NEWSLETTER Third Quarter 2006

Envision the care you want to deliver - let Nova help bridge the gap.

QUALITY INITIATIVES

DIABETES UPDATE
CELEBRATE THE PROGRESS

NCQA / ADA Provider Recognition

The following 23 providers / 4 PCP Sites have received Provider Recognition for Diabetes Care:

InterMed		PrimeCare	
Park Ave	**Stroudwater**	**Kennebunk**	**Biddeford**
Botler	Barr	Brown	Albaum
Emery	C. Cathcart	Carlson	S. Cutone
Ervin	W. Cathcart	Nugent	Fernandez
Higgins	Dobieski	Perry	Laprise
Zeitlin	Erickson	Vaughan	Sparks
	Fuchs-Ertman	Wilson	
	Gordon		

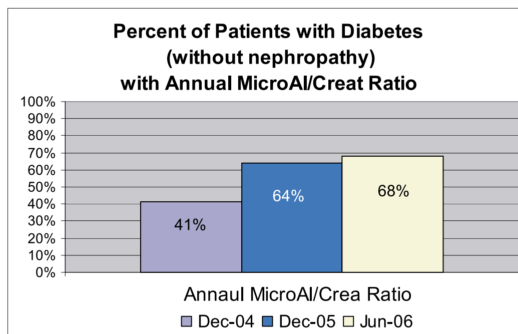
The goal is to have all PCPs recognized before year end.

The TEL Diabetes Project (registry and other aspects of the chronic care model) continues to help providers improve care. The implementation of the flags (red print) for tests overdue has prompted care consistent with evidenced based guidelines:

> ***I thought certain patients had been receiving annual eye exams, but the registry helped to discover that they were overdue.***

Joel Botler, MD

The percent of patients (without nephropathy) who receive an annual Microalbumin Creatinine Ratio has improved as follows:



Nova outcomes continue to exceed national benchmarks. The chart below shows the percent at goal:

	2004	2005	June 06	Target
HbA1c	49%	52%	50%	40%
BP	35%	42%	44%	35%
LDL	65%	68%	70%	36%

GUIDELINES FOR DIABETES CARE IN THE GERIATRIC POPULATION

William C. Ervin, MD

NovaHealth's diabetes initiative has set a HbA1c outcome goal of <7.0. Complications associated with diabetes have been well correlated with the degree of control: retinopathy, nephropathy, neuropathy, peripheral and cardiovascular are diminished. These have been well established by the DCCT and UKPDS studies.

In the geriatric population, (of which 25% will develop some form of diabetes), there are additional considerations. The degree of glycemic control has to be weighed in the setting of several other concerns and they are as follows:

- Five-year survival rate
- Co-morbid medical problems
- Depression
- Cognitive impairment

There have been several recent articles representing the American Geriatric Society stating that the goal of lower blood sugars is not necessarily appropriate.

Lower A1C targets will lead to:

- Hypoglycemia, with resultant diminished cognitive reasoning
- Coexisting confusion, cognitive impairment causing difficulties in polypharmacy
- Five-year survival rate that would exclude long-term hyperglycemia as a major contributor to their on-going co-morbid problems

For these reasons, our goals in treating diabetes (type I or type II) in patients over 65 must be modified. If indeed, their five-year survival rate is in question, an A1C goal of less than 8 is certainly appropriate. Additionally, for those patients with ongoing cognitive problems, without definitive supervision, A1C goals should be revised.

There are exclusions to this recommendation. There are extremely healthy 65 and older patients who have an extended life expectancy. Hyperglycemia over that time could well cause progression of complications. However, in the elderly, it is wise to limit polypharmacy, especially in the population with higher incidents of cognitive impairment. This also will diminish episodes of hypoglycemia, as well as, lessen financial hardships due to the cost of medications. For this reason, the following recommendations are made:

1. ***For patients under 65, HbA1c of less than 7 is the goal.***
2. ***For patients over 65, HbA1c of less than 8 is appropriate, unless you feel that they are in excellent health and have a greater than 10-year life expectancy.***

Targets for glucose control are HbA1c less than:

- 7.0 – American Diabetes Association
- 6.5 – American Association of Clinical Endocrinologists
- 6.5 – American Association of Diabetes Educators

CARDIAC UPDATE

The Pathways to Excellence 2006 Cardiovascular Process Measures due August 31, 2006 focused on:

> Annual LDL

> Annual BP

> Aspirin or Other Anti-thrombotic or Contraindications

> Smoking Status and Cessation Advice for Smokers

The Cardiovascular Health (CVH) module of TEL, designed by the Cardiac Task Force (CTF) in collaboration with the Diabetes Task Force (DTF) has been rolled out at each InterMed and PrimeCare site. Nova has conducted web based training on the new module and the combined DM/CVH form. An instruction document outlining the uses and requirements of each part of the progress note is found on the Nova website.

DEPRESSION:

Not Just a Psychiatric Problem

Gordon Clark, MD, MDiv, DFAPA, CPE, FACPE

Depression can no longer simply be considered a psychiatric problem. Most depression is treated in the primary care setting. Seventy-five percent of all psychotropic medication prescriptions are written by primary care providers. In addition, the enormous adverse impact of depression on co-morbid medical problems has become more apparent. According to D.L. Evans, "Depression has been shown to be an independent risk factor for type 2 diabetes mellitus[1] and is associated with nonadherence to oral hypoglycemics,[2] poor glycemic control,[3] increased healthcare costs,[4] and progression and earlier onset of microvascular and macrovascular complications, disability, and death[5]."

With regard to cardiovascular disease and depression, there is a bi-directional risk of one predisposing the other. In an article titled, "Depression and Heart Disease: Link is Clear" Charles Nemeroff, MD, PhD wrote the following:

> ***This is a remarkable story. Studies in the literature show an increased risk of depression in patients with ischemic heart disease. Other researchers have found that depression is a risk factor for poorer outcome after a myocardial infarction. In fact, depression is as important a risk factor for development of heart disease as cigarette smoking.***
>
> ***Another study demonstrated almost a six fold increase in mortality among depressed patients, compared with their nondepressed counterparts (JAMA 1993;270:1819-25).*** [6]

The morbidity and mortality risks that patients have with either diabetes or cardiovascular disease alone are significant. These risks are compounded by co-morbid depression. Early diagnosis and aggressive treatment of such co-occurring conditions both optimizes patient outcomes and minimizes health care costs. Other medical problems that commonly co-occur with depression include cerebrovascular disease, Alzheimer's disease, Parkinson's disease, epilepsy, cancer, HIV/AIDS, pain and obesity.

If you are interested in further information about assessment and treatment of depression please contact my office at 761-4761.

Additional References: Evans DL, Charney, DS, Lewis L, Golden RN, Gorman, JM, et al (2005): Mood Disorders in the Medically Ill: Scientific Review and Recommendations. Biol Psychaitry 58:175-189.

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[1] Eaton et al 1996: Kawakami et al 1999

[2] Ciechanowski et al 2000

[3] de Groot et al 2001

[4] Clechanowski et al 2000

[5] Black et al 2003; de Groot et al 2001.

[6] Nemeroff et al Clinical Psychiatry News, April, 2006

*********TEL TALE***********

The DTF, at the suggestion of Pam Travis, FNP at the PrimeCare Saco Site, has updated the registry to provide an additional alert. Patients on Metformin MUST have a yearly BUN/CREATININE performed. If the creatinine is >1.5 in males, or > 1.4 in females, they have an increased risk for developing lactic acidosis, and the drug MUST BE STOPPED. Therefore, if a patient is on metformin, there will be a red flag warning if:

- No creatinine
- Creatinine over 1.5 / 1.4 (M/F)
- No creatinine within 12 months

Please refer to the June 2006 TEL Enhancements posted on the Nova website regarding recent updates. TEL has a new and improved user friendly look and feel, with improved functionality and navigation links.

LBP UPDATE

Nova distributed sets of LBP Materials to all sites including the following:

LBP Brochures

Managing Acute Back Pain

Stretches for Acute LBP

Exercises for Acute LBP

Intermediate Exercises

Patient Education DVDs

Please contact Nova if you need more of any these materials.

IMPROVING OFFICE SYSTEMS

Michael N. Albaum, MD

Based upon input from Site Leadership we have developed and distributed a set of evidence based guidelines for reference in the exam rooms, including:

> An overview of the Chronic Care Model
> Low Back Pain Pathway
> Spine Evaluation Request
> Chest Pain Guideline
> Stress Test Worksheet
> Diabetes Definitions
> Glycemic Control Guideline
> Diabetes TEL Progress Note
> Cardiovascular Health Progress Note
> Heart Failure Guidelines
> High Blood Pressure Guidelines (JNC7)

In addition, a resource notebook has been provided to each office with information on community resources and steps to take to intervene when risk factors are identified, including information relative to:

> Tobacco Use
> Alcohol, Drug Use
> Obesity; Nutrition / Healthy Eating
> Domestic Violence
> Depression / other mental illness
> High risk Sexual Behavior
> Exercise / Inactivity
> Cholesterol
> Hypertension
> Diabetes Risk

All materials can also be found on the Nova Website.

PATHWAYS TO EXCELLENCE NEWS

The Maine Health Management Coalition, Office System Surveys for Primary Care Offices were submitted in June. Immunization, and diabetes outcomes were submitted in July. Pediatric asthma and CVH outcomes were submitted in August.

We report on office systems and our progress in chronic disease management to the Coalition in order to be scored against every other primary care practice in the state. Employers encourage their workers to use this site in choosing providers. In addition, we use our 'three blue ribbon' status in our presentations to payors, hospital boards, and employers to show that we not only talk about quality, but that we can demonstrate it. Although it takes a lot of work to set up the systems that allow this reporting, it is projects such as diabetes, asthma and CVH that distinguishes our group from others.

Contracting News

MEDICARE ADVANTAGE OPPORTUNITY

Thomas F. Claffey, MD

A due diligence team from NovaHealth, traveled to Houston in June to meet with representatives from Heritage Health and physicians and management currently participating in the Heritage Medicare Advantage (MA) product. The visit was a follow up to three previous meetings in Portland.

The CMS hierarchical condition categories (HCC) model of reimbursement risk adjusts capitated payments based upon severity. The methodology is intended to promote fair payments that reward efficiency and encourage excellent care for the chronically ill. The margin between the Medicare Fee for Service Rate for the counties in which we practice and the MA Rates is significant (23.9% in 2007). MA plans are attractive to members because they provide the potential to integrate traditional Medicare benefits, prescription drug benefits and supplemental coverage into a single product that is less costly for the patient.

Nova has decided that partnering with Heritage around the management of Medicare patients is consistent with the mission and values of the organization and the respective Member organizations. This will allow us to invest in improving systems of care for our current Medicare Membership that will improve health and result in enhanced revenue. Current plans to enhance the use of technology to streamline administrative requirements should mitigate the impact of resulting paperwork.

Heritage Health is owned by Universal American Financial Corp. For additional information see www.uafc.com. For more information regarding Medicare Advantage, visit the NovaHealth website.

NovaHealth News

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