

Provider Report™

Buckeye
Community Health Plan



JUST FOR WOMEN

The following tests look for early signs of cancer or infection. Buckeye members are being instructed to:

- Get breast cancer screenings.
- Do breast self-exams every month.
- Get their first mammogram between the ages of 35 and 39.
- Get yearly mammogram screenings starting at age 40.

Cervical cancer can be a deadly disease too. Yearly Pap tests can detect it. Pap tests should start at age 21. Teens should start getting the test earlier if sexually active.

Chlamydia is an infection that can lead to serious problems if not treated. Have a screening test done every year if sexually active. This can be done at the same time as the Pap test.

REMINDERS

HealthChek/EPST

Please be sure your patients are up to date with their HealthChek/EPST exams. Please use every opportunity to complete a HealthChek exam for patients, including during sick visits.

Rights and Responsibilities

Buckeye's Member Rights and Responsibilities are included in the Provider Manual.

Information regarding Buckeye's 2009 Quality Improvement Program Description is available for review upon request.

Are You Listening?

Patients want to know this first and foremost.



Patient satisfaction is an integral part of healthcare quality, and there's a strong relationship between the quality of physician communication and overall patient satisfaction.

On patients' communications wish list is a provider who listens to them, takes them seriously, treats them with dignity, encourages them to express their concerns and expectations and then addresses them, explains things in terms they understand and allows adequate time for discussion and questions.

When trying to balance workload demands with patients' desire for meaningful face time, you may be tempted to cut short the consultation and jump right into test-ordering mode, thinking that your patients would prefer such action. But results of a recent study published in the *Annals of Family Medicine* suggest that you could be missing a communications opportunity that might result in better patient care.

The study involved primary care physicians and patients whose office visit involved recent, commonly occurring complaints of unexplained causes. Patients were randomly assigned to physicians who either ordered immediate blood tests or instead initiated four weeks of watchful waiting to be followed up if the symptoms continued.

Did either of these approaches make a bigger impact on patient satisfaction and anxiety? No. But the researchers found that physician-patient communication had an influence. Patients who felt that they were being taken seriously, who were made aware of the seriousness of their complaints afterward, and whose physicians discussed testing tended to be more satisfied with the consultation.

The authors concluded: "Physicians overestimate the effects of additional testing in patients seeking care for unexplained complaints and underestimate how much they themselves can contribute to the well-being of their patients by discussing their worries."

Did you know? InterQual criteria are available for your review by request.

2 Six Criteria to Help Diagnose Back Pain

4 Diabetes 101: Better Education Efforts Needed

6 Helpful Flu Facts for Pregnant Patients

About That Back Pain

Let these criteria help guide your diagnostic options.



Back pain is a common problem that causes a patient to make an office visit. It is also a cause for many missed days of work and loss of income.

There are many causes of back pain, ranging from the traumatic to the insidious. Two common causes of upper back pain include myofascial and joint dysfunction. Common causes of low back pain are much more common and include muscle strain, degenerative disc disease and a lumbar herniated disc.

Low back pain is by far much more common and can be classified as acute or chronic. Acute back pain typically lasts from a few days to a few weeks, while chronic back pain is considered pain that lasts longer than three months.

A complete health history and physical exam can go a long way in determining the severity and possible etiologies of low back pain. Symptoms associated with back pain that require immediate medical attention include bowel or bladder dysfunction, progressive weakness in legs, or severe continuous abdominal pain with low back pain, fever and chills, severe trauma and history of cancer with recent weight loss.

The American College of Radiology has developed “appropriateness criteria” for imaging of low back pain. These criteria rate the appropriateness of certain imaging studies in the evaluation of back pain. There are six variants of the criteria based upon the presentation of the pain and associated symptoms:

- Variant 1 is based upon the presentation being uncomplicated acute low back pain and/or radiculopathy, nonsurgical presentation and no red flags.
- Variant 2 is low velocity trauma, osteoporosis, and/or age > 70.
- Variant 3 is suspicion of cancer, infection or immunosuppression.
- Variant 4 is low back pain and/or radiculopathy, surgery or intervention candidate.
- Variant 5 is prior lumbar surgery.
- Variant 6 is *Cauda equina* syndrome.

The entire criteria set with appropriateness ratings are located on the American College of Radiology’s website at acr.org. Utilizing these criteria will allow for more appropriate use of imaging and decrease patients’ unnecessary exposure to radiation. Treating patients appropriately and cost-effectively will also allow better use of healthcare resources.

HOW WE RATE

Here are some numbers that show how our members used and received services in 2008. These numbers are based on Buckeye’s claims information.



If you have questions about these rates, contact Provider Services at
1-866-296-8731

BUCKEYE COMMUNITY HEALTH PLAN 2009 HEDIS RATES

HEDIS Measure	2009 HEDIS (CY 2008)
Childhood Immunizations	
Dtap/DT	77.15%
IPV	90.17%
MMR	90.91%
HIB	96.07%
Hep B	84.52%
VZV	86.73%
Pneumococcal	75.68%
Combo 2	71.58%
Combo 3	60.44%
Childhood Measures	
Lead Screening in Children	55.03%
Appropriate Testing for Children with Pharyngitis	59.98%
Appropriate Testing for Children with an Upper Respiratory Infection (URI)	84.90%
Adolescent Well Care	31.27%
Annual Dental Visit (2–21 Years)	50.76%
Frequency of Well-Child Visits in the 1st 15 Months of Life	
No Visits in the 1st 15 Months of Life	2.80%
One Visit in the 1st 15 Months of Life	3.93%
Two Visits in 1st 15 Months of Life	5.34%
Three Visits in 1st 15 Months of Life	7.04%
Four Visits in 1st 15 Months of Life	10.94%
Five Visits in 1st 15 Months of Life	14.36%
Six or More Visits	55.60%
Well-Child 3-, 4-, 5-, 6-Year-Olds	62.19%
Comprehensive Diabetes Care	
HbA1c Testing	78.97%
HbA1c Good Control <7	NR
HbA1c Good Control <8	41.47%
HbA1c Poor Control >9 (the lower the better)	64.37%
Eye Examination	48.42%
Monitoring for Nephropathy	78.57%
LDL-C Screening	71.67%
Blood Pressure Control < 140/90	59.37%
Blood Pressure Control < 130/80	34.06%

Behavioral Healthcare Measures				
Antidepressant Med Management (Effective Acute Phase Treatment)				50.26%
Antidepressant Med Management (Effective Continuation Phase Tx)				32.86%
Follow-up Care in Children for ADHD Medications (Initial)				44.84%
Follow-up Care in Children for ADHD Medications (Continued)				53.83%
Follow-up After Hospitalization for Mental Illness (7 Day)				40.27%
Follow-up After Hospitalization for Mental Illness (30 Day)				47.90%
Frequency of Ongoing Prenatal Care				
< 21% of Expected Visits				8.35%
< 21–40% of Expected Visits				5.29%
< 41–60% of Expected Visits				9.86%
< 61–80% of Expected Visits				18.70%
> 81% of Expected Visits				57.80%
Cardiovascular Conditions				
LDL-C Screening for Patients with Cardiovascular Conditions				82.51%
LDL-C Level <100 mg/dL				39.64%
Controlling High Blood Pressure				54.88%
Persistence of Beta Blocker Post-MI				74.74%
Respiratory Conditions				
Appropriate Meds for Asthma				94.03%
Avoidance of Antibiotics in Adults With Bronchitis				20.91%
Use of Spirometry in the Diagnosis of COPD				35.95%
Rx Management for COPD—Corticosteroid				74.24%
Rx Management for COPD—Bronchodilator				86.44%
Musculoskeletal Conditions				
Anti-Rheumatic Drug for Rheumatoid Arthritis				75.68%
Use of Imaging Studies for Low Back Pain				81.65%
HEDIS Measure	2009 HEDIS (CY 2007)	2009 HEDIS (CY 2008)	Percent of Variance From CY 2007	NCQA Percentile
Women's Prevention and Screening				
Breast Cancer	33.81%	48.32%	↑14.51%	Below 50th
Cervical Cancer	66.75%	67.53%	↑0.78%	Below 50th
Chlamydia Total Rate	58.35%	54.33%	↓4.02%	50th percentile
Timeliness of Prenatal Care	86.37%	92.34%	↑5.97%	50th percentile
Postpartum Care	57.66%	72.99%	↑15.33%	90th percentile

Diabetes 101 for Patients More education is needed.

Don't assume that your diabetic patients understand their disease. A recent study published in *Diabetes Care* found that many low-income minority patients often lack knowledge about the disease. And some of the misconceptions they have can put their health at risk. The findings underscore the need for ongoing education.

Researchers surveyed adults with type 2 diabetes, 55 percent of whom were using insulin. All were getting regular medical care. Fifty-eight percent were Latino and 34 percent were African-American. The average annual income was below \$30,000. The average number of years of living with diabetes was 13.

Among the survey findings:

- 56 percent believe that 200 mg/dL or less was normal blood glucose level.
- 23 percent believe that there's no need to take diabetes medications when blood glucose levels are normal.
- 42 percent believe that blood glucose levels of 110 mg/dL or less is too low.
- 36 percent believe that they will not always have diabetes.
- 29 percent believe that their doctor will cure them of diabetes.
- 12 percent believe that they have diabetes only when their blood glucose levels are high.

The survey respondents more likely to have misconceptions about diabetes were those with poor blood glucose control (based on A1c levels) and those using insulin.

What You Can Do

Findings like those detailed above should spur you to review your diabetes patient education efforts. Are your efforts working? Do patients know what a normal blood glucose

level is? If you ask them basic questions during the office visit, you can take advantage of teachable moments to discuss and correct misconceptions.

Another approach is to ask patients to take a brief multiple-choice quiz consisting of basic questions about diabetes. Explain that they'll be helping you to find out if your diabetes education program needs improvement. A quick look at the answers before you enter the exam room will tell you if the patient is a candidate for an educational intervention—tactfully administered, of course. (In the case of younger patients, ask their parents/guardians to take the quiz, too.)

If you're working with minority populations, be sure your education

program is culturally sensitive and ongoing. Evidence shows that type 2 diabetes education tailored to the cultural needs of a target population results in improved blood glucose control, generally for up to six months.

Web Resources

Two consumer summary guides on diabetes are available online from the Agency for Healthcare Research and Quality. (Clinician guides also are available.) To download English and Spanish versions of "Pills for Type 2 Diabetes: A Guide for Adults," and "Premixed Insulin for Type 2 Diabetes: A Guide for Adults," visit the AHRQ website at effectivehealthcare.ahrq.gov/healthInfo.cfm?infotype=sg.



Prediabetes Rising

At least 25 percent of U.S. adults are known to have prediabetes, a condition that increases a person's risk of developing type 2 diabetes by three to 10 times. The Centers for Disease Control and Prevention defines prediabetes as a disease state of impaired fasting glucose of 100–125 mg/dL or impaired glucose tolerance of 140–199 mg/dL, or both.

People with the condition, which is closely linked with obesity, can head off diabetes by losing weight, increasing physical activity and improving their diet.

Primary care physicians are on the front line to screen for prediabetes in patients with risk factors such as body mass index above 25 kg/m and high blood pressure, and direct patients toward intensive lifestyle management.



Medical Record Review Updates

What you should know about our standards.

Buckeye Community Health Plan (Buckeye) requires medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review. Buckeye has established medical record standards to facilitate communication, coordination and continuity of care in order to promote efficient and effective patient care.

Buckeye has minimum standards for practitioner medical record keeping practices, which include medical record content, medical record organization, ease of retrieving medical records, maintaining confidentiality of patient information, compliance with standards and performance goals. Guidelines are listed in the Buckeye Provider Manual and include, but are not limited to, the following:

- Practitioners must keep accurate and complete medical records including, but not limited to, X-rays, laboratory tests, results, examinations and notes that document all medical services received by the member, including inpatient, ambulatory, ancillary and emergency care.

- Medical records must be prepared in accordance with all applicable state and federal rules and regulations and signed by the medical

professional rendering the services.

- Medical records must be accessible at the site of the member's participating primary care physician or provider.

- To ensure the member's privacy, medical records should be kept in a secure location.

- Practitioners are required to maintain all records for members for at least 10 years for adult patients and at least 13 years for minors.

Medical record content standards are outlined in the medical record review tool and are disseminated to all practitioners in the Provider Manual. The most current version of the standards can be viewed on Buckeye's provider website under the Quality Improvement tab. When there are significant changes in the requirements, the revisions may be distributed through the provider newsletter, through direct mailing, fax blast and Buckeye's website.

At a minimum, medical record documentation reviews will be conducted at least annually. Buckeye may conduct medical record reviews for the purposes including, but not limited to, utilization review, quality management, medical claim review, or member complaint/appeal investigation.

Physicians must meet 80 percent of the requirements for medical

record keeping. Elements scoring below 80 percent are considered deficient and in need of improvement. A follow-up audit will be conducted within six months for any practitioner whose overall score is below 80 percent. Medical record review results are filed in the Quality Improvement Department and shared with the Credentialing Department to be considered at the time of re-credentialing.

The results of the 2009 Medical Record Review indicated that all primary care physicians reviewed scored above the 85th percentile. Even though all providers scored above the 80th percentile, it was decided to look at each question of the medical record keeping tool to determine if any area of deficiency might exist with all providers. Sixty-three percent of the charts reviewed contained no documentation that Advance Directives were discussed with the member by the primary care physician.

The state of Ohio, and specifically the Ohio Department of Job and Family Services, provides an Advance Directive brochure that Buckeye is required to present to all new members upon enrollment. Also included in the Provider Manual is a section on Advance Directives.

What About Pregnancy And Flu?

A few helpful facts for your patients.

In the U.S., flu season runs between October and mid-May each year. ACOG and the CDC both recommend flu shots for almost all women who are pregnant during the flu season as the single best way to protect against the flu. According to ACOG, flu vaccination should be a routine part of prenatal care, and the ideal time to vaccinate pregnant women is in October and November.

Here are a few helpful facts for your patients:

- Pregnant women have higher rates of illness and death from the flu than any other group of people.
- The flu vaccine is safe and effective in pregnancy because it is an inactivated vaccine with killed virus.
- The nasal spray vaccine is not recommended for pregnant women, as it is a live, weakened virus.
- A baby under six months of age will have some immunity if his/her mother had a flu shot.
- Antiviral treatment is recommended for pregnant women

suspected of having influenza. Treatment should be started as soon as possible. The CDC states, "Pregnancy should not be considered a contraindication to oseltamivir or zanamivir use. Because of its systemic activity, oseltamivir (Tamiflu) is preferred for treatment of pregnant women."

■ This information applies to the seasonal influenza vaccine and not the 2009 H1N1 (swine flu) influenza virus.

Buckeye Community Health Plan is sending educational information to its members, including pregnant women, encouraging them to get the flu vaccine. Unfortunately the vaccination rates in pregnant women continue to be low in the United States. Please help us spread the word by sharing this information with your pregnant patients. They can protect their health and the health of their unborn baby by getting a flu shot at the beginning of the season.

Buckeye Preventive Health and Clinical Practice Guidelines

Buckeye Community Health Plan's (Buckeye) current adopted Clinical Practice and Preventive Health Guidelines include:

- ADHD
- Adult Preventive Care
- Asthma
- Diabetes
- Immunizations
- Lead Screening
- Major Depressive Disorder
- Pediatric Preventive Care
- Perinatal Care
- Schizophrenia

These guidelines, including the national standards source(s), are available and can be accessed on the Buckeye website at bchpohio.com. A hard copy of the guidelines can be obtained by calling Buckeye at 1-866-296-8731.

Flu Season Approaches

A quick review of guidelines to keep in mind as you prepare.



BY RONALD CHARLES,
M.D., MHA, FACP, FACHE, Vice President, Medical Affairs

Fall is once again upon us, and that means back to school, cooler weather and autumn leaves. For physicians, it's time to prepare for the flu season. Traditionally, that meant family physicians and internists have to make sure they encouraged patients over age 65 and those with certain chronic diseases to come in and get a flu vaccine.

Vaccination decreases the chances of someone getting the flu, diminishes the severity and duration of illness if someone gets it, and decreases the chances of a person getting a complication of the flu, such as a secondary pneumonia. New recommendations on who should receive the flu vaccine and what type of vaccine they should get have been made, and they affect all physicians—especially

those who care for children.

The CDC and the Advisory Committee on Immunization Practices (ACIP) have finalized new recommendations for flu vaccine administration. These recommendations are updated every year, but the recommendations for the 2009–2010 season are essentially unchanged from the previous year.

A new recommendation that began at the beginning of the 2008–2009 season, and which affected the practice of those who care for children and stated that all children between the ages of five and 18 years be immunized, continues with the 2009–2010 season. (See a summary of all the recommendations by ACIP at www.cdc.gov/flu.) This recommendation is in addition to one that already exists for the pediatric population that states children

between the ages of six months and 59 months be immunized. So the recommendation is for all children between the ages of six months and 18 years to receive influenza vaccination.

Buckeye Community Health Plan is also recommending the administration of the H1N1 vaccine when it becomes available this fall. Due to the limited supply that will be available, it is being recommended for those populations at greatest risk. Those most vulnerable to the H1N1 virus are pregnant women, children and young adults ages six months to 24 years, and those with chronic illnesses between the ages of 25 and 64.

Buckeye fully supports these recommendations and is willing to support the physicians in this effort. Our care management staff will be reinforcing the fact that all patients who should receive flu immunizations do so. This includes children, adults under 50, pregnant women and those planning on pregnancy during the flu season, and those between the ages of 18 and 64 with chronic pulmonary and immunocompromised illnesses.

We will be launching a telephonic campaign and mailings to patients, and collaborating with Federally Qualified Health Centers (FQHCs) and large rural multispecialty practices. Our goal is to work with physicians to ensure that this flu season will not be a burdensome one on your practices and the healthcare system.

A SUMMARY of ACIP's flu vaccine recommendations is available on the CDC's influenza website (www.cdc.gov/flu), including any updates or supplements to these recommendations that might be required during the 2009–2010 influenza season. Vaccination and healthcare providers should be alert to announcements of recommendation updates and should check the CDC influenza website periodically for additional information.

Put Patients' Wishes in Writing

Follow these steps to document Advance Directives.

Buckeye Community Health Plan (Buckeye) is committed to ensuring that its members know of, and are able to avail themselves of, their rights to execute Advance Directives. Buckeye is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding Advance Directives.

Any provider delivering care to Buckeye members must ensure adult members over the age of 18 receive information on Advance Directives and are informed of their right to execute Advance Directives. Providers must document such information in each patient's permanent medical record.

Buckeye recommends that:

- The first point of contact in the PCP's office should ask if the member has executed an Advance Directive. The member's response should be documented in the medical record.

- If the member has executed an Advance Directive, the first point of contact should ask the member to bring a copy of the Directive to the PCP's office and document this request.

- An Advance Directive should be included as a part of the member's medical record.

- If an Advance Directive exists, the physician should discuss potential medical emergencies with the member and/or family member/significant other (if named in the Advance Directive and if available) and with the referring physician, if applicable. Discussion should be documented in the medical record.

- If an Advance Directive has not been executed, the first point of contact within the office should ask the member if he or she desires more information about Advance Directives. If the member requests further information, member Advance Directive

education/information should be provided.

Buckeye's Member Services and CONNECTIONS representatives will assist members with questions regarding Advance Directives. However, no employee of Buckeye may serve as witness to an Advance Directive, or as a member's designated

agent or representative.

Buckeye's Quality Improvement Department will monitor compliance with this provision during initial office site visits and as scheduled thereafter. If you have any questions, regarding Advance Directives, contact Buckeye's Medical Management Department at 1-866-246-4359.

A Growing Need for COPD Awareness

While other major causes of death have been decreasing, COPD mortality has continued to rise. COPD is the fourth leading cause of death across the country. More than 12 million Americans are diagnosed with COPD, but research by the National Heart, Lung, and Blood Institute shows that many do not get optimal treatment.

Research also suggests an additional 12 million Americans may have COPD and remain undiagnosed. Recent advances in treatment for COPD offer real opportunities to improve your patient's quality and length of life. It is recommended by the National Heart, Lung, and Blood Institute and the National Institute of Health that all patients are diagnosed using Pulmonary Function Testing.

RISK FACTORS

- Persistent or progressive dyspnea
- Chronic cough or sputum production
- Decline in level of activity
- History of smoking
- Genetic factors
- Environmental exposure
- Occupational exposure

DIAGNOSIS: PULMONARY FUNCTION TESTING

- Refer for spirometry testing to determine severity
- Spirometry testing with a bronchodilator may distinguish COPD from asthma
- A criterion for diagnosis is a post-bronchodilator FEV1/FVC < 0.7

TREATMENT OPTIONS FOR COPD

- Aggressive management of COPD can make a difference for the patient.
- Advances in therapies have been shown to improve survival or quality of life for COPD patients.
- COPD patients should receive professional assistance for smoking cessation.



Gaining Ground on Asthma

Asthma-related deaths have declined. Now experts are focused on long-term control.

New medications and improved disease management tools over the past decade have resulted in more effective control of severe asthma in children, according to findings reported at the annual meeting of the American Academy of Allergy, Asthma and Immunology in March 2009.

The study compared young patients treated from 2004 to 2007 with those treated from 1993 to 1997. It found that use of oral corticosteroids in the more recent group was considerably lower, as was the average dose. Use of rescue inhalers also was lower.

Since the introduction of clinical

guidelines in 1991, asthma mortality has declined, but the disease continues to be a common reason for hospital admissions and emergency room treatment. The latest 2007 guidelines focus on asthma control, highlighting the need for action plans individualized for each patient. Given the complex nature of asthma, say experts, tailored interventions should take into account a variety of factors, including city or suburban conditions, the presence of allergens, stressful life events, and obesity, which can affect a person's response to medications.

New asthma education efforts are showing promising results among

younger patients, including a program that incorporates basketball camp and instruction in asthma control, and another that uses text messaging for medication reminders to teens.

Look for a renewed focus on better utilization of the 2007 guidelines, "Guidelines for the Diagnosis and Management of Asthma," which the AMA encourages physicians to follow.

Web Resource

The report "Guidelines for the Diagnosis and Management of Asthma" is available online at www.nhlbi.nih.gov/guidelines/asthma.

Enhancing the Medical Treatment Plan

Buckeye programs help create better outcomes

BY: DIANE ZATT
Care Manager, Buckeye
Community Health Plan

Meeting the complex needs of adults with disabilities and chronic medical conditions can be a challenging task for providers and managed care organizations alike. In addition to a complex clinical presentation, the Medicaid beneficiary often faces several socioeconomic barriers that further complicate the person's situation. Buckeye utilizes a variety of programs and community resources to minimize these barriers and enhance the overall effectiveness of the medical treatment plan.

Education

Education is a critical element in the control of chronic conditions. Buckeye provides disease-management services to members diagnosed with asthma, COPD, diabetes, HTN and HF through Nurtur. Members referred to Nurtur receive telephonic health coaching designed to improve overall health and well-being and provide additional resources to providers. Members referred to the HF program receive digital scales, while those enrolled in the asthma/COPD program may receive a home visit by a respiratory therapist. Certified diabetes educators and dietitians provide comprehensive diabetes education, including diet instruction to members enrolled in the diabetes program. Providers are encouraged to refer Buckeye members to Nurtur if they are not already enrolled.

Home Care

Home care services can be a cost-effective alternative to hospitalization or nursing-home care. Buckeye encourages providers to refer

members identified as having skilled nursing (medication management, safety evaluations, I.V. therapy, enteral therapy, wound care management, or behavioral health), physical, occupational or speech therapy needs to a participating home care agency. Additionally, members needing assistance with personal care and ADLs may have up to 14 hours of home health aide services per week.

MemberConnections®

MemberConnections is an outreach program through which Buckeye representatives visit members in their homes to help them navigate the complex healthcare system and connect with the resources they need. MemberConnections representatives have successfully located "hard to reach" members and provided education to those noncompliant with medical care. This past summer, our outreach included "The Fan Club," in which MemberConnections representatives delivered fans to members diagnosed with respiratory conditions and who met other program requirements.

CONNECTIONS Plus

CONNECTIONS Plus is a program that provides free cell phones to high-risk members who do not have safe, reliable access to a telephone. This program allows the member to have access to physicians, home care agencies, pharmacies and 911. Providers are encouraged to discuss this service with appropriate Buckeye members.

Pharmacy

One of the leading causes of medication noncompliance is lack of transportation to the pharmacy. When this is identified as a problem, mail-order pharmacy is an easy solution. Buckeye care managers can work with

members to arrange for mail order through RxDirect.

Specialists

Buckeye encourages the use of specialty services. Members who frequent the ED or have multiple inpatient admissions can often benefit from specialty services. Referrals to pain management can be helpful for the member with drug-seeking tendencies or has difficulty managing conditions such as sickle cell anemia. The manipulative techniques utilized by chiropractic providers can be beneficial to the member who chooses a non-pharmaceutical approach to pain management. Members diagnosed with diabetes are encouraged to see a podiatrist and are entitled to diabetic shoes with inserts on an annual basis.

Program Specialists

When a member has serious social issues, medical care is often put on the back burner. This is when the expertise of our highly trained Buckeye Program Specialists becomes critical. Program Specialists are instrumental in helping members with housing, safety, food, utility and rent issues. They also connect members with appropriate counseling programs when mental health and substance abuse issues become apparent. We also refer members to 2-1-1, a phone number that connects people with important social, health and government resources 24 hours a day. This program serves Ashtabula, Lake, Geauga, Cuyahoga, Summit, Lorain, Portage and Medina counties.

As you can see, Buckeye strives to do everything it can to enhance the medical treatment plan. We firmly believe that strong programs and utilization of community resources help create improved outcomes.

DRUG LIST CHANGES

EFFECTIVE AUGUST 2009

DL Additions With Clinical Edits

Rationale: to ensure appropriate usage

Loratadine/PSE 12HR

Loratadine/PSE 24HR

Naproxen DR 375mg

Naproxen DR 500mg

Omega-3 Fatty Acids (OTC)

Ortho Diaphragm

Rimantidine 100mg

Suprax 400mg QL=1

DL Additions Without Clinical Edits

Colestipol 1gm, 5gm

Slo-Niacin 250mg



US Script Prior Authorization Lines

Phone: 1-866-399-0928

Fax: 1-866-399-0929

Changes to Utilization Edits to Existing DL Medications:

Ondansetron 4, 8mg QL=60 Incr from 10/month to 60/month for maximum of 90 days

Ondansetron ODT 4, 8mg QL=60 Incr from 10/month to 60/month for maximum of 90 days

DID YOU KNOW?

BUCKEYE COMMUNITY HEALTH PLAN IS PLEASED

TO REMIND YOU that the Buckeye drug list (DL) as well as the Quick Reference Guide are available online at bchpohio.com under Provider Home in the Provider Quick Links section. Please refer to the DL for the most current list of covered medications.

FREQUENTLY USED FORMS

Please refer to the Buckeye website at bchpohio.com. Click Provider Home, then Resources, then Forms. Please use the US Script Prior Authorization form for non-DL medications. Caremark specialty drug prior authorization forms are also available for biopharmaceuticals and specialty injectable medications.



Telehealth: IT Goes the Distance

The future looks bright for this tech-friendly form of healthcare.

When information technology meets healthcare, the result is far-reaching in more ways than one. Telehealth—also called telemedicine, e-health, connected health and cyber-health—encompasses a broad range of applications for connecting patients, providers, insurers and information providers across distance. IT developments continue to expand the boundaries.

Everyday digital-based items like computers, the Internet, cell phones and data-storage devices are transformed into telehealth tools by special applications. Electronic health records, social-network disease support groups, e-prescribing, text-messaging health reminders, remote monitoring and video conferencing serve to close the distance between healthcare stakeholders and foster real-time interaction.

An example of telehealth in action is the use of “telestroke exams,” in which stroke specialists use telecon-

ferencing technology to remotely examine stroke patients for diagnosis and treatment. The exams are as effective as bedside workups, according to a review of existing studies published in *Stroke: Journal of the American Heart Association* and released online.

Recent Examples

A review of 11 studies published in the *European Journal of Cardiovascular Prevention & Rehabilitation* involving telephone and Internet-based interventions to reduce cardiac patients' risk factors found that patients who received telehealth interventions showed lower total cholesterol levels and systolic blood pressure compared with patients who did not receive telehealth interventions. **More of the patients who received telehealth interventions also stopped smoking and increased their physical activity levels.**

In another recent example, among

type 2 diabetes patients, those who participated in a 12-month Web-based care management program showed more improved glycemic control when compared with non-participants. The program included access to electronic medical records, secure e-mail with providers and feedback on glucose readings, and an interactive online diary for tracking exercise, diet and medication.

Using telehealth tools, patients with chronic illness can stay connected to providers who monitor their health status for signs of trouble and intervene to avoid hospitalizations. The connection keeps patients actively involved in the ongoing management of their illness and reduces healthcare costs.

Given the challenges of a rising rate of chronic illnesses, complicated by an aging population and unsustainable growth in healthcare spending, the future looks promising for telehealth.

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Provider Services: 1-866-296-8731

Visit Buckeye Community Health
Plan online at bchphio.com.

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