

# THE INSIDE STORY

## Introducing Your Provider Relations Representatives

### Mary Dean

Please welcome Mary Dean to Scott & White Health Plan (SWHP). Mary joined SWHP in November, 2010, as our new Contract Manager. Mary came to SWHP from Amerigroup Corporation of America in Austin and has many years experience in network management and development with companies such as Blue Cross Blue Shield, Aetna, and One Health Plan of Texas. Mary is also the Provider Relations Representative for Scott & White and also providers in the Austin and Bryan/ College Station area which include Llano, Burnet, Bastrop, and Brenham. She is eager to get to know you and assist with any questions you may have. She can be contacted at 254-298-3413 or [madean@swmail.sw.org](mailto:madean@swmail.sw.org).



### Dan Wiley

Dan is a veteran of Scott & White (SW) and Scott & White Health Plan (SWHP). He has been with the organizations for more than 35 years, most recently with Provider Relations since 2005. Dan is our Provider Relations Representative for the Waco and Temple area which includes Glen Rose, Hamilton, Clifton, Hillsboro, Gatesville, Waco, Temple and Killeen. Dan also represents our providers in the West Texas region which includes San Angelo and also the East Texas region which includes Tyler and Palestine. Dan can be reached at 254-298-3343 or [dwiley@swmail.sw.org](mailto:dwiley@swmail.sw.org).



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# Medical Director's Corner



*Dr. Marylou Buyse, Chief Medical Director, SWHP*

## FRIDAY FOCUS: HEDIS® Update: Asthma – Use of appropriate medications

This HEDIS measure reports the percentage of members 5-50 years of age who are identified as having **persistent asthma** and who were appropriately prescribed medication during the measurement year. In addition to being an important clinical concern, asthma management affords a significant opportunity for improvement at Scott and White as we scored in the 10th percentile last year. Our goal is to score in the 90th percentile.

The HEDIS methodology is complex for this measure, but here are the basics: Persistent asthma is defined as one of the following in the measurement year:

1. At least 1 **ED** or **inpatient** episode with asthma as the principle diagnosis.
2. 4 or more **outpatient** visits for asthma and 2 asthma prescriptions dispensed.
3. 4 **prescriptions** for asthma medication in one year.

To be compliant in the methodology, at least one prescription per year for an appropriate maintenance medicine must be dispensed for a patient with persistent asthma. These medicines include inhaled corticosteroids or steroid combinations, leukotriene modifiers, mast cell stabilizers, methylxanthines, or an antibody inhibitor.

This measure is based on the NAEPP guidelines which may be found here:  
[http://www.nhlbi.nih.gov/guidelines/asthma/gip\\_rpt.pdf](http://www.nhlbi.nih.gov/guidelines/asthma/gip_rpt.pdf)

While the guidelines are widely accepted by clinicians, the application proves difficult for many reasons. Patient education, helpful refill protocols, the use of medical teams, and efforts to overcome prescription financial barriers are some ways we can move the bar on this measure. As always, your ideas and feedback are appreciated.

Thanks for reading and for the quality work you do. All Friday Focus editions may be found at the SWHP website: <http://www.swhp.org/homepage/providers/fridayfocus>

Regards;

A handwritten signature in black ink that reads "M. Averitt D.O.".

**Mike Averitt, D.O.**  
**Scott & White Health Plan Medical Director**

## FRIDAY FOCUS: Teen Obesity: The next wave of a growing epidemic.

We all know many of us are overweight or obese. The causes of this are multi-factorial and the cure is easy to say and hard to do: diet and exercise; less of the first and more of the second.

This weeks' study in JAMA should alert all of us who care for (or have) overweight teens. A study showed that overweight teens are likely to become morbidly obese by age 30. Teens of both genders gain significant weight in their twenties with 51% of girls and 37% of boys becoming morbidly obese by age 30. An earlier study in 2005 showed significantly likely shortened life spans for today's overweight youth, about 2-5 years less life expectancy than their parents.

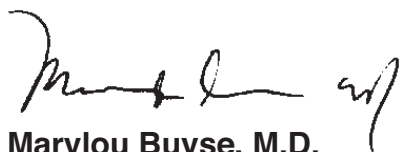
As physicians and good clinicians we know individuals with obesity and morbid obesity tend to develop hypertension and diabetes, as well as early cardiovascular disease.

What can you do now? Identify by BMI high risk teens and intervene. Follow their BMI's over time and intervene more intensively if BMI's continue to increase. Engage and educate overweight teens and suggest diet and exercise programs that will fit into their life. Nutrition counseling may be helpful as may organized physical activities. Reducing high calorie soft drinks such as soda and juice can be very helpful as can learning about healthier alternative food choices. Your nurses can assist you in this education and you play a critical role in identification, evaluation, promoting education and following results.

While Scott and White Health Plan have resources to assist you in these interventions, so do others. Let us know here at the health plan if there are informational resources or other ways we can assist you. We are both as a society and as a profession about to see another wave of obesity epidemic. This is a true epidemic; it is spreading quickly and is killing our patients. The time to act is now – we have a generation to save!!

**NOTICE:** Scott & White Health Plan (SWHP) would like to announce that Belton ISD has selected SWHP as their health benefits carrier beginning December 1, 2010. Belton ISD employees should provide their new SWHP member card at the time of service on or after December 1, 2010. Please notify your front desk and billing departments of this important change.

**Regards;**



**Marylou Buyse, M.D.**

**Scott & White Health Plan Chief Medical Director**

## FRIDAY FOCUS: HEDIS® Update: Hospital Readmissions

Plan All-Cause Readmissions - This will be a new measure for 2011 which will attempt to quantify potentially preventable readmissions. It will calculate the percentage of acute inpatient stays during the measurement year that are followed by an acute readmission, for any diagnosis, within 30 days for members  $\geq 18$  (excluding pregnancy). This value will be compared to a calculated average adjusted probability of readmission based upon severity of illness and co-morbidities.

In 2005, the 30-day hospital readmission rate for Medicare patients ranged from 14% to 22% in different areas of the country. Hospital discharge represents a critical transition point in a patient's care. It has been shown that initiatives to improve communication with patients and their caregivers, coordinate care post discharge, and improve the quality of care during the initial admission can avert many readmissions. NCQA suggests that readmissions associated with CHF, COPD, and CABG may offer the greatest potential for improvement.

We look forward to establishing our baseline during 2011 and working with you to avoid unnecessary readmissions for you and your patients. As always, thank you for the care you provide your patients and please call or e-mail with any questions. [SWHP Friday FOCUS homepage](#)

Regards;



**Scott Simpson, MD**  
**Scott & White Health Plan Medical Director**

## FRIDAY FOCUS: HEDIS® Update: URI and Bronchitis

With the cough and cold season upon us, this seemed a good time to discuss appropriate use of antibiotics for respiratory infections. Since the topics are similar, I have chosen to combine these two HEDIS® measures in this edition of the Friday Focus. The bronchitis measure is for patients age 18-64 while the URI measure is for patients 3 months – 18 years of age. In order to be compliant, an eligible patient diagnosed with acute bronchitis (466.0) or URI (465, 460) should not receive an antibiotic on or within 3 days of the diagnosis. There are exclusions for many coexisting diagnoses such as otitis media, sinusitis, impetigo, etc.

There are many existing guidelines that support withholding antibiotics for viral infections. Two of the references used by HEDIS® can be found here:

<http://pediatrics.aappublications.org/cgi/content/full/101/1/S1/181?ijkey=HlzGHlkB0sMNk&keytype=ref&siteid=pediatrics> and  
[http://www.wsma.org/files/Downloads/WSMERF/Acute\\_Bronchitis\\_08.pdf](http://www.wsma.org/files/Downloads/WSMERF/Acute_Bronchitis_08.pdf)

There are many recognized problems with the unnecessary use of antibiotics for viral syndromes including potential drug side effects, inducement of antibiotic resistance, and needless expense. It is important to understand that the use of the above two diagnoses defines a viral infection in HEDIS® methodology. Last year, Scott and White scored in the bottom 10th percentile nationally on each of these measures. This likely reflects a poor understanding of the meaning of these codes. There are two simple keys to improving our score in this area: (1) Don't prescribe antibiotics for viral infections and (2) when in your clinical judgment an antibiotic is warranted, appropriately code for a bacterial infection.

Thank you for taking time to read this and for the quality work you do. Every edition of Friday Focus may be found at the SWHP website:

<http://www.swhp.org/homepage/providers/fridayfocus>

Regards;



**Mike Averitt, D.O.**  
**Scott & White Health Plan Medical Director**

## FRIDAY FOCUS: HEDIS® Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

Rheumatoid arthritis is a debilitating condition affecting 2.5 million Americans. Evidence-based guidelines from the American College of Rheumatology support early treatment with DMARDs (disease modifying anti-rheumatic drugs). The majority of patients with rheumatoid arthritis should be started on a DMARD within 3 months of diagnosis. The goals for rheumatoid arthritis therapy are to prevent or delay joint destruction, relieve pain and maintain functional abilities.

No single test “confirms” the diagnosis of RA. Clinical symptoms, history, physical exam, laboratory and radiology findings are all reviewed to evaluate the patient. Some common laboratory findings are anemia, anti-CCP, elevated sedimentation rate and RF (although it is only positive in 30% of patients at initial diagnosis). Clinically, patients often notice bilateral pain, stiffness and swelling of the joints, worse at the beginning of the day; as well as fatigue. Early on, X-rays are often normal, but can help evaluate disease progression.

This HEDIS measure is for patients 18 years of age and older who were diagnosed with rheumatoid arthritis and dispensed one ambulatory prescription of a DMARD (example of a frequently used tier A formulary DMARD is methotrexate). The goal is 2 physician visits in an 11 month span to follow up on treatment.

Impressively, Scott and White scored in the 90th percentile on this measure in 2009. There was a slight slip in 2010, but with a little improvement we can be back to our goal of 90th percentile for 2011.

As always, your ideas and feedback are appreciated. Thanks for reading and for the quality work you do. All Friday Focus editions may be found at <http://www.swhp.org/homepage/providers/fridayfocus>



Beverly Grimshaw, MD  
SWHP Medical Director

## FRIDAY FOCUS: In honor of this month of valentines and hearts, we will look at HEDIS® cardiovascular measures.

### HEDIS® Update: Cholesterol Management for Patients with Cardiovascular Conditions

This HEDIS measure is for patients 18-75 years of age who were **diagnosed with an acute cardiovascular event** within the previous 2 years (**including PTCA, CABG or AMI**) or **ischemic vascular disease** on either an inpatient stay or outpatient visit.

The defined measurement is **LDL-C <100 mg/dL on a lab test**. If LDL-C testing is missing, or level is = or >100 mg/dL, HEDIS views that as not compliant.

Monitoring of LDL with a goal of <100mg/dL can decrease build-up of plaque reducing risk of cardiovascular events, and morbidity and mortality by as much as 40%. These guidelines are based on the National Cholesterol Education Program (NCEP) and [www.nhlbi.nih.gov](http://www.nhlbi.nih.gov).

To lower your patients' LDL recommend avoidance of trans fats and saturated fats in the diet (DASH, Ornish or Mediterranean diets are good) and increase dietary fiber. Encourage exercise and weight loss (even a 10-20 pound decrease can help). Lifestyle changes may lower LDL by 20%, but many patients will require medication which can lower LDL by 20-60% depending on the dose.

Last year, Scott and White scored **above the 50th** percentile on these measures, which is good, but we would **love** to do better. Our goal is to score at or above the **90th** percentile. A potential strategy for improvement may be to include LDL measurements in our refill protocols.

As always, your ideas and feedback are appreciated.

Thanks for reading and for the quality work you do. All FRIDAY FOCUS editions may be found at <http://www.swhp.org/homepage/providers/fridayfocus>



Beverly Grimshaw, MD  
SWHP Medical Director

## FRIDAY FOCUS: Can We Help You with Patient Engagement and Save You Time?

We believe we can, so please try our new VitalCare Health Coach programs and let us know what you think. We communicated with you late last fall about our new partnership with Health Dialog, an innovative company specializing in decision support and clinical guidance for patients. We have completed our transition, member notification, and are now looking forward to your referrals and feedback.

Health Dialog is now responsible for our 24/7 Nurse Advice line, all of our Disease Management programs\*, and a new decision support program.\* The Disease Management programs provide telephonic, nurse-based, clinical support for most chronic conditions. Health Dialog's nurses are experienced clinicians with expertise in their particular clinical area and behavior change techniques. They provide ongoing, whole person engagement, education, and guidance in support of your plan of care. Their goal is to aide your patient and/or their family in achieving as great a degree of confident self management as reasonably possible. They are available 24/7, 365 days a year, and each patient has an individual nurse.

The decision support program (Shared Decision-Making) provides telephonic clinician and interactive web based assistance to help patients explore their options in clinical situations where one option has not been proven superior to others (e.g. the management of non-metastatic prostate cancer). Current evidence-based information is shared in a non-biased and multiple format fashion that promotes a realistic consideration of the various pros and cons and individual preferences. Each of the thoroughly researched modules was developed by the non-profit Foundation for Informed Medical Decision Making, whose work is based on the research of John Wennberg in practice variation and preference sensitive care. The web-based material is only available through personal sign on via the SWHP web site. Please sign on as a member today via Scott & White Health Plan/MyPlan/My Health Tools & Resources/Health Crossroads and explore the content relative to your practice.

Our intent is to save you time by providing trusted support toward a better informed, more engaged, and self adherent patient population; who will in turn experience better outcomes and greater satisfaction. Please give us a try and let us know what you like and don't like.

VitalCare Health Coach Telephonic Referral - 1 877 505-7947 (you, your staff, or patient)

VitalCare Health Coach Fax Referral - 1 866 936-3045

VitalCare Physician Referral Fax Forms ..... [Shared Decision Making Referral Form](#)  
..... [Shared Decision Making RX/ Checklist Pad](#)

Friday Focus site ..... <http://www.swhp.org/homepage/providers/fridayfocus>.

Thank you for our consideration.



Scott Simpson, MD  
Scott & White Health Plan Medical Director

\* Not applicable to Senior Care



## FRIDAY FOCUS: HEDIS® Update: Persistence of Beta-Blocker Treatment after a Heart Attack

Beta-blockers after an AMI decrease the risk of a second event, and all-cause mortality, by 20-30%. Studies, and probably your personal experience, show that adherence to beta-blockers declines significantly during the first year of treatment. The ACC/AHA guidelines indicate that unless it is contraindicated, patients should continue beta-blocker therapy indefinitely, [www.acc.org](http://www.acc.org).

This HEDIS measure is for patients 18 years of age and older who were hospitalized for an inpatient stay with the diagnosis of acute myocardial infarction (AMI, 410.x1).

The defined measurement is persistent use of a beta-blocker for 6 months after discharge. Persistence in this case is defined as continuous use of the medication for at least 75% of the days in the first 6 months following discharge. This is an administrative measure, so only claims information is used to track compliance. Internal studies at SW Memorial show that virtually all patients are discharged with a prescription for a beta-blocker after MI. The poor HEDIS® scores largely are a result of either the patient not filling the prescription at a network pharmacy, or the drug appropriately being discontinued due to an adverse event or contraindication.

In order to address the former, SWHP is working on strategies to encourage the use of network pharmacies. Providers can help by writing for a 90 day supply with appropriate refills. Regarding the latter, it is important to code for, not just document, the diagnosis used to discontinue a beta-blocker. Appropriate codes for exclusion are those for asthma, hypotension, heart block > 1st degree, sinus bradycardia, and COPD.

Last year, Scott and White scored just above the 10th percentile on this measure. Our goal is to score at or above the 90th percentile. As always, your ideas and feedback are appreciated.

Thanks for reading and for the quality of work you do. All Friday Focus editions may be found at the SWHP website: <http://www.swhp.org/homepage/providers/fridayfocus>.

*Bleums*

Beverly Grimshaw, MD  
SWHP Medical Director



## FRIDAY FOCUS: How to Pick the Best Imaging Study for the Patient

The Scott and White Health Plan and the Scott and White Department of Radiology have partnered to provide a new telephone consult service for clinicians. We are pleased to announce that the service is now operational on a 24/7 basis.

By calling **254-724-1728 (4-1728 within the SW system)**, the clinician may speak directly to a **radiologist** regarding the best exam for a given clinical situation. With rapid advancements in imaging technology and public concerns about radiation safety, having convenient, rapid access to a radiologist can help us choose the most appropriate modality for our clinical concern, decrease the need for additional testing, and improve the service we give our patients.

Please understand that this **phone number is only to be used for provider to provider consultation**. It cannot be used for scheduling or other logistical issues. Also note that it does not replace the radiology listen line or the stat read line currently in place.

As always, we welcome your questions and comments and we hope you find this new initiative convenient and helpful. Thank you for taking the time to read this and for your consideration of the topic. This and every edition of Friday Focus is available at: <http://www.swhp.org/homepage/providers/fridayfocus>. Your questions or comments are always welcome and appreciated. Thank you for all you do to deliver the highest quality healthcare.

Regards;

A handwritten signature in black ink that reads "M. Averitt D.O.".

**Mike Averitt, D.O.**

**Scott & White Health Plan Medical Director**



## FRIDAY FOCUS: Psychiatry Update-Access to Alcohol and Drug Dependency Program

The National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimated that the economic cost of alcohol and drug abuse was \$246 billion in 1992 or \$962 for every person living in the US then. Furthermore, co-occurring psychiatric and medical conditions are common with substance use disorders and often profoundly complicate medical management.

In response, the Scott and White Department of Psychiatry offers intensive outpatient treatment of substance use disorders. The Alcohol and Drug Dependency Treatment Program (ADDTP) offers both a day program for Senior Care/Medicare patients and an evening program generally reserved for non-Medicare patients. ADDTP will evaluate the patient within 1-2 weeks of referral and often can start the patient in the program the same week. Same day urgent cases may be accommodated on a case by case basis. To access the program, simply send the referral to ADDTP, attention Hallie Brown.

Thanks for reading and for becoming aware of this easily accessible and important resource for our patients. This and every edition of Friday Focus is available at <http://www.swhp.org/homepage/providers/fridayfocus>. Your questions or comments are always welcome and appreciated. Thank you for all you do to deliver the highest quality healthcare.

Regards;

Craig Franke, M.D.



## **FRIDAY FOCUS: HEDIS® Update: Controlling High Blood Pressure**

Approximately 50 million Americans have high blood pressure. Aggressive control of this condition dramatically reduces mortality from heart disease, stroke and renal failure, especially in elderly hypertensive patients.

This HEDIS measure is for patients 18-85 years of age who were diagnosed with hypertension. The guidelines were based on JNC (Joint National Committee) recommendations and American College of Cardiology at [www.acc.org](http://www.acc.org).

In order to be compliant for the measure, the last blood pressure recorded in the chart in the measurement year must be less than 140/90. A separate measure for diabetics requires a blood pressure less than 130/80. In charts with more than one BP measurement at a given visit, the lowest recorded one will be used. If no BP is recorded, HEDIS® will assume “not controlled” and list as noncompliant.

Important keys to lowering blood pressure include reminding the patient of dietary, lifestyle and exercise changes, as well as the appropriate use of medications.

Last year, Scott and White scored above the 25th percentile on these measures. Our goal is to score at or above the 90th percentile. As always, your ideas and feedback are appreciated.

Thanks for reading and for the quality of work you do. All Friday Focus editions may be found at the SWHP website: <http://www.swhp.org/homepage/providers/fridayfocus>.

Regards;

**Beverly Grimshaw, MD**  
**Scott & White Health Plan Medical Director**



## FRIDAY FOCUS: HEDIS® Update: Comprehensive Diabetes Care

Diabetes is a highly prevalent and costly disease. Almost 21 million Americans have the disease, many are undiagnosed. Complications can be devastating, expensive and even fatal. SWHP offers Health Coaching via VitalCare which can help educate and support your patients in their quest for better medical compliance. Patients can access a Health Coach at 1-877-505-7947. There is NO COST to the patient.

Diabetes is a complex illness affecting multiple organs and the HEDIS® measure is likewise complex and reviews 10 different rates to determine how well diabetes is managed. This composite measure looks at the percentage of patients with diabetes (types 1 and 2) aged 18-75 years who meet the following criteria.

- Presence of a HbA1c test in past year
- HbA1c > 9.0% (poor control)
- HbA1c < 8.0% (controlled)
- HbA1c < 7.0% (for a selected patient population\*)
- Presence of a retinal eye exam in past year (by ophthalmologist or optometrist)
- LDL-C screening test
- LDL-C level < 100mg/dL
- Presence of monitoring for renal disease (ex. microalbumin test)
- Blood pressure < 140/90
- Blood pressure < 130/80

The results come from both claims/encounter data, and medical record review. In the event of multiple results (as with BP measurements or HbA1c) only the most recent is used for the HEDIS® criteria. It is also important to document dilated eye exams that may have occurred with other providers, preferably by scanning into the EMR, or by documenting date AND result of the exam in the clinic note. Since this is a hybrid measure, chart review is utilized in determining compliance.

\*Because of safety concerns related to aggressive HbA1c management in certain patients this criterion excludes patients aged 65 and over, and fragile patients with certain comorbid conditions such as ASCVD, CHF, prior MI, CKD/ESRD, dementia, blindness or amputation.

Last year, most of our Scott and White rates were in the 25-50th percentile on these measures, but an impressive rate of greater than the 75th percentile in the control of LDL-C below 100mg/dL was achieved. Our goal is to score at or above the 90th percentile in every measure.

As always, your ideas and feedback are appreciated. Thanks for reading and for the quality work you do. All Friday Focus editions may be found at the SWHP website: <http://www.swhp.org/homepage/providers/fridayfocus>. Your questions or comments are always welcome and appreciated. Thank you for all you do to deliver the highest quality healthcare.

Regards;

**Beverly Grimshaw**  
Scott & White Health Plan Medical Director



## FRIDAY FOCUS: What is NCQA/HEDIS®?

NCQA is an acronym for National Committee for Quality Assurance. NCQA is a not-for-profit organization founded in 1990 with a goal of improving national health care. The mission statement is “to improve the quality of health care” and the vision is “to transform health care quality through measurement, transparency and accountability.”

HEDIS stands for Healthcare Effectiveness Data and Information Set. It is a tool used by NCQA to measure performance in several areas of service and care for the healthcare field. Through Friday Focus we have shared many of these areas with you. HEDIS reviews 75 measures of performance which are very specifically defined so that accurate comparisons can be made between different groups. More than 90% of health plans participate in these quality measures, and the measures can be used to help determine which areas need focus. HEDIS measures are reevaluated at least every 3 years to determine their usefulness and retired if the measure no longer adds value to the system.

There are 3 ways in which data is collected for HEDIS measures: administrative/ supplemental, hybrid and survey data. Administrative reviews are done via claims and codes only. Supplemental data is allowed if approved by NCQA, and may include information from other areas that can improve scores and show a more valid picture of the quality care. An example of supplemental data would be childhood immunization data in state registries such as the Texas Immunization Registry. Hybrid measures utilize a specified number of chart reviews along with claims reporting. Some measures are done by patient survey, such as asking patients if they have had a screening test for osteoporosis or a flu shot. Patient satisfaction questions are also done by survey.

HEDIS scores are publicly reported, and the goal of reaching 90% will reflect positively on both Scott & White Health Plan and on Scott & White Healthcare. As an integrated system our mutual improvement is a common goal.

For more information on NCQA and HEDIS see <http://www.ncqa.org>. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

As always, your ideas and feedback are appreciated. Thanks for reading and for the quality work you do. All Friday Focus editions may be found at the SWHP website: <http://www.swhp.org/homepage/providers/fridayfocus>.

Regards;

**Beverly Grimshaw, M.D.**  
**Scott & White Health Plan Medical Director**

## SCOTT & WHITE HEALTH PLAN ANNOUNCEMENT

### ELIMINATION OF NETWORK SPECIALTY REFERRAL REQUIREMENT

SWHP is pleased to announce that a referral will no longer be required to insure payment to Network Specialists.

If a physician wishes to refer to an Out Of Network Specialist a Prior Authorization from SWHP is needed. Please go to [www.swhp.org](http://www.swhp.org), to the Provider tab to access our Prior-Authorization Form.

Members of SWHP are allowed to self refer to a Network Specialist without the need for a PCP referral. Providers may continue to use any referral processes they currently have in place, however SWHP will no longer be requiring this referral to make payment.

For services requiring Prior-Authorization, please go to [www.swhp.org](http://www.swhp.org), to the Provider tab to access our Prior-Authorization Form.

We are making this change to facilitate patient's access to care and to decrease the administrative work and demands on your office. Please let us know of other ways we can facilitate these important goals and appreciate your support in communicating this information to your staff.

Regards:



Dr. Marylou Buyse, M.D., M.S.  
Chief Medical Director



Maria Lima-Leite, MPH/HA  
Vice President, Medical Delivery Development

# Radiology Consult Service Announced

The Scott and White Health Plan and the Scott and White Department of Radiology have partnered to provide a new telephone consult service for clinicians. We are pleased to announce that the service is now operational on a **24/7** basis.

By calling **254-724-1728 (4-1728** within the SW system), the **clinician may speak directly to a radiologist** regarding the best exam for a given clinical situation. With rapid advancements in imaging technology and public concerns about radiation safety, having convenient, rapid access to a radiologist can help us choose the most appropriate modality for our clinical concern, decrease the need for additional testing, and improve the service we give our patients.

Please understand that this phone number is only to be used for **provider to provider** consultation. It cannot be used for scheduling or other logistical issues. Also note that it does not replace the radiology listen line or the stat read line currently in place.

With the ever increasing complexity both of medical practice and of imaging issues, we are excited to have this service conveniently available and hope you will find it helpful in your practice.

## Hearing Aid Benefit for SeniorCare Senior Preferred Plus Members

Senior Preferred Plus member benefits include coverage for hearing aids at 50% of the cost per hearing aid. The plan coverage limit is \$1,000 every two years. Members must pay for the hearing aid(s) and then submit their receipt and proof of payment to Scott & White Health Plan (SWHP) for reimbursement. Providers cannot bill SWHP for hearing aids.



# REMINDER

## SWHP Contracted Sleep Services Physicians/Providers

Health Services Division wants to remind you of the **preauthorization requirement for all sleep studies**. This preauthorization is needed in order for any claims payment consideration to occur. If the preauthorization determination is not in place, the claim will not pay and the Member (and you) will receive a denial for the payment of those services. As you are aware, this is an area of national scrutiny and we at SWHP are required to do our due diligence that services being paid are medically necessary and appropriate and handled to the terms and limitations of a Member's benefit.

SWHP utilizes national evidence-based criteria for its case reviews (i.e., InterQual®) and/or internally-developed criteria through our SWHP Technology Assessment Committee review process and/or specialty input for the development of policies/procedures on specific care/treatments. This criteria is available onsite for review through the UM and/or HSD Director and/or is available at a case level as needed.

The nurses and Medical Directors of the Plan are always available as needed for case criteria discussions telephonically or for discussions/clarifications with you as needed. You can reach us by calling the HSD locally at 254-298-3088 and/or on the toll free number at 888-316-7947.

### Scott & White Health Plan Policy Updates

Changes are being made to several policies at Scott & White Health Plan. These include:

#### **Existing Network Providers**

1. Adding Physicians to Existing Group Agreements
2. Tax Identification Number (TIN) Change Request Form (New!)

#### **New Providers:**

1. Contract and Credentialing Checklist

Specific details about these topics and much more can be found online in the Provider Manual, [www.swhp.org](http://www.swhp.org), click on the Provider Tab. Please contact us at 254-298-3064 if you have any questions.

### SWHP Network Providers and Administrative Staff

As a reminder, we encourage you to refer to the online Provider Manual for updates to payment policies, quality improvement programs, medical policies and general health plan information. In addition, SWHP generally applies CMS rules and regulations with regards to claim edits and payment policies. We ask that you routinely visit our website for more information as updates may occur throughout the year.

# Board Certification Requirements for SWHP Credentialing and Recredentialing

By Jim Rohack MD, Chair, SWHP Credentials Committee

Scott & White Health Plan (SWHP) is licensed by the Texas Department of Insurance, accredited by the National Commission for Quality Assurance (NCQA) and under contract with the Centers for Medicare and Medicaid Services, which require credentialing and recredentialing of practitioners who render services to SWHP members. SWHP credentials or recredentials approximately 1300 physicians each year. This process includes reviewing required documentation and ensuring that all information is current and meets regulatory standards. The purpose is to ensure members that physicians on the SWHP network are maintaining competence in the field of medicine that they are currently practicing.

Part of that process includes Board Certification verification. SWHP adopted a policy that to be credentialed on the SWHP network, a physician who has graduated from medical school after 1985 must have completed full residency training and have a current ABMS or AOA board certification in the specialty in which they practice (or be in the process of obtaining it).

For providers who are not in active process to be board certified, or who have let their certification lapse, SWHP provides an alternative process to document that maintenance of competence. This alternative is to participate in the CME requirement at the same level as those currently in the ABFP process. Thus, the individual physician must obtain no less than 50 AMA Physician Recognition Award (PRA) or equivalent CME credits annually, 25 of which should be Category I. Twenty five credits (Category I, II or combination) must be in the field in which the physician practices. As the Texas Medical license annual requirement is 24 CME credits of which half may be Category II, this is an additional 26 credits over the year or one credit every other week. With the multiple sources available for credit including online, print, audio as well as live presentations, the SWHP Credentials Committee, the majority being practicing physicians of multiple specialties, did not believe this alternative policy was burdensome.

Proof of CME requirement is required at the time of recredentialing for all non-board certified physicians who wish to use this alternative process. SWHP is unable to complete the recredentialing process without this and thus the file will be incomplete. Failure to complete the 50 CME credits per year requirement will result in the physician being ineligible to be a practitioner within the SWHP network. All new and current SWHP physicians are notified of this requirement at time of credentialing/recredentialing.

For specific questions, please contact the SWHP Credentials Coordinator, Donna Hoff RN, BSN at 254 298-3502 or email at [dhoff@swmail.sw.org](mailto:dhoff@swmail.sw.org).

# Overview of Quality Improvement Program 2011

## Scope of the QI Program

The scope of the QI Program is to monitor, evaluate and improve:

- The quality and safety of clinical care and quality of practitioners and providers
- The quality of service provided by the Health Plan

## QI Program Goals - Objectives

### QI Program Goals - Objectives

- Improve Member Outcomes – through prevention, decision making assistance and disease guidance, and case management for members with complex health needs
- Increase Customer Satisfaction - by prompt identification and resolution of dissatisfaction with administrative or medical processes and evaluation of processes for improvement when appropriate
- Improve Medical Safety -by fostering a supportive environment that helps providers to improve the safety of their practice, conducting continuous improvement activities devoted to improving SWHP pharmacy medication safety, and providing Members with information that improves their knowledge about clinical safety in their own care.
- Organizational Effectiveness - By achieving statistically significant improvements in HEDIS measurements and meeting or exceeding national averages
- Decrease Cost – through reducing the variations in clinical care and member services
- Meet the cultural and linguistic needs of the Membership by providing translators services, translated materials, cultural diversity educational offerings and a network that has multilingual providers

## Scott & White Health Plan's progress in meeting its goals:

SWHP has teams that are working to achieve improvement in Healthcare Effectiveness Data and Information Set (HEDIS®)\* rates.

Scott & White Health Plan achieved significant improvement in the following measures comparing HEDIS®2009 rates with HEDIS® 2010 rates:

- Access to Primary Care; age 25 months to 6 years old (Commercial)
- Access to Primary Care; age 12 to 19 years old (Commercial)
- Adult Access to Preventive/Ambulatory Services; age 65 and older (Medicare)
- Monitoring persistent medications; ACE or ARB (Commercial and Medicare)
- Monitoring persistent medications; Diuretics (Commercial and Medicare)
- Monitoring of persistent medications ; Anticonvulsants (Medicare)
- Monitoring persistent medications; combined (Commercial and Medicare)
- Chlamydia screen; age 16-24 (Commercial)
- Chlamydia screen; age 21-24 (Commercial)
- Comprehensive Diabetes Care; Hemoglobin A1c Testing (Medicare)
- Comprehensive Diabetes Care; Lipid (LDL-C) Control (<100 mg/dL) Medicare

## Areas of Focus for 2011 include but are not limited to:

- **Well Child Care:** Letters are mailed to parents to encourage well child office visits.
- **Diabetes Screening:** A Diabetes screening event is scheduled monthly to provide dilated eye exams, foot exams and laboratory testing. (Hemoglobin A1c, Lipid panel and urine microalbumin)
- **Vitality Coordinator:** A health improvement pilot program was started in 2010 for Licensed Practical Nurses to work in various S&W Clinics to help identify and assist members with any needed preventive care exams, immunizations and/or tests.

For more information on the SWHP Quality Improvement Program call the SWHP Quality Improvement Division at **254-298-3068**. Additional information regarding the SWHP Quality Improvement Program is found on the Scott & White Health Plan internet site: <http://www.swhp.org/homepage/providers/qi>

\*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

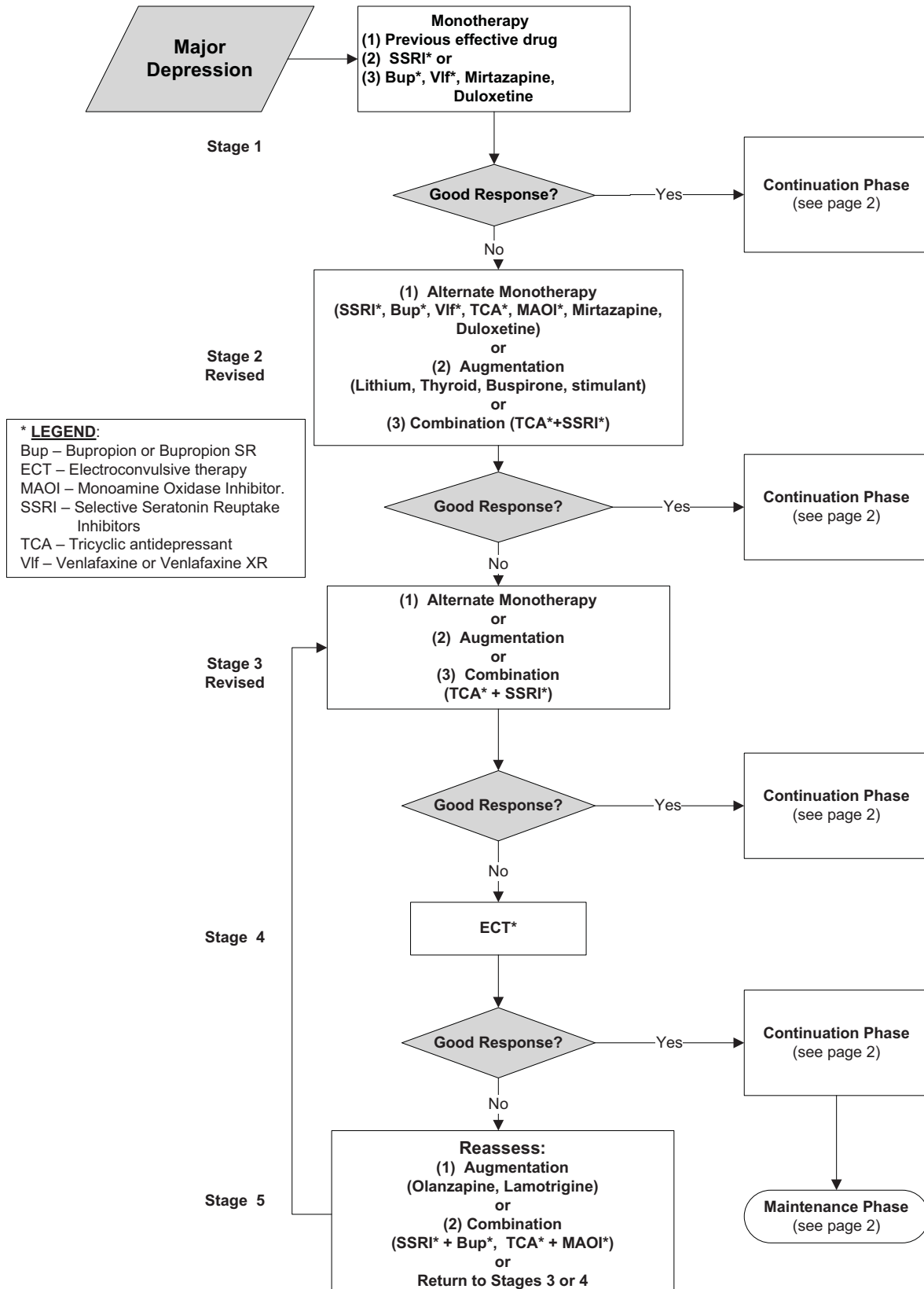
**Scott and White Health Plan  
Clinical Practice Guideline (Tier 1) for Use by Mental Health Specialists in  
Pharmacologic Management of Major Depression (Non-Psychotic, Non-Bipolar)**

Approved: December 1999 Revised: 2/2003; 2/2007 Reviewed: 2/2005; 2/2009, 12/2010

Source: Texas Medication Algorithm Project

Physician Contact: Dr. Virginia Maxanne Flores, M.D.

Reviewed in 2010 by: Department of Psychiatry, Scott & White Clinics



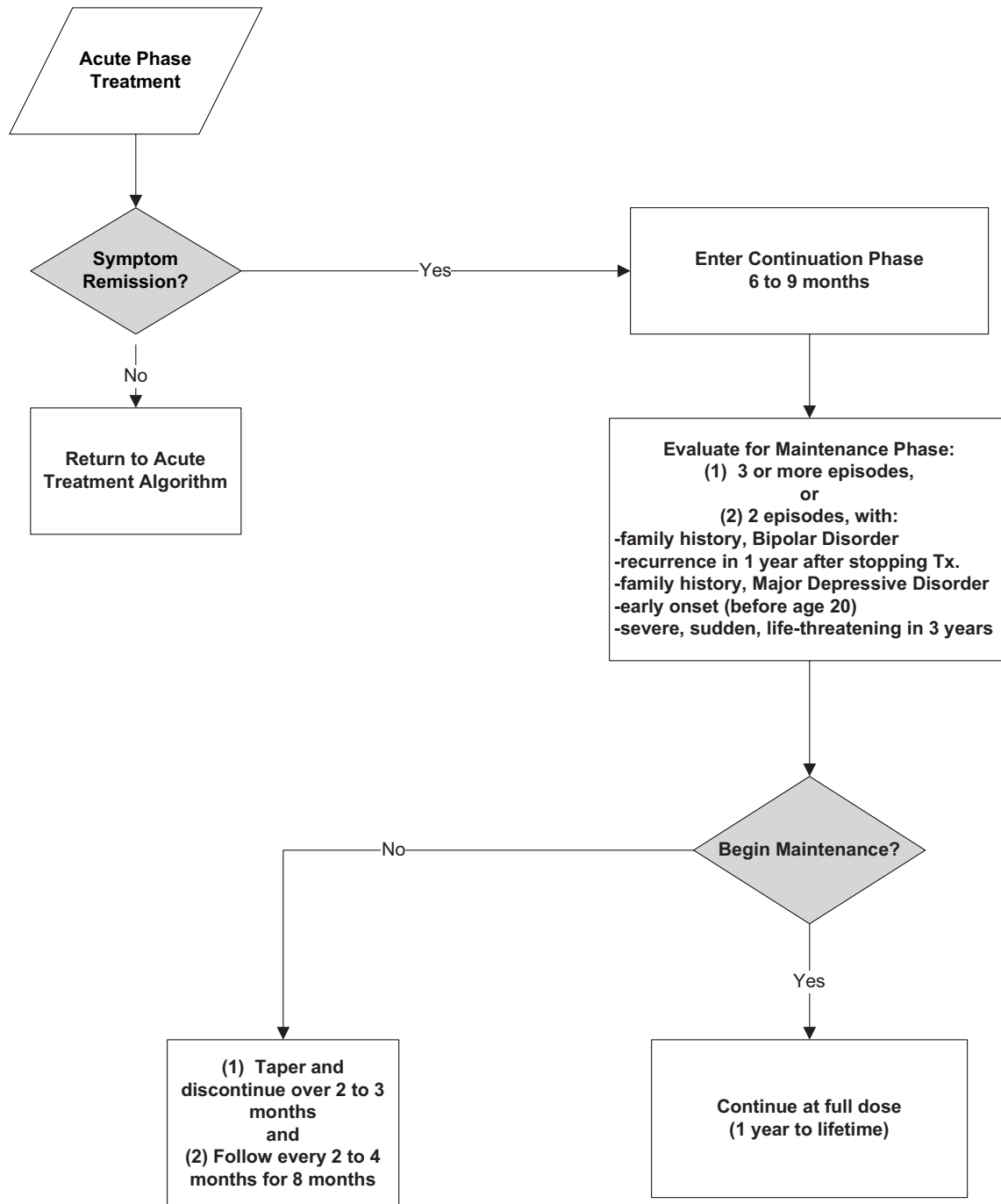
# Pharmacologic Management of Major Depression (Non-Psychotic, Non-Bipolar) Continuation and Maintenance Phases

Approved: December 1999 Revised: 2/2003; 2/2007 Reviewed: 2/2005; 2/2009, 12/2010

Source: Texas Medication Algorithm Project

Physician Contact: Dr. Virginia Maxanne Flores, M.D.

Reviewed in 2010 by: Department of Psychiatry, Scott & White Clinics



**Scott and White Health Plan  
Clinical Practice Guideline (Tier 1) for Use by Mental Health Specialists  
Pharmacologic Management of Schizophrenia**

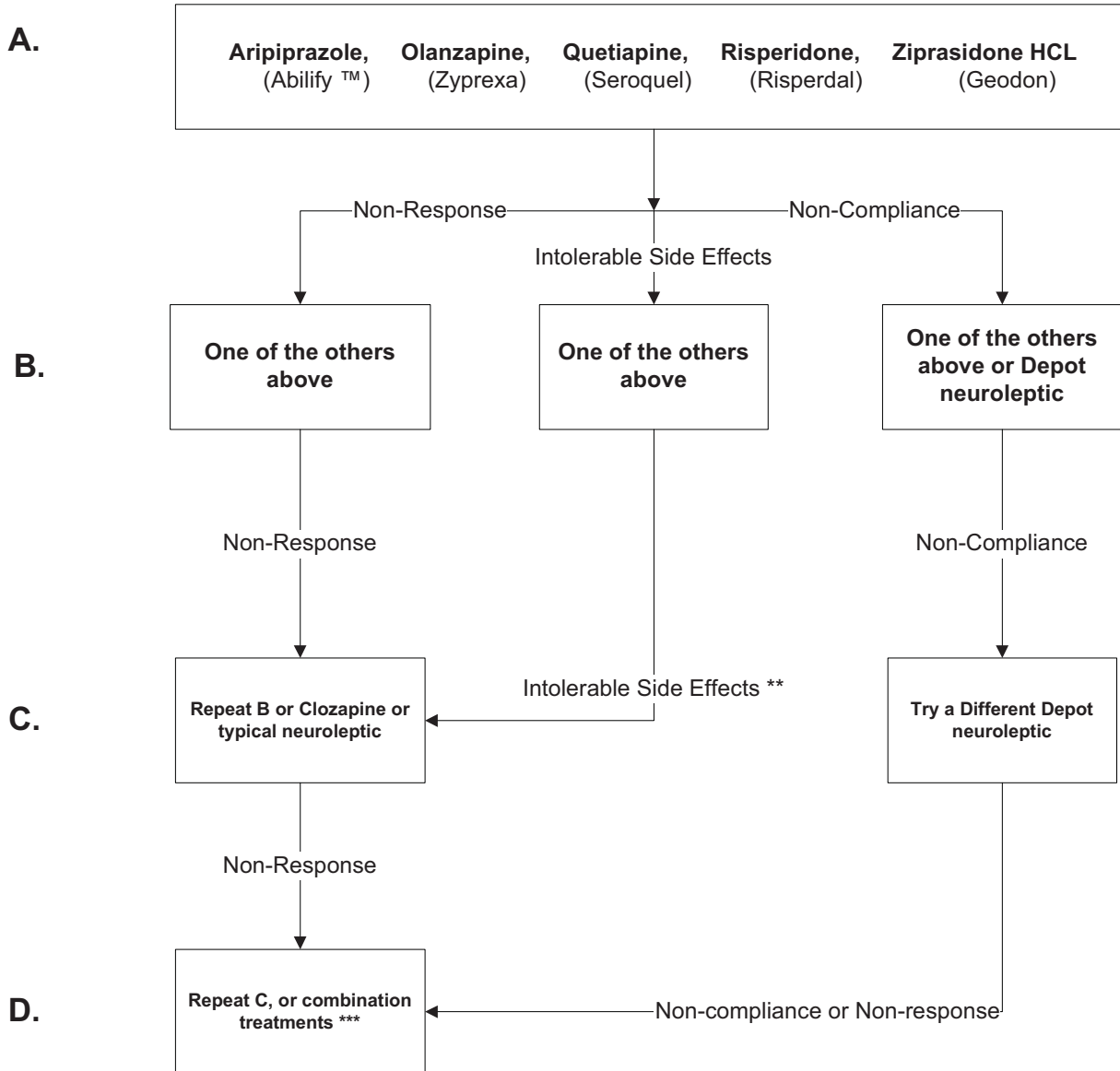
Adopted: Nov 1998 Reviewed: Dec 2000; Mar 2001; Feb 2003; Feb 2007; Feb 2009, December 2010 Revised: Feb 2005

Physician Contact: Dr. Virginia Maxanne Flores, M.D.; Dept. of Psychiatry, Scott & White Clinics

Source: Texas Medication Algorithm Project

2010 Review Conducted By: Department of Psychiatry, Scott & White Clinics

Try one of the following:



\* During first 72 hours of acute illness, additional medication for agitation, such as a benzodiazepine, may be necessary

\*\* Assumes trial of appropriate medication(s) for side effects

\*\*\* Could include, but not limited to, combination neuroleptics, mood stabilizer, benzodiazepine, antidepressant, electroconvulsive therapy

Source: [http://www.dshs.state.tx.us/mhprograms/pdf/SchizophreniaManual\\_060608.pdf](http://www.dshs.state.tx.us/mhprograms/pdf/SchizophreniaManual_060608.pdf)

**Scott and White Health Plan**  
**Tier 1 Guideline (Ophthalmology Dept.)**  
**Comprehensive Risk Reduction in Ulcerative Keratitis Associated with Extended Wear Contact Lens**  
**Approved: November 1998    Reviewed: Feb., 2003; Jan., 2005; Jan., 2007; Dec., 2008; Dec., 2010**

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**Purpose:** To decrease risk of ulcerative keratitis and corneal transplants among extended wear contact lens wearers.  
**Target Population:** Patients requesting and or using extended wear contact lenses.  
**Developed by:** Scott and White Health Plan Optometry Advisory Committee  
**Contact Person:** Sam Fulcher, M.D.

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## Clinical Practice Guidelines

- General practice is never to recommend the use of extended wear wearing schedules of any contact lens.
- Patients interested in contact lens wear should be fit only with daily wear lenses.
- Implicit in any fitting encounter are instructions and education regarding proper care and use of lenses.
- Implicit in any fitting encounter is discussion with the patient concerning signs and symptoms of Infectious Keratitis.
- Patients, whether current or new wearers, should be given written instructions outlining risks of extended wear lenses, to read and sign, acknowledging understanding and acceptance of risks. The original should be kept in the patient medical record, chart, and/or contact lens record with a copy given to the patient.

Source: American Academy of Ophthalmology

# New Location for SWHP

**Scott & White Health Plan has moved to a new location!**

SWHP has moved to our new location on the Scott & White (S&W) West Campus. The move occurred the weekend of December 10, 2010. We have outgrown our current space on the main S&W campus on 31st Street in Temple, TX. In addition, we are consolidating several Temple locations, where we have employees, into one central location.

New Mailing address:  
1206 West Campus Drive  
Temple, Texas 76502

See a map of our new location.

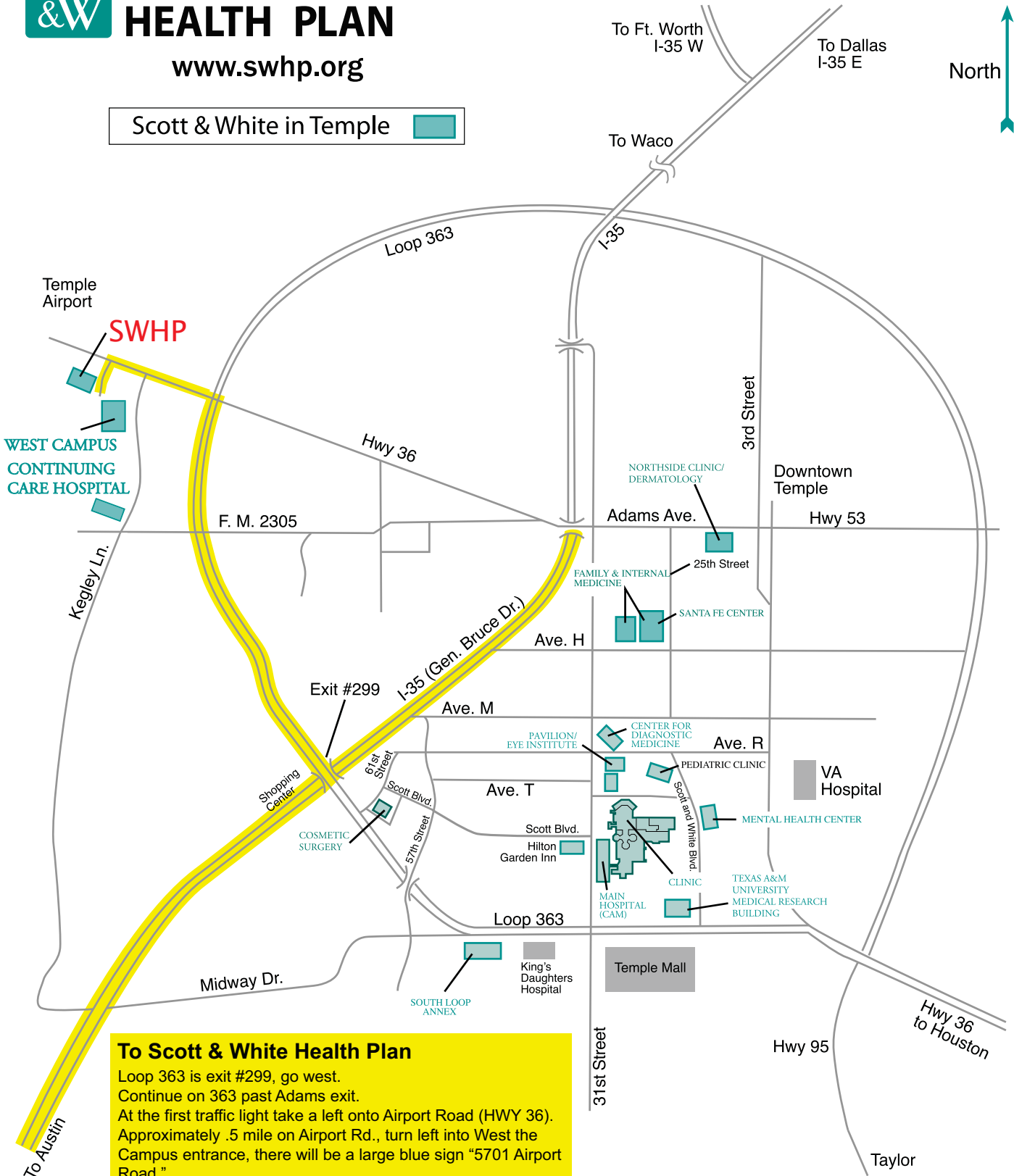




# SCOTT & WHITE HEALTH PLAN

www.swhp.org

Scott & White in Temple 



**To Scott & White Health Plan**  
 Loop 363 is exit #299, go west.  
 Continue on 363 past Adams exit.  
 At the first traffic light take a left onto Airport Road (HWY 36).  
 Approximately .5 mile on Airport Rd., turn left into West the  
 Campus entrance, there will be a large blue sign "5701 Airport  
 Road."  
 The SWHP Office is the first building on the right.

Scott & White Health Plan  
 1206 West Campus Dr.  
 Temple, TX 76501



## SCOTT & WHITE HEALTH PLAN

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### *Texas Friendly*

1206 West Campus Drive  
Temple, TX 76502

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