Did you know?

Go to **www.yhplus.com** for free, user-friendly, Web-based CME topics pertinent to your practice. Topics include:

- depression
- asthma
- substance abuse
- diabetes
- congestive heart failure
- COPD
- coronary artery disease

Look for new CME modules on the following behavioral health topics coming in March:

- pain management and opiate prescribing
- management of antipsychotic medication
- management of bipolar disorder ■

Primary Care Treatment of Depression *(Continued from page 1)*

you on medication compliance for patients with depression for both the acute phase (the first three months) and the continuation phase (the first six months) of the treatment cycle. Look for this information in your quarterly clinical metric feedback reports, presented in both aggregated and by patient metrics. This is an especially beneficial area for medication compliance outreach.

Once you've ascertained that your patients are taking their medication regularly, you may consider an augmentation strategy. Effective augmentation agents include buspirone, thyroid hormone, and lithium. An alternative approach involves the use of antipsychotic medications, but side effects can be very problematic.

Finally, don't underestimate the value of cognitive behavioral therapy (CBT). CBT can offer results independent of antidepressant medications and can even be superior at times, without the side effects! To learn more about CBT, see our list of resource articles at **www.yhplus.com**. ■

Visit the Your Healthcare Plus and the Illinois Health Connect web sites for information on upcoming events.

This newsletter is available on the Your Healthcare Plus and Illinois Health Connect websites:
www.yourhealthcareplusdr.com • www.illinoishealthconnect.com

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Volume 5, Issue 1 • January 2011

Provider Newsletter

ILLINOIS HEALTH CONNECT™ Your Home For Healthcare

Your Healthcare Plus™ *Extra help for better health*

Primary Care Treatment of Depression: Strategies to Use Today

Your Healthcare Plus (YHP) recently held a webinar hosted by two experts in the treatment of depression, Dr. Harold Carmel, a psychiatrist, and Dr. Mark Loafman, a family physician. The two did an excellent job applying an evidence-based approach to clarify the challenges of both recognizing and managing this condition in primary care. You can review the webinar slides by visiting **www.yhplus.com** and accessing the resources section of the Depression CME.

By discussing a complex medical case with both somatic symptoms and resistance to treatment, the doctors pointed to three major considerations in the treatment of such patients:

- under diagnosis and under treatment
- management of resistant depression
- value of cognitive behavioral therapy

First, the doctors discussed the problems of under diagnosis and under treatment of depression. Most patients with depression receive their care from primary care physicians, but as you've seen, they may not present with a specific complaint of having a depressed mood. Instead, many patients present with somatic symptoms. In such situations, it's important to initiate objective testing to ensure cases of depression are appropriately detected. The use of the Personal Health Questionnaire–2 (PHQ-2) and PHQ-9 can be especially helpful for making the diagnosis and the PHQ-9 is also helpful for following progress objectively over time. These tools can be found in the resources section at **www.yhplus.com** and can be used freely in your office without copyright infringement concerns.

The second area of focus was resistant depression. Findings of the STAR-D trial revealed that some patients may take up to 14 weeks to show improvement on medication. (A review article of STAR-D is available at **www.yhplus.com**.) If you find that patients are not responding even after a good therapeutic trial, there are several options to consider.

First, it's important to make sure your patients are taking their medication regularly. YHP now provides feedback to

(Continued on page 4)

NCQA Recognizes Elmhurst Clinic's Cutting-edge Approach

Elmhurst Clinic recently became the first practice in Illinois to be recognized from the National Committee for Quality Assurance (NCQA) for functioning as a medical home under the NCQA Physician Practice Connections–Patient-Centered Medical Home program.

The program evaluates a practice using nine standards that emphasize the use of patient-centered, coordinated care management processes. Recognition is available on three levels. While Elmhurst Clinic is the first and only practice to achieve Level 3 recognition, the Rush-Copley Family Medicine Residency Program and the SIU Family Medicine Residency Program–Carbondale have since earned Level 1 NCQA recognition.

"I don't think we're done," says Elmhurst Clinic chief executive officer Dr. Donald Lurye. "We'll probably never be done. You need respected physician champions who believe there's a better way to do things. There also needs to be recognition that medical care has gotten so complex and it transcends the capability of one human brain to keep track of and remember everything."

NCQA uses nine standards in its evaluation: access and communication, patient tracking and registry functions, care management, patient self-management support, electronic prescribing, test tracking, referral tracking, performance reporting, and improvement and advanced electronic communications.

Elmhurst Clinic began using an electronic medical records (EMR) system six years ago. It features a prescribing system that provides alerts, tracks referrals, and sends lab results directly to patient EMR. The challenge, according to Dr. Lurye, was to reorganize the way care was delivered to patients with chronic disease, starting with a focus on diabetes and asthma.

(Continued on page 2)

Supporting Your Practice

Medical Card Update

The Illinois Department of Healthcare and Family Services (HFS) continues its effort toward implementation of the new Medical Card. HFS will discontinue the current monthly paper card mailing and mail a new durable plastic card to participants eligible for medical benefits. The new Medical Card will not guarantee eligibility; instead providers will confirm eligibility before providing services. Participants will no longer receive a new card every month and should keep their plastic card even if they no longer qualify for medical benefits. The card can be used if they qualify for benefits at a later date. Replacement cards will be provided for lost or stolen cards.

HFS is working to meet the deadline for distribution of the new Medical Card by June 2011. ■

Elmhurst Clinic's Cutting-edge Approach *(Continued from page 1)*

Automated telephonic outreach has been a successful tool to generate encounters for monitoring and evaluating chronic illness, as well as scheduling preventive services. Lurye estimates that nearly 2,500 appointments per month are scheduled via automated outreach. "It was an interesting process with the reminder calls," Dr. Lurye says. "Initially it was 'What is this?' Now people expect it and look forward to it."

Outreach is now triaged, with those who have more severe chronic diseases getting more frequent reminders. According to Dr. Lurye, less than 1 percent of patients have opted out of receiving these automated calls.

The new model of care at Elmhurst Clinic stresses the importance of maximizing the value of each patient encounter. "You may be here for a sprained ankle or lower back pain or an upper respiratory infection," Dr. Lurye says. "But you may not have had a mammogram in three years. You may have a high hemoglobin A1C or may not have had one drawn. In addition, by studying our own data, we found there are missed opportunities there. So, we've reorganized the way our electronic medical record presents awareness of these issues, and have empowered our staff to look and see what some of the elements of chronic care are that may be missing. You may come in for reason A, but we may need to address reasons B, C, and D."

The implementation of their medical home model began with 9 physicians at the Schiller Street location in Elmhurst but has now extended to all 30 primary care physicians at Elmhurst Clinic's seven locations of service. Each of those seven locations has earned NCQA Level 3 recognition for the PPC-PCMH program.

While Medicaid patients make up roughly 10 percent of Elmhurst Clinic's payer mix, the clinic's approach is payer-blind, and the positive results show in the asthma and diabetic management statistics from their 2009 Illinois Health Connect (IHC) bonus payments. The 30 physicians who garnered NCQA recognition combined to score 90.4 percent in asthma management (122/135 patients served across all three age groups, ranging from 5-56 years old) and 89.4 percent (127/142) in diabetes management.

IHC providers already have similar tools at their disposal. The IHC Provider Portal, which can be accessed through the Illinois Department of Healthcare and Family Services' MEDI system, offers various online resources for enrolled medical homes. Online patient panel rosters can be viewed as a spreadsheet and easily sorted to identify patients who are due for preventive services such as well-child visits, pediatric lead testing, and mammograms. The Claims History tool produces a detailed record of Medicaid paid claims for prescriptions and immunizations, as well as office visits, hospitalizations, labs, and other procedures.

Some patients with chronic disease are eligible to participate in the patient-based Your Healthcare Plus disease management program. IHC also sends patients letters reminding them to schedule well visits with their assigned primary care physician, and IHC makes outbound calls to families to facilitate scheduling well-child visits. ■

Supporting Your Patients

Guidelines Make Diabetes Diagnosis Easier

There are approximately 5.7 million people with *undiagnosed* diabetes in the United States[1]; a few of them may be patients in your practice! The bad news is that until a diagnosis is made and appropriate treatment is initiated, these people are on the road to developing the well-known microvascular and macrovascular complications of the disease. The good news is that as of 2010, the American Diabetes Association (ADA) standards of care[1] support an easier alternative for diagnosing diabetes—a simple HbA1C test. This measurement of average blood glucose over the past two to three months does not require fasting, and the results are helpful in both detecting diabetes and identifying those people who are at risk for developing diabetes.

Risk Factors for Diabetes

Although not everyone needs this test, it is becoming common as a part of routine annual blood work. Knowing who is considered at high risk[2] for actually having or for developing diabetes is helpful. The common risk factors include (but are not limited to):

- obesity (especially abdominal)
- abnormal cholesterol levels
- high blood pressure (sustained readings >130/85)
- history of gestational diabetes
- Down's syndrome or certain other genetic syndromes
- diseases of the pancreas, including cystic fibrosis
- use of certain medications, such as:
  - long-term use of oral corticosteroids, nicotinic acid, or Dilantin (to name a few)
  - medication for controlling symptoms of schizophrenia or other severe mental health conditions; for example, Zyprexa, Risperdal, Clozaril, Abilify, Seroquel, Geodon, or Symbyax

The incidence of diabetes is also known to be higher among African Americans, Hispanics, and Native Americans.

A1C Test Results

The ADA has provided the following A1C test interpretive-results guidelines:

- A1C 6.5% on two different occasions: diagnosis: diabetes
- A1C between 5.7% and 6.5%: pre-diabetes or at-risk. Monitor this person closely and advise lifestyle modifications, such as moderate weight loss and increased activity. (Risk is a continuum.)
- A1C result 5.6% or lower: low risk for developing diabetes

Next Steps

Consider identifying those persons at risk (share risk information with your office staff and solicit their help) and implementing standing orders for the serum blood draw for at-risk individuals. Frequency should be based on test results. For persons with diagnosed diabetes, the standard of care is an A1C test every six months for persons in good control, and every three months for those with poor control or with therapy changes. Need help with patients who are struggling? If they are eligible for the Your Healthcare Plus (YHP) disease management program (information available on MEDI), you can call **1-800-973-6792** to make a referral. YHP staff will work closely with you to identify concerns and will partner with you to create an action plan for eligible patients. ■

[1] National Institute of Diabetes and Digestive and Kidney Diseases, *National Diabetes Statistics, 2007* fact sheet (Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, 2008), http://diabetes.niddk.nih.gov/dm/pubs/statistics/index.htm#allages.

[2] American Diabetes Association, Diagnosis and Classification of Diabetes, January 2010 http://care.diabetesjournals.org/content/33/Supplement_1/S62.full