THE QUARTERLY COMPASS

Spring 2022

SAINT ALPHONSUS HEALTH ALLIANCE

2022 SPRING NEWSLETTER

Saint Alphonsus Health Alliance

President's Message

Charles H. Chodroff, MD, MBA, FACP

Saint Alphonsus
Health Alliance President

SAVE THE DATE

Saint Alphonsus Health Alliance

PROVIDER NETWORK NIGHT

Tuesday, Oct. 25, 2022

more details to follow

PAYER HIGHLIGHTS

MediGold Medicare Advantage

In each issue of the Alliance Compass, we'll focus on the unique aspects of our various payers who have partnered with us to help improve the value and quality of healthcare in our community.

MediGold has partnered with Saint Alphonsus Health System to offer a Medicare Advantage health plan with several distinctive advantages to both providers and Medicare beneficiaries. As a wholly owned subsidiary of Trinity Health, MediGold fully supports the mission and values of Saint Alphonsus Health System. And, as a health plan founded by physicians, it has developed a unique approach to medical management

Alliance staff meet monthly with MediGold's medical leadership to identify opportunities to improve preventive services and assure the appropriate utilization of costly services such as inappropriate emergency department visits or hospital readmissions. The Alliance's contract with MediGold provides reimbursement to the Alliance when we meet our quality performance thresholds and reduce the use of harmful or unnecessary services.

One unique aspect of MediGold's medical management program is immediate access to a MediGold medical director to address a question from a network provider. If you are unsure if MediGold will approve a certain service or if your patient has been denied approval for a service, please call the Alliance at 208-367-5844. We'll put you in immediate contact with a MediGold medical director so that you can directly address your concerns. Dr. Greg Wise, MediGold's executive medical director believes this is the basis for the plan's success as it assures physicians retain control of all decisions regarding the care of their patients.

Warm regards,

Charles H. Chodroff, MD, MBA, FACP
President, Saint Alphonsus Health Alliance

Saint Alphonsus Health Alliance

Our Top 10 Quality Measures

The SAHA Performance Improvement team listened to the feedback of many practices and agreed that narrowing our focus to key quality measures would help prioritize the effectiveness of reporting and improve our performance. We chose these measures specifically because they were the most common measures among the payers, we wanted to highlight the triple weighted measures (those measures that impact our scores more profoundly) and some of these measures, like breast cancer screenings, were in need of the most improvement to reach the 4-star threshold set by CMS.

2022 Quality Metrics								
	Medicare Advantage					Commercial		Medicaid
#	Measure	Aetna	Humana	MediGold	Regence HMO	BCI QHP Connected Care	Trinith Health Aetna	Medicaid VCO
1	Annual Wellness Visits - Preventative Care Visits	✓	✓	✓	✓	✓	✓	✓
2	Breast Cancer Screening	✓	✓	✓	✓	✓	✓	✓
3	Cervical Cancer Screening					✓	✓	
4	Child and Adolescent Well Care Visit 3-21 Years						✓	✓
5	Colorectal Cancer Screening	✓	✓	✓	✓	✓	✓	
6	Controlling Blood Pressure		✓***	✓***	✓		✓	
7	DM: Diabetes Control (A1c <9)	✓***	✓***	✓***	✓			
8	Med Adherence: Cholesterol Medications (Statin)	✓***	✓***	✓***	✓			
9	Med Adherence: Diabetes Medications	✓***	✓***	✓***	✓			
10	Med Adherence: HTN Medications (ACE/ARB)	✓***	✓***	✓***	✓			

Legend: ✓ Metric included in pay for performance *** Triple weight

Bundled Payments Care Initiative - Advanced

The Alliance Expands its Portfolio of Services

The Alliance has assumed the management of the Bundled Payments Care Initiative – Advanced (BPCI-A), a Medicare program that offers hospitals the opportunity to assume the risk for the cost of services for a 90-day period following admission for selected conditions. Three Saint Alphonsus Health System (SAHS) hospitals have voluntarily participated with this program for the past 4 years for 43 different DRGs. If costs are kept below Medicare's calculated budget, the hospitals share in the savings with Medicare. Likewise, hospitals must reimburse Medicare for some of the costs that exceed the budget.

Although these programs have been managed successfully by the SAHS hospitals with positive financial results each year, the Alliance believes the efforts of this program closely align with the care management needs of other patients managed by the Alliance.

SAHS's success in this program has come primarily through close working relationships with staff in skilled nursing facilities. There are six nurse navigators who follow patients after discharge with close attention to those who are admitted to SNFs. Working with the staff at these facilities, the nurses focus efforts on reducing the SNF length of stay, assuring coordinated transfer to the home setting, and addressing evolving medical conditions rapidly to prevent hospital readmission.

Leslie Peterson-Criner, RN, has been selected as the Manager of Post-Acute Care for the Alliance to provide oversight of this program and extend the learnings from this program to other patients managed by the Alliance in the post-acute setting. Ms. Peterson-Criner worked for 6 years as a BPCI-A nurse navigator based out of Saint Alphonsus Hospital – Boise.

Acute Myocardial Infarction	280, 281, 282
Cardiac Arrhythmia	308, 309, 310
Congestive Heart Failure	291, 292, 293
Simple Pneumonia And Respiratory Infections	177, 178, 179, 193, 194, 195
Chronic Obstructive Pulmonary Disease, Bronchitis, Asthma	190, 191, 192, 202, 203
Renal Failure	682, 683, 684
Sepsis	870, 871, 872
Urinary Tract Infection	689, 690
Seizures	100, 101
Stroke	061, 062, 063, 064, 065, 066
Hip & Femur Procedures Except Major Joint	480, 481, 482
Major LE Joint replacement Inpatient (total hip, knee, ankle) Multi-setting	469, 470, OP HCPCS 27447
Major Joint Replacement Of The Upper Extremity	483

> *"BPIC-A staff from Boise, Nampa, and Ontario are excited to join the Alliance team and continue to collaborate on improving the health and care for our patients."*

In-Home ASSESSMENTS

In-home assessments (IHAs) provide an opportunity to better understand our patient's home life which in turn benefits both the patient and their provider. These assessments, typically completed by a nurse practitioner, are free to patients and help identify and assess social determinants of health (SDoH), review the medical history and current conditions, assess risk factors, and perform a complete medication review. IHAs have been proven to:

- **Reinforce the PCP/patient relationship** by creating suggestions for health topics to discuss with the member's PCP;
- **Promote program referrals to care management** for improved care across the continuum;
- **Offer a sense of empowerment** by increasing an understanding of the member's health care needs;
- **Decrease the risk of serious health events** and, prevent unnecessary utilization and admissions.

This type of assessment can supplement the provider's record with detailed information that may not be accessible or shared in an office visit.

IHAs can also improve performance on key quality measures that are able to be closed at the time of the visit. This may include:

- Controlling high blood pressure
- Osteoporosis management in women who had a fracture
- Follow-up after emergency department visit
- Transitions of care and, comprehensive diabetes management for retinal eye screenings and kidney evaluation

An assessment form, both left with the patient and sent to the PCP; summarizes the information collected during an in-home assessment.

Please encourage your patients to support this free service that can help you better manage your patients.

Our Focus on Health Equity

Saint Alphonsus Health Alliance believes that equitable care is quality care. One definition of health equity proposed by the CDC states, “Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. ″

Health inequities lead to differences in length of life, quality of life, rates of disease, disability, and death, severity of disease, and access to treatment.

Our payer’s quality measures are guided by HEDIS which uses NCQA definitions for these measure. The NCQA updates and releases these definitions yearly. This year, the definitions include measures of health equity with the expectation to report quality results by race and ethnicity stratifications for five HEDIS measures. NCQA will extend race and ethnicity stratification to fifteen measures by 2024.

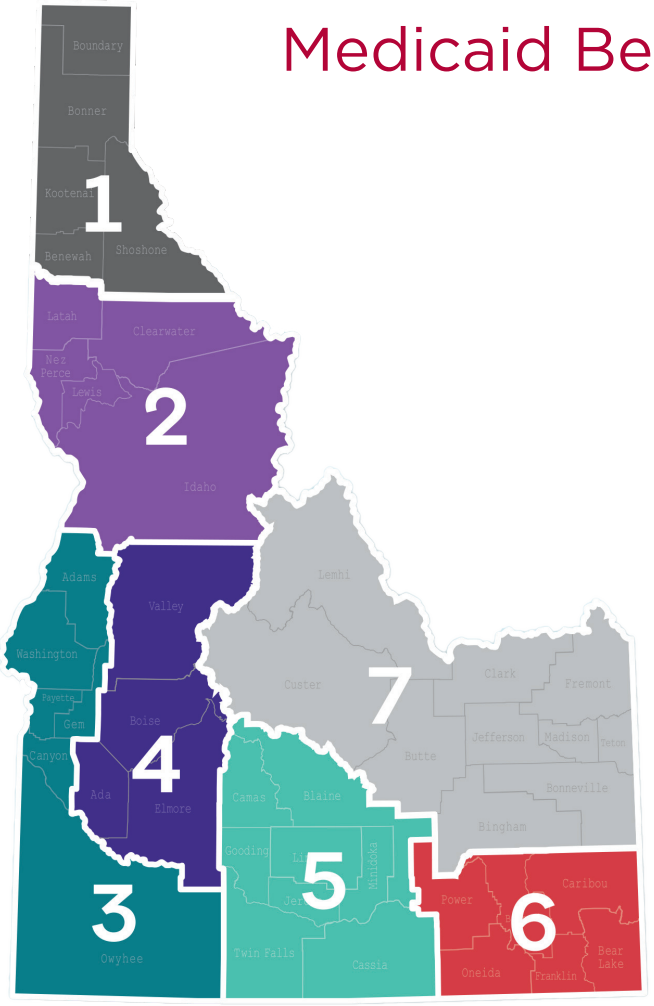
The Alliance will partner with you to provide the information, education and support your efforts to report all required quality measures appropriately. We share your commitment to provide the best possible care to all patients, even those who face barriers to care. Our reports will demonstrate our commitment to provide the highest quality of care, regardless of race or ethnicity.

Saint Alphonsus Health Alliance is here to support your health equity plan and welcomes conversations around these implementation plans.

Measures Selected for 2022 Stratification

Measure	Product Lines	Domain
Colorectal Cancer Screening (COL; COL-E)	Commercial, Medicare	Effectiveness of Care
Controlling High Blood Pressure (CBP)	Commercial, Medicaid, Medicare	Effectiveness of Care
Hemoglobin A1c Control for patients with Diabetes (HBD)	Commercial, Medicaid, Medicare	Effectiveness of Care
Prenatal and Postpartum Care (PPC)	Commercial, Medicare	Access & Availability of Care
Child and Adolescent Well Care Visits (WCV)	Commercial, Medicare	Utilization

Optum Idaho



Medicaid Behavioral Health Program

Access to behavioral health services is often very difficult, particularly for those covered by Medicaid.

Optum Idaho is the organization responsible for the Idaho Medicaid Behavioral Health Plan. This managed care plan covers outpatient behavioral health services for children, adolescents, and adults who are covered by Medicaid.

The plan uses a network of contracted behavioral health providers who offer adult peer support, youth support, family support, psychotherapy, medication management, and substance use assessment and disorder treatments. A full list of available services can be found here on the Optum website. Optum also offers a 24/7 Crisis Phone Line that provides crisis support to members, makes referrals, and connects members to resources. The 24/7 Crisis Phone Line is 855-202-0973.

Optum employees provide Field Care Coordination services, provider relations, and member outreach. Field Care Coordinators work with members and providers to navigate services.

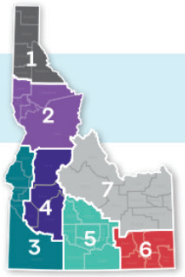
OptumIdaho.com

Want to make a Field Care Coordinator referral?
Need additional support with the Optum Idaho plan?

- **The referral form** is located on the Optum Idaho webpage (select For Network Providers > Forms > Field Care Coordinator Form).
- **Make a referral** by email to optum.idaho.fcc@optum.com or by fax to 888-891-1232.
- **Referral and assistance are available** by calling the Optum Provider Line at 855-202-0983 or the Optum Member Line at 855-202-0973.
- **Contact Alliance Clinician Team at 208-367-4103 for support** working with the Optum Idaho Plan or Field Care Coordinator team.

For more information about the plan, please visit the Optum | Idaho Behavioral Plan Website.

Optum Idaho Regional Representation



Field Care Coordinators (FCC)

Bring clinical expertise on all aspects of high-risk member treatment by working directly with providers, members and stakeholders in the community. Utilizing best practice treatments, FCCs strive to reduce hospitalizations and support our member's recovery and resiliency.

Zach Badger, LPC
208-914-2475
zachary.badger@optum.com
Region 1

Michelle McMenamy, LCPC
208-914-2291
michelle.mcmenamy@optum.com
Region 1 and 2

Crystal Lish, LCSW
208-914-2245
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Region 3

Darren Bushee, LCPC
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Region 3

Matthew Gosline
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Region 4

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Region 4

Krista Lane, LCPC
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Region 4

Cindy Shotswell, LCSW
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Region 5

Brittiny Barnes, LCSW
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Region 6 and 7

Ta'resa Crow, LCSW
208-914-2478
taresa.crow@optum.com
Region 7 **EPSDT**

Rina Lingelbach, LCPC
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rina.lingelbach@optum.com
EPSDT

Amy Wimer, CPRP, LSW, NCC, LPC
208-914-2449
amy.wimer@optum.com
EPSDT/UMOT

FCC Manager

Gail Baker, LCSW
208-914-2239
gail.baker@optum.com

Provider Relations Advocates

Bring provider relations and services, strategies relating to the development and management of a provider network including identifying gaps in network composition, recruiting providers and educating to operational expectations.

Karen Kopf
208-914-2266
karen.kopf@optum.com
Region 1 and 2

Jan Jacobs
208-914-2227
jan.jacobs@optum.com
Region 3 and 5

Brooke Bennett
208-914-2299
brooke.bennett@optum.com
Region 4

Brenda Valle
612-642-7925
brenda.valle@optum.com
Region 6 and 7

Provider Quality Specialists

Conduct routine site visits and treatment record reviews to monitor network compliance with Optum Idaho's documentation standards, supervisory agreements and applicable state and federal regulations.

Wayne Nubile, LCPC
763-321-3301
wayne.nubile@optum.com
Region 3, 4 and 5

Liz McDowell, LCSW
208-914-2476
elizabeth.mcdowell@optum.com
Region 1, 2, 6 and 7

Community Program Managers

Build and maintain relationships with community stakeholders, governmental partners and behavioral health boards by providing outreach and education with Optum Idaho.

Wendy Stoneberg
208-914-2276
wendy.stoneberg@optum.com

Tammy Lish-Watson
208-914-2279
tammy.lish-watson@optum.com

Member Outreach Manager

Leads member outreach, engagement and education activities. Collaborates with providers and local and state partners to deliver information about Optum Idaho to members across the state.

Rebecca Kuta
208-914-2272
rebecca.kuta@optum.com

Other Helpful Optum Numbers

Optum Idaho Member Access & Crisis Line (Available 24/7)
855-202-0973, TTY: 711

Optum Idaho Clinical Services
855-202-0983, Ext. 1
(Treatment and Authorizations)

Optum Idaho Provider Customer Service
855-202-0983, Ext. 2, 3, 4
(Claims Payment and Eligibility)

Optum

Depressive Syndrome Screening & Supports

> In 2020, an estimated **14.8 million** U.S. adults aged 18 or older had at least one major depressive episode with severe impairment in the past year.

The above number is quite likely to have increased substantially since the worldwide coronavirus impacts have been realized across regions of the world, and our health systems and communities have endured limitations to services along with substantial changes to so many aspects of every-day life.

Screening for depressive syndromes during primary care wellness office visits should be paired with further diagnostic assessment and ongoing support for depression such as social work care management from the Alliance Clinical Team.

Simplified screening tools such as the two-stage PHQ2/9 and the WHO-5 are widely used and validated in screening adult populations[2,3]. Social work team members at the Alliance are poised to complement SAHA provider affiliates with key referrals to community resources, self-management goal planning, and follow-up screenings or patient education[4].

In order to quickly access these services, please refer to the following:

For internal colleagues; use the order **REF2102**
(ambulatory referral to Social Work Care Manager)
in EPIC with the codes:

- **Z76.89** Encounter for social work intervention **1981163**
- **Z78.9** Need for follow-up by social worker **1829913**

Patient has eligible SAHA APM coverage - please see:
www.saintalphonsushealthalliance.org/managers/alliance-payor-information.html

AND has one of the following: A high EPIC readmission risk score with identified social work support needs. Mental health diagnosis new or recent acute social or behavioral event needing support by social work care management; Identifies needing assistance with mental wellbeing, legal, financial, and/or crisis support.

For external colleagues,
send information through secure email:
BOHSCareManagement@saintalphonsus.org

or call (208) 367-4103

or fax (208) 367-7238

Osteoporosis Management

in Women who had a Fracture (OMW)

CMS continues the expectation that all women ages 67-85 years of age who suffered a fracture need either a bone mineral density (BMD) test (e.g., DEXA scan) or a prescription for a drug to treat osteoporosis within six months of the fracture.

Bisphosphonates	Other Agents
Alendronate Ibandronate Risendronate Zolendronic acid	Denosumab (Prolia) Teriparatide (Forteo) Raloxifene (Evista) Abaloparatide (Tymlos)

Please consider scheduling your patients for a DEXA and/or prescribing one of the above medications **within six months of a fracture**, as appropriate. Due to delays in getting DEXA scans completed, we **strongly encourage** discussion of the importance of this test, and subsequent ordering of the DEXA scan at the initial TCM visit.

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