For more than a decade, we have been publishing the Accountable Provider newsletter. We hope that you have found that publication useful and its information valuable.

UPMC Health Plan strives to publish newsletters for members and physicians that are well-written, interesting, and timely. We set goals and continually evaluate whether we are meeting those goals.

A recent evaluation of our physician newsletter has led to several notable changes. First, we've changed the name of the newsletter to Physician Partner to more accurately reflect how we view our relationship with our network physicians. You are our partners in providing outstanding health care to your patients, our members. Second, each newsletter will now be broken down into several sections: Clinical Information, On the Web, Practice Information, and About UPMC Health Plan. These sections will make it easier for you to find the information you need. Third, we've reduced the number of newsletters to two a year so that we can produce a publication that will be a better resource for you.

If you would like to share your opinion about the Physician Partner newsletter, or if you would like to submit a suggestion for an article, please contact your Network Management representative. We welcome your suggestions.
We can help patients who have complex medical issues

UPMC Health Plan members who have complex medical or behavioral health conditions may benefit from additional support in managing their health, and we have a program that can help them. Our program encourages collaboration among providers who care for the same member.

Our health coaches coordinate health care services, support physician treatment plans, and identify gaps in care. They educate members and their caregivers on self-management of their condition. Health coaches also connect members with support services available in the community.

A health coach will contact members who could benefit from our complex case management program, based on claims data. Enrollment is voluntary and members may decide to disenroll at any time.

If the member agrees to participate, the health coach will assess the member’s needs and work with the physician, member, and caregiver to develop a work plan. The health coach will contact the member’s physicians, when needed and with permission, to clarify the plan.

Our health coaching staff includes nurses, social workers, diabetes educators, nutrition and exercise specialists, and more.

Please consider referring your patients to our complex case management program. To do so, contact us at 1-866-918-1588. Representatives are available Monday through Friday from 8 a.m. to 4:30 p.m.

A helping hand for members with chronic disease

Members who have a chronic disease have a lot on their mind. They may be overwhelmed by how many medications they need to take and when, dietary restrictions, and frequent doctor visits. UPMC Health Plan can help these members. Health coaches from our health management programs will work with members if they have asthma, COPD, diabetes, depression, or cardiovascular health issues like heart failure, coronary artery disease, hypertension, or high cholesterol.

Here’s what members can expect when they join the program:

• A health coach will call to ask about their health, diet, and medications, and how their condition affects their daily life. The health coach will help them learn more about the signs and symptoms of their condition, their medications, and their recommended diet and exercise guidelines if they are following a specific plan.

• With permission, the health coach will contact a participant’s doctor to keep him or her apprised of the member’s health status.

Please consider referring your patients to our health management programs. To do so, call 1-866-778-6073 toll-free. TTY services are available at 1-800-361-2629. Representatives are available Monday through Friday from 8 a.m. to 4:30 p.m.

UPMC for Kids benefit and copayment changes

Effective February 1, 2009, UPMC for Kids™ updated several of its benefits and copayments.

• Lifetime maximums have been removed for inpatient substance abuse detoxification admissions, substance abuse inpatient rehabilitation and nonhospital residential services, and outpatient substance abuse rehabilitation services.

• Low-cost (subsidized) members will no longer have copayments for outpatient mental health visits. Full-cost members will now be charged a copayment for well-child PCP and routine gynecology visits. All other copayments remain the same. All copayments are listed on the member’s UPMC for Kids ID card.

If you have any questions about CHIP, brought to you by UPMC for Kids, contact Provider Services at 1-800-650-8762. Staff members are available Monday through Friday from 8 a.m. to 5 p.m. Information is also available on our website at www.upmchealthplan.com/upmcforkids.
The Myers Group, a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, conducted UPMC Health Plan’s 2008 Provider Satisfaction Survey. Information obtained from this survey allows health plans to measure how well they are meeting their providers’ expectations and needs. Based on the data collected, this report summarizes the results and assists in identifying plan strengths and opportunities. The chart below presents the 2008 Summary Rates for UPMC Health Plan’s composites and overall satisfaction attributes and ratings. In the survey, providers were asked to rate UPMC Health Plan and all other health plans in which the provider participates. A comparison between these scores is displayed in the chart below.

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Summary Rate Definition</th>
<th>2008: UPMC Health Plan</th>
<th>2008: All Other Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Customer Service/Call Center</td>
<td>Very or somewhat satisfied</td>
<td>80.7%</td>
<td>77.0%</td>
</tr>
<tr>
<td>Provider Relations</td>
<td></td>
<td>69.3%</td>
<td>69.7%</td>
</tr>
<tr>
<td>Network</td>
<td></td>
<td>82.1%</td>
<td>81.1%</td>
</tr>
<tr>
<td>Utilization Management</td>
<td></td>
<td>69.7%</td>
<td>65.2%</td>
</tr>
<tr>
<td>Quality Management</td>
<td></td>
<td>75.4%</td>
<td>74.4%</td>
</tr>
<tr>
<td>Claims Processing</td>
<td></td>
<td>74.2%</td>
<td>71.6%</td>
</tr>
<tr>
<td>Pharmacy Benefits &amp; Services</td>
<td>Excellent or very good</td>
<td>39.1%</td>
<td>38.4%</td>
</tr>
<tr>
<td>Disease Management</td>
<td></td>
<td>54.1%</td>
<td>NA</td>
</tr>
<tr>
<td>Internet Technology</td>
<td></td>
<td>53.3%</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Overall Satisfaction and Loyalty</strong></td>
<td></td>
<td><strong>89.8%</strong></td>
<td><strong>NA</strong></td>
</tr>
<tr>
<td>Recommend to other patients</td>
<td>Definitely or probably yes</td>
<td>91.9%</td>
<td>NA</td>
</tr>
<tr>
<td>Recommend to other physicians</td>
<td></td>
<td>91.8%</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Overall Satisfaction</strong></td>
<td>Very or somewhat satisfied</td>
<td>85.6%</td>
<td>82.1%</td>
</tr>
</tbody>
</table>
UPMC Health Plan helps make Pittsburgh healthier

Part of UPMC Health Plan’s mission is making our community a healthier place to live and work. As obesity rates continue to rise, organizations in western Pennsylvania have joined forces to improve the health of adults and youth in our region, and UPMC Health Plan is right there with them.

We Can! Pittsburgh
UPMC Health Plan is proud to be part of We Can! Pittsburgh, a local movement that helps families in western Pennsylvania lead healthy lifestyles.

We Can! (Ways to Enhance Children’s Activity and Nutrition) is a science-based national education program developed by the National Institutes of Health — which is part of the U.S. Department of Health and Human Services. The program helps children ages 8 to 13 improve their food choices, increase their physical activity, and reduce the time they spend watching TV, using the computer, or playing video games.

UPMC Health Plan and its We Can! partners are developing programs that focus on healthy eating and active lifestyles for the youth of western Pennsylvania. The Children’s Museum of Pittsburgh has led the way by coordinating a number of different creative, family-friendly activities and events designed to get children and their families moving and thinking about healthy nutrition options.

Other local organizations involved in We Can! Pittsburgh include the Children’s Hospital of Pittsburgh of UPMC, the City of Pittsburgh, Children’s Community Pediatrics, and H.J. Heinz Company.

You can read more about We Can! by visiting the We Can! Pittsburgh website at http://www.upmchealthplan.com/spotlight/wecan.html. The site includes valuable resources for parents and physicians, information on the campaign, and links to partner websites.

HEALTHY Armstrong
HEALTHY Armstrong’s goal is to improve the health of families and to help children maintain a healthy weight through improved nutrition and increased physical activity. HEALTHY stands for Healthy Eating and Active Lifestyles Together Helping Youth.

UPMC Health Plan supports this initiative financially and by helping with communication efforts. We also offer help with research and tracking the success of the program.

In addition to UPMC Health Plan, other key partner organizations for this initiative include:
- Armstrong School District
- ACMH Hospital
- ACMH Hospital Foundation
- Children’s Community Pediatrics—Armstrong
- Armstrong County

Many changes have been made within the Armstrong School District. Groups meet to talk about ways to make the students healthier. The food program has also changed to now offer many more fresh fruits and vegetables. Other changes include:
- No deep fryers in the kitchens
- No high-fat desserts
- Only 1% or skim milk served
- Only bottled water or 100% juice drinks in school vending machines

If you want to read more, just go to www.healthyarmstrong.com to read a program overview and locate upcoming events.

UPMC Health Plan is proud to be part of these two community efforts that help parents help their children make healthy food choices and get more exercise.

LifeSmart
An estimated 51 million people in the United States have prediabetes or metabolic syndrome.

Poor lifestyle choices, such as overeating and being physically inactive, can lead to prediabetes. And metabolic syndrome includes multiple risk factors that may make some individuals more susceptible to developing type 2 diabetes, heart disease, and other conditions that can lead to premature death.

UPMC Health Plan and Heritage Valley Health System have teamed up to offer LifeSmart, a program for adults who are prediabetic or who have metabolic syndrome and who have a Heritage Valley physician. LifeSmart provides these people with the support they need to lead a healthier lifestyle.

It’s important for anyone at risk for diabetes or metabolic syndrome to maintain a healthy lifestyle. But making the right choices can be challenging. That’s where the LifeSmart program can help! Its Group Lifestyle Balance (GLB) program is based on the highly successful lifestyle interventions used in the University of Pittsburgh Diabetes Institute’s Diabetes Prevention Program. GLB can help patients learn to:
- Develop healthy eating habits
- Incorporate physical activity into daily life
- Develop problem-solving skills

In the first year of the program, participants decreased their weight by almost 8 percent, and 71 percent of participants increased their physical activity to at least 150 minutes per week.

If you are a Heritage Valley physician and would like more information about the LifeSmart program, please contact Heritage Valley Community Health Services at 1-866-328-8389. You may also contact your UPMC Health Plan Network Management representative or physician account executive.
UPMC Health Plan earns No. 1 ranking for customer service

UPMC Health Plan recently earned a first-place ranking for Customer Service in a well-known health insurance plan study of the Pennsylvania-Delaware region. This was the first year that UPMC Health Plan has been rated in this survey. Receiving the No. 1 customer service ranking recognizes the excellent work of our Member Services call center team.

Each plan is compared to others in its region in terms of members’ satisfaction with their overall health plan experience. The rankings are based on responses from millions of consumers and business customers and serve as industry benchmarks for measuring and tracking quality and customer satisfaction.

The study surveyed members from 131 major commercial health plans in 17 different geographic regions across the United States.
Clinical health policy changes

Colorectal screening coverage
The Act 62 Colorectal Screening Mandate amendment to the Insurance Company Law of 1921, P.L.682, No. 284, states that all health insurance policies shall provide coverage for colorectal cancer screening for covered individuals in accordance with the American Cancer Society guidelines for colorectal cancer screening. These guidelines are consistent with approved medical standards and practices.

The American Cancer Society guidelines state that:
1. Coverage for nonsymptomatic covered individuals who are age 50 and older include, but are not limited to:
   - An annual fecal occult blood test
   - A sigmoidoscopy, a screening barium enema, or a test consistent with approved medical standards and practices to detect colon cancer, at least once every 5 years
   - A colonoscopy at least once every 10 years
2. Coverage for symptomatic covered individuals include a colonoscopy, sigmoidoscopy, or any combination of colorectal cancer screening tests, at a frequency determined by the treating physician.
3. Coverage for nonsymptomatic covered individuals who are at high or increased risk for colorectal cancer and who are under age 50 include a colonoscopy or any combination of colorectal cancer screening tests in accordance with the American Cancer Society guidelines on screening for colorectal cancer.

The coverage required shall be subject to applicable annual deductibles, coinsurance, and copayment requirements.

Pennsylvania Autism Act
There is another update to the Act 62 Insurance Company Law of 1921 as it applies to autism coverage. It’s being referred to as the Pennsylvania Autism Act or Act 62. It states that some private insurers must begin covering the costs of diagnostic assessments and various treatment services for autism spectrum disorders (ASD) for individuals with ASD who are under age 21, up to $36,000 per year. The Pennsylvania Department of Public Welfare (DPW) will cover the costs of eligible individuals who have no private insurance coverage and eligible individuals whose costs exceed the annual $36,000 cap. The Pennsylvania State Board of Medicine, in consultation with the Department of Public Welfare, shall license professional behavior specialists and establish minimum licensure qualifications for them.

Frequently asked questions about the Pennsylvania Autism Act 62:

When does the law requiring insurance companies to cover services for children with ASD go into effect?
Insurers will be required to comply with the Act for policies offered, issued, or renewed on or after July 1, 2009, including the provisions that require many insurers to cover services for ASD.

Will Act 62 apply to all employer groups?
Employers that offer group health insurance coverage and have at least 51 employees are required to offer ASD services for children under age 21. Self-funded plans are not subject to the Act.

Please note that coverage applies to large group (51 or more employees) commercial products. However, in reference to UPMC Health Plan’s Adult Preventive Health Guidelines for colorectal screening, coverage applies to all products. The preventive guidelines are available on our website.
Are there limits on what private insurance is required to cover?
Private insurance companies are not required to cover the costs of services that fall outside the mandated services defined in Act 62. For those mandated services, though, there will be no limits on the number of visits to a provider. There is a $36,000 annual cap on coverage, after which DPW will pick up coverage. Beginning April 1, 2012, the cap will be adjusted upwards annually to account for inflation. Coverage may be subject to other limitations and exclusions as long as they are allowed under Act 62.

How will the law be enforced?
The Pennsylvania Insurance Department (PID) has strong regulatory powers to enforce the law. In addition, each health insurance company doing business in Pennsylvania is required to submit a compliance report to PID by January 2011.

What coverage is mandated by the law?
Act 62 requires coverage for diagnostic assessments and pharmacy, psychiatric, psychological, rehabilitative, and therapeutic care. These categories of mandated services are defined in the law. More specifically, the new act will cover evaluations and tests needed to diagnose a child’s autism disorder, as well as the development of a plan to provide health care services for a child. This plan may include medically necessary prescribed treatments such as behavioral analysis and rehabilitative care, prescription drugs, blood level tests, psychiatric and psychological services, speech/language, occupational, and physical therapy.

Is applied behavioral analysis (ABA) covered?
Yes, if it is medically necessary. The law’s definition of rehabilitative care specifically includes ABA.

Will all of the ASD diagnoses be covered, or just those diagnoses with the keyword of “autism”?
Any of the Pervasive Development Disorders defined in the current edition of the Diagnostic and Statistical Manual (DSM) are covered. These include autistic disorder, Asperger Syndrome, Rett Syndrome, Childhood Disintegration Disorder, and Pervasive Development Disorder (Not Otherwise Specified).

Does ASD have to be the primary diagnosis for the child in order to qualify for coverage under Act 62?
No, there is no requirement that ASD must be the “primary” diagnosis for the child to qualify for coverage under Act 62.

Will these services be covered by commercial carriers under Act 62?
Behavioral Specialist Consultation, Mobile Therapy, and Therapeutic Staff Support are all covered services under Act 62 as long as they fall under the definition of “treatment of autism spectrum disorders.” This means that they must be determined to be medically necessary and included in a treatment plan. These services could fall into the “rehabilitative care” or “psychological care” categories of care that are included in the Act.

Is case management covered?
Case management is not a mandated service under Act 62.

On July 1, 2009, will an insurance company be able to question a child’s existing ASD diagnosis?
Not until 12 months after the diagnosis was made. Under Act 62, an ASD diagnosis shall be valid for a period of not less than 12 months, unless a licensed physician or licensed psychologist determines a reassessment is necessary, and the reassessment indicates otherwise.

Will insurance companies be able to deny services if a child is not making “sufficient progress” or has reached a plateau in his or her progress?
No. The law specifically requires coverage of services intended to produce progress as well as those intended to prevent regression.

Will private insurers be developing their own medical necessity criteria?
Private insurers will use their own medical necessity criteria.

Which providers and services will be eligible for reimbursement under Act 62?
Reimbursement is required for any mandated service provided, pursuant to a comprehensive autism treatment plan provided by qualified professionals. These professionals include licensed physicians, physician assistants, psychologists, and clinical social workers; certified registered nurse practitioners; and those who work under their direction. Grandfathering clauses are included to ensure continuity of care for services provided by certain unlicensed professionals: those who work at the direction of the licensed professionals listed above, professionals enrolled in the Medical Assistance program, and behavior specialists pending their licensure.

I am a practicing Behavior Specialist in Pennsylvania — do I need to take any steps for additional licensure?
The State Board of Medicine in conjunction with DPW is developing regulations pertaining to the licensing of Behavior Specialists providing services for children and adolescents with autism. The regulations, specifics, and qualifications for this licensure will be forthcoming. Additional information will be posted on the PA Autism Insurance website (www.PAAutismInsurance.org) as it becomes available.

For questions about either of these significant changes in coverage, contact your Provider Services representative.
Consider generic medications first

The following text is excerpted from a UPMC Health Plan Pharmacy Provider Education brochure titled “Consider Generic Medications First.”

Most people believe that if something costs more, it has to be better quality. In the case of generic drugs, this is not true. As many physicians know, generic drugs must be therapeutically equivalent and therefore produce the same clinical effect and safety profile as the pioneer or innovator drug product. Therapeutically equivalent drugs (“A” rated drugs) must be:

**Pharmaceutically equivalent**
- Identical amounts of the same active drug ingredient in the same dosage form and route of administration
- Same standards of quality and purity

**Bioequivalent**
- Same rate and extent of absorption as the brand drug when studied under similar experimental conditions
- As a matter of fact, bioequivalent studies comparing 273 FDA-approved generic drugs to their innovator drug showed only 3%-4% difference in measures of bioequivalence

**Manufactured according to the same quality standards as brand-name drugs**
- The FDA evaluates the manufacturer’s adherence to good manufacturing practices before the drug is marketed.
- FDA periodically inspects manufacturing plants.
- FDA monitors drug quality after approval.
- For reformulations of a brand-name drug or generic versions of a drug, FDA reviews data showing the drug is bioequivalent to the one used in the original safety and efficacy testing.

**Generic alternatives are broadly available**
- Generic drugs are represented in all major drug classes.
- More generic drugs are entering the marketplace.
- 70% of new drugs offer little additional value over existing products.
- Generic alternatives are included as “first-line therapy” in many nationally accepted clinical guidelines for the management of key chronic diseases, including: Hyperlipidemia, Depression, Coronary Artery Disease, Congestive Heart Failure, Diabetes, and Hypertension.

**FDA ensures equivalence of generic drugs**
- Pharmaceutically equivalent
- Bioequivalent
- Manufactured by the same quality standards as brand-name drugs

When prescribing medications for your patients, think about the following:

**For physicians, generic alternatives are “first-line therapy” in many nationally accepted clinical guidelines for the management of key chronic diseases, including: Hyperlipidemia, Depression, Coronary Artery Disease, Congestive Heart Failure, Diabetes, and Hypertension.**

**Generic alternatives make “cents” for your patients**
- Generics cost your patients up to 90% less.
- Patients on three generic alternatives could save between $500 and $1,500 in one year’s time.
- Some generics are available for as low as $4 at various chain drug stores.
- Consider the impact generic drugs can have on your Medicare patients:
  - Medicare patients on 2 or more brand drugs are likely to reach the donut hole where additional out-of-pocket costs can exceed $1,600.
  - Lower prescription costs support better compliance.

Your physician account executive and Pharmacy provider network services manager are available to help you and your practice develop an action plan and provide additional resources for you and your patients. Call Provider Services at 1-866-918-1595 or contact your physician account executive or Pharmacy provider network services manager.

References:
Facts from the UPMC Center for Sports Medicine’s Concussion Program

A concussion occurs when a person receives a traumatic force to the head or upper body that causes the brain to shake inside of the skull. The injury is defined as a concussion when it causes a change in mental status, such as loss of consciousness, amnesia, disorientation, confusion, or mental fogginess. Between 1.4 and 3.6 million sports and recreation-related concussions occur each year, with the majority in high school students, according to the Centers for Disease Control and Prevention.

Because many mild concussions go undiagnosed and unreported, it is difficult to estimate the rate of concussion in any sport, but studies estimate that at least 10 to 20 percent of all athletes who play contact sports have a concussion each season. Also, the injury’s severity, effects, and recovery are sometimes difficult to determine. The decision to allow the athlete to return to the game is not always straightforward, although research has shown that until a concussed brain is completely healed, the brain is likely to be vulnerable to further injury. Allowing enough healing and recovery time following a concussion is crucial in preventing any further damage.

Research shows that the effects of repeated concussions in young athletes are cumulative. Most athletes who experience an initial concussion can recover completely as long as they are not returned to contact sports too soon. Following a concussion, there is a period of change in brain function that varies in severity and length with each individual. During this time, the brain is vulnerable to more severe or permanent injury. If the athlete sustains a second concussion during this time period, the risk of more serious brain injury increases.

In recent years, research has shown that even seemingly mild concussions can have serious consequences in young athletes if they are not properly managed. Loss of consciousness is not an indicator of injury severity. Traditional imaging techniques such as MRI and CT may be helpful in severe injury cases, but they cannot identify subtle effects believed to occur in mild concussion.

Over the past decade, scientific research has taught doctors more about the proper management of sports-related concussions, raised public awareness, and significantly changed the way professionals manage sports concussions. Recently published research includes data proving the usefulness of objective neurocognitive testing, such as ImPACT™, as part of the comprehensive clinical evaluation to determine recovery following concussion. Current international sports injury management guidelines emphasize using player symptoms and neuropsychological test results as “cornerstones” of the evaluation and management process. For more information about the ImPACT test, visit www.impacttest.com.
McGowan Institute for Regenerative Medicine

The McGowan Institute for Regenerative Medicine was established by the University of Pittsburgh School of Medicine and UPMC to serve as a single base of operations from which the university’s leading researchers and physicians develop new ways to repair tissues and organs impaired by disease, trauma, or congenital abnormalities. In addition, the Institute educates scientists and engineers about emerging technologies related to regenerative medicine and trains clinicians in the use of regenerative therapies. Just as important, the Institute commercializes the new technologies it develops so patients can benefit from them.

Originally established in 1992, the Institute takes its name from the late William G. McGowan, chief executive officer of MCI Communications. Mr. McGowan underwent a successful heart transplant at UPMC in 1987.

Research activities at the McGowan Institute are supported by government and industry grants as well as by gifts from individuals and foundations, including the McGowan Charitable Fund. Below are just a few examples of the work researchers are doing at the McGowan Institute:

- **Resuscitation Fluid** — A fluid derived from aloe vera has the potential to save the lives of patients with massive blood loss. In early tests, researchers found that a very small amount of the fluid increased survival time and helped body tissues take up more oxygen, even when blood or other fluids were not administered.

- **Nerve Guide** — Cells in the peripheral nervous system can regrow, but they sometimes have trouble linking up with each other, which is essential to restore feeling and function. To aid peripheral nerve regeneration, researchers have developed scaffolds made of FDA-approved biodegradable polymers and protein beads. Channels in the scaffolds act as guides for axons, the long arms of nerve cells, to grow longer and in the right directions. In early studies, a nerve guide, which was seeded with stem cells derived from fat, restored some hind leg mobility to paralyzed rats.

- **Esophagus and Trachea Reconstruction** — If a patient’s food tube or airway is damaged, scar tissue can form. Scar tissue makes breathing or swallowing impossible. Currently, no treatments for this condition exist other than to remove the damaged areas. Researchers are working on a method that uses natural scaffolds seeded with the patient's own cells to encourage the growth of healthy tissue instead of scar tissue. In early studies, a damaged section of the food tube was replaced with a specially formed scaffold constructed from a material already being used in humans. Within 90 days, the scaffold was replaced with functional tissue.

Annual chlamydia screenings a must for young women

A study sponsored by the CDC and the Agency for Healthcare Research and Quality lists chlamydia screening as one of the top most effective but underutilized preventive health services. It found that chlamydia screening provides great health benefits, both in terms of improving quality of life and offering the most value for health care dollars. The report states that more than half of sexually active women age 25 and younger have not been screened for chlamydia. An estimated 60,000 cases of pelvic inflammatory disease, 8,000 cases of chronic pelvic pain, and 7,500 cases of infertility would be prevented annually if the recommended chlamydia screening guidelines were followed.

Why aren’t the guidelines being followed? Experts say there are a number of reasons why physicians aren’t screening for chlamydia, including the belief that STD prevalence is low in their practice, physician age and gender, and practice setting (rural vs. urban).

And the women who are most in need of being screened are unlikely to bring the subject up themselves, so it is up to physicians and their health care staff to ensure that the appropriate patient base is tested. Girls who are sexually active in their teens may be even more susceptible to infection because their cervix has not matured.

The CDC recommends an annual chlamydia screening for all women who may be at risk. The at-risk group includes sexually active women who:

- Are under 25 years old
- Are pregnant
- Don’t consistently use barrier contraceptives
- Have signs of a possible cervical infection
- Have previously had an STD
- Are older women who have a new sexual partner or multiple partners

**If you are treating a woman who is under 25 years old and has had sex, she’s in the most at-risk group and should be screened for chlamydia.**
Clinical Guidelines on the Web

The Clinical Guidelines below are available at www.upmchealthplan.com. Select “For Providers” on the homepage and then “Medical Management” from the menu on the left. Next select “Clinical Guidelines” from the list. To view the Preventive Guidelines for children and adults, follow the steps above but scroll down the list until you see “Preventive Health Guidelines.”

Cardiology
- Adult Cholesterol Management
- Hypertension Management
- Heart Failure Guideline – Outpatient Management*
- Cardiovascular Risk Factors and Coronary Artery Disease

Diabetes
- Adult Diabetes
- Physical/Behavioral Health
- ADHD*
- Depression
- Substance Abuse and Dependence

Respiratory
- Asthma
- COPD

Women’s Health
- Prenatal Clinical Practice Guidelines
- Low Back Pain Quality Initiative
- Program Booklet
- Frequently Asked Questions
- Primary Care or First Contact Physician Algorithm
- Physical Therapists and Chiropractors Algorithm
- Workers’ Compensation: Primary Care or First Contact Physician Algorithm
- Workers’ Compensation: Physical Therapy and Chiropractic Algorithm
- Algorithm Legend
- Yellow Flags Form
- Revised Oswestry Low Back Pain Questionnaire
- Fear-Avoidance Beliefs Questionnaire
- Chiropractic Low Back Pain Summary Sheet
- PT Low Back Pain Summary Sheet

To request a hard copy of the clinical guidelines, call Provider Services at 1-866-918-1595.

*Includes recently updated information.
News from the *New England Journal of Medicine*

April 2, 2009
**Rehospitalization Among Patients in the Medicare Fee-for-Service Program**
Jencks S. F., Williams M. V., and Coleman E. A.
Reducing rates of rehospitalization has attracted attention from policymakers as a way to improve quality of care and reduce costs.

March 26, 2009
**Your Doctor's Office or the Internet? Two Paths to Personal Health Records**
Tang P. C. and Lee T. H.
As the baby boomers age and develop chronic diseases, the gap between patients' desire for information and physicians' ability to provide it is likely to increase. How will this gap be filled?

March 12, 2009
**Health Care 2009: Health Care and the American Recovery and Reinvestment Act**
Steinbrook R.
The economic impact of the American Recovery and Reinvestment Act of 2009 will not be apparent for months. Nonetheless, the bill’s approval — even before any new senior officials of the Department of Health and Human Services (DHHS) were in place — has jump-started the Obama administration’s plans for health care.

March 12, 2009
**The Growth of Hospitalists and the Changing Face of Primary Care**
Hamel M. B., Drazen J. M., and Epstein A. M.
Care by hospitalists has increased throughout the United States in small and large hospitals and in teaching and nonteaching institutions. In 2006, almost half of all hospitals and 84% of teaching hospitals had at least three hospitalists.

Feb. 26, 2009
**Health Care 2009: Slowing the Growth of Health Care Costs — Lessons from Regional Variation**
Fisher E. S., Bynum J. P., and Skinner J. S.
The expansion of health insurance coverage in the United States is likely to be on the front burner of health care reform efforts in the new presidential administration. But boiling on the back burner is perhaps the most serious threat to Americans’ access to care: rapid growth in health care costs.

Feb. 12, 2009
**Health Care 2009: Reforming Medicare’s Physician Payment System**
Wilenisky G. R.
This past July, after intense lobbying from physician groups, Congress once again stepped in to prevent physicians who provide care to Medicare patients from seeing a 4.5% reduction in their fees. Congress appropriately feared the potential problems with access to care that could result from such a fee reduction.

Jan. 22, 2009
**Health Care 2009: Great Expectations — The Obama Administration and Health Care Reform**
Oberlander J.
Health care reform is back. For the first time since 1993, momentum is building for policies that would move the United States toward universal health insurance. Groups long opposed to reform, including the insurance industry, are reportedly prepared to make a deal.

Jan. 15, 2009
**Visions for Change in U.S. Health Care — The Players and the Possibilities**
Iglehart J. K.
Under the incoming presidential administration, U.S. Democratic leaders are determined to achieve a long-elusive goal: securing “affordable, accessible health care for every single American,” as President-elect Barack Obama put it recently.
News from the *Journal of the American Medical Association*

April 8, 2009
**The Ethical Foundation of American Medicine: In Search of Social Justice**
Kirch D. and Vernon D.
Attention has once again turned to improving the cost and effectiveness of health care in the United States. While many have described the dysfunctional aspects of the U.S. health care system, the focus has prioritized issues of payment systems and delivery models over a fundamental underlying ethical conflict.

April 1, 2009
**Association Between Hospital-Reported Leapfrog Safe Practices Scores and Inpatient Mortality**
Kernisan L., Lee S., Boscardin J., Landefeld S., and Dudley A.
The Leapfrog Hospital Survey allows hospitals to self-report the steps they have taken toward implementing the Safe Practices for Better Healthcare endorsed by the National Quality Forum. The Leapfrog Group currently ranks hospital performance on the safe practices initiative by quartiles and presents this information to the public on its Web site.

April 1, 2009
**Quality, Transparency, and the U.S. Government**
Brook R.
Some solutions for producing a better health care system in the United States and abroad call for paying clinicians more for better performance. For this solution to work, valid and reliable measures of performance must be available.

March 11, 2009
**Setting the National Tobacco Control Agenda**
Leischow S.
President Obama’s recent comment that the White House will be smoke-free even if he continues to smoke and the report that cancer will surpass heart disease in 2010 as the leading cause of death in the world largely due to tobacco use are reminders that smoking — the leading preventable cause of death in the United States — remains a massive public health problem for this and future generations.

Feb. 11, 2009
**The Elusive Quest for Quality and Cost Savings in the Medicare Program**
Ayanian J.
Over the past 40 years, most physicians and hospitals have continued to receive regulated payments from Medicare with no limits on the volume of services provided and minimal oversight or coordination of care. In 2009, Medicare expenditures will exceed $400 billion, representing 13% of the federal budget and about one-fifth of all U.S. expenditures on health care.

Feb. 4, 2009
**Obesity and the Economy: From Crisis to Opportunity**
Ludwig D. and Pollack H.
Even in good economic times, obesity imposes great financial burden on society in the form of higher medical costs and lower worker productivity. The economic stimulus under consideration in Washington could help launch a comprehensive national obesity initiative with immediate public health benefits, while laying the foundations for economic well-being into the 21st century.

Feb. 4, 2009
**A Closer Look at the Economic Argument for Disease Prevention**
Woolf S.
Disease prevention has always been the preferred option for promoting health and reducing disease rates. For many, this health argument is reason enough to invest in prevention, economics aside. Others, citing scarce resources, advocate a careful assessment of the costs and savings associated with prevention.
Regardless of specialty or area of practice, if you see patients, you will probably encounter people who are involved in domestic violence situations. Asking someone if he or she is being physically abused is a very difficult thing to do. Many victims are not comfortable seeking help; they may even work very hard to keep the abuse private from everyone in their lives. You and your office staff are in a unique position to help because the healthcare setting is often the safest place for a patient to get help, especially if your staff knows how to screen for abuse and provide referrals.

Be on the lookout for the most common signs of domestic abuse, including:

- **Explanation inconsistent with injury.** Victims of abuse may hide the signs. If you suspect a patient is hiding the true source of his or her injury, you could say something like, “It’s been my experience that such an injury is usually not sustained by a fall down the stairs. Is there anything else you’d like to tell me?”

- **Old or untreated injuries.** A victim is assaulted an average of 35 times before notifying law enforcement. In an ongoing violent relationship, many nonlethal, nonemergency injuries may be sustained before the victim seeks medical attention.

- **Partner is controlling, unwilling to leave patient alone.** Often the abuser is the person who is bringing the victim to the emergency room or routine doctor visit and may appear to be caring and concerned, when in reality he or she is attempting to control the encounter and monitor the answers the patient gives. This is particularly true for pregnant women (25 percent of pregnant women are victims of abuse).

- **Strangulation.** All domestic abuse patients should be questioned about strangulation. Victims will normally not disclose this unless asked directly. Once the level of violence has escalated to strangulation, the victim is at greater risk for homicide.

Keep in mind that anyone in a relationship, regardless of gender, age, or size and strength can be a victim of domestic abuse. There are certain tactics to keep in mind when exploring this issue with a patient, including:

**Talk to the patient**
Ask open-ended, nonthreatening questions as a routine part of the assessment to keep the patient from feeling singled out. Some examples are: “Because family violence is a common problem, we ask all of our patients about it.” “Is there anything going on in your home that is causing you stress?” “I know you are here for your allergy shot, but I couldn’t help noticing the bruise on your arm.”

**Assure confidentiality**
Patients often worry that if they disclose abuse, the provider is obligated to notify law enforcement. Remind the patient of doctor-patient confidentiality. Often, patients require multiple encounters and familiarity with providers over a period of time before they will feel comfortable enough to disclose abuse.

**Be conscious of risk**
While it is optimal to screen for abuse during a short time alone with the patient, if you think that doing so would jeopardize the patient’s safety, then abandon attempts to screen for abuse at that time. Perhaps questioning can be conducted during routine follow-up phone calls.
Help your patients get all the benefits they can

If you have patients who are UPMC for You members (UPMC Health Plan’s Medical Assistance product) and who need to receive disability benefits, we can be a great help to them. The disability application process is complex and difficult, and fewer than 4 out of 10 applications are approved when initially filed. While it’s true that almost 70 percent of those denials are overturned, that process can take several years — and those people continue on without benefits while they wait. People who qualify may even receive added income from the Social Security Administration to help them meet the increased financial burden of dealing with a disability.

We work with Human Arc, an Ohio-based organization that specializes in governmental program eligibility and enrollment. UPMC for You members can receive no-cost assistance in applying for disability benefits.

Human Arc will help UPMC for You members with every step of the complicated application process, up to and including representation in the appeals process if the initial application is denied. Because Human Arc’s specialists are trained as nonlegal representatives, they can provide this assistance so patients and members don’t have to engage attorneys and incur out-of-pocket costs. For a family facing this challenge, this benefit is very valuable.

Please be aware that UPMC for You members have access to this no-cost service. If you believe your patients can benefit from help during the disability application process, please have them contact Human Arc at 1-866-569-5076.

Congratulations to Genesis Medical Associates/Northern Area Family Medicine

UPMC Health Plan takes great pleasure in congratulating Genesis Medical Associates/Northern Area Family Medicine for their commitment to providing quality care to UPMC Health Plan members. They are the #1 Primary Care Practice in the Partners Quality Incentive Rewards Program.

Practice management and staff were surprised and pleased that they were the top practice overall. It meant a lot to them that they were recognized for the hard work and quality care they provide to their patients as well as the strong relationships they have developed.
Early Periodic Screening Diagnosis and Treatment (EPSDT)

To a family with a disabled child, early intervention services are critically important. Such services provide individualized support to infants, toddlers, and young children with disabilities and their families. This support can often be embedded within learning opportunities that exist in the child’s typical routines, within the home and in community activities and education programs.

If you screen a child and suspect a problem, an EPSDT screen must be performed to determine treatment needs. If the child is younger than age 5 and is not receiving services at the time of screening, refer the child for services through CONNECT. CONNECT can be reached at 1-800-692-7288. CONNECT will determine appropriate eligibility for Early Intervention Program services. You also are responsible for:

- Contacting UPMC Health Plan’s Special Needs Department to inform them of your referral to CONNECT. This will allow us to perform our own information tracking.
- Developing a system that tracks treatment needs as they are identified and for ensuring that appropriate follow-up is pursued and reflected in the child’s medical record.
- Establishing a tracking system that provides information on compliance with EPSDT service provision requirements in the following areas:
  - Initial visit for newborns. The initial EPSDT screen should be the newborn physical exam in the hospital.
  - EPSDT screen and reporting of all screening results.
  - Diagnosis and/or treatment, or other referrals for children.
  - Other tracking activities include:
    Number of comprehensive screens (reported by age); hearing and vision examinations; dental screens; age appropriate screens; complete age appropriate immunizations; blood lead screens; prenatal care for teen mothers; provision of eyeglasses to those in need of them; dental sealants; newborn home visits; referral of very low birth weight babies to early intervention; referral of members under the age of 21 with elevated blood lead levels to early intervention; routine evaluation for iron deficiencies; and timely identification and treatment of asthma.

Did you know that you can read the current issues of Physician Partner on our website? Visit the e-Newsletter Center at www.upmchealthplan.com to read the entire Physician Partner newsletter or to sign up to receive any of our publications electronically.