Paramount Advantage Community Resource Guide Now Available

The 2012 Paramount Advantage Community Resource Guide is available! Please call Provider Relations at 419-887-2535 to request a copy or view online at paramounthealthcare.com. Click on “Members,” then “Advantage/Medicaid,” then “Extra Services and Programs” and finally, “Community Resource Guide.”

Healthchek News

Did you know you can complete Medicaid Healthchek required services during a sick visit? Are you aware you can bill for both? Make sure you fulfill and document: a comprehensive physical exam, physical and mental health development, anticipatory guidance and order appropriate labs. Treat issues that arise and/or make referrals as necessary. For further billing information, please go to www.paramounthealthcare.com click on “Providers,” then “Publications and Resources,” then “Healthchek.” There you will find the Healthchek Coding Guide.

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Thank you to all the Paramount providers and staff who graciously assisted us with our 2012 HEDIS® medical record reviews. Your help was greatly appreciated!
Case managers work with our members to provide education regarding their specific medical/behavioral health conditions. The goal is to decrease inappropriate ER usage, decrease hospital readmissions and decrease overall costs per member by promoting proper utilization of available benefits and resources.

The Ohio Department of Jobs and Family Services (ODJFS) has mandated that each member in high-risk care management should have a minimum of one quarterly face-to-face encounter with a member of the care management team — physicians and other providers are considered an integral part of this team.

Paramount Advantage has developed a Multidisciplinary Contact Worksheet which is available on the Paramount website (providers/medical policy) to facilitate collaboration between case management and other team members, and allow face-to-face encounters to take place in various settings.

If you have a patient that is enrolled in high risk care management, you/your office may be contacted by an Advantage Case Manager with a request for input regarding the member’s care treatment plan by use of this worksheet at your next contact with the member. Your prompt attention is requested and when the worksheet is returned to Paramount, it will be used to update the member’s treatment plan. As a provider, you can also use this worksheet if additional problems and/or goals are identified. Simply fax it back to the case manager, who will again update the care plan and continue to work with our members on these various issues.

If you have any questions regarding this mandatory face-to-face contact and/or the use of the Multidisciplinary Contact Worksheet, please call Julie Hoskins, RN, CCM, manager, case management, 419-887-2220.

NCQA Accreditation

It is my pleasure to inform you of the results of the NCQA Accreditation survey that concluded in March. Paramount has again received Excellent Accreditation status for our Commercial HMO and Elite (Medicare) products. Paramount Advantage has retained Commendable Accreditation status. This survey represents the triennial portion of the accreditation process: compliance with policy, structure and operational standards weighted at 54%. Each NCQA Accredited health plan is re-evaluated annually using annual HEDIS® (33%) and CAHPS® (13%) results. The Healthcare Effectiveness Data and Information Set measures outcomes of healthcare and utilization. The Consumer Assessment of Healthcare Providers and Systems assesses member satisfaction. The Medical Advisory Council and staff will review this year’s HEDIS® and CAHPS® rates when they are available in late summer, incorporating them into Paramount’s work plans for 2013.
CLINICAL PRACTICE GUIDELINES AND QUALITY REPORTS

The Clinical Guidelines for Physicians can be reviewed and printed by physicians and physician offices from the Paramount website. These guidelines are evidence-based and intended for use as a guide in caring for Paramount members. The Paramount Medical Advisory Council reviews and approves each guideline annually. The guidelines are adopted from various nationally recognized sources. The guidelines will not cover every clinical situation and are not intended to replace clinical judgement.

The following guidelines have been reviewed and approved by the Medical Advisory Council as of May 8, 2012:

- **The American Diabetes Association Position Statement: Standards of Medical Care in Diabetes-2012.** Summary of Revisions for the 2012 Clinical Practice Recommendations; and Executive Summary: Standards of Medical Care in Diabetes-2012 are available on Paramount’s website as well as the American Diabetes Association Position Statement: Standards of Medical Care in Diabetes-2012. For convenience, the Evidence for Changes in Recommendations for Medical Care in Diabetes - 2012 were also added. One new recommendation is that the CDC recommends administering the hepatitis B vaccination to adults with diabetes.

- **Immunization Guideline 0 — 6 years and 7 — 18 years** - This guideline is taken from the Centers for Disease Control and Prevention 2012 Recommended Immunization Schedule and approved by The Advisory Committee of Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP).

- **Pediatric Alcohol Guideline** - In September 2011, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) released Alcohol Screening and Brief Intervention for Youth; A Practitioner’s Guide along with A Pocket Guide for Alcohol Screening and Brief Intervention for Youth. The guide encourages practitioners to screen the adolescent population for personal use and also the individual’s friends/peer group use.

- **NCEP Guideline** - This guideline is based on The National Heart, Lung, and Blood Institute’s (NHLBI) National Cholesterol Education Program (NCEP) guidelines on the prevention and management of high cholesterol in adults (ATP III). National Cholesterol Education Program’s ATP III Guidelines At-A-Glance Quick Desk Reference is available online. The next expected update is scheduled for release later in 2012.

Also on Paramount’s website, you can find the Commercial, Advantage and Elite Quality Reports. The Quality Report contains results for the HEDIS® Effectiveness of Care measures as well as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey for members. To help us know how we are doing, Paramount reports information about the care, treatments and satisfaction levels of our members through a few key mechanisms. These mechanisms include HEDIS® and CAHPS®. The Commercial and Elite reports highlight some programs and interventions that have helped to improve rates. These reports also show Paramount’s rate as compared to the National Committee for Quality Assurance (NCQA) accreditation benchmarks in clinical care and member satisfaction. Go to www.paramounthealthcare.com, scroll down to the bottom of the homepage and find Quality Reports under Paramount in the gray area.

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).*  
*CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).*
Decision Memo for Intensive Behavioral Therapy for Obesity (CAG-00423N)
A new benefit for Paramount Elite Members

The Centers for Medicare and Medicaid Services (CMS) has determined the following:

The evidence is adequate to conclude that intensive behavioral therapy for obesity, defined as a body mass index (BMI) ≥ 30 kg/m², is reasonable and necessary for the prevention or early detection of illness or disability and is appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Medicare Part B and is recommended with a grade of A or B by the U.S. Preventive Services Task Force (USPSTF).

Intensive behavioral therapy for obesity consists of the following:

1. Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed in kg/m²);
2. Dietary (nutritional) assessment; and
3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

The intensive behavioral intervention for obesity should be consistent with the 5-A framework that has been highlighted by the USPSTF:

1. **Assess**: Ask about/assess behavioral health risk(s) and factors that may affect the choice of behavior change goals/methods.
2. **Advise**: Give clear, specific and personalized behavior change advice, including information about personal health harms and benefits.
3. **Agree**: Collaboratively select appropriate treatment goals and methods based on the patient’s interest in and willingness to change the behavior.
4. **Assist**: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
5. **Arrange**: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

For Medicare beneficiaries with obesity, who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting, CMS covers:

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for the second month through the sixth month;
- One face-to-face visit every month for the seventh month through one year, if the beneficiary meets the 3kg weight loss requirement.
For the purposes of this decision memorandum, a primary care setting is defined as one in which there is provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition.

For the purposes of this decision memorandum a “primary care physician” and “primary care practitioner” will be defined consistent with existing sections of the Social Security Act (§1833(u)(6), §1833(x)(2)(A)(i)(I) and §1833(x)(2)(A)(i)(II)).

§1833(u)
(6) Physician Defined.—For purposes of this paragraph, the term “physician” means a physician described in section 1861(r)(1) and the term “primary care physician” means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

§1833(x)(2)(A)
Primary care practitioner—The term “primary care practitioner” means an individual—
(i) who—
(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or
(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)).

While this benefit is limited to primary care practitioners and primary care settings, it does not preclude primary care practitioners from screening beneficiaries for obesity and referring those who screen positive with a BMI $\geq$ 30 kg/m² to other practitioners and/or settings for intensive multicomponent counseling; however, coverage remains only in the primary care setting.

Further information regarding the National Coverage Analysis (NCA) may be found at: http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAAIAAAA&NCAId=253&
Physician and office manager satisfaction surveys are performed in alternate years. The 2011 Physician Satisfaction Survey was conducted by DSS Research of Fort Worth, Texas to assess satisfaction of PCPs and specialists with the service they receive from Paramount. The survey began November 2011 and concluded in late January 2012.

Paramount views both surveys as critical to its long-term success and thus carefully reviews the results and establishes action plans for improvement where appropriate. The response rate for 2011 was 32.5% (610 surveys completed).

Results
Overall satisfaction with Paramount increased to 95.8% from 91.3% in 2009.

Plan Loyalty - Significantly more PCPs than specialists indicate satisfaction (PCPs 97.6% / Specialists 94.7%). Additionally, significantly more physicians would definitely recommend Paramount to patients and strongly agree that they see their relationship with the plan continuing on a long-term basis.

Quality of Care - improvement was seen in ALL measures.

- 98.2% agree that Paramount considers safety when adopting new technology or publishing guidelines (89.0% in 2009).
- 97.8% agree that Paramount implements programs that improve the health status of patients (89.7% in 2009).
- 96.0% agree that Paramount implements programs that encourage quality of care (91.8% in 2009).
- 90.2% agree that Paramount provides a venue for them to provide input or ask questions (79.8% in 2009).
- 89.1% agree that Paramount communicates guideline or procedural changes clearly and timely (84.7% in 2009).

Prior Authorization Process -
70.9% have requested prior authorization on elective imaging, of those:

- 83.6% found the process straightforward (76.2% in 2009)
- 94.7% were provided a verbal or fax response in 5 working days (same in 2009)
- 79.9% were provided alternatives, if denied (72.1% in 2009)
- 79.9% who appealed, were satisfied with the timeliness of process (72.9% in 2009)

46.7% have requested an authorization to an out-of-network specialist or out-of-network admission, of those:

- 86.7% found the process straightforward (74.5% in 2009)
- 95.9% were provided a verbal or fax response in 5 working days (88.5% in 2009)
- 92.6% were provided alternatives, if denied (88.1% in 2009)
- 80.4% who appealed, were satisfied with the timeliness of the process (72.3% in 2009)

83.6% agree that the list of services requiring prior authorization is available. (82.7% in 2009)
85.5% agree that Paramount’s UM decision making is fair and consistent. (76.5% in 2009)
Web-based prior authorization submission tool - 25.6% have used and 90.7% found easy to use.

Specialist Referral Elimination in 2011 (asked only of PCPs) - 90.7% feel their patients continue to discuss their desire/intent to see specialists without the referral requirement. 85.7% feel they are receiving communication at the same level as they did from specialists prior to the change.

Overall Utilization Management - significantly more physicians indicated that the Paramount UM process has improved in the last 12 months.
Case Management (CM) - 53.6% are aware of the program.
- significantly more PCPs (72.3%) than specialists (41.5%), less than in 2009, 57.2%.
- 63.8% have worked with a case manager on behalf of one of their patients (64.5% in 2009)
- 95.9% indicate that their experience has been positive (87.5% in 2009)
- 90.0% agree that CM has been helpful to assist in coordinating needed medical services (91.7% in 2009)
- 84.3% agree that CM helps to reduce unplanned hospital admissions and inappropriate ER use (76.1% in 2009)
- 83.2% agree that patients enrolled in CM have a better understanding of their health condition and self management skills (78.4% in 2009)

Disease Management -
- 84.1% awareness of Chronic Disease Management Programs (73.3% 2009)
- 84.9% agree that programs provide support to them and their patients (83.0% in 2009)

Prescription Drug Program - Awareness of and satisfaction with the prescription drug program increased significantly this year.
- 87.8% are satisfied with their ability to access information about the program (69.6% in 2009)
- 86.9% agree that the program controls costs for the health plan and the patient (76.8% in 2009)
- 81.0% are satisfied with the non-formulary medication exception process (59.3% in 2009)
- 79.8% are satisfied with the clinical quality of the preferred drug list (69.5% in 2009)
- 72.6% are aware that as of 10/1/2011 Paramount resumed handling the prescription drug program for Ohio Medicaid participants rather than the State of Ohio Medicaid.

Coordination of Care - Satisfaction with communication to support coordination of patient care increased significantly for many specialties. Psychiatry and Other Behavioral Health Practitioners are least likely to communicate with PCPs followed by OB/GYN.

Medical Directors - overall satisfaction 90.9% (87.4% in 2009), trendable measures significantly improved
- Accessibility by phone 89.3% (87.3 % in 2009)
- Knowledge - 89.9% (87.9% in 2009)

Utilization Management (UM) Nurses - overall satisfaction with UM nurses 88.5% (88.8% in 2009)
- Accessibility by Phone 90.7% (91.9% in 2009)
- Knowledge 87.0% (86.3% in 2009)

Internet and Technology - 60.1% are aware of the Provider Direct interactive website (67.8% in 2009)
- 37.4% aware Paramount launched an upgraded internet website September 2011, of those:
  - 96.2% found the website user friendly in information and content
  - 79.2% encourage staff to access websites to assist them efficiently manage their practice.
  - Significantly more Specialists (83.0%) / PCPs (72.5%)
- More physicians indicate the availability of electronic services for patients especially e-prescribing at 64.9% (36.2% in 2009)
  - More (27.7%) are offering e-appointments (16.5% in 2009)

The survey indicated that efforts to increase provider satisfaction should focus on the following:
- UM nurse facilitation of appeals
- UM nurse being easier to reach
- UM nurse responding more timely
- UM nurse providing more knowledgeable responses

Thank you to those who completed the survey!

Please note: All references to statistical significance are reliable at \( p \leq 0.05 \).
Patient-Clinician Communication: Basic Principles and Expectations

One of the most common reasons that Paramount members report concerns about quality of care is miscommunication. From the Institute of Medicine’s discussion paper *Patient-Clinician Communication: Basic Principles and Expectations*, the following concepts are intended to promote patient-centered clinical encounters.

**Expectations**

1. Mutual respect
   - Each patient (or agent) and clinician engaged as full decision-making partners
   - Respect for the special insights that each brings to solving the problem at hand
2. Harmonized goals
   - Common understanding of and agreement on the care plan
3. A supportive environment
   - A nurturing and secure services environment
   - A nurturing and secure decision climate
4. Appropriate decision partners
   - Clinicians, or clinician teams, with skills appropriate to patient circumstances
   - Assurances of competence and understanding by patient or agent of the patient
5. The right information
   - Best available evidence at hand, choices and trade-offs thoroughly discussed
   - Presentation by patient of relevant perceptions, symptoms, personal practices
6. Transparency and full disclosure
   - Candid and explicit acknowledgement to patient of limits in science and system
   - Patient openness to clinician on all relevant circumstances, preferences, medical history
7. Continuous learning
   - Effective approach established for regular feedback on progress
   - Established periodicity for course assessment and alteration as necessary