



Winter 2007 VOL. 10 ISSUE 1

# INfOCUS

**Best Practice 2**  
Staying Focused on the  
Customer Improves Care,  
Saves Lives

**CareFirst Commitment 5-6**  
American Stroke Association,  
CareFirst Strive to Provide  
'Power to End Stroke'

**CareFirst Wins NCQA Award  
for Closing The Gaps**

**Technology 7**  
New and Emerging Technology



**Disease Management 10**  
CareFirst and CareFirst  
BlueChoice Disease  
Management Initiatives

**Quality Improvement 14**  
2006 HMO Report Cards  
Released

**Philosophy of Care 16**

CLINICAL NEWS FOR PARTICIPATING PHYSICIANS AND PROVIDERS

Visit us at [www.carefirst.com](http://www.carefirst.com)

## Best Practice

### Staying Focused on the Customer Improves Care, Saves Lives

*The following is presented in an effort to highlight hospital “best practice” in the CareFirst and CareFirst BlueChoice service areas and to share with medical professionals throughout the region the innovative approaches hospitals are adopting in Maryland, Washington, D.C. and Northern Virginia. Their “best practice” approach to patient care is not only improving the quality of care but also helps contain the rising cost of care.*

A recent survey of the 100 most successful corporations in the United States revealed a common business philosophy: “Stay focused on the customer.”

Now that same philosophy applied by companies such as Microsoft, American Express and Coca Cola is being adopted at care centers throughout the CareFirst BlueCross BlueShield service area where doctors, nurses and other staff members “stay focused on the patient” to provide faster, better and more effective medical care. Underlying the improved procedures for delivering care that directly addresses the needs of patients is a business practice called “Lean Management” – a methodology adopted several decades ago by manufacturing companies in Japan to drive out waste, add value to work and serve the customers’ needs.

At St. Agnes Hospital in southwest Baltimore, Lean Management got its start in March 2005, under the direction of William Greskovich, Vice President of Operations and Chief Information Officer. Existing procedures were first reviewed and analyzed to determine what could be improved, what could be eliminated and what should be retained as is.

“We have found ways to identify wasted motion – from the moment a patient arrives at St. Agnes [Hospital] – and to streamline procedures that not only speed up the care process but also improve safety and cut costs,” says Ken McCormick, Director of Lean Management at the hospital.

A business management theory introduced in Japan after World War II by American statistician and efficiency expert W. Edwards Deming, Lean Management

encourages the smooth, unencumbered flow of work by cutting out unnecessary steps in the work process and using teamwork to identify and remedy problems as they occur. In a hospital setting, this translates into providing care as quickly and efficiently as possible – but without compromising patient safety, approved medical procedures or traditional expectations of comfort and attention. It also requires that the focus of all who are involved with providing care “stay focused on the customer” -- the patient.

“In the final analysis, Lean is a thought process,” McCormick says. “It is a way of thinking about how a product or service flows through a series of steps in the most efficient way possible.”

McCormick says that “flow” is improved when a strategy is developed to eliminate wasted motion, improve the balance of work among those involved in the production or service process, and a true sense of teamwork is achieved.

Dr. Daniel Winn, Associate Vice President and Senior Medical Director for CareFirst, says the thought process associated with Lean Management can have broad impact. “We have seen time and time again that what begins as a focus on efficiencies, ends up in improving clinical outcomes,” he explained.



Any attempt to introduce the principles of Lean Management all at once throughout an operation as large and as complex as the modern hospital would be a recipe for chaos. Since adopting Lean as its continuous improvement methodology, St. Agnes has completed 75 Lean Rapid Improvement Events (RIE), a specific set of procedures to introduce Lean Management techniques. One such RIE was used to focus on reducing the time it takes to get a patient who arrives complaining of chest pains from the Emergency Department to a life-saving procedure called percutaneous coronary intervention (PCI), a procedure previously, and more commonly, known as “angioplasty.”

The starting point for evaluating PCI procedures at St. Agnes was relatively simple: Maryland law mandates that when hospital emergency department physicians determine that PCI is appropriate for patients complaining of chest pain, it must be performed within 120 minutes of the patient’s arrival in at least 85 percent of such cases.

The “Lean Team” at St. Agnes set its goal to treat their PCI potential patients in 90 minutes or less from arrival at the Emergency Department to introduction of the “balloon” – a tiny air-filled instrument commonly used in angioplasty procedures to clear a blocked artery and prevent a heart attack.

The first step toward a Lean Management environment is called a Value Stream Analysis – a combination of “tools” and techniques used to evaluate an existing business process and to prescribe a plan for transforming it to achieve better results.

The Value Stream Analysis of existing procedures revealed that the Emergency Department and PCI staffs were required to take 66 steps – unique individual actions by various hospital staff members – to get a patient from the Emergency Department to the balloon procedure. The lapsed time was fixed at 119 minutes.

Under the “current state” or existing routines, patients arrived at the Emergency Department confused, in pain and not knowing where to go or what to do. They were frequently required to wait while the staff evaluated other

**“We have found ways to identify wasted motion – from the moment a patient arrives at St. Agnes [Hospital] – and to streamline procedures that not only speed up the care process but also improve safety and cut costs,”**

*Ken McCormick, Director of Lean Management at the hospital*

patients seeking care and decided who should be treated and in what order. Chest pain patients then were moved to a coronary treatment room where more time was lost waiting for heart specialists and nurses to arrive. The clock continued to tick as the patient was evaluated and a decision made in favor of primary angioplasty (PAMI). Once that decision was made, patients were moved to a cardiac catheterization lab and after additional preparation, the procedure would be performed. Total time: 119 minutes – just barely under the state’s mandated 120-minute standard.

To do better, the St. Agnes Lean Team advanced to the next step of the Lean Management strategy -

- Rapid Improvement Events (RIE). Extending over five consecutive days, this process depends on rapid, focused introduction of new procedures and evaluation of results to yield immediate improvements. Work areas were reconfigured, routines streamlined and operations integrated, all with a single objective in mind – decrease the time needed to provide care without compromising the quality or the outcome of care.

On day one of RIE, the team studied in detail the current conditions starting with patient arrival and Emergency Department procedures to identify “wasted motion” and other time-consuming inefficiencies. On day two, the team began to make necessary changes such as streamlining routines, moving equipment, pre-positioning needed supplies, testing and evaluating time-saving benefits. The majority of day three was devoted to testing and “de-bugging” the newly configured work areas.

By the end of day three, a new time-saving path from Emergency Department to PCI was in place and familiar to those who would be directly involved in making it work. Day four was designated as a “standard work” day to incorporate all the changes that had been introduced over the prior three days. This day is intended as a critical jumping off point to clearly establish what should be done, who should do it and what objectives and performance standards are expected.

“The Fourth Day is the heart and soul of a successful Lean Management transformation process,” says St. Agnes’ McCormick. “It ensures that a new ‘normal’ condition has been established.”

## Best Practice

The last day of the RIE week – day five – is designed to review what has been accomplished, evaluate the results and recognize those who contributed to the success of the initiative.

The evaluation of St. Agnes' effort to decrease the time from arrival at the Emergency Department with chest pain and the potentially life-saving PCI procedure revealed dramatic results. The original 66 administrative and medical steps and procedures had been reduced to only 36. And, instead of the 119 minutes from arrival to PCI, the patient's journey from pain, uncertainty and confusion to comfort and recovery had been reduced to only 77 minutes and 39 seconds, on average.

How did they do it?

The answer is at once complex and simple. It is complex in that a great many components of the process must be identified, evaluated, revised or integrated with a single purpose in mind – do it better, faster, more efficiently. It is simple in that some of these many components involved the very obvious – but often overlooked:

- New signage outside and inside the Emergency Department to guide patients, simplify their arrival and get them promptly on the right track to the right care.
- Stopwatches for chest pain patients so that nurses and doctors always know just where they are in the 90-minute time continuum.

- A redesigned questionnaire for chest pain patients arriving at the Emergency Department.
- Clip boards with complete medical and personal documentation that stay with the patient while at St. Agnes.



Some tasks within the Emergency Department were re-assigned, a new 12-lead EKG monitor was used in the resuscitation room and two rooms in the Emergency Department were designated for patients who arrived with chest pains. These rooms were outfitted with locked refrigerators for medications specifically intended for use by physicians treating chest pain.

St. Agnes's success with the Lean Management approach translates directly into a more important outcome than simply decreasing the lapsed time from Emergency Department to PCI. In the final analysis, it means patients receive faster and better care. Lives are saved. And the

“customers” who arrive at the St. Agnes Emergency Department complaining of chest pains leave with a sense that throughout their hospital visit they were the focus of concern for skilled, experienced physicians, nurses and staff personnel who know their jobs and do them well.

### American Stroke Association, CareFirst Strive to Provide “Power to End Stroke”

Dr. Eric M. Aldrich slowly names the demons: High blood pressure. Diabetes. Smoking. High cholesterol. Each, he says, is a contributing factor for the high rate of stroke among African-Americans.

“Problem is, we know that people of African descent in the United States have twice the risk of having a stroke,” says Dr. Aldrich, an assistant professor of neurology at Johns Hopkins Hospital. “What we have to do is inform them about preventive measures to take to reduce the numbers.”

Dr. Aldrich is working with CareFirst BlueCross BlueShield and the American Stroke Association to reduce the high incidence of stroke in the African-American community through an initiative called “Power to End Stroke,” a grassroots effort to increase stroke awareness and prevention.

Through word of mouth and networking, the “Power to End Stroke” program will inform the members of the African-American community of the signs, causes and preventive measures of stroke.

“A lot of it is about modifying human behavior,” said Dr. Aldrich, who said changes such as stopping smoking and lessening alcohol consumption, and improving eating and exercise habits can reduce the likelihood of a stroke.

Stroke is the third leading cause of death in the Mid-Atlantic region and blacks have almost twice the risk of suffering first-ever strokes than whites, Dr. Aldrich said.

In addition, stroke is the main cause of disability and the third most common type of death in Maryland behind heart disease and cancer. In Maryland, someone suffers a stroke every three to four minutes.

“It is diet, smoking, genetic or a combination of all of them,” Dr. Aldrich said.

The “Power to End Stroke” program will be more personal and one-on-one in nature than other stroke prevention programs that used higher profile media campaigns.

The initiative will include local business leaders and discuss the financial impact of stroke, the distribution of physician toolkits specifically designed to help doctors better inform patients and radio advertising. CareFirst has made a \$75,000 grant to the initiative.

“The campaign will be instrumental in creating awareness about stroke risk factors and advising people on stroke prevention,” said Jon Shematek, M.D., CareFirst Vice President, Quality and Medical Policy. “CareFirst looks

forward to working with the American Stroke Association to lower the number of people having strokes in the African-American community and beyond.”

The “Power to End Stroke” effort also will correct many myths about stroke, such as it affects only older people, when 25 percent of those who suffer a stroke are under age 65.

Another misconception is that stroke victims never fully recover. In fact, 40 percent of those who suffer a stroke show no signs of their setback upon recovery.

Dr. Aldrich recalls when actor Robert Guillaume suffered a stroke while filming the television series “Sports Night” in the late 1990s.

Guillaume, famous for his television role of “Benson” and subsequently the central character of “Sports Night,” suffered a stroke and was forced to take a break from filming.

“But he recovered and went through rehab and came back to continue acting on the show,” Dr. Aldrich said.

Call the American Stroke Association at 888-4-stroke or visit [www.shoppower.org](http://www.shoppower.org) to order Power to End Stroke health education materials for your patients.

CareFirst has a limited number of Power to End Stroke Physician Tool Kits containing brochures, pledge cards, pins, posters and quizzes that you can distribute to your patients. If you would like to order a Physician Tool Kit for your office, please send an email to [health.communications@carefirst.com](mailto:health.communications@carefirst.com).



# CareFirst Commitment

## CareFirst Wins NCQA Award For Closing The Gaps

The National Committee for Quality Assurance (NCQA) recognized CareFirst recently for its Closing the Gaps initiative. After carefully reviewing more than 60 applications from all across the country, NCQA selected CareFirst as one of ten winners in the Recognizing Innovation in Multicultural Health Care Award for partnering with organizations to provide better care to the community.

### Closing the Gaps

Lack of health care insurance, language barriers and variations in health care practices mean that too many of the region's residents do not always receive the appropriate care. CareFirst partnered with organizations during the last two years to address the disparities in health care among Hispanic, Asian and African American communities.



### La Clinica Del Pueblo

CareFirst partnered with La Clinica Del Pueblo in Washington, D.C. to improve diabetes care among the local Latino population. Some 150 low-income Latino patients are participating in this innovative three-year program.

### Boat People SOS

Vietnamese women are reluctant to be screened for cervical cancer which puts them at higher risk for developing the disease. CareFirst partnered with Boat People SOS in Fairfax, Virginia to raise awareness of the disease and improve screening rates by 10 percent.

### Hair, Heart and Health

A joint venture between CareFirst and the University of Maryland School of Medicine, Hair, Heart and

Health was launched late last year at a small number of Baltimore area barbershops and hair salons.

Hair stylists received free training and certification as Blood Pressure Measurement Specialists and screen their customers for free. The goal is to identify those with high blood pressure so they can seek medical care and lessen their health risk.

Statistics from the American Heart Association show that heart disease and stroke cause more deaths among African Americans than any other ethnic group.

“The Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic*

*Disparities in Health Care* provides a blueprint for eliminating health disparities,” said Malcolm Joseph, M.D., CareFirst Medical Director.

“The Institute of Medicine’s recommendations for reducing racial and ethnic disparities in health include increasing awareness about disparities among the general public, health care providers, insurance companies and policy makers. CareFirst has implemented the Institute of Medicine’s recommendations and the Care Commitment initiatives are effectively reducing health care disparities.”

“This award means a lot to CareFirst and validates all the hard work by everyone, departments and key personnel to implement the ‘Closing the Gaps’ initiatives,” said Doris Addo-Glover, RN, MSN, Senior Quality Improvement Specialist. “I am proud that NCQA chose CareFirst as one of its recipients for innovation in multicultural health care.”

“This is particularly true, since we had to develop creative and innovative ways to reach communities with high disease prevalence. Closing the Gaps addresses both regional and national concerns to reduce health disparities and CareFirst has demonstrated its commitment to be a part of the solution.”

### FluMist™ Not Covered

CareFirst and CareFirst BlueChoice will not cover the FluMist™ intranasal vaccine for local and NASCO members during the 2006-2007 flu season. This does not apply to members with FEP coverage.

FluMist™ offers no medical advantage over the traditional shot. As a result, CareFirst and CareFirst BlueChoice consider FluMist™ a personal choice item, and is excluded

from coverage. Providers may bill members who choose to receive FluMist™.

The influenza vaccine by injection is covered for members with an immunization benefit. Be sure to verify member eligibility and benefits prior to rendering services, as benefit limitations may apply.

### Pharmacy and Therapeutics Committee

The CareFirst Pharmacy and Therapeutics Committee (P&T Committee) is comprised of CareFirst and community physicians and pharmacists responsible for developing and maintaining the Formulary (Preferred Drug List) along with other Formulary-related policies. The P&T Committee meets six times a year on the second Tuesday of every other month at the CareFirst Columbia Gateway office. If you are interested in becoming a member of our P&T Committee,

please fax or mail your curriculum vitae (CV) and letter of interest to:

CareFirst BlueCross BlueShield  
100 S. Charles St., Tower II  
Baltimore, Md. 21201  
Fax: 410-528-7013  
Attn: Daniel J. Winn, M.D. Chairman, P&T Committee

*NOTE: Committee members must be Board Certified.  
An honorarium is awarded.*

## Technology

CareFirst and CareFirst BlueChoice's Technology Assessment Committee – which includes CareFirst and CareFirst BlueChoice physicians, 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 and CareFirst BlueChoice'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](http://www.carefirst.com) by clicking on Medical Policies. The Technology Assessment Committee recently made the following determinations:

#### Mechanical embolus retrieval system, e.g. MERCI® system for acute ischemic stroke

Intravenous administration of tissue plasminogen activator (IV-TPA) is the treatment of choice for acute ischemic stroke. Unfortunately, there is a rather narrow three-hour time window during which IV-TPA must be administered. Thus, only about 10 percent of acute ischemic stroke patients can be treated this way. A proposed alternative is to mechanically remove the embolus to restore circulation to the area of infarct using a specially designed catheter. The MERCI® system by Concentric Medical, Inc. is an example of such a catheter.

#### **CareFirst and CareFirst BlueChoice determination:**

The MERCI® system is the only such catheter retrieval system that has an FDA clearance specific to removal of clots in acute ischemic stroke patients who are either ineligible for IV-TPA therapy, or who have failed IV-TPA therapy. There have been a few studies performed on small groups of eligible patients that have focused on the feasibility of the device, and general safety and efficacy considerations. These studies have shown for the most part that the MERCI® device can be used to remove emboli and recanalate vessels that were formerly blocked. The studies have not adequately addressed the overall question of improved patient outcomes.

# Technology

## New and Emerging Technology

### Mechanical embolus retrieval system, e.g. MERCI® system for acute ischemic stroke (continued)

The FDA's Neurological Devices Advisory Panel, in reviewing safety and efficacy data, raised questions about the design and focal issues of the studies, and cited documentation of device fractures and ruptured vessels as safety concerns. Despite the panel's concerns, however, clearance for marketing was granted. One clinical specialist in stroke treatment rendered the opinion that the device should not have been given clearance for marketing based on the currently available evidence. CareFirst and CareFirst BlueChoice have therefore determined that the MERCI® system is considered experimental/investigational.

### Carotid artery angioplasty and stent (CAS) placement for carotid stenosis

Owing to the success of treating coronary artery stenosis with angioplasty and stenting, the same approach has been proposed as an alternative to carotid endarterectomy in treating carotid artery stenosis. To help protect against emboli from the site, adjunctive use of distal embolic protection devices has been advocated.

#### *CareFirst and CareFirst BlueChoice determination:*

Carotid artery endarterectomy is a well-proven technique for treating significant carotid disease, and is still regarded as the procedure of choice in most circumstances where surgical intervention is indicated. CAS in its earliest stages of development was performed without distal embolic protection, and results from these earlier studies tended to show that outcomes were not at least as good as those seen in carotid endarterectomy, owing to a significant number of treatment related embolic events. With the development of distal embolic protection devices, the number of treatment-related adverse events showed a significant decline and based on a few well-designed clinical trials, CAS is gradually gaining acceptance. Clinical studies are continuing, however, and at this time most expert reviewers recommend that CAS be considered not as an alternative to carotid endarterectomy, but rather as an intervention for patients with significant, symptomatic carotid disease for whom carotid endarterectomy is indicated, but who are at high risk for surgery. Pending the results of the studies in progress, CareFirst and CareFirst BlueChoice consider CAS to be experimental/investigational.

### Total ankle arthroplasty with prosthetic joint implant

Total ankle arthroplasty using a prosthetic joint implant apparatus was originally developed in the 1970s as an alternative to ankle joint fusion surgery for patients with severe arthritis. However, the procedure was abandoned years later when these prosthetic designs demonstrated a high percentage of failures, necessitating removal. Once again, fusion surgery became the standard. Recently, there has been renewed interest in using prosthetic joint replacements for severe arthritis of the ankle, and a number of new designs have been developed or are in the process of development. In the U.S., the Agility® device was cleared for marketing in 2002.

#### *CareFirst and CareFirst BlueChoice determination:*

The need for long-term outcomes data is crucial to devices of this type, as device failure historically is not seen in joint replacement devices over short to intermediate time intervals. Currently, there is insufficient data to determine if the Agility® or other modern designs will prove advantageous over time as compared to total ankle fusion procedures. Therefore, CareFirst and CareFirst BlueChoice consider total ankle replacement surgery experimental/investigational.

### Extracorporeal shock wave therapy for musculoskeletal conditions other than plantar fasciitis

Extracorporeal shock wave treatment has long been recognized as a method of lithotripsy for kidney stones. In recent years, the treatment has been modified to treat musculoskeletal conditions such as chronic plantar fasciitis, tendonitis of the elbow and adhesive capsulitis of the shoulder joint.

#### *CareFirst and CareFirst BlueChoice determination:*

A review of the evidence published in peer reviewed journals indicates that in well-designed studies, evidence for improvement in patient outcomes is conflicting and may involve placebo effects. An evidence-based review published by the Cochrane organization suggests that these conditions appear to be more responsive to more conventional treatment, i.e. steroid injection, than to treatment with shock wave therapy. Therefore, CareFirst and CareFirst BlueChoice have determined that this technology is considered experimental/investigational.

## Thermal capsulorrhaphy for chronic shoulder instability

The rationale for this treatment is based on the idea that using local application of heat to the soft tissues of the shoulder joint would shrink and tighten the joint structures as a minimally invasive method to relieve instability of the joint.

### **CareFirst and CareFirst BlueChoice determination:**

The available evidence consists mainly of limited, case series reports which did not involve adequate numbers of subjects to achieve statistical significance, controls or randomization. Expert reviewers have commented that the procedure tends to have a high rate of failure, and that overall results have not been as promising as originally anticipated. CareFirst and CareFirst BlueChoice have therefore determined that thermal capsule repair of the shoulder is experimental/investigational.

## Dynamic spinal stabilization

Dynamic spinal stabilization as represented by the Dynesys® system is designed as an adjunct to lumbar discectomy and fusion. Unlike more rigid techniques of spinal fusion, the Dynesys® allows for some flexibility in the lower spine. Dynesys® is also proposed as an alternative to discectomy and fusion for chronic discogenic low back pain, however the device has not been FDA labeled for this application.

### **CareFirst and CareFirst BlueChoice determination:**

The available evidence to date does not give indication that the use of dynamic stabilization can improve outcomes, as the data involves small, uncontrolled study groups with short follow-up periods. There is no evidence from well-designed clinical studies that dynamic stabilization is at least as safe and effective as conventional methods of fusion. One reviewer has suggested a high rate of re-operation for the device. Therefore, CareFirst and CareFirst BlueChoice have determined that dynamic spinal stabilization, e.g. Dynesys®, is considered experimental/investigational.

## Intensity modulated radiation therapy (IMRT)

IMRT is a sophisticated method for delivery of 3D conformal radiotherapy. IMRT involves a careful measurement of tumor type, size and shape, followed by meticulous treatment calculations, and finally by delivery of radiation using a linear accelerator equipped with collimators that shape the radiation beams to the tumor. The effect is maximization of therapeutic radiation dosages while minimizing radiation damage to healthy tissue surrounding the tumor mass.

### **CareFirst and CareFirst BlueChoice determination:**

The published evidence indicates that IMRT allows for tumor destruction with reduced or minimal damage to healthy tissue surrounding the tumor in cases of prostate cancer and tumors of the head and neck area. Studies are continuing for other tumor types and locations. The literature and expert opinion indicates that the decision to use IMRT is often based on the individual patient's tumor type, location and morphology. Although there are no studies to indicate IMRT is more effective than other forms of radiation delivery using such standards as disease free survival and quality of life, IMRT has been shown to be an effective method of radiation delivery where preserving healthy tissue is essential. For these reasons, CareFirst and CareFirst BlueChoice consider IMRT to be medically necessary for tumors of the head and neck region and the prostate, and also in situations involving other tumor types or locations where the radiation oncologist determines that IMRT is the method of choice for providing proper radiation dosage while minimizing damage to adjacent healthy tissue structures.

## Vascular angioscopy

Direct visualization of the interior of arteries was at one time a research tool to study the morphology of atherosclerotic plaque. Angioscopy is now sometimes used as an adjunctive procedure in peripheral vascular bypass procedures to evaluate possible sites for graft placement. There does not appear to be a defined clinical indication for angioscopy in other vessels such as the coronary arteries.

### **CareFirst and CareFirst BlueChoice determination:**

CareFirst and CareFirst BlueChoice consider vascular angioscopy medically necessary when used as an adjunct procedure in peripheral bypass procedures, but experimental/investigational for other applications such as coronary artery angioscopy.

# Disease Prevention and Disease Management

Recent Literature Related to:

## CareFirst and CareFirst BlueChoice Disease Prevention and Management Initiatives

By Richard S. Safeer, MD, Medical Director, Preventive Medicine

*CareEssentials: As part of the Disease Management component of CareEssentials, the CareFirst and CareFirst BlueChoice multi-faceted care management program that provides you with essential tools for patient care, this article is intended to call your attention to recent literature that may be of interest to you. For more information on how to enroll your patients in one of our disease management programs, please call 800-783-4582.*



## Disease Management

### HYPERTENSION

### Where to Find it:

Despite the large amount of attention that high blood pressure receives, two out of three Americans with hypertension are not controlled. The Veterans Affairs Tennessee Valley Healthcare System implemented system changes and assessed provider and patient interventions to improve blood pressure control. Improving blood pressure control through provider education, provider alerts and patient education is an attempt to alter health care system to improve outcomes. The project randomly assigned providers to one of the following three groups:

Ann Intern Med. 2006; 145:165-175.

- Provider education alone (directed to web link to JNC-VII Report on Prevention, Detection, Evaluation and Treatment of high Blood Pressure)
- Provider education (web link mentioned previously) and an electronic notification of the patients' blood pressure from a pharmacy (alert)
- Provider education, provider alert and patient education (a letter to patient recommending methods of controlling blood pressure).

The patients receiving care from providers in the intervention arm that included provider education, alert and patient education were more likely ( $P = 0.013$ ) to achieve their systolic blood pressure goals than patients in the provider group who received provider education only. The authors do not believe the improved blood pressure control was a result of additional anti-hypertensive medication use. Rather, behavior change such as medication adherence to previously prescribed medicines, along with diet and exercise, were accountable. Despite the improved blood pressure control of some patients in this study as a group, the physicians fell far short of taking the aggressive action recommended in JNC - VII to reach blood pressure goals.

CareFirst and CareFirst BlueChoice disease management programs, such as Coronary Artery Disease, Heart Failure and Diabetes, work on bringing blood pressure to recommended levels. This goal is achieved through medication compliance as well as lifestyle changes. We follow your lead to educate your patients on the steps needed to take to live optimally with their disease. You can refer your members to our disease management programs by calling 800-783-4582.

# Disease Prevention and Disease Management

## ASTHMA

### Where to Find it:

Inhaled corticosteroids are a mainstay in many asthmatics' maintenance regimens. However, their role in mild to moderate acute exacerbations is less well known. Although systemic corticosteroids are proven effective in asthma exacerbations, the potential side effects are more likely than with inhaled corticosteroids. There is good data to support use of oral corticosteroids in severe asthma flare ups. However, the information available on the effectiveness of inhaled versus oral corticosteroids on mild to moderate asthma exacerbations is not conclusive.

American Journal of Health Promotion 2006;20[5]: 319-323.

Schuh et. al. concluded that high-dose inhaled fluticasone does not replace oral prednisolone in children with mild to moderate acute asthma. Patients in a pediatric emergency room presenting with a forced expiratory volume of 50 percent to 79 percent at one second (FEV1) were solicited to participate in this randomized double-blinded trial. The participants were treated equally except that half received inhaled fluticasone in the ER followed by instructions to continue fluticasone at home for five days. The other half was given oral prednisolone in the ER and enough of the medicine to take at home, also for five days.

“Our study shows that children with mild to moderate acute asthma treated with prednisolone derive greater immediate relief of airway obstruction than those given inhaled fluticasone, with a clinically and statistically significant difference at four hours.” The authors recognize that other studies asking a similar question have had different outcomes; that being, studies showing no difference between oral and inhaled corticosteroids or even showing more benefit from the inhaled medium. The authors argue that their study is better because it measures FEV1 as an outcome. “The FEV1 has been found to be the best objective clinical indicator of the degree of asthma severity in school-aged children with asthma...” The authors believe their “population likely had enough inflammatory edema and mucous plugging to prevent adequate delivery of inhaled fluticasone into the lungs...”

CareFirst and CareFirst BlueChoice asthma disease management nurses can help your patients understand the importance of their medication and how to properly take them. Participation in an asthma disease management program can decrease the chances of your patient ending up in the emergency room. Call 800-783-4582 to refer your patient.

## OTITIS MEDIA

### Where to Find it:

Each year, about 15 million antibiotic prescriptions are written for the treatment of otitis media. Left untreated, otitis media usually resolves spontaneously, with a similar complication rate to those who were treated with antibiotics. With antibiotic resistance a public health concern, it is imperative to determine a more judicious way of dispensing antibiotics for otitis media.

JAMA 2006;296(10):1235-1241.

Emergency room physicians routinely treat children with otitis media. However, they usually do not share the historical relationship that primary care doctors have established with their patients. The investigators of “Wait-and-See Prescription for the Treatment of Acute Otitis Media” were determined to find an alternative for emergency room clinicians that would decrease antibiotic use without negatively altering clinical outcomes.

Consenting parents of children with acute otitis media were randomized to receive either a prescription to fill immediately (“standard prescription”) or one to fill and begin using if their child wasn't better or getting worse 48 hours after that day's visit (the “wait-and-see prescription”).

The “wait-and-see prescription” approach reduced antibiotic use by 56 percent without significant differences in clinical outcomes from the “standard prescription” group. There have been two previous studies that illustrated the benefits of a watchful waiting approach in the treatment of otitis media, both in the primary care office where a patient – physician relationship had already been established. The authors conclude that a “wait-and-see prescription” for treating acute otitis media will “reduce both the costs and adverse effects associated with antibiotic treatment and should reduce selective pressure for organisms resistant to commonly used antimicrobials.”

# Disease Prevention and Disease Management



## Prevention

### WHAT'S NEW IN PREVENTION?

### Where to Find it:

Vaccination recommendations are constantly evolving and intended recipients of the influenza vaccine have become a larger pool. With the acknowledgement that children under age two had comparable hospitalization rates for influenza as people age 65, the Advisory Committee on Immunization Practices in 2002 encouraged children between six and 23 months to receive the vaccination. Furthermore, caregivers and household contacts of children younger than two years were also targeted for this preventive service.

Pediatrics 2006;118(3):1167-1175.

The results of Influenza Vaccination Coverage of Children Aged 6 to 23 Months: The 2002-2003 and 2003-2004 influenza seasons was less than stellar. Only 4.4 percent and 8.4 percent (in respective years) of children in this age group were fully immunized against influenza.

Morbidity and Mortality Weekly Report published an update from the Advisory Committee on Immunization Practices in July of 2006 ([www.cdc.gov](http://www.cdc.gov)). The report recommended the following groups receive the influenza vaccine.

- Persons at high risk for influenza-related complications and severe disease, including children aged 6 to 59 months
- Pregnant women
- Persons older than 50 years
- Persons of any age with certain chronic medical conditions; and
- Persons who live with or care for persons at high risk, including household contact who have frequent contact with persons at high risk and who can transmit influenza to those persons at high risk
- Health care workers

Remember, patients six months to nine years who have not been previously vaccinated for influenza should be given two doses, four weeks apart.

# Disease Prevention and Disease Management

## An Ounce of Prevention is Worth a Pound of Cure

CareEssentials now offers improved Disease Prevention programs to provide valuable tools to help our members live healthier lives. The program's primary goal is to help patients make healthy lifestyle choices. For more details on how to enroll your patients in one of our Disease Prevention programs, please call 800-783-4582.

Health Facts ...

- About 33 percent of all U.S. deaths (about 800,000 deaths each year) can be attributed to tobacco use, lack of physical activity and poor eating habits.
- Smoking is the leading cause of preventable deaths.
- In 2005, among the total U.S. adult population surveyed, 60.5 percent were either overweight or obese.
- About 90 percent of middle-aged Americans will develop high blood pressure in their lifetimes, and nearly 70

percent of those who have it now do not have it under control.

- Physical inactivity is a leading contributor to disease and disability, accounting for 22 percent of colon cancer, 18 percent of osteoporotic fractures and 12 percent of diabetes and hypertension.
- Seventy percent of all cancers are a result of our behaviors: smoking, diet, physical inactivity and obesity.
- It would take nearly eight hours a day for a primary care clinician to deliver the preventive services recommended by the U.S. Preventive Services Task Force.
- Your patients spend far more time making independent decisions that affect their health outside of your office, and they do so with minimal training or information.

## The Power of Prevention:

### CareFirst Disease Prevention Programs

Tremendous achievements in health are possible if we focus on the risk factors that underlie chronic diseases. Access to high quality and affordable prevention measures are essential if we are to curb the rise of chronic disease.

<b>MyHealthProfile</b>	<p>A health risk assessment tool that provides a personalized health report which includes medical history, preventive services, emotional health and lifestyle choices.</p> <p>Assesses a member's readiness to change an unhealthy behavior and tailors customized interventions to that degree of readiness.</p> <p>Provides members a personalized health report that identifies potential health risks and offers prevention recommendations.</p>
<b>Lifestyle Management Interventions</b>	<p>A personalized, self-directed, and web-based interactive tool that is designed to help members improve their health by guiding them into more appropriate lifestyle choices.</p> <p>Program modules include stress management, nutrition, smoking cessation, weight management and exercise.</p>
<b>Healthy Lifestyle Coaching Program</b>	<p>Telephone support for members at high risk for future disease.</p> <p>Members develop a relationship with a Health Coach trained in Motivational Interviewing and Behavior Change Theory.</p> <p>Health Coaches help members set achievable goals so they can make a permanent change in health behavior.</p>

# Quality Improvement

## 2006 HMO Report Cards Released

The Maryland Health Care Commission (MHCC) recently released its 10th annual guide for consumers comparing the performance of the seven Maryland Health Maintenance Organizations (HMOs). Measuring the Quality of Maryland HMOs and POS Plans, the 2006/2007 Consumer Guide is a tool to help users select a health plan, learn how their health plan compares to others in Maryland, learn how health insurance works and compare measures of quality of care and service that plans provide to their members.

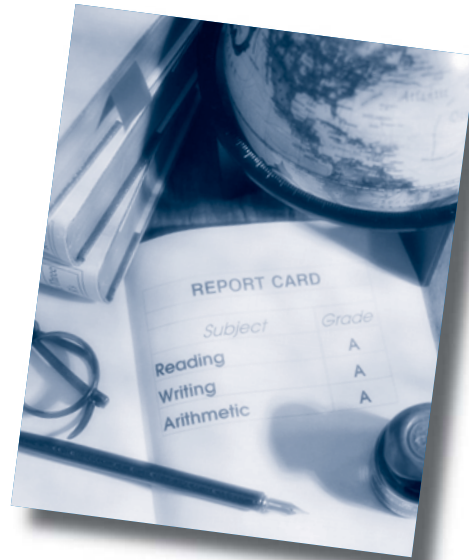
### CareFirst BlueChoice demonstrated above-average performance in the following measures:

- Adolescent well-care visits (above-average for three years)
- Well-child visits for infant and children
- Rating of health plan
- Rating of health care

### CareFirst BlueChoice demonstrated average or below-average performance in the following measures:

- Anti-depressant medication management
- Breast cancer screening
- Adolescent immunizations
- Childhood immunizations
- Colorectal cancer screening
- Postpartum care
- Getting care quickly

Report card results are based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS® 3.0H) survey and clinical data from the Health Plan Employer Data and Information Set (HEDIS) audits. The Consumer Guide report card is published by MHCC and is available at <http://mhcc.maryland.gov/hmo/index.htm>. You may obtain print or CD copies of the report by calling MHCC toll free at 877-245-1762.



Also available on the MHCC web site is a report entitled Comprehensive Performance Report: Commercial HMOs and Their POS Plans in Maryland that contains all the measures and results that health plans were required to report to the state. The report shows data trended over a three-year period demonstrating how consistently each plan performed or attempted to improve the system.

### HEDIS Results

Health Plan Employer Data and Information Set (HEDIS) developed and maintained by the National Committee for Quality Assurance (NCQA) measures the quality of care and services provided to HMO members. HEDIS is mandated for HMO plans; CareFirst and CareFirst BlueChoice participate yearly in this study.

Information collected from HEDIS 2006 reveals the following areas of opportunity to improve services to our members:

- Adolescent Immunizations
- Anti-depressant Medication Management
- Postpartum Care
- Colorectal Cancer Screening
- Breast Cancer Screening

The quality of medical care a practice delivers to its patients can be measured many different ways, but we believe that one way is to deliver nationally accepted interventions that prevent disease and ameliorate illness.

*(continued on page 15)*

# Quality Improvement

## 2006 HMO Report Cards Released (Continued from page 14)

Here are a few easy ideas that your practice can do to improve the quality of care:

Adolescent Immunizations	Anti-depressant Medication Management	Postpartum Care	Colorectal Cancer Screening age 50 and above	Breast Cancer Screening age 40 and above
Hepatitis B vaccine 3 dose series ideally given over 6 month course Recombivax HB 2 dose regime for adolescents 11-15 years of age	First follow-up visit within 1-4 weeks	Follow-up visit 21-56 days after delivery	Colonoscopy every 10 years. or	Mammography every 1-2 years
Varivax History of disease or vaccine prior to age 13	3 visits in 12 week acute phase		Flexible sigmoidoscopy every 5 years or	
Measles, Mumps, Rubella 2nd dose of MMR by age 13	Continue medication for at least 12 months		Fecal occult blood testing annually plus Flexible sigmoidoscopy every 5 years or	
			Double contrast barium enema every 5 years or	
			Annual fecal occult blood test	

### Adolescent Immunizations:

About 1.25 million people in the United States currently have the Hepatitis B virus, and 20 to 30 percent of them acquired the disease in childhood. About 80,000 people a year are infected with the Hepatitis B virus.

In 2004, 800,000 children had a case of Varivax (Chicken Pox) in the United States. Prior to the vaccine, that number was estimated at four million per year. About half of all children with chicken pox visit a health care provider due to symptoms of their illness, such as high fever, severe itching, dehydration or headache.

Immunization registries are confidential, computerized information systems that collect vaccination data within a geographic area. By consolidating vaccination records from multiple health care providers, generating reminder and recall notifications, and assessing clinic and vaccination coverage, registries serve as key tools to increase and sustain high vaccination coverage. Providers are encouraged to join a registry in their area.

#### Maryland Immunization Registry

Contact Jennifer Lenoci-Edwards (410)767-6794 email: jedwards@ntamar.com

#### Washington D.C. Immunization Registry System

Contact Cheree Thomas (202)576-7130 email: cthomas@trey-industries.com

#### Delaware VACAttack

Contact Martin Lute (302)744-4940 email: mluta@state.de.us

#### Virginia Immunization Information System

Contact Archer Redmond (804)864-8074 email: archerredmond@vdh.virginia.gov

#### West Virginia Statewide Immunization Information System

Contact Tim Neeley (877)408-8930 Web site <http://wvsiis.wvdhhr.org/wvsiis>

### Anti-depressant Medication Management:

Once diagnosis of depression has been established and medication management initiated, frequent office visits with the prescribing physicians during the first four to 12 weeks of treatment are usually necessary to assess efficacy and side effects, as well as make any medication adjustment to optimize response.

If treating a patient in concert with a behavior health therapist conducting psychotherapy, then only one of these three follow-up visits needs to be with a PCP.

### Postpartum Care:

About one of every eight women has postpartum depression. Postpartum depression can begin at any time within the first three months after delivery. A postpartum visit 21-56 days after delivery is strongly advised and includes details of delivery, physical exam, laboratory

tests, and counseling on breast feeding, contraceptive methods and postpartum depression.

*National Institute of Mental Health, NIH* at (301) 496-9576 or <http://www.nimh.nih.gov>

*National Women's Health Information Center* at NWHIC at 1-800-994-9662 or <http://www.4woman.gov>

### Colorectal Cancer Screening:

The American Cancer Society estimated 145,290 new cases of colorectal cancer in the United States in 2005 of those 2,760 were for Maryland. Colorectal cancer is the third most common cancer in both men and women. Continuing medical education is offered free on line at [www.carefirst.com](http://www.carefirst.com) : ACS Guidelines for Early Cancer Detection (overview of cancer screening recommendations)

### Breast Cancer Screening:

The American Cancer Society estimated 211,240 new cases of invasive breast cancer in the United States in 2005. An estimated 40,410 breast cancer deaths are anticipated in 2005. Breast cancer ranks second among cancer deaths in women. Mammography is a valuable early detection tool. Recommend starting women at age 40 with a screening mammography every 1-2 years with or without clinical breast examination.

*American Cancer Society* at 1-800-ACS-2345 or [www.cancer.org](http://www.cancer.org).

# Philosophy of Care

**We represent** a philosophy of health care that emphasizes active partnerships between patients and their physicians. We believe that comprehensive health care is best provided by networks of health care professionals who are willing to be held accountable for the satisfaction of their patients and the quality of their services. We are committed to high standards of quality and professional ethics and to the principle that patients come first.

**We believe** that patients should have the right care, at the right time and in the right setting. This includes preventive care, as well as comprehensive care for acute and chronic illness --- at home, at the doctor's office and in the hospital.

**We believe** that all health care professionals should be held accountable for the quality of the services they provide and for the satisfaction of their patients.

**We believe** that patients should have a choice within their health plans of physicians who meet high standards of professional training and experience, and that informed choice and the freedom to change physicians are essential to building active partnerships between patients and doctors.

**We believe** that health care decisions should be the shared responsibility of patients, their families and health care professionals, and we encourage physicians to share information with patients on their treatment options, medical conditions and health status.

**We believe** that consumers have a right to information about health plans and how they work. We believe that working with people to keep them healthy is as important as making them well.

**We value** prevention as a key component of comprehensive care, reducing the risks of illness and helping to treat small problems before they can become more severe.

**We believe** that access to comprehensive, affordable care gives consumers the value they expect and contributes to the peace of mind that is essential to good health.

## CareFirst's Mission

The mission of CareFirst BlueCross BlueShield is provide health benefit services of value to customers across the region comprised of Maryland and the National Capital Area. To fulfill this mission, CareFirst BlueCross BlueShield commits to:

- Offer a broad array of quality, innovative insurance plans and administrative services that are affordable and accessible to our customers
- Fairly address the needs of customers in each jurisdiction in which we operate
- Conduct business responsibly as a non-profit health service plan, to ensure the plan's long-term financial viability and growth
- Collaborate with the community to advance health care effectiveness and quality
- Support public and private efforts to meet needs of persons lacking health insurance
- Foster health systems integration and health care cost containment to benefit the people in areas we serve and
- Promote respect, fairness and opportunity for our associates

InfOCUS is published three times a year by CareFirst BlueCross BlueShield's Corporate Communications Department.

**Interim Chief Medical Officer and Sr. Vice President of Medical Affairs**  
Jon Shematek M.D.

**Editor**  
Robert Hilson  
newsletter.editor@carefirst.com

*For current administrative news, look for the most recent edition of BlueLink.*



CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association. © The Blue Cross and Blue Shield names and symbols are registered trademarks of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.

Presorted Standard  
U.S. Postage  
**PAID**  
Baltimore, Md  
Permit No. 7217

10455 Mill Run Circle  
Mail-Stop OM1-800  
Owings Mills, MD 21117