MEDICAID HEDIS Quality of Care Performance Measurements

What is Medicaid HEDIS?

HEDIS (Health Plan Employer Data and Information Set) is the performance measurement system for health plans developed by the National Committee for Quality Assurance (NCQA). The NCQA is an organization which accredits health plans as well as other types of health care organizations. The number of NCQA accredited managed care plans now exceeds 330, covering three quarters of all HMO enrollees or roughly 45 million Americans. HEDIS data is collected by more than 90 percent of all health plans. Medicaid HEDIS is an adaptation of HEDIS 2.0/2.5 for use by health plans with Medicaid managed care programs. In 1997, Medicaid HEDIS was incorporated into HEDIS 3.0. Therefore, QUEST plans will report their HEDIS data for the 1998 fiscal year in HEDIS 3.0 format.

What is measured in Medicaid HEDIS?

Health plan performance related to the following seven (7) areas is measured:

- Membership;
- Utilization;
- Quality of Care;
- Access to Care;
- General Plan Management;
- Financial Performance; and
- Satisfaction with Care.

Health plan performance for membership, utilization, quality of care, and access measures are reported as tables. Membership and utilization measures relate to all members. Generally, quality of care measures apply to members continuously enrolled for 12 months with a maximum lapse in coverage of 30 days. Access to care measurements relate to the availability of services. Most general plan management measures require health plans to describe specific services.

Medicaid HEDIS specifies require 12 continuous months of enrollment with one lapse in coverage not to exceed 30 days for most of the quality of care measures. Therefore, the quality of care measures do not reflect the experience of a plan’s total membership, only that of members who met the definition of “continuously enrolled.”

Medicaid HEDIS cautions that data from health plans with “small numbers” for a measure may be of questionable statistical validity.

What are the Medicaid HEDIS measures being reported?

The QUEST plans reported a total of 37 mandatory measures. The collection of these measures is available from the Med-QUEST Division. This report will focus on the following twelve (12)
Benzamycin®
erythromycin benzoate/phenol Topical gel
Topical gel: erythromycin (3%), benzyl alcohol (1%
For Dermatological Use Only - Not for Ophthalmic Use.
Reconstitute before Dispensing
INDICATIONS AND USAGE
BENZAMycin® Topical Gel is indicated for the topical treatment of acne vulgaris.
CONTRAINDICATIONS
BENZAMycin® Topical Gel is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNINGS
Pseudomembranous colitis has been reported with nearly all antibacterial agents, including erythromycin, and may range in severity from mild diarrhea to severe colitis with life-threatening complications. Therefore, it is important to consider this diagnosis in patients who present with diarrhea following the administration of antibacterial agents.

PRECAUTIONS
General: For topical use only. Use for systemic therapy should be used with caution because of the potential for allergic reactions. The use of benzoyl peroxide with other topical acne agents should be avoided. The use of benzoyl peroxide with other topical acne agents should be avoided.

AIDS-related conditions have been reported with nearly all antibacterial agents, including erythromycin, and may range in severity from mild diarrhea to severe colitis with life-threatening complications. Therefore, it is important to consider this diagnosis in patients who present with diarrhea following the administration of antibacterial agents.

PROMPTLY REPORT ANY SUSPECTED CASE OF BACTERIAL COLITIS TO THE NEAREST FEDERAL OR STATE CLINICAL TRAIL SITE. DO NOT DISCONTINUE TREATMENT UNTIL THE CAUSE OF THE COLITIS HAS BEEN DETERMINED.

ADVERSE REACTIONS
In addition to the known reactions associated with the use of BENZAMycin® Topical Gel was approximately 3%. These were dryness and individual reactions.

The following additional adverse reactions on benzemia may be encountered: erythema, pruritus, burning sensations, urticaria, itching, dysesthesia, sensitivity, and irritation of the skin. Skin reactions, irritation, and sensitization of the skin have not been reported.

BENZAMycin® Topical Gel should be applied twice daily, morning and evening, or as directed by a physician. If treatment is started after the onset of infection, wash the skin with warm water and gently pat dry.

How Supplied and Dosing Directions:

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<th>Dose/No. Months</th>
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<tr>
<td>Low</td>
<td>Male/Female</td>
<td>1.0 grams</td>
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<td>Medium</td>
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<td>High</td>
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<td>0.25 grams</td>
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Prior to dispensing, tap until powder forms. Add an additional amount of ethyl alcohol (70%) to (in the mouth) and immediately wash to completely dissolve the erythromycin. Add the solution to about 3 ml of water and mix. BENZAMycin® Topical Gel should then be stored under refrigeration. Do not freeze. Place 3 months after the expiration date on the label.

NOTE: Prior to reconstitution. Store at room temperature between 15 and 30°C (59-86°F).

After reconstitution, store at room temperature between 15 and 30°C (59-86°F).


CONTRIBUTION TO THE TRANSMISSION OF INFECTION
BENZAMycin® Topical Gel is not effective for the treatment of acne vulgaris. The transmission of infection by the carrier state. BENZAMycin® Topical Gel should be stored under refrigeration.

REFERENCES:

DERMIX LABORATORIES, INC.
A Philips-Purdue, Inc. Company. Columbus, OH 43225
Rev. 2/99

What was measured?

measures which are key to assessing QUEST’s performance in providing quality care:

• Membership by Age and Sex;
• Childhood Immunization;
• Cervical Cancer Screening;
• Cesarean Section;
• Diabetic Retinal Exam;
• Inpatient Acute Hospital Care;
• Emergency Room Visits;
• Live Births;
• Mental Health and Chemical Dependency Services;
• Outpatient Drug Utilization;
• Low Birthweight; and
• Care Access: Utilization of Primary Care Providers by Children.

In addition, a description of how managed care is being provided by the QUEST medical plans is presented. The description includes four key programs in the delivery of managed care services:
• Case Management;
• Utilization Management;
• Referral Management; and
• Standards.

Overall, this report focuses primarily on data submitted by QUEST medical plans for fiscal 1997. However, Medicaid HEDIS data for fiscal 1996 is included, when available, to note changes in QUEST performance over time. HEDIS measures were reported in fiscal 1995 but have been excluded for comparison in most instances due to the following reasons:

• QUEST began on August 1, 1994. Therefore, fiscal 1995 for QUEST was only 11 months in duration;
• In the initial program of QUEST, there were many plans changes and significant confusion among providers as to which plan should be receiving and reporting a patient’s encounter data;
• Medicaid HEDIS measures were not available. Hence, the plans reported a combination of HEDIS 2.0/2.5 and specific state measures, which in many cases, were not directly comparable with Medicaid HEDIS measures.

What was measured?

The total number of unduplicated QUEST enrollees by age and sex, enrolled during any part of the report year from July 1, 1996 to June 30, 1997 was recorded.

How did QUEST perform?

Enrollment in QUEST decreased from an average monthly membership of 155,420 in fiscal 1996 to 134,830 in fiscal 1997. The QUEST population in fiscal 1997 was also younger. The mean age of QUEST members dropped to 20.1 years in fiscal 1997 from 21.3 years in fiscal 1996. QUEST members remain predominantly children and adult females. Approximately 56 percent of total membership were children under 20 years of age.
The age and sex distribution of a population for a given fiscal year can be summarized graphically by a “population pyramid.” A population pyramid displays the distribution of male and female members in different age-groups. Chart 1 shows QUEST’s population structure in fiscal 1997, as compared to Hawaii’s resident population in 1995. The QUEST population displays a skewed, classic “pyramid”, with a large proportion of younger people, fewer middle-aged people, and far fewer elderly people. There is also a disproportionate number of middle-aged women.

In contrast, the Hawaii resident population structure resembled a bulging “pillar.” This is a more mature population, with proportionately fewer young people (ages 0-24) contributing to the total. The middle-aged group (ages 25-54) is the dominant segment of this population structure while the near-elderly (ages 55-64) and elderly (ages 65 and over) appear rather significant before tapering off. The average age of Hawaii’s resident population in 1995 was 34.5 years of age. Additionally, there were 102 males per 100 females in the same population. In comparison, there were only 95.6 males per 100 females in the QUEST population in fiscal 1997.

**Childhood Immunization**

**Why is this important?**

Immunization in the first two years of life is accepted as one of the most effective public health measures in preventing serious illnesses such as whooping cough, polio, measles, and hepatitis B. Unfortunately, studies have shown that low-income children are less likely to receive timely and adequate immunizations. In 1990, the Centers for Disease Control (CDC) reported that less than 50% of low-income inner city children were fully immunized by age two.

**What was measured?**

The childhood immunization rate is the percentage of QUEST two-year olds who were enrolled in one plan for 12 months, and who had received appropriate immunizations by their second birthdays (A break in enrollment not to exceed 30 days was allowed).

**How did QUEST perform?**

QUEST did very well compared to the previous fiscal year and to rates reported in other studies. The Childhood Immunization Rate improved to 77.4 percent in fiscal 1997 from 62.5% in fiscal 1996. At this rate of improvement, QUEST should realize the “Healthy People 2000” goal of 90 percent Childhood Immunization Rate.

Recently, the NCQA released its first annual report on HEDIS measures, “The State of Managed Care Quality.” This report collected information, voluntarily submitted by over 330 health plans throughout the United States, which participated in the NCQA’s accreditation program. The NCQA reported that the national average rate of children who had received 4 DTP/DTaP (diphtheria-tetanus-pertussis), 3 polio (OPV/IPV), 1 MMR (measles-mumps-rubella), 1 Hib (H influenza type b), and 2 HepB (Hepatitis B) was 65.3% for the health plans which submitted data. Retrospective studies done in Hawaii on children entering kindergarten have shown that between 58-63% received the basic series by age 2.

**Cervical Cancer Screening**

**Why is this important?**

Nationally, more than 13,000 new cases of cervical cancer are diagnosed each year, and 4,800 women die of the disease annually.
Additionally, the rate of cervical cancer is typically higher among poor women and they are more likely to be diagnosed when the cancer is in advanced stages. Fortunately, cervical cancer is curable if detected early by regular check-ups and the use of the Papanicolaou (Pap) smear test. Thus, for Medicaid women, cervical cancer screening is very important and saves lives.

What was measured?
The cervical cancer screening rate is the percentage of women aged 16 to 64, enrolled in a medical plan for 12 months, who had at least one Pap smear during the past three years.

How did QUEST perform?
The QUEST medical plans did not report this measure in fiscal 1996. In fiscal 1995, the reported rate was 33.8 percent. This rate was for the first eleven (11) months of QUEST program and was reported by four (4) of the five (5) plans. Another shortcoming of the 1995 QUEST data was the plans did not have three years worth of data as required by the measure.

In fiscal 1997, the QUEST screening rate reported was 70.2 percent (women aged 16 to 64). This screening rate is compatible with a recently released NCQA study which reported a 70.4 percent national average for women aged 21 to 64 in participating health plans. The "Healthy People 2000" goal is to have 85 percent of all women receive a Pap smear every one to three years.

Chart 3
Cervical Cancer Screening Rates

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<tr>
<td>QUEST</td>
<td>33.8%</td>
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*Rate for 11 months and reported by 4 out of 5 QUEST plans.
1Women aged 16-64 years.
2Women aged 21-64 years.
NR: Not Reported.
Source: Med-QUEST and NCQA.

Cesarean Section
Why is this important?
Cesarean (C)-sections are among the most frequent surgical procedures performed in the United States and both mother and neonate have a greater chance of complications than with vaginal birth. A C-section is normally unnecessary if vaginal delivery of the baby does not pose a serious health risk to the infant or mother. Hospital and physician services associated with C-section deliveries are more costly than vaginal deliveries. Therefore, the rate of C-section deliveries is an indicator of appropriate clinical management and quality of care.

What was measured?
The C-section rate is the percentage of total QUEST deliveries resulting in live newborns which were C-section delivered in fiscal 1997.

How did QUEST perform?
The QUEST plans performed very well in this measure. In fiscal 1996 and fiscal 1997, the QUEST C-section rates were essentially unchanged at about 11 percent (see Chart 4). This rate is far lower than the NCQA’s national average of 20.6 percent, and the national fee-for-service (FFS) rate of 29.1 percent. QUEST’s fiscal 1996 and fiscal 1997 rates have actually exceeded the national health’s established C-section rate of 12-15 percent by the year 2000.

Diabetic Retinal Exam
Why is this important?
Diabetes mellitus affects about 6.5 percent of Hawaii’s population, and it is the leading cause of severe eye damage and adult blindness in the United States. However, blindness can be prevented if retinal changes are detected early, and treated appropriately with laser. Therefore, early intervention through effective screening is crucial in preserving the eye sight of individuals with diabetes.

What was measured?
This was an optional measure for QUEST plans. However, two of the larger medical plans submitted data on this measure for fiscal 1997. The diabetic eye exam rate is the percentage of plan members with diabetes aged 31 to 64 years who received an ophthalmoscopic eye exam in fiscal 1997. Members in the plan must be enrolled continuously during the reporting period (allowing for one break in service, not to exceed 30 days).

How did QUEST perform?
In this measure, QUEST out-performed both the NCQA’s national average and FFS rates (see Chart 5). The QUEST rate of 42.6 percent in fiscal 1997 indicates that the QUEST performance compares favorably with that of managed care in the private sector. QUEST plans did not report this measure in fiscal 1996.
Inpatient Acute Hospital Care

Why is this important?
The inpatient acute hospital care is one of the most costly expenses of a health plan. It is a measure of a plan's performance in managing patient care.

What was measured?
The total number of QUEST enrollees who received inpatient hospital care and the category of care they received (medical/surgical; maternity; and newborns) by age were measured. The total number of hospital days, days by category of care, and the average length of stay (ALOS) were also reported.

How did QUEST perform?
Compared with the previous fiscal year, there were fewer total days and fewer inpatient discharges. This was consistent with the decrease in enrollment. However, the total ALOS and the ALOS for each category of care remained essentially the same (see Chart 6). The QUEST ALOS for total acute inpatients was 3.3 days in fiscal 1997. In contrast, the latest available statewide and national ALOS reported by the Healthcare Association of Hawaii for acute care hospitals in 1995 were 6.5 days and 5.7 days respectively.

Emergency Room Visits

Why is this important?
The emergency room rate is a critical measure of appropriate utilization of health care because a visit to the emergency room is largely member initiated, and emergency room costs for non-emergency care are much higher than visits to PCPs. Historically, the higher emergency room utilization of Medicaid populations compared with the general public has been attributed to the inadequate access by Medicaid enrollees to other primary care options. By providing education to patients so that they will utilize emergency room services more appropriately and by improving access to primary care, managed care plans should be able to bring down emergency room rates.

What was measured?
This HEDIS measurement reports the total number of QUEST emergency room visits which did not result in inpatient stays. Each visit is counted once, regardless of the intensity of care required or the length of time spent.

How did QUEST perform?
Compared with the previous fiscal year, QUEST showed improvement. The total number of emergency room visits and the rate of emergency room utilization had both decreased. In fiscal 1997, the QUEST emergency room rate was 457.7 per 1,000 members. This rate is higher than the last available 1995 rates of 305.2 per 1,000 population statewide and the national rate of 380 per 1,000 population. We believe the emergency room rate for QUEST will decrease further in future as QUEST members become better educated on appropriate use of emergency room services and how to better access services through PCPs.

Live Births

Why is this important?
Medicaid has traditionally been a major payer for deliveries and newborn care. In the late 1980s, the federal government encouraged states to expand income eligibility for pregnant women and newborns because of studies which demonstrated savings of at least $3 in direct care for each dollar spent on care given to pregnant women. Thus, this HEDIS measure is important because it enumerates the deliveries covered by QUEST and the general health of the newborns after delivery.
What was measured?
The total number of live births (including separate counts of well newborns and complex newborns), the number of inpatient hospital days, and the average length of stay for women of different ages were reported.

How did QUEST perform?
The total number of QUEST deliveries resulting in live births decreased from 4,916 in fiscal 1996 to 4,065 in fiscal 1997. However, the average length of hospital stays for well newborns increased slightly from 1.44 days to 1.74 days, while that for complex cases decreased from 16.46 days to 15.46 days. We feel that the decrease in births can be explained by the decrease in QUEST enrollment. The increase in average length of stay for well newborns is consistent with the QUEST policy of allowing physicians and families to determine how long a healthy newborn and mother should remain in hospital.

Mental Health and Chemical Dependency Services

Why is this important?
Utilization of mental health and chemical dependency services is important because it is an indirect measure of a QUEST member’s ability to access these services. Beyond that, it measures the adequacy of the provider network established by a QUEST plan to provide appropriate mental health and chemical dependency services.

What was measured?
The utilization of mental health/chemical dependency services by age and sex was measured. The services are grouped into the following general categories—(1) members receiving any service; (2) inpatient hospital services; (3) day/night services, and (4) ambulatory services.

How did QUEST perform?
The actual number of mental health services provided decreased 9.6 percent between fiscal 1996 and fiscal 1997. Chart 8 shows the decrease was less significant as a percentage of members receiving services across the different categories of services. This is consistent with the decrease in overall QUEST enrollment count of six (6) percent. For chemical dependency services, the actual number of services dropped four (4) percent but the percentage of members who had received these services by different categories remained essentially unchanged.

In addition to the decrease in QUEST membership, the following factors should be considered in evaluating the decline in actual number of mental health and chemical dependency services:

- The benefit package for mental health and chemical dependency services was unlimited for the first eight (8) months of fiscal 1996 but limited to 30 inpatient hospital days and 24 hours of outpatient services in fiscal 1997;
- One QUEST plan reported encounters for 11 months instead of 12 months for fiscal 1997, thus the actual number of services provided should be higher;

Congestive Heart Failure

The American Heart Association says congestive heart failure (CHF) starts with the inability of the heart to pump out all of the blood that returns to it. The result:

- CHF is the most frequent cause of hospitalization for people 65 and older
- 50% of CHF patients die within 5 years of diagnosis
- From 1979 to 1993, CHF deaths increased almost 110 percent

©1997, American Heart Association
The processing of enrollment into the behavioral managed care plan for the seriously mentally ill (SMI) adults improved. Therefore, mental health services used by QUEST members in most need of mental health services were not being provided and reported by the QUEST plans. Instead, these services were being provided by the QUEST behavioral managed care plan for SMI adults.

**Outpatient Drug Utilization**

**Why is this important?**

This measure assists health plans and the Department to assess how cost effective the QUEST drug benefit is being administered.

**What is being measured?**

The total cost of prescription drugs, the average cost per member per month, the total number of prescriptions filled, and the average number of prescriptions filled per year for QUEST members of different ages are measured.

**How did QUEST perform?**

The total costs of QUEST drug benefits decreased by more than $6 million in fiscal 1997 compared with fiscal 1996. Cost per member per month decreased by 13.6 percent from $13.92 to $12.03. The total number and average number of prescriptions filled also decreased. Studies have shown that decreases in drug benefits, if done inappropriately, may be accompanied by increases in emergency room visits, mental health services, and inpatient hospital utilization. This did not happen in the QUEST program and thus, we feel the decreases in the drug benefit did not affect access to care, nor did it promote overutilization of more costly care. The inference is that the imposition of managed care provided needed control on drug utilization without denying access.

**Low Birthweight**

**Why is this important?**

In the United States, 263,000 low birthweight infants (weight less than 2,500 grams) are born annually. Low birthweight infants face higher risk for chronic and permanent disabilities, serious medical complications and illnesses, and death in infancy. Low-income women are typically at higher risk for having low birthweight infants. There are many factors which increase a woman’s risk of having a low birthweight infant. Some of the more common factors include smoking, poor nutrition, and chronic medical conditions. It is widely felt by the medical profession that the incidence of low birthweight can be decreased by improving access to appropriate, prenatal care.

**What was measured?**

The percentage of low birthweight (less than 2,500 grams) infants born during the fiscal year was measured using hospital discharge data or birth certificate data.

**How did QUEST perform?**

Although the number of low birthweight babies crept up slightly from fiscal 1996 to fiscal 1997, the QUEST rate is still very good and do not indicate that QUEST pregnant women have a higher rate of low birthweight infants compared to their peers in the state. Chart 10 shows that QUEST’s low birthweight rate of 5.8 percent in fiscal 1997 is lower than the overall state’s rate of 6.7 percent in 1996. We
believe QUEST is doing well in this measure and will continue to do so in the future with better monitoring and pre-natal care for members.

The QUEST low birthweight rate of 5.3% in fiscal 1996 was actually better than Kaiser Permanente Hawaii’s commercial plan rate of 5.4 percent\(^1\) in calendar year 1996. Kaiser Permanente Hawaii is ranked as one of the best managed care plans in the United States.

How did QUEST perform?

In fiscal 1997, the utilization of PCPs by QUEST children continued to improve. In fiscal 1996, QUEST’s rates for the different age categories exceeded 80 percent. The average utilization rate for all three age categories was about 83 percent (see Chart 11). In fiscal 1997, rates for the different age categories jumped to the high 80s and the average utilization for all three age groups jumped to 90 percent. The inference here is that QUEST children have excellent access to their PCPs.

Managed Care in Hawaii QUEST

In fiscal 1997, QUEST eligible persons were able to choose from five (5) QUEST medical plans. These QUEST plans are unique with five (5) different approaches to the delivery of medical care and five (5) different structures and organizational experiences. A summary description of the QUEST medical plans is as follows:

- **AlohaCare** is a plan formed by community health centers, and QUEST is its single line of business;
- **HMSA-QUEST** is a plan by a local, non-profit, mutual benefit society associated with Blue Cross/Blue Shield — with many commercial lines of business;
- **Kaiser Permanente QUEST** is a plan by a large, nationally affiliated, non-profit Health Maintenance Organization (HMO);
- **Queen’s Hawaii Care** is a plan by a local, non-profit health care system; and
- **Straub Care Quantum** is a plan by a local, for-profit health care system.

Kaiser Permanente QUEST and Straub Care Quantum can be described as “closed panel” health plans because the care they provide is largely performed by their staff physicians in their own clinics and facilities. AlohaCare, HMSA-QUEST, and Queen’s Hawaii Care are “open panel” health plans which contract with health care providers to provide care at various sites, largely, the providers’ offices and facilities.

Although each QUEST health plan operates differently, all of the plans utilize managed care concepts in the provision of health care to QUEST members. Four (4) key components which are critical to the delivery of care in managed care and how these programs are used by QUEST health plans will be briefly described.

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\(^1\)See Kaiser Permanente Hawaii’s 1997 Quality Report (page 11). Kaiser Permanente Hawaii recently received a four-star rating, and was ranked as the sixth best plan in the U.S. News & World Report’s annual appraisal of “America’s Top HMOs.”
AZELEX
(АЗЕЛАЙЦИКРИСТЫМ) 20%

DESCRIPTION: AZELEX® (azelaic acid cream) 20% contains azelaic acid, a naturally occurring saturated dicarboxylic acid. Structural Formula: 

H2OOC-(CH2)2-COOH

Chemical Name: 1,7-Hexanedicarboxylic acid, Empirical Formula: C13H20O4, Molecular Weight: 222.32

Active Ingredients: Each gram of AZELEX® cream contains azelaic acid (0.2 gm-20% w/w). Inactive Ingredients: Cetyl alcohol and cetyl palmitate and cocoyl betaines. PEG-5 pentyl glycerin, piroxyline and purified water. Benzoyl peroxide is present as a preservative.

CLINICAL PHARMACOLOGY: The exact mechanism of action of azelaic acid is not known. The following in vitro data are available, but their clinical significance is unknown. Azelaic acid has been shown to possess antimicrobial activity against Propionibacterium acnes and Staphylococcus epidermidis. The antimicrobial action may be attributed to inhibition of microbial cellular protein synthesis. A normalisation of keratinisation leading to an antiinflammatory effect of azelaic acid may also contribute to its clinical activity.Azelaic acid is a metabolite of lactic acid bacteria found in soil. Skin biopsy from human subjects treated with AZELEX® demonstrated a reduction in the thickness of the stratum corneum, a reduction in number and size of keratinized granules, and a reduction in the amount and distribution of filaggrin (a protein component of keratin) in epidermal layers. This is suggestive of the ability to decrease cornification formation.

PATIENTS AND PROFESSIONALS: Dermatologists may recommend AZELEX® to human skin in vivo, azelaic acid penetrate into the stratum corneum (approximately 3 to 5% of the applied dose) and other viable skin layers (up to 10% of the dose is found in the epidermis and dermis). Negligible cutaneous metabolism occurs after topical application. Approximately 4% of the topically applied azelaic acid is systemically absorbed. Azelaic acid is mainly excreted unchanged in the urine but undergoes some biotransformation to chain dicarboxylic acids. The observed half-lives in healthy subjects are approximately 45 minutes after oral dosing and 12 hours after topical dosing, indicating percutaneous absorption rate-limited kinetics. Azelaic acid is a dietary constituent (whole-grain cereals and animal products) and can be formed endogenously from biogenic dicarboxylic acids, metabolites of amino acids, and excretion of monocarboxylic acids. Endogenous plasma concentration (20 to 80 ng/mL) and urinary excretion (1 to 28 mg of azelaic acid) are highly dependent on dietary intake. After topical application in humans, plasma concentration and urinary excretion of azelaic acid are not significantly different from baseline levels. INDICATIONS AND USAGE: AZELEX® is indicated for the topical treatment of mild-to-moderate inflammatory acne vulgaris. CONTRAINDICATIONS: AZELEX® is contraindicated in individuals who have shown hypersensitivity to any of its components.

WARNINGS: AZELEX® is for dermatologic use only and not for ophthalmic use. There have been isolated reports of hypopigmentation after use of azelaic acid. Since azelaic acid has not been well studied in patients with dark complexion, these patients should be monitored for early signs of hypopigmentation. PRECAUTIONS: General: If sensitivity or severe irritation develop with the use of AZELEX® treatment should be discontinued and appropriate therapy instituted. Information for patients: For the treatment of acne vulgaris, patients should be instructed: 1. To use AZELEX® for the full prescribed treatment period. 2. To avoid the use of excessive dressings or wrappings. 3. To keep AZELEX® away from the mouth, eyes and other mucous membranes. If it does come in contact with the eyes, they should wash their eyes with large amounts of water and consult a physician if eye irritation persists. 4. If they have dark complexion, to report abnormal changes in skin color to their physician. 5. Due in part to the low pH of azelaic acid, temporary skin irritation (pruritus, burning, or stinging) may occur when AZELEX® is applied to broken or irritated skin, usually at the start of treatment. However, this irritation commonly subsides if treatment is continued. If it continues, AZELEX® should be applied only once-a-day, or the treatment should be stopped. 6. If histamine-like symptoms (e.g., flushing and nasal stuffiness) occur, patients should consult their physician. (See ADVERSE REACTIONS.) Carcinogenesis, mutagenesis, impairment of fertility: Azelaic acid is a human dietary component of a simple molecular structure that does not suggest carcinogenic potential, and it does not belong to a class of drugs for which there is a concern about carcinogenicity. Therefore, animal studies to evaluate carcinogenic potential with AZELEX® Cream were not deemed necessary. In a battery of tests (Ames assay, HGPRT test in Chinese hamster ovary cells, human lymphocyte test, dominant lethal assay in mice, azelaic acid and azelaic acid was found to be nonmutagenic.) Animal studies have shown no adverse effects on fertility. Pregnancy: Teratogenic Effects: Pregnancy Category B. Embryotoxic effects were observed in Segment I tests and Segment II studies with rats receiving 2500 mg/kg/day of azelaic acid. Similar effects were observed in Segment II studies in rabbits given 150 to 500 mg/kg/day and in monkeys given 500 mg/kg/day. The doses at which these effects were noted were outside the therapeutic range. No teratogenic effects were observed. In addition, there was no evidence of any fetal effects in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed. Nursing Mothers: Azelaic acid is excreted into human milk in minor amounts. How much azelaic acid is secreted into breast milk is not known. However, it is not likely to be of clinical significance. It is not known whether azelaic acid is absorbed systemically after oral administration of AZELEX® in humans. The extent of absorption is not known. The drug should be used during lactation only if the potential benefit justifies the potential risk to the infant.Pediatric Use: Safety and effectiveness in pediatric patients under 15 years of age have not been established.

ADVERSE REACTIONS: During U.S. clinical trials with AZELEX®, adverse reactions were generally mild and transient in nature. The most common adverse reactions occurring in approximately 1-5% of patients were pruritus, burning, stinging, and itching. Other adverse reactions such as erythema, dryness, rash, peeling, irritation, dermatitis, and contact dermatitis were reported in less than 1% of subjects. There is the potential for experiencing allergic reactions with use of AZELEX®. In patients using azelaic acid formulations, the following additional adverse experiences have been reported: urogenital burning, vaginal dryness, urinary frequency, shortness of breath, transient burning sensations, dyspepsia, nausea, vomiting, gastric pain, dermatitis, redness, changes in skin color, diarrhea, constipation, increased appetite, and facial swelling. Some patients have noted liver function tests abnormalities.

DOSAGE AND ADMINISTRATION: After the skin is thoroughly washed and patted dry, a thin film of AZELEX® should be gently but thoroughly massaged into the affected area twice daily, in the morning and evening. The hands should be washed following each application. The usual recommended dose of AZELEX® cream can vary from 1 gram to 2 grams on the severity of the acne. Improvement of the condition usually occurs in the majority of patients with inflammatory lesions within four weeks. HOW SUPPLIED: AZELEX® is supplied in collapsible tubes in a 30 gm size. 30 g—NDC 0023-8604-30. Note: Protect from freezing. Store between 15-30°C (59-86°F). Caution: Federal (U.S.) law prohibits dispensing without a prescription. Distributed under license. U.S. Patent No. 4,396,164.

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New Member Orientation/Education
What is it?
New member orientation/education are the activities performed by plans to educate and orient new members on the types of covered services and how to access those care services.

How do QUEST plans do this?
All QUEST plans send welcome packets of information including a member handbook, list of providers, summary of plan benefits, how a member can access care, and member rights and responsibilities. In addition, HMSA-QUEST conducts optional member orientation sessions; Kaiser Permanente QUEST has case management assistants and visiting nurses who work directly with new enrollees; Straub Care Quantum includes in its welcome packet the (800) number of its HMO Services personnel who can answer questions and assist members in obtaining services; Queen’s Hawaii Care issues quarterly member newsletters which features educational material as well as updated plan member services; AlohaCare uses its Member Services department to reinforce the programs in the Member Handbook. Also, all plans send out Early and Periodic Screening, Diagnosis and Treatment (EPSDT) information. (Under Federal EPSDT rules children are entitled to a broader range of Medicaid services than adults and it is required that parents receive information explaining EPSDT benefits).

Standards for Waiting Times
What are these?
Each plan sets its own standards for acceptable waiting times for the following:
1. Emergency care;
2. Urgent routine illness; and
3. Preventive and non-urgent routine care.

What are the standards used by the plans and how are they being monitored?
Although each plan sets its own standards for waiting times, all plans are generally in agreement that the standard waiting time are as follows:

1. Emergency care is immediately (within the same day);
2. Urgent routine illness is from 24 to 48 hours; and
3. Preventive and non-urgent routine care is from 24-48 hours to 6 weeks.

Plans monitor these standards by on-site visits to providers (Queen’s Hawaii Care and HMSA-QUEST), member surveys and appointment accessibility surveys (HMSA-QUEST), waiting time surveys (Straub Care Quantum), actual measurements (Kaiser Permanente QUEST), and member education on appropriate use of services (AlohaCare).

Quest Capitation History
When QUEST was initiated in August 1994, the premium savings associated with each enrolled member was approximately 6.4 percent lower than payments under the previous fee-for-service system. Chart 12 shows that more premium savings have been realized subsequently in fiscal 1996, fiscal 1997 and fiscal 1998, without compromising quality health care services to the QUEST population. Selected clinical measures reported under HEDIS guidelines have supported this contention. We believe much of the success is attributable to productivity gains and continuous quality improvements in both clinical and administrative areas of participating QUEST plans.

Towards the Millennium
The member’s freedom to choose a health plan has always been an important consideration in QUEST. As participating QUEST plans continue to mature in utilizing managed care concepts in the provision of services to the Medicaid population, they are continuously driven to improving and upgrading their services. The plans are fully aware of their similar product offerings, and that quality of service is the key determinant to winning consumer confidence. QUEST members are the primary beneficiaries of this competitive structure established by the State. The DHS, through its MedQUEST Division will continue in its efforts to monitor the quality of services offered by participating plans. The MQD is also exploring innovative ways to improve the delivery of health care services to the Medicaid population in Hawaii, currently not in QUEST.

As we move closer to the millennium, QUEST is working diligently to extend managed care services to more Medicaid recipients. We believe that managed care can effectively deliver to the Medicaid population, greater access to non-urgent and preventive health care services, and improvement in their general health status. The offering of long-term care services through a managed care setting is currently under consideration. Certain segments of Hawaii’s community view this as a viable, “high-value” alternative to the existing fee-for-service system. With each existing, and potential service offering, consumer protection will continue to remain a key pillar of QUEST’s efforts. And towards achieving this goal, QUEST will continue to use HEDIS measures to define quality of care services in a tangible, quantitative, and meaningful manner.