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INSIDE THIS ISSUE

A VIEW INSIDE FROM THE MEDICAL DIRECTORS

Our Summer issue of *Clinical Update* focuses on a new Connections℠ Health Management Program initiative that supports patients who are considering weight loss (bariatric) surgery. Additional information can be found on page 2.

Clinical Update is your resource for current clinical information. *Clinical Update*, when used in conjunction with our other publications, keeps you and your staff informed of valuable administrative and policy information as well as important clinical topics.

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Connections℠ Weight Loss Surgery Decision Support Program Begins June 2006

Obesity Epidemic

Obesity has been termed an epidemic in the United States. It is estimated that approximately 65 percent of adults are either overweight or obese, and more than 5 percent of the population is morbidly obese.[1] Morbid obesity is associated with serious medical problems, including type 2 diabetes, hypertension, sleep apnea, heart disease, osteoarthritis, and gastroesophageal reflux disease.

Unfortunately, many obese patients are unable to lose a significant amount of weight through diet, exercise, and/or medication. These individuals are often attracted to weight loss (bariatric) surgery because it can result in a much greater weight loss. However, this is not an easy decision for patients to make. Bariatric procedures can have serious complications, including the risk of death. This procedure also requires a patient to make significant, lifelong changes in his or her eating habits. People who have had bariatric surgery may develop post-operative medical, surgical and/or psychological complications that require additional treatment.

Connections℠ Weight Loss Surgery Decision Support Program

Beginning in June 2006, the Connections Health Management Program will offer a new clinical initiative to support patients who are considering weight loss surgery. Through this initiative, Connections Health Coaches, who include nurses and registered dietitians, will be able to discuss the pre- and post-surgical issues unique to someone considering bariatric surgery. We urge you to refer to Health Coaching any members who may be considering weight loss surgery and would benefit from decision support. Members may also receive, if appropriate, a free evidenced-based video discussing the decision for weight loss surgery.[2]

Connections Health Coaching will focus on the following areas:

- Education about what to expect from bariatric surgery, including necessary lifestyle and dietary changes after surgery and support in making those changes
- Education about non-surgical approaches to weight loss, including diet, exercise, and medication
- Education about prevention, identification, and management of post-surgery complications
- Assistance in developing the skills to find, understand, and use evidence-based information about bariatric surgery
- Support for physician-patient interactions by helping patients prepare for office visits

Provider tools have been developed for this initiative, including a body mass index (BMI) calculator and an accompanying information card with referral criteria to help identify appropriate candidates for this program.

The weight loss surgery support initiative is Connections' second new decision support initiative for 2006. In March, Connections launched a depression screening program for members with chronic conditions. To learn more about the available tools and resources for members and providers, please call the Connections Program Provider Support Line at (866) 866-4694.

Note: This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, etc.) and/or employer group. HMO and PPO member coverage may be verified through Provider Services.

References:

[1] Hedley AA, Ogden CL, Johnson CL, Carroll MD, Curtin LR, Flegal KM. Prevalence of Overweight and Obesity Among U.S. Children, Adolescents, and Adults, 1999–2002. JAMA. 2004; 291:2847–50.

[2] Produced by the Foundation for Informed Medical Decision Making.

Connections℠ AccordantCare™ Provider Reports

The Connections℠ AccordantCare™ Program offers providers, both primary care physicians and specialists, reports on their members who are interactively working with a Connections AccordantCare nurse. In these personalized reports, doctors will receive individual care plans on their specific patients which include treatments, comorbidities, patient-reported problems, and any relevant topics the nurses discussed with the member.

Report requests are filled within 10 days. To request a report about an individual member, or for more information about the Connections AccordantCare Program, call (866) 398-8761. The program provides support and education for members with any of the 15 complex, chronic conditions listed below:

- Seizure Disorders
- Rheumatoid Arthritis
- Multiple Sclerosis
- Parkinson's Disease
- Systemic Lupus Erythematosus (SLE)
- Myasthenia Gravis
- Sickle Cell Disease
- Cystic Fibrosis
- Hemophilia
- Scleroderma
- Polymyositis
- Dermatomyositis
- Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
- Amyotrophic Lateral Sclerosis (ALS)
- Gaucher Disease

SMART™ Registry Release for June 2006

The next release of the SMART™ Registry is scheduled for June 2006. This release will continue to address diabetes as the targeted clinical initiative. A diabetes-only Group Report will be included in the SMART Registry. Provider Service Specialists (PSSs) will continue to be available to meet with physicians or other clinical care practitioners to provide support in the use of the SMART Registry and with the program referral tools that can link members with Connections℠ Program Health Coaches.

During these meetings, the PSSs will work with providers to review the diabetes-only filtered report and provide diabetes education tools for providers to use with their members, such as a diabetes wallet card or BMI card. The filtered report allows practices to look at a manageable number of members and identify clinical gaps in care, member by member. Many practices place the Patient-Specific Reports in patient charts, as a reminder to close a specific gap at the time of the member's next office visit.

To speak with a PSS about any aspect of the Connections Program, please call the Provider Support Line at (866) 866-4694.

A PSS can help providers:

- Make a Health Coach referral
- Request a CD-ROM version of the SMART Registry
- Request a SMART Registry report filtered for other conditions
- Utilize the SMART Registry to identify high-risk patients and close clinical care gaps
- Obtain resource tools, including Connections referral pads, fax referral forms, and member materials

June 2006 Registry Enhancements:

- A new column has been added to the Group Report, Disease-Specific Report, and Patient-Specific Report to identify patients who are currently in contact with a Health Coach. This column appears in the "Services Received" section of each report (previously called "Clinical Care Received").
- The title "Patient Volume by Clinical Indicator" has been added to the Group Report. An explanation is included in the "Overview" page for the Group Reports.

Magellan Prevention Programs

Magellan Health Services Southeast Care Management Center (SE CMC) conducts prevention activities in order to reduce the prevalence and severity of behavioral health disorders. Currently, the SE CMC has three prevention initiatives in progress: Cardiac Depression, Health Risk Assessment, and Offspring Depression.

Cardiac Depression Screening: The targeted population for the cardiac depression screening initiative is adults (ages 18 and older) who suffer from significant coronary artery disease (CAD). As studies indicate, clinical depression occurs in 17-45 percent of people who have CAD. One of the goals of this program is to educate this high-risk population about depression, its effects on cardiac illness, and its treatment. Using three depression-screening tools (Whooley, PHQ-9, and SF-12), members showing positive results will be referred for further evaluation and treatment. In 2005, 71 percent of referred members screened positive for depression. All members accepted referrals for treatment and at the three month follow-up, 86 percent were still in treatment.

Health Risk Assessment: The targeted population for the health risk assessment initiative is Medicare members. Depression in older adults frequently goes untreated because there is a misconception that depression is a normal part of aging, due to chronic illness and loss. AmeriHealth identifies members at risk and refers them to Magellan for screening and follow-up, as needed. Two depression screening tools are used (PHQ-9 and SF-12) for a baseline measurement of depression and social functioning. The member is offered a referral to a behavioral health provider or has the option to be evaluated by their existing behavioral health provider or primary care physician (PCP). In 2005, Magellan contacted all referred members and spoke to 73 percent of them. Of the 73 percent, 17 percent were already receiving treatment for depression and another 12 percent accepted a referral for treatment.

Offspring Depression Screening: The targeted population for the offspring depression screening initiative is children (ages 9-17 years old) with a parent who suffers from Major Depressive Disorders. One of the goals of this program is to promote early identification of depression in these children, who by virtue of family history and circumstance, are at an increased risk of developing depression. Parents with Major Depressive Disorders are identified based on prior year contact with Magellan. The parent is sent educational information and a Brief Screening for Adolescent Depression tool to complete and return. The response rate in 2005 was 5 percent with 26 percent of those returned screened positive for depression, and 36 percent* accepted referral for treatment.

For a full description of the Magellan Prevention Programs, please visit *www.magellanhealth.com.*

The SE CMC staff is interested in hearing your suggestions or questions about our prevention programs. Please contact the Behavioral Preventive Health Care Manager at (877) 742-1531 with comments.

**Percent combined with members that self-referred.*

Preventing West Nile Virus

As warmer weather arrives, please remember that clinical and laboratory information about the West Nile Virus (WNV) infection is available from the Centers for Disease Control and Prevention (CDC) online at *www.cdc.gov/ncidod/dvbid/westnile/index.htm.* Information about each state is available on this website under the Resources tab. You may also call the CDC at (800) 311-3435.

The WNV infection first emerged in the Western Hemisphere in 1999 in the New York City area and has since spread across the U.S. The principal route of human infection is through the bite of an infected mosquito. In 2005, the total human cases reported in the U.S. to the CDC numbered 2,949.

Of the 2,949 cases reported to the CDC, 1,272 (43 percent) were reported as West Nile meningitis or encephalitis, 1,566 (53 percent) were reported as West Nile fever (milder disease), and 111 (4 percent) were clinically unspecified.

General Medical Record Review (DE and PA)

We would like to share the results of our annual General Medical Record Review (GMRR). A yearly assessment of sample primary care physician (PCP) medical records is conducted to ensure that PCPs keep track of and actively coordinate the care of members.

In 2005, GMRR scores met the established 90 percent performance goal for approximately one half of the indicators for Pennsylvania and 9 out of 13 indicators for Delaware. The specific results for each state are listed below.

Delaware

The four out of 13 indicators that fell below 90 percent were the following:

- Separate problem list completed for each member (79 percent)
- Documentation of history of substance abuse (61 percent)
- Documentation of history of alcohol abuse (86 percent)
- Separate immunization record of both children and adults in the chart (65 percent)

Eight of the nine indicators for the Clinical Appropriateness Review met the requirements for the given standard at 100 percent. The only indicator to fall below 100 percent was evidence of a discharge summary for members hospitalized during the previous year (70 percent).

The indicator for the presence of a tickler system to remind patients about preventive visits showed statistically significant increases in three of the four categories—the only exception was the presence of a proactive reminder system.

The four categories for each type of system are as follows:

1) Database (computerized)
2) Manual
3) Individual identified at time of PCP visit (reactive)
4) Members identified by PCP's database (proactive, population-based)

Offices can be credited with having any or all of these systems. For the Continuity of Care non-reminder system indicators, 100 percent of offices met the requirements for these four indicators: reminding members to keep their next appointment, identifying and processing/calling members who missed an appointment, follow-up appointments made for members with chronic diseases, and the availability of prevention materials. There was a statistically non-significant decrease from 2004 to 2005 in the percentage of providers who provided routine gynecological services (83 percent in 2004 to 74 percent in 2005).

Pennsylvania

This is the first year that data is available for this population. The seven out of 13 indicators that fell below 90 percent include:

- All pages of the record contain member name and ID number (78 percent)
- Separate problem list completed for each member (63 percent)
- Documentation of history of alcohol abuse (89 percent)
- Documentation of history of substance abuse (68 percent)
- Consult summaries, lab, and x-rays initialed by physician (85 percent)
- Date for return visit or "return prn" for each encounter (80 percent)
- Separate immunization record of both children and adults in the chart (68 percent)

Eight out of nine of the indicators for Clinical Appropriateness met the requirements for the given standard at 100 percent. The only indicator to fall below 100 percent was evidence of a discharge summary for members hospitalized during the previous year (75 percent).

The indicator for the presence of a tickler system to remind patients about preventive visits was separated into these four categories:

1) Database (computerized)
2) Manual
3) Individual identified at time of PCP visit (reactive)
4) Members identified by PCP's database (proactive, population-based)

Offices can be credited with having any or all of these systems. Twenty-nine percent of the offices reviewed used a database reminder system, 62 percent used a manual reminder system, 86 percent used a reactive reminder system, and 22 percent used a proactive reminder system. For the Continuity of Care non-reminder system indicators, over 90 percent of offices met the requirements for four of the indicators: reminding members to keep their next appointment (95 percent), identifying and processing/calling members who missed an appointment (95 percent), follow-up appointments made for members with chronic diseases (98 percent), and the availability of prevention materials (99 percent). The only indicator that fell below 90 percent of the records reviewed in 2005 was the provision of routine gynecological services (73 percent).

For Delaware and Pennsylvania, we will continue to make tools available via the AmeriHealth website, *Provider Manual,* and direct mailings in order to promote coordination and continuity of care inclusive of medical record documentation tools, provider medical record standards, and the SMART™ Registry for PCPs via the Connections℠ Health Management Program.

Clinical Practice Guidelines Study Results for Asthma and Diabetes (DE and PA)

In 2005, we conducted studies to assess the delivery of care and adherence to *Clinical Practice Guidelines* for services received in 2004 among enrolled members in both Delaware and Pennsylvania. The study results are listed below for these states.

Asthma Clinical Practice Guidelines Study Results

Delaware

- The percentage of members referred to a specialist remained low: 11 percent in 2003 to 12 percent in 2004. Network providers indicated that they have noted an increase in member compliance with asthma treatments that have become easier to use. As a result, improved disease management at the PCP level may have impacted the need for specialist referrals.
- A new measure, documenting evidence of communication between the PCP and specialist (80 percent), was added to the survey for 2004.
- There was an increase from 71 percent in 2003 to 80 percent in 2004, in the percentage of charts with documentation that asthma is reassessed within six months of a PCP visit for asthma.

Pennsylvania

This is the first year of data available for this population. The data listed below will be used as the baseline for future analysis.

- The percentage of members referred to a specialist was 20 percent.
- The percentage of charts with documented evidence of communication between a PCP and specialist was 90 percent.
- Documentation that asthma is reassessed within six months of a visit for asthma symptoms/exacerbation was 75 percent.

Diabetes Clinical Practice Guidelines Study Results

Delaware

- Documentation indicated that screening had been completed for an HbA1c test and increased from 83 percent in 2003 to 85 percent in 2004 for diabetic members.
- Screening for LDL-C increased from 92 percent in 2003 to 94 percent in 2004 for diabetic members.
- Screening for retinal eye examinations decreased from 59 percent in 2003 to 53 percent in 2004 for diabetic members.
- There was little change in the percentage of diabetic members with documented monitoring for nephropathy (51 percent) from 2003 to 2004.

Pennsylvania

This is the first year that data is available for this population. The data below will be used as the baseline for future analysis.

- Documentation indicating that HbA1c screening done in 2004 was 83 percent.
- Screening for LDL-C for diabetic members was 92 percent in 2004.
- Screening for retinal eye examinations for diabetic members was 41 percent in 2004.
- The percentage of diabetic members with documented monitoring for nephropathy was 47 percent in 2004.

We continue to foster educational opportunities for members with chronic conditions, inclusive of the Connections℠ Health Management Program and clinical gap campaigns. PCPs receive a biannual SMART™ Registry claims-based report that allows practitioners to track and manage the care of patients with both asthma and diabetes. We also review, revise, and distribute *Clinical Practice Guidelines* and medical record standards for practice groups on an annual basis.

Cervical Cancer Prevention

According to the American Cancer Society (the Society), cervical cancer incidence and mortality rates have decreased significantly in the past several decades with most of the reduction attributed to widespread use of Pap tests.[1] The National Cancer Institute (NCI) suggested the biggest gain in reducing cervical cancer incidence and mortality would be achieved by increasing screening rates among women who have not been screened or who have not been screened regularly.

The Society's Recommendations[2]

The Society's recommendations below address when to begin screening, when screening may be discontinued, whether to screen women who have had a hysterectomy, appropriate screening intervals, and new screening technologies, such as liquid-based cytology and Human Papilloma Virus (HPV) DNA testing.[3]

- Begin screening three years after the onset of vaginal intercourse, but no later than 21 years of age. Screening should be done every year with regular Pap tests, or every two years using liquid-based tests.
- Beginning at age 30, women who have had three normal Pap test results in a row, may get screened every two to three years. Alternatively, for women over 30, cervical cancer screening with HPV DNA testing and conventional or liquid-based cytology could be performed every three years. However, health care providers may suggest screening more often if a woman has certain risks such as HIV or a weakened immune system.
- Women age 70 or older who have had three or more normal Pap tests in a row ***and*** no abnormal Pap tests in the last 10 years, may choose to stop having cervical cancer screening
- Women with a history of cervical cancer or in utero exposure to diethylstilbestrol (DES) should follow the same guidelines as average risk women before age 30, but should continue with that protocol after age 30.
- There is no specific age to stop screening for women with a history of cervical cancer, women with an in utero exposure to DES, and women who are immunocompromised (including HIV-positive patients). Women in these risk groups should continue cervical cancer screening for as long as they are in reasonable good health and would benefit from early detection and treatment.
- Cervical cancer screening is not indicated for women who have had a total hysterectomy for benign gynecological disease. However, women who have had a subtotal hysterectomy should be screened according to the recommendations for women at average risk. Women with a history of cervical intraepithlial neoplasia (CIN) 2/3 who have undergone hysterectomy, or for whom it is not possible to document the absence of CIN 2/3 as an indication for hysterectomy, should be screened until three documented, consecutive, technically satisfactory normal/negative cervical cytology results (within a ten-year period) are achieved.
- Women with severe co-morbid or life-threatening illness may discontinue cervical cancer screening.

Potential Benefits of HPV DNA Testing

The Society supports the use of HPV DNA testing for women over the age of 30. The potential benefits are as follows:

- Women who have negative results of both cervical cytology and HPV DNA tests are further reassured that they are at low risk for cervical cancer.
- Women who have repeated positive results for high-risk HPV subtypes are at higher risk for cervical cancer and may potentially benefit from more intensive surveillance.

HPV Vaccine

The U.S. Food and Drug Administration (FDA) has reviewed two HPV vaccines developed to protect against HPV types 16 and 18, the two types most commonly found in cervical cancer; one also protects against HPV 6 and 11, which cause genital warts.[4] The FDA has approved the Gardasil Vaccine, however, the recommendations of the Advisory Committee on Immunization Practices are pending. (Please refer to *www.amerihealth.com/medpolicy* for updates regarding coverage.) The other vaccine from GlaxoSmithKline is pending FDA action.

Women should continue receiving regular Pap tests since infections from other strains may still occur.[5] The vaccine will not protect women with previous/current HPV infection.[6] Additionally, the age at which women should begin receiving the HPV vaccine has not been

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Cervical Cancer Prevention (continued)

determined.[7] The Society's revised guidelines stress the need for health care professionals to develop a management algorithm for women with normal/negative cytology results, but positive test results for high–risk HPV DNA subtypes. The Society does not recommend HPV testing any more frequently than every three years and stresses that women who choose to undergo HPV DNA testing should receive counseling and education about HPV.

How AmeriHealth Can Help You

Our programs are designed to reach out to women who have not been screened or who have not been screened regularly. Through our annual Cervical Cancer Screening Program, members receive reminder mailings to further encourage the scheduling of their regular Pap tests. Members are also encouraged to visit *www.amerihealthexpress.com* and may link to the website of the College of American Pathologists to request a free e-mail reminder to schedule their annual Pap test—a simple action that can save their lives. All women are encouraged to increase their knowledge and awareness of cervical cancer, to discuss prevention, early detection, and treatment options with their health care practitioners. The NCI recommends educating women about risk factors for cervical cancer, because it may lead to lifestyle and behavioral changes that result in decreased exposure to those factors.

Providers are also encouraged to use each office visit as the primary opportunity to remind all of their female patients of the importance of receiving regular Pap screenings.

References:

[1] The American Cancer Society. Cancer Facts & Figures 2006.

[2] CA: A Cancer Journal for Clinicians: American Cancer Society Guidelines for the Early Detection of Cancer, 2006; 56;11–25.

[3] Statistics, 2004. CA A Cancer Journal for Clinicians. Vol. 54/No. 1 January/February 2004.

[4-7] The American Cancer Society. Frequently Asked Questions About Human Papilloma Virus (HPV) Vaccines: www.cancer.org on April 10, 2006.

Cholesterol Management, Obesity and Proper Nutrition, Immunization Recommendations, Abdominal Aortic Aneurysm Screening, and Prostate Cancer Screening

We actively encourage our male members to receive regular checkups, screening tests, and information recommended by nationally-recognized preventive health authorities such as the Centers for Disease Control and Prevention.

The Men's Health program was created to address health concerns unique to the needs of men. This program describes the importance of understanding all the components of a healthy lifestyle, including: health risks, regular health screenings, immunizations, balanced diet, regular exercise, avoiding tobacco, and stress management.

Members have an opportunity to improve their overall health by taking the online Personal Health Profile (PHP). The PHP includes interesting health facts, screening recommendations, exercise plans, and more. Members can receive an instant online report assessing their current health habits with suggestions on how to improve their overall health. Members can visit *www.amerihealth.com/members/health_resources* and select the AmeriHealth Healthy Lifestyles℠ Programs option.

Men's Health Topics: Important Issues to Consider

Cholesterol Management

Therapeutic lifestyle changes, such as a low saturated fat and a low cholesterol diet, physical activity, and weight control remain the cornerstone of treatment.

Obesity and Proper Nutrition

As mentioned in Winter *Clinical Update* and according to the American Academy of Family Physicians, obesity is the fastest-growing health problem in the United States.

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Cholesterol Management, Obesity and Proper Nutrition, Immunization, Recommendations, Abdominal Aortic Aneurysm Screening, and Prostate Cancer Screening (continued)

It is one of the most serious chronic conditions of our time. Obesity among Americans, both adults and children, has doubled over the past two decades. Approximately 64% of the U.S. population is either overweight or obese.

We continue to embrace a proactive approach in the health of our members. This is why we are encouraging you to discuss with your patients the following:

- Potential health risks related to weight
- Body Mass Index (BMI)
- Recommendations for weight management through healthy eating and physical activity
- Weight management programs
- Fitness programs

For additional information on weight loss surgery, refer to the article *Connections℠ Weight Loss Surgery Decision Support Program Begins June 2006* on page 2 of this issue.

Immunization Recommendations

The following adult immunization schedule is recommended:

- Flu shot every year starting at age 50
- Tetanus-diphtheria shot every 10 years
- Pneumonia shot once at age 65

Abdominal Aortic Aneurysm Screening

The United States Preventive Services Task Force recommends a one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography. The major risk factors for AAA include age (65 or older), male gender, and a history of smoking.[1]

Prostate Cancer Screening

Other than skin cancer, prostate cancer is the most common type of cancer found in American men. Although we do not know how to prevent this type of cancer, we do know that certain risk factors increase the chances of a man getting prostate cancer.

Some risk factors such as diet, can be controlled. Others, such as family history, cannot be changed.

The effectiveness of routine screening for prostate cancer has not been established. According to the American Cancer Society, men aged 50 or older with a life expectancy of greater than 10 years should be given information about the potential benefits and limitations of screening and should be allowed to make their own choice about screening in consultation with their health care providers.[2] Members can call the Connections Program at (800) 275-2583 to obtain Health Coaching and a free evidenced-based video on the topic of prostate cancer screening.

References:

[1] U.S. Preventive Services Task Force. The Guide to Clinical Preventive Services 2005 Recommendations. AHRQ Pub. No. 05-0570 June 2005.

[2] Smith, R., Cokkinides, V., Eyre, H. American Cancer Society Guidelines for the Early Detection of Cancer 2005. CA Cancer J Clin. 2005:55(1)31–44.

Frequently Dialed Numbers

	NEW JERSEY	DELAWARE
American Imaging Management (AIM) (Call for CT, MRI/MRA, PET, and Nuclear Cardiology for AH NJ members only)	**(800) 859-5288**	
Clinical Pharmacy Services Prescription Drug Preauthorization	**(888) 671-5280** To precertify specific prescription drugs (i.e., Provigil, Thalomid, Enbrel) or drug classes (Cox-2 inhibitors, erectile dysfunction drugs). You may also call to receive full list of prescription drugs requiring precertification.	
Hours: Mon-Fri 9:00 AM–5:00 PM	Toll-free Fax: **(888) 671-5285**	
Pharmacy Appeals	**(888) 494-8213 (Option 1)**	
Blood Glucose Meter Hotline	**(888) 494-8213 (Option 2)**	
Corporate and Financial Investigations Department		
Anti-Fraud and Corporate Compliance Hotline	**(866) 282-2707**	
Credentialing Violation Hotline	**(215) 988-6534**	
Connections℠ AccordantCare™ Program	**(866) 398-8761**	
Connections℠ Kidney Program	**(866) 303-4257 (4CKP)**	
Connections℠ Programs Provider Support Line (Disease Management and Decision Support)		
Physician Hotline	**(866) 866-4694**	
Member Access Number	**(800) 275-2583**	
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