TOTAL HEALTH CARE

Provider Connection

VOLUME 13, ISSUE 1

WINTER 2010

Electronic Prescribing (e-prescribing) Offers Many Benefits

Get Connected Today!

Make the switch from handwritten to electronic prescriptions. You will save time, money and help improve patient safety.

- E-prescribing helps drive down health care costs by reducing the potential for medication errors. Prescribers can check for harmful drug interactions by reviewing the patient's medication history at point of service.
- Exchanging prescription information electronically between prescribers and pharmacies improves the accuracy of the prescribing process and saves time. You will experience reduced pharmacy phone calls and faxes related to prescription renewal authorizations. Pharmacy staff will experience reduced need to key in prescription data.
- Mobile devices and wireless networks allow prescribers to write prescriptions everywhere they go.
- E-prescribing provides an automated process for prescription renewal requests.
- Prescribers can reduce patients' costs when prescribing medications that are preferred by the patient's health plan, as you can confirm benefit information prior to sending an e-prescription or you can choose a less expensive drug option at time of prescribing.
- E-prescribing improves patient compliance with therapy by reducing the number of unfilled prescriptions and provides convenience by reducing and eliminating the hassle of dropping off and waiting for prescriptions to be filled at pharmacies.

In conjunction with our Pharmacy Benefit Manager, we provide Electronic Prescribing to our providers through Sure Scripts. There is no cost for transactions to the prescriber, as long as they have an appropriate Electronic Medical Record or e-prescribing system. We encourage you to consider E-prescribing and start reaping the benefits today.

Electronic Health Records

Electronic health records (EHRs), when used in a meaningful way, provide better patient care, reduce dangerous medical errors, and help control health care costs; however, they need to be implemented correctly in order to be effective. Such records may include a whole range of data in comprehensive or summary form, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal stats like age and weight, and billing information.

The Medicaid EHR Incentive Program provides incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. Total Health Care has provided links on our website to the latest health IT news and initiatives to help educate our eligible providers on how to maximize use of the EHR for improved quality of care. Total Health Care encourages our eligible providers to access these valuable links at www.Totalhealthcareonline.com/Providers.

INSIDE THIS EDITION

Patient Access Guidelines

The table below identifies set guidelines for how quickly our members may be able to see their primary care physician (PCP). The standards are based on National Committee for Quality Assurance (NCQA) requirements. Every year we measure how well we are meeting these guidelines. We appreciate the effort of all PCP offices to adhere to these standards.

Primary Care Practitioner (PCP)	*Response Standards*
Regular and Routine Care Appointments (i.e., preventive/well-care, routine non-symptomatic, physical, annual GYN exam)	Within thirty (30) days
Routine Non-Urgent (i.e., symptomatic)	Within seven (7) days
Urgent Care Appointments (i.e., persistent diarrhea/vomiting, high fever)	Within twenty-four (24) hours
Emergency Care (i.e., life-threatening conditions)	Twenty-four (24) hours/ seven (7) days a week at any hospital in or out of plan
Office Visit Wait Time for Scheduled Appointments	Within 15 minutes members should be taken to the exam room.
	Within 30 minutes of a members appointment the member will be seen by their Doctor
Behavioral Health Care	*Response Standards*
Non-Life-Threatening Appointments	Within six (6) hours
Urgent Care Appointments	Within forty-eight (48) hours
Routine Office visit	Within ten (10) business days
Telephone	*Response Standards*
THC's Member Services (during normal business hours)	Within 30 seconds an actual agent answers call.
Behavioral Health Care	Within 30 seconds an actual agent answers call.
After Hours Care (when THC's Member Services Department is closed)	Within 30 seconds an actual agent answers call.
Call Abandonment Rate	Less than 5% of calls will be abandoned.

NEW ADDITIONS!!!

We're pleased to welcome the following new ancillary providers to our network:

Silver Pine Imaging
20475 W. 10 Mile Rd
Southfield, MI 48075
(248) 421-1180

Riverside Hearing Center
14600 King Rd, Ste D
Riverview, MI 48193
(734) 486-4444

PRIVACY & PHI

Total Health distributes it's policy on privacy & protected health information (PHI) to it's members annually. For a copy of this policy, please visit our website at www.totalhealthcareonline.com/Providers or contact the Provider Relations Department at (313) 871-2000.

PHARMACY NEWS

The following changes were made at the December 2010 P&T meeting:

- Inhaled Corticosteroid Long Acting Beta 2 Agonist Therapy Class Review

Preferred covered agents include Dulera & Symbicort with a step therapy respiratory agent. **Removing Advair 250\50mcg & 500\50mcg from the drug formulary;** Advair 100/50 is covered for members under the age of 12

Formulary Approved Combination Inhaled Corticosteroids with Step Therapy		
Inhaled Low Dose Corticosteroids	Inhaled Medium Dose Corticosteroids	Inhaled High Dose Corticosteroids
Advair 100/50 (under age 12)	Dulera 100/5	Dulera 200/5
Symbicort 80/4.5	Symbicort 160/4.5	

- Testosterones Therapy Class Review

Testosterone cypionate injection is the preferred prior authorized Androgen. For initial ap proval or continuation of therapy, a completed prior authorization and free testosterone levels are needed for review. Androderm Patch has been removed from the drug formulary.

- Nonsteroidal Anti-inflammatory Class Review

Adding Daypro (oxaprozin), Ponstel (mefenamic acid) with a days' supply limit of 7 days and a daily dose limit of 1250mg/day, and Relafen (nabumetone) to the drug formularies

Drug Prior Authorization Criteria

Prior Authorization Criteria for prescription drugs is available upon request to the Pharmacy Department for THC Providers. If you would like a copy of specific drug criteria you may request it in writing or you may call the Pharmacy Department at 313-871-2000, and press 9.

Pharmaceutical Management Procedures

Visit our website to view the Condensed and Expanded Drug Formularies for Commercial and Medicaid Members. Listed under the Condensed formularies are THC's pharmaceutical management procedures to include generic substitution, step therapy, quantity limits, and prior authorization request. If you would like a copy of the formularies or pharmaceutical management procedures, you may call the Pharmacy Department at 313-871-2000, and press 9.

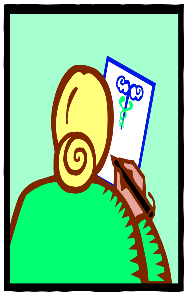
If you should have any pharmacy questions, please feel free to call us at 313-871-2000, option 9.

Members Satisfaction with their Primary Care Provider

In 2010, the conducted a Consumer Assessment of Healthcare Providers and Systems Clinical & Group Survey (CG-CAHPS). The CG-CAHPS asks patients to report on and rate their experiences with a specific physician and the physicians practice. The following table illustrates the Summary Rates for each composite, attribute, and additional measures for the respondents:

Composite/Attributes/Additional Measures		Valid n	Summary Rate
Getting Appointments and Health Care When Needed			**64.8%**
Q6.	Received appointments when needed for care needed right away	249	71.5%
Q8.	Received appointments when needed for routine care	332	78.3%
Q10.	Received answers to questions on same day when calling during office hours	233	70.4%
Q12.	Received answers to questions as soon as needed when calling after office hours	56	66.1%
Q13.	Saw doctor within 15 minutes of appointment time	421	37.5%
How Well Doctors Communicate			**80.1%**
Q14.	Doctor explained things in a way that was easy to understand	419	80.4%
Q15.	Doctor listened carefully to you	419	82.6%
Q17.	Doctor gave easy to understand instructions for taking care of health problems	369	81.6%
Q18.	Doctor seemed to know important information about medical history	417	75.3%
Q19.	Doctor showed respect for what you had to say	417	84.4%
Q20.	Doctor Spent enough time with you	410	76.1%
Courteous and Helpful Office Staff			**74.1%**
Q24.	Clerks and receptionists were helpful	411	70.1%
Q25.	Clerks and receptionist treated you with courtesy and respect	406	78.1%
Additional Measures			
Q22.	Office followed up to give test results	338	66.9%
Q23.	Overall rating of doctor	412	75.5%

We appreciate the hard work and professional medical services our physicians and their staff provide to Total Health members. To help increase the findings of future provider satisfaction surveys, we have provided our Access to Care Standards in this publication. Additionally, an article entitled Tracking Test Results as well as tips on office etiquette are included for reference and as reminders for offices who wish to use them. Thanks again!



Tracking Test Results Within a Physician Practice

The following information is not a guideline nor does it establish a standard of care—it is information that may be helpful to some practices. Not all of the suggestions are adaptable to every practice setting,

Physicians order a number of tests for patients, many of which are performed by laboratories and organizations outside the physician's practice. The importance of monitoring such tests and communicating information about test results to patients cannot be overstated since most patients await such information anxiously. Despite the importance of tracking such information, as many as one-third of the physicians in a recent survey indicated they had no reliable way to track test results in their practices.

Numerous methods and systems exist to help monitor and report test results to patients. Some offices rely on electronic services that allow patients to call into a system and retrieve test results. Others use a written system of charting test results and communicating those results to the patient. While there are many systems used to track and communicate test results, there are some general issues that should be considered before implementing any such system:

1. Establish a written policy that lists information to be tracked, specific actions to be taken, who is responsible for implementing and overseeing the system, and a policy regarding confidentiality of results. Employees should have a clear understanding of their personal responsibilities in the process.
2. Be willing to start from scratch. The use of technology applied to poorly designed procedures will only make the problem worse. The old system may need to be completely redesigned in order to be effective.
3. Keep it simple. The fewer steps involved and number of handoffs required, the less opportunity there is to misroute information.
4. Make use of available technology. Computer systems can assist in managing test results by alerting when a test result is due or when a patient should return for follow up care. Some electronic medical records allow physicians to order tests through the system and have the results sent to an electronic queue or "mailbox." Smaller practices that are not ready for a total electronic system can still use basic word-processing, spreadsheet, and database software to manage parts of their tracking system.
5. Give special attention to clinically significant results. In addition to establishing in-office procedures, laboratories conducting tests for the practice should be instructed to communicate clinically significant results to the practice quickly and by phone instead of assuming a written report is received.

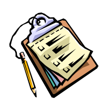
There are numerous systems physician practices might use to track test results. The following information sets out six [6] steps to include in such a system. These steps may not be applicable to every practice, especially those that use electronic systems to monitor and report test results. In addition, not every one of the six steps may be applicable to offices that have their own laboratory or are hospital-based. Physicians should review the steps outlined below to see how each of them might be applicable to their individual practices.

The six steps involved in establishing such a system include: (1) Determine a system to implement to track test results (2) Determine the data to be tracked (3) Review test results (4) Notify patients of the results (5) Follow up with the patient, if needed, and (6) Document the results and the notification of the patient.

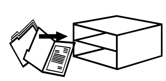
1. Determine a system to implement to track test results

There are various systems used in physician practices to track the information discussed in Section 1 above. Some systems are electronic in nature and perform much of the work for the practice. But such systems can be expensive. Whichever method is used, it is important to document the information in the patient's medical record [See # 6 below]. Systems used to track test results might include:

⇒ Create a "PENDING" file. Some offices chart tests ordered by a physician and place a copy of the order in a separate file entitled "PENDING." Once the test results are received by the office, they are noted in a patient's chart, removed from the PENDING file, and placed in a separate file entitled "TO BE REVIEWED." That file is then reviewed daily by the physician, who checks off that the test has been reviewed.



⇒ Create a log of tests ordered. Some offices use a separate log that allows information about patient tests to be logged and tracked. Information kept in such a log may include the patient's name – date the test was ordered – the type of test ordered – date results are received – date results are reviewed – and date the patient was notified. Such logs are reviewed by staff frequently to ensure that test results have been received and passed on to the patient. After a specific number of days, follow up is made with the lab or patient if that section of the log was not completed. It might also be helpful to create a "PENDING RESULTS" file cabinet where patient files can be kept while tests are being ordered. Such files can then be easily retrieved and the appropriate information recorded.



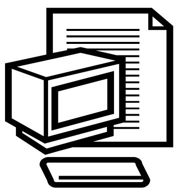
⇒ Create a "PENDING" tray for patient charts. Some offices do not keep separate logs or files for test results. Instead, they keep a file tray entitled "PENDING" for files of patients awaiting test results. The only documentation regarding such tests is then made in the patient record. While such a system does cut down on documentation, it may also be burdensome and difficult to review all tests that have been ordered to see which ones might be outstanding or lack patient notification.

⇒ Electronic systems. There are systems available to track test results electronically. Phone systems exist that allow patients to call into the system to retrieve their test results. Each patient is provided with a code to access his or her particular test result. The system then logs the date and time that the patient retrieved the test results, and allows offices to leave specific messages for patients regarding the results. Other electronic systems note all the patient information in the patient's chart if such charts are kept electronically [most practices, however, do not maintain electronic medical records].

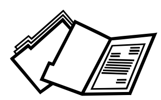
⇒ Basic computer technology. An office does not need an electronic medical record system to track test results electronically. Basic computer programs can be used as well. For instance, Microsoft Outlook can be used to set up an automated reminder when test results are due. Basic programs such as Excel and Word can also be used to set up spreadsheets or tables to track test results.

2. Determine data to be tracked

When ordering a test on a patient, practices should track specific information throughout the process – from the time the test is ordered to the point at which notification to the patient is made. Specific data to be tracked might include:



⇒ Name of physician who ordered the test
⇒ Patient name or identifier
⇒ Type of test to be conducted
⇒ Date test was scheduled
⇒ Lab or facility that conducted the test
⇒ Date test results received
⇒ Results reviewed by
⇒ Patient notification date

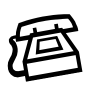


3. Review test results

A system used to track test results should include standard procedure for reviewing such results in a timely manner. Whichever employee within the practice first receives the test results should note when the results were received [whether in the logbook, file or medical record depending on the system used to track such results] and the results should be provided to the physician who ordered the test as soon as possible for the physician's review.

Some offices have physicians review test results daily. Each test result should be signed or initialed by the physician once it is reviewed and the results passed on to the patient. The documentation noting that the test was reviewed should also be filed in the patient's medical record.

4. Notify patients of the results



Some practices have a standard procedure of telling patients, "If you don't hear from us, your test results are fine." This should NOT be normal procedure. To ensure patient satisfaction, and to ensure no test result "slips through the cracks," it should be standard procedure to inform patients of all test results, whether they are normal or abnormal. Patients should also be told to call the practice if they have not received their test results within a set time-frame [ì.e., 3-5 days].

Offices might consider developing a preprinted notice that lists common lab tests to be mailed to the patient when a result is normal. Some computer systems have letter templates for specific tests and appropriate values and comments are simply filled in. To avoid HIPAA issues, practices should not communicate test results on a postcard or leave test results on an answering machine

As discussed previously practices familiar with the use of technology may want to consider a test result voice mail system. With these types of systems, the physician's staff audio records the test results and follow-up instructions into secure mailboxes. Patients are given a unique ID number. When they call the test result system, they speak their name and enter their ID number. The time and date that the patient accessed their results is recorded and relayed to the physician's office. If the patient does not retrieve results after a designated amount of time, the system will report those patients to the physician, for follow up.

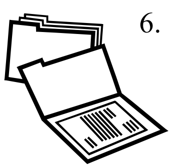
Any system for reporting test results to a patient should address abnormal test results differently than normal results. However such results are handled, incoming abnormal test results should be separated from normal test results, given a priority status, and routed to the physician for review. The patient should then be notified by phone. If the patient cannot be reached by phone, a certified letter may be sent asking the patient to call the office.

In addition, there should also be systems in place to handle life-threatening results or results that require immediate attention as determined by the physicians in the practice. Such results should be reported to the physician immediately. Offices might also consider repeating such tests with a fresh specimen.

Finally, if the results would somehow change or modify a patient's course of treatment, the treating physician may want to communicate that information to the patient personally.

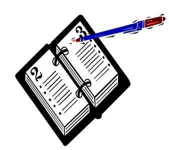
5. Follow up with the patient if needed

A follow-up system may prevent a patient from being harmed because of failure to make return office visits or recommended testing. An effective follow-up system should track recommended diagnostic tests. Sometimes a patient may not be aware of the importance of completing the recommended testing. It is necessary to have a system in place to identify if the patient followed through with the testing. This could be as simple as a log in which ordered tests are recorded and then marked off when results are received. If a patient refuses to have a test, the physician should make the patient aware of any risks involved in not having the test performed. This should be documented in the patient's medical record.



6. Document the results and the notification of the patient

Whatever system is implemented to track test results, it is very important that every step of the process be documented. The original laboratory sheet with the results should be included in the patient's chart. The date the patient was notified or the date test results were mailed should be carefully documented in the chart as well. And it is always important to document in the medical record any questions the patient may have about the test results and any recommendations given.



Whatever system is used to track test results, medical practices should consider educating their patients on the system in place to track results. The patients therefore would know who to call if they do not receive such information – who to call for a follow up appointment – when to expect their results – and how to obtain the results. Perhaps a flow chart handed out to patients explaining the process with numbers to call for specific questions may help alleviate patients' concerns about their results. It might also diminish expectations that some results will be available the next day.

Office Etiquette Tips

The office is the place where you spend most of your day among colleagues and co-workers. They could be older or younger, and many of them may become your friends. Still you should always maintain proper office etiquette and decorum with both your actions and your words. While there may time for fun in some office settings, it is always better to err on the side of caution and be careful when expressing yourself at work.

Following are some guidelines to better present yourself at work and project a professional image:

Your Desk
Your desk is just like your physical appearance, it should be tidy and clean. Take pride in your work area and be more efficient at your job. A dirty and messy desk is a sign of neglect. Thus, clean up your act.

Your Appearance
Always dress professionally. Be mindful of your office dress code and follow it.

Your Physical and Verbal Behavior
Your behavior at work is reflective of your personality. The way to walk, sit at your desk and handle yourself at a meeting or with a group of co-workers is very important.

Common Courtesy
This is often forgotten. Always make eye contact and say hello. Put your problems or preoccupations aside and focus on the people around you every now and then.

Finally here are some other office etiquettes practices:

- ✓ Say good morning
- ✓ Say thank you
- ✓ Say please
- ✓ Be helpful
- ✓ Be friendly
- ✓ Be polite
- ✓ Seek help for anger problems
- ✓ Ask permission to enter a co-worker's space or cubicle
- ✓ Show appreciation
- ✓ Control your emotions
- ✓ Have a sense of humor
- ✓ Be courteous and show respect toward others
- ✓ Take responsibility for your mistakes
- ✓ Be helpful; ask if you can help

Resources:

http://www.a-to-z-of-manners-and-etiquette.com/office-etiquette.html

http://www.howtodothings.com/careers/a3478-how-to-practice-business-office-etiquette-and-manners.html

http://www.dgreetings.com/gift-ideas/corporate-gifts/office-etiquette.html