Gold Coast Health Plan℠
A Public Entity

Gold Coast Health Plan Pharmacy Services Newsletter

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CMO Message — by Charles Cho, M.D.

The key articles in this newsletter address findings of the recently published 2012 Health Effectiveness Data Information Set (HEDIS) and provide suggestions as to how Gold Coast Health Plan (GCHP) can improve some of these measures.

HEDIS measures may be new to some of you. Essentially, HEDIS is a measure of how well certain groups of community providers are doing in rendering quality medical care against the standards established by the National Committee for Quality Assurance (NCQA).

Of the 25 measures that GCHP participated and reported, we met 15 minimum performance levels (MPL) while failing 10. This was not bad for the first year of a start-up health plan; however, GCHP must do better in 2013.

Some examples of these measures are immunizations, cervical cancer screening, pre and post-partum care and well child visits, just to name a few. In the coming months, we will go over these results with various clinics and individual practices to show how they performed and identify ways to improve on them for the next year.

In this issue, we cover 3 measures. The first of which — *Avoidance of Use of Antibiotics in Treatment in Adults with Acute Bronchitis* — needs some explanation. It is very stringent, and GCHP failed this measure.

The intent of this measure — in most cases — is to avoid the use of antibiotics when treating adults with acute bronchitis. The study showed that nearly 90% of cases are due to virus. The MPL was 18.98% while our providers had 13.87%. What this means is that based on the NCQA standard we did not “avoid” prescribing antibiotics enough.

For adults diagnosed with acute bronchitis, GCHP providers used antibiotics 86.13% of the time, while NCQA says the use should not have exceeded 81.02 %. This is a tough one, as most physicians tend to prescribe antibiotics for sick patients with acute bronchitis. On the other hand, there is no dispute that antibiotics are not indicated for respiratory viral illnesses. Also, it should be noted that the use of antibiotics with a diagnosis of pneumonia is not against the standard of medicine. The GCHP Medical Advisory Committee will discuss how this measure can be addressed to achieve a better score.

GCHP did well regarding the HEDIS measure on *Immunization for Adolescents* with 65.21% while MPL was 50.36%. Nonetheless, we tend to neglect this age group, because they are relatively healthy. The article on this subject is quite timely and should serve as a good reference guide and reminder.

On HbA1c measure two separate issues were involved. We passed on testing with 81.75% against the MPL of 78.54%; however, GCHP providers failed in achieving MPL of HbA1c to < 8.0 with only 37.96% of cases against the MPL of 42.09%. The American Diabetic Association (ADA) recommends <7% for good diabetic care. We must strive to achieve that goal.

I hope this Pharmacy Newsletter is helpful to you in understanding the HEDIS measure reporting and how we can improve on it.

DUR: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Acute bronchitis is one of the most common diagnosis for adults in the United States. Approximately, 5 percent of adults self-report an episode each year and up to 90 percent of these people seek medical attention. According to the college of Chest Physicians (ACCP), acute bronchitis is defined as an acute cough illness, with or without phlegm production, lasting for up to three weeks. ACCP limits treatment assessment and guideline to patients who are considered to have “uncomplicated” acute bronchitis. Patients with underlying issues such as AIDS, chemotherapeutic treatments, and congestive heart failures are excluded from the discussion. Acute bronchitis is a self-limiting respiratory disorder that is diagnosed only in the absence of pneumonia, the common cold, acute asthma, or an exacerbation of chronic obstructive pulmonary disorder.

The etiology of acute bronchitis can be either bacterial or viral in nature. Several randomized trials and meta-analysis studies (on the effects of antibiotics on the duration and severity of cough) have led to the conclusion that viral infections are the primary cause of acute bronchitis. Respiratory viruses such as influenza A and B, respiratory syncytial virus, coronoavirus, rhinovirus, and a few others are responsible for more than 90 percent of the cases of acute bronchitis. Yet, viruses are rarely identified because viral cultures and serologic assays are seldom performed. Although rapid diagnostic tests exist for several bacteria that are linked to acute bronchitis, their routine use is not cost-effective because bacteria are the causative agent in less than 10 percent of the cases.

Despite the low rate of infection by bacterial agents, the diagnosis of acute bronchitis has become synonymous with antibiotic treatment. Studies have shown that 70-90 percent of office visits for acute bronchitis receive antibiotic treatment even though this illness is (without the presence of pneumonia) often self-limited. Routine treatment with antibiotics does not have consistent impact on duration or severity of illness or on potential complications such as pneumonia. However, despite multiple evidences that antibiotics are ineffective, an average of 80 percent of patients received an antibiotic.

The primary diagnostic objective needs to be the exclusion of pneumonia. According to ACCP guidelines, the absence of abnormalities in vital signs and chest exams sufficiently reduces the likelihood of pneumonia. Normal vital signs criteria are: a) heart rate less than 100 beats per minute; b) resting respiratory rate less than 24 breaths per minute; c) oral temperature less than 38 degrees Celsius. For chest exams, the absence of asymmetrical lung sounds, rales, an egophony will minimize the likelihood of pneumonia. If any of the variables are positive, then the recommendation is to perform a chest X-ray for diagnosis of pneumonia.
An exception to non-antibiotic treatment of acute bronchitis is in cases with etiology of Bordetella pertussis. Pertussis bronchitis occurs in 10-20 percent of these cases where the cough lasts longer than 2-3 weeks. There is no clinical features to distinguish pertussis from acute bronchitis. Pertussis in adults with previous immunity does not lead to the classic features of whooping cough that is normally present in children. Suspicion for diagnosis and treatment of pertussis in primary acute bronchitis is limited to patients with the high probability of exposure, such as during a time of documented outbreaks. Antibiotic treatment, in this case, is definitely necessary to limit the spread of the disease. In addition, if the patient has a post-infectious cough lasting for weeks without another apparent cause and it is accompanied by paroxysms of coughing, post-tussive vomiting, and/or an inspiratory whooping sound, the diagnosis of a B. pertussis infection should be made unless another diagnosis is proven. The Centers for Disease Control (CDC) and ACCP guidelines recommend macrolides, such as erythromycin or azithromycin, as first-line therapy for pertussis. If erythromycin cannot be given, alternative choices are doxycycline or trimethoprim/sulfamethoxazole. In all cases, diagnostic tests for pertussis must always be performed along with antibiotic treatment.

A 12-month retrospective study of Medi-Cal Fee-for-Service (FFS) recipients was conducted to determine whether adults between 18-64 years of age with acute bronchitis filled a prescription for an antibiotic within three days of being diagnosed. The study indicated only those patients who are normally healthy and were considered to have “uncomplicated” acute bronchitis.

- Over 69 percent of recipients filled a prescription for an antibiotic medication
- Of the recipients who received an antibiotic, 50 percent received a broad spectrum antibiotic

The data suggest that patients are being **over-treated** with antibiotics for acute bronchitis. Half of the patients that received an antibiotic were prescribed a broad-spectrum antibiotic, which is a contributing factor to the emergence and spread of antibiotic-resistant bacteria. Rather than prescribing an antibiotic as an empiric treatment, ACCP recommends symptomatic treatments for patients.

Bacterial bronchitis, viral bronchitis, and the common cold share many of the same symptoms, thus making the clinical distinctions between these diagnoses difficult if not impossible. Nonetheless, studies have shown that antibiotic treatment shows no benefit on duration of illness, limitation of activity, or loss if work. Patient satisfaction with care is not dependent on an antibiotic prescription, but rather on physician-patient communications. Studies have shown that physician-educational intervention to reduce the use of antibiotics for acute bronchitis did not lead to greater patient dissatisfaction, longer duration of illness or such findings and the treatment of ACCP, it is recommended that clinicians to refrain from routine prescribing of antibiotics for uncomplicated acute bronchitis.

Immunizations for Adolescents Review

BACKGROUND

In the United States, vaccination programs that focus on infants and children have decreased the occurrence of many childhood, vaccine-preventable diseases. How- ever, many adolescents (i.e., persons 11–21 years of age i.e., as defined by the American Medical Association [AMA] and the American Academy of Pediatrics [AAP]) and young adults (i.e., persons 22–39 years of age) continue to be adversely affected by vaccine-preventable diseases (e.g., varicella, hepatitis B, measles, and rubella), partially because vaccination programs have not focused on improving vaccination coverage among adolescents.

These recommendations for the immunization of adolescents were developed to improve vaccination coverage among adolescents and focus on establishing a routine visit to health-care providers (i.e., providers) for adolescents ages 11–12 years. Such a visit provides the opportunity for a) ensuring vaccination of those adolescents not previously vaccinated with hepatitis B vaccine, varicella virus vaccine (if indicated), or the second dose of the measles, mumps, and rubella (MMR) vaccine; b) administering a tetanus and diphtheria toxoid (Td) booster; c) administering other vaccines that may be recommended for certain adolescents; and d) providing other recommended preventive services.

Flexibility in scheduling vaccinations is an important factor for improving vaccination coverage among adolescents. Because multiple-dose vaccines or simultaneous administration of several vaccines may be indicated for adolescents, providers may need to be flexible in determining which vaccines to administer during the initial visit and which to administer on return visits.

IMMUNIZATION AS A PREVENTIVE HEALTH SERVICE FOR ADOLESCENTS

Administration of vaccinations should be integrated with other preventive services provided to adolescents. The importance of improving the vaccination levels and of providing other preventive services indicated for adolescents and young adults has been emphasized recently by many national organizations (Exhibit 1). In particular, AAP has advocated and provided specific recommendations for the vaccination of adolescents. Similarly, AMA and the Health Resources and Services Administration (HRSA) have proposed comprehensive recommendations that provide a framework for organizing the content and delivery of preventive health services (including vaccinations) for adolescents. The United States Preventive Services Task Force (USPSTF) has advocated specific vaccinations for adolescents that are based on the patient's age and risk factors. In addition, the American Academy of Family Physicians (AAFP) has recommended delivery of preventive services based on reviews by USPSTF and the AAFP Commission on Clinical Policies and Research. Guidelines recommended by these organizations include the delivery of preventive health services during a series of regular visits by adolescents to providers. These services include specific guidance on health behaviors; screening for biomedical, behavioral, and emotional conditions; and delivery of other health services, including vaccinations. The recommendations for vaccination of adolescents adopted by the Advisory Committee on Immunization Practices (ACIP), AAP, AAFP, and AMA are consistent with those of other groups that promote preventive health services for adolescents.

SCHEDULING VACCINATIONS

Simultaneous Administration of Vaccines

Extensive clinical experience and experimental evidence from studies of infants and children have strengthened the scientific basis for administering certain vaccines simultaneously. Although specific studies have not been conducted regarding the simultaneous administration of all vaccines recommended for routine use in adolescents, no evidence has established that this practice is unsafe or ineffective.

All indicated vaccinations should be administered at the scheduled immunization visit for adolescents who are 11–12 years of age. However, some adolescents may require multiple (i.e., four or more) vaccinations, and the provider may choose not to administer all indicated vaccines during the same visit. In these circumstances, the provider may prioritize which vaccines to administer during the visit and schedule the adolescent for one or more return visits. Factors to consider in this decision include which vaccines require multiple doses, which diseases pose an immediate threat to the adolescent, and whether the adolescent is likely to return for scheduled visits.

Documentation of Previous Vaccinations

Providers may encounter adolescents who do not have documentation of previously received vaccines. In these circumstances, providers should attempt to assess each adolescent's vaccination status through documentation obtained from the parent, previous providers, or school records. If documentation of an adolescent's vaccination status is not available at the time of the visit, the following strategy is recommended while awaiting documentation: a) for those vaccinations required by law or regulation that the adolescent previously was subject to, assume that the adolescent has been vaccinated (unless required vaccinations have not been administered for religious, philosophic, or medical reasons) and withhold those vaccinations; and b) administer those vaccines that the adolescent previously was not subject to by law or regulation.

STATE VACCINATION LAWS AND REGULATIONS

In the United States, state vaccination laws and regulations for kindergarten through grade 12 are effective in ensuring high coverage levels among school attendees and have led to a marked decline of overall morbidity and mortality from vaccine-preventable diseases. Additional state laws and regulations requiring documentation of up-to-date immunization of adolescents or a reliable history of disease- related immunity at entry into sixth or seventh grade would ensure implementation of these recommendations and would lead to further reduction in transmission of vaccine-preventable disease.

RECOMMENDATIONS FOR VACCINATION OF ADOLESCENTS

The recommendations for administering each vaccine are consistent with current ACIP, AAP, AAFP, and AMA documents (Exhibit 2). However, the Td recommendation has been changed recently such that the ages at which the first Td booster is administered may be lowered from 14–16 years to 11–12 years. General recommendations and vaccine-specific recommendations for providers are as follows:

General Recommendations

- Establish a visit to providers for adolescents ages 11–12 years to screen for immunization deficiencies, and administer those indicated vaccines that have not been received. During the initial visit, schedule appointments to receive needed doses of vaccine that are not administered during the initial visit. Provide other indicated preventive services during this and all other visits.
- Check the vaccination status of adolescents during each subsequent visit to providers and correct any deficiencies, including those associated with the three- dose series of hepatitis B vaccinations.

Vaccine-Specific Recommendations

- **Hepatitis B vaccine.** Vaccinate adolescents 11–12 years of age who have not been vaccinated previously with the three-dose series of hepatitis B vaccine. Ensure completion of the series by scheduling the vaccinations that are needed and by following up on those adolescents who do not receive these scheduled vaccinations. In addition, adolescents >12 years of age who are at increased risk for HBV infection should be vaccinated.

- **MMR (second dose).** Administer the second dose of MMR to adolescents who have not received two doses of MMR at ≥12 months of age.
- **Td booster.** Administer a booster dose of Td vaccine to adolescents at ages 11– 12 or 14–16 years if they have received the primary series of vaccinations and if no dose has been received during the previous 5 years. All subsequent, routine Td boosters (i.e., in the absence of tetanus-prone injury) should be administered at 10-year intervals.

- **Varicella virus vaccine.** Administer varicella virus vaccine to adolescents ages 11– 12 years who do not have a reliable history of chickenpox and who have not been vaccinated with varicella virus vaccine.

- **Influenza vaccine.** Administer influenza vaccine annually to adolescents who, be- cause of an underlying medical condition, are at high risk for complications associated with influenza. If seen at a time of year when vaccination is not indicated, schedule the adolescent for an influenza vaccination at the appropriate vaccination time (i.e., September–December). Vaccinate adolescents who have close contact with persons at high risk for complications associated with influenza. This vaccine also may be administered to adolescents who have no underlying medical condition to reduce their risk for influenza infection.

- **Pneumococcal polysaccharide vaccine.** Administer pneumococcal vaccine to adolescents who have chronic illnesses associated with increased risk for pneumococcal disease or its complications. Use adolescents' visits to providers to ensure that the vaccine has been administered to persons for whom it is indicated.

- **Hepatitis A vaccine.** Administer hepatitis A vaccine to unvaccinated adolescents who a) plan to travel to or work in a country that has high or intermediate endemicity of HAV infection*; b) reside in a community that has a high rate of HAV infection and periodic outbreaks of hepatitis A disease; c) are administered clot- ting factors; or d) have any of the following conditions or risk behaviors: chronic liver disease, use of illegal injecting or non-injecting drugs (i.e., if local epidemiologic data indicate current or past outbreaks of hepatitis A disease have occurred among persons who have such risk behaviors), or if they are males who have sex with males.

Immunizations for Adolescents (IMA) HEDIS Summary Guidelines

Summary of Changes to HEDIS 2013

Description

The prescription of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

An updated schedule of recommended children's vaccination aims to clarify and simplify the list of vaccinations that adolescents need to stay healthy and avoid preventable diseases.

- Key among the vaccination changes is the new recommendation that pregnant women or teens be given the combined tetanus, diphtheria, and acellular pertussis (Tdap) vaccination during each pregnancy to protect their infant from pertussis (whooping cough), even if they have previously had a Tdap vaccination.

The HEDIS measure follows CDC, ACCP, and ACIP guidelines for immunizations. It is very important for providers to ensure that their adolescent patients receive the required immunizations per established CDC, ACCP, and ACIP guidelines and the HEDIS measurement requirements (see below).

Description

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Eligible Population:

Adolescents who turn 13 years of age during the measurement year.

Guidelines:

Meningococcal

- One meningococcal conjugate or meningococcal polysaccharide vaccine on or between the member's 11th and 13th birthdays.

Tdap/Td

- One tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) on or between the member's 10th and 13th birthdays.

Combination 1 (Meningococcal, Tdap/Td)

- Adolescents who received one meningococcal vaccine on or between the members 11th and 13th birthday and one tetanus, diphtheria toxoids an acellular pertussis vaccine (Tdap) or one one tetanus, diphtheria toxoids vaccine (Td) on or between the member's 10th and 13th birthday.

Medication Management for People With Asthma (MMA): HEDIS Summary Guidelines

Summary Changes for HEDIS 2013

The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. To rate are reported;

1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.
2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.
3. Treatment period is determined by the earliest prescription dispensing date for any controller medication during the measurement year.

Guidelines:

Members (patients) that have persistent asthma who met at least one of the following criteria during the both the measurement year and the year prior to the measurement year:

- At least one ED visit.
- At least one acute inpatient encounter with asthma as the principle asthma.
- At least four outpatient asthma visits on different dates of service, with asthma as one of the main criteria and at least two asthma medication dispensing events.
- A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed in the measurement year, must have diagnosis of asthma, in any setting, in the same measurement year as the leukotriene modifier.

Exclusions:

- Members with a diagnosis of emphysema, COPD, cystic fibrosis, or acute respiratory failure.
- Members who have no asthma controller medications dispensed during the measurement year.

For Your Patients / For Your Practice: The Importance of A1C Testing

The combination of self-monitoring of blood glucose and A1C testing is key in assisting patients with diabetes avoid diabetes complications.

Frequent self-monitoring of blood glucose is necessary for those patients who have glycemic excursions, are prone to hypoglycemia or use insulin with a sliding scale or correction factor, but it is A1C testing that provides the overall picture. The UK Prospective Diabetes Study (UKPDS) indicated each 1% drop in A1C reduced the risk for mortality associated with diabetes by 21% and the risk for myocardial infarction by 14%.[1] In addition to being predictive of potential diabetes complications, A1C testing also provides feedback on your chosen treatment modality.[2]

HEDIS A1C Results

HEDIS measures show that physicians are achieving an A1C of less than eight percent in 50% of patients and uses this as the HEDIS goal.[3]

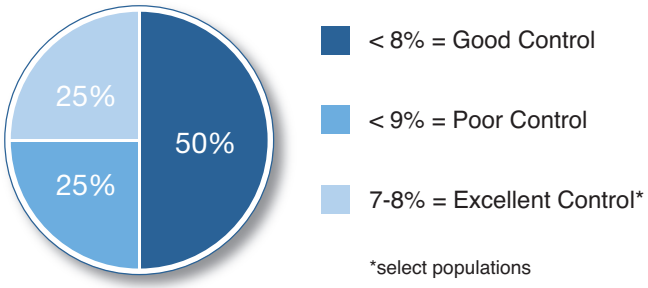
ADA Standard of Care

The American Diabetes Association (ADA) recommends an A1C of 7% in most patients with diabetes.[4]

Helping Patients Achieve A1C Goals

Recent research in a national sample of people with type 2 diabetes revealed that forty nine percent of the over twelve hundred people studied had been provided an A1C goal by their health care provider.[4] To assist your patients in minimizing complications, it is important to explain A1C, let them know their result and your recommend target. Encourage them to meet their recommended target through medication adherence and behavioral changes.

HEDIS A1C Results



Translating A1C Results for Patients

A1C%	eAG mg/dl	A1C%	eAG mg/dl
5.5	111	9.0	212
6.0	126	9.5	226
6.5	140	10.0	240
7.0	154	10.5	255
7.5	169	11.0	269
8.0	183	11.5	283
8.5	197	12.0	298

Estimated average blood glucose (eAG) is a tool to help patients translate their A1C result into a number with which they are familiar and can identify.[5] Try using this tool to relate A1C to your patients.

1. UK Prospective Diabetes Study (UKPDS) Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). Lancet. 1998; 12;352(9131):837–853.
2. National Committee for Quality Assurance (NCQA). HEDIS 2013: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2012. various p.
3. Cassagrande SS, Burrows NR, Geiss LS, et.al. Diabetes knowledge and its relationship with achieving treatment recommendations in a national sample of people with type 2 diabetes. Diabetes Care. 2012;35:1556-1565.
4. American Diabetes Association. Standards of medical care in diabetes. Diabetes Care 2013;36:S4-S10.
5. Nathan DM, Kuenen J, Berg R, et.al. For the A1C-derived average glucose (ADAG) study group. Translating the A1C assay into estimated average glucose values. Diabetes Care. 2008;31:1473-1478.