Choosing Wisely® Identifies Most Overused Tests/Treatments

The American Board of Internal Medicine (ABIM) Foundation in collaboration with over a dozen medical specialty groups, the Consumer Reports Health Rating Center and a number of consumer partners has developed Choosing Wisely®. This program aims “to help physicians and patients engage in conversations about the overuse of tests and procedures and support physician efforts to help patients make smart and effective care choices.”

The ABIM encourages dialogue between physicians and patients to help patients choose care that is:

- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Truly necessary

Participating medical specialty organizations have promoted the “choose wisely” concept by identifying five tests or procedures commonly used in their fields whose necessity should be discussed to help patients make wise decisions about the most appropriate care based on their individual situation.

The medical specialty societies supporting the Choosing Wisely initiatives listed in this article include:

- American Academy of Allergy, Asthma & Immunology (AAAAI)
- American Academy of Family Physicians (AAFP)
- American College of Cardiology (ACC)
- American College of Physicians (ACP)
- American College of Radiology (ACR)
- American Society of Nuclear Cardiology (ASNC)

Additional specialty partners were added April 4, 2012, and published their lists in the Fall of 2012. Examples of the first 45 overused tests and treatments compiled by the specialty societies include, but are not limited to:

- Sinus CT scans and antibiotics for uncomplicated acute rhinosinusitis
- Diagnosing or managing asthma without spirometry
- Imaging for low back pain—unless certain “red flags” are present
- Pap smears in women younger than 21
- Routine preoperative chest radiography of any type unless patient have cardiopulmonary symptoms
- Stress cardiac imaging and coronary and other advanced imaging, indicated only in patients with symptoms or markers of high-risk

For more information about the Choosing Wisely initiative, visit ChoosingWisely.org.
New Gonorrhea Treatment Recommendations

All U.S. state governments require reporting a diagnosis of gonorrhea (*Neisseria gonorrhoeae* or *N. gonorrhoeae*) to the local and/or state Department of Health. In 2011, over 300,000 cases of gonorrhea were reported, rendering it the second most commonly reported infection. Gonorrhea can lower resistance to infection with HIV and is a major cause of pelvic inflammatory disease, ectopic pregnancy and infertility.

From penicillin in the 1940s to fluoroquinolones in 2007, *N. gonorrhoeae* has shown a remarkable propensity to develop antimicrobial resistance. The Gonococcal Isolate Surveillance Project (GISP) studied urethral *N. gonorrhoeae* isolates collected in the U.S. during 2006-2011 and found evidence of declining cefixime susceptibility. Results of the GISP have prompted the Centers for Disease Control and Prevention (CDC) to update the recommendations for treatment.

The goals of treatment of patients with gonorrhea are to limit transmission, prevent complications and slow emergence of antimicrobial resistance. For uncomplicated urogenital, anorectal and pharyngeal gonococcal infection, treat with:

- Combination therapy of ceftriaxone 250 mg in a single intramuscular dose and
  - Azithromycin 1 gram orally as a single dose or
  - Doxycycline 100 mg orally twice daily for 7 days

**NOTE:** The CDC no longer considers cefixime a first-line drug for the treatment of gonorrhea due to increasing minimum drug concentrations required to inhibit growth, as well as treatment failures. If cefixime is used as an alternative agent, then the patient should return in one week for a test-of-cure at the site of infection.

For persistent infection after treatment (treatment failure) with the recommended combination therapy regimen:

- Culture relevant clinical specimens and perform antimicrobial susceptibility testing of *N. gonorrhoeae isolates*. The laboratory should retain the isolate for possible further testing.

- Consult an infectious disease specialist, a STD/HIV Prevention Training Center ([www.nnptc.org](http://www.nnptc.org)) or the CDC (404.639.8659) for treatment advice, and report the case to the CDC within 24 hours of diagnosis.

For details, refer to:

CDC. *Update to CDC’s Sexually Transmitted Diseases Treatment Guidelines, 2010: Oral Cephalosporins No Longer a Recommended Treatment for Gonococcal Infections.* MMWR 2012;61(31):590-594.
Leapfrog Hospital Quality and Safety Survey

The Leapfrog Group Hospital Quality and Safety Survey was launched in 2001 to provide public reporting of quality and safety practices in U.S. hospitals. Leapfrog’s public reporting initiatives offer valuable benchmarking capabilities to hospitals, as well as providing consumers and purchasers of healthcare with the information they need on the quality and safety of their hospitals.

The Leapfrog Hospital Survey asks hospitals to voluntarily report on a dashboard of evidence-based process, structural and outcomes measures. Most of these measures are endorsed by the National Quality Forum and harmonized with the reporting requirements of regulatory bodies, such as The Joint Commission, CMS and others. However, Leapfrog is the only national organization to implement the measures and publicly report hospitals’ progress in meeting them.

Some facilities are still reluctant to complete the Leapfrog survey. It is important to consider the advantages of reporting to Leapfrog. Reporting demonstrates to purchasers and the general public that you are willing to disclose information to the public, to review your safety practices, and to identify opportunities for improvement.

New in the 2012 Leapfrog Survey:

- **Smooth Patient Scheduling**: Hospitals report on their use of operations management methods to smooth patient flow across all operating rooms that service inpatients, eliminating unnatural fluctuations in patient scheduling and resulting in more optimal scheduling of patient procedures. Hospitals that fully meet Leapfrog’s standard can document at least a 5% improvement in utilization across all units by the end of the first year — or at least a 10% improvement in utilization across all units by the end of the second year — or at least a 15% improvement in utilization across all units — or an average utilization of 85% or greater across those units post-implementation.

- **Patient Experience of Care Composite**: Hospitals report on their HCAHPS scores for Pain Management, Communication about Medicines, and Discharge Home. Leapfrog calculates a patient experience of care composite for each hospital. Hospitals that fully meet Leapfrog’s standard have received at least 91.7% of the possible scoring points on the bundle of three HCAHPS composite measures as determined by national data.

- **Magnet Status**: A hospital that reports to Leapfrog they have earned Magnet status through the American Nurses Credentialing Center automatically earns full credit for Safe Practice #9 Nursing Workforce. Magnet status is reported in its own column in the results file.

For more information go to Leapfrog’s website at [leapfroghospitalsurvey.org/about-the-survey/](http://leapfroghospitalsurvey.org/about-the-survey/).
Alcohol Screening and Brief Intervention in the Emergency Department

According to the American College of Emergency Physicians (ACEP), patients presenting to the emergency department (ED) represent the entire spectrum of alcohol-related problems, including drinkers “at-risk” for injury and illness, those presenting with “harmful/problem drinking” such as the impaired driver, all the way to those with signs and symptoms of alcohol dependence.

ACEP notes that multiple studies have demonstrated the efficacy of brief intervention in the ED. An ED visit offers a potential “teachable moment” due to the possible negative consequences associated with the event. Studies have shown that patients who are directly referred from the ED to alcohol treatment are more likely to keep their initial appointments.

ED DIRECT is an acronym that ACEP recommends to guide brief intervention in the ED:

- Empathy: Adopt a warm, reflective and understanding style. Avoid a blaming, confrontational or coercive style.

- Directness: Maintain eye contact and raise the subject, “I would like to take a few minutes to talk about your alcohol use.”

- Identify willingness to change:
  - “On a scale from 1-10 how ready are you to change your drinking patterns?”
  - If the response is 6 or less, then ask, “Why not less?”
  - If the response is greater than or equal to 7, then the patient is ready, move on to recommendations.
  - The response will help the physician to identify discrepancies and assist the patient to move along the continuum from ambivalence to change.

- Recommend action/advice:
  - All Patients: “We recommend that you never drive after drinking.”
  - At-Risk/Harmful Drinkers:
    - Statement of recommended drinking limits
    - Follow-up with your primary care physician
  - Screen positive, but unsure if dependent drinker:
    - Abstain from drinking, and refer for further assessment to social work, psychiatry or a specialized treatment facility or alcohol counselor.

- Dependent Drinkers:
  - Abstain from drinking and refer to a detoxification center, specialized alcohol treatment facility, Alcoholics Anonymous (AA) and primary care.

Elicit response: “How does this sound to you?” or “Where does this leave you?”

Clarify and confirm action:

- Possible clarification:
  - “We have just completed a screening test for a whole spectrum of alcohol problems that may lead to an increase risk of illness and injury. We are not attempting to label you as an ‘alcoholic.’ We are recommending what we know to be safe drinking limits. We want you to follow up with your primary care physician, just as we would with any patient who has screened positively for other health problems, such as high blood pressure or a high sugar level.”

- Possible confirmation:
  - “We are very concerned about your drinking. In the interest of your health (and family) we recommend immediate referral for further assessment and treatment. We know that cutting back or abstaining from alcohol is very difficult to do on your own. We would like to offer you help.”

- Telephone referral:
  - “Would you be willing to speak with a counselor, social worker, etc., now?”
  - “I’d like to call right now for an appointment or referral. What do you think?”

For more information visit:

- The ACEP website at [http://www.acep.org](http://www.acep.org)
SuperWell® Disease and Maternity Management Program

To assist members that are pregnant or those diagnosed with certain chronic diseases, we are offering the SuperWell Disease and Maternity Management Program. In addition to Maternity, this program is available for eligible members diagnosed with one or more of the following conditions:

- Heart failure
- Chronic obstructive pulmonary disease
- Diabetes
- Coronary artery disease
- Asthma
- Chronic pain conditions
- Depression

Because many of the above conditions coexist in the same individual, this program can provide the intensive support necessary to make your management more effective. Enrollment in the program provides structured education and support by specially trained Health Coaches. Patients benefit from routine monitoring, education on complication management and stresses the importance of following the prescribed treatment plan.

To enroll a patient into the SuperWell Disease and Maternity Management Program, call us at 800.861.4826.

Contacting Care Management

The Care Management department is available to address inquiries about utilization management functions, such as inpatient admissions, denials, appeals and referrals (including Behavioral Health services), Monday through Friday, excluding holidays, from 8:15 a.m. to 4:15 p.m. EST. Please refer to the phone numbers on the member’s ID card.

Case Management services are available to help coordinate care, provide information on community resources and provide patient education. Call 800.258.3175 for more information.

We Would Like to Hear from You

Do you have a comment or suggestion you would like to share with us? We are always interested in hearing from providers regarding our efforts to partner with you to provide the highest quality of care to our members. Contact the Clinical Quality Improvement (CQI) department at 800.586.4523, email us at ClinicalQuality@MedMutual.com, or write to us at the address listed to the right.
Sleep Deprivation and Healthcare

Sleep deprivation is defined as the percentage of workers reporting six or fewer hours of sleep per day. Over the last 25 years, the number of healthcare workers suffering from sleep deprivation and fatigue rose from 28% to 32%.

Healthcare workers may be scheduled for 10 to 12 hour shifts and/or off-shifts requiring their sleep to occur at irregular times that are often out of sync with normal circadian rhythms. This can lead to trouble falling asleep, shorter sleep duration and waking up frequently.

Lack of sleep is a topic that’s rarely included in healthcare education programs. Over 52% percent of night shift healthcare workers reported sleep duration under six hours per day. Chronic sleep deprivation can impair job performance and raise the risk for errors that can endanger patients and cause injuries to the healthcare worker.

Shift work and long work hours are associated with a growing number of health risks, including:
- Obesity
- Smoking
- Metabolic disturbances
- Mental disturbances
- 40% increased risk for breast cancer
- Adverse reproductive outcomes
- Cardiovascular, gastrointestinal, and musculoskeletal disorders
- Circadian disruption as a probable carcinogen

Shift work, long work hours and fatigue also have a financial impact, with an annual estimated cost to employers of $116 billion or $2,000 per employee. Factors affecting cost involve:
- Reduced productivity
- Increased healthcare and worker compensation costs
- Increased errors
- Worker attrition due to disability, death, and moving to jobs with less demanding work schedules
- Absenteeism

In recognition of the strong scientific evidence linking better sleep to reduced rates of disease, injury, disability and premature death, Healthy People 2020 and the Joint Commission have launched efforts to curb the negative effects of sleep deprivation. Recommendations include:
- Increase the proportion of healthcare workers who get 7 or more hours of sleep per day
- Increase the proportion of healthcare workers with sleep apnea who seek medical evaluation
- Reduce the rate of vehicular crashes attributed to drowsy driving
- Examine and improve work schedules, staffing, and hand-off processes
- Consider fatigue as a factor in all adverse events
- Involve staff in the design of their schedules
- Create and implement a fatigue management plan
- Educate staff about sleep and fatigue
- Support staff who work long shifts
- Encourage organizations that allow naps during the work shift to provide good sleep environments and adequate release from work responsibilities

For more information on this topic, including additional strategies for healthcare employers, managers, and workers, visit:
- [www.jointcommission.org/assets/1/18/S2-JQPS-11-07S-lockley.pdf](http://www.jointcommission.org/assets/1/18/S2-JQPS-11-07S-lockley.pdf)

Source: “Running on Empty: Fatigue and Healthcare Professionals” Claire C. Caruso, PhD, RN; © 2012 Public Information from NIOSH and Medscape, Posted: 08/02/2012
For Your Information

We remain committed to supplying providers with the programs, information and support needed to ensure the health and well-being of our members and the communities we serve. Access our website, Provider.MedMutual.com, for the following:

Our Provider site includes information regarding:
- Tools & Resources
- Products & Services
- Become a Network Provider
- Health & Wellness

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