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Redefining Provider Performance Assessment

From Paul Mendis, MD, Chief Medical Officer of Neighborhood Health Plan



NHP has launched a new Provider Performance Assessment (PPA) initiative based, in part, on feedback from a series of physician focus groups conducted in recent months. We heard that the parameters chosen should be clinically meaningful, outcomes based, and reflect events which ultimately our affiliated practices are able to influence. Data should be timely, actionable and, for primary care practices, should be focused at the group, rather than the individual level. Wherever possible, measures should incorporate all of a practice's patients rather than those belonging to a single health plan.

While all of those principles could not be incorporated in each measure, NHP has used the framework of IHI's Triple Aim in identifying measures which capture members' care experience, population health, and the cost of care:

- The overall rate of satisfaction with a practice will be measured initially via existing CAHPS* scores and, in subsequent phases, results of site-based surveys will be utilized. The percentage of unassigned members at a practice site trended over time will serve as a supplemental care experience measure.
- Population health measures will include: HbA1c control in diabetics, blood pressure control in hypertensives, mammography screening rates, post-partum follow-up visit rates, and the comprehensiveness of childhood immunizations at age two.
- Effectiveness in cost management will be assessed with measures that in many cases also serve as indicators of quality, such as: preventable hospital admission rates, 30-day hospital readmission rates, non-emergent ER visit rates, primary care follow-up after hospitalization, and generic prescribing.

Ten practices have begun working with NHP as PPA pilot sites. Based on their experiences, a modified version of this model will be disseminated more broadly later this year and into 2011. It is anticipated that future iterations will incorporate concepts from the patient centered medical home pilots and payment reform discussions as they evolve in the Commonwealth. [\[CQ\]](#)

*CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Prophylactic Acetaminophen Before Vaccination in Infants Reduces Vaccine Response

By Fran Lowry, Freelance Writer
October 2009, Medscape Medical News

The prophylactic administration of acetaminophen (paracetamol) to reduce fever or febrile convulsions after vaccination in infants actually results in reduced immunogenicity and should not be routinely recommended, according to a new study published in the October 17 issue of *The Lancet*.

"Although fever is part of the normal inflammatory process after immunization, prophylactic antipyretic drugs are sometimes recommended to allay concerns of high fever and febrile convulsion," write Roman Prymula, MD, from the University of Defence, Hradec Kralove, Czech Republic, and colleagues. "Evidence lending support to this approach is scarce; the level of fever is unrelated to the onset of convulsion, and antipyretic drugs are ineffective in prevention of benign febrile convulsion in children who are at risk."

The aim of the study was to assess the effect of acetaminophen on infant febrile reaction rates and vaccine responses.

Vaccination Open-Label Studies Performed

The authors performed 2 consecutive (primary and booster) vaccination open-label studies. Healthy infants aged 9 to 16 weeks were randomly assigned to receive 3 prophylactic acetaminophen doses every 6 to 8 hours in the first 24 hours (n = 226 infants) or to no acetaminophen (n = 233 infants) after each vaccination with a 10-valent pneumococcal nontypeable *Haemophilus influenzae* protein D-conjugate vaccine (PHiD-CV) coadministered with the hexavalent diphtheria-tetanus-3-component acellular pertussis-hepatitis B-inactivated poliovirus types 1, 2, and 3-H influenzae type b (DTPa-HBV-IPV/Hib) and oral human rotavirus vaccines.

Prophylactic acetaminophen did reduce febrile reactions, the investigators

report. The percentage of children with a temperature of 38°C or greater after at least 1 dose was significantly lower in the prophylactic acetaminophen group after primary vaccination (94/226; 42%) and after booster (64/178; 36%) vs the no-prophylactic acetaminophen group after primary vaccination (154/233; 66%) and after booster (100/172; 58%). Fever greater than 39.5°C was uncommon in both groups.

Unexpected Finding Reported

However, an unexpected finding was a substantial reduction in the primary antibody response to each of the 10 pneumococcal conjugate vaccine serotypes and to Hib polysaccharide, diphtheria, tetanus, and pertactin antigens. "After boosting, lower antibody GMCs persisted in the prophylactic... [acetaminophen] group for antitetanus, protein D, and all pneumococcal serotypes except for 19F," the study authors write.

"To our knowledge, such an effect of prophylactic... [acetaminophen] on postimmunisation immune responses has not been documented before. Remarkably few published studies have assessed the effects of antipyretic drugs on child vaccine responses," Dr. Prymula and colleagues write.

They conclude that the clinical relevance of their findings is unknown and needs further assessment but suggest that the prophylactic administration of antipyretic drugs at the time of vaccination "should nevertheless no longer be routinely recommended without careful weighing of the expected benefits and risks."

Comments: Important Question Raised

In an accompanying comment, Robert T. Chen, MD, from the Centers for Disease Control and Prevention in Atlanta, Georgia, and colleagues, write that Dr. Prymula and colleagues raise an important question regarding the clinical

and public health implications of reduced antibody concentrations with the use of acetaminophen. This is particularly important with regard to the extent to which acetaminophen might reduce population protection.

"This point has implications, especially for *Haemophilus influenzae* and pneumococcus, for which higher and sustained antibody concentrations are needed to interrupt the carrier state and reduce transmission within the population," they write.

Dr. Chen and colleagues add that vaccine policymakers should assess the implications of the study findings for vaccination programs, concluding, "Prymula and colleagues present a compelling case against routine use of... [acetaminophen] during paediatric immunizations."

Anna Taddio, PhD, from the Hospital for Sick Children and the University of Toronto, Toronto, Ontario, Canada, agrees. Dr. Taddio told Medscape Pediatrics that today's vaccines are safer, with fewer adverse effects, and that recent studies have begun to show that antipyretics do not do as much to reduce fever and alleviate pain and other uncomfortable symptoms associated with infant vaccinations as previously believed.

"In general, fewer people are recommending routine use of Tylenol, so this study is helping that pendulum sway more to the 'don't use' end by suggesting that you shouldn't give... [acetaminophen] just in case a child may develop side effects, because this might be contributing to a problem which no one else has ever shown before—that... [acetaminophen] interferes with the vaccine."

She concurred with Dr. Chen and colleagues that the new finding raises public health concerns.

Continued on next page

Bringing Hope to Haiti

By Matthew Collins, MD, Medical Director, Neighborhood Health Plan, and a Family Practitioner

“The amount of protective antibody was a little bit lower for some of these vaccines, so if everybody’s levels are a little lower, some people may continue to carry the organism. This might not mean much for an individual, but we don’t know whether other people in the population will be getting infected.”

Dr. Taddio added that she considers the use of prophylactic acetaminophen an option to be considered in case a child has a severe reaction after being vaccinated.

“Because this study showed reduced protective antibodies with [acetaminophen] and because other studies fail to show that [acetaminophen] actually helps as much as we thought, I won’t recommend that parents give it to their kids. I would say that’s out of the books now. If a child does develop a fever and is very uncomfortable, then you can give it. That’s a common sense approach anyway. Why would you give drugs unnecessarily?” [CQ](#)

This study was funded by GlaxoSmithKline Biologicals. Dr. Prymula has disclosed various financial relationships with GlaxoSmithKline. Dr. Chen and Dr. Taddio have disclosed no relevant financial relationships. Lancet. 2009;374:1305-1306, 1339-1350. Reprinted with permission from Medscape.com, 2010. Available at: <http://www.medscape.com/viewarticle/710788>.

Affirmation

NHP recognizes that underutilization of medically appropriate services has the potential to adversely affect our members’ health and wellness. For this reason, NHP promotes appropriate utilization of services. NHP’s utilization management (UM) decisions are based only on appropriateness of care and service and existence of coverage. NHP does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, nor does NHP provide financial incentives to UM decision-makers to encourage decisions that result in underutilization. [CQ](#)

The images and stories of the earthquake shocked me as they did everyone. I thought immediately of my Haitian patients and the suffering they must be going through. Also, I was struck with a desire to help in any way I could. The first thing I did was donate money to Partners in Health, a non-profit that works to bring modern medical care to poor communities in 12 countries around the world, and has been working in Haiti for 20 years. Then I surfed the Internet trying to find agencies in need of volunteer physicians. An opportunity to volunteer soon came up.

The University of Massachusetts Medical School had received a call for assistance from a hospital in La Romama, Dominican Republic. The staff from this hospital was organizing a medical aid mission to Port-au-Prince and needed volunteer physicians to go. For many years UMass physicians and students have been traveling to La Romana to volunteer in the hospital and surrounding clinics. As an assistant professor with the Department of Family Medicine and Community Health at UMass Medical School, I was among the pool of physicians solicited to volunteer.

Our team was assembled by the office of the Dean of the medical school and consisted of five family physicians, three emergency medicine physicians, one orthopedist, two pediatricians (including the Dean himself), an internist, a nurse practitioner, and a nurse. The trip was rapidly planned, vaccinations were dispensed, materials were collected and, before we knew it, we were on a plane heading for the Dominican Republic early Monday morning, January 25th. We rendezvoused with the local organizing team in La Romana, packed our supplies and ourselves into a bus, and travelled overnight into Haiti.

“As we travelled through the destruction and chaos of the quake we were just awestruck at not only the devastation and desperate circumstances, but the remarkable resilience of the Haitian people.”

We arrived in Port-au-Prince at about 10:00 a.m. the following day and, as tired as we were, loaded our gear into trucks and set off to set up our first clinic. The organizing team from the Dominican Republic had established contacts with local police,

tent community organizers, and local pastors to arrange

security, sites in need of medical attention, and a place for us to stay.

Each day we were escorted by police to a new tent camp. The camps varied in population and medical needs. They ranged in size from 1,000 to 5,000 people by our estimates and appeared from the organizing team’s perspective to be growing by the day. There certainly were a lot of traumatic injuries in among the residents, but of greater concern was the prevalence of infectious disease.

At each camp we established a triage system to identify the sickest. Those individuals were then registered and rapidly seen by the most appropriately trained provider in our group. A team of outstanding Creole interpreters facilitated our communication. We used our ample supply of medications, vaccines, food, rehydration solutions, and compassion to treat most of the patients on-site. We also established connections with a UN hospital to refer those in need of more advanced care. Among those referred was a 10-month old baby with a skull fracture. Fortunately, this baby’s care was handed over to a volunteer neurosurgeon working at the UN clinic.

In the end, we treated 980 people and delivered food or supplies to an even larger number. We also delivered hope for the camps we served, letting people know that the organizing team had plans to return weekly to each site with a new team of volunteers.

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Asthma: It's All About Control

By James Glauber, MD, MPH

Senior Medical Director, Neighborhood Health Plan

Assessment of asthma control is a central theme of the 2007 NHLBI Asthma Treatment Guidelines. This is in contrast to earlier versions of the guidelines, which emphasized disease severity classification. Why the change? Disease severity is a static property of the individual, whereas asthma control is a dynamic, ongoing dimension of the disease and is the target of treatment.

According to the guidelines, asthma control is defined as “the degree to which manifestations of asthma (symptoms, functional impairment, and risks of untoward events) are minimized and the goals of therapy are met.” While disease severity may be assessed at diagnosis, before a patient is on a long-term control medication, asthma control should be assessed on an ongoing basis to guide treatment decisions. Both asthma severity and control are assessed in two distinct domains: impairment and risk. Impairment encompasses asthma’s impact on a patient’s quality of life and functional capacity. Risk refers to the likelihood of future adverse events such as exacerbations, medication side effects, and progressive loss of lung function. These two domains, impairment and risk, may respond differently to treatment. Regardless of a patient’s disease severity the goal of treatment is the same: well-controlled asthma.

Assessment of the impairment domain can be accomplished through the use of standardized, easy-to-administer questionnaires such as the Asthma Control Test (ACT), Childhood Asthma Control Test, Asthma Control Questionnaire, and the Asthma Therapy Assessment Questionnaire (ATAQ). Neighborhood Health Plan has adopted the Asthma Control Test; English and Spanish versions of the ACT can be downloaded from the on-line

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MONITORING CONTROL DETERMINES ONGOING THERAPY

Asthma control is achieved by:

1. Reducing impairment, which includes:
 - a. Prevention of chronic and troublesome symptoms
 - b. Reducing need for inhaled short-acting bronchodilator to relieve symptoms
 - c. Maintenance of near normal lung function
 - d. Maintenance of normal activity levels
 - e. Patient and family satisfaction
2. Reducing risk, which includes:
 - a. Prevention of recurrent exacerbations
 - b. Prevention of progressive loss of lung function
 - c. Avoidance of adverse effects of pharmacotherapy for asthma

	Components of Control (>12 Years of Age and Adults)	Classification of Asthma Control (>12 Years of Age)		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤ 2 days/week	> 2 days/week	Throughout day
	Nighttime awakenings	≤ 2x/month	1–3x/week	≥ 4x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤ 2 days/week	> 2 days/week	Several times per day
	FEV1 or peak flow	> 80% predicted/ personal best	60–80% predicted/ personal best	< 60% predicted/ personal best
	Validated questionnaires			
	ATAQ	0	1–2	3–4
	ACQ	≤ 0.75	≥ 1.5	N/A
	ACT	≥ 20	16–19	≤ 15
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	— > 2/year — Consider severity and interval since last exacerbation	
	Progressive loss of lung function	Evaluation requires long-term follow-up care		
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
	Recommended Action for Treatment	<ul style="list-style-type: none"> • Maintain current step • Regular follow-ups every 1–6 months to maintain control • Consider step down if well controlled for at least 3 months 	<ul style="list-style-type: none"> • Step up 1 step • Reevaluate in 2–6 weeks • For side effects, consider alternative treatment options 	<ul style="list-style-type: none"> • Consider short course of oral systemic corticosteroids • Step up 1–2 steps • Reevaluate in 2 weeks • For side effects, consider alternative treatment options

Chart information from A Pocket Guide for the Busy Managed Care Professional: Guidelines in Asthma Management for Managed Care. Based on updated 2007 NAEPP/NHLBI Asthma Guidelines, sponsored by PRIME and produced through an educational grant from GENENTECH and NOVARTIS

How is my Asthma?

For patients with limited literacy or English-language skills, a picture is worth a thousand words.

Asthma self-management education is essential for helping patients control their asthma and to improve patient outcomes. NHP is pleased to offer asthma resources that use pictures to illustrate the key components of asthma self-management:

- Level of asthma control
- Self monitoring
- Proper inhaler technique

Self-Management Education

Materials Available for Download:

How is my Asthma?: Easily assess your patient's level of asthma control with this colorfully illustrated tool.

Illustrated Asthma Care Plan: Helps your patients to have a clear understanding of when and how to use their control and quick relief medications.

Easy, illustrated Instructions for Medication Delivery Devices: Help your patients get the most out of their medications by giving them step-by-step illustrated instructions for proper delivery device technique. Instructions are available for:


- An inhaler with a spacer
- An inhaler with a spacer and a mask
- A nebulizer
- A nebulizer with a facemask
- A diskus
- An OptiHaler® spacer
- An Asmanex®Twisthaler®
- A Pulmicort Flexhaler™
- HFA cleaning and priming

NHP Asthma Toolkit

Now in Six Languages

All PDFs of asthma toolkit flyers are now available in English, Spanish, Portuguese, Chinese, Vietnamese, and Haitian Creole.


Find all of the tools here:

http://www.nhp.org/pages/providers_clinicalresources_asthmatoolsdownload.aspx 

Components of Control (Children 5–11 Years of Age)	Classification of Asthma Control (Children 5–11 Years of Age)		
	Well Controlled	Not Well Controlled	Very Poorly Controlled
Symptoms	≤ 2 days/week	> 2 days/week or multiple times on ≤ 2 days/week	Throughout day
Nighttime awakenings	≤ 1x/month	≥ 2x/month	≥ 2x/week
Impairment Interference with normal activity	None	Some limitation	Extremely limited
Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤ 2 days/week	> 2 days/week	Several times per day
Lung function FEV ₁ or peak flow	> 80% predicted/ personal best	60–80% predicted/ personal best	< 60% predicted/ personal best
FEV ₁ /FVC	> 80% predicted	60–80% predicted	< 60% predicted
Risk Exacerbations requiring oral systemic corticosteroids	0–1/year Consider severity and interval since last exacerbation	≥ 2/year	
Reduction in lung growth	Evaluation requires long-term follow-up care		
Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
Recommended Action for Treatment	<ul style="list-style-type: none"> • Maintain current step • Regular follow-ups every 1–6 months • Consider step down if well controlled for at least 3 mo. 	<ul style="list-style-type: none"> • Step up at least 1 step • Reevaluate in 2–6 weeks • For side effects, consider alternative treatment options 	<ul style="list-style-type: none"> • Consider short course of oral systemic corticosteroids • Step up 1–2 steps • Reevaluate in 2 weeks • For side effects, consider alternative treatment options

Availability of the Appropriate Practitioner to Discuss UM Decisions

In all instances of medical necessity denials, it is NHP's policy to provide the treating/referring practitioner with an opportunity to discuss a potential denial decision with the appropriate practitioner. NHP is accessible to practitioners

seeking information about the utilization management process and authorization requests and decisions from 8:30 a.m. to 5:30 p.m. Monday through Friday. Please call 1-800-462-5449 or 617-772-5565. The fax number is 617-772-5512 or 617-478-7175. For after-hours requests and utilization management issues, you may leave a message or fax. These lines are available 24/7. All requests and messages will be retrieved on the next business day. 

Prenatal Counseling Reduces Domestic Violence

By Chris Emery, Contributing Writer, Published: January 21, 2010 MedPage Today

Pregnant African-American women who received counseling to improve their physical and psychological health and safety were less likely to be the victims of domestic violence during pregnancy and postpartum, a new study found.

Women who received the cognitive and behavioral integrated intervention were less likely to experience recurrent episodes of intimate partner violence victimization (OR 0.48, 95% CI 0.29 to 0.80), according to a report in the Jan. 21 issue of *Obstetrics & Gynecology*.

Counseled women who had reported previous minor intimate partner violence were significantly less likely to experience further episodes during pregnancy (OR 0.48, 95% CI 0.26 to 0.86) and after they gave birth (OR 0.56, 95% CI 0.34 to 0.93).

Furthermore, counseled women were less likely to give birth very preterm (<33 weeks gestation) than mothers who received no counseling (1.5% versus 6.6% respectively; $P=0.03$), and babies of counseled women had a longer mean gestational age at delivery.

"A relatively brief intervention during pregnancy had discernible effects on intimate partner violence and pregnancy outcomes," Michele Kiely, DrPH, of Eunice Kennedy Shriver National Institute of Child Health and Human Development, and colleagues wrote.

"Screening for intimate partner violence as well as other psychosocial and behavioral risks and incorporating similar interventions in prenatal care is strongly recommended."

Intimate partner violence is a pattern of assault and coercion that includes the threat or infliction of physical, sexual, or psychological abuse.

Approximately 4.8 million episodes of intimate partner violence occur every year in the U.S. in women 18 years and older, according to the CDC.

Victims are at higher risk for a range of psychobehavioral and health problems, including complications during pregnancy and adverse pregnancy outcomes, such as preterm delivery and low birth weight.

Kiely and colleagues set out to determine whether a cognitive behavioral intervention administered during pregnancy could reduce intimate partner violence and improve birth outcomes in a population of African-American residents of Washington, DC.

Of the 1,044 women enrolled in the study between July 2001 and October 2003, 521 were randomly assigned to receive the intervention and 523 to receive usual care. At an initial interview, 336 of the women reported intimate partner violence victimization in the past year, evenly divided between the intervention group and usual care.

The women in the intervention group received individually tailored counseling and information that addressed the problems they reported.

The counselors provided information about the types of abuse and the cycle of violence and assessed the level of danger to which the women were exposed. They discussed preventive options the women might consider, such as filing a protection order, and the development of a safety plan.

The women also received a list of community resources and information on the health risks of smoking and how to cope with depression.

The complete intervention included eight prenatal sessions delivered during routine prenatal care visits, and researchers conducted follow-up inter-views over the phone with the women.

They found that women in the intervention group who had previously experienced severe intimate partner violence showed a significant reduction in episodes after giving birth (OR 0.39, 95% CI 0.18 to 0.82) and that women who experienced physical violence specifically showed significant reductions by their first follow-up

Neighborhood Health Plan Partners with Text4baby

prenatal visit (OR 0.49, 95% CI 0.27 to 0.91) and postpartum (OR 0.47, 95% CI 0.27 to 0.82).

“There is evidence that this intervention for pregnant African-American women reduced intimate partner violence victimization during pregnancy and improved pregnancy outcome,” the authors wrote.

“If generalizable, our results should encourage healthcare providers and third party payers to go beyond screening for psychosocial and behavioral risks to providing services during prenatal care to address such risks. The potential cost savings associated with reduction of births within the highest risk category may be substantial.”

The authors cautioned that the study was not designed to test whether the intervention was effective at reducing adverse pregnancy outcomes but rather focused on reducing the psychobehavioral risks.

They also noted that only 59% of the women in the intervention group completed all eight of the sessions, indicating that as a group they were only modestly committed to participating in the program.

Further improvements could be made to the intervention strategy to address other issues, such as alcohol and drug use, they wrote. “Had we addressed these, we might have been even more successful,” they concluded. [CC](#)

The study was funded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development and the National Center on Minority Health and Health Disparities.

The authors reported no financial conflicts of interest.

Primary source: Obstetrics & Gynecology

Source reference:

Kiely M, et al “An integrated intervention to reduce intimate partner violence in pregnancy” *Obstet Gynecol* 2010; 115: 273–83.

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text4baby

A free service of the
National Healthy Mothers, Healthy Babies Coalition

NHP is the first health plan in Massachusetts to become an Outreach Partner with text4baby, a free program that sends health-related text messages to expectant mothers and mothers of infants.

“The text4baby program is an important step in responding to high infant mortality rates and premature births due to poor perinatal health,” said Deborah C. Enos, President and CEO of Neighborhood Health Plan. “NHP did not hesitate to sign on as an Outreach Partner because we recognize the power of this program to be able to reach women at a critical time in their pregnancy, and affect simple behavioral changes that could have a significant impact on infant health and mortality.”

Each year in the U.S. more than 500,000 babies are born prematurely, and an estimated 28,000 children die before their first birthday.* In response to this national public health crisis, the National Healthy Mothers, Healthy Babies (HMHB) Coalition launched text4baby to help new mothers care for their health and give their babies the best possible start in life.

Women who sign up for the service by texting BABY to 511411 (or BEBE in Spanish) receive free SMS text messages each week, timed to their due date or baby’s date of birth. These messages focus on a variety of topics critical to maternal and child health, including birth defects prevention, immunization, nutrition, seasonal flu, mental health, oral health, and safe sleep. Text4baby messages also connect women to prenatal and infant care services and other resources.

Outreach Partners

The National HMHB Coalition is working with a broad range of partners to encourage the women they reach to take advantage of this free service. Outreach partners include state and local health departments, community health centers, WIC programs, health plans, retail partners, community organizations, major medical associations, and nonprofit organizations.

Text4baby is made possible through a broad, public-private partnership that includes government, corporations, academic institutions, professional associations, tribal agencies and non-profit organizations. Founding partners are HMHB, Voxiva, CTIA—The Wireless Foundation and WPP. U.S. government partners include the White House Office of Science and Technology Policy and the Department of Health and Human Services. The mobile health platform is provided by Voxiva and free messaging services are generously provided by participating wireless service providers. Implementation partners include BabyCenter, Danya International, Syniverse, Keynote Systems, and The George Washington University.

“Promoting prenatal and post partum health is one of NHP’s major health and quality initiatives, and a priority in our efforts to address health disparities in our State,” said Paul Mendis, Chief Medical Officer for NHP. “Our partnership with text4baby is a natural extension of our work in these areas.”

*Martin JA, Hamilton BE, Sutton PD, et al. Births: Final data for 2003. National vital statistics reports; vol 54 no 2. Hyattsville, MD: National Center for Health Statistics. 2005.

Physical Abuse Raises Women's Health Costs over 40 Percent

By Jeff Grabmeier, Director
Research Communications, Ohio State University

Women experiencing physical abuse from intimate partners spent 42 percent more on health care per year than non-abused women, according to a long-term study of more than 3,000 women.

And the costs don't end when the abuse does. The study revealed that women who suffered physical abuse five or more years earlier still spent 19 percent more per year on health care than women who were never abused.

"Along with all the physical and emotional pain it causes, domestic violence also comes with a substantial financial price," said Amy Bonomi, co-author of the study and associate professor of human development and family science at Ohio State University.

The study is the largest to date to examine health care costs and utilization based on the timing and type of domestic violence that women suffer, Bonomi said.

The study, co-authored with researchers from the Group Health Cooperative and the University of Washington in Seattle, was published online in the journal *Health Services Research*. It will also appear in a print edition.

The research examined data from 3,333 randomly selected women who belonged to Group Health, a health care system in the Pacific Northwest.

Women in the study were surveyed about whether they experienced any physical or emotional abuse from intimate partners and if so, when it occurred. Researchers then studied patterns of health care use and costs by the women over an 11-year period, from 1992 through 2002.

"We were able to track health care costs for quite a long time, giving us a good picture of how much domestic violence is actually costing our health care system," Bonomi said.

Women experiencing ongoing physical abuse had the highest health care costs, 42 percent higher than non-abused.

"It's likely that these women need more health care because they are seeking care for immediate injuries and associated health problems," Bonomi said.

Women who had been physically abused within the last five years, but not currently, had 24 percent higher yearly health costs. Abuse that occurred more than five years ago resulted in 19 percent higher costs.

The study separately examined women who experienced psychological abuse, which included verbal threats and chronic controlling behavior.

Those suffering psychological abuse within the past five years, but not currently, had yearly health care costs that were 33 percent higher than those of non-abused women. "It's possible that it takes additional time for women with psychological abuse to seek care for their experiences," Bonomi said.

Another striking finding was that all abused women, whether they experienced physical or psychological abuse, used significantly more mental health services than non-abused women, Bonomi said.

Women suffering ongoing physical abuse were about 2.5 times more likely to visit a mental health provider in the past year than were non-abused women. The rate for psychologically abused women was two times higher.

"This lends support to the idea that mental health providers should always ask women about their abuse history when they first come in for treatment," Bonomi said.

But mental health was just one of several areas in which abused women used more services. Physically abused women used significantly more primary care,

pharmacy, specialty care, laboratory and radiology services.

For psychologically abused women, more services were needed in specialty care, pharmacy, and radiology.

Group Health, the health care system whose members were surveyed for the study, provides health and insurance services to more than 500,000 people in the Pacific Northwest. [cc](#)

Bonomi conducted the study with Melissa Anderson and Robert Thompson of The Center for Health Studies at Group Health Cooperative in Seattle; and Frederick Rivara of the Harborview Injury Prevention and Research Center at the University of Washington.

The study was funded by the Group Health Community Foundation and the federal Agency for Healthcare Research and Quality.

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Domestic Violence Program ROI Tool

The Family Violence Prevention Fund and Physicians for a Violence Free Society have developed a simple, excel-based return-on-investment (ROI) tool you can use to better understand the costs and benefits of incorporating a comprehensive domestic violence program as part of your practice.

To download a copy of the ROI tool, learn more about the health impact of abuse and how to reduce costs by implementing a domestic violence program, visit http://www.endabuse.org/section/programs/health_care/_business_case.

If you do download and use the tool, we want to hear about it! Please send all success stories, challenges, and "a ha!" moments from the use of the ROI tool to Sara Nechasek, NHP's Domestic Violence Initiative Project Manager, sara_nechasek@nhp.org, or call 617-772-5689.

Pharmacy & Therapeutics Update

The NHP pharmacy benefit strives to provide a high quality benefit while controlling the ever-rising cost of a pharmacy benefit. As part of this effort, NHP uses several different programs including medication tiering, mandatory generic substitution, prior authorization, step therapy, and quantity limits. All pharmacy programs are reviewed by the NHP P&T committee on an annual basis to assure the programs are clinically sound and relevant. The NHP P&T committee reviews new to market medications after they have been available for six months. Prior to P&T review, new-to-market medications are blocked and reviewed as a prior authorization.¹

Preferred Drug List (PDL) Update

The Pharmacy and Therapeutics Committee has reviewed the following medications.

Tier 1 (Generics)

Subutex (buprenorphine sublingual)
 Aceon (perindopril tablet)
 Prevacid (lansoprazole capsule)
 Ultram ER (tramadol ER tablet)
 Optivar (azelastine OS)
 Loprox Shampoo (Ciclopirox shampoo)
 Valtrex (valacyclovir tablet)
 Pulmocort Nebulizer Susp (budesonide)
 Mirapex (pramipexole tablet)

Tier 2

Toviaz (fesoterodine fumarate)
 Uloric (febuxostat)

Tier 3

Savella (milnacipran)

Quantity Limitations²

The Pharmacy and Therapeutics Committee has voted to implement a quantity limit² on the following:

Savella (milnacipran) 60 tablets/30 days
 Uloric (febuxostat) 30 tablets/ 30 days

Prior Authorization¹

The Pharmacy and Therapeutics Committee has voted to implement a Prior Authorization¹ program on:

Savella (milnacipran)
 Uloric (febuxostat)

For the most up-to-date information regarding the NHP pharmacy programs and the current medical necessity criteria, check the drug look-up and pharmacy section on www.nhp.org by clicking on "Drug Lookup" under "Quick Links."

¹ Prior Authorization is an individual case review compared to P&T-established guidelines, or NHP New-to-Market policy, before a prescription for the specific medication will be covered.

² Quantity Limits promote cost-effective prescribing by limiting the number of units of medication that can be dispensed over a given time. These are established based on strengths available and the recommended doses.

³ Step Therapy is an automated case review, based on P&T-established guidelines and the individual member's NHP pharmacy profile. This process occurs with a pharmacy claim submission and does not require provider intervention if prior NHP pharmacy claims indicate use of the first line and/or second line medications.

⁴ Requests for a not covered medication are reviewed on a case by case basis.

Member Rights and Responsibilities

NHP Member Rights

As valued members of Neighborhood Health Plan (NHP), our members have the right to:

- Receive information about NHP, our services, our providers and practitioners, your covered benefits, and your rights and responsibilities as a member of NHP.
- Receive documents in alternative formats and/or oral interpretation services free of charge for any materials in any language.
- Have your questions and concerns answered completely and courteously.
- Be treated with respect and with consideration for your dignity.
- Have privacy during treatment and expect confidentiality of all records and communications.
- Discuss and receive information regarding your treatment options, regardless of cost or benefit coverage, with your provider in a way which is understood by you. You may be responsible for payment of services not included in the *Covered Services* list for your coverage type.
- Be included in all decisions about your health care, including the right to refuse treatment and the right to receive a second opinion on a medical procedure at no cost to you.
- Change your primary care provider.
- Access emergency care twenty-four (24) hours a day, seven (7) days a week.

- Access an easy process to voice your concerns, and expect follow-up by NHP.
- File a grievance or appeal or if you have had an unsatisfactory experience with NHP or with any of our contracted providers, or if you disagree with certain decisions made by NHP.
- Make recommendations regarding NHP's "Member Rights and Responsibilities."
- Create and apply an Advance Directive, such as a will or a health care proxy, if you are over 18 years of age.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Freely apply your rights without negatively affecting the way NHP and/or your provider treats you.
- Ask for and receive a copy of your health record and request that it be changed or corrected, as explained in the "Notice of Privacy Practices" in your *NHP Member Handbook*.
- Receive the covered services you are eligible for as outlined in the *Covered Services* list enclosed with your *NHP Member Handbook*

NHP Member Responsibilities

Members of Neighborhood Health Plan also have responsibilities. It is a member's responsibility to:

- Choose a primary care provider, the provider responsible for your care.
- Call your primary care provider when you need health care.

- Tell any health care provider that you are an NHP member.
- Give complete and accurate health information that NHP or your provider needs in order to provide care.
- Understand the role of your primary care provider in providing your care and arranging other health care services that you may need.
- To the degree possible, understand your health problems and take part in making decisions about your health care and in developing treatment goals with your provider.
- Follow the plans and instructions agreed to by you and your provider.
- Understand your benefits and know what is covered and what is not covered.
- Call your primary care provider within forty-eight (48) hours of any emergency or out-of-network treatment. If you experienced a behavioral health emergency, you should contact your behavioral health provider, if you have one.
- Notify NHP and MassHealth of any changes in personal information such as address, telephone, marriage, additions to the family, eligibility of other health insurance coverage, etc.
- Understand that you may be responsible for payment of services you receive that are not included in the *Covered Services* list for your coverage type. [GO](#)

It's All About Control

Continued from page 4

asthma toolkit on the NHP website: http://www.nhp.org/pages/providers_clinicalresources_asthmatoolsdownload.aspx

The Asthma Control Test can be quickly completed by patients during office visits. The information gleaned helps to characterize a patient's asthma as well controlled, partially controlled, or poorly controlled. Asthma treatment can be modified according to the patient's level of control. Note that spirometry is recommended as a core component of comprehensive asthma assessment.

To learn more about our Asthma Program or, if you would like to refer a patient for asthma care management, please call 617-478-7181. [cc](#)

Summary of the NHP 2009 Quality Improvement Program Evaluation

Every year, Neighborhood Health Plan develops an annual Quality Work Plan with specific objectives, goals, and planned activities for clinical quality improvements, service quality improvements, and patient safety.

The 2009 Quality Work Plan included initiatives in 26 areas including asthma, diabetes, and maternal and child health care; member and provider satisfaction; member safety; behavioral health; and health equity.

NHP is proud to report that it attained many notable achievements in 2009.

The HEDIS goal for the percent of members with asthma who are using a control inhaled steroid is approximately 91%. NHP went over that goal for the first time in 2009.

Another important initiative that exceeded targets was the screening of children for behavioral health issues at well-child visits.

The Maternal and Child Health Program met its target of identifying more than 20% of MassHealth women prior to delivery who receive care management. It also met the goal of identifying more than 75% of pregnancies prior to delivery.

Although claims payment goals at the 30-day levels were met, the goal for claims paid within 45 days was not met. Access to care represents an opportunity to NHP for improvement.

More information about NHP's 2009 Quality Evaluation and the 2010 Work Plan is available on nhp.org at www.nhp.org/Pages/quality.aspx. [cc](#)

Bringing Hope to Haiti

Continued from page 3

As we travelled through the destruction and chaos of the quake we were just awestruck at not only the devastation and desperate circumstances, but the remarkable resilience of the Haitian people. Haitian-Americans I spoke with before the trip had warned me of this, that although the Haitians would be grieving the loss of so many, they would also be resuming their daily lives. It was such a lesson for me to see a people in the worst circumstances express gratitude, graciousness and perseverance.

It is clear that the people of Haiti need our help, not only with all types of humanitarian aid, but also aid in the rebuilding. As for advice to those who are considering how they might help, I would say to be ready to do whatever you are called to do. Keep your heart open. [cc](#)

For more information:

UMass Medical — www.umassmed.edu/globalhealth/Haiti_earthquake

Partners in Health — www.laromana.org/www.pih.org/home2.html

Components of Control (Children 0-4 Years of Age)	Classification of Asthma Control (Children 0-4 Years of Age)			
	Well Controlled	Not Well Controlled	Very Poorly Controlled	
Impairment	Symptoms	≤ 2 days/week	> 2 days/week	Throughout day
	Nighttime awakenings	≤ 1x/month	> 1x/month	> 1x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤ 2 days/week	> 2 days/week	Several times per day
Risk	Exacerbations requiring oral systemic corticosteroids	0-1/year Consider severity and interval since last exacerbation	2-3/year	> 3/year
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
Recommended Action for Treatment	<ul style="list-style-type: none"> • Maintain current step • Regular follow-ups every 1-6 months • Consider step down if well controlled for at least 3 mo. • Step up at least 1 step • Reevaluate in 2-6 weeks • For side effects, consider alternative treatment options • Consider short course of oral systemic corticosteroids • Step up 1-2 steps • Reevaluate in 2 weeks • For side effects, consider alternative treatment options 			



**Neighborhood
Health Plan™**

Your health. Our promise.

Deborah Enos
President and Chief Executive Officer

David Segal
Chief Operating Officer

Paul Mendis, MD
Chief Medical Officer

James Glauber, MD, MPH
Senior Medical Director

Matthew Collins, MD
Medical Director

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Director of Marketing & Corporate
Communications

Laurie Hill Dunning
Senior Communications Specialist
Marketing & Corporate Communications

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Comments or Suggestions?
Clinician_Quarterly@nhp.org

Care Management Programs Including AccordantCare

NHP's internal Care Management and Disease Management programs serve members across physical, behavioral and psychosocial conditions. Our Care Management programs are designed to provide comprehensive, multidisciplinary, and fully integrated care management services that compliment and support the care delivered by providers as they help our members make effective use of available health care resources. Our holistic and culturally-sensitive model is intended to support member adherence to Providers recommended treatment and facilitate self-management. Program participation is voluntary and part of NHP's health plan benefit, at no cost. Members are identified through our enrollment process, medical and pharmacy utilization resource data, clinician, provider and self-referrals.

NHP's internal Care Management and Disease Management programs include Regional Care Management, the Care Partnership Program, Social Care Management, Parent Advisor, Smoking Cessation, HIV/AIDS, Maternal Child Health, Pediatric, Behavior Health, Diabetes, Asthma, and NHP's CMA Complex Care Management, providing care to our neediest members in their homes and other community settings.

Neighborhood Health Plan also offers expanded disease management programs to members with chronic conditions, through its delegated partnership with AccordantCare.™

These disease management programs provide members access to:

- An AccordantCare team of nurses 24 hours a day, 7 days a week
- Regular follow up with a registered nurse to monitor changes in health
- Easy-to-read newsletters and booklets
- Useful health management tools

Disease management programs are offered in: chronic obstructive pulmonary disease, coronary artery disease, heart failure, seizure disorders, rheumatoid arthritis, multiple sclerosis, Crohn's disease, Parkinson's disease, systemic lupus erythematosus (SLE), myasthenia gravis, sickle cell disease, cystic fibrosis, hemophilia, scleroderma, polymyositis, chronic inflammatory de-myelinating polyradiculoneuropathy (CIDP), amyotrophic lateral sclerosis (ALS), dermatomyositis, and Gaucher disease.

All of NHP's clinical programs are part of NHP's health plan benefit. A member's participation is voluntary and at no cost. To learn more about our programs or refer patients to our programs call NHP Customer Care Center at 1-800-462-5449. [CQ](#)