrated healthcare services to any patient of the clinic within the county. The clinic includes two physicians and three physician assistants. Cheyenne County Clinic has been an early partner of the Kansas Practice Transformation Network, working with Mary Monasmith, Kansas Healthcare Collaborative Quality Improvement Advisor.

"I think all the success stories brought about by this mobile integrated healthcare service are keeping costs down," Monasmith said. "It's keeping patients out of the emergency room and it is improving their health."

For example:

One diabetic patient had frequent visits to the emergency room because she didn't take her medication properly. When a fall resulted in a wound on her foot that wouldn't heal, the patient needed surgery, but had no support, no one to drive her. Church drove her to Denver for the surgery, stayed for two days, then brought her home. "They were able to save her foot."

Another positive outcome involved a patient who was seen at the clinic several times for neck pain and chronic pain medication. After a visit to the ER for pain and numbness, he was admitted to the hospital and referred for surgery. After surgery, all pain medication was discontinued. "He had been taking quite a bit of pain medication, but you can't stop cold turkey. He didn't want to be addicted, he was just trying to reduce the pain." Church consulted with the primary care physician and set up a pain management program, gradually decreasing the dosage.

The benefits of mobile integrated health include a reduction in emergency room visits and hospital stays and an improvement in patient outcomes and overall health. The grant that launched the program has expired. Church said there are enough private funds to carry on a little longer. "The program is beneficial to the people of this community. I will be sad if we can't sustain it."

New Medicare Cards Offer Greater Protection

The Centers for Medicare and Medicaid Services (CMS) recently announced a new fraud prevention initiative to help combat identity theft and safeguard taxpayer dollars that removes Social Security numbers from Medicare cards. Scheduled to begin mailing the new cards in April 2018, CMS will use a unique, randomly-assigned number called a Medicare Beneficiary Identifier (MBI), to replace the currently used Social Security Number-based Health Insurance Claim identifier. CMS has a New Medicare Card homepage linking to the latest details including How to talk to your Medicare patients about the new Medicare card.