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CareFirst BlueChoice

CareFirst BlueCross BlueShield

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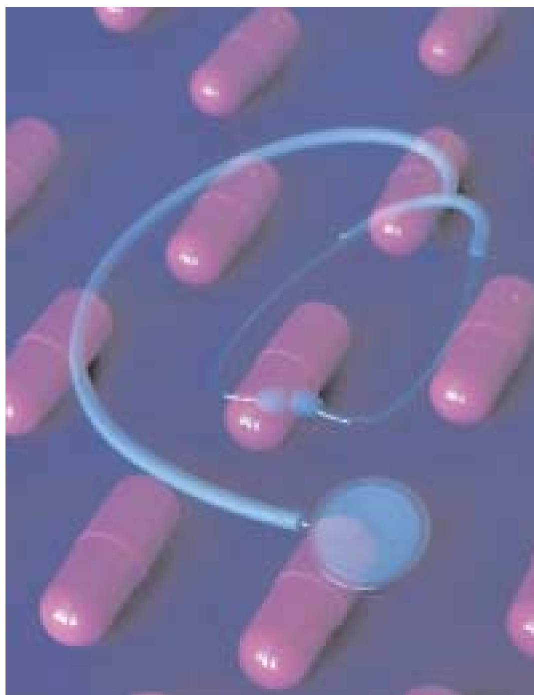

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MDxL Hospitalist Program at Area Hospitals

The following is presented in an effort to highlight hospital "best practices" around the region. CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (CareFirst BlueChoice) want to share with you the innovative ways in which Maryland, Virginia and Washington, D.C. hospitals are improving quality of care while controlling the rising cost of health care. Look for additional "best practice" features in future issues of InFocus.

Quietly and without fanfare, the treatment that many CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice members receive when they go to the hospital is getting more efficient and personal. Members that seek care in the emergency departments of eight hospitals have access to hospitalist services through MDxL, a physician-network management company that works with area hospitals and physicians to help optimize the quality, efficiency and outcomes of patient care.

> **This is a win-win situation for everybody involved. Patients are able to get the most efficient, safest and accurate care when hospitalists are involved.**
>
> *– Dr. Dennis Friedman, MDxL Cardiologist*

A 2002 survey of 2,500 patients served by hospitalists indicates a high level of overall satisfaction with the care received. Patients liked the frequent and timely attention and the availability of a personal physician in the hospital who could provide authoritative answers to their many questions.

Doctor surveys have established that they too were generally in favor of the hospitalist idea. Primary care physicians found the hospitalist "helpful and efficient," although doctors and hospitalists both cautioned that frequent and open communications is essential to make the system work for doctors, patients and the hospital.

How the Program Works

When a CareFirst or CareFirst BlueChoice member visits the emergency room of a participating hospital, a hospitalist assumes the role of the patient's primary care physician.

If the member is admitted, the hospitalist will coordinate and request the necessary procedures and tests, as well as any special care or attention required. If a member does not need to be admitted to the hospital, the hospitalist can coordinate medically necessary tests in an outpatient setting.

Hospitalists communicate regularly with the patient's regular physician, as well as with the patient and his or her family. Hospitalists also coordinate a patient's discharge, including home care, hospice and assisted living as necessary.

"A well-designed, sophisticated hospitalist program allows a doctor to visit individual patients and to monitor their care two or three or more times a day," says Dr. Daniel J. Winn, senior medical director for CareFirst. "They know how their hospital best functions, and that's very important because hospitals are usually big, complex operations— often operating under stress."

Benefits of Hospitalist Programs

- **Hospital admission avoidance:**
  Hospitalists appropriately and consistently redirect 20% of proposed admissions to an outpatient setting according to MDxL.

- **More time with patients:**
  Since hospitalists work full-time in one hospital, they are familiar with the particular hospital's systems, can coordinate care efficiently and, as a result, give patients the attention they need.

- **Specialized care:**
  When necessary, patients are placed under a hospitalist whose specialty coincides with the patient's diagnosis. "Patients feel that their level of care is upgraded because they get to see a specialist right away," says MDxL pulmonologist Dr. Jay Weiner.

- **Quality, more efficient care:**
  Hospitals run more efficiently because the MDxL hospitalists know the hospital system well. "Because the hospitalists at Holy Cross Hospital are a stable group, they have a good relationship with each other and the hospital's staff," said associate director of emergency medicine at Holy Cross Hospital Dr. Jim DelVecchio. As a result, the rate of denied days and services is very low.

- **Open communication:**
  - Protected online data and automatic fax generation allows the patient's PCP, specialists and CareFirst or CareFirst BlueChoice to know what is happening with their mutual patients.
  - Since hospitalists are the patient's main point of contact in the hospital, they have the opportunity to get information more quickly and, as a result, are more likely to adhere to their plan of care.

*Care*Essentials: Utilization Management

As part of the Utilization Management component of *Care*Essentials, our care management program that provides you with essential tools for patient care, CareFirst and CareFirst BlueChoice partners with MDxL to provide hospitalist services to our members.

Network Hospitals with Hospitalist Programs

Hospitals that participate in MDxL's program and have hospitalists on staff include:

- Doctor's Community Hospital
- Holy Cross Hospital
- Laurel Regional Hospital
- Montgomery General Hospital
- Prince George's Hospital Center
- Shady Grove Adventist Hospital
- Suburban Hospital
- Washington Adventist Hospital

Common Questions:

Question	Answer
Can a hospitalist continue to care for a patient after he or she is discharged?	To ensure continuity of care after the patient is discharged, the hospitalist may continue to treat the patient for the diagnosed condition until it is appropriate to transfer the patient back to his PCP.
Can members be admitted to the hospital without a referral from their physician?	Members who are seen by hospitalists do not have to wait for their own physicians' referral to be admitted for care. If a member needs to be admitted, his or her PCP is contacted. If the PCP is not available to evaluate the patient, MDxL will assign a hospitalist to conduct the evaluation.
Will MDxL automatically care for all of my patients?	Participating PCPs may elect to have MDxL coordinate care for all future admissions of their CareFirst or CareFirst BlueChoice patients.
How will a physician know when his or her patient has been admitted to/discharged from a hospital?	MDxL faxes the patient's PCP when a member is admitted through the emergency room and when the patient is discharged.

Disease Management

Recent Literature Related to:

CareFirst and CareFirst BlueChoice Disease Management Initiatives

By T.A. Dadisman, MD, Medical Director, Preventive Medicine and Health Promotion

*Care*Essentials: Disease Mangement

As part of the Disease Management component of *Care*Essentials, our care management program that provides you with essential tools for patient care, this article is intended to call your attention to recent information concerning diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease.

DIABETES • *What's Available:*	Where to Find It:
The clinical implications section of **Detection of Silent Myocardial Ischemia in Asymptomatic Diabetic Subjects. (The DIAD Study)** states, "The DIAD patient population may be considered representative of asymptomatic patients with type 2 diabetes seen in everyday diabetes practice. At the time of enrollment, great care was given to ensure that patients had no symptoms or signs suggestive of CAD. The findings of the DIAD study suggest that greater than one in five asymptomatic patients with type 2 diabetes, aged 50–75 years, have silent myocardial ischemia. More importantly, 1 in 16 patients overall and 1 in 12 men have markedly abnormal (moderate-to-large) myocardial perfusion abnormalities. Thus, … totally asymptomatic patients with diabetes have at least an intermediate probability of CAD, a prevalence that may justify screening by noninvasive testing such as stress myocardial perfusion imaging." The conclusion section states, "…traditional cardiac risk factors (hypertension, smoking, family history, or dyslipidemia), as well as novel biomarkers (including high-sensitivity CRP, homocysteine, lipid subfractions, and plasminogen activator inhibitor 1), did not emerge as significantly predictive of abnormal tests. This may be due to the generally increased levels of these markers in our study population or might reflect the impact of treatment with statins, ACE inhibitors, and thiazolidinediones, as well as generally aggressive blood pressure and glucose control."	*Diabetes Care* 2004; 27(Aug):1954-1961 http://care.diabetesjournals.org

CORONARY ARTERY DISEASE • *What's Available:*	Where to Find It:
A Practical and Evidence-Based Approach to Cardiovascular Disease Risk Reduction is an excellent, comprehensive article from the Ciccarone Preventive Cardiology Center at Johns Hopkins University. Dr. Blumental, et al, summarizes, "As the list of medications and interventions for CVD continues to grow, clinicians and patients must remain informed of these therapies. An 'ABC' approach, as we have used in this review, can help by providing evidence for current therapies as well as a framework on which to build an individual therapeutic course of action. The use of this approach can help to increase adherence to guidelines, thereby further helping to reduce morbidity and mortality from CVD." **ABCs of Cardiovascular Disease Risk Management** article is classic Hopkins in format and depth and cites 140 references in support.	*Archives of Internal Medicine* 2004; 1640(14, 26Jul):1490-1500 http://archinte.ama-assn.org
From the limitations, expectations, and conclusion of ALLHAT: Setting the Record Straight, "The simple question ALLHAT [Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial] was designed to address has been answered. As first-step agents, the newer drugs (ACE inhibitors, calcium-channel blockers, and beta-blockers) add no value over and above diuretics in preventing CHD or any of the other major forms of CVD. They are less effective in preventing heart failure and are more expensive than diuretics. Many researchers and clinicians seemed to have been surprised by the following ALLHAT results: 1) Angiotensin-converting enzyme inhibitors were not the best form of first-step antihypertensive drug therapy in preventing cardiovascular events, and 2) calcium-channel blockers were not the worst agents in terms of CHD and deaths. Some of these expectations were derived from preclinical studies, extrapolation from surrogate outcomes, and case-control and other observational studies, all of which had limitations. This is why results from randomized, double-blind, clinical end point trials are needed whenever possible to provide the optimal basis for therapeutic decisions. Individual trials and meta-analyses of trials support or are consistent with ALLHAT results …" The conclusion states, "Lowering high blood pressure is of fundamental importance in reducing CVD risk. How it is lowered does matter. Antihypertensive drugs vary in their efficacy to lower blood pressure and can have blood pressure-independent effects, as seen with regard to preventing heart failure. Diuretics should remain the preferred first-step drugs for treatment of hypertension and should be a cornerstone in the arsenal for care of hypertensive patients."	*Annals of Internal Medicine* 2004; 141(1, 6Jul):39-46 www.annals.org

CONGESTIVE HEART FAILURE • *What's Available:*	Where to Find It:
The Fear of Beta-Blocker Therapy in Heart Failure – Time to Forget (ed.) refers to a companion article in this same issue which discusses the "…results of 9 clinical trials involving more than 14000 patients with follow-up periods ranging from 6 to 24 months. Beta-blocker therapy was associated with a 27% relative reduction in all-cause mortality and an absolute risk reduction of 34 deaths per 1000 patients per year. It is thus indisputable that beta-blocker therapy saves lives of patients with systolic heart failure regardless of the severity, cause, or chronicity of the disease." This editorial states, "Although it is quite clear that beta-blocker therapy is extremely beneficial and lifesaving, some practical guidelines are worth mentioning in relation to initiation and titration of beta-blocker therapy. In clinical practice, one should start beta-	*Archives of Internal Medicine* 2004; 164(13, 12 Jul):1370-1371 http://archinte.ama-assn.org

CONGESTIVE HEART FAILURE• *What's Available:* (continued)	Where to Find It:
blocker therapy only in a stable patient in the absence of cardiogenic shock. The more severe the heart failure is and the lower the blood pressure, the smaller should be the initial dose of the beta-blocker. In patients with severe heart failure and low blood pressure, the titration of the dose of beta-blocker should also be slower. Thus, a general principle one can follow for beta-blocker therapy in patients with heart failure is 'start low and go slow.'"	
The results section of **The Incidence of Congestive Heart Failure in Type 2 Diabetes** states, "Patients with diabetes were much more likely to develop CHF than patients without diabetes (incidence rate 30.9 vs. 12.4 cases per 1,000 person-years, rate ratio 2.5, 95% CI 2.3-2.7). The difference in CHF development rates between persons with and without diabetes was much greater in younger age-groups. In addition to age and ischemic heart disease, poorer glycemic control (hazard ratio 1.32 per percentage point of HbA1c) and greater BMI ([hazard ratio] 1.12 per 2.5 units of BMI) were important predictors of CHF development." The authors state, "Our multivariate results emphasize the importance of controlling modifiable risk factors for CHF, namely hyperglycemia, elevated blood pressure, and obesity. Younger patients may benefit most from risk factor modification."	*Diabetes Care* 2004; 27(Aug):1879-1884 http://care.diabetesjournals.org

ASTHMA & COPD • *What's Available:*	Where to Find It:
Pharmacological Management to Reduce Exacerbations in Adults With Asthma is a systematic review and meta-analysis that states, "Inhaled corticosteroids are the single most effective therapy for adult patients with asthma. However, for those unable or unwilling to take corticosteroids, the use of leukotriene modifiers/ receptor agonists appears reasonable. Long-acting $beta_2$ agonists may be added to corticosteroids for those who remain symptomatic despite low-dose steroid therapy. Anti-IgE therapy may be considered as adjunctive therapy for young adults with asthma who have clear evidence of allergies and elevated serum IgE levels."	*Journal of the American Medical Association* 2004; 292(3, 21Jul):367-376 http://jama.ama-assn.org
Because of the April 2004 implementation of CareFirst's asthma/COPD disease management program, **Contemporary Management of Chronic Obstructive Pulmonary Disease** (*Scientific Review and Clinical Applications*) from last year is brought to your attention. The conclusion of the *Clinical Applications* state, "With the recent understanding of the pathogenesis of COPD, primary preventions should provide the best hope to control the rapid rise of this disease. Thus, smoking cessation and attention to control environmental and work-site pollution are key areas worthy of more attention. For patients who have developed COPD, a variety of treatment modalities (pharmacological and nonpharmacological) can make a difference in their health outcomes." The *Scientific Review* states, "A significant body of evidence supports the use of long-acting bronchodilators and inhaled corticosteroids in reducing exacerbations in patients with moderate to severe COPD." In the *Clinical Applications*, the authors found, "In general, long-term administration of oxygen should be reserved for individuals with COPD who have arterial hypoxemia (PaO2 ≤55 mm Hg), or a PaO2 between 55 and 60 mm Hg with evidence of pulmonary hypertension, cor pulmonale, or secondary erythrocytosis (hematocrit >55%). In these patients, continuous domiciliary oxygen therapy (for >15 h/d) sufficient to correct hypoxemia (PaO2 >60 mm Hg or SaO2 >90%) has been shown to improve survival."	*Journal of the American Medical Association* 2003; 290(17, 5Nov):2301-2312 and 2313-2316

OTHER ITEMS OF INTEREST • *What's Available:*	Where to Find It:
The introduction of **Evaluation and Management of the Cardiovascular Patient Embarking on Air Travel** states, "This case-based review describes the risks of air travel in a 65-year-old man with known cardiovascular disease. After reviewing the limited data on safe air travel after myocardial infarction and the common complications after both percutaneous intervention and coronary artery bypass grafting, we provide recommendations on safe air travel after myocardial infarction. We discuss the safety of both preflight screening and the in-flight environment with regard to pacemakers and implantable automatic defibrillators. We also review the literature on in-flight venous thrombosis and provide recommendations to prevent in-flight deep venous thrombosis."	*Annals of Internal Medicine* 2004; 141 (2, 20Jul):148-154, www.annals.org
The results of **Hand Hygiene among Physicians: Performance, Beliefs, and Perceptions** state, "Adherence [to hand-washing] averaged 57% and varied markedly across medical specialties. In multivariate analysis, adherence was associated with the awareness of being observed, the belief of being a role model for other colleagues, a positive attitude toward hand hygiene after patient contact, and easy access to hand-rub solution. Conversely, high workload, activities associated with a high risk for cross-transmission, and certain technical medical specialties (surgery, anesthesiology, emergency medicine, and intensive care medicine) were risk factors for nonadherence." The conclusions state, "Physician adherence to hand hygiene is associated with work and system constraints, as well as knowledge and cognitive factors. At the individual level, strengthening a positive attitude toward hand hygiene and reinforcing the conviction that each individual can influence the group behavior may improve adherence among physicians. Physicians who work in technical specialties should also be targeted for improvement." See also the editorial in this same issue, **Hand Hygiene – Of Reason and Ritual**, which concludes, "The age of reason is over. Hand hygiene and use of alcohol-based hand-rub solutions must become a ritual, automatic behavior. We must bind alcohol hand-rub solution dispensers on every doorpost in every health care facility. Physicians must use these products as a matter of ritual on entering and leaving every patient's room. In every specialty, we must act as role models for our students and trainees so that they become inculcated into this ritual. We must change the rules so that health care workers expect to be observed and given direct, immediate feedback until the behavior of role models becomes everyone's ritual. Some day, a technological advance will make this ritual obsolete. Until then, ritual it must be."	*Annals of Internal Medicine* 2004; 141(1, 6Jul):1-8 www.annals.org

New and Emerging Technology

CareFirst and CareFirst BlueChoice's Technology Assessment Committee -- which includes CareFirst and CareFirst BlueChoice physicians and nurses and external consulting physicians -- reviews new and developing technologies. The committee relies on current medical literature, local expert consultants and physicians to determine whether those technologies meet CareFirst's criteria for coverage. Coverage policies applicable to national Blue Cross Blue Shield accounts and Federal Employees Benefits Programs may differ from those at the local account level. The review criteria can be found in the *Providers & Physicians* section of www.carefirst.com by clicking on *Medical Policies*. The Technology Assessment Committee recently made the following determinations:

Laparoscopic Uterosacral Nerve Ablation (LUNA) Procedure for Chronic Pelvic Pain

Ablation of the uterosacral nerve, usually with a laparoscopic laser proposed as either adjunct to ablation of endometrial implants or as treatment for primary dysmenorrhea.

CareFirst and CareFirst BlueChoice determination
There are few well-designed studies addressing the **contribution of laparoscopic laser ablation to pain relief from endometriosis.** The studies that are published established that endometriosis patients who do not respond well to hormonal mediation with anti-prostaglandins ablation of endometrial implants can effectively relieve symptoms. However, in studies where LUNA was used as an adjunct, authors tend to conclude that LUNA adds no incremental benefit. Therefore, **we consider LUNA not medically necessary in this application**.
LUNA has also been used as a **treatment for primary dysmenorrhea**, with varying degrees of success. Some small studies reported unclear outcomes -- improvement of observed symptoms vary from 33% to 80% of the patients. One early study involved a cohort of 21 patients randomized to LUNA vs. control. A 2000 Cochrane systematic review analyzing three randomized controlled trials that qualified for inclusion in the meta-analysis noted that patients who underwent LUNA experienced some short-term relief, but did not experience statistically significant relief in the long-term. There is insufficient data to permit conclusions concerning the effect of LUNA on outcomes of patients with primary dysmenorrhea. As a result, **we consider LUNA to be experimental/investigational for this application**.

Pulsed Electrical Stimulation (PES), e.g. BIO-1000® System for Treatment of Osteoarthritis of the Knee

An electrical stimulation unit designed to deliver PES to the knee. The purpose of the BIO-1000 unit is to stimulate new cartilage growth in the arthritic knee and to delay or obviate the need for surgery.

CareFirst and CareFirst BlueChoice determination
Studies of PES to the knee generally involve small study groups, where reported results lack statistical power to support conclusions regarding favorable outcomes. The studies also generally observed results over short-term only. A Cochrane review reported that PES has a small to moderate effect on outcomes for knee osteoarthritis in terms of reducing subjective symptoms and improving of activity, and that further studies are needed. The claim that PES can cause new cartilage growth could not be substantiated in the literature. The claim that PES can prevent surgery for the arthritic knee was based on a retrospective study that contained significant methodological flaws (i.e., historical controls, lack of randomization and possible study bias). Since the evidence does not permit conclusions on the effect on overall patient outcomes, **we consider the technology experimental/investigational**.

Bone Anchored Hearing Aid (baha® system)

A hearing aid that uses bone conduction of the sound impulse through an implant in the temporal bone.

CareFirst and CareFirst BlueChoice determination
The device is a **covered benefit in plans that provide benefits for hearing aids**, up to the limit specified in the plan. The charge for surgical implantation of the device in the bone is eligible for coverage. Under plans that exclude coverage for hearing aids, there is no benefit for the device or any associated expenses, including the charge for surgical implantation.

First-Trimester Pregnancy Screening with Fetal Nuchal Translucency (FNT) Measurement for Assessment of Risk for Chromosomal Aneuploidy

A diagnostic ultrasound focused on the area of the fetal neck is performed with certain serum markers, such as free beta HCG and PAPP-A, to evaluate the probability of the fetus being born with a condition like Down syndrome.

CareFirst and CareFirst BlueChoice determination
This assessment was performed in response to the American College of Obstetrics and Gynecology's announcement of an updated practice advisory on first-trimester screening. **We consider first-trimester screening medically necessary.**

Magnetic Resonance Spectroscopy (MRS)

A related procedure to magnetic resonance imaging (MRI), MRS provides information about the chemistry and functional physiology of the examined tissue. MRS uses the same basic principles as MRI. The major difference is that MRS signals are displayed in graphic form with spectral peaks characterizing the chemical entities detected.

CareFirst and CareFirst BlueChoice determination

Centers for Medicare and Medicaid Services (CMS) commissioned three evidence-based technology assessments in 2003. The first assessment, conducted by the Technology Evaluation Center (TEC), concluded that the limitations in methodologies and patient samples made assessing the sensitivity and specificity values difficult. The few studies that met review criteria showed inconsistent methods of confirming diagnosis, heterogeneity of the study population, lack of standardized criteria for interpretation of results, retrospective methods, and small sample sizes. As a result, sensitivity in the studies showed a broad range -- 79%-100% -- as well as specificity -- 74%-100%. These results illustrate the weaknesses of the study design and measurement criteria; it is not possible to reach reliable conclusions on the effect on outcomes. The second assessment, conducted by the Agency for Healthcare Research and Quality (AHRQ), describes the lack of uniformity in the criteria that defines the "outcome of interest." In terms of net health outcomes, the reviewers note that there is not enough evidence to draw conclusions on the effect on health outcomes, due to small sample size and methodological limitations. The report concludes that human studies confirm that the procedure is technically feasible, and that there may be a benefit for some of the proposed indications. However, there is a lack of standardized techniques for acquiring and reporting data from MRS and there is a lack of evidence demonstrating how information from MRS influences diagnostic and therapeutic decision-making. Finally, CMS convened an independent panel to perform an evidence-based assessment. The conclusions of the CMS technology assessment group in the final analysis were consistent with the report from the TEC and the AHRQ assessments. While there are a large number of studies on the technical feasibility of MRS, few published studies evaluate its diagnostic accuracy and whether it can favorably affect diagnostic ability and treatment choice. The published articles show a number of methodological weaknesses that preclude conclusions on the validity of and ability to generalize the findings. There is a lack of evidence regarding the diagnostic accuracy of the test. There are no controlled studies comparing existing diagnostic strategies with MRS alone or as adjunct to demonstrate the effect of MRS on net health outcomes. Therefore, **we consider magnetic resonance spectroscopy to be experimental/investigational**.

Pre-Implantation Genetic Diagnosis (PGD)

PGD involves an in-vitro fertilization procedure, followed by a biopsy and genetic analysis of the embryo before implantation. The technique uses either fluorescent in-situ hybridization technology or polymerase chain reaction to analyze for the presence of genetic-based defects or aneuploidy and translocation carriers. The procedure may also be used for tissue matching of siblings for tissue donor purposes.

CareFirst and CareFirst BlueChoice determination

PGD generated concerns regarding the ethics of when to offer it because of the in-vitro nature of the procedure and the fact that embryos will ultimately be selected or destroyed based on the genetic analysis. These questions will ultimately be resolved through legal regulation, professional practice standards or a combination of regulatory mechanisms. PGD involves the use of proven laboratory technologies, so it is **not** considered experimental/ investigational. We determined that PGD may be considered medically necessary in screening of embryos for single-gene diseases where one or both parents are known to be carrying the disease. **PGD is considered not medically necessary as screening for aneuploidy or translocations in high risk individuals**, as effective methods for detection are already in use post-conception. Likewise, **PGD is considered not medically necessary for selecting embryos for potential tissue donor matches for siblings.**

PGD must be performed with in-vitro fertilization. Benefits may not be available for individuals seeking PGD if the member does not qualify for IVF benefits under the terms of her plan.

Computer-Assisted Orthopedic Surgery

Computer-assisted surgery (CAS) refers to navigational systems that assist the surgeon in the operating room by providing guidance and feedback regarding the patient's anatomy, with the purpose of improving outcomes in terms of more precise anatomical alignment in joint replacement surgery or trauma surgery

CareFirst and CareFirst BlueChoice determination

CAS was developed to improve alignment in total joint arthroplasty and delicate spinal surgery, and, by extension, to improve patient outcomes. The published literature contains review articles describing how these systems work, and the goals of incorporating these systems into the mechanics of orthopedic surgeries. There are no well-designed, randomized comparison studies that validate the claims for improved patient outcomes made by the proponents of CAS. At the present time, **we consider computer-assisted surgery experimental/investigational** because of the insufficient evidence to determine if the technique improves patient outcomes.

Weighing the Risks of Opiate Prescriptions

By Anthony G. Massey, MD, Associate Medical Director, MidAtlantic Service Center of Magellan Behavioral Health

When prescribing opiate medications for patients with chronic nonmalignant pain, providers should balance the risks of abuse of these addictive medicines against the risk of inadequately treating painful medical conditions. These risks are usually weighed by performing individual assessments to evaluate a patient's unique risk for opiate misuse.

At one time, most providers thought that most patients have a high risk for abuse of opiates, and the long-term use of these medications should be restricted. This attitude first changed in the care of patients with malignancies or other terminal conditions. More recently, there has been a growing recognition of the role of selected opiates in a comprehensive treatment paradigm of nonmalignant chronic pain.

Many providers review chronic pain patients' substance abuse history to assess the risk of their abuse of prescribed opiates. However, research has failed to validate this information. One study found that within a group of patients with nonmalignant pain, a history of previous substance abuse did not predict which patients would abuse opiates. The U.S. Drug Enforcement Administration supports the use of narcotics for the treatment of chronic pain even in patients who may be currently enrolled in a narcotic treatment program such as a methadone maintenance program.

More recently, there has been a growing recognition of the role of selected opiates in a comprehensive treatment paradigm of nonmalignant chronic pain.

Valid Risk Assessment

Certain behaviors during treatment may help providers assess a patient's potential for abuse of opiates. A study by Chabal, et. al., reviewed five risk criteria for diagnosing opiate abusers within a population of patients receiving opiates for chronic nonmalignant pain. If the patient who is taking prescribed opiates:

- Focuses overwhelmingly on opiate issues during pain clinic visits and it gets in the way of treatment and persists into and beyond the fourth visit
- Has no acute changes in his/her medical condition, but refills prescriptions early on a regular basis, and, as a result, increases opiate use
- Makes numerous telephone calls or visits related to opiate prescriptions.
- Shows a pattern of opiate prescription problems, such as lost, spilled or stolen medications
- Has several sources for receiving opiates, such as ERs, other providers or illegal sources.

While this study suggests that patients who meet three of the five criteria have a very high likelihood of opiate abuse, patients who meet even one of these criteria should trigger a red flag. Such patients would likely need a more formal substance abuse assessment or simply a referral to a psychiatrist or addiction medicine specialist.

References:

1. Fishbain DA, Rosomoff HL, Rosomoff RS. Drug abuse, dependence, and addiction in chronic pain patients. Clin J Pain 1992;8:77-85

2. Good P. DEA: pain management in addiction medicine. Drug Enforcement Administration: U.S. Department of Justice; March, 2000

3. Chabal C, Erjavec MK, Jacobson L, Mariano A, Chaney E. Prescription Opiate Abuse in Chronic Pain Patients: Clinical Criteria, Incidence, and Predictors. Clin J Pain 1997;13:150-155

Tools to Help Diagnose Depression

By T.A. Dadisman, MD, Medical Director, Preventive Medicine and Health Promotion

Over half of all depressed patients are treated in primary care practices. However, fifty percent of significantly depressed patients go unnoticed. Please be sure to routinely screen your patients for depression. Here are two easy to use tools to help screen for depression.

The *Patient Health Questionnaire-2 (PHQ-2)* and the *Patient Health Questionnaire-9 (PHQ-9)*, used serially, are perhaps the best validated two-stage tools to detect major depression in primary care offices. These two helpful tools can yield overall accurate results of 95 percent in the diagnosis of depression. These tools can be found in "Efficient Identification of Adults with Depression and Dementia," a recent article by Jane M. Thibault, M.S.S.W., PH.D., and Robert William Prasaad Steiner, M.D., PH.D. in American Family Physician 2004; 70 (6, 15 Sep):1101-1110, http://www.aafp.org/afp/20040915/1101.html.

Patient Health Questionnaire-2

The PHQ-2 is the initial screen and asks how often a patient has been "bothered by:" "little interest or pleasure in doing things" and "feeling down, depressed or hopeless." Patients can answer on a scale from 0 to 3 (i.e., not at all to nearly every day).

According to the article, the PHQ-2 can give a probability of major depressive disorder ranging from about 15 percent to nearly 79 percent, and a probability of any depressive disorder of 37 percent to 93 percent.

Patient Health Questionnaire-9

The PHQ-9 with nine questions and similar scoring is an excellent confirmation of a diagnosis of major depressive disorder for patients that have a positive result on the PHQ-2. The PHQ-9 can also be used to monitor the severity of the patient's depressive symptoms and their response to treatment.

If you prefer not to use formal questionnaires, the article lists the suggested questions from the 4th edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for a major depressive episode to diagnose major depression, monitor response to treatment and detect recurrence or relapse of major depression.

For CareFirst's *Clinical Practice Guidelines for Depression in Adults in the Primary Care Setting*, visit the *Physician & Providers* section of www.carefirst.com and click on *Clinical Resources* in the Solution Center. Contact Quality Improvement at 410-528-7997 for hard copies of these guidelines.

For additional information on depression, see "Awareness About Depression," in Journal of the American Medical Association 2003; 289 (23, 18 June): 3145-3151, http://jama.ama-assn.org/cgi/content/full/289/23/3169.

CDC Reinstates Four-Dose Administration of PCV7

Effective immediately, the Centers for Disease Control (CDC) recommends that providers resume the routine four-dose administration of PCV7 (trade name, Prevnar) to children. These recommendations are issued in consultation with the American Academy of Family Physicians, the American Academy of Pediatrics and the Advisory Committee on Immunization Practices (ACIP).

Due to production problems earlier this year, there was a shortage of Prevnar which led to the fourth dose of the series being withheld in February 2004 and then, the third dose was withheld beginning in March 2004. Providers may administer the recommended four-dose schedule for young children. According to the schedule, children aged 2 months, 4 months, 6 months and between 12 to15 months should each receive one dose of Prevnar. The CDC also recommends a catch-up schedule for children who missed vaccinations during the shortage.

This information can be accessed directly from http://www.cdc.gov/nip/news/shortages/default.htm#Which. You may also call the CDC's national immunization hotline at 800-232-2522.

Help Educate Female Patients About Heart Disease

Less than half of American women know that heart disease is their biggest health threat. Most women fail to make the connection between heart disease risk factors and their personal risk of developing heart trouble.

The Heart Truth campaign's goal is to educate women about their risk of heart disease. The Heart Truth makes it easy to educate your patients about the dangers of heart disease. Visit www.hearttruth.gov and click on *Campaign Materials* at the bottom of the page to get materials to share with your patients, including:

- *When Delicious Meets Nutritious* - recipes for heart health
- *The Heart Truth: Women and Heart Disease* - overview of and risk factors for heart disease
- *The Heart Truth for Women: If You Have Heart Disease* - treatment options; heart attack symptoms
- *Action Plans* for African American Women and Latinas

The Heart Truth campaign is sponsored by the National Heart, Lung, and Blood Institute, part of the National Institutes of Health, U.S. Department of Health and Human Services, and is reaching women with important heart health messages in community settings through a network of national and grassroots partner organizations.

*Care*Essentials: Disease Management

As part of the Disease Management component of *Care*Essentials, our care management program that provides you with essential tools for patient care, CareFirst offers a free, comprehensive program for members who have or are at risk for congestive heart failure and coronary artery disease. For more information, visit the *Providers & Physicians* section of www.carefirst.com and click on *Disease Management*. To refer a member, call 800-783-4582.

On National Wear Red Day, Friday, February 4, Americans nationwide will support the Heart Truth campaign by wearing red to show their support for women's heart disease awareness.

CareFirst Celebrates 70th Anniversary

In 1934, a group of hospitals, in Washington, D.C. came together to form Group Hospitalization, Inc. That small hospital group has evolved into what we all know today as CareFirst BlueCross BlueShield, which makes this year its 70th birthday. After 70 years of serving Maryland and the National Capital Area, CareFirst remains proud of its tradition of providing caring service.

CareFirst's strength, stability and seven decades of innovation lead the way in providing **The Benefits of Blue** to providers and members through out the Mid-Atlantic region.

Thank you for choosing to participate in the CareFirst networks and continuing to provide quality care to our members.

Varicella Reminder

The incidence of varicella in the U.S. is highest between late winter and early spring. When assessing patient immunization status, children without a reliable history of chickenpox or with an uncertain history of immunization should be considered susceptible.

Varicella vaccination also should be considered for adolescents and adults at high risk of exposure, including:

- residents and staff of institutional settings, including college students, inmates and staff of correctional institutions
- military personnel
- teachers of young children
- day-care workers
- non-pregnant women of childbearing age
- international travelers
- health care workers
- susceptible family contacts of immunocompromised individuals

Combating Obesity

As part of its *Shape Up…Live Well* anti-obesity initiative, CareFirst BlueCross BlueShield is combating obesity by awarding grants to 12 groups with creative programs designed to prevent and reduce obesity and its associated health risks.

"The combination of poor diet and inactivity is the number one cause of preventable death in the U.S., after smoking," said Medical Director T.A. Dadisman, M.D. "CareFirst is dedicated to encouraging people to become active. *Shape Up…Live Well* is a perfect opportunity to help motivate people in the communities we serve."

Some sponsored programs include:

- A year-long program from the **Johns Hopkins School of Nursing** that helps prevent or limit obesity in two Baltimore City schools.
- **Calvert Walks,** a community-based program at Calvert Memorial Hospital that promotes walking and proper eating.
- An **Evergreen Cove Holistic Center and the Talbot County Health Department** program targeting the underinsured and uninsured to become physically active and lose excess weight.
- **"Get Hip and Healthy"** program at Open Gates, a community-based Baltimore clinic, promotes healthy diet and physical activity among high risk and overweight adults.
- **DC Scores**, an organization that uses physical fitness, literacy and service learning to improve the lives of 630 public school children, will launch a program designed to reduce health risks by promoting healthy lifestyles and physical activity.
- **Christiana Care Health Services** designed a program for third, fourth and fifth graders to implement weight management programs and healthy lifestyle classes.

A team of CareFirst associates, medical professionals and external grant-makers chose from more than 200 non-profit and charitable organizations that were invited to submit proposals for battling obesity. Programs were chosen based on project goals and objectives, inclusion of evidence/ research-based components, scope, comprehensive outcome measures and the background of the organization.

*Care*Essentials: Prevention

You may direct your patients to our Weight Management Center, the latest addition to the prevention component of CareEssentials, our care management program that provides you with essential tools for patient care. To access the center, visit www.carefirst.com and click on *My CareFirst.*

Increased Virulence of Clostridium Difficile

The bacterium, *Clostridium difficile*, is the most common cause of antibiotic-associated diarrhea, accounting for at least 15 percent of all episodes. *C. difficile* is primarily spread by health care personnel who come in contact with contaminated patients.

Current Epidemic

A strain of *C. difficile* with increased severity virulence has become prevalent in several hospitals in the U.S.A. and Canada. These organisms show:

- Resistance to fluoroquinolones, a class of broad-spectrum antibiotics
- Additional resistance to antimicrobials, which may be allowing the bacterium to flourish
- Additional toxin, which may be related to the increased virulence of the bacterium
- Missing gene that regulates production of the A and B toxins normally made by the bacterium. Researchers believe the absence of the gene could produce more of the toxin.

Prevention

To help prevent the spread of *C. difficile:*

- Prescribe antibiotics judiciously
- Place patients with *C. difficile*- associated disease in a private hospital room
- Practice good hand hygiene* between examining patients
- Encourage your patients to:
  - Wash hands with soap and water, specifically after using the bathroom and before eating
  - Clean bathroom and kitchen surfaces with disinfectant

*See **Hand Hygiene Among Physicians: Performance, Beliefs and Perceptions** *Annals of Internal Medicine* 2004; 141(1, 6Jul):1-8, http://www.annals.org.

Resource: ProMED-mail (03Oct2004), a program of the International Society for Infectious Diseases

2004 MHCC HMO Report Cards Released

The Maryland Health Care Commission (MHCC) recently released its annual guide for consumers on the performance of seven Maryland Health Maintenance Organizations (HMOs). The annual performance reports are a source of objective, independently audited information on the quality of commercial HMOs. They contain information on:

- Frequency that members obtain preventive and wellness services
- Member satisfaction with the health care they receive
- How members feel about their health plan

Report card results are based on the Consumer Assessment of Health Plans Survey (CAHPS® 3.0H) and clinical data from Health Plan Employer Data Information Set (HEDIS®) audits. The report card, *The 2004 Consumer Guide to Maryland HMOs & POS Plans,* is published in its entirety by MHCC and is available at www.mhcc.state.md.us or by calling the Commission at **877-245-1762**.

The National Committee for Quality Assurance (NCQA) also publishes HEDIS results and compares many HMOs on a national and regional basis in *The State of Health Care Quality 2004* report available on NCQA's Web site at www.ncqa.org.

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