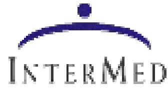


NEWSLETTER First Quarter 2003

NovaHealth is an Independent Practice Association established to ensure that participating providers have the economic freedom to focus on improving their patients' health status and to partner with patients to manage care.

2003 STRATEGIC PLAN

Tom Claffey, MD

Based upon input from the Nova Leadership Meeting in the fall, the Nova Managers (the Board of the LLC) adopted a strategic business plan for 2003. Below are highlights from the plan.

Nova continues to be an Independent Practice Association established to ensure that participating providers have the economic freedom to focus on improving their patients' health status and to partner with patients to manage care.

The vision has been expanded to include a focus on provider satisfaction. This element has been implicit in all that Nova has done, but has now been explicitly included as a key strategy.

Strategies:

- *Improve care processes in order to improve quality.*
- *Continuously improve the level of patient satisfaction and loyalty.*
- *Continuously improve the level of provider satisfaction.*
- *Enhance high healthcare value in a financially viable manner.*

Market Trends:

Market trends outlined in the report include the following:

- National health expenditures are projected to total $2.8 trillion, growing at a mean annual rate of 7.3 percent during the period 2001 – 2011.
- Health spending is expected to grow 2.5 percent per year faster than nominal gross domestic product, so that by 2011 it will constitute approximately 17.0 percent of GDP.
- In addition to increases in deductibles and co-payments, more sophisticated innovations such as tiered provider networks will be seen.
- The cost of private health insurance is increasing at an annual rate in excess of 12 percent, while individuals are paying more out of pocket and receiving fewer benefits.
- Under-use of beneficial services and overuse of medically unnecessary procedures are widespread and are estimated to cost $1,700 per employee per year.

Redesign of Care Model & Payment Mechanisms

The vast majority of the country's health care resources are spent on patients with chronic conditions, yet the delivery system consists of silos, often lacking even rudimentary capability to exchange patient information, coordinate care across settings and multiple providers and ensure continuity of care over time. However, as efforts are made to address the concerns several regulatory, payment and legal barriers are apparent.

Employers continue to define value as follows:

$$\text{Value} = \frac{\text{Quality Outcomes + Patient Satisfaction}}{\text{Cost}}$$

Creating value involves leveraging clinical, financial and human resources to optimize health status and create a positive experience for the patient. The IOM Crossing the Quality Chasm Report has increased awareness of the fact that current payment methods provide little financial reward for improvements in quality and even pose barriers to innovation.

Nova is in a unique position to:

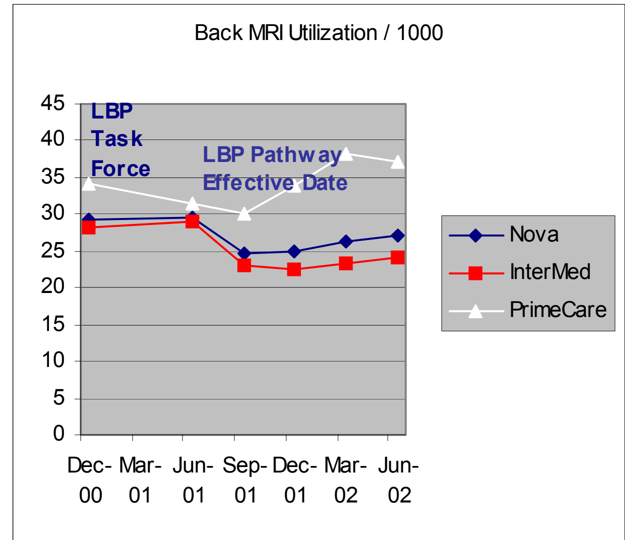
- Lead in the integration of care through the development of clinical pathways;
- Design and implement care processes that improve quality; and
- Invest in internal efficiencies.

Effective implementation will result in the delivery of a higher value to customers. Continued brokering of relationships with purchasers will result in financial reward for improved value.

If you would like a copy of the NovaHealth 2003 Strategic Business Plan, please contact Linda Sabourin (lsabourin@nova-health.org, 846-5621).

Quality Initiatives

The Task Force has reviewed the 12-month data and recommended that Update Meetings be held at each site to remind physicians and staff of the value of this project. As indicated in the graph below, the rate of back MRIs initially decreased after the education programs, adoption of the Pathway and development of patient education materials. The subsequent increase appears to be due to lack of focus on the project and the delay in distributing quarterly data.



Updated data will be distributed and a survey conducted to obtain input on the current process. The Spine Center will be participating in the updates. Please make every effort to attend one of the luncheons.

The Task Force has developed a curriculum for a group visit for patients with chronic back pain. The curriculum will track the materials developed by Margaret Caudill, MD and will be posted on the nova-health.org website shortly. If you have patients whom you feel would benefit from such a program, please contact a Task Force Member. The program is slated to begin in June of this year.

Diabetes Task Force Update

Bill Ervin, MD

CDEMS Registry Chosen

After a 9-month pilot, the Task Force has decided to use a diabetes registry utilizing CDEMS software. Practice demographic data has been imported electronically, lab data from PathLab and SMMC lab systems has been loaded and updated and an iterative approach to increasing accuracy has been outlined. The data elements have been revised to make the forms simpler and more user-friendly. The sequence of data elements has been designed to follow the logical flow of an office visit. The data from the registry will be used to establish baseline measures that will inform project focus and allow

us to measure the impact of changes. Extensive reporting tools exist within the program.

Anthem HbA1c Pilot Project

Many thanks to those who cooperated in obtaining the missing information for our Anthem HbA1c project. After receipt of information from all PCPs the baseline data relative to compliance with an annual HbA1c test for this population was:

Computer generated registry	1226
Inactive	104
Not Diabetic	98
Patients with diabetes	1024
With HbA1c	955= **93%**

Further details will be posted on our website. Feedback has indicated surprise that some of these patients were overdue for important testing and gratitude for help in identifying such needs.

Plans to Improve Care

Once all the missing HbA1c tests are obtained, we will report our baseline numbers for this population. We will be integrating elements of the chronic care model in order to help our patients outlined improve glycemic control. This data will allow patient specific follow up and will measure whether the changes in care processes are improving the HbA1c levels.

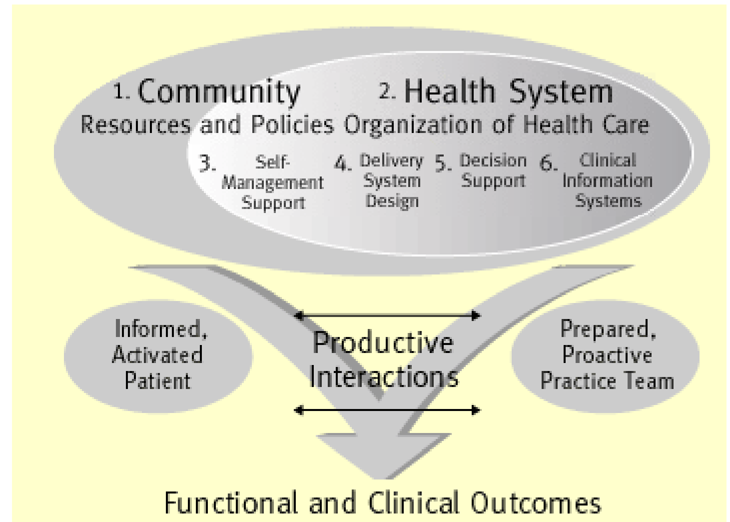
The Chronic Care Model

The Chronic Care Model has identified factors that influence interactions between patients and providers to produce better care and improved outcomes. The Task Force has designed a plan that integrates the elements outlined in the chronic care model into our diabetes project.

These elements are intended to help our practices create productive interactions between informed activated patients and prepared proactive practice teams.

1. Community Linkages: The Task Force has been in discussion with various community-based resources and continues to explore potential linkages.

Overview of the Chronic Care Model



2. The Health Care Organization: The Strategic Plan for 2003, discussed above, includes an emphasis on the Diabetes Project.

3. Self-Management Support: The DCCT and UKPDS showed that achieving glycemic control minimizes serious long-term complications. Adherence to a management plan required to maintain glycemic control, however, is difficult without an active role played by the patient, collaboration with a care team, emphasis on self-management and the involvement of the patient in problem solving. As you are aware, the majority of diabetes care is self-care.

The importance of patient education and self-management support is clear from the literature. However, as noted in Practical Psychology for Diabetes Clinicians, most physicians were trained to deliver care and not to facilitate self-care. The time constraints of a traditional office visit and communication obstacles compound the challenge.

The Task Force has design a care management model that focuses on the integration of self-management support.

4. Delivery System Design: The CDEMS registry program will provide the backbone for implementing an appointment system, follow up system, planned visits and coordination of care among providers. The Task Force has conducted research over the last nine months regarding effective care models for the treatment of patients

with diabetes. A decision has been made to retool our current workforce with knowledge of the chronic care model with an emphasis on role of self-management. We will be integrating nurse practitioners and physician assistants in a team care approach. An education program is scheduled to begin in the second quarter of 2003 and a Physician Education Program is scheduled for 6:00 PM May 14, 2002.

5. Decision Support: As you know we have partnered with EBM Solutions, to provide web based access to diabetes guidelines, patient education materials and diabetes specific self-management tools. We plan to work with EBM Solutions to develop a method of integrating patient access to such web-based tools into the current care process. The Diabetes Task Force has reviewed the EBM Solutions guidelines and materials relative to diabetes and endorsed their use within the IPA.

6. Clinical Information Support: The CDEMS registry outlined above and the process for integrating its use into the practice workflow will serve as our clinical information support.

EVERY SINGLE ONE

The project that has been researched, piloted and designed in order to improve care and distinguish our groups as delivering evidence based effective care will only succeed *if every single one of our physicians and staff* are behind this project. To date the project has received incredible enthusiasm. We ask you to join in. This is an opportunity to look beyond the very busy every day steps we take to meet the immediate needs of our patients and to improve the care we deliver.

CONTRACTING NEWS

Anthem HMO Maine Ahead of Budget in 2002

Early in 2003 we received a surplus sharing distribution from Anthem. Our actual medical expenses per member per month were below the negotiated target. The Nova Managers voted to distribute a portion of the surplus to the participating providers who have worked with us to convert evidence based medicine into changes in care processes with greater integration between specialties.

The current contract terms include a medical trend provision that compares our increase in expenditures per member per month to the increase found in a peer comparator group (i.e. patients with a primary care physician in the same geographic areas we serve). Terms are also included that support efforts and reward results in the diabetes, cardiac and back pain areas.

ADMINISTRATIVE ISSUES

Harvard Pilgrim

As of February 1, 2003 Nova has a new Harvard Provider Representative. Jan MacLeod can be reached in the Portland office at (P) 756-6341, (F) 761-0194 or jan_macleod@harvardpilgrim.org.

Anthem / BCBS of Maine

In response to our concerns regarding their lengthy, difficult to read remittances advices, as of March 11th Anthem has begun generating their EOBs twice weekly.

Effective March 21, 2003, Anthem has implemented a change to their Interactive Voice Response (IVR) system to be compliant with HIPAA privacy rules. When using the IVR to retrieve claim status, eligibility, or membership information, you will now be prompted to enter the patient's date of birth to identify your patient. The rules will also not allow them to continue to provide lists of names of the members on a contract. If you have any questions about using the IVR, please contact Provider Service at 1-800-832-6011 or 822-8181.

Cigna Healthcare

Effective March 17, 2003, participating physicians no longer need to notify CIGNA HealthCare of referrals to in-network specialty care providers.

As a result of this change:

- Participating physicians will no longer need to enter or inquire about a referral via the Provider Access Line (PAL) or via MedUnite for the following services:
  - PCP referrals to in-network specialists
  - Notification for diabetic retinal eye exams
- Notification for non-life threatening emergency room/urgent care
- Referrals to physical therapy, speech therapy and occupational therapy for the first six visits. Precertification is required after the first six visits.
- Chiropractic services for HMO members will continue to be managed in accordance with the Maine Chiropractic Mandate. For non-HMO members referrals are not required for the first six visits. Precertification is required after the first six visits.
- **Exception for notification of pregnancy:** OB/GYN physicians should continue to notify CIGNA HealthCare upon diagnosis of pregnancy, as this initiates enrollment in the CIGNA HealthCare Healthy Babies® prenatal education and support program.
- Note that providers may continue to use PAL for verification of eligibility and benefits.

Cigna has been careful to remind Providers that this change is designed to help simplify the administration of referrals and NOT to eliminate the need for managing our patients' care. PCPs and Specialists should continue to communicate pertinent referral information (diagnoses / indications, results / recommendations, etc.) and evidence of that communication should be kept either in the patient's chart or in the group's practice management system (or both). Cigna has indicated that they will conduct random and targeted chart audits in order to help ensure that the new process is followed.

Please note that there are no changes to the current precertification process. Services that require precertification must continue to be authorized by CIGNA HealthCare, including requests to refer a member to an out-of-network provider.

Also effective March 17th, the Health Services department has been shifted from NH to Pittsburg, PA. The move has reportedly resulted in some fairly significant on hold times – Cigna is aware of the problems and is working to resolve them. Until further notice, when calling Cigna for a "notification number" for MRIs, MRAs, CTs and Nuclear Cardiac Imaging studies, please continue to use 800-909-2227. The phone number and prompts will likely change in the future, details will follow.