



NEWSLETTER SECOND QUARTER 2007

Envision the care you want to deliver - let Nova help bridge the gap.

QUALITY INITIATIVES

IMPROVING HOW WE COMMUNICATE INSIDE NOVA HEALTH

Quality Metric Reporting

Nova has worked with the InterMed and PrimeCare Site Managers to develop a reporting tool that will keep the sites up to date on their performance relative to key quality metrics. We now have a Quality Performance Metrics Report (QPMR) that the sites will update monthly and report to the sites. In addition, we've developed an easy to update monthly format for PCP specific comparative data for diabetes, ischemic vascular disease and asthma to be created at the site level.

The charts will identify care teams with best practices. Others can then inquire as to how their practice differs and design processes to achieve improved results.

Contracting Updates

Nova provides contracting updates and receives feedback from the following sources:

- Nova Managers
- Nova Payer Issues Committee (comprised of business office management from Member and Participating Provider Organizations)
- Referral Management Committees
- InterMed & PrimeCare Physician Meetings
- InterMed & PrimeCare Site Leadership Meetings
- Nova CEO Meetings
- InterMed and PrimeCare Management Team Meetings

Feedback from these groups on financial and administrative issues informs the contracting strategy and negotiations. This feedback loop is important to our ability to obtain contract improvements and to continually broker profitable relationships with key payers in the market.

Strategic and Market Updates

The Nova Quarterly Newsletter is intended to provide information regarding market trends and Nova strategies. Nova leadership participates in organizations believed to be the thought leaders in the Maine Healthcare Community and remain informed on national trends. This information is summarized in the Nova Newsletter. In addition, Nova will be hosting an annual meeting in early 2008 to inspire leadership to continually look to the future of the organization and the value it delivers to the member and participating providers.

Orientation

Nova conducts a portion of the new employee orientation program at InterMed and PrimeCare each month to introduce new employees to initiatives supported by Nova. In addition, we are planning a new physician orientation for all participating providers who have joined the practices since the last orientation program.

Nova Website

The Nova website is intended to provide easy access to details regarding the quality initiatives, contracting and the vision, values and mission of the organization.

Physician Leadership Site Connection

Nova relies upon the physician leadership from the Nova board and practice site leadership presenting updates at their site meetings regarding quality, contracting and the closer link between the two on a monthly basis.

AQI SPECIALTY METRICS: OB-GYN AND CARDIOLOGY

Information regarding important quality metrics relative to OB-GYN and Cardiology has been reviewed by the sites involved. The focus of our efforts will remain on:

Cardiology

- Annual Lipid Profile
- Ace Inhibitor or ARB Therapy – CAD and diabetes and/or LVSD
- Lipid Lowering Drug Therapy

OB/GYN

- Breast Cancer Screening for women age 40-69 annual or 1 year prior
- Cervical Cancer Screening for women age 21-64 annual or 2 years prior
- Annual Chlamydia Screening for women age 18-25 who are sexually active
- Postpartum Follow Up between 21 – 56 days after delivery.

Our focus in these areas will help increase the likelihood that our patients receive evidence based preventive care. In addition, our plans are anticipated to result in high scoring on pay for performance measures such as Anthem Quality Insights (AQI). Points are earned under AQI for clinical process measures, generic drug utilization rates, technology and AQI portal usage.

For more information feel free to contact Joel Johnson at Nova by phone 846-5621 or email hjjohnson@nova-health.org



The Diabetes Registry Summary Report now includes:

At ABC Goal indicating the percent of patients with diabetes at goal for HbA1c, BP and LDL.

At Goal for 7 Process Measures indicating the percent of patients with diabetes with HbA1c, BP, LDL, Microalbumin Creatinine ratio (if patient does not have nephropathy) Eye Exam, Foot Exam, Smoking Assessment and Cessation Counseling if applicable.

NETWORK UPDATES

ORTHOPAEDIC ASSOCIATES IMPROVING CLINICAL INTEGRATION

Orthopaedic Associates (OA) has been meeting with Nova to improve clinical integration so that our mutual patients receive superior access to high quality care. We have revamped the bi-directional flow of information between the PCP office and OA and improved the courier service schedule to provide timely delivery of films. OA has also dedicated a fax number just for Nova referrals (553-7192)

Communication between network providers and improved systems results in better care and prevents redundancies.

Reminder: For Streamline Access

- Use the New Nova Form
- Include Patient Contact Info
- Include Office Contact Info



SPORTS MEDICINE CENTER NEWS

Orthopaedic Associates (OA) regrets to announce that Dr. Linc Avery is leaving OA's Sports Medicine Center. As one of our senior surgeons, he has played an important role over the past twenty years in providing high quality surgical care to our community and to athletes both locally and nationally. We wish him well in his next venture.

The OA Sports Medicine Center is the largest center within Orthopaedic Associates. A team of fellowship-trained, board certified physicians diagnose, treat and provide surgical and physical rehabilitation services for a full range of musculoskeletal injuries – from shoulders and knees to hands, wrists and ankles. The physicians and staff at the OA Sports Medicine Center would like to reassure you that we are committed to maintaining ease of access for your patients and scheduling staff. Our subspecialty trained physicians and highly skilled physician assistants will continue to manage the care of your patients already established with us. We are also committed to accommodating your new patient referrals in a timely and efficient manner while adjusting to the departure of Dr. Avery.

In addition, we will be welcoming in the fall Benjamin Huffard, MD, a fellowship trained, board-eligible physician, to OA's Sports Medicine Center. Please do

not hesitate to call our office for further assistance or to address any concerns you may have about your patients currently under the care of Dr. Avery. We look forward to continuing our partnership with you in the care of all of your patients needing Orthopaedic care. We may be reached at (207) 828-2100.

Sincerely,

Douglas W. Brown, M.D.
Thomas F. Murray, Jr., MD
Eric D. Hoffman, MD
Sports Medicine
Arthroscopic Surgery

Scott M. Benevides, PA-C
Cheryl S. DeGrandpre, PA-C
Denise D. Emple, PA-C
Brian L. Halla, PA-C
Physician Assistants

William M. Heinz, M.D.
D. Scott Marr, MD
Lucien R. Ouellette, MD
Sports Medicine

CONTRACTING NEWS



IMPROVED TERMS

Effective 7/1/07, HPHC will be rewarding our high quality with improved contracting terms. After discussions with HPHC, Nova concluded negotiations on a three year agreement with incentives tied in part to achieving quality targets. HPHC has moved to the 2007 RVUs. The current HMO/PPO membership is approximately 3,345 (2,145 InterMed; 1,200 PrimeCare). It is estimated that the PPO membership is approximately the same. An agreed upon efficiency metric will be included in the agreement effective in 2008.

COST AND QUALITY: WHAT IS THE CONNECTION?

$$\text{VALUE} = \frac{\text{Cost of Care}}{\text{Quality of Care}}$$

By Michael Albaum, MD

With health insurance premiums rising and more of our fellow Mainers going without insurance coverage, it is time for us as providers of health care services to step up efforts to address both the quality and affordability of care. Employers and payors are clamoring for 'efficiency' measures to rate health care facilities, groups, and even individual providers. The definition of 'efficiency' is a bit slippery at this time, however. Without robust and uniformly applied measures of quality, some health plans have been using the only data available to them: cost data, and using that as the measure of efficiency. Plans and employers indicate that they want to compare costs given an agreed upon level of quality for a given service. We are choosing to engage in this process to ensure that the conversation is about quality as well as cost, rather than to cede the process to health plans.

We want to be involved in the development and reporting of efficiency measures for the following reasons:

1. We have established our credentials as providers of excellent care, we improve our reputation when we also demonstrate that we are providers of cost effective care;
2. We have learned that being at the table allows us to gain useful knowledge in modifying our systems of care to achieve best practices;
3. Lastly, should we fail to favorably impact health care cost trends for our patients, those patients (and plans) will shift dollars to others who purport that they can (e.g. disease management firms, radiology prior authorization outfits, etc).

The first step is to look at the services we provide or control and ask whether we are efficient spenders of health care dollars. In several areas we can likely do better:

A. Radiological Services

Our initial effort to provide decision support for evidence based ordering focused on guidelines for use of MRI in low back pain, bone density testing, and nuclear stress tests. Although none of us like the prior authorization process the health plans impose, the state or regional data suggests that most providers don't have decision support at the point of care to determine what imaging test is most appropriate. Plans like Harvard noted a sharp decline in utilization when a prior authorization was required. I would propose that as groups that have their own imaging services, we want to assure ourselves that advanced imaging is being ordered in accordance with accepted guidelines. We should position ourselves as having internal decision support and review robust enough that we can demonstrate to the plans that there is no point in requiring prior authorizations from us; our program is more rigorous than the plans' and we will pass their criteria every time.

B. Prescribing Practices

With regard to our prescribing practices, we need to recognize that for many conditions there is no evidence that newer, more expensive, more highly marketed drugs offer any advantage over available generics. We need to acknowledge that even though the cost to the patient may be masked by a low co-payment (or level co-payment in MaineCare), that when we write for a more expensive drug where a less expensive drug is available we are wasting health care dollars. In the end, those dollars come out of patient's pockets in the form of higher premiums, or out of tax payers pockets to support ever increasing costs of MaineCare to the State.

C. Referral Process

Our patients look to us for recommendations about who to go to for consultations and procedures. We are working to obtain solid information about practice variation with respect to quality and cost in providers and facilities we refer to. We will be piloting a tool (Profsoft) that will allow us to start looking at these patterns.

These are big challenges. But as any of you who have been through your first full day of patients in the EHR can attest, we rise to big challenges.

CREATING VALUE THROUGH PHYSICIAN PRESCRIBING PATTERNS: Percent of Generic Focus

By Thomas Claffey, MD

Given the “cost / quality” connection outlined above, and the increasing emphasis on generic prescribing in health plan contracting, we are looking for clinically appropriate

ways to reduce pharmaceutical costs through the use of generic or less costly medications. Our efforts will also reduce our patients’ expenses and perhaps improve compliance, particularly when patients are on multiple drug regimens.

In the past our four most expensive classes of drugs have been:

- 1) statins
- 2) antidepressants
- 3) proton pump inhibitors; and
- 4) oral contraceptives.

We plan to design prompts in the electronic health record to help us identify appropriate generics when we prescribe. We are however being measured on this metric now by the health plans. We will in the meantime post the names of generic drugs in each of the four categories in all our exam rooms. Hopefully that will aid everyone in choosing appropriate generic medications.

NovaHealth News

Place
Stamp
Here

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