

GATEWAY HEALTH PLAN

JULY
2006



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Thomas Hart Family Practice Center Earns Gateway's 100 Percent Club Distinction

Medical Management

The Thomas Hart Family Practice Center in York, Pennsylvania has earned the 100 Percent Club Award from Gateway Health Plan. It is one of three practices in central Pennsylvania to earn this distinction in the Fall of 2005. The award is given to practices with more than 50 Gateway members on their panel who exceed their peer group in 100 percent of Gateway's utilization and quality indicators.

Established in 1968, the Thomas Hart Family Practice Center was one of the first pilot residency training centers for the emerging specialty of family medicine. Today, it is home to 24 residents and 8 faculty attending physicians, who handled over 27,000 patient visits last year.

Thomas Hart is based at York Hospital, a community teaching hospital in the Wellspan Health system. York Hospital has 466 beds and serves a population of 480,000 in south central Pennsylvania. Solucient has named it a 100 Top Hospital for the sixth time since 1997, a distinction shared by only nine other hospitals in the country.

(Cont. on page 2)



Pete Keim, MD, Vice President and Chief Medical Officer of Gateway Health Plan presents 100 Percent Club Award to members of the Thomas Hart Family Practice Center. Pictured (from left to right) are: Tara Loucks, Clinical Coordinator; T. Vanessa Hopkins, Sr. Physician Office Assistant; Sharla Hart, MD, Chief Resident; Brian Taylor, MD, Chief Resident; Peter Keim, MD, Vice President and Chief Medical Officer of Gateway Health Plan; and Robert Fawcett, MD, Medical Director.



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Thomas Hart Family Practice *(Cont. from page 1)*

"It takes an across-the-board effort to earn an award like Gateway's 100 Percent Club," says Robert Fawcett, M.D., medical director of Thomas Hart Family Practice Center. "Our front office staff, nurses, physicians, residents, and faculty deserve a lot of credit."

Faculty and residents of Thomas Hart have received numerous awards in recognition of their quality and leadership in the past several years, including the All-Star Scholar Award from the Emig Research Center for Scholarly Achievement in Graduate Medical Education and Research, an "Emerging Leader" award by the Family Medicine Education Consortium, a Pfizer Teacher Development Award, Drexel University College of Medicine Dean's Special Award for Excellence in Clinical Teaching, and the Pennsylvania Academy of Family Physicians and the American Academy of Family Physicians' Exemplary Teaching Award for Part-Time Faculty.

"As medical educators, the Gateway award is especially meaningful to us," said Bruce Bushwick, M.D., residency director of Thomas Hart. "Our mission is to improve lives by providing high-quality, family-centered health care to our community and exceptional education to family physicians. Winning the Gateway award recognizes that we are passing this knowledge on to our next generation of family medicine practitioners."

Gateway Health Plan congratulates the Thomas Hart Family Practice Center on their outstanding service and commitment to the community and Gateway members.



Lunch is on the Way!

Congratulations to the Buhl Farm Community Health Center for being selected as the first winner of Gateway's "Where Do You Read Your Clinical Times?" contest. This multi-specialty practice, located in Hermitage, Mercer County, wins a luncheon and our appreciation for not only submitting a photo, but also for reading Clinical Times.



Dawn Roper, practice coordinator for the health center, submitted the photo and told us that the providers and staff enjoy reading Clinical Times, and that they receive a lot of valuable information from the newsletter.

Practice members in the photo include (front row, from left to right) Dr. Valeri Roth (ENT), Dr. Michael Roth (FP), Jennifer Hanahan MOAII, (back row) Diane Woods FOA, and Jessica Hunt FOA. Buhl Farm Community Health Center provides patients with endocrinology, podiatry, neurology, orthopedics, and family practice services.

The contest continues, so get out your cameras and show Gateway where you are reading your Clinical Times! Mail or e-mail entries to:

Mail entries to:
Gateway Health Plan
Where Do You Read Your Clinical Times Dept.
c/o Marcia Haught
US Steel Tower, Floor 41, 600 Grant St.
Pittsburgh, PA. 15219-2704

Entries may also be e-mailed to
mhaught@gatewayhealthplan.com. (Preferred)

100 Percent Club Recognizes Superior Performance

Gateway Health Plan congratulates these practices for achieving the highest level of performance, as measured in the Spring 2006 Provider Portfolio Report:

- CCP Russelton Pediatrics in Tarentum
- Butler Memorial Associates (Internal Medicine) in Chicora

The Provider Portfolio reports quality and utilization measures for Primary Care Physicians with 50 or more members in Southwestern Pennsylvania and the Lehigh Valley and Capital areas of the state. These two practices have distinguished themselves by scoring above average in all areas of measurement.

Free CMEs Available for Colorectal Cancer Prevention & Detection

In an effort to increase colon cancer testing rates for people age 50 and over, the American Cancer Society has developed several educational materials and tools to assist healthcare providers discuss colorectal cancer with their patients. A variety of free patient educational material, including brochures, posters and other screening reminders can be accessed on line at www.cancer.org/colonmd.

To further assist physicians in the prevention and early detection of this cancer, the American Cancer Society (accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education) is also offering free continuing medical

education credits (CMEs) on colorectal cancer prevention and early detection.

Through this no-cost CME module, participants receive one hour of continuing medical education credits and learn to:

- Recognize risk factors, prevention strategies, and identify individuals who are at risk
- Develop appropriate screening strategies and intervals based on patient risk profiles
- Understand the benefits and limitations of the various screening methodologies and new technologies
- Incorporate proven strategies to enhance cancer screening and follow-up of abnormal tests.

This module is open to physicians and all other health care providers who advise patients. The CME activity can be accessed online at www.cancer.org/cme. For more information, call 1-800-ACS-2345 or visit www.cancer.org.

Allegheny County Physicians: Mark This Date!

The Allegheny County Immunization Coalition (ACIC) will host its first annual immunization conference on October 5, 2006 at the Green Tree Holiday Inn in Pittsburgh.

CME credits will be offered for conference participants. The Allegheny County Health Department will be distributing a conference brochure to local providers in August.

Atherosclerosis-Induced Disease: The Periodontal-Medical Link

by Michael D. Weitzner, DMD, MS; Director, Clinical Operations, Dental Benefits Provider

Dental Perspective

A major contributing factor in the majority of cases of cardiovascular disease (CVD) and cerebrovascular disease (stroke) is atherosclerosis. Recent literature seems to implicate inflammation and possibly autoimmunity in the pathogenesis of atherosclerosis. A number of pathogens appear to be associated with the formation of atherosclerotic plaques, and alterations in the immune responsiveness may affect the removal of organisms from these plaques. Additionally, serum inflammatory markers, such as C-reactive protein (CRP), appear to be elevated in patients with atherosclerosis.

As early as 1988, literature began to appear which suggested that periodontal inflammation may have a role in CVD. They noted that in subject populations, patients who had a myocardial infarction (MI) had worse periodontal health than the control group and that

risk indicators for CVD have also been shown to be elevated in subjects with periodontal disease.

The reviewers began with a focused question, "Does periodontal disease influence the initiation/progression of atherosclerosis (and therefore CVD, stroke, and peripheral vascular disease)?" Reviewers looked at articles describing 20 non-randomized studies investigating the connection between poor oral health and atherosclerosis-induced CVD. While four of the articles did not establish a strong connection, 16 articles did indicate a modest association between periodontal disease and CVD.

Studies have also looked at the association of periodontal disease with parameters linked with atherosclerosis-induced disease such as elevation of CRP, fibrogens, white blood cells, cholesterol, and cytokines, as well as the effect of periodontal treatment on atherosclerosis-induced disease. None of these showed a clear, strong associa-

tion. The reviewers speak to the need for a large-scale, multi-center randomized trial of periodontal therapy to firmly establish the causal relationship between periodontal disease and atherosclerosis-induced disease.

The Consensus Report, based on the reviewer's findings, noted that the connection "may reflect chance occurrence, the sharing of common antecedent susceptibility or resistance traits, common behaviors or exposures or the influence of one condition on another." The panel concluded by stating "patients and health care providers should be informed that periodontal intervention may prevent the onset or progression of atherosclerosis-induced disease." However, based on the American Association of Periodontics Workshop on Contemporary Science in Periodontics reviews and on the growing body of literature, there is increasing evidence for a link between periodontal disease and atherosclerosis-induced disease.

Domestic Violence: Treating Both the Victim & the Abuser

by Kathy Neff, RN, BSN

Special Needs Unit

Because all forms of family violence are major public health issues, physicians play a key role in lessening the prevalence, scope, and severity of child maltreatment, intimate partner violence, and elder abuse. And because a physician is frequently the first non-family member to whom an abused individual turns for help, they have a unique opportunity and responsibility to intervene.

Most patients are reluctant to initially disclose abuse because of shame, concerns related to the loss of confidentiality, or fear of reprisals from the batterer. However, patients report a sense of relief when their physician raises the topic of abuse, and they become anxious to talk about their feelings.

The American Medical Association has issued treatment guidelines on domestic violence, which can be accessed at www.ama-assn.org/ama1/pub/upload/mm/386/domesticviolence.pdf.

Physicians at times may find they are treating both the victim and the abuser in the family, which presents an ethically and legally complicated situation.

Recognizing & Treating the Abuser

There is a broad spectrum of clinical presentations for the abuser, which can range from perpetrators with milder disturbances to those with severe mental illness. Frequently encountered characteristics of the battering male include the following:

- History of witnessing violence as children
- Substance-abusing parent(s)
- Personal substance abuse
- Tendency to minimize violence, deny it, or blame others
- Jealousy, possessiveness, dependency on partner
- Low self-esteem, insecurity

- Poor problem-solving skills, inability to handle stress
- Ineffective communication skills
- Anger and hostility
- Rigid ideas of male/female roles, rights, and responsibilities

Physicians should consider referring the abuser to an anger management program. Through these programs, abusers are taught to:

- See anger as an emotion and violence as a behavior
- Take full responsibility for their behavior
- Understand that abuse is a choice and that they can choose not to be abusive, no matter how they are feeling
- Understand the effects of abuse on their partner and their children.
- Identify and change attitudes that lead to abusive behavior

Physicians should also consider referring the abuser to the Pennsylvania Coalition Against Domestic Violence/National Resource Center on Domestic Violence at 800-932-4632. (Address: 6440 Flank Drive, Suite 1300, Harrisburg, PA 17112-2778.) This organization can assist in connecting the abuser to resources in their area.

Evaluating & Treating the Victim

When evaluating the victim of domestic violence, the assessment should include these steps:

- Talk to the patient in a private place, away from the abuser.
- If children are with the patient, find a staff member to stay with them if possible.
- Approach the topic of domestic violence as you would any other health risk. If the patient becomes upset or denies abuse, simply explain that all patients are screened for domestic violence, and that health care professionals are gravely concerned about the danger.

A victim will choose when they wish

to share the history of abuse, but failing to do so does not mean they are not listening and paying attention to valuable information regarding the cycle of violence.

You may be the first person, particularly the first professional, to acknowledge the problem. Often that factor by itself will help the victim to see that they are not alone in this experience, and that there is help available.

If the patient acknowledges the abuse, health care professionals should consider this course of action:

- When the patient discloses that they are being battered, ask if they would like to stay in a private area for a while. If the partner is waiting, ask if the person feels safe going home with them. If the patient doesn't feel safe, ask if immediate assistance would be of value and contact the PA Coalition Against Domestic Violence hotline at 1-800-932-4632.
- Inform the patient about any reports that need to be filed (police, child protective services, etc.).
- Advise the patient of their options including immediate transport to a shelter, shelter information for a later date, returning to the partner after getting a follow-up appointment to return to the health care setting, or waiting for the police to file a report for visible injuries.
- Teach the patient the signs of escalating physical danger, particularly access by the partner to weapons, threats they have made, and others.
- Provide information about a protective order, and any other resources available in the community for immediate protection and the protection of the children, as well as the domestic violence shelter.

Victims of abuse should be referred to the National Domestic Violence Hotline—1-800-799-SAFE (7233)—

(Cont. on page 5)

Domestic Violence

(Cont. from page 4)

a 24-hour, toll-free number for crisis intervention, assistance, counseling, and referrals.

Tough law enforcement, aggressive prosecutions, prevention programs, and available shelters are integral components of an effective program to deal with domestic violence. Perhaps the most important component of an effective domestic violence program is the identification of families in distress—and that's where physicians play a key role.

If you have any questions about domestic violence programs or would be interested in having one of Gateway's Case Managers involved with your patient, please call the **Special Needs Unit** (see the Contact Information on the back page).

Guidelines & Review Standards on Gateway's Website

Throughout the year, Gateway reviews and revises its clinical guidelines, and presents them to our Physician Advisory Workgroups and/or QI/UM Committee for approval. Most recently, the Hypertension, Cardiac, Lead, and Child and Adult Preventive guidelines underwent this process.

Our clinical and preventive care guidelines can be viewed by accessing Gateway's website, www.gateway-healthplan.com. There, select Pennsylvania Medicaid or Medicare Assured, Providers, and Clinical Guidelines. Gateway's Medical Record Review standards for PCPs and Specialists, and Medical Record Keeping standards for PCPs are also located on the Medicaid site.

You can request a copy of Gateway's guidelines and standards by calling the **QI Department** (see back page).

Treating Patients With HIV & Other Co-Morbidities

by HIV Physician Advisory Workgroup

Case Management

With the advent of effective antiretroviral therapy (ART), many patients are living with HIV as a chronic treatable infection. The approach to these patients is thus changing, as they struggle to deal with this disease and other co-morbid conditions.

Behavioral health issues and Hepatitis C are two co-morbidities that HIV patients frequently encounter. A comprehensive, holistic approach is key in helping this group of individuals with their complex health problems.

Linking medical and behavioral health services is critical to improve compliance with medication and treatment regimes. For example, many clinicians have found that scheduling both medical and behavioral health appointments at the same facility, on the same day, whenever possible results in improved patient adherence and treatment outcomes.

In treating patients with both HIV and Hepatitis C, there are numerous concerns to consider. The following are general guidelines that should be considered when discussing treatment options with these patients:

- Treatment should be individualized, with a full medical and psychological assessment conducted prior to initiating treatment.
- A holistic approach to treatment should be embraced.
- Patients with alcohol and/or substance abuse and psychiatric illness should be treated for these condi-

tions BEFORE attempting to start HCV treatment. Otherwise, the likelihood of successful compliance with and response to HCV treatment is very low.

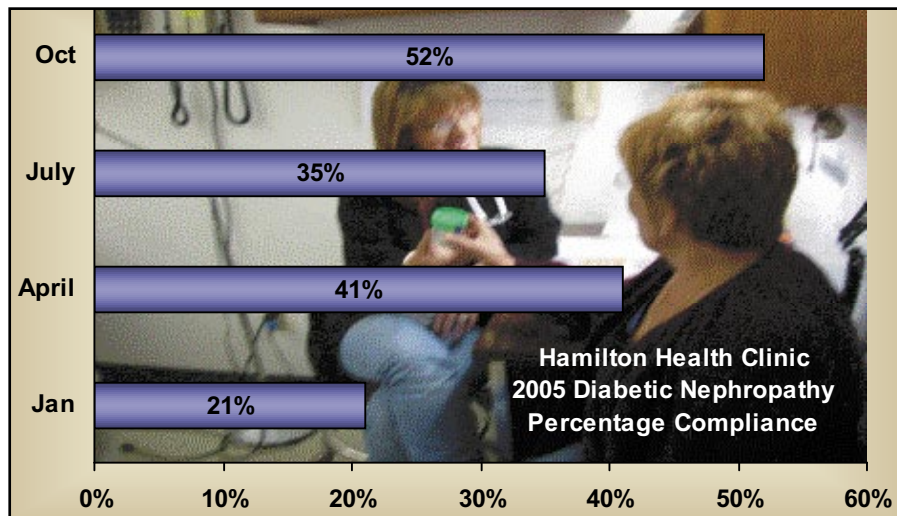
- Patients should have stable HIV disease for at least 6-12 months prior to beginning HCV treatment. Patients with low CD-4 counts should be on ART to attempt to increase the count.
- HIV treatment (if medically indicated) with combination ART should be performed on all patients BEFORE treatment for Hepatitis C.
- Patients should be "ready" for treatment, prior to initiating pharmaceutical intervention.
- Patients with Genotype 2 or 3 may have a greater likelihood of success. These patients should also be considered for re-treatment if there is virologic failure with the initial treatment. Patients with Genotype 1 can also be considered for treatment. However, the duration of therapy in HIV patients is usually 1 year, but can be 2-3 years, and the chance of treatment success is much lower.
- A center that has experience treating co-infected patients with adequate staff support for close follow-up is an important consideration for the treatment of these patients. (See the box for recommended treatment centers.)

If you have any questions or additional thoughts regarding this information, please feel free to contact **Kathy Neff, RN, BSN** at 412-255-4224.

Gateway's HIV Physician Advisory Workgroup has identified the following centers as having the experience and resources to treat Hep C in patients with underlying HIV disease:

- Allegheny General Hospital's Positive Clinic in Pittsburgh, PA
 - Regional Gastroenterology Associates in Lancaster, PA
 - Lancaster Gastroenterology Inc. in Lancaster, PA

Standing Orders: Hamilton Health Center's Key to Diabetic Success



Pamela Ubrinek, RN, Adult Medicine Nurse Team Leader, receives a microalbumin urine sample from a patient as a result of CQI team-developed Diabetic Standing Nursing Orders.

Embracing a Continuous Quality Improvement (CQI) philosophy, the staff of Hamilton Health Clinic in Harrisburg identified process flows and barriers to the routine collection of diabetics' urine for microalbumin testing. The team developed and implemented Diabetic Standing Nurse's Orders that authorized staff to obtain and send urine for testing. The result was a doubling of screening rates across all payers.

Lonnie Fuller, MD, the clinic's medical director, attributed this success and other diabetic process improvements to "high collaboration" rather than "high technology."

Hamilton Health Center Diabetic Standing Nursing Orders

Nursing personnel shall complete the following items at every scheduled visit in Adult Medicine.

- Place Pink Sticker on all Diabetic patient charts.
- Complete the diabetic flow sheet at each scheduled visit.
- Complete Referral to Ophthalmology if no visit is recorded within the past year. Diagnosis = Diabetic Eye Care.
- Complete Referral to Podiatry if no visit is recorded within the past year. Diagnosis = Diabetic Foot Care.
- Complete Referral to Diabetes Education Program if no visit is recorded. Diagnosis = Diabetes Mellitus.
- Urine for Microalbumin if none is recorded within the past 12 months or none recorded in the past 3 months and last value of microalbumin/creatinine > 30 mg/g.
- Lipid Profile if none is recorded within the past 12 months or none recorded in the last 3 months and the last LDL value > 100 mg/dl.
- Finger Stick glucose on each visit.

Diabetic Nephropathy Testing Helps Prevent ESRD

by Caesar DeLeo, MD, Medical Director & Jude Lauffer, RNC, BS Ed

Disease Management Diabetes is a leading cause of kidney failure in the United States. If aggressive intervention is not initiated, individuals with diabetic kidney disease progress to kidney failure in several years. This progression is influenced primarily by glycemic control and blood pressure. Early detection and intervention, along with improved glycemic and blood pressure control can help reduce the risk of progression of nephropathy and renal failure necessitating dialysis.

The American Diabetes Association

and the National Kidney Foundation recommend that all persons with Type 2 diabetes and those with Type 1 diabetes for at least 5 years undergo yearly screening for and/or monitoring of diabetic nephropathy.

Despite the development and promulgation of national clinical practice guidelines, rates for screening for diabetic nephropathy remain low. According to national HEDIS data for all health plans, the mean compliance with screening standards for diabetic nephropathy was 44.22% for the year 2004.

Albumin/Creatinine Ratio Results	
Condition	Value
Normal	< 30 mg/g
Microalbumin	30-300 mg/g
Macroalbumin	> 300 mg/g

A routine urinalysis/dipstick for protein is not sensitive enough to detect microalbumin and is therefore not an appropriate test for early detection of diabetic kidney disease. Testing for microalbumin can be carried out by one of several methods:

(Cont. on page 7)

(Cont. from page 6)

- 24-hour urine collection for microalbumin
- Timed urine for microalbumin
- “Spot” urine for microalbumin

A “random” or “spot” urine tends to be the easiest and most accurate test because overnight or timed urine collections are more cumbersome, fraught with collection error, and less apt to be completed.

Results are reported as an *albumin/creatinine ratio*. The following table provides the normal and abnormal ratio levels.

Albumin excretion can vary from day to day and can be affected by uncontrolled blood pressure, high blood glucose, fever, urinary tract infection, and strenuous physical activity. It is therefore recommended that an elevated value be confirmed in approximately 3-6 months before microalbumin is diagnosed.

Once persistent microalbumin or macroalbumin has been detected, chronic kidney disease has begun and a full evaluation of kidney functioning should be completed. The estimated

Glomerular Filtration Rate (GFR), derived from serum creatinine, is the best marker of kidney function. Once a person has an albumin/creatinine ratio of greater than 300mg/g (macroalbumin), urine protein excretion can be followed using the protein/creatinine ratio. The protein/creatinine ratio can also be used to follow the progression of kidney disease and response to therapy.

References:

- American Diabetes Association Clinical Practice Guidelines - www.diabetes.org
- National Committee on Quality Assurance (HEDIS) - www.ncqa.org
- National Kidney Foundation KDOQI Clinical Practice Guidelines - www.kidney.org

Secondary Prevention of CVD Saves Lives

by Pedro J. Cardona, MD, MBA, Medical Director

Medical Management

The prevalence of cardiovascular disease (CVD) is on the rise due to a combination of increase in life expectancy and increase in risk factors. There have been reports regarding an increase in body mass index (BMI) in the population in general, lack of fruit and vegetable intake, and physical inactivity—all of which are considered risk factors. Associated with an increase in BMI is the risk for developing diabetes and elevated cholesterol levels.

CVD Facts

- Approximately 1,200,000 Americans will have a new or recurrent coronary attack every year.
- Post MI, even elderly patients and patients with diabetes and heart failure can benefit from the use of beta-blockers.

For secondary prevention of myocardial infarction (MI), aggressive risk reduction improves patient survival, reduces recurrent events, reduces the need for interventional procedures, and improves quality of life. Taking these benefits into consideration, it is of paramount importance to practice prevention even in patients with established CVD.

Use of beta-blockers following an MI reduces mortality in the acute and long-term period. The American Heart Association and the American College of Cardiology recommend starting beta-blockers in post-MI and acute ischemic syndrome patients. The beta-blockers should be continued indefinitely.

To help physicians and hospitals implement evidence-based guidelines in the acute treatment of coronary artery disease and heart failure, the American Heart Association has developed the program Get With The Guidelines. This hospital-based quality initiative helps ensure that patients are initiated and discharged on appropriate medications and with risk-modification counseling. For more information, you can visit www.americanheart.org/getwiththeguidelines.

Gateway’s Help Your Heart Cardiac Program can also assist physicians and members with guideline recommendations in the outpatient setting. Members enrolled in this program have significantly reduced readmission rates. (See page 12 for phone numbers).

Secondary prevention of cardiovascular disease, including use of beta-blockers after an MI, can save thousands of lives.



Gateway Helps “Race for the Cure”

Almost everyone has been touched in some way by the devastating effects of breast cancer. Gateway is always working to support the goal of eliminating breast cancer and, through telephonic outreach and member reminders, encourages its members to get their mammograms.

This year we took added steps to support the goal to eliminate breast cancer. On Mother’s Day, 35 members of our staff represented Gateway at the “Race for the Cure” in Schenley Park in Pittsburgh. Staff members generously donated their time, and raised money for this cause. Plans are already underway to make Gateway’s participation in the 2007 “Race for the Cure” even better.

17P: A New Weapon in Reducing Preterm Birth

by *Caesar DeLeo, MD, Medical Director*

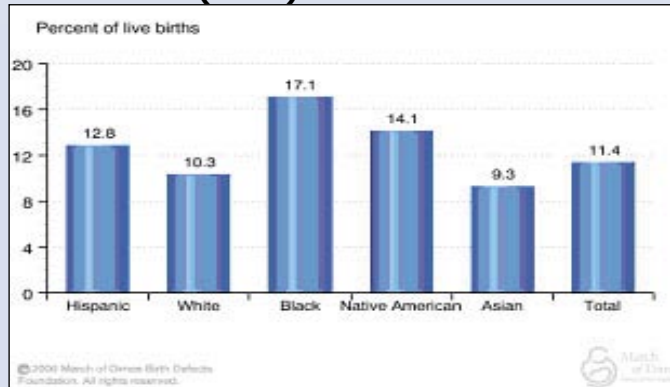
According to statistics collected by the World Health Organization, in 2002 the United States ranked #25 among the world's nations in overall infant mortality. That is twice the infant mortality rate of Iceland and one-third that of Mexico.

Preterm birth is associated with significant neonatal morbidity (respiratory distress, CNS hemorrhage, sepsis, necrotizing enterocolitis), mortality, and strain on non-medical resources (lost days from work, lost days from school, learning disabilities, future school performance, etc.).

The 2003 incidence of preterm births in Pennsylvania was 11.4%. This represents an increase in magnitude of more than 9% between 1993 and 2003. The incidence varies by ethnicity, with almost a two-fold disparity between black women and their Asian and white counterparts.

In addition to routine prenatal care, administration of the drug 17 hydroxyprogesterone acetate ("17P") to certain select women with a history of preterm

Preterm Birth as a Percentage of All Live Births in PA (2003)



National Center for Health Statistics, final natality data. Retrieved June 1, 2006, from www.marchofdimes.com/peristats.

delivery has been demonstrated to reduce the risk of preterm birth. The American Academy of Obstetrics and Gynecology (ACOG) in 2003 released a position statement supporting the use of 17P to reduce the risk of preterm birth in select women with histories of preterm labor.

Several factors account for 17P's slow but increasing rate of adoption across the state and nation.

This drug must be injected - either by the patient, by someone else, or at the physician's office. More importantly, large pharmaceutical companies do not produce 17P as a branded product, do not market or promote it, and pharmacies do not stock it. Consequently, pharmacies that compound drugs must prepare 17P into oil for intramuscular injection and ship it to the patient or physician's office.

Gateway covers 17P through Medmark, which will compound the drug and ship it overnight directly to your office or to the member's home. Initiating 17P treatments for Gateway members is as easy as making two phone calls:

1. Notify Gateway's Pharmacy Department (800-528-6738)
2. Place the order with Medmark by phone (888-347-3416) or fax (877-231-8302).

Back-to-School Checkup can be EPSDT Visit

by *Khlood Salman, Dr. PH*

School-age children need to be up to date on immunizations, screenings, and vision and hearing examinations before school enrollment. The Commonwealth of Pennsylvania requires proof of immunizations and a summary of that coverage is reported to CDC. An immunization goal of 95% of children in kindergarten through the first grade was proposed to be achieved by 2010. Providers can help to achieve this goal.

The Department of Adolescent and School Health (DASH) at the CDC recommends including a behavioral risk as-

essment as part of each routine health screening and EPSDT. Behavioral risk issues include areas such as use of tobacco, alcohol, and illegal drugs; poor eating habits; sexual behaviors that result in STD or unintentional pregnancy; and behaviors that result in injuries. Injuries are the leading cause of the most serious illnesses and premature deaths of adolescents in the United States.

Yearly EPSDT screenings (Well Care Child visits) are recommended by the American Academy of Pedi-

atrics (AAP) for children 2 years and older. Gateway encourages all providers to take advantage of back-to-school, summer camp, sports, or driver's license physicals to perform a complete EPSDT screening. Gateway reimburses an administrative fee for EPSDT screens when they are submitted with appropriate diagnosis and procedure codes.

Helping Patients Keep Postpartum Visits

by *Chris Ann Uhler, RN, BSN*

Preventive Health

The postpartum visit, like the follow through of a golf or tennis swing, is an essential component in achieving an optimal maternal outcome. The postpartum visit is so important because it allows physicians to:

- Detect postpartum complications
- Detect postpartum depression
- Recommend smoking cessation counseling, if necessary
- Suggest breastfeeding support
- Discuss family planning and birth spacing
- Educate patients about nutrition and physical activity to prevent obesity
- Assure the infant is getting well child care.

The postpartum visit to the practitioner's office should occur within eight

weeks after delivery. This time frame is part of HEDIS (Healthplan Employer Data and Information Set), a set of performance measures increasingly used by managed care plans, employers, researchers, and government agencies to assess quality.

Home care visits, while a valuable and covered adjunct to postnatal care, are not a substitute or take the place of a postpartum visit.

As a practitioner, you are very influential in helping your patients understand the necessity of the visit. Do not underestimate your influence. Here are some tips for helping ensure that women keep their postpartum visit:

- Discuss the postpartum visit with your patient prior to discharge.
- Schedule the appointment prefer-

When billing for postpartum visits, please utilize:

- ICD-9 code 91.46
- V Codes V24.1, V24.2, V25.1, V76.2, or V72.3.

ably at or shortly after the time of discharge.

- Use the hospital staff to reinforce scheduling the postpartum visit.
- Schedule appointments to occur between 3 and 5 weeks after delivery. This allows for rescheduling of missed appointments by the eighth week.
- Have your office mail a reminder card or place a reminder phone call about the appointment.
- Gateway can help with scheduling postpartum visits and helping to resolve transportation issues to and from postpartum appointments. Call Preventive Health for assistance (see page 12).

Summer is a Good Time to Consider Synagis

by *Edwin J Kairis, MD, Medical Director*

Medical Management

Synagis (palivizumab), a monoclonal antibody against respiratory syncytial virus (RSV), has been very successful in protecting high-risk infants from serious complications when the virus is contracted. While it is indicated for monthly dosing during RSV season, there is no data regarding the clinical effectiveness of a seventh dose at the end of the season.

Gateway considers November 1 to be the beginning of RSV season. Requests will be reviewed by Gateway's pharmacy department beginning Monday, October 16, 2006 so that the first dose of the season can be processed through Medmark starting Monday, October 23.

Gateway Health Plan is continuing to refine its process so that information concerning your high-risk members can be easily communicated to the health plan. This minimizes the need for return phone calls, which interrupt the

workflow in a busy practice. We plan to re-design the request form so that you and your staff will be reminded of the current recommendations as the form is being completed.

Considering the most recent respiratory season, we have identified a few points worth reviewing:

- Summer and early fall are appropriate times to consider which of your patients will require the injections this upcoming respiratory season.
- When reviewing the medical appropriateness of Synagis, Gateway follows the published guidelines of the American Academy of Pediatrics. These guidelines can be accessed at www.aap.org.
- The request form should always include the child's gestational age and birth weight, as we often have no administrative means of finding this information.
- Including an intensive care nursery discharge summary with the request gives Gateway additional informa-

tion that helps us in making a determination of coverage. Additionally, it helps us to understand why an exception may need to be made for a child whose clinical history would not normally qualify him for Synagis.

- Risk factors for infants greater than 35 weeks gestation do not need to be indicated, as the only two published indications for this gestational age are chronic lung disease and/or hemodynamically significant congenital heart disease and an age less than two.
- Children who have had a definitive repair of their congenital heart disease are not considered to be candidates for Synagis.
- Because there is not yet a published indication for Synagis in children with severe neuromuscular disease, these requests will be considered on a case-by-case basis.

As always, we value your input and are always available to discuss individual issues as they arise.

Osteoporosis: Under Diagnosed & Under Treated

by *Khlood Salman, Dr. PH*

Preventive Health

Osteoporosis is a very common condition associated with increased morbidity, mortality, and cost. In the United States, 26% of women age 65 years and older and more than 50% of women 85 years of age and older have osteoporosis. Bone mineral density (BMD) correlates with the risk of fractures. Over 1.5 million fractures per year are attributable to osteoporosis.

Gateway Health Plan recommends routine screening begin at age 60 for women identified as high risk because of their weight or lack of estrogen use.

Clinical assessment of osteoporosis risk factors and objective measures of bone mineral density can help to identify patients who will benefit from intervention.

Major risk factors include:

- Age 65 and older
- Lower body weight (less than 70 kg)
- No current estrogen use

Others factors include decreased physical activity, low calcium and vitamin D intake, family history, smoking, alcohol, and caffeine use.

A stepwise approach to osteoporosis treatment includes:

- Step 1 – Calcium (at least 1200 mg per day) and vitamin D (400-800 IU per day) supplementation, physical activity, and fall prevention
- Step 2 – Treatment of secondary causes of osteoporosis
- Step 3 – Pharmacotherapy (e.g., biphosphonates, estrogen/hormone therapy, calcitonin, and teriparatide) (Gass & Dawson, 2006)

Women seem more likely to consider pharmaceutical therapy when they are aware of their BMD testing results. Still, compliance with long-term use of pharmacotherapy is low. An important approach to reducing the rate of fractures is first to target treatments to patients at high risk for fracture and then to develop strategies to improve treatment continuation rates (Gass & Dawson, 2006). Providers also should discuss with women the risk of taking estrogen and other hormone replacement therapy (HRT) before prescribing it.

References

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Home Care Recommended After Cardiac Procedures

by *Jude Lauffer, RNC, BS Ed.*

Disease Management

Since home care has an immediate impact in the management of patients and can lead to improved outcomes, physicians should be the leading advocates for these services.

Gateway suggests that home care be initiated after every coronary artery bypass grafting (CABG) procedure, for patients requiring a hospital stay for coronary stenting, and after admission for heart failure. Hospital stays for CABG and stenting procedures in particular are likely to involve a change in medications. The reality of the home environment can be contrary to the practitioner's impression during an office visit or hospital stay. Medication misunderstanding, non-adherence, and lack of support are direct causes of re-admissions—too many of which may have been preventable.

We also encourage you to enroll your patients in Gateway's Help Your Heart Cardiac Program (see box). We look forward to working with you and your patients.

Help Your Heart Cardiac Program

Members can be referred to Gateway's Help Your Heart Cardiac Program by calling:

- PA Medicaid - 1-800-642-3550, Option 3
- PA Medicare Assured - 1-800-685-5212, Option 3

A Look at Gateway's Medicare MTM Program

by Renee Rayburg, RPh

Pharmacy Perspective

The Center for Medicare and Medicaid Services (CMS) has required all Medicare Part D plans to establish a Medication Therapy Management program (MTM program) designed to optimize therapeutic outcomes by improving medication use and reducing adverse drug events.

To meet the needs of the Medicare-required MTM program, Gateway intends to incorporate its current approach utilizing multiple disease management programs along with a Pharmacy Utilization Review program. This program is designed to improve prescription use through increased safety and appropriate prescribing, and to generate better access to necessary therapies for the targeted population.

Gateway utilizes a holistic approach to improve the overall health and livelihood of its members entitled Prospective Care Management (PCM). All

disease management programs, including the MTM program, are integrated within PCM.

To be eligible for a plan's MTM program, a beneficiary must meet all three of the following criteria:

1. Have multiple chronic diseases
2. Have filled multiple covered Part D drugs
3. Be likely to incur annual costs of at least \$4,000 for all covered Part D drugs.

Gateway will identify eligible members on a quarterly basis. Participation in the program is voluntary. Members who choose to participate will be funneled into the appropriate disease management, case management, or pharmacy program.

Gateway provides disease or case management programs for HIV/AIDS, diabetes, cardiac, asthma, and high-risk pregnancy. The MTM program will focus on additional disease states such as COPD, schizophrenia, bipolar disorder, osteoarthritis, and rheumatoid arthritis.

Members may be provided with educational materials, opportunities to discuss their medication regimen with a Gateway pharmacist, and possible physician interventions when warranted. The ultimate goal of the program is to improve the overall health and well being of Gateway members through enhancements in their medication regimen.



Formulary Updates

The Gateway formulary is updated on a regular basis. The listed medication changes reflect the decisions made by Gateway's Pharmacy and Therapeutics committee. Please review the changes and update your Gateway formulary book as necessary.

Please note that the Gateway Formulary can now be accessed online at www.gatewayhealthplan.com. Additional copies may be printed directly from our Formulary website, or requested through Provider Services by calling 1-800-392-1145 for the Medicaid formulary or 1-800-685-5201 for the Medicare Assured formulary.

Medicaid & Medicare Formulary Additions	
Brand Name	Generic Name
Fexofenadine	Fexofenadine
Glimepiride	Glimepiride
Levemir	Insulin detemir
RibaPak	Ribavirin
Tizanidine	Tizanidine (tablets only)
Zonisamide	Zonisamide
Medicare Formulary Deletions	
Arava (brand name)	
Copegus (brand name)	
Zithromax (brand name)	
Zonegran (brand name)	

Please contact the **Gateway Pharmacy Department** with all formulary questions and other pharmacy benefit concerns at **1-800-528-6738 (for Medicaid members)** or **1-800-685-5215 (for Medicare Assured members)**. Inquiries may also be faxed to 412-255-4544 or 888-245-2049, Attn: Pharmacy Department.



You can contact the departments listed below directly or request paper copies of documents by calling the phone numbers provided. Information can be accessed on our website (www.gatewayhealthplan.com). Be sure to choose **PA Medicaid or Medicare Assured** for program-specific information then click on Providers.

Information Central

Heading	Department	Medicaid Phone #	Medicare Phone #
Provider Manual (includes Environmental Assessment Standards, Confidentiality Policy, Patient Safety, New Technology, Member Rights & Responsibilities) Forms & Reference Materials (includes Living Will) Provider Satisfaction Survey Grievance and Appeals Privacy Policy Pharmacy Information, including Formulary	Provider Services	800-392-1145	800-685-5201
		800-392-1145	800-685-5201
		800-392-1145	800-685-5201
		800-392-1145	800-685-5201
Medical Record Review & Medical Record Keeping Standards Clinical Guidelines Patient Safety Newsletters	Quality Improvement (QI)	412-255-1144	412-255-1144
		412-255-1144	412-255-1144
Health Resources: (Disease Management Programs, Special Needs, Child Health, Patient Education)	Case Management & Disease Management (DM)	800-642-3550	800-685-5212
Utilization Management	UM	800-392-1146	800-685-5205
Patient Education	DM	800-642-3550	800-685-5212



Clinical Times

PHYSICIAN NEWSLETTER

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