CLINICIAN Quarterly

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Responding to Challenging Economic Times

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

Paul Mendis, M.D.

The current economic crisis has intensified pressure on all health plans to examine every aspect of operations and clinical programs to achieve administrative and medical cost savings without compromising quality. There is particularly intense pressure on the Commonwealth's Medicaid health plans due to the precipitous decline in the state's revenues. The Executive Office of Health and Human Services and the Connector are seeking to preserve coverage and benefits as much as possible, but the result is a dearth of revenues for participating health plans to cover rising medical and administrative costs.

In response to these challenges NHP is reducing its administrative costs associated with staff and non-staff line items. Our goal is to make these reductions invisible to members and network clinicians. Through our trade organization, the Massachusetts Association of Health Plans, we are participating in discussions with other stakeholders to streamline credentialing, standardize coding and claims submission rules, and develop common metrics for Pay for Performance programs. In addition, our CEO, Deborah Enos, has been a member of the Payment Reform Commission which will recommend new models for provider payment that, over several years, will better align incentives to achieve the dual aims of controlling escalating medical costs and improving quality.

Our care management programs will employ more robust case finding procedures. Emphasis will be placed on improving collaboration with community-based clinicians and achieving tighter integration of medical and behavioral health services at the health plan level. By January, 2010, we will have expanded our community-based complex-care management program. Modeled after NHP's Community Medical Alliance program this enhancement will bring care management activities directly into the homes of our most challenging subset of patients.

Where appropriate, we will be identifying and steering members to utilize vendors chosen for their cost and quality. This approach will be employed in the near term for glucometers and elective high-tech imaging studies. Evidence-based guidelines will be applied more vigorously in assessing the appropriateness of high tech imaging, ultrasounds, nuclear cardiology studies, selected high-cost medication classes, pain management procedures, and back surgery. Specific details about these programs will be forthcoming in the weeks and months ahead. ■

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FEATURED TOPICS

▶ **Depression and Chronic Medical Illness** | Jay A. Koslof, Psy.D., Beacon Health Strategies
▶ **Grassroots Advocacy on the Hill: 2009 Disability Policy Seminar** | Laura Noble, NHP Clinical Operations
▶ **Corticosteroid Courses No Help for Preterm Delivery Risk** | Crystal Phend, Staff Writer, *MedPage Today*

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Multiple Corticosteroid Courses No Help in Pregnancies at Risk for Preterm Delivery

By Crystal Phend, Staff Writer, MedPage Today
Published: December 18, 2008
Reviewed by Robert Jasmer, MD
Associate Clinical Professor of Medicine, University of California, San Francisco

Multiple courses of corticosteroids for women at risk of preterm delivery do not improve fetal outcomes and may actually impair fetal growth, researchers found.

A course of antenatal corticosteroids every 14 days did not impact overall morbidity and mortality compared with placebo (12.9% versus 12.5%, P=0.83), Kellie E. Murphy, M.D., of Mount Sinai Hospital here, and colleagues reported in the Dec. 20-27 issue of The Lancet.

In the randomized trial, infants exposed to multiple doses of corticosteroids had a lower birth weight (P=0.0026), length (P0.001), and head circumference (P0.001).

Action Points

- Explain to interested patients that prior studies of weekly repeat dosing of corticosteroids for women at risk of preterm delivery has been associated with safety signals including higher risk for cerebral palsy and attention problems.
- Note that long-term follow-up of children exposed to repeat corticosteroid courses is needed to determine the clinical relevance of reduced birth size.

The results show that women at risk of preterm labor should be given only a single course of corticosteroids without repeat dosing, Dr. Murphy said.

That was the same message emphasized when the trial findings were reported earlier this year at the Society for Maternal-Fetal Medicine meeting. (See: SMFM: Multicourse Steroids Offer No Benefit for Preterm Delivery)

In an accompanying commentary, John P. Newnham, M.D., of the University of Western Australia in Perth, and Karen Simmer, M.B.B.S., Ph.D., of King Edward and Princess Margaret Hospitals in Perth, agreed, calling the trial an important milestone.

"Single-course therapy is of considerable benefit," they wrote, "but we should be aware of the potential dangers of giving too much of a good thing."

In two prior trials, weekly corticosteroid dosing for women who continued to be at risk for preterm labor after the initial dose showed no growth problems, but there were some worrisome safety signals for children through age two years, including higher risks for cerebral palsy (relative risk 5.7, P=0.12) and attention problems (P=0.04). (See: Corticosteroids Deemed Safe in Pregnancy but Questions Linger)

To see whether less frequent dosing would be safer, the researchers conducted the international Multiple Courses of Antenatal Corticosteroids for Preterm Birth Study (MACS).

The trial included 1,858 women in 20 countries who remained at risk for preterm delivery at 25 to 32 weeks' gestation and had received a single course of corticosteroids 14 to 21 days prior.

Participants were randomized to receive placebo or intramuscular betamethasone (Celestone), administered in two 12-mg doses 24 hours apart, every 14 days until 33 weeks of gestation or delivery.

Most women (72%) received one or two repeat courses of corticosteroids in the trial.

Compared with placebo, multiple courses of corticosteroids did not reduce the composite primary outcome of perinatal or neonatal mortality or significant neonatal morbidity—defined as severe respiratory distress syndrome, bronchopulmonary dysplasia, intraventricular hemorrhage, periventricular leukomalacia, or necrotizing enterocolitis (hazard ratio 1.04, 95% confidence interval 0.77 to 1.39).

Nor were there significant benefits for subgroups by gestational age at randomization, preterm rupture of the membranes, or single versus multiple pregnancies.

Neonatal respiratory and other individual outcome measures showed no advantage of repeat corticosteroid dosing for women at risk of preterm labor.

At birth, infants exposed to multiple courses of antenatal corticosteroids weighed on average 113 g less (P=0.0026), were 0.9 cm shorter (P0.001), and had head circumferences 0.6 cm smaller on average than those exposed to only an initial course (P0.001).

"These findings are concerning," the researchers said, "and are consistent with those from randomized controlled trials of weekly courses of antenatal corticosteroids."

To determine the clinical relevance of corticosteroid's effect on fetal size, further follow-up is needed, Dr. Murphy's group said. Drs. Newnham and Simmer agreed that long-term follow-up of children in MACS is needed, particularly for problem areas in other trials, such as behavior, growth, glucose tolerance, and blood pressure.

The trial had preplanned secondary outcome measures at 18 to 24 months of age, for which data collection is being finished now, Dr. Murphy said. She noted that the study is funded to follow children to age five, but "ideally we should try to follow them even longer."

There may still be some avenues to pursue with multiple dosing in the research setting, such as a single course of rescue corticosteroids if women again present with acute symptoms of preterm labor, Dr. Murphy said.

But, her group noted that outcomes were no better with corticosteroids versus placebo for infants born within seven days of repeated study drug administration.

The lack of benefit and potential harm with repeat dosing in several studies reinforces the importance of studying outcomes meticulously, she said.

Even with what seems a simple intervention, "we need to appreciate that any of our interventions have the potential for long-term benefits but also long-term harm," she concluded. ■

The study was supported by a grant from the Canadian Institutes for Health Research. The researchers reported no conflicts of interest.
The data coordinating center was supported by grants from Sunnybrook Health Sciences Center, Women's College Hospital and the University of Toronto. Betamethasone and placebo were purchased from Schering-Plough Corporation and Eminent Services Corporation.
Drs. Newnham and Simmer reported no conflicts of interest.
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Grassroots Advocacy on the Hill: Public policies for full inclusion of people with disabilities a top priority.

Laura Noble, Parent Advisor, NHP Clinical Operations

Over 550 advocates for persons with disabilities from grassroots networks around the country gathered in Washington, D.C., at the 2009 Disability Policy Seminar to discuss public policy issues that dramatically affect the quality of life of people with disabilities. New York and Massachusetts advocates received a round of applause for the strongest presence with over 100 participants between them. Participants at the three-day event heard from leading public policy experts, disability advocates, and Congressional staff about key policies and topics including:

- health care reform,
- long term services and supports,
- direct support professionals,
- housing,
- employment,
- education,
- vocational rehabilitation,
- asset development,
- Social Security, and
- Autism Spectrum Disorder.

The event culminated in over 150 visits to Congressional offices to advocate for key disability programs and issues.

Health Care Reform and Health Care Disparity

Health Care reform is a top priority this year for Congress and the Obama Administration. There are over 46 million Americans without health insurance and a recent summary of several studies issued by the U.S. Department of Health and Human Services reported that health care spending reached $2.2 trillion in 2007, which is nearly double the average of other developed countries (The ARC, 2009).

Reform must also address health care disparity, a critical concern for many people with developmental disabilities. The U.S. Surgeon General's 2002 report, *Closing the gap: A national blueprint to improve the health care needs of persons with mental retardation,* stated that this population has poorer health, and less access to medical care, than the general population for several reasons, including a lack of qualified health care professionals who are willing to treat them. To help remedy that disparity, advocates want the Public Health Services Act amended to require that medical schools, dental schools and their residency programs provide training to improve competency and clinical skills in providing care to patients with intellectual and developmental disabilities as a condition for receiving federal funds.

> *More than 54.4 million Americans (19%) report having some level of disability.*
>
> U.S. Census Bureau, 2005

Many in Congress and the health care industry have recognized the need to address the shortage of primary care physicians, nurses and dentists. In Massachusetts, health care centers are addressing workforce related issues by offering education and job training programs to employees and the community. NHP has supported the efforts of the Massachusetts League of Community Health Centers in strengthening the state's health care workforce by sponsoring graduate level certification programs through Suffolk University's Public Management Department.

Long Term Supports and Services

The disability and aging communities are particularly concerned with the topic of long term supports and services and want this issue to be included in health care reform. While there are 46 million people without health insurance, it is estimated that 250 million people are without coverage for these invaluable supports.

Long term supports and services (i.e., personal assistance with activities of daily living like taking medication, managing household chores, preparing meals, assistive technologies, etc.) allow people to live in their homes or in community-based settings rather than in costly institutions. Presently, states are only required to provide these services in nursing homes and institutions. It is estimated that nearly ten million Americans need long-term services and supports now and 40 percent of these people are under the age of 65. Since there is no national program to address this need, nearly half of all funding for long-term services is provided through Medicaid and conservative estimates report that hundreds of thousands are waiting for services.

There are too many pressures on Medicaid to provide long term services and supports. Advocates have urged legislators to support legislation that would call for a national insurance program which would be financed through modest voluntary payroll deductions. Eligible individuals could receive assistance through a cash benefit and without forcing them into poverty to receive Medicaid benefits (The CLASS Act, S. 697/ H.R. 1721). Additionally, advocates want the Medicaid program to be improved by eliminating the "institutional bias" which consumes 60% of the funding for these services (The Community Choice Act). These changes would allow individuals a true choice to receive services at home or in the community. While there is commitment by some Senators to include long-term supports and services in health care reform, there is no guarantee this will happen without strong public support.

Care managers at NHP, including the Parent Advisors to Children with Special Health Care Needs (CSHCN), seek to empower NHP members through education and the development of self-advocacy skills. Care managers help members make effective use of available health care resources and connect members with resources and supports in the community.

For additional information on the 2009 Disability Policy Seminar and the legislative agenda, visit www.thearc.org/NetCommunity/Page.aspx?pid=1709. To contact the NHP Parent Advisors/Clinical Department, call Laura Noble 617-204-1416 and Lauri Medeiros 617-772-5780. ■

Neighborhood Health Plan's Diabetes Program

NHP's Diabetes Program is intended to provide outreach to members at varying levels of intensity based on a stratification of clinical data to help members more effectively manage their diabetes, reduce the risk for short and long term complication, enhance member understanding of diabetes and good self-management practices and improve their self-assessed quality of life.

Member Resources

- Newly-enrolled members with a diagnosis of diabetes or newly-diagnosed members receive mailings that contain educational resources and recommendations to assist them in better managing their condition. Topics covered include:
  - General information about diabetes
  - Staying healthy
  - Weight management booklet, *Thumbs Up*
  - An action plan for personal goals
  - *Healthwise Handbook*
  - A pedometer
  - *Weekly Diabetes Planner*
- Members identified as being higher risk receive complex care management services from our diabetes care managers. The diabetes care manager conducts an assessment and develops individualized care plans based on the needs of the member, which may include the following:
  - Disease-specific education on the importance of glucose monitoring, the connection with dental health, medication adherence, timely preventative screenings, disease signs and complications, weight management, dietary needs and the importance of communicating with their physicians
  - Referral to NHP's Tobacco Treatment Specialist for quitting smoking and our on-site behavioral health care managers for managing depression
- Collaboration with the member/family, PCP, and other health care providers to implement a care management plan. Periodic mailings including a flu shot reminder and notice of missed recommended screening tests
- Reimbursement for outpatient diabetes educators and registered dietitians
- Free registration in Weight Watchers™ programs
- A culturally-competent diabetic education material, *Rosa's Story*, in Spanish that includes a workbook and audio CDs

NHP distributes surveys quarterly to identify barriers to obtaining a retinal exam to those members who have not had an exam in the past 12 months. Those members who return the survey and have identified a barrier are outreached by a care manager to assist with the barrier.

Provider Resources

NHP provides physicians with information derived from the health plan claims data to support them in managing their patient's outcomes, which include:

- Practice site-specific reports issued quarterly, with detailed member-level information over a 12-month period that includes:
  - Number of diabetic-related hospitalizations
  - Number of diabetic-related visits to the ER
  - Receipt of HbA1c test
  - Receipt of LDL test
  - Receipt of retinal screening examination
  - Presence of a cardiovascular co-morbidity
  - Last dispensed ACE/ARB
  - Last dispensed statin
- Semi-annual reports to PCP including patient-specific information for missed key screenings.
- *Massachusetts Guidelines for Adult Diabetes* developed through the Massachusetts Department of Health, visit www.nhp.org.

Outcome Measurements and Effectiveness

Some of the key measures that NHP looks at to assess the program include:

- HEDIS measure: *Comprehensive Diabetes Care*
- Member satisfaction with diabetes educational tools
- Member satisfaction with care management intervention
- *Quality of Life* assessment

For more information about the NHP Diabetes Program call 1-800-432-9449 and ask to speak to a diabetes care manager or email us at CareManagement@nhp.org. When e-mailing, please remember not to provide PHI. ■

Practice Guidelines

NHP endorses the Massachusetts Health Quality Partners' *Adult and Pediatric Preventive Care Guidelines*, the National Heart, Lung, and Blood Institute's *Guidelines for the Diagnosis and Management of Asthma*, and the *Massachusetts Asthma Action Plan*, the Institute for Clinical Systems Improvement's guideline on *The Treatment of Major Depression in Adults in Primary Care*, the *MA Guidelines for Adult Diabetes Care*, the U.S. Department of Health and Human Services' guidelines for HIV/AIDS *Treatment Information Service Guidelines*, and the Massachusetts Health Quality Partners' *Prenatal Care Guidelines.*

To access these guidelines endorsed by NHP, click on Providers, Clinical Resources and then Clinical Practice Guidelines at http://www.nhp.org.

Paper copies of all guidelines are also available upon request. Contact Catherine Jason, Manager of Clinical Compliance and Education for the Clinical Operations Department, at 617-204-1427 or 1-800-433-5556, extension 1427. ■

Depression and Chronic Medical Illness: A Negative Synergy

Jay A. Koslof, Psy.D., Beacon Health Strategies

Your 72-year old patient with diabetes appears in your office. She is accompanied by her daughter who reports that her mother has been refusing to stick with her prescribed diet, has been inconsistent with monitoring her blood sugars, and has been refusing to increase her physical activity. You speak to your patient about the importance of her compliance with self-care. This is not the first time you have had this conversation with this patient. Perhaps you are getting frustrated, as well, because without the patients' cooperation, you believe her ability to improve is uncertain.

So what is your next step? Perhaps the solution is right there in front of you. Your patient may be suffering from major depression. As a result, her dysphoric mood and non-adherence with self-care has been impeding her recovery.

Depression is a debilitating illness that affects 17.6 million Americans of all ages each year. Individuals diagnosed with depression may struggle with mild but chronic melancholy to more severe episodes that interfere with daily functioning and sense of well-being. It is well known that depression often co-exists with other mental health conditions. However, the extent to which depression affects people who suffer from chronic medical illness is significantly underestimated. Studies have shown that both moderate and major depression have an adverse effect on a plethora of chronic medical illnesses including coronary heart disease and myocardial infarction (MI), diabetes mellitus, chronic obstruction pulmonary disease, asthma, arthritis, stroke, cancer, and HIV.

Numerous studies identify major depression in adults as a risk factor for the later development of two of the most common medical illnesses associated with shortened lifespan in adults—coronary heart disease and diabetes mellitus. Approximately 20% of patients with newly-diagnosed coronary disease also have major depression. Researchers have reported a fourfold rise in the risk of mortality in patients with both depression and congestive heart failure (CHF), as well as with depressed patients during the first six months following an acute MI. While smoking, hypertension, and reduced exercise contribute to the severity of cardiac disease, depression has remained an independent predictor of cardiac morbidity and mortality after controlling for these risk factors.

Recent prevalence data supplied by the American Diabetes Association indicates that a total of 23.6 million children and adults, representing 8% of the population, are suffering from diabetes. Among this population of diabetics, it is estimated that 10% to 30% of individuals diagnosed with diabetes suffer from depression as well. These rates are significantly greater than the 3%–4% prevalence of major depression found in the general population of the United States. Patients with diabetes mellitus and co-morbid depression (DM/D) have a higher risk of mortality from all causes compared to patients with either condition alone.

Researchers have determined that patients with DM/D are less likely to implement self-management tasks needed to control their blood sugars than their non-depressed counterparts, spent fewer days than others following the recommended diet, exercise and glucose self-monitoring regimens, were 2.3 times more likely to miss medication doses than non-depressed patients, and were also less likely to feel in control of their disease.[1, 2]

Self-management of diabetes is critical to achieving optimal blood-sugar control and avoiding diabetes-related complications such as stroke, hypertension, blindness, kidney disease, and amputations due to poor circulation. The authors concluded from their study that the effect of depression on these patients with type 2 diabetes presented barriers to good medical outcomes, and suggested an increased focus on improving self-management skills and patient empowerment to enhance improved health outcome.

Severe asthma is a debilitating disease that is adversely affected by depression, as well. According to Rubin, the synergistic effect of the two chronic and incapacitating illnesses results in a worsening of both conditions.[3]

Other researchers have suggested that depressive symptoms are more common in asthmatics than in the general population, and may be associated with asthma morbidity and mortality. However, the authors caution providers that the presence of depressive disorders, not symptoms, is the basis for psychiatric diagnosis and treatment. Consequently, the prevalence of major depression and other depressive disorders in this population is not well determined and is a need for further study.[4]

As in the case of coronary heart disease and diabetes, screening and treatment for depression in patients with chronic asthma is recommended. Management of depressive symptoms via counseling and medication provides relief and improved outcome for both conditions.

Several authors concluded that greater vigilance in recognizing and treating depression among patients with diabetes and other chronic diseases is likely to improve their outcomes significantly.

To be effective, physicians who treat patients with chronic medical illness and depression must attend to how the chronic medical illness and depression interact, and to focus on appropriate treatment for both chronic conditions.

Screening tools that may be effective in identifying depression in medically ill patients include public domain tools such as the *Patient Health Questionnaire* (PHQ-9) or the *Beck Depression Inventory* (BDI), which are brief and easy to use in the primary care setting.

Continued on page 8

NHP's Asthma Management Program

Given that asthma is the predominant chronic illness among our membership, NHP has a multifaceted Asthma Management program that focuses on improving our adult and child members' understanding of what controlled asthma means, understand their medications, proper way to use an inhaler, environmental triggers and managing exacerbations. Our program provides outreach to members and providers at varying levels of intensity based on a stratification of medical and pharmacy claims data. Built on the *NHLBI Asthma Management Guidelines*, our program reinforces the physician's treatment plan.

Member Resources

- Members meeting the HEDIS definition of persistent asthma receive mailings that contain educational resources and tools to assist them to better manage their condition including:
  - Asthma Control Test
  - *Take Charge of Your Asthma* booklet
  - *How to use your asthma medications* DVD
  - Flu shot reminders
- Members identified as being at the highest risk receive complex care management services from our asthma care managers. The asthma care manager conducts an individualized assessment to evaluate asthma control employing the *Asthma Control Test*, and provides a personalized care management plan that reinforces the physician's treatment plan with interventions to minimize exacerbations and reduce impairment.
- *Quick Relief Medication Dose Tracker*
- *Asthma Action Plan*, member education for self completion and discussion with their physician
- Asthma home visit program is available to all members with asthma and usually consists of one visit to the home.
- Enhanced *Asthma Home Visit Program*

With a clinician referral for members meeting severity criteria, the Enhanced Asthma Home Visit Program provides intensive home visits to patients by a specially-trained clinician. The program provides a home environment and asthma control assessment and targets education about asthma, specific triggers, medications, and proper use of equipment. The program also provides equipment to reduce exposure to home environmental allergens and irritants: mite-proof bedding encasings, HEPA air cleaner and HEPA vacuum cleaner. This intensive asthma home-based service is available to allergic asthma patients whose asthma is uncontrolled despite adequate controller therapy due to exposures in the home.

Provider Resources

NHP provides physicians with information derived from health plan claim's data to support them in managing their patient's outcomes, which include:

- Practice site specific reports issued quarterly with detailed member-level information over a 12-month period that include:
  - Summary of asthma related hospitalization
  - Summary of asthma-related emergency room visits
  - Summary of Specialist visits
  - Summary of pulmonary function tests
  - Dispensed controller, bronchodilator and systemic steroid prescriptions
- Bi-weekly trigger reports to primary care sites identify patients with current problematic asthma control based upon:
  - An asthma related ER visit occurring in the previous six weeks, or
  - Receipt of a rescue medication in the past two weeks AND three or more rescue medications in the prior four months, or
  - Receipt of a systemic steroid in the past two weeks AND three or more systemic steroids in the prior four months
- A comprehensive member asthma utilization profile is provided for each member identified on the trigger report. This includes chronologically listed systemic steroids, rescue medications, controller medications, outpatient asthma exacerbation visits, asthma-related ER visits and hospitalization, and asthma specialist visits occurring over the prior four months
- An on-line asthma toolkit on the Provider Section of www.nhp.org. Providers can download a pictorial asthma action plan, asthma control assessment tool, and eight easy-to-use pictorial guides explaining proper use of the various asthma inhalational devices. A multilingual DVD can also be ordered that provides simple instruction on the use of these devices. www.nhp.org
- National Heart, Lung and Blood Institute Clinical Practice Guidelines, www.nhp.org

Outcome Measurements and Effectiveness

- Plan and practice-level measures describing hospital-based utilization, primary care follow-up after these events, rescue, controller, and systemic steroid dispensing patterns, asthma specialist utilization, and use of pulmonary function testing
- Member satisfaction with asthma educational tools
- Member satisfaction with care management intervention
- *Quality of Life* assessment

For more information, or to refer a member to this program, call 1-800-432-9449 and ask to speak with the Asthma Care Manager, or email us at CareManagement@nhp.org for more information. When e-mailing, please remember not to provide PHI. ■

Pharmacy Update — e-Prescribing

The eRx Collaborative continues to lead the industry with more than 17.8 million electronic prescriptions transmitted to date. Nearly 83,000 prescriptions changed in 2008 as a result of drug alerts.

The eRx Collaborative, formed by health plans in 2003 to jump-start the use of comprehensive e-prescribing technology in Massachusetts, has announced that in 2008, more than four million electronic prescriptions were transmitted through the Collaborative. This brings the five-year total of electronic prescriptions transmitted through Collaborative prescribers to 17.8 million. In addition, the eRx Collaborative deployed 350 new prescribers during the year.

The opportunity to catch potentially harmful drug-drug interactions or drug-allergy interactions is a hallmark safety feature of electronic prescribing. As of December 31, 2008, approximately 82,600 electronic prescriptions were changed due to drug safety alerts, two percent of the electronic prescriptions written.

Blue Cross Blue Shield of Mass. (BCBSMA), Tufts Health Plan and Neighborhood Health Plan (NHP) are founding members of the eRx Collaborative. The program offers physicians and other prescribing clinicians the ability to improve patient safety and increase healthcare affordability. The eRx Collaborative uses applications developed by Zix Corporation (PocketScript®) (NASD: ZIXI) and DrFirst (Rcopia™). The program has assisted more than 5,600 prescribers to adopt e-prescribing since the start of the program.

e-Prescribers are able to access enhanced information when prescribing for patients in participating plans, such as patient eligibility and formulary information. In addition, the program enables prescribers to:

- Access patient-specific dispensed drug histories to determine the patient's current and past prescriptions
- Create new and renew prescriptions electronically
- Send prescriptions for non-controlled substances directly to the pharmacy via fax or by Electronic Data Interchange (EDI) and/or print the prescription to paper
- Receive renewal requests from the pharmacy electronically
- Check for drug-drug and drug-allergy interactions
- Access a drug reference guide

In 2009, the eRx Collaborative will continue to promote e-prescribing in Massachusetts, but will no longer sponsor renewal or new licenses. The Collaborative will transform into an educational resource to promote e-prescribing among Massachusetts constituents. Specific areas of focus for the eRx Collaborative will be:

- Physician practice education and engagement
- Vendor education and engagement around deployment of complete eRx functionality
- Consumer education and engagement.

About the eRx Collaborative

For more information, visit the website: www.erxcollaborative.org. ■

Massachusetts Leads the U.S. in e-Prescriptions

As a result of its fourth annual nationwide review and audit of electronic prescribing activity in the United States, Surescripts® has determined that Massachusetts finished 2008 as the leading e-prescribing state in the entire nation. The Bay State sent more than 6.7 million prescriptions electronically, representing 20.5 percent of all eligible prescriptions in the state (as compared to 2.3 percent in 2005). Rhode Island, second in the nation for 2008, sent just over 1 million e-prescriptions, 17.3 percent of total prescriptions in that state.

Surescripts, in conjunction with the State Alliance for E-Health, commended Massachusetts with the Fourth Annual Safe-Rx™ Award. The annual Safe-Rx Awards are given to the top ten e-prescribing states in the nation and the five additional states that have shown the most significant improvement in the use of e-prescribing over the previous year. The rankings are determined by the number of prescriptions routed electronically as a percentage of the total number of prescriptions eligible for electronic routing.

The awards were announced at a luncheon and press conference at the National Press Club in Washington, D.C., on Monday, June 22, 2009.

Surescripts created the Safe-Rx Awards to recognize the outstanding leadership shown by states and stakeholders across the country that have helped to make the prescribing process as safe and efficient as possible. The Awards also serve to educate the public about the role of technology in prescribing medications and the benefits for patients, pharmacists and physicians.

About Surescripts

Surescripts is the result of a 2008 merger between the country's two leading health information networks: RxHub and SureScripts. Surescripts operates the country's largest electronic prescribing network, connecting prescribers in all 50 states through their choice of e-prescribing software to the nation's leading payers, chain pharmacies and independent pharmacies. Through its work in standards, certification, education and collaboration at the national, regional and state levels, Surescripts and its network have become the backbone that facilitates e-prescribing. For more information, go to www.surescripts.com. ■

Information found on the SureScripts website at www.surescripts.net.

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Depression from page 5

Whereas patients with chronic illness are recognized as having debilitating depression, and that the combination of the two exacerbates morbidity and negative outcome, both conditions require appropriate treatment. Treatment for depression can involve referring patients to mental health clinicians trained in cognitive-behavioral therapy (CBT) and other related psychotherapies, in addition to psychopharmacological interventions with SSRI antidepressant medications, which have few cardiotoxic side effects, and are likely to alleviate severe symptoms of depression, and promote improvement in the patient's medical condition.

Randomized trials in the literature demonstrate that both antidepressant medications and CBT are effective for patients with DM/D. In one study, researchers found that 67% of DM/D patients receiving fluoxetine showed improvement after eight weeks of treatment compared with 37% of patients receiving placebo.[5] In a second study, 71% of DM/D patients randomized to a 10-week CBT intervention achieved remission compared with 22% of patients randomized to diabetes education alone. 58% of the CBT group was in remission at the six-month follow-up, compared with 26% controls.[6]

Traditional symptoms of depression, such as a lack of energy and motivation, negative patterns of cognition, internalization, pessimism, and passive and ineffective coping strategies, create barriers to efficacious self-care. Successful treatment of depression may modify patient's negativity and decrease the intensity of the dysfunctional beliefs that pose obstacles to self-management and self-care.

Coordination of clinical treatment and communication among cross-specialty providers is essential to optimal patient care. Health care systems that house behavioral health (co-located) and primary care clinicians in the same location have a distinct advantage in this regard.

Case managers can be particularly effective in managing patients with depression and chronic medical illness by using the telephone for follow-up and monitoring of the patient's self-care between outpatient encounters. This practice has been found to increase patient compliance and adherence to self-care management, and can ensure that patient care is collaborative, coordinated, and appropriately integrated. ■

References:

1. Egede P, Nietert J, Zheng D: Depression and all-cause and coronary heart diseases mortality among adults with and without diabetes: Diabetes Care June 2005; 28 (6): 1339-1345.
2. Egede P and Ellis: The effect of depression on diabetes knowledge, diabetes self-management, and perceived control in indigent patients with type 2 diabetes. Diabetes Technology and Therapeutics June 2008; 10 (3): 213-219.
3. Rubin, NJ: Severe Asthma and Depression: A Clinical Review. Arch Fam, 1993: 2:433-440.
4. Zielinski, TA, Brown, ES, Nejtek, VA, Khan, DA, Moore, JJ, Rush, AJ. Depression in Asthma: Prevalence and Clinical Implications. Primary Care Companion J Clin Psychiatry, 2:5, October 2000.
5. Lustman PJ, Freedland, KE, Giffith LS, Clouse, RF: Fluoxetine for depression in diabetes: a randomized double-blind placebo-controlled trial: Diabetes Care: 2000; 23(5): 618-623.
6. Lustman PJ, Griffith LS, Freedland KE, Kissel SS: Cognitive behavior therapy for depression in type 2 diabetes: A randomized controlled trial. Ana Intern Med 199: 613-621.

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