AHIP
America's Health Insurance Plans

Innovations in Chronic Care

A New Generation of Initiatives to Improve America's Health

AHIP
Center for Policy
and Research

Innovations in Chronic Care

A New Generation of Initiatives to Improve America's Health

America's Health Insurance Plans is a national association representing nearly 1,300 members providing health benefits to more than 200 million Americans. AHIP and its predecessor organizations have advocated on behalf of health insurance plans for more than six decades.

As the voice of America's health insurers, our goal is to advance a vibrant, private-public health care system, one characterized by consumer choice, product flexibility, and innovation. We support empowering consumers with the information they need to make health care decisions, promoting health care quality in partnership with health care providers, and expanding access to affordable health care coverage to all Americans.

AHIP's mission is to effectively advocate for a workable legislative and regulatory environment at the federal and state levels, one in which our members can advance their vision of a health care system that meets the needs of consumers, employers, and public purchasers.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

AHIP wishes to thank the staff who developed and implemented the chronic care initiatives described in this book. Their leadership, vision, and creativity are helping millions of Americans with chronic conditions live longer, healthier lives.

AHIP staff who contributed to this report include:

Ellen Bayer, Director, Special Projects
Karen Heath, Policy Analyst
Christelle Jang, Policy Analyst

Review editors include:

Carmella Bocchino
Mary Beth Donahue
Stephanie Kanwit
Jeff Lemieux
Susan Pisano
Jane Rooney

Design: Ted Lamoreaux

Jana Altieri
MVP Health Care
New York

Elise Anderson
Blue Shield of California
California

Andrew Baskin
Aetna
Connecticut

Charles Baumgart
Presbyterian Health Plan
New Mexico

Bobbi Berg
Blue Cross and Blue Shield of Illinois
Illinois

Andrew Bertagnolli
Kaiser Permanente
California

Holly Bode
Ovations
Washington, D.C.

Chase Braden
Humana Inc.
Kentucky

Karen Bray
Optima Health
Virginia

Diane Bridgeman
Blue Care Network of Michigan
Michigan

Stacy Brinkley
WellPoint, Inc.
Virginia

Deborah Chambers
MVP Health Care
New York

Jon Chastain
Humana Inc.
Kentucky

Heidi Deja
Blue Cross and Blue Shield of North Carolina
North Carolina

Susan Dezavelle
Presbyterian Health Plan
New Mexico

Ann Fleischauer
UnitedHealth Group
Minnesota

Jackie Flowers
BlueCross BlueShield of Tennessee
Tennessee

Thomas Foels
Independent Health Association
New York

Yrena Friedmann
Aetna
California

Kiran Ganda
Health Dialog
Massachusetts

Sabrina Girolami
Geisinger Health Plan
Pennsylvania

Jim Glauber
Neighborhood Health Plan
Massachusetts

Sheila Gould
HealthNow New York
New York

Catherine Grant
Tufts Health Plan
Massachusetts

Ellen Grant
HealthNow New York
New York

Sandy Harnden-Warwick
Sterling Life Insurance/ Olympic Health Management
Washington

David Herr
Rocky Mountain Health Plans
Colorado

Lynne Higgins
Great-West Healthcare
Colorado

Sam Ho
UnitedHealthcare
California

Lynda Karig Hohmann
HealthNow New York
New York

Amy Johnson
Medica
Minnesota

Regine Joly
Blue Cross and Blue Shield of Florida
Florida

Randall Krakauer
Aetna
Connecticut

Premila Kumar
Horizon Blue Cross Blue Shield of New Jersey
New Jersey

Judy Langley
Aetna
Pennsylvania

Karen Lloyd
HealthPartners
Minnesota

Ronald Maiorana
HIP Health Plan of New York
New York

David McCulloch
Group Health Cooperative
Washington

Geraldine McNamara
Blue Cross Blue Shield of Massachusetts
Massachusetts

Pamela Menard
Independent Health Association
New York

Melissa Merculief
Community Health Plan
Washington

Kenneth Mitchell
UnumProvident
Tennessee

Esther Nash
Independence Blue Cross
Pennsylvania

Patricia Neurohr
Highmark Blue Cross Blue Shield
Pennsylvania

Michael Norris
Great-West Healthcare
Colorado

Jenny DesVaux Oakes
Health Plan of Nevada
Nevada

Charles Payton
Health Net, Inc.
California

Richard Precord
Health Alliance Plan
Michigan

Nico Pronk
HealthPartners
Minnesota

Michael Reardon
CIGNA HealthCare
Connecticut

Mary Ann Roberts
Capital District Physicians' Health Plan, Inc.
New York

Carla Rosenkrans
Harvard Pilgrim Health Care
Massachusetts

Mary-Margaret Serfilippi
Blue Cross and Blue Shield of Florida
Florida

Lori Stephenson
Rocky Mountain Health Plans
Colorado

Mary Trieste
Empire BlueCross BlueShield
New York

Michael Voloudakis
Healthways
Tennessee

Lelis Welch
BlueCross BlueShield of Tennessee
Tennessee

Carol Wilhoit
Blue Cross and Blue Shield of Illinois
Illinois

Michelle Wong
Kaiser Permanente
California

William Wood
AMERIGROUP Corporation
Virginia

Meeting the Challenge of Chronic Care

By Karen Ignagni
President and CEO, America's Health Insurance Plans

At the core of health plans' 21st century chronic care programs is a powerful force that is as old as health care itself. It's the power of being connected to someone who cares—a nurse case manager, say, or a group of patients managing similar conditions. These crucial connections are helping patients become more actively engaged in their care than ever before so that they can make the most of the modern-day tools available to improve their health.

Anyone who has a chronic illness knows that managing it successfully is a major challenge – something that can be very hard to do alone, over time, without ongoing help. One of the measures of success in the health care system is how well we provide that help.

With more than 130 million Americans affected by chronic illnesses, much is at stake. At the personal level, the goal is to design and implement carefully targeted programs that meet the full spectrum of individual patients' needs, improving their quality of life and enabling them to maintain the highest possible level of self-sufficiency. At the societal level, the goal must be to continually improve the quality and effectiveness of chronic care initiatives in order to make the best possible use of the nation's health care dollars and to enhance the productivity and creativity of our population.

As you will see in this report, America's health insurance plans are working on many fronts to achieve these twin goals.

Health plans are uniquely positioned to initiate, refine, and sustain innovative programs to improve chronic care. As part of their ongoing quality improvement activities, health plans collect and assess population-wide data that make it possible to broadly measure progress and implement necessary programmatic changes. And they are particularly well-equipped to reach out to members with information and programs tailored to their specific needs.

The range of health plans' chronic care outreach initiatives is enormous. Here are just a few examples:

- A Colorado health plan offers a program to help members with cancer cope with their symptoms, reduce side effects from treatment, access health services, and find support groups and sources of financial assistance. Eighty-seven percent of members enrolled in the program in 2004 and 2005 said they were highly satisfied, and the rate of hospital readmissions for members discharged with cancer diagnoses fell by 17% from 2004 to 2005.

- A New York health plan provides members with chronic back pain information on effective strategies to reduce pain, and it gives members at highest risk of complications the opportunity to consult with nurses trained as health coaches. Coaches assess members' needs – such as losing weight or modifying work environments – and help them pursue goals to meet their needs. Surveys of program participants in 2005 found that the percent of members reporting their back pain as "none," "very mild," or "mild" increased from 28.2% upon enrollment to 44.3% one year later. The proportion of members reporting that their back pain did not interfere with work increased from 10.9% upon enrollment to 22.9% a year later.

- To increase life expectancies for members who have had heart attacks, a Michigan health plan's nurse case managers contact heart attack patients within seven days of their hospital discharge to verify that beta-blocker medications were prescribed. The health plan also offers ongoing case management to help heart attack patients develop care plans, access services such as smoking cessation and rehabilitation programs, and live healthy lifestyles. From 2004 to 2006, 100% of members who had heart attacks received beta-blockers within seven days of their hospital discharge.

- A California health plan offers a program to help members with complex conditions such as Lou Gehrig's disease, advanced cancer, and trauma complications live at home for as long as possible and avoid unnecessary emergencies. Nurses conduct home visits to assess members' needs and provide coaching to help them manage pain and other symptoms; follow physicians' treatment plans; learn about clinical trials; and plan for end-of-life care as needed. From 2003 to 2004, 89% of program participants said it had improved their quality of life.

We offer this report in the hope that readers will find it eye-opening and inspiring. And we hope that the initiatives described here will inspire replication. The chronic care innovations summarized in this report have one thing in common: *they work*. They are making life better for millions of Americans with chronic illnesses. AHIP and the health plans responsible for the success of these programs stand ready to work with everyone who is committed to expanding the horizons of chronic care.

FOREWORD

New Advances in Chronic Care: Improving Lives and Adding Value to the Health Care System

HEALTH PLANS ARE HELPING PEOPLE LIVE BETTER. Thanks to rapid advances in medical science, today Americans are living longer than ever with conditions that were virtually untreatable 50 years ago, from chronic pain to cancer and kidney disease. The goal of chronic care today is not only to keep people alive who suffer from chronic illnesses, but also to help them live better, with fewer symptoms, so that they can fully participate in and enjoy a wide range of activities.

Reaching this goal requires an emphasis on prevention, personal responsibility for healthy lifestyles, and early intervention to promote care strategies that are effective in improving quality of life.

Health insurance plans are taking on the challenge to improve the lives of patients with chronic conditions. The initiatives profiled in this book provide living evidence that health plans' chronic care strategies are working to improve health and enhance quality of life for millions of Americans.

HEALTH PLANS ARE USING A NEW GENERATION OF CHRONIC CARE STRATEGIES. Throughout their history, health insurance plans have been on the leading edge of efforts to encourage prevention and timely, evidence-based care for individuals with chronic conditions. What has changed is that health plans now have the tools and expertise to help physicians customize care strategies to individuals' unique needs.

Continuing in the spirit of innovation that drove early disease management efforts in the late 1980s and early 1990s, health plans are pursuing a new generation of chronic care initiatives that take personalized service to a new level. Today's chronic care innovations—which vary widely in design—reflect four interconnected trends:

Providing health coaching for behavior change. Offering members at high risk of complications the chance to work with health professionals—usually nurses—trained as health coaches to help them make the lifestyle changes needed to improve their health, understand and follow physicians' treatment plans, and address unmet health and social service needs.

Harnessing advancements in information technology. Using tools such as electronic medical records, new computer operating systems, electronic scales, and electronic registries to drive programs aimed at increasing individuals' use of effective care; coordinating medical, behavioral, and social services; and improving physician performance.

Caring for the whole person. Moving from a silo approach to chronic care that targeted individual diseases (i.e., with one program for asthma, one for diabetes, and one for depression) to a comprehensive strategy addressing the needs of each person as a whole. As part of this process, health plans' nurse case managers identify barriers—such as financial need, lack of transportation, untreated symptoms of depression, and inadequate social support—that can impede effective treatment, and they help members overcome these barriers.

Offering a continuum of care. Providing a full spectrum of services—ranging from wellness and prevention to acute, chronic, and end-of-life care—that can make a difference in the way patients think about their health conditions and improve health outcomes.

NEW TOOLS AND STRATEGIES HELP PATIENTS LIVE LONGER AND STAY HEALTHIER. Health plans are designing today's chronic care initiatives using the lessons learned over more than a decade of innovation, refinement, and technological change. Highly integrated health plans were the original pioneers in disease management.

With their long track record of implementing preventive care programs to address public health priorities such as immunization, mammography, and Pap testing, health plans were able to apply valuable lessons learned about outreach strategies that work, about incentives that encourage healthy lifestyle changes and use of effective treatments, and about how to track individuals' progress in obtaining recommended care.

Today's health insurers have the information and communication tools they need to promote early intervention, interaction with practitioners and patients, delivery of appropriate treatments and services, and ongoing monitoring of patient progress to help people live longer, healthier lives.

CHRONIC CARE IS BECOMING MORE CUSTOMIZED. Consistent with our community's longstanding tradition of continuous quality improvement, health plans have built upon and modified past chronic care models to overcome implementation challenges and meet consumers' changing needs.

The groundbreaking disease management programs of the 1990s took a unified, population-based approach. For example, a program would seek to identify everyone in a covered workforce who had diabetes and then offer educational materials and services to help manage the disease.

While this wide-angle strategy clearly has merit, its impact in some cases has been difficult to measure and convey to employers hoping to see quantifiable returns on investment in the short term.

The solution to that challenge—a solution increasingly within the capabilities of health plans and their information technologies—is to assess the covered population for potential risk of disease, identify the severity of individual illnesses, and offer a multi-dimensional program based on individuals' risk of complications.

In such a program, for example, a person who is taking asthma medications regularly and who has not had asthma-related emergencies would receive annual reminders to have flu shots and quarterly asthma newsletters, and he or she would have access to a toll-free number that could be used to contact a nurse with questions or concerns.

By contrast, someone who has experienced severe asthma symptoms leading to multiple trips to the emergency room in the past year would have an additional option: regular phone consultations with a nurse case manager who could help him or her understand the condition, use effective medications to prevent symptoms, obtain transportation to doctor visits as needed, and modify his or her home environment to minimize factors that irritate the condition (e.g., dust, pet hair).

Individuals suffering from depression as well as asthma who have used the emergency room as a regular source of care, who lack social support, and who have financial needs that make it difficult to access medical

and behavioral health services would be paired with nurses and social workers who could provide a more intensive level of case management.

In these situations, case managers would develop action plans to address all of members' unmet needs; would consult with them frequently by phone and in person as needed; and would link them with physicians, behavioral health specialists, support groups, and sources of financial assistance to ensure that they could access services in a timely manner.

These multi-dimensional approaches, in which health plans focus the most intensive resources in the areas of greatest need, are making it possible to demonstrate the value of chronic care initiatives to consumers and those who pay for their care.

CHRONIC CARE PROGRAMS ARE INCREASINGLY FORWARD-LOOKING. The early disease management initiatives often were triggered when individuals experienced major health care events, such as a heart attack or an extended hospital stay due to complications from diabetes. Health plans would receive a claim for the hospital visit and follow up with the member to provide information and services.

While these approaches continue to produce positive results, health plans now have improved data capabilities that allow them to identify and address needs on a prospective basis, before someone requires hospitalization. Today health plans are using new software tools and "predictive modeling" techniques to evaluate members' patterns of health care use on a regular basis to determine which members are most likely to experience serious complications or fail to obtain follow-up care as prescribed.

Based on this information, health plans' nurse case managers reach out to individuals most at risk; for example, members with diabetes who have not seen their primary care physicians in several years and who are not having regular eye and foot exams as recommended. During these conversations, nurses help members take action to avoid complications such as blindness and foot infections.

RESULTS OF FIRST-GENERATION CHRONIC CARE PROGRAMS WERE IMPRESSIVE. Even as chronic care programs and techniques have advanced, the evidence emerging from peer-reviewed research on first-generation chronic care programs increasingly shows that these programs have been successful in improving individuals' health, increasing use of recommended treatments, and reducing unnecessary emergencies and hospital stays.

- A 2004 study of more than 40,000 individuals with diabetes found that health plan members participating in a diabetes care program in 10 sites throughout the country had significantly higher rates of dilated retinal exams, microalbumin tests, and cholesterol tests, and lower rates of tobacco use than did those in the control group. Program participants also used recommended medications (i.e., ACE inhibitors) at higher rates than those in the control group.[1]

- A study of nearly 5,000 health plan members with asthma found statistically significant improvements in the percent of individuals who took recommended controller medications and who received care from allergists or pulmonologists. At the same time, the number of emergency room visits per 1,000 declined by 32% over a one-year period, from 390 to 265, and the number of hospital admissions for the condition decreased by nearly 33% during the same time frame, from 89 per 1,000 to 60 per 1,000.[2]

- A review of nearly 70 published studies over an 11-year period on chronic care programs for individuals with asthma (of which more than half were randomized controlled trials) found that these programs were associated with: significant reductions in absenteeism from school or work in 88% of studies that measured these effects; significant reductions in asthma-related hospitalizations in 77% of studies that measured changes in hospital admissions; and significant declines in asthma-related emergency room visits in 83% of studies that evaluated programs' impact on emergency care.[3]

- A 1999-2001 study of more than 1,500 health plan members with Medicare or employer-sponsored coverage who participated in a chronic care program for heart failure found statistically significant improvements in use of recommended ACE inhibitor medications and increased rates of cholesterol testing compared with a baseline period. In addition, the number of emergency room admissions per thousand after the program's first year was 24.6% below the level prior to the program's implementation.[4]

- A 2002 study of more than 6,000 health plan members found that among those participating in a program for individuals with chronic obstructive pulmonary disease for more than 90 days from 1996-2000, the percent of individuals reporting breathing difficulties that interfered with their normal activities declined from 63% to 48%. The percent reporting night-time wakening with shortness of breath more than occasionally fell from 25% to 15%, and those who experienced wheezing more than occasionally decreased from 24% to 13%.[5]

NEXT-GENERATION PROGRAMS ARE BUILDING ON THE SUCCESS OF THE PAST. The success stories described in this report demonstrate that health insurance plans are building on the encouraging results of early innovations in chronic care with new programs that are exceeding expectations. Health plans' chronic care initiatives are making chronic conditions more manageable. They also are adding value to the health care system by promoting healthy behaviors and preventing unnecessary complications and health emergencies. They are useful tools that deserve to be studied, understood, and widely used.

For those interested in learning more about a specific initiative profiled here, contact information is provided. AHIP fully shares our member companies' commitment to the goal of making quality care more affordable and accessible throughout the United States, and we offer this report in that spirit and as a step toward that goal.

---

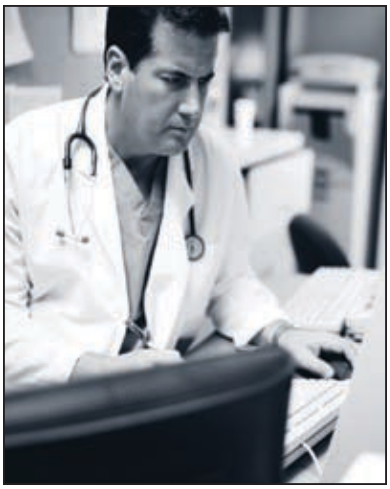
[1]Villagra, V., & Ahmed, T. (2004). Effectiveness of a disease management program for patients with diabetes. *Health Affairs.* 23(4): 255-266.

[2]National Committee for Quality Assurance (2002). *Asthma Disease Management: Removing Barriers to Optimal Care.* Washington, D.C.

[3]Gillespie, J. L. The value of disease management – Part 3. Balancing cost and quality in the treatment of asthma. *Disease Management.* 5(4): 225-232.

[4]Clarke, J., & Nash, D. (2002). The effectiveness of heart failure disease management: Initial findings from a comprehensive program. *Disease Management.* 5(4): 215-223.

[5]Zajac, B. (2002). Measuring outcomes of a chronic obstructive pulmonary disease management program *Disease Management.* 5(1): 9-23.



CHAPTER 1

Forging New Frontiers in Chronic Care

As purchasers in the public and private sectors continue to grapple with rising health care costs, they are recognizing that a broad array of chronic conditions—not just a few of the most common illnesses—contribute to these costs. As a result, AHIP members are pursuing new paths in chronic care to address major health issues such as obesity, migraines, cancer, depression and anxiety, chronic pain, hepatitis C, and osteoporosis. These initiatives are increasing members' energy levels, improving workplace productivity, and helping individuals live healthier lives.

At the same time that chronic care programs are showing impressive results in employer-sponsored health benefits programs, these initiatives are working to improve health care quality and reduce costs in Medicare and Medicaid. Health plans that participate in public programs are using a variety of strategies to promote physical fitness, improve health and functional status, and prevent unnecessary hospital admissions among beneficiaries. The profiles in this section illustrate the increasing diversity of chronic care programs, as well as their potential for continued expansion in the years ahead.

These initiatives are increasing members' energy levels, improving workplace productivity, and helping individuals live healthier lives.

Aetna
Connecticut

We want you to know® Aetna

Promoting Effective Migraine Relief to Boost Energy and Productivity

PROGRAM AT A GLANCE

Goal ▸ Enhance members' quality of life by promoting proven strategies to relieve migraine headaches.

Key Strategies

- Help members understand the causes of migraines and effective treatments.
- Increase physicians' awareness of migraine treatments that work and increase their use.
- Reduce unnecessary use of ineffective migraine-related treatments and procedures.
- Offer employers tools to promote women's health and effective migraine care in the workplace.

Results in Brief

A preliminary evaluation in April 2005 found that three quality-of-life measures had improved significantly since the program's nationwide launch in July 2004:

- how often headaches made members wish they could lie down;
- how often headaches made members too tired to work or perform activities of daily living; and
- how often headaches limited their ability to concentrate or perform their activities of daily living.

FROM CONCEPT TO ACTION

Helping Members Understand and Prevent Migraines

After hearing from plan sponsors that many of their employees were suffering from migraines that affected workplace productivity, Aetna conducted migraine management pilot programs in 2002 for HMO members in Metropolitan New York, Cincinnati and Northern Ohio, and Colorado. Aetna analyzed claims to identify members who had at least two emergency room visits, inpatient admissions, outpatient office visits, pharmacy claims or MRIs or CAT scans with diagnoses of migraines.

Informational Materials for Members

In the New York pilot, Aetna reached out to members with informational booklets on migraines; information on effective migraine medications; brochures on treatment strategies that can help prevent migraine emergencies (e.g., taking medications early in the headache process); information on how to obtain advice through Aetna's 24-hour nurse line; migraine "diaries" to help members track symptoms, conditions and activities associated with their migraines; and information on how to avoid "medication rebound," which occurs when migraine maintenance medications are not taken on time. The booklets and brochures encouraged members to discuss the migraine-related information with their doctors.

In the Ohio and Colorado pilots, Aetna sent each member identified as suffering from migraines an informational brochure and a questionnaire to assess his or her symptoms, frequency of migraines, knowledge, economic burden of the headaches, and satisfaction with migraine treatments.

Members who filled out the surveys were enrolled in the program. Members who indicated difficulties with symptom control, dissatisfaction with current treatment or other problems received additional information on treatment options and migraine diaries to track their symptoms and conditions that triggered migraines.

Each member enrolled in the program received a follow-up survey to assess changes in his or her symptoms in the past six months, frequency of migraines, knowledge, economic burden, and satisfaction with treatment.

Information for Physicians

As part of the New York pilot, Aetna provided copies of Glaxo SmithKline's "Migraine Matrix" to the primary care physicians of all members identified for the program and to all neurologists in its network. The Matrix provided a note-card summary of best practice clinical guidelines from the American Academy of Neurology and the American Headache Society on effective migraine treatment. Aetna also offered physicians the opportunity to attend a free continuing medical education (CME) class on migraine treatment.

In the Colorado and Ohio pilots, physicians received lists of their patients with migraines, along with copies of the informational brochure sent to members, copies of a white paper on migraine management and a CD-based CME program called "Customizing Migraine Treatment for Your Patient." In addition, physicians received summaries of patient responses to the questionnaire, so that they could address patient-specific issues such as unusual symptoms or increasing frequency of migraines.

Pilot Program Results

To evaluate the impact of the New York pilot, Aetna compared the use of MRIs (which are often overutilized in migraine care) and use of medications which are effective in migraine treatment during a six-month period (February-July 2003) after the pilot was implemented to these rates during a six-month period (February-July 2002) before the pilot's implementation. The rate of MRI use per 1,000 members with migraines after the pilot was 17 percent lower (1.59) than it was before the pilot (1.91). Conversely, the use of recommended migraine medications per 1,000 members was 13 percent higher after the pilot's implementation (20.96) than it was during a six-month period prior to the pilot (18.48).

In the Ohio and Colorado pilots, the percentage of members reporting that they were receiving timely relief from migraines was higher after completion of the program (71.1 percent) than at the beginning (67.2 percent). Members also reported greater ability to resume normal activities after completing the program than at the beginning (61.7 percent versus 55.7 percent), a reduced frequency of having three or more migraines per month (58.7 percent versus 62.3 percent), greater ability to recognize symptoms that trigger migraines (59.3 percent versus 51.6 percent), fewer days of missed work or school (51.0 percent versus 61.8 percent), less use of emergency room and urgent care services (12.2 percent versus 16.5 percent), and higher levels of satisfaction with migraine treatments (69 percent versus 61.2 percent). This information is based on an analysis conducted in November 2003.

Expanding to the Full Membership

To build on the pilot programs' results and to respond more effectively to the high prevalence of migraines among members, Aetna Pharmacy Management and Aetna Integrated Informatics launched a migraine management program for fully insured Aetna HMO and PPO plan members nationwide in July 2004. Aetna uses advanced methods of data analysis to identify members—based on their diagnoses, combinations of medications and prior use of services—who are most at risk for having emergency room visits for migraines within the next six months. Aetna offers members the opportunity to receive program information in Spanish, as well as the opportunity to opt out.

Information Packets, Nurse Hotline and Case Management for Members

Aetna sends members in the highest risk category packets with general information about migraines; headache diaries to track their symptoms and the conditions that lead to migraines; brochures discussing lifestyle changes that can help prevent migraines; and a toll-free number for a 24-hour nurse line they can call to obtain more information.

Nurses staffing the hotline ask members questions to determine if they could benefit from case management and if so, the nurses contact Aetna's regional case managers to arrange for follow-up calls. Case managers provide ongoing support, and they encourage members to take their medications as recommended, use their headache diaries to track symptoms and conditions leading to migraines, and avoid conditions that trigger headaches.

Workplace and Web-Based Resources for Women

In recognition of the fact that migraines occur disproportionately among women, Aetna developed workplace and Web-based resources on migraines for primarily female audiences. Aetna offers employers a health education program called Resources for Women, which they can use to promote women's health in the workplace.

The program, which is designed to be presented in the workplace by non-medical professionals, includes presentation materials, self-care guides, comprehensive information about migraines, and other tools (such as posters) to help raise employee awareness about the effects of migraines and the treatments available. The program is provided on CD-ROM with detailed instructions on how to print out all program materials.

Members can obtain additional information on migraines in the women's health section of Aetna's Web site—Women's Health Online (http://womenshealth.aetna.com). The site includes information on the phases, warning signs, risk factors (e.g., family history of migraines) and common issues (such as diet, stress, and hormonal changes) that can trigger migraines. The site also includes a migraine diary and action plan that members can download to record their symptoms and conditions associated with onset of migraines.

Combining Migraine Education and Outreach with More Comprehensive Strategies

This year, Aetna is making the migraine management program part of a more comprehensive initiative, the Aetna Health Connections Disease Management program. Through this initiative, members with migraines or any of 30 other chronic conditions who are at high risk of complications and meet the program's criteria (e.g., due to frequent emergency room visits or other indicators that their care may not be consistent with evidence-based best practices) are paired with nurses who serve as their primary contacts within the health plan. Nurses provide comprehensive support and information to members about their chronic conditions and any health risk factors associated with them.

Information for Physicians

As part of the program, Aetna sends physicians of patients identified as having the highest risk of emergency room visits copies of *Quick Guides*, based on clinical practice guidelines for migraines developed by the American Academy of Neurology and the American Headache Society. Also, the health plan provides these doctors with copies of a white paper on migraines (developed by participating physicians and Aetna's

medical director) that discusses effective diagnosis, treatment, and management of migraines. Physicians can also access the information from Aetna's secure physician Web site.

In addition to sending general information to physicians of patients at the highest risk, Aetna provides them with actionable information on individual members' use of the emergency room, migraine-related medications taken, and use of MRIs and CAT scans for migraines. Aetna encourages physicians to review the information and take action as needed in light of the clinical guidelines for migraine treatment.

Results

A preliminary evaluation of the nationwide migraine management program in April 2005 found statistically significant improvements in three measures of member quality of life: how often headaches made members wish they could lie down; how often headaches made members too tired to work or perform activities of daily living; and how often headaches limited their ability to concentrate or perform their activities of daily living.

The program did not have a statistically significant impact on medical costs. Aetna attributes this result to the low-intensity nature of the outreach conducted and is incorporating the program into the more comprehensive Aetna Health Connections Disease Management Program, as described above.

For more information, contact:

Yrena Friedmann, Pharm.D.
Director of Clinical Quality Management Programs
Aetna Pharmacy Management
6571 Windflower Drive
Carlsbad, CA 92009
(760) 804-7359
FriedmannYM@aetna.com

BlueCross BlueShield of Tennessee

Tennessee

Promoting Effective Care for Hepatitis C

PROGRAM AT A GLANCE

Goal ▸ Increase use of effective treatments for hepatitis C and avoid continued use of treatments that fail to improve members' health.

Key Strategies

- Help members understand effective treatments for hepatitis C and encourage them to take recommended medications.
- Offer support and suggestions to help members cope with the condition.
- Provide physicians with information on effective diagnosis and treatment strategies.

Results in Brief

Medication costs for hepatitis C treatments fell by $1.63 million in 2004.

FROM CONCEPT TO ACTION

Improving the Quality of Life for Members with Hepatitis C

Recognizing that many patients with hepatitis C were not taking medications as recommended and that others were continuing treatments that failed to improve their health, BlueCross BlueShield of Tennessee implemented a hepatitis C disease management program in 2001.

Identifying Members Who Can Benefit

On a monthly basis, BlueCross BlueShield of Tennessee analyzes pharmacy claims to identify members receiving prescriptions for hepatitis C treatment (e.g., Rebetron, Pegasys, Peg-Intron, or Infergen).

Nurses first call these members' prescribing physicians to verify their diagnoses and the dates they began treatment. At that time, nurses provide information to physicians about the benefits of conducting genotype blood tests for hepatitis C patients early in the treatment process. Genotype tests indicate the strain of hepatitis C that individuals have and help determine the recommended length of treatment. Typically, a course of treatment ranges from 24 to 48 weeks.

Two to three weeks after members have begun treatment, nurses call them to provide information about the disease, discuss possible medication side effects, emphasize the need to take medications as recommended, and offer ongoing information and support for the remainder of the treatment cycle. At the 12th week of treatment, nurses contact program participants' physicians to determine the results of viral load blood tests, which indicate whether medications are working as intended.

Also during the 12th week, nurses contact program participants by phone to ask a series of questions to assess their health status and determine whether they are taking medications as prescribed. Nurses also send members information about hepatitis C, refer them to Web-based information resources, and link them with support groups that can help them cope with the condition.

Nurses encourage members to complete the recommended course of treatment and offer suggestions on how to manage medication side effects, which can include fatigue, nausea, and depression.

If viral load tests indicate that members are not responding to medications, BlueCross BlueShield of Tennessee nurses contact their prescribing physicians, who can follow up as needed.

Results

- By helping to ensure that patients who are responding to medications continue taking them while at the same time helping avoid the continuation of medication regimens that are failing to improve patient health, BlueCross BlueShield of Tennessee reduced medication costs for hepatitis C treatments by $1.63 million in 2004.
- In 2006, BlueCross BlueShield of Tennessee created a new online system that allows members with hepatitis C to provide feedback on the program. The new system will make it possible for the health plan to evaluate the program's impact on quality of life and patient satisfaction.

For more information, contact:

Lelis Welch
Senior Manager, Utilization Management Program Development
BlueCross BlueShield of Tennessee
801 Pine Street, 4G
Chattanooga, TN 37402
(423) 535-7906
Lelis_Welch@BCBST.com

Jackie Flowers
Manager, Specialty Programs
BlueCross BlueShield of Tennessee
801 Pine Street, 1G
Chattanooga, TN 37402
(423) 535-7687
Jacqueline_Flowers@BCBST.com

Capital District Physicians' Health Plan, Inc.

New York

Making Fitness Fun to Help Children and Adults Lose Weight

PROGRAM AT A GLANCE

Goal ▸ Helpchildren and adults adopt healthy lifestyles to achieve and maintain healthy weight.

Key Strategies

- Promote healthy lifestyle choices and activities.
- Provide adults with interactive, Web-based tools to design customized weight loss plans and fitness programs.
- Offer children hands-on healthy cooking classes, backpacking opportunities, and nature hikes.
- Partner with Radio Disney's *Move It!* Program to offer incentives for children to engage in physical activity.

Results in Brief

- In 2006, 79% of adults responding to the health plan's survey about the program reported reductions in body mass index (BMI).
- On average, self-reported weight loss among adults surveyed about the program was 14.3% of total body weight.
- Fifty percent of members responding to a 2006 survey about children's experience with the program reported reductions in children's BMI measurements during the year.

FROM CONCEPT TO ACTION

New Initiatives to Overcome Obesity

To address the increased prevalence of obesity and its link to chronic conditions such as diabetes and heart disease, Capital District Physicians' Health Plan, Inc. (CDPHP) established the Weigh 2 Be℠ program for adults in 2003 and the KidPower℠ program for children ages 5 to 17 in 2004.

Weigh 2 Be℠

CDPHP promotes Weigh 2 Be℠ in all of its publications and on its Web site, as well as at community health fairs and worksite wellness programs. Physicians, inpatient care coordinators, member services representatives, and staff of the health plan's disease management and case management programs refer members to the program, and individuals can self-refer. The health plan also analyzes medical, lab, and pharmacy claims to identify members who could benefit. Based on these analyses and referrals, health educators and case management nurses contact members and offer the opportunity to enroll.

Upon enrollment, each participant receives a packet with information on stress management, fitness, and nutrition, along with a $65 rebate coupon for completing a 10-week WeightWatchers® program. In addition, members can access a variety of interactive fitness and weight loss tools on the CDPHP Web site. Program participants also can enter their weight and other measurements on the site to determine their BMIs, and they can calculate the number of calories they are consuming each day by entering information on their food and beverage intake.

CDPHP's health education classes guide members in the process of using written and online Weigh 2 Be℠ support materials for fitness and healthy nutrition. Also as part of the program, the health plan offers weight management classes, taught by nurse health educators and dieticians, that cover topics such as metabolism, fitness, healthy nutrition, and stress management. Fitness classes led by certified fitness instructors include aerobics, resist-a-ball for beginners, Pilates, and walking for fitness.

KidPower℠

To promote enrollment in KidPower,℠ CDPHP uses similar communication strategies as those used in Weigh 2 Be,℠ and it receives referrals to the program from physicians, member services staff, and disease and case management professionals. Parents also can refer their children.

Each child enrolled in KidPower℠ receives a backpack with items to promote healthy eating, including a book called *Trim Kids*. The book explains healthy nutrition, fitness, and behavior modification techniques. In addition, it includes stickers—color coded in red, yellow, and green— and a Stop Light refrigerator magnet board to help children identify foods that they should consume in small, medium, and large quantities. Information about Radio Disney's *Move It!* program, a Fast Food slide guide, and an offer to purchase a pedometer also are included in the backpack.

KidPower℠ classes include hands-on healthy cooking sessions, rock climbing, nature hikes, creative movement for children, and Pilates. Through Radio Disney's *Move It!* program, children receive cards for designating the types of physical activities they complete each day (e.g., jumping rope, dancing, riding a bicycle). Once they have recorded

a month's worth of activities, they can exchange the cards for collectible Disney pins at special events such as college basketball games, sailing regattas, or interactive performances that incorporate music, movement, and dance that are held throughout the region.

CDPHP tracks members' progress in Weigh 2 Be℠ and KidPower℠ by asking them to submit information on their height and weight upon enrollment and by surveying them annually about weight loss and other healthy lifestyle changes.

Personalized Service and Support for Members with Chronic Conditions

Health educators refer members participating in Weigh 2 Be℠ and KidPower℠ to the health plan's disease management programs and to case management nurses as needed. In addition, CDPHP's disease management and case management nurses often encourage members with chronic conditions such as heart failure, diabetes, hypertension, and asthma to participate in Weigh 2 Be℠ and KidPower℠ to improve their health and well-being.

Results

Weigh 2 Be℠

Among the approximately 1,200 adults responding to CDHP's 2006 survey about the program:

- Seventy-nine percent reported reductions in BMI measurements.
- Average reported weight loss was 14.3% of total body weight.
- Sixty-nine percent said they were satisfied with the program.

KidPower℠

As of December 2006, more than 700 children were enrolled in KidPower.℠

- Fifty percent of respondents to CDPHP's 2006 survey on KidPower℠ said that children's BMI measurements had declined during the year.
- Sixty-eight percent of children enrolled in the program said they were satisfied with it.

For more information, contact:

Mary Ann Roberts, R.N., B.S.Ed.
Health Educator
CDPHP
500 Patroon Creek Boulevard
Albany, NY 12206
(518) 641-3262
mroberts@cdphp.com

Empire BlueCross BlueShield
New York

Building Skills at Work Sites to Help Employees Maintain Healthy Weight

PROGRAM AT A GLANCE

Goal ▸ Help members develop skills for making the lifestyle choices needed to maintain healthy weight.

Key Strategies

- Conduct interactive group sessions at work sites that promote daily exercise and healthy eating.
- Offer employers suggestions for creating healthy work environments.

Results in Brief

Among employees participating in a 2004 pilot:

- Eighty-five percent said they had made at least two behavioral changes to help them live healthier lifestyles.
- Eighty-nine percent of program participants with body mass index measurements of 25 or more had lost weight.

FROM CONCEPT TO ACTION

Workplace Strategies to Promote Exercise and Healthy Diet

Recognizing that being overweight increases an individual's risk for developing a chronic condition, Empire BlueCross BlueShield created a work site wellness program called Healthy Weigh to Change in 2004. The program, which seeks to reduce the risks of chronic disease, provides classes led by registered dietitians, as well as Web- and phone-based resources to help members live healthy lifestyles.

The program is offered to Empire members regardless of their health status or body mass index (BMI). Empire implemented the program at work sites because most adults spend the majority of their waking hours at work, where they often face barriers to weight loss (e.g., sedentary work activities and the availability of unhealthy foods). The program helps members develop skills for making the lifestyle choices necessary to maintain healthy weight.

Tailored Programs to Meet Employee Needs

Before conducting classes at a work site, Empire shares detailed program information with the benefits department and confers with staff on scheduling preferences specific to employee needs and work hours. For example, Healthy Weigh to Change classes in a factory open 24 hours a day, seven days a week would be organized differently from those in a 9-to-5 work setting.

To promote program activities at work sites, Empire provides posters and holds kick-off events several weeks before classes begin. These events provide "meet-and-greet" opportunities for employees, so that they can speak with class instructors, review program materials, ask questions, and register for classes.

In addition, the kick-off provides an opportunity for instructors to learn about employee demographics and primary languages spoken so that they can tailor classes accordingly. For example, during one event, the instructor determined that approximately half of the employees signed up for classes spoke Spanish. Therefore, Empire provided a bilingual instructor.

Interactive Group Sessions and Follow-Up

Employees enrolled in Healthy Weigh to Change attend seven weekly, one-hour sessions taught by registered dietitians certified in adult weight management, along with a follow-up session several weeks later. Each class session includes a lecture, small group discussions, and a question-and-answer period. Instructors provide coaching and discuss strategies for meal planning, portion control, eating out, and snacking. *Walking Works*,© an initiative that follows the recommendations of the President's Council on Physical Fitness and Sports, is an integral component of the program.

During each session, instructors emphasize that daily exercise is the optimal way to promote wellness and maintain healthy weight. Employees receive binders with program content, homework assignments, and tools to track progress (e.g., activity logs, food diaries and sample menus to help with meal planning).

In addition, participants receive items related to class topics (e.g., a pedometer and water bottle to encourage walking, and an insulated lunch bag to encourage healthy eating at work), and they can access online tools through *Walking Works* to help them form walking groups for fitness. All program materials are available in Spanish.

To track participants' progress, the instructor records weight and body mass index at the beginning and end of the program and administers a "Healthy Habits Survey" that asks about nutrition and exercise. At the follow-up session, the instructor discusses individual progress, strategies to avoid "relapse" in weight gain, next steps, and resources to help employees maintain healthy weight. Upon completion of the classes and

Building Skills at Work Sites to Help Employees Maintain Healthy Weight (cont'd)

follow-up session, Empire sends each employer an aggregate summary of the group's progress, based on information collected at the program's beginning and end, along with suggested strategies to promote a healthy work environment (e.g., offering healthy food options in the cafeteria and in vending machines).

Additional Tools

Besides attending classes, all Empire members can access a variety of Web and phone-based resources with information on nutrition, exercise, and healthy lifestyles, including:

- *MyHealth* at www.empireblue.com, an online resource for health information, services, and tools, powered by WebMD;
- *24/7 NurseLine*, a toll-free phone line through which individuals can access information on more than 1,100 wellness-related topics in English and Spanish; and
- *The WebMD Learning Series*, a series of four-week, online programs that offer the opportunity to chat online with instructors about wellness issues.

Members may use these tools during and after the Healthy Weigh to Change program to help them achieve and maintain healthy lifestyles.

Results

Among the 52 employees who participated in the first pilot of Healthy Weigh to Change in 2004, 84% of participants attended at least five of the seven classes. One hundred percent of Spanish-speaking participants attended at least five classes.

At the conclusion of the series:

- Eighty-five percent of program participants said they had made at least two behavioral changes to help them live healthier lifestyles (e.g., modifying snacking and increasing exercise).
- Seventy-two percent of Spanish-speaking participants said they had adopted at least two healthy lifestyle changes (e.g., organizing lunch-time walking groups).
- Eighty-nine percent of program participants with body mass index measurements of 25 or more had lost weight.
- All English-speaking participants had lost an average of 3.2 pounds, and individuals with body mass index measurements of 25 or more had lost an average of 4.3 pounds.
- Spanish-speaking participants had lost an average of 5.6 pounds, and Spanish-speaking participants with body mass index measurements of 25 or more lost an average of 6.1 pounds.

For more information, contact:

Mary Trieste, B.S.N., R.N.
Director, Health Education
Empire BlueCross BlueShield
15 Metrotech Center
Brooklyn, NY 11201
(718) 312-4430
Mary.Trieste@Empireblue.com

Geisinger Health Plan
Pennsylvania

Taking a Proactive Approach to Osteoporosis Prevention

PROGRAM AT A GLANCE

Goal ▸ Identify members at risk of osteoporosis before symptoms develop and help them prevent the disease.

Key Strategies

- Contact members at risk of osteoporosis and provide information on how to prevent it.
- If individuals at high risk of the condition take medications with side effects potentially leading to bone fractures, coordinate with physicians to find safer alternatives.
- Contact primary care physicians regularly to discuss effective diagnosis and treatment of the disease.

Results in Brief

- From 2002 to 2003, the proportion of members at moderate and high risk of osteoporosis who had bone mineral density tests increased from 51% to 67%. These rates held steady for two additional years.

FROM CONCEPT TO ACTION

Promoting Early Screening and Treatment

Based on the success of a pilot program that one of its participating rheumatologists implemented in the late 1990s to increase screening and treatment for osteoporosis, Geisinger Health Plan (GHP) developed an osteoporosis prevention and treatment program in 2002. The health plan analyzes claims on a monthly basis and develops lists of individuals whose demographic characteristics and medical histories place them at risk of osteoporosis. Geisinger staff involved with the health plan's other disease management initiatives also are trained to recognize risk factors for osteoporosis and can enroll members in the program.

Women are at risk of osteoporosis if they: weigh less than 127 pounds; smoke; have had fractures and are over age 45 and/or have family members in this age group who have had fractures; have been on steroid medications for more than three months; and/or have lost more than 1 ½ inches of height. Men are at risk if they: have been on steroid medications for more than three months, have had hormone therapy, radiation therapy, or surgical treatments for prostate cancer; have had fractures and are over age 45; and/or have lost more than 1½ inches of height.

Individuals at high risk of osteoporosis include: women over age 45 who have had bone fractures; women under age 45 who take steroid medications for chronic conditions; men over age 70 who have had bone fractures; and men under age 70 who take steroid medications for chronic conditions.

Providing Personalized Outreach

To promote timely diagnosis and treatment of osteoporosis, registered nurse case managers contact members at risk of the condition by phone or arrange office visits to provide them with key information about prevention and treatment. During these phone calls and meetings, case managers explain risk factors for osteoporosis; discuss ways to prevent the condition (e.g., increasing calcium intake, quitting smoking, exercising regularly, making home modifications to prevent falls); and discuss the benefits of bone mineral density testing and medications for osteoporosis.

If members are at high risk for the condition, nurses review their prescriptions to avoid the use of medications that could increase the risk of falls and provide extended case management follow-up as needed.

Case managers working with members at high risk provide a variety of services to promote effective treatment and reduce the risk of falling. For example, if case managers find that members are taking medications that could lead to cognitive impairment or loss of balance, they follow up with their physicians to identify safer alternatives.

If members are experiencing side effects from medications, case managers contact their physicians to discuss possible changes in doses or prescriptions.

Case managers work with pharmacy assistance programs as needed to help low-income members obtain recommended medications. They may coordinate with Area Agencies on Aging (AAAs) to conduct home safety inspections to identify items that could lead to falls, and they can help arrange for transportation to doctor visits.

Case managers generally contact members at high risk of complications at least once a month for the first three months and on a quarterly basis for the remainder of the year. Subsequently, in the absence of adverse events (e.g., falls, reactions to medications), case managers contact members every four to six months to check on their health

status. Contacts can be more frequent as needed.

Offering Information to Physicians on Evidence-Based Care

Besides working with members on an ongoing basis, Geisinger's disease management case managers maintain regular contact with primary care physician offices by phone, e-mail, and in person to discuss the needs of members with osteoporosis.

During these discussions, case managers emphasize the benefits of timely evaluation and treatment of the condition, suggest that they conduct bone mineral density testing and prescribe medications recommended for the condition, and direct them to Geisinger's Web site to review the health plan's clinical practice guideline for osteoporosis.

The guideline is based on data from the National Osteoporosis Foundation, the American Association of Clinical Endocrinologists, and the Surgeon General's Report on Bone Health and Osteoporosis.

Results

- From 2002 to 2003, the proportion of members at moderate and high risk for osteoporosis who had bone mineral density tests increased from 51% to 67%.
- The proportion of members with osteoporosis who were taking effective medications increased from 29% at the program's outset to 36% within six months of the program's implementation.
- These rates held steady for two additional years.

For more information, contact:

Sabrina Girolami
Director, Care Coordination
Geisinger Health Plan
100 North Academy Avenue
Danville, PA 17822
(570) 271-8763
sgirolami@thehealthplan.com

Great-West Healthcare
Colorado

Offering Support and Guidance For Members with Cancer

PROGRAM AT A GLANCE

Goal ▸ Help members with cancer cope with treatment, symptoms, and medication side effects and help them access medical, financial, and cancer support services.

Key Strategies

- Educate members about cancer.
- Suggest strategies to cope with pain and nausea.
- Help members obtain referrals to specialists, set up home treatments, order medical equipment, coordinate services for other health conditions, and arrange hospice care if needed.
- Provide emotional support to members and their families.
- Guide members to support groups and sources of financial assistance.

Results in Brief

- Eighty-seven percent of members enrolled in the program in 2004 and 2005 said they were "highly satisfied" with it.
- From 2004 to 2005, the rate of hospital readmissions for Great-West members who were discharged with cancer diagnoses fell by 17%, from .048 per 1,000 to .040 per 1,000.

FROM CONCEPT TO ACTION

Helping Cancer Patients Meet their Needs

In response to rising cancer rates among its members, along with increasing cancer treatment costs, Great-West Healthcare established an oncology management program for members age 18 and older in 2003.

To identify individuals who can benefit from the program, Great-West analyzes medical and pharmacy claims on a bi-monthly basis. Physicians, hospital staff, Great-West medical management and customer service staff, and employers refer members to the program, and individuals can self-refer.

Cancer nurse specialists then contact members by phone to describe the services available through the program and offer them the opportunity to participate. In addition, they follow up with members' oncologists to make them aware of the program's benefits and services.

Ongoing Support from Nurses

Once members are enrolled in the program, nurse care managers contact them by phone on a regular basis, often once a week and no less than once a month, to help address a variety of medical, social, and health-related issues. Individuals participating in the program can access care managers through a toll-free number any time to ask questions or discuss concerns.

During their phone conversations, nurses help members cope with issues they are experiencing during the time periods between scheduled doctor visits and medical procedures. For example, they offer support and suggest strategies for coping with pain and nausea.

If members feel that their pain and nausea are not being well controlled through medications, nurses contact their physicians to request adjustments as needed. Care managers discuss recommended diet and exercise routines and suggest options to reduce side effects from treatment. They also emphasize the importance of staying well hydrated and taking recommended medications.

Care managers can play a key role in coordinating members' care by helping them access services for other health conditions (e.g., depression and diabetes), obtaining referrals to specialists, making arrangements with specialty pharmacies to obtain medications at discounted rates, setting up home treatments, obtaining preauthorization for treatments and procedures, ordering medical equipment, and arranging for hospice care as needed.

To help members cope with the difficulties of living with cancer, care managers can guide members to support groups in their communities, and they can help them apply for financial assistance, for example, to help pay for medications.

Members remain in the program for an average of six to seven months. If they have questions or concerns about any health or benefit issue (including those unrelated to cancer) after being discharged from the program, they can continue to contact their nurse care managers, who can provide emotional support and assistance on an ongoing basis.

Offering Support and Guidance For Members with Cancer (cont'd)

Results

- From 2004 to 2005, the rate of hospital readmissions for Great-West members who were discharged with cancer diagnoses fell by 17%, from .048 to .040 per 1,000.
- The rate of hospital admissions due to cancer complications in 2004 was 60% below the health plan's projection (21% versus 35%).
- In contrast, Great-West members with cancer who were terminally ill spent an average of 33.4 days in hospice care in 2004, higher than the projected estimate of 20 days.
- Eighty-seven percent of members enrolled in the program in 2004 and 2005 said they were "highly satisfied" with it.

For more information, contact:

Lynne Higgins, R.N.
Director of Disease Management
Great-West Healthcare
8505 East Orchard Road, 2T1
Greenwood Village, CO 80111
(303) 737-2740
lynne.higgins@gwl.com

Michael Norris
Associate Vice President, Medical Outreach Programs
Great-West Healthcare
8505 East Orchard Road, 2T1
Greenwood Village, CO 80111
(303) 737-1050
michael.norris@gwl.com

HealthPartners
Minnesota

Giving Members Tools to Stay Fit and Maintain Healthy Weight

PROGRAM AT A GLANCE

Goal ▸ Help all members maintain healthy weight and help individuals who are obese lose weight.

Key Strategies

- Offer incentives and guidance to encourage all members to eat healthy diets and exercise regularly.
- Provide health coaching to help individuals who are obese lose weight.
- Offer additional coaching to members undergoing bariatric surgery, to help them understand the procedure and live healthy lifestyles before and after.

Results in Brief

From 2004 to 2005, members enrolled in one component of the initiative called "A Call to Change...Healthy Lifestyles, Healthy Weight"® lost an average of 13 pounds, or two body mass index (BMI) units, within a year of beginning the program.

FROM CONCEPT TO ACTION

A Suite of Programs to Address Obesity

To address the fact that nearly 60% of Minnesota residents are overweight or obese, HealthPartners launched the CareSpan Overweight and Obesity initiative in 2004. The initiative is comprised of four interrelated programs:

- The Frequent Fitness Program, to encourage members to join fitness facilities and exercise regularly;
- The 10,000 Steps® program, to promote moderate physical activity through walking;
- A Call to Change ... Healthy Lifestyles, Healthy Weight,® a course based on a series of phone consultations with dietitians and exercise specialists; and
- The Medically Supervised Weight Loss Surgery Program, to improve health and promote effective care for members undergoing bariatric surgery.

Members can sign up for the programs individually or in combination. The 10,000 Steps® program is available to all HealthPartners members. The Frequent Fitness program is open to all members age 18 and over, and up to two people per household can participate. The A Call to Change ... Healthy Lifestyles, Healthy Weight® phone course is available to members with body mass index measurements of 25 or more, and individuals are required to take the course as a condition of receiving coverage for weight loss medications. The Weight Loss Surgery Program is offered to individuals scheduled for bariatric surgery.

To identify members who can benefit from CareSpan programs, HealthPartners analyzes results of health risk assessment surveys and receives referrals from health care practitioners. Health plan staff (i.e., registered dietitians and exercise specialists) contact individuals based on this information and offer the opportunity to enroll. Individuals also can self-refer to most of the programs.

The Frequent Fitness Program

Members who join the Frequent Fitness program and exercise at participating gyms at least eight times per month receive $20 discounts on their monthly dues. Some fitness centers also reduce or waive their initiation fees for HealthPartners members.

10,000 Steps® Program

The 10,000 Steps® program encourages regular exercise through a combination of incentives and Web- or paper-based support tools. Members who join the program receive step-counting pedometers in the mail and are encouraged through e-mails or hard-copy tip sheets to walk at least 10,000 steps per day.

Individuals set their own goals and track their progress on personalized Web pages or in journals. They also receive suggestions on healthy meal planning and links to additional online health resources. Members who keep track of their steps are entered into drawings for prizes, such as gift certificates for local department stores.

HealthPartners offers a "Lose Weight" edition of 10,000 Steps® that provides additional tools, including a guide to healthy eating and instructions for muscle-conditioning exercises. Members can choose the program that best meets their needs.

A Call to Change ... Healthy Lifestyles, Healthy Weight®

Individuals identified through health risk assessments or by health care practitioners as having BMIs of 25 or greater have the option of joining the A Call to Change ... Healthy Lifestyles, Healthy Weight® phone course. Participants complete up to ten 20-minute scheduled phone calls with registered

Giving Members Tools to Stay Fit and Maintain Healthy Weight (cont'd)

dietitians and exercise specialists during which they develop personalized action plans for weight loss.

Members' phone calls with registered dietitians focus on healthy eating and weight loss, and their conversations with exercise specialists cover strategies for increasing physical activity and developing regular exercise programs. Depending on each individual's needs and preferences, either a registered dietitian or an exercise specialist serves as the member's primary counselor and provides additional information on managing stress, preventing relapse, and problem-solving to lose and maintain healthy weight.

Program participants use a variety of support tools, including food and activity logs, weekly weight charts, and action planners to track long- and short-term progress in meeting lifestyle goals. Counselors encourage individuals enrolled in A Call to Change ... Healthy Lifestyles, Healthy Weight® to participate in the 10,000 Steps® and Frequent Fitness programs on a long-term basis to help them maintain healthy weight.

Individuals typically are enrolled in the phone course for five to six months. Counselors follow up with members six months after they have completed the course to assess their progress and help them obtain additional assistance as needed. Individuals can continue to contact counselors with questions or concerns.

Medically Supervised Weight Loss Surgery Program

Members who are scheduled for bariatric surgery have the option of participating in the Medically Supervised Weight Loss Surgery Program, a modified version of the A Call to Change ... Healthy Lifestyles, Healthy Weight® phone course. The program helps individuals lose weight prior to surgery and provides additional information on the procedure's benefits, risks, and long-term impact on daily living. Members enrolled in the program have a series of regular phone consultations with registered dietitians and exercise specialists before and after surgery to discuss effective eating and exercise strategies.

Program participants have the option of receiving electronic scales so that they can weigh themselves daily and answer questions about their use of weight loss tools such as pedometers and food logs. Data entered into the scale are transmitted to the registered dietitians and exercise specialists serving as individuals' counselors.

Counselors review the information prior to scheduled phone calls and contact members as needed to address significant changes in weight and/or eating and exercise routines. Counselors also provide disease-specific information to help members access timely and effective care for conditions associated with obesity, such as diabetes, high cholesterol, and high blood pressure.

To ensure that members undergoing bariatric surgery receive high-quality care, HealthPartners created the Weight Loss Surgery (WLS) Network using a Centers of Excellence approach. As part of the program, the health plan contracts with six general hospitals and an academic medical center that adhere to evidence-based guidelines for effective care. To be included in the network, participating facilities must report annually on 42 data elements, including details on their surgical procedures, complication rates, and follow-up to assess individuals' health conditions and BMI measurements.

Results

From 2004 to 2005:

- Approximately 8,500 individuals were enrolled in the 10,000 Steps® program. More than 40% of individuals who completed the program increased their daily step counts by at least 10%. Participants who completed the Lose Weight edition of the program lost an average of 3.8 pounds.
- Members enrolled in A Call to Change ... Healthy Lifestyles, Healthy Weight® lost an average of 13 pounds, or 2 body mass index units, within a year of beginning the program.
- In 2004, HealthPartners received the U.S. Department of Health and Human Services Innovation in Prevention Award in recognition of the strategies and approach used in the 10,000 Steps® program.

For more information, contact:

Nico Pronk, Ph.D.
Vice President, Center for Health Promotion
HealthPartners
8100 34th Avenue South
Bloomington, MN 55425
(952) 967-6729
Nico.P.Pronk@HealthPartners.com

HealthPartners
Minnesota

Guiding Members with Depression to Effective Treatment

PROGRAM AT A GLANCE

Goal ▸ Ensurethat individuals with depression obtain care consistent with the medical evidence.

Key Strategies

- Help members with depression access care from behavioral health specialists.
- Remind individuals to refill prescriptions for antidepressants.
- Offer case management and health coaching to ensure that members at high risk of hospitalization follow prescribed treatment plans.
- Facilitate access to regular outpatient care for members with depression who are discharged from hospitals.
- Offer incentives and comparative data to promote physicians' use of best-practice guidelines for depression treatment.

Results in Brief

A 2006 comparison of health care use among individuals identified for the high-risk component of the program with that of individuals with similar conditions in a control group found that:

- Use of outpatient behavioral health services per 1,000 members was 7% higher.
- The number of inpatient days per 1,000 members was 22% less.
- The number of emergency room visits per 1,000 members for behavioral health conditions was 5% lower.

FROM CONCEPT TO ACTION

A Proactive Approach to Addressing Depression

To address the high prevalence of depression and its impact on members' well-being, HealthPartners created an integrated disease management and case management program for individuals with depression in 2003.

To identify members who can benefit from the program, HealthPartners analyzes medical and pharmacy claims, as well as responses to health risk assessments (HRAs). Based on this analysis, the health plan identifies members with depression and those at risk of developing the condition in the upcoming 12 months, and it provides information and services based on the severity and complexity of members' conditions. The services include health coaching, decision support, care coordination and information for self-management.

Information and Services Based on Risk Level

Linking Members with Treatment and Support Services

All members whose HRA responses indicate that they may be at risk of depression (e.g., if they indicate emotional concerns, engage in binge drinking, or have a history of depression) receive one or two phone calls from HealthPartners' social workers, psychiatric nurses, or psychologists. During these calls, behavioral health professionals ask members whether they have had frequent mood disturbances, changes in sleep or appetite patterns, and/or difficulties with concentration and productivity.

If individuals have experienced these symptoms, behavioral health staff encourage them to undergo clinical evaluations for depression, help them schedule appointments, and take action to ensure that they can keep their appointments (e.g., by finding practitioners with evening hours or with practice styles consistent with their preferences).

Program staff also link members with community agencies that provide behavioral health education, support groups, housing, and financial assistance as needed.

Web-Based Information

Each member with depression whose claims suggest a low risk of complications receives a one-time mailing listing a link to depression-related information on HealthPartners' Web site. The site includes a description of depression symptoms and treatment options, suggestions for healthy lifestyles, and an interactive self-quiz to identify symptoms of depression. If members score above a specified threshold on the quiz, they are encouraged to schedule appointments with behavioral health specialists, and they are directed to the online list of HealthPartners' participating behavioral health professionals.

Newsletters and Medication Reminders

To help prevent complications among individuals who are beginning treatment with antidepressants, HealthPartners

Guiding Members with Depression to Effective Treatment (cont'd)

offers a six-month information support and medication reminder program. With the consent of these members' health care practitioners, the health plan sends monthly newsletters with de-stigmatizing information about depression treatment, suggestions for healthy lifestyle changes such as improving diet and increasing exercise, and recommendations to contact physicians with questions about symptoms or side effects. In addition, HealthPartners sends each member enrolled in the program up to two prescription refill reminders per month. Members receive first reminders approximately 10 days before refill dates, and, if prescriptions remain unfilled, they receive second reminders five days later. Subsequently, if a member does not fill a prescription, HealthPartners notifies his or her prescribing physician for follow-up.

Case Management

Members at high risk of hospitalization within 12 months receive regular phone calls from psychologists, social workers, and psychiatric nurses trained as case managers. During these calls, case managers provide health coaching to help members follow treatment plans developed by their primary care practitioners and behavioral health specialists, and they help members understand how these plans relate to their personal goals.

For example, if a member's depression is interfering with her goal of obtaining a graduate degree, the coach may explain that attending group therapy and taking prescribed medications would improve her moods and increase her energy level so that she could complete the required coursework.

Case managers communicate with members' primary care and behavioral health care practitioners to coordinate care, and they link members with HealthPartners' other disease management programs (e.g., for coronary artery disease, diabetes) as needed.

The frequency of case managers' contact with members varies based on need and could range from several times per week to once a month. Individuals generally are enrolled in this component of the program for four to eight months.

Outpatient Support

To avoid unnecessary readmissions among individuals hospitalized for depression, the program seeks to promote ongoing outpatient care. When members are about to be released from hospitals, HealthPartners' behavioral health specialists obtain information about their discharge instructions and contact them by phone within three days of discharge to review the information. During these calls, behavioral health staff describe the importance of receiving ongoing behavioral health treatment, and they help members overcome barriers to outpatient care.

Recognizing and Rewarding Optimal Care

To encourage primary care physicians and behavioral health specialists in its network to follow best-practice guidelines for depression treatment developed by the Institute for Clinical Systems Improvement (ICSI), HealthPartners offers financial incentives in varying amounts, depending on practice size and patient volume.

Awards are based on health care practitioners' performance in documenting patients' diagnoses and their response to treatment; the proportion of their patients who remain on prescribed antidepressants for at least six months; and the extent to which they meet target goals for prescribing generic drugs.

Results

More than 130,000 HealthPartners members have received services through the program since its inception. A 2006 comparison of health care use among individuals identified for the high-risk component of the program with that of individuals with similar conditions in a control group found that:

- Use of outpatient behavioral health services per 1,000 members was 7% higher.
- The number of inpatient days per 1,000 members was 22% less.
- The number of emergency room visits per 1,000 members for behavioral health conditions was 5% lower.
- In 2006, the per-member, per-month cost of health care for individuals identified for the program was 22% lower than the cost of care for members with similar conditions in a control group. The program saved an estimated $3 million last year, and its return on investment was 5:1.

For more information, contact:

Karen D. Lloyd, Ph.D., L.P.
Senior Director, Behavioral Health Strategy
HealthPartners
8100 34th Avenue South
Mailstop: 21103M
Minneapolis, MN 55440
(952) 883-7162
Karen.d.lloyd@healthpartners.com

Health Net, Inc.
California

Providing House Calls and Round-the-Clock Physician Access to Seniors at Risk

PROGRAM AT A GLANCE

Goal ▸ Maintainfrequent, in-person contact with Medicare beneficiaries at high risk of medical complications to prevent unnecessary emergency room visits and hospital stays.

Key Strategies

- Conduct regular primary care visits in beneficiaries' homes, as well as in-person urgent and emergency-related visits as needed.
- Assess medications and home environments and make changes as needed to eliminate hazards.
- Provide each participating beneficiary with 24/7 access to his or her personal "home care physician."

Results in Brief

An analysis of the program's return on investment will be available in 2007.

FROM CONCEPT TO ACTION

The Senior Member Home Physician Program

Health Net established its Senior Member Home Physician Program in April 2005 to provide a higher level of personalized service for Medicare beneficiaries who are identified through claims analysis as having high use of or potential for emergency room and/or inpatient admissions within a one-year time frame. The program is offered to Health Net's Medicare Advantage members who are patients of two large physician groups in Northern California.

Health Net analyzes medical and pharmacy claims to identify potential candidates for the program. Primary care physicians, hospitalists, and case managers also may refer members to the program. Case managers contact members to confirm that they would benefit from the program and to offer them the opportunity to enroll. Beneficiaries are not required to be homebound to qualify.

Comprehensive Medical, Pharmacy, and Safety Evaluations

A home care physician (an internist, family practitioner, or geriatrician) visits the residence of each member newly enrolled in the program to conduct an extensive medical evaluation. The visiting physician also reviews the member's medications to identify duplication, potential drug interactions, and opportunities to use equally effective generic drugs.

Also during initial visits, physicians evaluate members' home environments to identify issues that represent potential hazards and recommend modifications. For example, if an individual has difficulty with balance, the visiting physician may recommend modifying the position of furniture with sharp edges and installing a bar to hold onto when getting into and out of the bath tub.

Routine House Calls and Twenty-Four Hour Access

Home care physicians make house calls to members once or twice a month for routine monitoring, and they make urgent and emergency-related visits as necessary. Members also can contact their doctors 24 hours a day, seven days a week, to address their needs.

Home physicians can order lab tests and X-rays, and they can initiate home-based respiratory and infusion services. If members receiving services through the program enter hospice care, they can continue receiving medical support and treatment from the same home physician. To maintain continuity of care, Health Net encourages members to continue seeing their primary care physicians (PCPs) as needed. Home care physicians send members' PCPs detailed reports on their visits.

Results

As of August 2006, 157 Medicare beneficiaries were enrolled in the program. Health care practitioners serving program participants have an average of 3.5 phone-based or in-person encounters per member per month. An analysis of the program's return on investment will be available in 2007.

For more information, contact:

Charles Payton, M.D., M.B.A.
Chief Medical Director
Health Net of California
21281 Burbank Boulevard, Suite LNR 426R
Woodland Hills, CA 91367
Mail Stop CA-900-04-16
(818) 676-5457
Charles.E.Payton@healthnet.com

Humana Inc. and Healthways

Kentucky and Tennessee

Giving Older Adults a New Way to Get Fit and Socialize

PROGRAM AT A GLANCE

Goal ▸ Increase exercise and improve health among Medicare beneficiaries.

Key Strategies

- Provide complimentary access to fitness centers, where beneficiaries can use exercise equipment and swimming pools and take group classes such as yoga, water aerobics, and weight training.
- Offer a self-directed walking program for beneficiaries who do not live near participating fitness centers.
- Hold potluck meals, holiday celebrations, and birthday parties at fitness centers for program participants.

Results in Brief

Surveys of program participants in Central Florida found that from 2004 to 2005:

- The percentage of individuals reporting "very good" or "excellent" health increased from 48% to 56%.
- Self-perceived health status (defined as "excellent," "very good," "fair," or "poor") improved for 67% of respondents.
- The percent of respondents who said they exercised less than once a week fell from 19% to 8%.

FROM CONCEPT TO ACTION

Promoting Physical Fitness among Medicare Beneficiaries

Because many of its elderly members have chronic conditions and face challenges maintaining healthy weight, Humana partnered with Healthways to provide the SilverSneakers® Fitness Program to Medicare Advantage members beginning in 2004. The program combines exercise with social support to promote healthy living.

The majority of Humana's Medicare Advantage members are eligible for SilverSneakers. To encourage enrollment, Healthways sends beneficiaries flyers and brochures that describe the program and list participating fitness centers near their homes.

After Healthways sends these mailings, member services staff contact beneficiaries by phone to offer the opportunity to participate. To sign up for SilverSneakers, beneficiaries visit participating fitness centers, where they complete enrollment forms, learn how to use exercise equipment, and receive information on exercise safety. SilverSneakers members have complimentary access to participating centers, where amenities typically include treadmills, weight machines, free weights, swimming pools, and indoor walking tracks. SilverSneakers members also can take a variety of group exercise classes tailored to the needs of older adults.

The SilverSneakers signature class focuses on muscle strength and range of movement, and other classes include activities such as yoga, water aerobics, and circuit-based weight training. All courses include multi-level conditioning exercises, which feature choreography geared to participants' fitness levels.

Individuals who do not live near partnering fitness centers can participate in SilverSneakers® Steps, a self-directed, pedometer-based physical activity program. Members can sign up for SilverSneakers Steps through the mail, by phone, or online. Program participants receive pedometers and activity logs to track their daily steps, and they are encouraged to report their progress to Healthways. Members also receive quarterly newsletters with articles that encourage physical activity and provide healthy recipes and tips for living a healthy lifestyle.

Social Support

Through their participation in SilverSneakers, members have the opportunity to attend a variety of special events, including potluck meals, holiday celebrations, and birthday parties. These events generally are held at participating fitness centers before or after SilverSneakers exercise classes. Through these events, members can develop and maintain friendships with other program participants and extend their social support networks.

To encourage participation in SilverSneakers, Humana provides fitness-related incentive gifts, such as water bottles, T-shirts, gym bags, towels, and sweatshirts. Members are eligible for the gifts if they visit fitness centers frequently and on a regular basis.

Giving Older Adults a New Way to Get Fit and Socialize (cont'd)

Results

As of December 2006, more than 125,000 Humana members were enrolled in SilverSneakers in 31 states, the District of Columbia, and Puerto Rico. Surveys of program participants in Central Florida found that from 2004 to 2005:

- Self-perceived health status (defined as "excellent," "very good," "good," "fair," or "poor") improved for 67% of respondents.
- The percentage of individuals reporting "very good" or "excellent" health increased from 48% to 56%.
- Among the 50% of respondents who reported losing weight, average weight loss was eight pounds.
- The percent of respondents who said they exercised less than once a week fell from 19% to 8%.
- In 2005, 47% of respondents reported eating more healthfully, and 37% reported increasing their social activities since joining the program in the previous year.

For more information, contact:

Jon Chastain
Finance Manager, Senior Segment
Humana Inc.
500 West Main Street
Louisville, KY 40202
(502) 580-2928
jchastain@humana.com

Michael Voloudakis, Ph.D., M.P.H.
Senior Analyst, Health and Economics Outcomes
Healthways
9280 S. Kyrene Road, #134
Tempe, AZ 85284
(480) 783-9555, ext. 414
Michael.Voloudakis@healthways.com

Kaiser Permanente
California

KAISER PERMANENTE®

Attacking Chronic Pain on Multiple Fronts

PROGRAM AT A GLANCE

Goal ▸ Ensurethat members with chronic pain receive effective care and avoid use of treatments that do not work or are harmful.

Key Strategies

- Promote use of treatment guidelines based on the medical evidence.
- Encourage approaches tailored to member needs, including cognitive behavioral therapy, relaxation and meditation, complementary and alternative medicine, psychiatric care, and coordination with chemical dependency services.
- Develop comprehensive care plans to address all of members' health conditions and offer health coaching to help members follow care plans.
- Offer primary care physicians continuing medical education on effective pain treatment.

Results in Brief

Analysis of the program's impact on members' functional status, health outcomes, and health care costs will be available in 2007.

FROM CONCEPT TO ACTION

Recognizing the Impact of Chronic Pain

In response to employers' concern about increased absenteeism and worker's compensation claims due to chronic pain and in light of evidence that individuals with the condition were not receiving effective care, Kaiser Permanente implemented a chronic pain management initiative in 2000.

The program's goal is to ensure that members with chronic pain receive treatment based on scientific evidence and to avoid use of treatments that are ineffective and/or harmful. Individuals served through the program have conditions such as chronic headache pain, nerve disorders (e.g., diabetic neuropathy, complications of HIV or shingles), back pain, or other painful bone or muscle conditions.

A Multidisciplinary Approach

In designing the program, Kaiser first convened a work group of physicians, physical therapists, psychologists, pharmacists, nurses, and osteopaths with expertise in chronic pain to develop clinical practice guidelines. Based on analysis of the scientific literature and results of health outcomes research, the group developed guidelines emphasizing a multidisciplinary approach to treatment, including physical therapy; prescribed medications; regular walking and stretching exercises; meditation and other stress management techniques; and psychotherapy for depression and/or anxiety.

Kaiser distributed the guidelines to medical directors in all of its regions, each of which developed implementation strategies tailored to member needs.

Reaching out to Members with Chronic Pain

Case Management and Cognitive Behavioral Therapy

In Southern California, primary care physicians refer patients with moderate to severe pain to a chronic pain program that provides case management and cognitive behavioral therapy. Nurse case managers contact program participants regularly by phone to discuss strategies for managing the condition effectively, such as changing sleep patterns, following exercise programs, moderating activity levels, addressing depression and anxiety, and/or changing medications. In addition, members attend 10 weekly sessions of cognitive behavioral therapy led by psychologists. Sessions focus on changing thought and behavior patterns associated with pain and using relaxation and meditation techniques effectively. Case managers check to ensure that members attend these sessions, and they help them overcome barriers (e.g., lack of transportation or child care) to participation.

Members with mild chronic pain have the option of attending health education classes that emphasize strategies such as improving relationships, obtaining treatment for depression or anxiety, improving sleep habits, and engaging in activities at a manageable pace to minimize pain.

Tailored Treatments and Information for Members and Physicians

In Northern California, Kaiser developed a registry to identify members with moderate to severe chronic pain, based on their diagnoses and use of health services (i.e., frequent physician visits, hospital admissions, and/or emergency room visits due to pain). Kaiser nurses contact these members' primary care physicians to describe the program and

encourage them to refer patients. Case managers call members referred to the program to assess their pain levels, describe the program, and offer the opportunity to enroll.

Upon joining the program, each member is evaluated by a care team comprised of a physician specializing in chronic pain treatment, a psychologist, and a physical therapist. Based on findings from the evaluation, the team develops a care plan for reducing pain.

The plan is shared with the member's primary care physician, who can incorporate it into a comprehensive strategy to address all of the member's health conditions. Physicians may adjust patients' medication regimens, and they provide supplemental pain treatments, such as therapeutic injections, as needed.

Through a series of regular phone consultations with members, case managers help members follow the care plan, for example, by suggesting effective pain management techniques or by providing referrals for acupuncture, psychiatric care, and other services to address factors contributing to pain. The frequency of case managers' contact with members varies based on need and may range from once a week to once every six months.

In addition to receiving case management services, program participants attend group sessions in which psychologists and physical therapists conduct cognitive behavioral therapy and provide guidance on pain management techniques such as relaxation and meditation.

Individuals with the most severe pain levels also have the opportunity to work with social workers, who can help them access a wide range of services, including chemical dependency treatment, acupuncture, and neurological evaluations.

To improve primary care physicians' performance in treating chronic pain effectively, Kaiser sponsors continuing medical education (CME) programs, inter-regional symposia, and presentations by chronic pain experts. Sessions focus on topics such as use of long-acting pain medications; warning signs of chemical dependency; and strategies for incorporating stretching, relaxation, and stress management in care plans for patients with chronic pain.

Complementary and Alternative Medicine

In the Mid-Atlantic region, California, and the Pacific Northwest, Kaiser's pain management initiative includes use of complementary and alternative medicine. Following evaluation by their primary care physicians, members receive referrals to programs that integrate biofeedback, acupuncture, and/or hypnosis in the treatment process.

Addressing Dual Diagnoses

In its Northwest region, Kaiser developed a program to address chronic pain associated with chemical dependency. Physicians and psychologists with expertise in chemical dependency meet regularly with members' primary care physicians and case managers to develop individualized care plans. Plans focus on coordinating services such as pain management, specialty mental health care, chemical dependency treatment, and social services needed to improve members' health and well-being.

Besides offering a variety of pain management services for members, Kaiser provides detailed information about chronic pain on its Web site (www.kp.org), where members can download pain diaries to track symptoms and record pain-related information to discuss with their physicians.

Results

Kaiser is currently evaluating the program's impact on patients' functional status, health outcomes, and health care costs and will release its findings in 2007.

For more information, contact:

Andrew Bertagnolli, Ph.D
Care Management Consultant
Care Management Institute
Kaiser Permanente
1 Kaiser Plaza, 16th Floor
Oakland, CA 94612
(510) 271-5771
Andrew.Bertagnolli@kp.org

Medica and United Behavioral Health

Minnesota

Providing Tips and Tools For Members with Depression

PROGRAM AT A GLANCE

Goal ▸ Promoteeffective treatment and reduce symptoms for members with depression.

Key Strategies

- Provide members with "tip sheets" on understanding depression, working effectively with therapists, and taking recommended medications.
- Offer health coaching to help members follow physicians' treatment plans and develop skills to avoid symptoms of depression.
- Conduct home visits as needed to help members overcome barriers to care, such as lack of transportation and child care.
- Give primary care physicians toll-free access to psychiatrists to confer about cases without identifying individual patients.

Results in Brief

Within three months of enrolling in the program in 2006, 52% of members at high risk of complications showed significant improvement in a survey measuring the frequency of their depression-related symptoms.

FROM CONCEPT TO ACTION

A Comprehensive Approach to Depression and Chronic Care

In light of strong evidence indicating that individuals with depression often have other chronic medical conditions, Medica partnered with United Behavioral Health (UBH) in 2004 to implement Health Advantage by Medica,® an integrated approach to depression treatment.

Medica and UBH identify individuals who can benefit from the program through claims analysis indicating diagnoses of depression, multiple chronic medical conditions and prescriptions for antidepressant medications.

Medica and UBH receive referrals to the program from therapists, employee assistance programs (EAPs), nurses staffing 24-hour advice lines, case managers from other chronic care programs, and customer service staff. Individuals also can self-refer. Upon identifying a member who could benefit, UBH sends a brochure with general information about the program, along with a post card that can be returned to Medica to learn more.

Assistance Tailored to Level of Risk

Based on claims analysis and information gained through an initial enrollment call to members who have indicated interest, Medica and UBH group members with depression into categories of "high," "moderate," or "low" based on the complexity of their conditions. Individuals are considered to be at high risk if they have a combination of medical and behavioral health conditions, such as cancer and chronic pain with a diagnosis of depression.

Educational Materials

Members who have enrolled in the program and are determined to be at low risk of complications and hospitalization receive welcome packets with general information on depression, as well as appointment and medication trackers to help them remember therapist visits and medication schedules.

Subsequently, members receive a series of "Tip Sheets" on a monthly basis on issues such as understanding depression, working effectively with therapists, recommended medications, healthy sleep habits, and exercise.

Health Advocates

Program participants at high or moderate risk of complications receive regular phone calls from nurses, social workers, or psychologists known as Health Advocates. During these calls, Health Advocates help members understand depression and overcome barriers to effective treatment. For example, they can arrange transportation to therapy appointments and set up medication reminder systems. Health Advocates also encourage members to talk with their primary care physicians (PCPs) about any medication side effects so that PCPs can adjust doses or prescriptions as needed.

In support of physicians' treatment plans, Health Advocates also help members improve life skills related to depression. For example, a member whose symptoms of depression increase as her schedule becomes more hectic may be encouraged to establish priorities, set limits, and learn communication skills to become more assertive.

Health Advocates also help members address gaps in their care. For example, if members are receiving medication monitoring services but are not working with therapists to address their depression, Health Advocates can help them find therapists to meet their needs. With members' consent, Health Advocates can contact therapists to convey concerns or discuss members' progress in the program.

Providing Tips and Tools For Members with Depression (cont'd)

Home Visits

For individuals who have enrolled in the program but who have not responded to phone-based follow-up, Medica and UBH contract with five community health centers in 11 Minnesota counties to conduct home visits.

As part of this program, which began in January 2005, social workers meet with members to address issues similar to those discussed by phone and help members overcome barriers to treatment by coordinating other services they may need (e.g., transportation and child care). The frequency of these meetings is determined by members' needs and can range from weekly to monthly.

Members typically remain in the Health Advantage Program for three to four months, and they can continue to contact Health Advocates with questions or concerns at any time after completing the program.

Support for Physicians

To help physicians provide effective care for members with depression and other chronic conditions, Medica and UBH provide all PCPs in Medica's network with access to a toll-free number that they can use to confer with psychiatrists about cases. PCPs do not need to identify members in order to engage in these consultations.

In addition, Medica and UBH mail PCPs summaries of depression treatment guidelines developed by the Institute for Clinical Systems Improvement (ICSI), along with "pocket guides" outlining recommended antidepressant medications and doses. Medica and UBH also send physicians "Tip Sheets" on depression-related topics that they can distribute to patients as needed.

Results

As of December 2006, approximately 600 individuals were participating in the Health Advantage program, which has served more than 2,000 members since its inception.

Within three months of enrolling in the program in 2006, 52% of members categorized as high-risk showed significant improvement in a survey measuring the frequency of their depression-related symptoms (e.g., lack of interest in activities, feelings of hopelessness). During the same time frame, 49% of members at moderate risk and 28% of members at low risk showed significant improvement in symptoms. Eighty-five percent of members said they were satisfied with the program overall.

For more information, contact:

Amy Johnson
Clinical Program Manager
Medica
401 Carlson Parkway
CP 405
Minnetonka, MN 55305
(952) 992-8586
Amyjo.Johnson@medica.com

MVP Health Care
New York

Giving Members and Physicians Tools to Eliminate Back Pain

PROGRAM AT A GLANCE

Goal ▸ **To help members eliminate back pain, reduce pain-related emergencies, and avoid unnecessary hospital stays.**

Key Strategies

- Offer health coaching to help members develop and pursue goals for reducing back pain.
- Send members information on strategies to reduce back pain.
- Conduct workshops on how to reduce stress and avoid situations that trigger back pain.
- Send physicians clinical practice guidelines on effective back pain treatment and offer suggestions for incorporating guidelines into everyday practice.

Results in Brief

Surveys of program participants in 2005 found that:

- The percentage of program participants reporting their back pain as "none," "very mild" or "mild" increased from 28.2% upon enrollment to 44.3% one year later.
- The percentage of members reporting that their back pain did not interfere with work increased from 10.9% upon enrollment in the program to 22.9% a year later.

FROM CONCEPT TO ACTION

Promoting Effective Strategies for Chronic Back Pain

In response to increased use of unproven, high-cost treatments for low back pain among members, MVP Health Care established the Back Care Program in 2002.

The program encourages members to try a variety of strategies—such as increasing exercise; stretching on a regular basis; quitting smoking; losing weight; modifying work environments; taking pain management medications; and/or having physical therapy or chiropractic care—to eliminate back pain and thus reduce emergencies and avoid hospitalization. The program is based on national guidelines from the Institute for Clinical Systems Improvement.

To identify individuals with chronic low back pain, MVP analyzes medical claims on a quarterly basis. Members who have had at least two claims, at least 10 weeks apart, with diagnoses of low back pain are considered eligible for the program. Health care practitioners and MVP staff members refer individuals to the program, and members can self-refer.

A Two-Tiered Approach Based on Severity of Back Pain

To determine whether members are at high risk of complications and/or hospitalization, MVP analyzes results of health risk assessment surveys, which ask about the severity of back pain; the extent to which it affects physical activity, emotional well-being, and social activities; energy and fatigue levels; and self-perceived health status. MVP provides a variety of incentives for members to complete the surveys, such as stress balls and tools for back massage.

Health Coaching

When MVP identifies an individual with back pain as high-risk, a member of the health plan's outreach staff calls him or her to describe the program and offer the opportunity to participate in a series of phone-based health coaching sessions.

Members enrolled in this component of the program have regularly scheduled phone consultations with registered nurses trained as health coaches for back care. Coaches assess members' needs (e.g., losing weight, stretching, modifying work environments), and they help them develop individualized plans with goals for meeting these needs. Coaches provide information on the anatomy of the back, and they offer strategies for changing diet and increasing exercise as needed.

Coaches also ask questions to screen members for depression and stress. Based on their responses, members are encouraged to speak with their primary care physicians (PCPs) or to seek care from behavioral health specialists.

Coaches provide members with a toll-free number for MVP's Behavioral Health Access Center, where individuals trained in behavioral health screen members to determine the level of care they need and help them find behavioral health care practitioners. To ensure consistency of care, coaches may contact members' health care practitioners to discuss treatment plans and goals.

The frequency of calls is determined by member needs and can be as often as weekly for up to a year. The average length of participation in the program is four months. Upon completion of the program, each member receives a discharge survey asking about his or her back pain symptoms and pain levels. To track reductions in members' back pain, MVP sends the survey again at intervals

Giving Members and Physicians Tools to Eliminate Back Pain (cont'd)

of six months and one year following completion of the program.

Informational Materials

Each member enrolled in the Back Care Program, including those at both low and high risk, receives the *Spine Column*, a biannual newsletter that provides information on effective care for back pain, along with a back care workbook.

The newsletter covers topics such as exercise and stretching, smoking cessation, weight loss, and effective pain relief medications. Once a year, the newsletter includes a quiz to test members' knowledge of the articles' contents. MVP provides incentives, such as cookbooks with healthy recipes, for members to complete and return the quiz.

The workbook provides general information on effective strategies to reduce back pain, along with a log for tracking information related to back care, such as medications, diet, exercise, and treatments that have provided effective pain relief.

Depending on their responses to the health risk assessment survey, members may receive supplemental materials to meet their needs. For example, a member whose responses suggest that he or she may be depressed would receive a letter from a psychiatrist explaining the symptoms of depression, along with guidance for seeking care.

The Personal Health Improvement Program

Members can gain additional information to help control their back pain by participating in MVP's Personal Health Improvement Program. The program consists of six weekly, two-hour classroom sessions, in which health care professionals help individuals understand how moods and behavior can affect their health. Members learn how to reduce stress and avoid situations that trigger back pain.

Support for Physicians

To supplement the information and services provided to members with back pain, MVP provides support for health care practitioners who treat patients with the condition. Once a year, the health plan sends each primary care physician and specialist treating a high volume of MVP members a CD that includes the health plan's *Physician Quality Improvement Manual*. The manual includes clinical practice guidelines on treatment for back pain; suggested strategies for incorporating the guidelines into everyday practice; a pain diary for distribution to patients; and a patient tip sheet on controlling back pain.

MVP also provides PCPs lists of their patients who were eligible for the high-risk component of the program but did not enroll, so that physicians can follow up to encourage participation.

Results

More than 5,100 members participated in the Back Care Program in 2005. Analysis of MVP's 2005 health risk assessments found that:

- The percentage of members reporting their back pain as "none," "very mild," or "mild" increased from 28.2% upon enrollment in the program to 44.3% one year later.
- The percentage of members reporting that their back pain did not interfere with work increased from 10.9% upon enrollment in the program to 22.9% a year later.
- Nearly 94% of members said they were very satisfied with the program one year following their enrollment.

In recognition of the program's innovative approach and value to employers, MVP won the New York Health Plan Association's Achievement Award in 2004.

For more information, contact:

Deborah Chambers
Director, Quality Improvement
MVP Health Care
625 State Street
Schenectady, NY 12305
(518) 388-2264
dchambers@mvphealthcare.com

Jana Altieri, R.N., M.S.
Quality Improvement Program Manager
MVP Health Care
625 State Street
Schenectady, NY 12305
(518) 388-2363
jaltieri@mvphealthcare.com

Neighborhood Health Plan
Massachusetts

Guiding Members to Relief from Chronic Migraines

PROGRAM AT A GLANCE

Goal ▸ Reduce the frequency of headaches for members with chronic migraines.

Key Strategies

- Send members with frequent migraines information about the condition and direct them to speak with primary care physicians about effective treatment.
- Send primary care physicians "migraine utilization profiles" which detail members' migraine-related medications, emergency room and outpatient visits, and use of diagnostic imaging services in the past six months.

Results in Brief

From 2005 to 2006, the proportion of migraine-related emergency room visits among members with the condition declined from 13% to 9%.

FROM CONCEPT TO ACTION

Promoting Effective Preventive Care for Migraines

In response to studies estimating that 80% of individuals with chronic migraines who could benefit from preventive therapy were not receiving it, along with evidence that preventive medications can reduce the frequency of headaches by 50% for most individuals with migraines, Neighborhood Health Plan (NHP) established a migraine management program in 2005.

NHP analyzes pharmacy data on a quarterly basis to identify members who have received at least three acute, symptom-relieving migraine medications within the past six months.

Based on this analysis, the health plan generates a migraine utilization profile listing members' names; relevant medications (acute, preventive, and narcotic) and the dispensing date, dose, quantity, and prescribing physician; migraine-related emergency room and outpatient visits; and neuro-imaging studies (i.e., CT scans or MRIs) within the last six months. NHP sends the report to each member's primary care physician.

Assessing the Impact of Migraines

NHP sends each identified member a mailing in English and Spanish that includes a validated survey (called the Headache Impact Test) to assess the impact of migraines on his or her daily life. The survey includes questions about pain levels and the frequency with which headaches interfere with the ability to perform daily activities.

Each mailing also includes an explanatory letter from NHP's medical director and instructions on how to score the survey's results. Instructions direct members with high scores to speak with their physicians about effective treatments for migraines. The mailing includes an educational booklet on migraines in English and Spanish.

NHP sends letters to members' primary care physicians (along with the migraine utilization profile) notifying them that it will send the mailings to their patients, who may therefore seek further migraine-related care. Along with each physician letter, NHP encloses a booklet listing doses and monthly costs for acute and preventive migraine medications.

Evaluation Forthcoming

In Fall 2005, NHP began an evaluation of the program's impact and currently is measuring changes in:

- the percent of members who have used at least one preventive medication for migraines in the last six months;
- the ratio of preventive to acute-care migraine medications taken;
- the percentage of members who took two or more narcotic medications for migraines in the past six months; and
- the percentage of members with a migraine-related emergency room visit in the past six months.

Preliminary analyses indicate that from 2005 to 2006, the proportion of migraine-related emergency room visits among members with the condition declined from 13% to 9%. Additional results will be available in late 2007.

For more information, contact:

Jim Glauber, M.D., M.P.H.
Medical Director
Neighborhood Health Plan
253 Summer Street
Boston, MA 02210
(617) 428-7434
Jim_Glauber@nhp.org

Sterling Life Insurance Company

Washington

STERLING HEALTH PLANS
Real People. Wise Choices.℠

Helping Seniors Sort Out their Medications

PROGRAM AT A GLANCE

Goal ▸ Prevent adverse reactions and other medication-related complications among Medicare beneficiaries taking multiple prescriptions.

Key Strategies

- Obtain lists of all members' prescriptions, over-the-counter medications, herbal treatments, and supplements.
- Discuss with members the reason for which each treatment was prescribed; the prescribed dosage; number of times per day it should be taken; and potential adverse effects.
- Contact physicians as needed to prevent adverse medication reactions.

Results in Brief

An evaluation of the program's impact on health care quality and costs will be available in late 2007.

FROM CONCEPT TO ACTION

Reducing Unnecessary Complications and Hospital Stays

Because Medicare beneficiaries with chronic conditions often have multiple prescription medications and have difficulty taking them as prescribed, Sterling Life Insurance Company implemented a voluntary Medication Education program for its Medicare Advantage members in 2006. The program's goal is to reduce the unnecessary complications and hospitalizations that can occur when prescription drugs are taken incorrectly.

Sterling identifies individuals who can benefit from the program by analyzing responses to health risk assessments that all Medicare Advantage beneficiaries are asked to complete upon enrollment. In addition, physicians, nurses, and social workers can refer members to the program.

To maximize participation, Sterling sends letters to physicians describing the program and encouraging them to refer Sterling Medicare Advantage patients. Sterling nurses call patients referred to the program to describe its benefits and offer the opportunity to enroll.

Step-by-Step Review of Medications

Once individuals sign up for the program, nurse care coordinators contact them by phone to obtain lists of all prescription and over-the counter medications, herbal treatments, and supplements that they are taking. Care coordinators forward these lists to members' prescribing physicians for verification, and they send members educational materials about the listed items.

Subsequently, care coordinators schedule a series of calls with members to discuss the reason for which each treatment was prescribed; the prescribed dosage; number of times per day it should be taken; and potential adverse effects, such as interactions with foods or other medications. Care coordinators identify barriers to taking medications as directed, and they suggest strategies for overcoming these barriers (e.g., speaking with doctors about generic drugs, investigating available sources of financial assistance).

Follow-up with Physicians and Pharmacists

If, during these discussions, nurse care coordinators identify the potential for complications (e.g., if individuals are taking medications incorrectly, if some of their medications could interact to cause an adverse reaction, and/or if they are taking double doses of the same medication prescribed by two different doctors), they tell members to contact their physicians immediately, and, if necessary, they contact physicians directly.

Sterling is in the process of analyzing the program's impact on health care quality and costs, and results are anticipated by late 2007.

For more information, contact:

Sandy Harnden-Warwick
Manager, Medical Management
Sterling Life Insurance/Olympic Health Management
2219 Rimland Drive, Suite 100
Bellingham, WA 98226
(360) 392-9157
sandy.harnden-warwick@sterlingplans.com

UnitedHealth Group
Minnesota

OVATIONS
A UnitedHealth Group Company

Closing Treatment Gaps for Individuals in Need

PROGRAM AT A GLANCE

Goals
- **Helplow-income elderly and/or disabled Medicaid beneficiaries live independently in their communities.**
- **Improve the health of frail and/or elderly Medicare and Medicaid beneficiaries in nursing homes.**

Key Strategies

- Conduct regular, in-person visits in nursing homes to assess beneficiaries' health and coordinate with primary care physicians to ensure that they receive needed care.
- Arrange for on-site health services, such as lab procedures and administration of oxygen, in nursing homes.
- Help beneficiaries access services such as home care, personal attendant services, and transportation assistance.
- Arrange for home modifications as needed, such as removal of area rugs and installation of grab bars.

Results in Brief

A 2004 survey of more than 1,000 program participants found that:

- 91% of respondents were satisfied with the program;
- 93% believed that care managers listened to and addressed their concerns; and
- 89% believed that the program helped them access services that they did not previously have.

FROM CONCEPT TO ACTION

Improving Health Care Quality and Outcomes

To improve quality of care and health outcomes for Medicare and Medicaid beneficiaries with chronic conditions, the Evercare division of Ovations (a UnitedHealth Group company) offers care coordination in nursing homes, as well as in home and community settings. The program began in two Minnesota nursing homes in 1988 after nurse practitioners found that residents were experiencing gaps in care that led to unnecessary hospitalizations.

Subsequently, the Evercare model has been implemented in health plans throughout the country in conjunction with a variety of public programs, including special needs plans for institutionalized individuals, special needs plans for dually eligible Medicare and Medicaid beneficiaries, and in plans operating under state Medicaid contracts. Using nationally recognized guidelines for evidence-based care, Evercare combines primary, acute, and long-term care services into a single system of care designed to close gaps in treatment of chronic and other conditions and slow the progression of illness and disability.

Coordinating Care in Nursing Homes

In the nursing home component of the program, Evercare partners with long-term care facilities to address the medical needs of frail and/or elderly Medicare and Medicaid beneficiaries. Evercare staff work with nursing home administrators to identify residents with multiple chronic conditions who could benefit from clinical care coordination.

Subsequently, staff meet with these residents and their family members, if available, to discuss the program's benefits and offer the opportunity to enroll. Beneficiaries served through the program often have conditions such as dementia, coronary artery disease, diabetes, and chronic obstructive pulmonary disease, and they have been admitted to hospitals frequently due to complications such as pneumonia, dehydration, and changes in cognitive status.

Comprehensive Medical Assessments

Once beneficiaries enroll in the Evercare program, nurse practitioners meet with them to conduct physical exams; take comprehensive medical histories; and assess their cognitive functioning levels, limitations in activities of daily living, and nutritional needs. In addition, nurse practitioners review all medications to identify duplicative prescriptions, as well as the potential for adverse interactions. If necessary, nurse practitioners contact individuals' primary care physicians to discuss possible medication changes. Nurses work with enrollees' physicians to develop plans of care for all conditions identified during this process.

Regular Visits with Nurse Practitioners

Following their initial assessments, nurse practitioners schedule visits with beneficiaries as needed to identify changes in health status; review the effectiveness of treatment plans; assess enrollees' progress in meeting health goals; determine beneficiaries' and family members' perception of needs; and discuss any staff member concerns about care.

Onsite Treatment

As part of its care coordination efforts, Evercare works with participating nursing homes to arrange for needed services—such as intravenous (IV) treatments, X-ray and lab procedures, and administration of oxygen—so that beneficiaries who experience sudden

changes in health status (e.g., fever, pneumonia) can receive treatment on-site and, in many cases, avoid the need for hospitalization. In these situations, nurse practitioners work closely with enrollees' primary care physicians and specialists to ensure that they receive all of the diagnostic and medical services needed to address their conditions in a timely and effective manner.

Promoting Independent Living

To help low-income elderly and individuals with disabilities live independently in their communities (e.g., at home, in assisted living facilities, or in adult care homes) for as long as possible, Evercare offers a range of health and social services to Medicaid beneficiaries in six states (AZ, FL, MA, MN, TX, and WA). Evercare works with state Medicaid agencies, Area Agencies on Aging, and local consumer groups (e.g., the AARP, Alzheimer's Association, National Kidney Foundation) to identify individuals who can benefit from the program.

Depending on the state, staff of Area Agencies on Aging, public program outreach staff, or other outreach professionals contact beneficiaries to offer them the opportunity to enroll. In some states, beneficiaries pre-qualify based on their income and functional status, and they have the option of choosing Evercare as their care management organization.

Once individuals have enrolled, nurses or social workers trained as care managers conduct assessments and develop care plans tailored to enrollees' medical, behavioral health, and social service needs. For example, care plans could include regular visits from home care nurses to provide wound treatment; personal attendant services to help with bathing, dressing and eating; regular transportation to and from doctor visits; and enrollment in community support groups. Care managers also screen enrollees for depression and help them schedule appointments with behavioral health specialists if needed.

Depending on enrollees' health status, care managers may conduct in-person assessments of their home environments to check on safety issues and arrange for home modifications (e.g., removing area rugs, installing grab bars in bathrooms) to prevent falls or improve accessibility. In addition, they conduct follow-up home visits if enrollees' health status or care needs change. Enrollees can contact their care managers at any time to ask questions or obtain help with medical, behavioral health, or social service issues.

Results

Approximately 100,000 beneficiaries in 35 states receive services through Evercare's integrated care model. In 1999, Evercare received the Award for Innovation and Quality from the American Society of Aging.

A 2004 enrollee satisfaction survey of more than 1,000 Medicaid beneficiaries found that:

- 91% of respondents were satisfied with Evercare;
- 95% planned to continue their membership;
- 93% believed that care managers listened to and addressed their concerns; and
- 89% believed that Evercare helped them access services that they did not previously have.

A study of Medicaid beneficiaries receiving Evercare's home and community-based services in Florida from January 2003 through December 2004 found that:

- Individuals enrolled in the program were nine times less likely to enter nursing homes within 24 months for extended stays than those in a comparison group.
- Nursing home stays among program participants were shorter (averaging 43 days) than those of individuals in the control group (which averaged 132 days).

For more information, contact:

Holly Bode
Vice President, Public Policy
Ovations
701 Pennsylvania Avenue, NW Suite 530
Washington, D.C. 20004
(202) 383-6430
holly_bode@uhc.com

UnumProvident
Tennessee

Paving the Way to Productivity For Employees on Short-Term Disability

PROGRAM AT A GLANCE

Goal ▸ Facilitatetimely return to work among AOL employees who submit short-term disability claims for behavioral health conditions.

Key Strategies

- Ensure that employees diagnosed with behavioral health conditions undergo evaluations by behavioral specialists within two days of submitting short-term disability claims.
- Help employees identify and reduce sources of stress in the workplace.
- Coordinate with AOL to make reasonable accommodations that facilitate timely return to work.
- Provide employees with information about their conditions, answer questions, and link them with needed services such as support groups and transportation assistance.

Results in Brief

Among sites participating in the program pilot, from 2004 to 2005:

- The average duration of short-term disability declined by 34%.
- Costs for behavioral health care associated with short-term disabilities were reduced by 73%.

FROM CONCEPT TO ACTION

Preventing Unnecessary Delays in Behavioral Health Treatment

In response to concern about a disproportionately high number of short-term disability claims among staff of America Online, Inc.'s (AOL's) member services call centers, UnumProvident worked with Horizon Health, Matria Healthcare and AOL to implement an absence management pilot program in 2005. The program provides evaluation and treatment to employees who submit short-term disability claims for behavioral health conditions (e.g., depression, anxiety, stress) so that they can return to work in a timely manner.

In developing the program, UnumProvident staff worked with AOL to identify factors contributing to the large number of lost work hours associated with behavioral health disabilities. This analysis revealed long delays between the time of primary care physicians' initial diagnoses and employees' first visits with behavioral health specialists. To address the issue, the project team designed a process to ensure that AOL associates who are diagnosed with behavioral health conditions undergo evaluations by behavioral health specialists within two days of submitting short-term disability claims. To participate in the program, employees are required to sign authorizations allowing health care practitioners to provide summary information about their conditions to UnumProvident.

Return-to-Work Planning

After assessing employees' conditions and receiving their authorizations, behavioral health professionals send reports to UnumProvident describing individuals' diagnoses, functional limitations, prescribed medications, and projected return-to-work dates. Subsequently, UnumProvident's vocational rehabilitation specialists contact employees by phone to help them prepare for returning to work. During these calls, vocational specialists focus on identifying and reducing sources of stress in the workplace, developing return-to-work plans, and discussing potential workplace accommodations to ease the return-to-work transition. The frequency and duration of these calls varies based on individual needs. Vocational specialists also coordinate with AOL to make reasonable accommodations that facilitate timely return to work. For example, these arrangements may include allowing individuals to return to work initially on a part-time or transitional basis and/or modifying responsibilities to account for functional limitations.

Program participants also receive regular phone calls from nurse case managers, who provide them with information about their conditions, answer questions, help them follow physicians' treatment plans, and link them with needed services, such as support groups and transportation to doctor visits. Case managers continue to contact members once they have returned to work to help with the transition and avoid the need for additional absence.

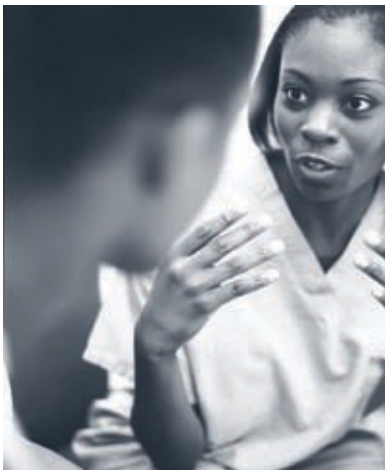
Results

AOL reported the following results at the call center sites participating in the pilot. From 2004 to 2005:

- The total number of short-term disability claims declined by 25%.
- The average duration of short-term disability decreased by 34%.
- Costs for behavioral health care associated with short-term disabilities were reduced by 73%.
- Based on these results, AOL expanded the program to all of its member service call center sites throughout the country.

For more information, contact:

Kenneth Mitchell, Ph.D.
Vice President, Health and Productivity Program
UnumProvident
1 Fountain Square
Chattanooga, TN 37402
(423) 294-8015
kmitchell@unumprovident.com



CHAPTER 2

Addressing Health Disparities and Health Literacy

Research consistently has shown that Americans receive health care services in sync with the latest scientific evidence only about half of the time. Moreover, racial and ethnic minorities in the U.S. receive a lower quality of care than non-minorities and are at greater risk for chronic diseases.

AHIP member companies are taking on the challenge of health care disparities. Health insurance plans are organized in a way that makes it possible to focus on areas of greatest need; collect data on the race, ethnicity, and primary language of enrollees; develop quality improvement programs to address health disparities among populations; create member materials that are culturally and linguistically appropriate; and improve care for all enrollees.

Health insurance plans are using their unique capabilities to develop Spanish language materials and programs for Latino members with diabetes; implement community-based asthma education programs for Medicaid beneficiaries; coordinate with church and community groups to promote wellness among African Americans; offer home-based case management to help Medicaid beneficiaries overcome barriers to effective care; and more.

AHIP member companies are taking on the challenge of health care disparities.

AHIP soon will be launching *Models that Work*, a Web-based compendium of health plan programs and strategies to reduce health care disparities and improve quality. The compendium will serve as an online clearinghouse for health insurance plans to share promising practices, with the goal of stimulating continuous improvement. For more information about the compendium and to learn about AHIP's series of Tools to Address Disparities in Health, please visit www.ahip.org/healthandmedicine/diversityandculturalcompetency.

Aetna
Connecticut

Taking a Multi-Faceted, Bilingual Approach To Diabetes Care

PROGRAM AT A GLANCE

Goal ▸ Increase use of recommended care and improve health for members with diabetes.

Key Strategies

- Offer health coaching to promote recommended preventive care; encourage healthy lifestyle changes; and arrange for transportation and other assistance to facilitate effective treatment.
- Send physicians materials for distribution to patients, including Spanish and English-language diabetes information kits, a video with prominent Latino spokespeople discussing diabetes care, and a CD-ROM with diabetes information in English and Spanish.
- Work with community-based coalitions throughout the country on projects to promote effective diabetes care, including an initiative to distribute diabetes consumer guides to primary care physician offices.

Results in Brief

From 2004 to 2005:

- The percent of members with diabetes who had HbA1c blood tests increased from 84.4% to 86.4%.
- The percent of members with diabetes whose cholesterol levels were below 130 mg/dL increased from 60.5% to 62.9%.
- The proportion of members with the condition who underwent preventive eye exams rose from 46.2% to 50%.

FROM CONCEPT TO ACTION

Pursuing a Broad Range of Strategies

To address the high prevalence of diabetes, its potential complications, and the high cost of treatment, Aetna expanded its ongoing disease management initiatives to create the Integrated Comprehensive Diabetes program in 2006. The program uses a broad range of strategies, including: regular member communication; health coaching; support for physicians; development of patient information in Spanish; and participation in community coalitions to improve care for individuals with diabetes.

Member Education and Coaching

On a monthly basis, Aetna analyzes medical, lab, and pharmacy data to identify members with diabetes who can benefit from the program. Depending on their use of hospital and emergency room care and on key indicators of their health status (e.g., HbA1c blood levels, cholesterol readings), Aetna divides members into categories based on their risk of complications and hospitalization in the upcoming year.

All members with diabetes receive biannual newsletters and periodic mailings with information on multiple health conditions, including diabetes, asthma, heart and kidney disease; topics such as healthy eating and exercise strategies; and recommendations for regular preventive care services (e.g., flu shots, HbA1c testing, screening for kidney disease, eye and foot exams).

These materials list the toll-free number that members can call to speak with a nurse case manager about their needs. Members newly diagnosed with diabetes receive complimentary glucose meters and check lists to track their use of preventive care services. Individuals who have not had these services at recommended intervals receive periodic reminder letters.

Members at high risk of complications receive phone calls from nurse case managers trained as health coaches. During their initial conversations with members, case managers assess their needs, provide information about diabetes and recommended preventive care; discuss strategies for healthy eating; describe how to recognize signs of high and low blood sugar levels; and ask questions to screen for depression. Nurses coordinate with Aetna's behavioral health case managers to ensure that individuals with depression receive needed care.

Case managers contact members on a quarterly basis or more often if necessary to promote use of effective diabetes care. For example, if a member's blood sugar remains above recommended levels, the case manager may call him or her once a week to address the underlying reasons and pursue strategies, such as changes in diet or exercise, to improve health.

Case managers also help members overcome barriers to effective treatment (e.g., by arranging for transportation or linking them with sources of financial assistance). Members can contact their case managers at any time via a toll-free number.

Support for Physicians

Besides providing information and support to members with diabetes, Aetna provides a variety of materials to physicians. These include: tracking sheets to document patients' use of diabetes-related preventive care; chart stickers to highlight the dates on which

services were provided; exam room posters illustrating recommended eye and foot exams; and periodic mailings aimed at increasing rates of specific tests and procedures (e.g., screening for kidney disease). Aetna notifies physicians when one of their patients is enrolled in the program, and case managers contact them as needed to address issues related to individuals' health status and care.

Materials in Spanish

Because diabetes is especially prevalent in the Latino population, Aetna distributed diabetes patient information kits (funded by Novo Nordisk) in Spanish and English to physicians in metropolitan areas with large Latino populations in 2004 and 2005. Each kit included a booklet explaining recommended diets, exercise regimens, and preventive care; a diary to track blood sugar levels; fact sheets on foot care and leg exercises; an illustrated flip chart explaining the physiology of diabetes; and a video called *Diabetes: A Guide for Hispanic Americans.*

The video featured prominent Latino spokespeople explaining the services that individuals with diabetes can expect to receive during doctor visits, and it described strategies for healthy eating. To encourage member involvement in the treatment process, the video included a segment showing a patient asking questions during a physician visit. Aetna enclosed a survey asking physicians which components of the kits were most useful and what other materials they would find most helpful to support their care of Latino patients with diabetes.

Based on physician's feedback (e.g., concern about storage space for written materials), Aetna partnered with the American Diabetes Association (ADA) in 2006 to distribute CD-ROMs in English and Spanish to all of its participating primary care physicians providing diabetes care. Topics covered on the CDs include insulin resistance, medication management, recommended tests and procedures for individuals with diabetes, and strategies for counting carbohydrates. It also includes patient tools such as a blood glucose log and diary for tracking diet and exercise. Physicians can print out and use materials on the CD as they see fit (e.g., displaying them in office waiting rooms, reviewing them with patients during visits, and/or giving them to patients to take home).

Community Coalitions

To promote high-quality diabetes care throughout the country, Aetna works with community-based diabetes coalitions on a variety of special projects. For example, in the Washington, D.C., metropolitan area in 2005, Aetna participated in the Network to Improve Community Health (NICH), a coalition of employer groups, health plans, and representatives of the American Diabetes Association and the Agency for Healthcare Research and Quality (AHRQ).

As part of the project, Aetna arranged for staff of its two lab service providers (Quest and Labcorp) to hand-deliver consumer guides based on the ADA's diabetes preventive care guidelines to offices of 300 primary care physicians serving high volumes of Aetna members with diabetes.

Results

Use of Recommended Preventive Care

From 2004 to 2005:

- The percent of members with diabetes who had HbA1c blood tests increased from 84.4% to 86.4%.
- The proportion of members with the condition who underwent preventive eye exams rose from 46.2% to 50%.
- The cholesterol testing rate among members with diabetes increased from 89.5% to 91.6%.
- The percent of members with diabetes whose cholesterol levels were below 130 mg/dL grew from 60.5% to 62.9%.
- The rate of testing for kidney disease among members with diabetes grew from 45% to 50.8%.

Depression Screening

Among the approximately 1,500 members with chronic conditions who participated in Aetna's medical and behavioral health case management programs from 2003 to 2005, on average:

- Measures of physical health (e.g., level of physical activity and depression-related limitations in ability to work) improved by 8.9%;
- Measures of mental health (e.g., extent to which members limited social interaction, felt "down" or "blue," or experienced calm and peaceful feelings) improved by 44.9%; and
- An average of 3.95 fewer days of work or school were missed due to illness.

Physician Support

- Ninety-nine percent of physicians who received Aetna's diabetes patient information kits in Spanish and English said they had found them useful, and 57% said they previously lacked access to diabetes-related patient information in Spanish.

For more information, contact:

Judy Langley, R.N., C.P.H.Q.
Director, Quality Management
Aetna
980 Jolly Road
Blue Bell, PA 19422
(972) 444-0094
LangleyJE@Aetna.com

AMERIGROUP Corporation
Virginia

Keeping Medicaid Beneficiaries Healthy at Home

PROGRAM AT A GLANCE

Goal ▸ HelpMedicaid beneficiaries who have been hospitalized frequently for long time periods stay healthy and avoid unnecessary readmission.

Key Strategies

- Identify factors leading to frequent hospital admissions—such as lack of a regular source of care and inability to afford medications—and help eliminate them.
- Conduct regular home visits to discuss members' needs, implement action plans to improve health, and prevent complications that could lead to hospital readmission.

Results in Brief

From 2005 to 2006, the number of inpatient days among individuals enrolled in a Maryland pilot of the program fell by 55%.

FROM CONCEPT TO ACTION

In-Home Case Management

Upon finding that 1 percent of its members in Maryland (505 individuals) accounted for 50% of hospital stays unrelated to maternity or neonatal care, AMERIGROUP implemented the 505 Program on a pilot basis in the state in 2005. The program was expanded to all of the health plan's service areas in 2006.

Through the 505 Program, AMERIGROUP provides home-based case management to help Medicaid beneficiaries overcome barriers to effective care and avoid unnecessary hospitalization. Many members served through the program have chronic conditions such as diabetes, inflammatory bowel disease, congestive heart failure, chronic wound conditions, peripheral vascular disease, and depression.

In each of its states of operation, AMERIGROUP develops a list of members ranked by the number of hospital admissions and total inpatient days in the past year. Members with histories of frequent hospital admissions and a large number of inpatient days receive phone calls from nurses, who describe the program and offer the opportunity to participate.

Regular Meetings with Nurses and Social Workers

Each newly enrolled member receives an in-home assessment from a care team, comprised of a registered nurse and social worker who discuss his or her needs and identify the factors that have led to frequent hospitalization (e.g., lack of a regular source of care, poor diet, lack of transportation, inability to afford medications). Also during the initial visit, the nurse and social worker ask members questions to screen for depression.

Action Plans to Improve Health

Following their initial assessments, care teams meet with the health plan's medical director to develop lists of issues to address for each member, along with action plans to address health conditions that could have complications leading to hospital readmission. Subsequently, nurses and social workers have regular home visits with program participants (typically on a weekly basis but more frequently as needed) to discuss their needs, implement action plans, and address other issues that arise.

For example, if individuals are not responding to treatment with oral medications, the care team may arrange for installation of home medical equipment to administer medications intravenously. If beneficiaries' medical needs are not being met by their primary care physicians, nurses link them with appropriate specialists.

In addition, care teams help members with depression access care from behavioral health care practitioners. Because of their frequent, in-person contact with members, care teams are well-positioned to identify newly emerging health or social service needs quickly and take action to avoid emergencies.

Each care team serves a maximum of 30 Medicaid beneficiaries. Individuals often are enrolled in the program throughout their membership with AMERIGROUP, with less frequent meetings (e.g., monthly or quarterly) once their conditions have been stabilized and they are receiving effective services on an ongoing basis. Beneficiaries can use a toll-free number to contact their care teams at any time to ask questions or to obtain assistance.

Results

From 2005 to 2006, the total number of inpatient days among individuals enrolled in the Maryland pilot of the 505 program fell by 55%. AMERIGROUP currently is analyzing the program's impact nationwide, and results will be available in 2007.

For more information, contact:

Dr. William Wood
National Medical Director
AMERIGROUP Corporation
4425 Corporation Lane
Virginia Beach, VA 23462
(757) 962-6432
wwood@amerigroupcorp.com

Community Health Plan
Washington

Pursuing a Community-Wide Strategy to Prevent Asthma Emergencies

PROGRAM AT A GLANCE

Goal ▸ Promoteuse of effective asthma care for children and adults to prevent unnecessary asthma-related emergencies.

Key Strategies

- Reduce member cost-sharing for asthma controller medications and provide coverage for six group and/or planned asthma care visits per year.
- Offer health coaching to help members with moderate to severe asthma obtain effective care and access public programs and community resources.
- Sponsor physicians' attendance at the Asthma Educator Institute and offer physicians training on proven tools to diagnose and treat asthma.
- Provide community health centers with reports on members' use of asthma-related health services and encourage staff to follow up with patients to promote recommended care.
- Collaborate with community agencies throughout the state to develop effective strategies for serving low-income individuals with asthma.

Results in Brief

From 2000 to 2005:

- The percent of children who had emergency room visits for asthma fell from 32.3% to 12.8%.
- The rate of hospital admissions among children with asthma decreased from 5.4% to 2.6%.

From 2001 to 2005:

- The proportion of Medicaid beneficiaries with asthma who used controller medications increased from 52% to 86%.

FROM CONCEPT TO ACTION

A Multi-Faceted Approach to Improving Asthma Care

To reduce the high number of asthma-related emergencies among its members, many of whom are Medicaid beneficiaries, Community Health Plan established a chronic care initiative for children and adults with asthma in 2001.

The health plan uses a variety of tools and strategies to implement the program, including: information and support for members based on their risk of complications; reduced pharmacy copayments and coverage for asthma-related group and planned visits with health care practitioners; and actionable information for physicians and community health centers to promote effective care. Community Health Plan also collaborates with public- and private-sector organizations throughout the state to improve asthma care.

Identifying Members Who Can Benefit

To identify members with asthma and determine their risk of complications, Community Health Plan analyzes medical and pharmacy claims each month using an automated registry system. Individuals are considered to be at high risk of complications if they have had emergency room visits and/or hospital admissions for asthma and/or if they are using asthma rescue medications to address severe symptoms rather than relying on controller medications to prevent the onset of symptoms.

Information and Support

Newsletters and Reduced Copayments

All members with asthma receive welcome letters, followed by quarterly newsletters and biannual asthma-related mailings. These materials encourage members to work with their primary care physicians (PCPs) to develop asthma action plans, and they include information on recommended treatments, tips on recognizing and avoiding conditions that trigger asthma symptoms, and strategies for coping with allergy season.

In addition, to promote use of effective treatments, Community Health Plan offers reduced cost-sharing for asthma controller medications. Whereas members previously paid 50 percent coinsurance (i.e., $25 to $30 per prescription), they now have a $10 copayment for all brands.

Group and Planned Visits

Besides having access to written materials and reduced copayments for effective medications, all members with asthma have coverage for up to six group and/or planned visits per year. During group visits, health care practitioners (i.e., physicians, nurses, or certified asthma educators) provide information about the condition; explain techniques to address it effectively (e.g., by taking controller medications every day, using peak flow meters, and following action plans); answer members' questions; and respond to their concerns. Group visits also provide opportunities for members to share their experiences and gain support from others with the condition.

When members make appointments for planned asthma visits, health care practitioners review their charts to identify diagnostic or preventive care services (e.g., spirometry tests to measure lung function or flu shots) that they are missing. Physician office staff follow up with members to ensure that they have the recommended treatments before meeting with their PCPs. With these services provided in advance, PCPs can use planned visits to discuss test results, recommended medications, and/or additional strategies to address asthma effectively.

Regular Contact with Nurses and Social Workers

Besides receiving information and benefits

Pursuing a Community-Wide Strategy to Prevent Asthma Emergencies (cont'd)

focused on asthma care, individuals with moderate to severe asthma receive phone calls from nurses and/or social workers trained as disease managers. During these conversations, disease managers administer health risk assessment (HRA) surveys to determine members' health and social service needs and identify barriers to care (e.g., disabilities or language difficulties). Depending on the survey's results, disease managers work with members and their primary care physicians to determine whether they need follow-up medical appointments and/or new care plans. Disease managers may provide members with general information about asthma medications, and they communicate with physicians, with members' consent, regarding treatment issues (e.g., adverse reactions, side effects, safety concerns) that require medical attention. Disease managers also provide members with informational materials and may refer them to community resources (e.g., Meals on Wheels, transportation assistance), as well as state and federal public programs (e.g., Medicaid, SSI).

Support for Health Care Practitioners

Informational Mailings

To increase physicians' awareness of effective asthma treatment, Community Health Plan sends all participating PCPs asthma-related materials on a quarterly basis, including the most current practice guidelines, sample asthma action plans (translated into six languages), journal articles highlighting evidence-based practices, case studies, and links to Web sites with additional information.

E-Prescribing Messages

Community Health Plan's e-prescribing system serves as an additional vehicle to encourage network physicians to prescribe controller medications for asthma. Physicians who send prescriptions for asthma rescue medications through their personal digital assistants (PDAs) receive e-mail messages noting that National Asthma Education Prevention Programs guidelines recommend use of controller medications for effective asthma care.

Reports for Community Health Centers

Besides communicating regularly with PCPs about asthma care, Community Health Plan provides participating community health centers with actionable reports on a quarterly basis with patient- and clinic-specific information about emergency room use, hospital admissions, office visits, and use of controller and rescue medications among their patients with asthma. In 2007, clinics will receive biweekly "trigger" reports listing patients who use asthma rescue medications extensively without using controller medications. Community Health Plan encourages clinic staff to follow up with members to provide information on effective asthma care, develop new treatment plans, and discuss possible changes in medication.

Clinic-Based Needs Assessments and Physician Surveys

After reviewing clinic- and physician-specific performance on nationally recognized measures of quality asthma care, Community Health Plan's clinical quality project managers conduct assessments of participating clinics to identify best practices and areas in need of improvement. The health plan also surveys physicians to assess factors such as staff training needs, use of asthma action plans, and use of electronic systems to track asthma care and outcomes.

Based on results of these surveys, Community Health Plan has offered additional training to health care practitioners, provided clinics and physicians with asthma tool kits on CDs, and offered professional support to help clinics implement new asthma programs.

The Asthma Educator Institute

Through a partnership with the American Lung Association of Washington and the Washington State Asthma Initiative, Community Health Plan encourages participating physicians to learn more about asthma care by sponsoring their attendance at the annual Asthma Educator Institute. The Institute focuses on the latest research on the prevention, diagnosis, and treatment of asthma.

Topics include strategies for incorporating evidence-based asthma care guidelines into everyday clinical practice; environmental and psychosocial factors affecting treatment; and effective new medications. The Institute offers professional networking opportunities, and physicians earn continuing medical education credits for attendance.

Collaborating with Community Partners

To increase the impact of its asthma program and help spread the program's benefits throughout the state, Community Health Plan collaborates with community agencies such as the Seattle-King County Public Health Department, the King County Asthma Forum, the Washington State Asthma Initiative, and the Steps to a Healthier US Initiative.

Organizations involved in the partnership share information and resources and work together to develop effective strategies for serving low-income populations. Through a partnership with the American Lung Association of Washington, Community Health Plan's participating health care practitioners can receive training in evidence-based tools to diagnose and treat asthma.

Results

From 2000 to 2005:

- The percent of children who had emergency room visits for asthma fell from 32.3% to 12.8%.
- The proportion of adults with asthma-related emergency room visits declined from 26% to 17%.
- The rate of hospital admissions among children with asthma decreased from 5.4% to 2.6%.
- Hospital admission rates for adults with asthma declined from 6.1% to 1.7%.

From 2001 to 2005:

- The proportion of Medicaid beneficiaries with persistent asthma who used controller medications increased from 52% to 86%.
- Among members with persistent asthma who had private coverage, use of controller medications grew from 60% to 81%.

For more information, contact:

Melissa Merculief, R.H.I.A.
Clinical Quality Project Manager
Community Health Plan
720 Olive Way, Suite 300
Seattle, WA 98101
(206) 613-8903
mmerculief@chpw.org

Harvard Pilgrim Health Care
Massachusetts

Reducing Health Care Disparities for Latino Members with Diabetes

PROGRAM AT A GLANCE

Goal ▸ Increase use of eye screening exams among Latino members with diabetes.

Key Strategies

- Collaborate with a local supermarket and pharmacy chain to conduct free eye care screening and education in neighborhoods with high percentages of low-income Latino residents.
- Collaborate with a local chain of optometry providers to offer coupons for dilated retinal exams with no copayments for members in neighborhoods with high percentages of low-income Latino residents.

Results in Brief

- From 2003 to 2005, the overall rate of dilated retinal exams among the health plan's members with diabetes grew by 1.3 percentage points. The increase among Latino members was 1.4 percentage points.
- Eye exam rates for members with diabetes in the targeted communities were no higher than those in other communities that served as control groups. However, health plan staff have learned valuable lessons that will provide the basis for future outreach. In addition, the health plan has initiated dialogue with community organizations to promote the success of future endeavors.

FROM CONCEPT TO ACTION

A Two-Part Initiative to Promote Recommended Care

As part of its involvement in the National Health Plan Collaborative to Reduce Racial and Ethnic Disparities,[1] Harvard Pilgrim analyzed member and claims data in late 2004 to identify any major gaps in care for members in typically disadvantaged population groups.

A key finding from this analysis was that Latino members with diabetes – particularly those who lived in low-income neighborhoods where a high percentage of residents had not completed high school – were less likely than African American, Asian or white members to undergo eye screening exams at recommended intervals.[2] In response to this finding, Harvard Pilgrim implemented a two-part initiative to increase rates of annual eye exams among Latino members with diabetes.

Collaborating with Local Supermarkets

In the project's first phase, Harvard Pilgrim collaborated with a local supermarket chain to implement a free eye care screening and education program in neighborhoods with high proportions of low-income Latino residents.

Outreach in English and Spanish

In September 2005, the health plan sent letters and other materials in English, Spanish, and Portuguese to all members in the targeted communities, and the supermarket posted multilingual flyers in its stores. The letters and flyers invited individuals with diabetes to have free dilated retinal exams at designated supermarket pharmacies in their neighborhoods.

An educational brochure (in English, Spanish, and Portuguese) on the importance of retinal screening for patients with diabetes was included with the member letter. Harvard Pilgrim also sent letters to primary care physicians who practiced in the communities where screenings were held, to notify them of the events and encourage them to promote the service among their patients with diabetes, including individuals who were not health plan members.

Screening in Supermarket Pharmacies

During October 2005, three screening events were conducted in Metropolitan Boston supermarket pharmacies, and one was held at a supermarket pharmacy in Southeastern Massachusetts. Each member attending a screening session received an eye exam with a specialized camera to detect diabetic retinopathy. An optometrist explained the exam's results and directed individuals with evidence of diabetic retinopathy to seek follow-up care immediately.

Optometrists also provided counseling on recommended eye care, answered questions, and provided lists of additional resources. If the member needed further follow-up, the optometrist provided a listing with contact information for ophthalmologists located in or near members' communities. This listing designated the ophthalmologists' offices where Spanish and/or Portuguese were spoken.

To supplement the information provided by optometrists, pharmacists were available to answer questions about diabetes medications. Nurses offered additional guidance on diabetes care, and nutritionists provided counseling on recommended food choices and conducted supermarket tours focusing on healthy eating and food labels. Discount coupons for healthy foods were also provided.

Individuals received written summaries of their screening results, as well as

Reducing Health Care Disparities for Latino Members with Diabetes (cont'd)

recommendations for follow-up (e.g., having additional eye exams within six months or a year, depending on screening results). To promote coordination of care, Harvard Pilgrim sent these results to members' primary care physicians.

Partnering with Local Optometry Providers

Beginning in October 2006, Harvard Pilgrim partnered with a local optometry chain to launch the program's second phase. The health plan mailed letters in English and Spanish to members with diabetes who lived in selected communities (i.e., those with high proportions of Latino members and in close proximity to one of the optometry chain's stores) and who had not yet had annual eye exams.

The letters encouraged members to have eye exams as recommended by December 31, 2006. Enclosed with each letter was a coupon that entitled the member to a dilated retinal exam with no copayment at any of the optometry chain's facilities.

Other Efforts to Improve Diabetes Care

In a further effort to improve eye screening for individuals with diabetes, Harvard Pilgrim made changes to its benefit packages and procedures that became effective in January 2006. For example, members with diabetes seeking ophthalmology appointments for dilated retinal exams no longer need referrals.

The health plan also has made diabetes care an important component of its pay-for-performance programs. Harvard Pilgrim's Quality Advance program rewards physicians when members with diabetes have the recommended LDL-cholesterol and HbA1c blood level tests and when members' test results improve. In 2005, Harvard Pilgrim's Quality Grant program began offering funding to physician groups that take innovative approaches to diabetes care (e.g., by establishing electronic systems to track member screening rates and by contacting members with diabetes by phone to schedule appointments for dilated retinal exams).

In 2006, the Quality Grant program added a focus on reducing racial and ethnic health disparities.

Results

- From 2003 to 2005, the overall rate of dilated retinal exams among Harvard Pilgrim members with diabetes increased by 1.3 percentage points. The increase among Latino members was 1.4 percentage points.
- These results were not attributable to the health plan's outreach activities. The rates of dilated retinal exams in neighborhoods where the supermarket outreach was conducted were no higher than in similar communities that served as control groups. In addition, very few of the eye exam coupons sent out in the program's second phase had been redeemed by the end of 2006; therefore, that initiative is not expected to affect the rate of dilated retinal exams in targeted neighborhoods during 2006.
- The success of the two initiatives, according to health plan staff, was in creating awareness of the additional research needed to understand the needs and preferences of Latino members with diabetes and to develop more effective outreach strategies.
- As part of its follow-up research, Harvard Pilgrim has initiated dialogue with a community health center, hospital, and social service agency that have extensive experience serving Latino residents. These organizations have provided suggestions on effective location, scheduling, and publicity to maximize the success of health-related outreach events.

Lessons Learned

Based on insights gained through ongoing research and dialogue with community organizations, Harvard Pilgrim has identified the following lessons learned:

Community Partnerships

- Working with local service providers, community and church groups could enhance the effectiveness of future outreach. Community organizations with experience serving Latino populations in some cases can provide transportation and other assistance to increase turnout.

Scheduling

- Health-related outreach activities should be scheduled in conjunction with other community events that tend to attract large crowds. These could include, for example, sporting events, concerts, or events providing help with tax filing.
- Events seeking to reach members who work should be scheduled during afternoon and evening hours or on weekends.
- Programs conducted in late fall and early winter may fail to reach Latino members who spend the colder months in their countries of origin.

Publicity and Personal Communication

- Events should be publicized through channels most likely to reach Latino members. These include, for example, Latino newspapers and radio stations, as well as churches, local service providers and small grocery stores in Latino neighborhoods.
- Personal communications through trusted individuals – such as doctors, nurses, and community health workers – may be more likely than written communications to motivate members to undergo recommended preventive care screenings.

Effective Themes

- Family and cooking may be effective themes for future outreach activities. For example, messages may emphasize the importance of staying healthy for one's children. Special events could feature nutritional counseling, meal planning advice, and discounts on food items, while also providing health services such as eye exams.

For more information, contact:

Carla Rosenkrans
Project Manager, Clinical Programs and Quality Measurement
Harvard Pilgrim Health Care
93 Worcester Street
Wellesley, MA 02481
(617) 509-7565
Carla_Rosenkrans@harvardpilgrim.org

[1]The Collaborative is a public-private partnership in conjunction with the Agency for Health Care Research & Quality (AHRQ), the Robert Wood Johnson Foundation, the Center for Health Care Strategies, The Institute for Healthcare Improvement, the RAND Corporation, and eight other health plans.

[2]American Diabetes Association guidelines recommend that individuals with diabetes undergo dilated retinal exams at least once a year to help prevent the onset of diabetic retinopathy.

PacifiCare,® a UnitedHealthcare company
Minnesota

Building a Full Suite of Programs For Wellness and Chronic Care

PROGRAM AT A GLANCE

Goals
- **Help all members stay healthy.**
- **Increase use of recommended treatments and procedures among members with chronic conditions.**

Key Strategies

- Offer all members Health Credits,SM which can be redeemed for prizes such as gift cards and iPods, for making healthy lifestyle choices, such as quitting smoking or losing weight.
- Provide disease management to help members with chronic conditions who are at risk of complications address symptoms effectively, pursue diet and exercise plans, and access needed services such as transportation and installation of home medical equipment.
- Provide case management to help individuals at highest risk of complications access services such as behavioral health care, life planning, and financial assistance for medications.
- Reduce health disparities among African American and Latino members through services such as a Spanish-language nurse advice line and a project with African American community groups to address nutrition, stress, and women's health.

Results in Brief

From 2001 to 2005:

- Use of beta-blocker medications among members with congestive heart failure increased from 63% to 83%.
- The percent of members with diabetes whose LDL-cholesterol levels were below 130 mg/dL increased from 44% to 65%.
- The percent of members age 18-56 with asthma who took controller medications increased from 62% to 71%.

FROM CONCEPT TO ACTION

A Continuum of Care

Beginning in 1997, to improve members' quality of life and help slow the growth of health costs, PacifiCare® (now a UnitedHealthcare company), developed a suite of wellness and chronic care programs for individuals with asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease, cancer, end-stage renal disease, depression, and/or coronary artery disease.

The programs address members' needs on a continuum, from wellness programs available to all members, to case management for individuals who are at high risk of hospital admissions or emergency room use within the upcoming 12 to 18 months.

Member Incentives to Promote Wellness

All members are eligible for PacifiCare's wellness program. Through this program, members can earn Health Credits℠ by taking actions such as using PacifiCare's Virtual HealthClub℠ to design customized fitness programs; using online coaching services to meet wellness goals; quitting smoking; meeting targets for weight loss; or completing health risk assessments. Members can redeem health credits for gift cards to stores such as Nordstrom, Borders, and Starbucks; exercise balls; discounts on home fitness equipment; and iPods.

Educational Materials and Reminders

For members living with chronic conditions such as diabetes, coronary artery disease, heart failure, and asthma, PacifiCare offers a series of condition-specific programs called Taking Charge.℠ Members in these programs receive educational newsletters and information on effective care for their conditions, along with reminders to have recommended preventive care services.

Disease Management

For members who have had hospital admissions or emergency room visits within the past 12 to 24 months for specific chronic conditions, PacifiCare offers case-based disease management programs. Members who enroll in these programs have a series of phone consultations with registered nurses who are trained as health coaches.

During these calls, nurses ask members questions about their health status, lifestyle, and symptoms. Nurses discuss effective strategies for addressing symptoms, and they review recommended diet and exercise regimens for specific conditions. Nurses also screen members for depression and refer them for behavioral health services as needed.

Nurses can also help coordinate installation of home medical equipment and transportation to appointments if necessary. They send reports to members' physicians about their progress and follow up with physicians as needed, for example, to inform them of changes in symptoms or difficulties with following treatment plans.

Building a Full Suite of Programs For Wellness and Chronic Care (cont'd)

PacifiCare
A UnitedHealthcare Company

Case Management

PacifiCare also uses software to predict individuals' future risk of complications and hospitalization. For members with chronic conditions who have had hospital admissions or used the emergency room for their conditions within the past 12 to 18 months, who are at risk for future hospitalizations, and/or whose cases are identified as complex because they have several chronic conditions or unmet needs for behavioral health services, the health plan offers a High-Risk Case Management Program.

Through this program, nurse case managers provide a wide range of services to address the full spectrum of member needs, for example, linking members with behavioral health specialists, pharmacy assistance programs to help pay for medications, and social workers who can provide life planning services.

Case managers and disease management nurses in the case-based disease management programs coordinate with each other to assess members' eligibility for each of these programs and help them enroll as needed.

Addressing Disparities in Care

To address disparities in care for African American and Latino members, PacifiCare developed extensive, community-based programs called African American Health Solutions (AAHS) and Latino Health Solutions (LHS). LHS includes, for example, a Spanish-language Web site and toll-free, 24/7 nurse line with information in Spanish, printed and phone-based case management services available in Spanish, and use of Spanish language content in member publications.

Through the AAHS program, PacifiCare works with community and church groups to develop programs and materials on topics such as nutrition, stress management, cholesterol management, and women's health.

Results

From 2001 to 2005, the percent of PacifiCare members who received recommended treatments and procedures for their conditions improved as follows:

Congestive Heart Failure

- Use of beta-blocker medications among members with congestive heart failure increased from 63% to 83%.
- The percent of members with the condition who had physician visits within six weeks of hospital discharge increased from 77% to 86%.

All Cardiovascular Conditions

- The average rate of beta-blocker treatment following heart attacks rose from 91% to 96%.
- The proportion of members with cardiovascular conditions who received LDL-cholesterol screening increased from 68% to 82%.
- The percent of members with LDL-cholesterol levels below 130 mg/dL rose from 47% to 70%.

Diabetes

- The rate of HbA1c blood level testing at recommended intervals among members with diabetes increased from 81% to 87%.
- The percent of members with diabetes whose HbA1c levels were above clinically recommended levels fell from 41% to 30%.
- The percent of individuals with diabetes who had LDL-cholesterol tests within recommended time frames rose from 78% to 92%.
- The proportion of members with the condition whose LDL-cholesterol levels were below 130 mg/dL increased from 44% to 65%.

Asthma

The percent of members who took controller medications for asthma increased:

- From 61% to 74% among members age 5-9;
- From 57% to 68% among individuals age 10-17; and
- From 62% to 71% among adults age 18-56.

For more information, contact:

Sam Ho, M.D.
Chief Medical Officer
Pacific and SW Regions
PacifiCare, a UnitedHealthcare Company
5757 Plaza Drive
Cypress, CA 90630
(714) 226-6879
sam.ho@phs.com

Promoting Excellence in Medical Practice

Major studies by the Institute of Medicine (IOM)[1] and the RAND Corporation[2] have found that individuals in the United States do not receive the care recommended for their health conditions about half of the time. Both studies highlighted the critical need to improve health care quality for all Americans. In its landmark report, *Crossing the Quality Chasm*, the IOM called for health care purchasers in the public and private sectors to create an environment that fosters and rewards improvement by aligning payment incentives with quality care.

Health insurance plans have long been in the forefront of initiatives that use innovative payment arrangements to encourage better care for individuals with chronic illnesses, promote population-based health care, and make a more systematic investment in prevention. These payment arrangements—as well as new efforts to realign payment policies to be consistent with safe and effective care—have three major objectives: (1) to encourage higher-quality clinical performance; (2) to provide purchasers and consumers with greater value for their health care dollars; and (3) to support consumers in making informed health care decisions.

Health insurance plans have long been in the forefront of initiatives that use innovative payment arrangements to encourage better care for individuals with chronic illnesses.

The programs featured in this chapter use a range of strategies to promote excellence in care. Some recognize and reward health care practitioners for providing care according to the medical evidence; others focus on improvements in key health status indicators among members. Some reward health care providers for documenting that they have conducted tests and procedures according to nationally recognized clinical practice guidelines, and others use public recognition of individual physicians with stars symbolizing quality.

AHIP continues to encourage and advance these efforts. Through its work with AQA, AHIP is collaborating with a broad coalition of more than 135 public- and private-sector organizations to develop mutually agreed-upon strategies for: measuring performance at the physician or group level; collecting and aggregating data in the least burdensome way possible; and reporting meaningful information to consumers, physicians, and other stakeholders. For more information about the AQA's work, visit www.aqaalliance.org.

[1]Institute of Medicine (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, D.C. National Academy Press.

[2]McGlynn, E.A., et al. (2003). The quality of health care delivered to adults in the United States. *New England Journal of Medicine.* 348(26). 2635-2645.

Blue Cross and Blue Shield of Illinois

Illinois

Providing Blue Stars and Rewards for High-Performing Physician Groups

PROGRAM AT A GLANCE

Goal ▸ Increase use of recommended care for members with asthma, coronary artery disease, and diabetes.

Key Strategies

- Provide rewards from a Quality Improvement (QI) Fund to physician groups that meet or exceed targets for providing care according to evidence-based clinical practice guidelines.
- Offer guidance to physician offices to encourage documentation of recommended care, such as eye exams for members with diabetes and asthma action plans for individuals with asthma.
- List blue stars in member newsletters, physician directories, employer materials, and the health plan Web site next to physician groups who earn high performance awards for care associated with the three conditions.

Results in Brief

- From 2000 to 2005, the percentage of members with asthma who received written asthma action plans increased from 21% to 73%.
- From 2003 to 2005, the percentage of members with coronary artery disease whose cholesterol levels were below 130 mg/dL increased from 59% to 71%.
- From 2003 to 2005, the percentage of members with diabetes whose LDL-cholesterol levels were below 130 mg/dL increased from 61% to 74%.

FROM CONCEPT TO ACTION

Incentives for Excellence

To motivate physicians to provide recommended services for members with asthma, coronary artery disease, and diabetes, in 2000, Blue Cross and Blue Shield of Illinois (BCBSIL) established a pay-for-performance program for the 80 medical groups (MGs) and independent practice associations (IPAs) that comprise its HMO network.

Each year in its MG/IPA contracts, BCBSIL establishes targets for the percentage of patients who receive care for these conditions in accordance with evidence-based clinical practice guidelines. The health plan makes payments from its Quality Improvement (QI) Fund to physician groups who meet or exceed these thresholds, and it uses a "blue star" rating system to publicly recognize those that achieve the highest levels of performance in providing effective treatments and procedures.

Information Support

To identify members with asthma, coronary artery disease, and diabetes, BCBSIL analyzes inpatient, outpatient, and pharmacy data. Once a year, the health plan sends data request forms to physician groups for each of their patients who have been identified as having one of the three conditions.

Physician office staff complete the forms to indicate the extent to which these patients received recommended services for the conditions (e.g., eye exams for members with diabetes, blood pressure and cholesterol tests for patients with coronary artery disease, and asthma action plans for individuals with asthma).

BCBSIL includes detailed guidance with the data request forms, and it conducts annual training sessions for physician office staff. Office staff also may contact a designated BCBSIL nurse at any time during the year to ask questions about the project.

Physician offices have six months to conduct outreach to patients, provide the recommended services, and return completed forms to the health plan. Health plan nurses review these forms, along with supporting documentation provided by physician office staff, to verify their accuracy.

Disease-Specific Performance Targets

Asthma

To be eligible for QI Fund payments for asthma care, physician groups must demonstrate that they have provided written asthma action plans to at least 60% of their patients with asthma within the past two years. BCBSIL provides higher payments if 70-84% of patients have asthma action plans and the highest payments to groups documenting that they have provided asthma action plans to 85% or more of their patients.

To count toward the QI Fund payments, asthma action plans must include instructions on how to take daily medications, how to monitor asthma, and what to do if symptoms worsen. Health care practitioners must document that they have reviewed these plans with patients and that patients have received copies. Primary care physicians generally are responsible for developing

Providing Blue Stars and Rewards for High-Performing Physician Groups (cont'd)

asthma action plans, though in some cases, specialists, respiratory therapists, or nurse practitioners may develop them.

Coronary Artery Disease

To improve care for members with coronary artery disease, BCBSIL offers physician groups QI Fund payments based on the percentage of their patients with the condition for whom they use electronic or paper flow sheets to track six components of preventive care:

- LDL-cholesterol levels;
- Smoking status;
- Blood pressure;
- Weight;
- Recommendations for physical activity; and
- Use of anti-platelet or anti-coagulant medications, including aspirin.

Physician groups receive payments if at least 60% of their patients with coronary artery disease have had cholesterol tests performed between 60 and 270 days following hospital discharge and are being tracked for at least four of the other five preventive care measures.

Groups that track these measures for 80% or more of their patients receive the highest payments. The health plan provides an additional payment to each physician group that screens at least 30% of its patients with coronary artery disease for depression.

Diabetes Care

Physician groups can receive up to seven separate QI Fund payments for diabetes care. To be eligible for these payments, physician offices must document that among their patients with the condition:

- 85% have hadHbA1c blood tests performed and tracked on flow sheets during the year;
- 70% have flow sheets documenting HbA1c levels below 9%;
- 65% have flow sheets documenting LDL-cholesterol levels below 130 mg/dL;
- 50% have flow sheets documenting screening for kidney disease;
- 55% have flow sheets documenting eye exams;
- 30% are screened for depression; and
- 25% meetBCBSIL's criteria for "overall diabetes preventive care" (defined as having HbA1c levels below 9%, LDL-cholesterol levels below 130mg/dL, having annual eye exams, and being screened for kidney disease).

A Star Rating System to Recognize Performance

To recognize physician performance in the program, BCBSIL's HMO member newsletter, physician directories, employer materials, and public Web site list one star next to physician groups to represent each of the three conditions for which they have earned QI Fund payments in the top tiers. The health plan also awards stars to MG/IPAs for meeting performance thresholds for childhood immunization, Pap tests, and mental health follow-up, so that each physician group can receive up to six blue stars.

Results

Asthma

- From 2000 to 2005, the percentage of members with asthma who received written asthma action plans increased from 21% to 73%. Based on this improvement, BCBSIL estimates that the program helped avoid the need for more than 3,000 asthma-related emergency room visits and more than 900 hospital admissions.

Coronary Artery Disease

- From 2003 to 2005, the percentage of members with coronary artery disease whose cholesterol levels were below 130 mg/dL increased from 59% to 71%, and the percentage whose cholesterol levels were below 100 mg/dL increased from 42% to 57%. In addition, during this period, the percent of members with the condition who were screened for depression increased from 15% to 51%.

Diabetes

- From 1999 to 2000 (when BCBSIL first included HbA1c testing in the pay-for-performance program), the percent of members with diabetes who had HbA1c tests rose from 66% to 74%. In subsequent years, the rate has continued to grow, reaching 83% in 2005.
- LDL-cholesterol levels for members with diabetes likewise have improved since being included in the QI Fund program in 2004: From 2003 to 2005, the percentage of members with diabetes whose LDL-cholesterol levels were below 130 mg/dL increased from 61% to 74%.
- When screening for kidney disease was added to the program in 2005, the screening rate rose from 38% to 60%.

For more information, contact:

Carol Wilhoit, M.D., M.S.
Medical Director, Quality Improvement
Blue Cross and Blue Shield of Illinois
300 E. Randolph
Chicago, IL 60601
(312) 653-2446
wilhoitc@bcbsil.com

Bobbi Berg
Director, Quality and Research
Blue Cross and Blue Shield of Illinois
300 E. Randolph
Chicago, IL 60601
(312) 653-7745
Bobbi_Berg@bcbsil.com

Independent Health Association
New York

Providing Physician Incentives for Practice Excellence

PROGRAM AT A GLANCE

Goal ▸ Preventlife-threatening complications from childhood asthma, adult diabetes, and cardiovascular disease.

Key Strategies

- Provide payment incentives to primary care physicians and pediatricians who document that they provide recommended care to members with the three conditions.
- Send physicians reports summarizing their performance in providing recommended services to members with the three conditions.
- Offer physicians the opportunity to work with experts who can help them modify office procedures to promote efficient and effective care.
- Provide physicians continuing medical education (CME) credits for attending one-on-one information sessions on quality improvement.

Results in Brief

From 2003 to 2006:

- The percent of members with asthma who were using asthma action plans increased from 28% to 76%.
- The percent of members with diabetes whose HbA1c blood levels were below 7 rose from 31% to 45%.
- The proportion of members with diabetes whose LDL-cholesterol levels were below 100 mg/dL rose from 30% to 51%.

FROM CONCEPT TO ACTION

Pay for Participation

To help prevent potential life-threatening and costly complications from the most prevalent chronic conditions among its members, Independent Health Association established the Practice Excellence program in 2003. Initially the program focused on childhood asthma (ages 5-18) and adult diabetes, and it was expanded in 2005 to include cardiovascular disease.

The health plan uses a "Pay for Participation" approach, offering payment incentives to primary care physicians and pediatricians who treat at least 190 Independent Health members and who submit data from patient records indicating whether they have conducted tests and procedures for the three conditions consistent with clinical practice guidelines developed by the American Diabetes Association, the National Heart, Lung, and Blood Institute, and the Centers for Disease Control and Prevention.

Independent Health identifies a random sample of patients from each physician's practice (15 patients with asthma, 15 with diabetes, and 15 with cardiovascular disease as the primary diagnosis) who have had at least two visits with the physician in the past 12 months.

Office staff in participating physicians' offices fill out online forms indicating whether patients have received screening tests, procedures, or medications that are recognized as indicators of effective, high-quality care for the three conditions.

For example, Independent Health collects data on the date and results of the most recent HbA1c tests, dilated eye exams, foot exams, kidney function tests, and cholesterol tests for members with diabetes.

For patients with asthma, the health plan requests information on whether and when patients have had recommended pulmonary function tests and flu shots; whether they have asthma action plans; and whether they are taking controller medications, which can prevent asthma emergencies when taken on an ongoing basis. Data collection for members with cardiovascular disease focuses on the dates and results of the most recent comprehensive risk assessment for heart disease, cholesterol tests, blood pressure screening, measurements of body mass index, and documented guidance for smoking cessation.

Physician offices have approximately four weeks to complete the process and return data to Independent Health. Physicians participating in the Practice Excellence Program can earn up to $2.40 per Independent Health member, per month. Incentive payments can total 10% to 15% of a physician's Independent Health revenue throughout their participation in the program.

Feedback to Physicians

Based on the data submitted by physician offices, Independent Health develops an "adherence-to-guideline score" for each patient, indicating the extent to which he or she has had the recommended treatments and procedures for asthma, diabetes, and/or cardiovascular disease, along with an overall score indicating the physician's performance in providing

treatment according to scientific evidence of effectiveness. The health plan also develops a summary report that compares physicians' average performance on these indicators across their specified patients to that of all other physicians participating in the program. Each participating physician receives a two-page report summarizing results, along with tip sheets outlining strategies for increasing the proportion of his or her patients who receive recommended services for the three conditions.

Organizational Support for Physicians

To help physicians improve their performance in providing quality care, Independent Health offers them the opportunity to work with physician account executives (PAEs), who are trained in system improvement, office redesign, and organizational communication, as well as the specifics of care for asthma, diabetes, and cardiovascular disease.

PAEs visit physician offices with high volumes of Independent Health members on a regular basis (e.g., bimonthly) to help them improve the efficiency and effectiveness of their operations.

For example, they can help office staff develop procedures to analyze physicians' upcoming appointment schedules and contact patients with diabetes, asthma, and/or cardiovascular disease to ensure that they have recommended lab tests or procedures in advance of their visits. Under such a system, physicians can use office visits to fully assess patients' health status and make informed decisions about next steps.

In addition to making PAEs available to work with office staff, Independent Health offers Continuing Medical Education credits to physicians who attend one-on-one information sessions with PAEs on topics such as appointing a quality improvement officer for the practice and developing action plans to improve care for individuals with diabetes, asthma, and cardiovascular disease based on review of their medical records.

Results

More than 90% of PCPs who are eligible for the program participate in it.

Asthma

- The percentage of members with asthma who were using action plans increased from 28% in 2003 to 76% in 2006. Use of controller medications for asthma increased from 61% in 2003 to 83% in 2006. The average overall patient "score" (on a scale of 10) on all indicators of high-quality asthma care increased from 4.8 in 2003 to 7.7 in 2006.

Diabetes

- The percentage of members with diabetes whose HbA1c levels were less than 7 increased from 31% in 2003 to 45% in 2006. The proportion of members with LDL-cholesterol levels less than 100 mg/dL increased from 30% in 2003 to 51% in 2006. The average overall patient "score" (on a scale of 10) on all indicators of high-quality diabetes care increased from 4.4 in 2003 to 5.5 in 2006.

Cardiovascular Disease

- From 2005 to 2006, the percent of members for whom physicians had documented family histories of cardiac disease, tobacco use, and exercise and activity patterns (used to assess individuals' risk of heart disease) increased from 52% to 62%.
- During this time, the proportion of individuals for whom physicians had documented goals for reducing blood pressure and cholesterol levels rose from 61% to 69%, and documentation of body mass index measurements rose from 36% to 73%. From June through December 2006, the overall "score" (based on a 10-point scale) for members undergoing recommended blood pressure and cholesterol tests and reaching goals for cholesterol and blood pressure levels increased from 4.3 to 4.8.

For more information, contact:

Pamela Menard
Vice President, Health Promotion and Care Management
Independent Health Association
511 Farber Lakes Drive
Buffalo, NY 14221
(716) 635-3623
PMENARD@independenthealth.com

Thomas J. Foels, M.D.
Medical Director
Independent Health Association
511 Farber Lakes Drive
Williamsville, NY 14221
(716) 635-3854
drfoels@independenthealth.com

Rocky Mountain Health Plans
Colorado

Driving Physician Performance to New Levels in Diabetes Care

PROGRAM AT A GLANCE

Goal ▸ Improvethe health and health care of individuals with diabetes.

Key Strategies

- Offer payment incentives to physicians based on:
  (1) key health status indicators among their patients with diabetes; and
  (2) use of quality improvement strategies such as scheduling planned visits for diabetes care.
- Send physicians reports comparing their performance in providing effective diabetes care to that of other physicians.

Results in Brief

During the program's pilot phase from September 2003 to September 2005:

- The percent of members with diabetes who had LDL-cholesterol levels below 100 mg/dL in the previous 14 months increased from 29% to 42%.
- The percent of members with diabetes who had blood pressure readings below 130/80 increased from 25% to 34%.

FROM CONCEPT TO ACTION

Partnering with Physicians

To encourage health care practitioners to provide effective diabetes care, Rocky Mountain Health Plans (RMHP) worked with the Mesa County Physicians Independent Practice Association (MCP IPA) to develop a diabetes care pilot program in 2003.

The program, which incorporated performance measures based on American Diabetes Association guidelines, included two types of incentives: (1) lump-sum incentive payments to physicians based on their performance in improving key measures of diabetes care (e.g., HbA1c blood levels, LDL-cholesterol levels, blood pressure readings, and aspirin use); and (2) case management fees paid to physicians for support in implementing the Chronic Care Model (CCM)[1] for diabetes.

Improving Physician Performance on Key Measures

To improve physician performance in providing effective diabetes care, RMHP and MCP IPA offered each primary care physician a lump-sum payment each quarter based on HbA1c blood levels, LDL-cholesterol levels, blood pressure readings, and aspirin use among his or her patients with diabetes. Physicians participating in the program submitted patient-specific data to RMHP on each of these measures. RMHP validated, analyzed and aggregated the data for each physician to determine his or her overall performance on each measure for members with diabetes. Based on a comparison of each physician's performance with that of other participating doctors, the health plan and IPA provided incentive payments averaging $5,000 per physician annually.

At the end of each quarter, the IPA sent each participating physician a report describing his or her performance and the performance of his or her group practice, along with a comparison of the physician's performance with that of all physicians in the pilot.

Promoting the Chronic Care Model

Also as part of the initiative, primary care physicians had the option of implementing the Chronic Care Model. For physicians who agreed to use the model, RMHP clinical staff provided training on its six elements and on use of quality improvement cycles to promote excellence in care delivery and to achieve better outcomes. Physicians' quality improvement strategies included, for example, scheduling planned visits for diabetes care and using a new patient care registry developed by RMHP. Physician office staff used a variety of strategies to maximize the benefits of planned visits, such as working with patients to ensure that they had all recommended tests in advance so that visits could focus on results and next steps.

The patient care registry, which RMHP provided and installed in participating physician offices at no cost, was a freestanding ACCESS database that showed patients' progress toward completing the recommended regimen for diabetes care and tracked key health status indicators (e.g., HbA1c blood levels, blood pressure readings, cholesterol levels).

The registry allowed each practice to identify individuals with diabetes who had not undergone important tests or procedures so that office staff could contact them to schedule appointments. Primary care physicians who implemented the Chronic Care Model, demonstrated ongoing quality improvement efforts, and used the patient care registry received case management fees of $120 per patient with diabetes per year. RMHP's quarterly

Driving Physician Performance to New Levels in Diabetes Care (cont'd)

performance reports to physicians listed the total amounts earned through these fees as well as amounts earned from the lump-sum incentive program.

Results

Although RMHP's primary care physicians in Mesa County had the opportunity to opt out of the pilot program, 100% (approximately 80 physicians) participated by submitting data for the performance improvement component of the program. Approximately 50% also adopted the Chronic Care Model.

The pilot was associated with statistically significant improvements in diabetes care for Medicare, Medicaid, and privately insured members. From September 2003 to September 2005:

- The percentage of members with diabetes who had LDL-cholesterol levels below 100 mg/dL in the previous 14 months increased from 29% to 42%.
- The percent of members with diabetes who used aspirin on a daily basis increased from 56% to 82%.
- The percent of members with diabetes who had blood pressure readings below 130/80 increased from 25% to 34%.
- The percent of members with diabetes whose HbA1c blood levels were less than or equal to 7% or had improved by 1% within the previous six months increased from 43% to 48%.
- Practices using the Chronic Care Model achieved significantly better outcomes on each measure than those not using the model.

Based largely on reductions in hospital admissions and lengths of stay attributable to the program, RMHP estimated that health care costs for members in the pilot were approximately $73 per member with diabetes per month less than projections, which were based on costs prior to the program's implementation. RMHP is conducting a formal evaluation of the program, and depending on the results, the health plan will decide whether to implement the initiative throughout its network.

For more information, contact:

David Herr, M.D.
Chief Medical Officer
Rocky Mountain Health Plans
2775 Crossroads Boulevard
Grand Junction, CO 81506
(970) 248-5123
dherr@rmhp.org

Lori Stephenson, R.N.
Director, Quality Improvement
Rocky Mountain Health Plans
2775 Crossroads Boulevard
Grand Junction, CO 81506
(970) 248-5124
lori_stephenson@rmhp.org

[1]The Chronic Care Model is a nationally recognized system of patient-centered care for chronic conditions based on scientific evidence of effectiveness. The model, developed by staff at the MacColl Institute for Healthcare Innovation, identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are: the community; the health system; self-management support; delivery system design; decision support; and clinical information systems. The Robert Wood Johnson Foundation has provided funding to the MacColl Institute to test the model nationally across varied health care settings, and the national program is called "Improving Chronic Illness Care" (ICIC).

UnitedHealthcare
Minnesota

UnitedHealth Group®

Placing a Premium on Outstanding Performance

PROGRAM AT A GLANCE

Goal ▸ Promotehigh-quality health care for members throughout the country.

Key Strategies

- Recognize physicians who meet specified benchmarks for effective care with "Premium Designations" symbolized by stars on the health plan's Web site.
- Inform members which health care practitioners and facilities in their communities have earned the Premium Designation and offer referrals to these providers as needed.
- Create a Centers of Excellence program to provide members with access to facilities with strong track records for quality care and positive health outcomes for treatment of complex cancers, kidney disease, and organ failure.

Results in Brief

From 2003 to 2006, the percent of members using Centers of Excellence for organ transplants increased from 65% to more than 95%.

FROM CONCEPT TO ACTION

A Performance-Based Approach to Improving Care

To promote high-quality care for members throughout the country, UnitedHealthcare created the UnitedHealth Premium Designation℠ program as a supplement to its ongoing chronic care and Centers of Excellence network initiatives in 2005.

The Premium Designation program recognizes and rewards physicians and other health care professionals who meet quality and efficiency-of-care standards based on scientific evidence of effectiveness.

To identify health care practitioners for the Premium Designation program, UnitedHealthcare analyzes nationally recognized performance measures, such as the percent of a physician's patients who have had recommended care for diabetes (e.g., regular HbA1c tests, eye exams, screening for kidney disease), coronary artery disease (e.g., statins, regular LDL-cholesterol tests, beta blocker medications after heart attack), asthma (e.g., controller medications), and other health conditions (e.g., sinusitis, epilepsy, migraines). For each physician's practice, the health plan also measures post-surgical complication and hospital readmission rates, as well as key indicators of patient health (e.g., HbA1c, LDL and HDL cholesterol levels).

Members searching UnitedHealthcare's Web site can view the names of health care practitioners who meet the program's performance standards. Physicians who meet the program's quality criteria are recognized with a "quality star," and those who meet both quality and efficiency-of-care criteria (based on risk- and case mix-adjusted analyses of costs per episode of care) are recognized with two stars. Only physicians who meet the quality standard are eligible for the efficiency star.

Nurse health advisors working with members enrolled in UnitedHealthcare's chronic care programs for conditions such as asthma, diabetes, coronary artery disease, cancer, congestive heart failure, kidney disease, and back pain let members know which health care practitioners and facilities in their communities have earned the Premium Designation and explain its significance. Health advisors also may provide referrals to premium-designated practitioners and facilities if individuals are not satisfied with their current health care providers, are seeking second opinions, or are not receiving care consistent with the medical evidence.

Coaching from Nurse Health Advisors

Individuals with chronic conditions are linked with nurse health advisors if their medical, lab, pharmacy claims or responses to UnitedHealthcare's health risk assessment surveys suggest they are at high risk for complications or hospitalization within 12 months. The program also receives referrals from physicians, employers, UnitedHealthcare's 24-hour nurse line, social workers in the company's employee benefit call center, disability insurers, and United Behavioral Health.

During a series of regularly scheduled phone consultations with members, nurse health advisors help them understand their health conditions, explain recommended treatments, determine whether they are taking medications as prescribed, and help them follow physicians' treatment plans. Health advisors determine whether members have had tests and procedures recommended for their conditions, and

they can schedule appointments and facilitate transportation to doctor visits. They ask questions to screen members for depression, evaluate levels of family and social support, and coordinate with United Behavioral Health to provide referrals to behavioral health specialists as needed. Health advisors also provide coaching on lifestyle changes (e.g., diet, exercise, smoking cessation) to improve members' health.

Following a catastrophic event such as trauma, nurse health advisors may contact individuals every day to help ensure that their conditions are stabilized. Subsequently, they may speak with members on a regular basis or as needed to track progress, answer questions and provide assistance. Health advisors provide support based on members' needs, and the duration of their contact with members can range from several days to more than a year.

Centers of Excellence

Besides having access to nurse health advisors and Premium Designation information, individuals with complex cancer (e.g., brain, liver, or esophageal cancer), kidney disease, or organ failure have the opportunity to use UnitedHealthcare's Centers of Excellence. In each state, UnitedHealthcare reviews nationally reported data on facilities' patient volume, number of complications, mortality rates, and results from its own analyses to develop a Centers of Excellence network of facilities with strong track records of high-quality care and positive health outcomes. Dialysis facilities were added to the program in 2005.

When members are scheduled for organ transplants, dialysis, or treatment for complex cancer, nurse consultants with training in these procedures contact them by phone to describe Centers of Excellence facilities' performance in providing quality care. If individuals are interested in seeking care at a Center of Excellence, nurses help them find the facility best suited to their needs, and they can coordinate with Center staff to schedule treatments and procedures.

Results

From 2003 to 2006, the percentage of UnitedHealthcare members using Centers of Excellence for organ transplants increased from 65% to more than 95%.

For more information, contact:

Ann Fleischauer
Director, Communication and Public Relations
Specialized Care Services, a UnitedHealth Group company
9900 Bren Road East
Minnetonka, MN 55343
(952) 936-4950
ann_fleischauer@uhc.com

CHAPTER 4

Using Effective New Tools in Chronic Care

Effective chronic care is a "high-touch" endeavor, with nurses and doctors working hand-in-hand on an ongoing basis with consumers, to help them access all of the medical, social service, and behavioral health services they need. In the past several years, health insurance plans have taken customized service to a new level, aided by a host of new tools and strategies that are producing increasingly positive results. Consistent with privacy standards established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), health plans continue to analyze claims and reach out to members with chronic disease diagnoses through phone calls, informational mailings, and reminders to schedule preventive care visits and screenings recommended by nationally recognized guidelines for evidence-based care. Health plans also are encouraging members to fill out health risk assessment surveys after they sign up for coverage and at employee health fairs, so they can identify members who could benefit from chronic care programs and offer them the opportunity to enroll.

In the past several years, health insurance plans have taken customized service to a new level, aided by a host of new tools and strategies that are producing increasingly positive results.

To identify members with chronic conditions who are at greatest risk of complications early, before they end up in hospital emergency rooms, growing numbers of health plans use advanced predictive modeling techniques. Health plans then "risk-stratify," offering outreach and information tailored to individuals' potential risk of complications and/or hospitalization. Plans offer extensive one-on-one health coaching and case management to help members at highest risk maintain optimal health.

Phone- and Web-based innovations also are enhancing the effectiveness of chronic care programs. Health insurance plans use state-of-the-art interactive voice response (IVR) systems to reach out to members by phone, ask questions about their use of chronic care services, and encourage them to schedule appointments for preventive care. To support members' self-care goals, health plans provide extensive online health libraries and Web-based tools to help individuals make healthy lifestyle changes. In addition, health plans are using advanced information systems to track member care and promote timely communication and coordination among all of the health professionals working to meet individuals' needs.

These initiatives are producing measurable results: Key health status measures—such as cholesterol, blood sugar, and blood pressure levels—are improving. More members are using recommended preventive care services—such as flu shots, dilated retinal exams, and foot exams—than in past years. More are taking medications, such as beta-blockers following heart attack, controller medications for asthma, and ACE inhibitors for congestive heart failure, that have proven effective in improving health. Unnecessary hospital admissions and emergency room visits are on the decline. By helping individuals with chronic conditions live healthy and productive lives, health plans are making important progress in improving health care quality and reducing unnecessary costs throughout the health care system.

Aetna
Connecticut

Taking a Global Approach to Chronic Care for Medicare Beneficiaries

PROGRAM AT A GLANCE

Goal ▸ Improve health status and remove barriers to care for Medicare beneficiaries with chronic conditions.

Key Strategies

- Conduct global assessments of Medicare beneficiaries' needs, including medical care, behavioral health, transportation, home care, financial assistance, and end-of-life care.
- Provide case management to help members access effective care and follow physicians' treatment plans.
- Use sophisticated information systems to track member needs and facilitate care coordination.

Results in Brief

Since 2002, rates of hospital admission for program participants have been 26% below rates for members formerly in disease management programs that did not integrate medical services with behavioral health and social services.

FROM CONCEPT TO ACTION

Providing a Full Spectrum of Services

Recognizing that Medicare beneficiaries with heart failure, diabetes, and other chronic conditions often have additional medical or behavioral health needs, Aetna developed the Geriatric Case Management Program for Medicare Advantage members in 2003.

The program takes an integrated approach that combines medical treatment, screening and care for depression, end-of-life care options, and strategies to address additional needs (e.g., transportation, home care, social services) prevalent among the elderly.

Aetna created two Geriatric Case Management units to conduct the program in regions of the country with large Medicare populations, as well as a national unit to conduct the program in other areas to ensure that all Aetna Medicare Advantage members have access to its services. Each unit is comprised of nurse case managers, social workers, and behavioral health care coordinators.

Identifying Members Who Can Benefit

Aetna uses several methods to identify members who could benefit from the program. The health plan conducts health risk assessments by phone for all new members to identify chronic conditions and other issues that could be addressed effectively through disease management, case management, and other specialized services.

In addition, Aetna analyzes medical, pharmacy, and laboratory claims data to identify members with chronic conditions, including asthma, coronary artery disease, and diabetes. It combines these data with information from the medical management process to target members with health conditions and other needs that could most benefit from the program. Physicians, case management nurses, and family members can refer people to the program, and individuals can self-refer.

Aetna's nurse case managers also conduct monthly reviews of data from the health plan's predictive modeling program, which has the ability, through claims analysis, to predict which members may need case management services. Besides providing timely identification of case management needs, this monthly analysis facilitates effective coordination of care.

Comprehensive Care Plans

Based on the health plan's analyses and referrals, nurses contact members by phone to describe the program and offer the opportunity to enroll. Once members decide to participate, nurse case managers contact them again by phone to conduct more global assessments of their needs, identify other health conditions that need to be addressed, and identify any barriers (e.g., finances, dementia, or depression) preventing them from receiving the care they need. Case managers contact members as often as needed, to ensure they are obtaining effective care and are following physicians' treatment plans.

Case managers have operating systems on their desktops that allow them to monitor and coordinate activities with Lifemasters, Aetna's disease management partner for heart failure and diabetes. Based on the additional information that these systems provide about members' health, case managers develop global chronic care plans that account for all of their members'

Taking a Global Approach to Chronic Care for Medicare Beneficiaries (cont'd)

conditions and ensure that they receive services from social workers, behavioral health case managers, and other professionals as needed.

Home Visits

For members who are difficult to reach by phone, Aetna provides home-based case management in selected service areas. Aetna plans to expand the programs to all of its major Medicare Advantage service areas in the next two years.

Services for Nursing Home Residents

For members who need long-term care in nursing homes, Aetna provides on-site care management in select areas. Over the next two years, Aetna plans to expand the program to all regions of the country for its Medicare Advantage members. Aetna likewise will expand care management for sub-acute care provided in nursing homes to include all Medicare Advantage members nationwide.

Results

- Sixteen percent of Aetna's Medicare Advantage members participate in the Geriatric Case Management program each year. Since 2002, rates of hospital admission for program participants have been 26% below historical rates for members formerly in disease management programs that did not integrate medical services with behavioral health and social services. In 2005, the number of hospital inpatient days for program participants was 30% below the number for Medicare fee-for-service (FFS) members in areas where Aetna operates.
- In Aetna's 2004 physician satisfaction survey, 92% of physicians rated their overall satisfaction with the congestive heart failure and diabetes programs as good to excellent. In addition, in the health plan's 2003 member satisfaction survey, 98% of participants in the Geriatric Case Management Program rated its services for chronic heart failure as good to excellent, and 96% of participants rated the diabetes component of the program as good to excellent.

For more information, contact:

Randall Krakauer, M.D.
National Medical Director, Retiree Markets
Aetna
1 Farr View
Cranbury, NJ 08512
(609) 708-2286
krakauermdr@aetna.com

Aetna
Connecticut

Offering Tools for a Healthy Life for Members with Heart Failure

PROGRAM AT A GLANCE

Goal ▸ Preventcomplications from heart failure.

Key Strategies

- Provide members with "Heart Conditions Journals" for recording symptoms such as shortness of breath or chest pain and encourage them to contact physicians immediately for follow-up.
- Offer health coaching from disease management health professionals, to provide members with information about congestive heart failure, help them follow treatment plans, and promote lifestyle changes, such as smoking cessation and weight loss, to improve health.
- Send primary care physicians information about the program and post clinical practice guidelines for chronic heart failure on the health plan's physician Web site.

Results in Brief

Ninety-six percent of members surveyed in 2004 said they were satisfied with the program, and 92% of physicians said they were satisfied with it.

FROM CONCEPT TO ACTION

Reducing Complications from Heart Failure

In an effort to reduce complications associated with chronic heart failure, Aetna introduced the Chronic Heart Failure (CHF) Disease Management Program in 1993. Since the program's inception, Aetna has enhanced its work by incorporating state-of-the-art methods of data analysis to identify members early who are most at risk of complications that lead to emergencies and hospitalization.

The health plan provides these members with services on an ongoing basis to help them stay healthy and avoid complications. In addition, to improve coordination of care, Aetna developed a comprehensive utilization management system. This comprehensive system combines all of its medical management information to allow all Aetna medical professionals to view data on members' use of services—for congestive heart failure and all other conditions—easily, on a single platform.

Aetna analyzes medical, pharmacy and laboratory claims data to identify members with chronic conditions, including asthma, coronary artery disease and diabetes. It combines these data with information from its medical management system to target members with chronic heart failure who could most benefit from the program. Physicians, case management nurses, and family members can refer people to the program, and individuals can self-refer.

Resources for Members

Aetna sends all members identified for the program introductory packets that invite them to participate and describe the program's activities and benefits. When members decide to participate, they receive phone calls from nurse case managers, who administer clinical needs assessments.

Topics discussed during these assessments include: members' physical and mental health status; dietary needs; history of hospitalization, emergency room use, and medications. In addition, case managers conduct screenings for depression, which often accompanies other chronic conditions. Based on responses to these assessments, case managers determine the program activities best suited to each member's needs.

Each member participating in the program receives a Heart Conditions Journal. Members can record any instances of chest pain or shortness of breath in the journal and are instructed to report these symptoms immediately to their physicians so that treatments can be provided as needed. Members are encouraged to bring the journals to doctor visits to have their blood pressure readings entered. Members also receive educational mailings on a quarterly basis on topics such as monitoring their symptoms, eating a healthy diet, exercising regularly, and taking medications.

Each member identified with heart failure is considered to be at high risk of complications and is offered the opportunity to consult regularly by phone with a nurse case manager, who serves as the member's regular point of contact. Nurses set up calls with members based on their preferences for frequency of contact. These calls can be monthly and are at least once every three months.

During their phone consultations with members, nurse case managers teach them about congestive heart failure and review physicians' treatment plans.

Offering Tools for a Healthy Life for Members with Heart Failure (cont'd)

They help members identify symptoms that need to be addressed immediately, and they discuss lifestyle changes—such as smoking cessation or weight loss—that can help improve members' health. Nurses monitor key clinical indicators by reviewing members' entries in their Heart Conditions Journals, and they communicate with members and their treating physicians as needed to help prevent complications.

Information for Physicians

To increase physicians' awareness of CHF and the latest treatment recommendations, Aetna sends all of its participating primary care physicians caring for patients with heart failure information about its Chronic Heart Failure Disease Management Program. Aetna also posts the American College of Cardiology/American Heart Association's most recent clinical practice guidelines for chronic heart failure on its secure physician Web site.

Results

- In its 2004 annual satisfaction survey of members, 96% of members expressed overall satisfaction with the Chronic Heart Failure program. Of physicians surveyed, 92% expressed overall satisfaction with the CHF program.
- In 2003, Aetna's Caring for Chronic Heart Failure program won the Best Disease Management Program in Managed Care Award from the Disease Management Association of America (DMAA).

For more information, contact:

Andrew Baskin, M.D.
National Medical Director
Aetna
980 Jolly Road
Blue Bell, PA 19422
(215) 775-6803
BaskinAM@aetna.com

Blue Care Network of Michigan

Michigan

Helping Members with Heart Failure Take Charge of their Health

PROGRAM AT A GLANCE

Goal ▸ Increase use of effective care and avoid unnecessary hospital and emergency room visits for individuals with congestive heart failure.

Key Strategies

- Help members use "personal health cards" to track their blood pressure, weight, and cholesterol levels.
- Provide access to a licensed medical social worker, who can help members address financial concerns, find transportation and other community resources, and address end-of-life issues as needed.
- Offer health coaching to help members follow diet and exercise recommendations, take medications as prescribed, and quit smoking.
- Offer digital monitors to help members identify early warning signs of heart failure complications.

Results in Brief

- In 2005, 70% of members enrolled in the program used ACE inhibitor medications as recommended, and 70% reported using beta-blockers as prescribed.
- In 2005, 98% of members rated the program as "very good" or "excellent," and 98.4% of these members said they would recommend the program to others.
- Total savings from the program from 2003 to 2004 was more than $1.3 million, attributable to reductions in emergency room visits and inpatient admissions.

FROM CONCEPT TO ACTION

Promoting Effective Treatment

Recognizing that congestive heart failure is a debilitating condition that often leads to hospitalization if not treated on an ongoing basis, Blue Care Network of Michigan (BCN), in conjunction with Alere® Medical, implemented a congestive heart failure program in 1999 for members age 18 and older. The program seeks to increase physicians' use of effective methods for treating congestive heart failure, increase members' use of recommended medications and services, and help avoid unnecessary hospitalizations and emergency room visits.

Identifying Members Who Can Benefit

Blue Care Network uses a variety of sources to identify members with congestive heart failure, including claims, direct referrals from health care practitioners, member self-referrals and other BCN departments. As members are identified, they are added to the disease management registry. Unless they opt out, members in the registry receive introductory packets and regular mailings on chronic care issues. Each member enrolled in the case management program receives an initial phone call from a nurse case manager, who conducts a health risk assessment and evaluates his or her functional status as well as physical and emotional well-being. Because individuals with congestive heart failure often suffer from depression that can impair their ability to follow care plans, nurses also ask questions to screen members for depression and refer them to behavioral health care practitioners as needed. On a quarterly basis, nurse case managers contact program participants to conduct follow-up health risk assessments and functional status surveys to measure changes in their conditions.

Program Activities Based on Risk Levels

In April 2003, Blue Care Network of Michigan began using new software to determine which members were at highest risk of complications, including hospitalization, due to congestive heart failure. The software analyzes members' claims and demographics and divides them into risk groups. Members are assigned risk levels based on their responses to the case management health assessment. These members receive services through the program based on their level of risk.

Written Materials

Members at the lowest risk of complications receive mailings that emphasize regular communication with physicians and the importance of following their physicians' treatment plan. The information also provides the names and phone numbers of Blue Care Network nurses. Periodically, these members receive material about lifestyle issues, such as diet and smoking, that affect their health and the important signs and symptoms to monitor every day (e.g., weight gain, level of difficulty with physical activity). These members also receive quarterly newsletters that address issues such as following a low-sodium diet, taking recommended medications, and following their physicians' treatment plan. Individuals can opt out of the program at any time.

Personal Health Cards to Track Key Clinical Findings

Blue Care Network gives program participants "personal health cards" they can use to track key clinical findings, such as blood pressure, weight, and cholesterol levels. Nurses help members understand what these readings mean, and they work with members to monitor and track the values over time. The cards list a toll-free number members can use to contact a nurse with any questions or concerns.

Helping Members with Heart Failure Take Charge of their Health (cont'd)

Blue Care Network of Michigan
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Health Education Classes and Assistance from a Certified Licensed Medical Social Worker

Blue Care Network offers members a variety of health education programs, including nutritional counseling, smoking cessation, and weight management. All members with congestive heart failure also have access to Blue Care Network's certified licensed medical social worker, who can help them address financial concerns, access community resources, find transportation, and address end-of-life issues as needed.

Regular Phone Contact with Nurse Case Managers

In addition to receiving the written materials provided to low-risk individuals, members considered to be at moderate risk of complications can receive regular phone calls from nurse case managers. Enrolled individuals receive phone calls from nurses at least two or three times per quarter, or more frequently based on individual need.

Members considered to be at high risk of complications and hospitalization receive all the program's written materials and may receive phone calls from nurse case managers at least two to three times per month. The frequency of contact may change based on members' needs.

During telephone calls to members in the moderate- and high-risk groups, nurse case managers provide suggestions on nutrition and weight management issues; discuss effective medications; encourage members to take recommended medications as prescribed; counsel them on quitting smoking and refer them to smoking cessation programs; and help coordinate any medical, behavioral, and social work services they need. Case managers conduct health assessments and functional status surveys every three months to determine whether members' health status has changed and whether they have met the goals established in their care plans.

Regular Weight and Symptom Management to Alert Physicians to Potential Problems

Members with congestive heart failure who meet specified criteria (e.g., are at least 18 years old, have a land-line phone, weigh no more than 475 pounds) and whose physicians agree to participate have the option of enrolling in a weight and symptom management program conducted by Alere® Medical. Each member enrolled in the program receives a digital scale with a DayLink® monitor to identify early warning signs of congestive heart failure complications.

Members weigh themselves on the scales in the morning and evening, and they answer questions about their symptoms (e.g., whether they are experiencing foot swelling and shortness of breath and whether they have missed medication doses or skipped recommended exercise). Monitors transmit the answers to Alere® over the telephone line to nurses who review the information and alert members' doctors and the health plan of any potentially problematic changes in symptoms or weight.

Regular Communication with Physicians

Besides providing extensive information and services to members with congestive heart failure, Blue Care Network communicates regularly with their physicians. Primary care physicians receive Blue Care Network's clinical practice guidelines on congestive heart failure, as well as reports on each of their patients in the program.

Case management reports describe patients' health and functional status, medications, identified needs for behavioral health services, progress toward member goals established in their care plans, risk of complications, recent hospitalizations, and recommendations for additional health care services.

The reports provide physicians with an opportunity to provide written feedback about the program and to convey additional information about the member's treatment plan. Nurses providing case management to individuals at moderate and high risk of complications work with these members' primary care physicians and specialists to develop individualized care plans, including goals and activities tailored to members' needs.

BCN's physician newsletter further reinforces the program by including regular articles on congestive heart failure and clinical outcome updates for the Alere® home monitoring program.

Results

Improvements in Quality and High Satisfaction

- In 2005, 70% of members enrolled in the Alere® program used ACE inhibitor medications as recommended, and 70% reported using beta-blockers as prescribed. From mid-2004 through the end of 2005, members' self-reported psychological well-being, as measured on the functional assessment tool administered by case managers, increased from 47.5% to 49.9%.
- Ninety-eight percent of members responding to a 2005 survey rated the Alere® program as "very good" or "excellent," and 98.4% of these members said they would recommend the program to others.
- Seventy-six percent of respondents to a 2005 physician survey said they believed the program was having a positive impact on patients, and 52.4% said the program helped them better monitor patients' health conditions.

Cost Savings

- Total savings from the program from 2003 to 2004 exceeded $1.3 million, attributable to reductions in emergency room visits and inpatient admissions.
- In 2004, the number of inpatient admissions per thousand members at high risk of complications who were enrolled in the CHF program was 1,337, compared with 1,953 per thousand members in the same risk group who were not enrolled in the program.
- The number of emergency room visits per thousand members enrolled in the program in the two highest risk groups was 1,849, compared with 2,179 members with the condition who were not enrolled in the program.

For more information, contact:

Diane Bridgeman
Director
Medical Management — Mail Code C336
Blue Care Network of Michigan
20500 Civic Center Drive
Southfield, MI 48076
(248) 799-6767
dbridgeman@bcbsm.com

Blue Cross and Blue Shield of Florida

Florida

Collaborating in Real Time to Keep Heart Failure Patients Healthy

PROGRAM AT A GLANCE

Goal ▸ Promoteeffective care and avoid unnecessary hospitalization for individuals with heart failure.

Key Strategies

- Offer health coaching to encourage use of recommended medications, help members eat healthy diets, and identify issues that warrant physician follow-up.
- Update physicians on members' symptoms regularly by fax or phone so that they can respond quickly.
- If members do not refill recommended prescriptions, contact physicians to promote timely follow-up with patients.

Results in Brief

- From 2003 to 2004, the percent of members with congestive heart failure who had LDL-cholesterol levels below 130 mg/dL increased from 69% to 72%.
- Between the first and fourth quarters of 2005, the number of hospital admissions per 1,000 for individuals with congestive heart failure decreased from 0.16 to 0.11, and hospital days per 1,000 decreased from 0.90 to 0.76.

FROM CONCEPT TO ACTION

A Tailored Approach Based on Members' Needs

To increase members' knowledge and improve health outcomes among individuals with congestive heart failure, Blue Cross and Blue Shield of Florida implemented the Blueprint for Health® Congestive Heart Failure Program in 1997. Members are eligible for the program if they are 18 years or older, are members of the health plan's HMO or Medicare Advantage plan, and have a diagnosis of congestive heart failure.

To identify members eligible for the program, Blue Cross and Blue Shield of Florida analyzes medical and pharmacy claims, diagnosis codes for doctor visits and hospital care, and the state census of hospital patients. Physicians, medical management nurses, and case managers can refer individuals to the program, and members can self-refer. Based on claims analyses and referrals, nurse case managers contact members by phone or through direct mail to describe the program and offer the opportunity to opt out.

Initial Risk Assessments

Nurses contact newly enrolled program participants by phone to assess the severity of their conditions, using the New York Heart Association's classification system. During the initial call, nurses give members a phone number to call if they have questions. Based on results of the risk assessment, Blue Cross and Blue Shield of Florida determines how often nurses should contact members to check their health status and help them address their needs.

Welcome Packets

All new Blueprint members receive welcome packets with an overview of the program; information on effective care for congestive heart failure; the phone number to call with questions; and a refrigerator magnet with a list of reminders for monitoring daily weight, avoiding salt, and taking medications as prescribed.

Packets also include a survey to determine how much members know about congestive heart failure, whether they are following a prescribed plan of care, which medications they are taking, and whether they are following the diet recommended for the condition. The survey asks members whether they would like to work on a regular basis with nurse case managers or whether they would prefer to receive written educational information only. Nurses make at least three attempts to contact by phone members who have not completed the survey, and if they still are unable to reach them, send letters describing the program's benefits and encouraging participation.

Regular Mailings

All program participants receive quarterly and annual mailings that include seasonal information, such as tips on how to stick to a diet over the holidays, and coupons for flu shots. Blue Cross and Blue Shield of Florida sends an annual mailing (usually at the end of the year with a calendar) that includes a brochure on depression and congestive heart failure, as well as a leaflet on how to avoid emergencies that lead to hospitalization.

Regular Telephone Consultations with Nurses

If nurses determine through their initial risk assessments that members have symptoms placing them at risk of hospitalization (e.g., fatigue or discomfort with physical activity, heart palpitations, chest pain), they contact them by phone on a regular basis, anywhere from weekly to monthly. During these calls, nurses ask them about their symptoms, weight, and diet; determine whether they are taking

recommended medications; and identify issues that warrant additional follow-up with physicians.

Regular Communication with Physicians

In addition to providing information and one-on-one phone consultations to members with congestive heart failure, Blue Cross and Blue Shield of Florida communicates regularly with their physicians. The health plan sends physicians copies of the American College of Cardiology/American Heart Association clinical practice guidelines for treating congestive heart failure and lists the guidelines on its Web site. In addition, when members enroll in the program, Blue Cross and Blue Shield of Florida faxes a letter to their physicians describing the program, encouraging them to have their patients participate, and providing the name and phone number for the nurse who will be in contact with each member.

To ensure that doctors can respond in a timely manner to changes in their patients' health status or symptoms (e.g., increased swelling, discomfort with physical activity, palpitations, overnight weight gain of three pounds or more), case management nurses fax regular updates—through a program called "Faxination"—to these doctors as soon as they learn about issues of concern. When nurses identify urgent issues, they contact physician offices immediately by phone.

If it is not clear whether a member is taking medications as recommended or if the member indicates that he or she is not taking prescribed medications, the case management nurse asks the health plan's Pharmacy Department to check the member's prescription refill history. If the Pharmacy Department confirms that prescriptions were not refilled, case management nurses contact members' physicians so that they can work with patients to ensure that they follow recommended care plans.

Results

- As of June 2005, nearly 3,000 individuals were enrolled in the program.
- Average inpatient length of stay for members admitted with congestive heart failure decreased by nearly 9%, from 6.62 in 2004 to 6.04 in 2005.
- Between the first and fourth quarters of 2005, the number of hospital admissions per 1,000 for individuals with congestive heart failure decreased from 0.16 to 0.11, and hospital days per 1,000 decreased from 0.90 to 0.76.

From 2003 to 2004:

- The percent of members with congestive heart failure who had LDL-cholesterol levels below 130mg/dL increased from 69% to 72%.
- The proportion of individuals with the condition whose blood pressure levels were below 130/80 mm/Hg rose from 63% to 72%.

For more information, contact:

Regine Joly
Manager, Regional Health Management Programs
Blue Cross and Blue Shield of Florida
8400 NW 33rd Street
Suite 100
Miami, FL 33122
(305) 921-7430
regine.joly@bcbsfl.com

Blue Cross and Blue Shield of Florida

Florida

Creating a Road Map to Better Health for Members with Asthma

PROGRAM AT A GLANCE

Goal ▸ Increase use of recommended treatments and prevent unnecessary complications and emergencies among members with asthma.

Key Strategies

- Provide health coaching to help members understand asthma, follow physicians' treatment plans, and use peak flow meters correctly.
- Identify members' reasons for not filling prescriptions for asthma maintenance medications, such as lack of transportation or knowledge, and follow up to address these reasons.
- Arrange in-home asthma education sessions as needed and provide age-appropriate educational videos on the condition and effective treatment.
- Send primary care physicians quarterly reports on members' use of effective asthma medications and their hospital and emergency room use.

Results in Brief

- From 2002 to 2004, use of recommended controller medications among members with asthma increased from 60.8% to 64.2%.
- Asthma-related emergency room visits among members enrolled in the program for at least a year fell from 18.6 visits per 10,000 in 2003 to 14 visits per 10,000 in 2004.

FROM CONCEPT TO ACTION

The Blueprint for Health® Asthma Program

To increase the proportion of members with asthma who use effective treatments and to reduce unnecessary emergency room use and hospital admissions, Blue Cross and Blue Shield of Florida implemented an asthma disease management program called Blueprint for Health in 1995.

Finding Members Who Can Benefit

To identify members eligible for the program, Blue Cross and Blue Shield of Florida analyzes medical and pharmacy claims, diagnosis codes for doctor visits and hospital care, and the state census of hospital patients. Physicians, medical management nurses, and case managers can refer individuals to the program, and members can self-refer. Members are eligible for the program if they are age five to 56, are members of the health plan's HMO or Medicare Advantage plan, and have a primary diagnosis of asthma. The health plan automatically enrolls all members eligible for the program and gives them the opportunity to opt out at any time.

Varied Programs Based on Risk of Complications

General Information and Flu Shot Reminders for All Members with Asthma

All members with asthma, regardless of their risk of developing complications, receive introductory packages in the mail upon joining the program. These packages include general information on asthma, effective medications, goals for asthma care, daily journals for recording asthma symptoms, and lists of asthma-related information resources. The packet also includes information on the importance of flu shots for individuals with asthma and phone numbers members can call to speak with nurses specializing in asthma care. Once a year, Blue Cross and Blue Shield of Florida mails each program participant a brochure with a reminder to have a flu shot, along with a discount coupon for the shot.

Web-Based Tools

Blue Cross and Blue Shield of Florida offers members with asthma a variety of Web-based tools. Through Blue Cross and Blue Shield of Florida's Web site, www.bcbsfl.com, members can access tools to determine their asthma-related health risks, benefit information associated with asthma care, as well as links to agencies providing asthma-related services. Members with employer-sponsored coverage also have access to online information offered in partnership with Health Dialog, through the company's Web site, www.thedialogcenter.com.

Symptom Management

Also in conjunction with Health Dialog, Blue Cross and Blue Shield of Florida offers a 24-hour nurse advice line to help members with employer-sponsored coverage interpret their symptoms and take appropriate action. After receiving a member call on this line, nurses conduct one or more follow-up calls to provide general information about health and preventive care and to help the member access any needed services.

Phone Consultation and Additional Services for Members at Highest Risk

Members who have had inpatient admissions for asthma or who have not filled prescriptions for asthma maintenance medications are at high risk of complications. Blue Cross and Blue Shield of Florida's nurse case managers consult regularly with these members by phone for at least a month and longer if needed, to provide

Creating a Road Map to Better Health for Members with Asthma (cont'd)

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

information about effective asthma care, answer questions about health benefits, ensure that they are following physicians' recommendations, provide training on use of peak flow meters, and encourage them to follow up with their physicians, if necessary. Based on their conversations with members, nurses also send them information specific to their needs, including information to address gaps in their knowledge about asthma.

Blue Cross and Blue Shield of Florida mails members who have not filled prescriptions for asthma maintenance medications surveys to identify reasons why they have not done so. Nurses contact these members to address issues identified in the survey (e.g., difficulties with transportation or lack of knowledge about the importance of taking asthma maintenance medications).

Nurses can arrange additional services as needed under the treating physician's direction, such as in-home asthma education sessions conducted by respiratory therapists, nurses, or social workers. All members who have had hospital admissions for asthma also receive age-appropriate videos on the condition and effective treatment.

Information for Physicians

In addition to providing information and services to members with asthma, Blue Cross and Blue Shield of Florida provides both general and patient-specific, actionable information to their physicians. Blue Cross and Blue Shield of Florida provides all of its primary care physicians with clinical practice guidelines on asthma developed by the National Institutes of Health (NIH), and it lists the guidelines on its Web site. The health plan also includes articles on asthma care in its physician newsletter, Blueline, and it offers continuing medical education (CME) programs on asthma focusing on the NIH guidelines.

On a quarterly basis, the health plan sends all primary care physicians reports listing all of their patients who have had emergency room or inpatient admissions for asthma and who have used quick-relief asthma medications (which are needed when asthma symptoms worsen) more often than controller medications for asthma (which help prevent symptoms from occurring when used on a regular basis). In addition, every six months, Blue Cross and Blue Shield of Florida sends all primary care physicians with asthma patients reports on these members' total medical care and prescription use.

Based on information from these reports, physicians can follow up with patients to help them follow recommended care plans. The reports include contact information for the health plan's asthma case managers so that physicians can coordinate with case managers in this process.

Results

Blue Cross and Blue Shield of Florida's asthma program has led to improvements in key measures of high-quality asthma care, as follows:

- Use of long-term controller medications among members with asthma increased from 60.8% to 64.2% from 2002 to 2004.
- Asthma-related emergency room visits among members enrolled in the program for at least a year fell from 18.6 visits per 10,000 in 2003 to 14 visits per 10,000 in 2004.
- In 2004, asthma-related inpatient admissions were 4.2 per 10,000, compared with 4.4 per 10,000 in 2003.

For more information, contact:

Mary-Margaret Serfilippi, R.N., M.S.N.
Director, Medical Management/Care Coordination
Blue Cross and Blue Shield of Florida
Senior Solutions
4800 Deerwood Campus Parkway, DCC6-1
Jacksonville, FL 32246
(904) 905-7920
Marymargaret.serfilippi@bcbsfl.com

Blue Cross and Blue Shield of Florida

Florida

Providing an Actionable Blueprint for Effective Diabetes Care

PROGRAM AT A GLANCE

Goal ▸ Promotedelivery of diabetes care according to the medical evidence.

Key Strategies

- Offer health coaching to help members follow physicians' care plans.
- Send members reminders to have recommended services, such as dilated retinal exams and HbA1c blood tests.
- Provide Web-based tools to help members learn about diabetes-related health risks, diabetes care benefits, and agencies providing diabetes-related assistance.
- Send primary care physicians actionable information on their patients' use of HbA1c blood tests, LDL-C cholesterol tests, kidney function tests, and dilated retinal exams.

Results in Brief

From 2004 to 2005, the percent of members with diabetes who had their HbA1c blood levels tested increased from 83.5% to 94.7%.

FROM CONCEPT TO ACTION

The Blueprint for Health® Diabetes Program

Upon determining that a large portion of its membership had diabetes, Blue Cross and Blue Shield of Florida implemented the Blueprint for Health® Diabetes Program in 1998. In 2004, the company enhanced the program to address depression, which often is associated with diabetes. The program provides education and support for members and extensive information for physicians.

Finding Members Who Can Benefit

Blue Cross and Blue Shield of Florida analyzes medical and pharmacy claims data on a monthly basis to determine which members have diabetes. Physicians, nurse care coordinators, medical management staff, and customer service personnel can refer people to the program, and members can self-refer. Members are eligible for the program if they:

- are 18 years or older and are members of Blue Cross and Blue Shield of Florida's HMO or Medicare Advantage plan; and
- have at least one primary care physician visit with a diagnosis of diabetes or have had at least one hospital, outpatient, or emergency room claim with a diagnosis of diabetes.

Ongoing Information and Support for Members

Based on claims analyses and referrals, nurse case managers contact members by phone or through direct mail to describe the program and offer the opportunity to opt out. Upon enrollment in the program, each member receives an introductory packet with an offer for a complimentary glucometer to measure blood sugar levels; a list of community resources, including the American Diabetes Association, the local Area Agency on Aging, the National Diabetes Information Clearinghouse; diabetes-related Web links; and brochures on effective care for diabetes.

If members previously had hospital admissions for diabetes or were referred to the program by physicians, hospital discharge planners, or health plan staff, they also receive introductory phone calls from nurse care coordinators to assess their needs for information or assistance.

Based on this information, nurses work with members to develop a schedule for additional calls. Through a series of regular phone appointments, nurses provide coaching and support to help members follow physicians' care plans.

Blue Cross and Blue Shield of Florida sends members enrolled in the program a variety of educational materials on an ongoing basis, based on nationally recognized clinical practice guidelines for diabetes care and self-management. Topics discussed in these mailings include: suggestions on food portion sizes; recommended goals for blood glucose control; strategies for maintaining good kidney function; information on depression and diabetes, neuropathy, foot care, and heart disease; and the recommended schedule for having dilated retinal exams.

Annual Mailings

Once a year, Blue Cross and Blue Shield of Florida sends members calendars and education packets with additional information related to diabetes, such as how to count carbohydrates, how to recognize symptoms of complications related to diabetes, and which diagnostic tests they should have on a regular basis.

Providing an Actionable Blueprint for Effective Diabetes Care (cont'd)

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Encouraging Regular Eye Exams and Blood Glucose Tests

Based on analysis of claims and lab data, Blue Cross and Blue Shield of Florida identifies members with diabetes who have not had dilated retinal exams or HbA1c blood tests in the previous 12 months and mails them reminders to have these tests done. Nurse care coordinators contact members who have not had HbA1c blood tests in the past year and whose HbA1c blood glucose levels are above 9%. Care coordinators discuss the importance of HbA1c testing as well as the complications associated with elevated blood sugar levels.

Web-Based Tools

Blue Cross and Blue Shield of Florida offers members with diabetes a variety of Web-based tools. Through Blue Cross and Blue Shield of Florida's Web site, www.bcbsfl.com, members can access tools to determine their diabetes-related health risks, benefit information associated with diabetes care, as well as links to agencies providing diabetes-related services. Members with employer-sponsored coverage also have access to online information offered in partnership with Health Dialog, through the company's Web site, www.thedialogcenter.com.

Symptom Management

Also in conjunction with Health Dialog, Blue Cross and Blue Shield of Florida offers a 24-hour nurse advice line to help members with employer-sponsored coverage interpret their symptoms and take appropriate action. After receiving a member call on this line, nurses conduct one or more follow-up calls to provide general information about health and preventive care and to help the member access any needed services.

Information and On-Site Consultations for Physicians

Blue Cross and Blue Shield of Florida sends physicians copies of all program materials, along with lists of their patients with diabetes. The health plan also provides physicians copies of the American Diabetes Association's clinical practice guidelines, lists the guidelines on its Web site, and includes articles on diabetes care in its quarterly physician newsletter, *Blueline*. Physicians can obtain additional information on diabetes by request.

Continuing Medical Education Classes

To promote use of clinical practice guidelines for diabetes care, Blue Cross and Blue Shield of Florida schedules educational sessions with primary care physicians throughout the state, and it offers continuing medical education (CME) courses on topics such as achieving better outcomes for patients with diabetes, cholesterol management, and the prevention of kidney disease.

Helping Physicians Address Depression and Diabetes

Because individuals with diabetes often suffer from depression, Blue Cross and Blue Shield of Florida sends physicians annual mailings with evidence-based information on diagnosis, treatment, and referrals for patients with these two conditions. The *Blueline* physician newsletter includes articles on correct coding of visits for behavioral health visits and treatment for members with diabetes. The health plan also works with MHNet, a provider of behavioral health services, to promote coordination of care between members' primary care and behavioral health providers.

Actionable Information on Patient Care

Besides sending general reference material, Blue Cross and Blue Shield of Florida sends primary care physicians actionable information on the extent to which their patients with diabetes have had HbA1c blood glucose tests, LDL-C cholesterol tests, kidney function tests, and dilated retinal exams at recommended intervals. The health plan mails primary care physicians lists of their patients with diabetes who have not had HbA1c tests annually during the measure period and encourages them to follow up. In addition, Blue Cross and Blue Shield of Florida sends health care practitioners a variety of additional information and materials based on their patients' risk levels.

One-on-One Visits with Case Managers

Once a year, Blue Cross and Blue Shield of Florida's diabetes case managers visit the offices of primary care physicians who have more than 30 patients with diabetes. During these visits, case managers and physicians review patients' charts, discuss information related to key indicators of high-quality diabetes care, and discuss opportunities for improvements in care. Case managers send physicians reports summarizing the information conveyed during these visits and provide their contact information so that physicians can follow up with questions or other requests.

Results

From 2004 to 2005, the percent of members with diabetes who had their HbA1c blood levels tested increased from 83.5% to 94.7%.

For more information, contact:

Mary-Margaret Serfilippi, R.N., M.S.N.
Director, Medical Management/Care Coordination
Blue Cross and Blue Shield of Florida
Senior Solutions
4800 Deerwood Campus Parkway, DCC6-1
Jacksonville, FL 32246
(904) 905-7920
Marymargaret.serfilippi@bcbsfl.com

Blue Cross and Blue Shield of North Carolina

North Carolina

Offering Members Incentives and Support for Using Effective Care

PROGRAM AT A GLANCE

Goal ▸ Improve health and increase use of recommended services among members with chronic conditions, such as asthma, diabetes, migraines, heart disease, and fibromyalgia, as well as those who are overweight or obese.

Key Strategies

- Offer health coaching and case management to help members work with their physicians on care plans suited to their needs.
- Offer members with congestive heart failure electronic scales to monitor weight and symptoms every day so that doctors and nurses can respond quickly to changes in health status.
- Provide a variety of incentives—such as free blood glucose meters to members with diabetes, free peak flow meters for individuals with asthma, and discounts on blood pressure monitors for members with heart conditions—to encourage members to use recommended care.

Results in Brief

- From 2004 to 2005, knowledge among program participants with migraines about strategies to manage their headaches improved by 71%.
- From 2002 to 2005, the rate of inpatient hospitalizations for program participants with congestive heart failure dropped by 38%.
- From August 2004 to August 2005, 46% of members participating in the program's weight management activities increased the number of days per week that they exercised.

FROM CONCEPT TO ACTION

Member Health Partnerships℠

In 1998, Blue Cross and Blue Shield of North Carolina (BCBSNC) launched a suite of disease management programs to address a broad range of conditions, such as asthma, diabetes, heart disease, and migraines. In addition, the health plan offered a specialty care program providing support for 14 less common conditions (e.g., rheumatoid arthritis, multiple sclerosis, lupus, and Parkinson's disease).

In 2004, BCBSNC added a program targeting obesity and overweight issues, and in 2007, the health plan combined all of these programs to create Member Health Partnerships, an integrated chronic care initiative. The program takes a team approach to care coordination, with health coaches working together to ensure that members receive all of the health services they need.

Blue Cross and Blue Shield of North Carolina analyzes claims on a monthly basis to identify members who can benefit from the program. The program also receives referrals from doctors, hospital discharge planners, and case managers, and members can self-refer.

Initial Mailings

Upon identifying members for Member Health Partnerships, Blue Cross and Blue Shield of North Carolina staff sends them program summaries, enrollment information, and enrollment surveys with questions about their health behaviors, knowledge of their health conditions, effects of these conditions on their ability to work, and limitations in activities of daily living. As part of the enrollment survey, members can indicate if they would like to work one-on-one with nurse case managers or health coaches to address their needs.

Each program participant is paired either with either a case manager or a health coach, depending on the complexity of his or her needs and his or her readiness to make health-related changes. Individuals with complex needs generally work with case managers.

Health Coaching and Case Management

Within two weeks of receiving survey responses, health coaches and case managers call members who chose these options to discuss their conditions and ongoing treatments. Based on the member's preference, the health coach or case manager can set up a schedule for regular phone consultations. During these calls, coaches and case managers provide information on effective care, and they offer suggestions (e.g., how to organize information about their medications, procedures and tests, and how to track conditions that trigger their symptoms) that can help members work with their doctors to develop care plans suited to their needs.

Based on information gathered during their regular conversations with members, case managers identify individuals with congestive heart failure who are at high risk of complications

Offering Members Incentives and Support for Using Effective Care (cont'd)

and offer them the opportunity to use electronic scales to monitor their weight and symptoms on a daily basis. The scales transmit member data over phone lines to the case managers, who monitor changes and contact the member to follow up and suggest treatment options that they can discuss with their doctors.

Informational Materials

In addition to providing health coaching, Blue Cross and Blue Shield of North Carolina sends members regular mailings on effective care for their conditions, as well as information on new treatment developments, generic drugs, healthy lifestyles, and strategies to avoid adverse drug interactions.

In addition, each member receives a "health organizer," a notebook that includes general health information, schedules for recommended preventive care, tools to track progress in reaching health-related goals, the phone number for BCBSNC's nurse advice line, and contact information for local health care practitioners. In addition, members receive self-help tips and information on nutrition, alternative therapies, and effective medications.

Member Incentives

To enhance the impact of the program's mailings and health coaching consultations, Blue Cross and Blue Shield of North Carolina offers incentives to members for using effective treatments. For example:

- Members with diabetes who enroll in BCBSNC's disease management program receive free blood glucose meters and home delivery of testing supplies. Deductibles for testing supplies used in diabetes care are waived for program participants.
- Program participants with asthma can order free peak flow meters to monitor their lung capacity, as well as free spacers to make their inhalers more effective and easier to use. The health plan reduces copayments for controller medications that prevent asthma emergencies when used on an ongoing basis.
- Members participating in disease management activities for heart conditions receive discounts on blood pressure monitors, heart rate monitors, and electronic and other scales.
- All members who enroll in Member Health Partnerships are eligible for six medical nutrition therapy visits with registered dietitians. There are no copayments or coinsurance for these visits when provided by credentialed dieticians in office-based settings.

Measuring the Program's Impact

After a member has been enrolled in the program for six months, Blue Cross and Blue Shield of North Carolina staff sends a follow-up survey to identify changes in health status, track improvements in condition-specific knowledge, and measure satisfaction with the program. Based on survey responses, BCBSNC has enhanced the Member Health Partnerships program and has identified topics for additional communication with members. For example, feedback from surveys led BCBSNC to include additional articles in its member magazine on how to save money with generic drugs and when to use the emergency room.

Results

As of December 2006, more than 200,000 members had been identified for Member Health Partnerships and received some type of outreach. Eighty-six percent of members actively participating in the program said they were satisfied with it. Overall, the initiative has achieved a return on investment of 3:1. Results for specific health conditions are as follows:

Diabetes

- From 1998 to 2005, the number of diabetes-related hospital admissions among members enrolled in the program declined by 13%.

Migraines

- From 2004 to 2005, program participants' knowledge about strategies to manage their headaches improved by 71%.

Heart Disease

- From 2002 to 2005, the number of program participants with congestive heart failure who reported weighing themselves each day increased by 43%.
- During the same time period, the rate of inpatient hospitalizations for congestive heart failure declined by 38%.

Asthma

- From 2001 to 2005, the number of asthma-related hospital admissions among members enrolled in the program fell by 16%. During this time frame, the number of members enrolled in the program with written action plans to address the onset of asthma symptoms increased by 14%.

Obesity and Overweight

From August 2004 to August 2005:

- Forty-seven percent of members participating in BCBSNC's Healthy Lifestyle Choices℠ program lost weight, with an average weight loss of 9.5 pounds.
- Forty-six percent of program participants increased the number of days per week that they exercised.
- Seventy percent of participants with severe hypertension reduced their blood pressure levels.

For more information, contact:

Heidi Deja
Program Manager, Public Relations
Blue Cross and Blue Shield of North Carolina
P.O. Box 2291
Durham, NC 27702
(919) 765-3005
Heidi.deja@bcbsnc.com

Blue Cross Blue Shield of Massachusetts

Massachusetts

MASSACHUSETTS

Streamlining Support Services for Members with Chronic Conditions

PROGRAM AT A GLANCE

Goal ▸ Improveknowledge and promote informed decision-making for members with the most prevalent chronic conditions: asthma and diabetes.

Key Strategies

- Train a team of member service associates on benefits and standards of care for asthma and diabetes.
- Automatically route calls from members with asthma or diabetes to the designated member service team.
- Help members with asthma and diabetes address their care and benefits needs quickly so that they can begin working with nurse case managers as soon as possible to develop action plans for improving health.

Results in Brief

From 2005 to 2006, the proportion of members with diabetes who had dilated retinal exams increased from 67.4% to 74.7%.

FROM CONCEPT TO ACTION

Providing Immediate Expert Service to Members with Asthma and Diabetes

To provide an enhanced level of member service to individuals with the most prevalent chronic conditions, Blue Cross Blue Shield of Massachusetts (BCBSMA) launched the Complex Conditions Service Model in 2004. Initially the program provided assistance to members with diabetes, and in late 2005, the health plan expanded the program to address issues related to asthma.

Under this model, when individuals with asthma or diabetes call BCBSMA's member service line and enter their identification numbers, their calls are routed automatically to a designated team of member service associates. Members of the team completed three days of training on asthma and diabetes benefits and standards of care, and they continue to receive ongoing training in these areas from nurses in BCBSMA's Health Care Services Department.

Through this program, member service associates help individuals with a wide variety of care and benefits issues. For example, they describe the importance of regular preventive care for diabetes, and they describe the health plan's benefits for annual eye exams, foot exams, HbA1c blood level tests, nutrition counseling, and fitness. They also tell members where to purchase glucometers to measure their blood sugar levels on a daily basis. Individuals with asthma can talk with member service associates about local stores that carry nebulizers and inhalers needed to treat the condition effectively, and associates describe the health plan's benefits for prescription drugs, allergy testing, and flu shots.

Besides providing information about care and benefits, member service associates inform individuals with asthma and diabetes about BCBSMA's disease management programs and provide referrals to these programs when appropriate. They also can put members in contact with disease management nurses and dieticians to answer specific clinical and nutrition questions. They can help members find health education classes on asthma and diabetes care in their communities, and they may refer them to additional resources available through the American Diabetes Association, the American Lung Association, and the Juvenile Diabetes Research Foundation.

By helping members address all of their customer service needs in a timely manner, the program makes it possible for them to focus on working with nurse case managers to develop action plans for improving their health immediately upon enrollment in BCBSMA's disease management programs.

Promoting Professional Staff Development

In addition to improving member service for individuals with asthma and diabetes, the Chronic Conditions Service Model has provided an important source of professional development for BCBSMA staff. Member service staff participating in the program have been eager to attend information sessions with clinical experts on asthma and diabetes, and they have become involved in community outreach and fundraising activities related to the conditions. In addition, the program has fostered collaborative team work between BCBSMA's member service and disease management departments.

Results

- Since BCBSMA launched the model's diabetes component, member service associates have handled more than 8,000 calls from individuals with the condition. In 49% of these calls,

Streamlining Support Services for Members with Chronic Conditions (cont'd)

associates engaged members in discussions about diabetes. Twenty-nine percent of these conversations focused on prescription drugs, and 29% related to preventive care (e.g., benefits for routine physicals, fitness, and nutritional counseling). From 2005 to 2006, the proportion of members with diabetes who had dilated retinal exams increased from 67.4% to 74.7%.

- Since implementation of the model's asthma component, member service associates have handled more than 1,000 asthma-related calls. Forty-five percent of these calls related to asthma medications; 44% focused on preventive care; and in 11% of calls, associates provided information about respiratory devices, pulmonary function tests, and allergy testing.

For more information, contact:

Geraldine McNamara, B.S.N., R.N.
Director, Population Management
Blue Cross Blue Shield of Massachusetts
One Enterprise Drive
Quincy, MA 02170
(617) 246-9706
geraldine.mcnamara@bcbsma.com

Blue Shield of California

California

blue of california

Helping Members with Complex Conditions Live Comfortably at Home

PROGRAM AT A GLANCE

Goal ▸ Helpmembers with complex conditions such as Lou Gehrig's disease, advanced cancer, and trauma complications live at home for as long as possible and avoid unnecessary emergencies.

Key Strategies

- Conduct home visits to assess members' needs.
- Help members manage pain and other symptoms; follow physicians' treatment plans; make optimal use of health benefits; learn about participation in clinical trials; and plan for end-of-life care as needed.
- Help participants access all of the covered products and services they need, such as durable medical equipment and visits with specialists.

Results in Brief

From 2003 to 2004:

- The rate of hospital admissions among individuals enrolled in the program was 38% lower than among individuals with similar conditions in a control group.
- Eighty-nine percent of program participants said it had improved their quality of life. Ninety-six percent said it provided a useful service, and 92% said they were "extremely satisfied" or "somewhat satisfied" with the program.
- Members participating in the program had 22% more home care visits than those in a control group.
- The number of emergency room visits among program participants was 30% lower than for members of a control group.

FROM CONCEPT TO ACTION

The Complex Case Management Program

Blue Shield of California established the Complex Case Management program in 2003 to address the needs of members with complex conditions such as Lou Gehrig's disease, advanced cancer, and complications from trauma.

Consistent with these members' preference to avoid extended stays in health care facilities, the program helps participants and their families understand their conditions, obtain needed treatments while living at home, and avoid unnecessary emergencies and hospital admissions.

The program initially was launched on a pilot basis for HMO members enrolled through the California Public Employees Retirement System (CalPERS), and in 2005, it was expanded to include all privately insured members.

Blue Shield of California analyzes daily hospital admission data and reviews medical and pharmacy claims on a monthly basis to identify individuals for the program. Nurse case managers contact members by phone to describe the program and offer the opportunity to enroll. Nurses conduct initial home visits with program participants to assess their needs, and they work with members and their families to develop goals in seven areas: pain and symptom management; adherence to physicians' treatment plans; feedback to physicians; disease-specific knowledge and awareness of treatment options; education and support for family members; optimal use of health benefits; and end-of-life planning as needed.

After the initial in-person meeting, each member enrolled in the program has a series of scheduled phone consultations with a nurse case manager. Often nurses contact members twice per week, but the frequency is based on member needs. During these calls, nurses help members understand their conditions and treatment alternatives, including the option of enrolling in clinical trials. They help members follow their physicians' treatment plans (e.g., taking medications at the recommended intervals, eating recommended foods) and ask about any symptoms or side effects (e.g., nausea, dehydration) they are experiencing. Depending on members' responses, nurses may follow up with physicians so they can adjust treatment regimens as needed. Case managers also help members access all of the covered products and services they need, for example, by arranging for referrals to specialists and/or obtaining durable medical equipment.

Case managers also can help members with end-of-life planning, such as developing advance directives and arranging for hospice care. On average, individuals are enrolled in the program for five months; however, they can continue to contact their case managers with questions or concerns any time after completing it.

Helping Members with Complex Conditions Live Comfortably at Home (cont'd)

blue of california

Results

During the program's pilot phase, from 2003 through 2004:

- Eighty-nine percent of program participants said it had improved their quality of life. Ninety-six percent said it provided a useful service, and 92% said they were "extremely satisfied" or "somewhat satisfied" with the program.
- The rate of hospital admissions among individuals enrolled in the program was 38% lower than among individuals with similar conditions in a control group.
- The number of emergency room visits among program participants was 30% lower than for members of the control group.
- Members participating in the program had 22% more home care visits than those in the control group.
- The number of days spent in hospice care was 62% higher for individuals enrolled in the program than for those in the control group.
- The overall cost per case was 26% lower for members participating in the program than for members in the control group.
- The program's overall return on investment was 2:1.

For more information, contact:

Elise Anderson
Manager, Media Relations
Blue Shield of California
6701 Center Drive West
Los Angeles, CA 90045
(310) 568-2866
elise.anderson@blueshieldca.com

CIGNA HealthCare
Connecticut

Joining Forces Across Specialties to Address a Full Spectrum of Member Needs

PROGRAM AT A GLANCE

Goal ▸ Increase use of recommended services and prevent unnecessary complications among members with chronic illnesses such as asthma, chronic obstructive pulmonary disease, low-back pain, depression, and osteoarthritis.

Key Strategies

- Offer health coaching to help members follow physicians' care plans and make healthy lifestyle changes.
- Provide cross-training for chronic care nurses so that they can effectively serve individuals with multiple health conditions.
- Organize chronic care units to make it easy for staff to consult with colleagues and coordinate members' care.

Results in Brief

- A study published in *Health Affairs* found that the health plan's diabetes care program for 43,000 members from 1998-2001 was associated with significant improvements in four key measures of diabetes care: increased use of dilated retinal exams (9.5% improvement); micro-albumin testing (15% improvement); cholesterol testing (10.7% improvement); and reduced use of tobacco (3.5% improvement).
- A separate study found that members enrolled in the diabetes program for at least six months in 2001 had higher scores for six diabetes-related measures of quality care than did individuals not enrolled in the program.

FROM CONCEPT TO ACTION

Cross-Training Staff and Coordinating Care

In light of the medical evidence indicating that an integrated approach to chronic care is most effective, CIGNA HealthCare has used this approach since it began offering disease management programs in the late 1990s. CIGNA's initiatives focus not only on chronic diseases such as asthma, diabetes, and congestive heart failure, but also on behavioral health issues that often accompany chronic conditions, and on pharmacy issues—such as not wanting to take prescribed medications—that are common to individuals with multiple chronic conditions.

CIGNA's chronic care programs offer information and services to members with asthma, chronic obstructive pulmonary disease, diabetes, congestive heart failure, coronary artery disease, low-back pain, obesity, depression and a group of 10 other conditions, such as osteoarthritis, osteoporosis, and acid-related stomach disorders, which likewise have a significant impact on members' quality of life and on health care costs.

Addressing a Broad Range of Conditions

CIGNA's chronic care nurses are cross-trained so they can recognize and address issues associated with numerous conditions, and CIGNA's chronic care units are organized to make it easy for nurses to consult with colleagues and work together to coordinate all of the services that members need.

Identifying and Contacting Members

CIGNA analyzes claims to identify members with chronic conditions who can benefit from its care coordination programs. Physicians and chronic care nurses also can refer members to these programs. The health plan sends letters to members' physicians telling them how their patients can benefit. Individuals identified for the program are automatically enrolled and have the opportunity to opt out.

After sending members introductory letters telling them they will be contacted and giving them the opportunity to opt out, CIGNA's chronic care nurses call each identified member to administer a clinical survey with questions about demographics, health status, care plans, and issues related to depression. Based on members' responses, nurses may help them set up doctor appointments, set lifestyle goals (e.g., exercise, weight loss) to improve their health, and address barriers to following care plans.

If members' responses to the clinical survey indicate that they may be experiencing depression, nurses place them in touch with behavioral health care practitioners so that they can quickly access the services they need. In the last several years, as clinical information technology has improved, CIGNA has been able to identify members at the greatest risk of complications early—before their conditions worsen—so that nurses trained in disease management and case management can begin working with them one-on-one to improve their health. Nurses maintain regular phone contact with members who are most at risk of complications to ensure that they receive the care they need in a timely manner.

Health Coaching

After their initial phone calls with members, nurses follow up regularly by phone, with frequency depending on individual needs. During these calls, nurses provide coaching to help members meet condition-specific goals and follow physicians' care plans. For

Joining Forces Across Specialties to Address a Full Spectrum of Member Needs (cont'd)

example, consultations with members who have osteoarthritis or osteoporosis address the importance of exercise, diagnostic procedures, and taking vitamins C and D. Nurses working with members who have diabetes stress the importance of regular blood sugar monitoring and eye exams. Nurses help members with asthma identify and avoid conditions that trigger their symptoms, and they emphasize the importance of using asthma "controller" medications regularly to prevent asthma emergencies. Besides providing members with information on using effective care, CIGNA's nurses work with them to incorporate healthy lifestyle changes into their everyday activities.

Educational Materials

CIGNA sends members enrolled in its disease management programs educational materials and reminders tailored to their needs. Materials include condition-specific workbooks with information on effective care, exercise and nutrition guidelines, recommended schedules for physician visits and preventive care, and recommended targets for key measures such as blood pressure and cholesterol, if applicable.

Chronic care nurses may send members additional materials as they identify specific needs (e.g., information on smoking cessation programs for members who say they want to quit).

Preventive Care Reminders

Members enrolled in CIGNA's disease management programs receive quarterly reminders for the preventive services recommended for their conditions, such as flu shots (for participants in all disease management programs) and eye and foot exams for members with diabetes.

Members with asthma receive reminders about filling their prescriptions for controller medications, as well as hints on how to identify and avoid conditions that trigger asthma symptoms. Members with depression receive reminders about filling prescriptions for their maintenance medications.

Addressing Health Conditions Associated with Being Overweight

In response to members' changing needs, in January 2006, CIGNA launched a comprehensive program for members with health conditions associated with being overweight, such as hypertension and high cholesterol. As part of this program, a nurse trained in motivational techniques conducts scheduled phone calls with each program participant to discuss diet, nutrition, exercise, stress management and effective medication use, and to ensure that he or she receives the medical care needed for health conditions (e.g., hypertension and high cholesterol) often associated with being overweight.

The nurses and doctors involved with the program work to help members understand the health risks of being overweight, and they help program participants take steps to lose and stabilize their weight effectively. Through these efforts, the program seeks to prevent heart problems by lowering members' cholesterol and blood pressure levels and to prevent the onset of Type 2 diabetes.

Results

CIGNA's chronic care programs have increased use of effective care for all of the conditions targeted, including use of ACE inhibitors for cardiac care, statins for diabetes and cardiovascular disease, and controller medications for individuals with asthma.

While cost savings have varied for different conditions, on average, in 2005, CIGNA's chronic care programs reduced hospital admissions by 7.1% and reduced medical costs associated with these conditions by an average of 11%.

Overall, CIGNA's chronic care programs are saving an estimated $2 to $3 for every dollar spent. The initial return on investment for CIGNA's new program for individuals who are overweight is projected to be 1.5:1 to 2:1.

A study published in the July/August 2004 issue of *Health Affairs* examined the impact of CIGNA's diabetes care program for 43,000 members in 12 states from 1998 -2001 and found that:

- Quality of care improved significantly in four key measures of diabetes care: increased use of dilated retinal exams (9.5% improvement); micro-albumin testing (15.0% improvement); cholesterol testing (10.7% improvement); and reduced use of tobacco (3.5% improvement).
- Overall medical costs for members with diabetes declined by an average of five to eight percent.
- Overall per-member-per-month costs for individuals with diabetes were 24.7% lower in the sites where the program was implemented ($417) than in sites where it was not implemented ($554).
- Costs for inpatient care were 11.4% lower in program sites than in control-group sites.
- There were 30% fewer hospital admissions per 1,000 members in the sites where the program was implemented than in the control-group sites.

A separate study published in *Disease Management* in April 2005 found that members enrolled in CIGNA's diabetes care program for at least six months in 2001 had higher scores for six diabetes-related measures of quality care (rates of HbA1c blood level testing and HbA1c blood levels within recommended ranges; rates of LDL-C cholesterol screening and percent of members with LDL-C cholesterol levels within recommended ranges; and percent of members who had eye exams and kidney function tests at recommended intervals) than did individuals not enrolled in the program.

For more information, contact:

Michael Reardon, M.D.
Medical Director, CIGNA Well Aware for Better Health® Program
CIGNA HealthCare
900 Cottage Grove Road
Hartford, CT 06152
(860) 226-9081
michael.reardon@careallies.com

Group Health Cooperative
Washington

Using Electronic Medical Records to Promote a New Model of Planned Care

PROGRAM AT A GLANCE

Goal ▸ Improvethe organization of care and health outcomes for members with chronic conditions such as diabetes and heart disease.

Key Strategies

- Send members annual reminder messages to schedule appointments with primary care physicians to develop Collaborative Care Plans, which list all member medications, goals to improve health status, and strategies to achieve goals.
- Use electronic medical records to document and track member progress in meeting health care and lifestyle goals.
- Encourage physicians to discuss Collaborative Care Plans during patient visits and print "after-visit summaries" that include copies of the plans and proposed next steps to achieve care goals.

Results in Brief

Analysis of the program's impact on member satisfaction, quality improvement, and health care costs will be conducted in 2007.

FROM CONCEPT TO ACTION

New Model of Planned Care

To create a more seamless, patient-centered system of care for individuals with chronic conditions, Group Health Cooperative (GHC) adopted a new approach in 2006 that harnesses the power of its electronic medical records system, MyGroupHealth, to implement key elements of the Chronic Care model. Initially, GHC used this approach, designed to improve systems of care and improve health outcomes, for members with diabetes and/or heart disease. The initiative is being expanded to include all members with chronic conditions in 2007.

Identifying Member Needs

To identify member needs, GHC analyzes medical, lab, and pharmacy data from MyGroupHealth on an ongoing basis to determine whether members have had treatments recommended for their conditions (e.g., blood pressure and cholesterol tests for individuals with heart disease, HbA1c tests, eye and foot exams for individuals with diabetes), whether they have visited their primary care physicians (PCPs) in the past year, have been admitted to the hospital, and/or have used the emergency room within the past year. GHC also analyzes responses to online health risk assessments that members can fill out in physician waiting rooms, on laptops in the workplace, or from home computers on the MyGroupHealth Web site. GHC integrates risk assessment data into members' electronic medical records and flags those with major needs so that physicians can conduct outreach and other follow-up.

Developing Collaborative Care Plans

Once needs are identified through risk assessments, claims analysis, and other information in members' electronic medical records, GHC sends members annual reminder messages, either via e-mail or regular mail (depending on whether members have chosen the e-mail option) to schedule appointments with primary care physicians to develop Collaborative Care Plans.

PCPs use MyGroupHealth to review member records online on an ongoing basis so that they can help members develop these plans, which lists all member medications, including the condition that each medication is intended to address; prioritized goals for improving health status (e.g., having regular eye exams, exercising, losing weight, quitting smoking); and strategies for meeting these goals. For example, strategies may include having planned appointments for recommended preventive care, using pedometers to track daily exercise, using pill organizers to ensure that medications are taken correctly, and/or monitoring blood pressure levels at home.

Depending on member needs, Collaborative Care Plans also may include follow-up with nurses to address medical issues, consultations with nutritionists on strategies for improving diet, and/or regular phone contact with health educators or behavioral health counselors. Physicians and office staff use MyGroupHealth to document and track members' progress in meeting their health care and lifestyle goals.

Using Electronic Medical Records to Promote a New Model of Planned Care (cont'd)

During office visits, physicians may send messages to patients' home e-mail addresses to remind them of important action items. At the end of patient visits, physicians print "after-visit summaries" that include copies of Collaborative Care Plans, along with recommended next steps for meeting their goals.

GHC plans to track member satisfaction, clinical quality improvements, and cost savings attributable to its new approach to care, and results are anticipated in 2007.

For more information, contact:

David McCulloch, M.D., F.R.C.P.
Medical Director, Clinical Improvement
Group Health Cooperative
Mail Stop CEB-138
1600 E. John Street
Seattle, WA 98112
(206) 326-3935
scott.cj@ghc.org

HealthNow New York

New York

Closing Gaps in Care for Members with Chronic Conditions or ADHD

PROGRAM AT A GLANCE

Goal ▸ Ensurethat individuals with diabetes, depression, asthma, chronic kidney disease, cardiovascular conditions, and attention deficit hyperactivity disorder (ADHD) receive care consistent with nationally recognized clinical practice guidelines.

Key Strategies

- Send members "Gap Reports" that list recommended treatments and/or appointments that they are missing; compare their most recent lab test results with recommended results for their conditions; and encourage them to contact physicians.
- Offer health coaching to help members understand their conditions and effective treatments; make appointments for needed services; obtain transportation and/or home medical equipment; and link with community-based services, such as support groups and Meals on Wheels programs.
- Provide behavioral health coaching to help individuals with depression and other health conditions (asthma, diabetes, coronary artery disease, congestive heart failure, and chronic obstructive pulmonary disease) pursue physicians' treatment plans and gain the skills and confidence needed to address their conditions effectively.
- Provide guidance to parents and physicians on effective strategies to address ADHD and arrange for expert consultations on individual cases.

Results in Brief

HealthNow will evaluate the program's impact on health care quality, costs, and member satisfaction in the second quarter of 2007.

FROM CONCEPT TO ACTION

The Health Management Program

To increase the use of effective services on an ongoing basis for members with diabetes, depression, asthma, chronic kidney disease, cardiovascular conditions, and attention deficit hyperactivity disorder, in 2005 HealthNow New York (HealthNow) revamped its disease management programs—which previously had addressed individual chronic conditions separately—to create a new, patient-centered system known as the Health Management program.

Gap Reports

HealthNow analyzes data from medical, pharmacy, and lab claims, as well as available lab test results on a monthly basis to identify members with chronic conditions who have not had tests and procedures recommended by national guidelines and/or who have been admitted to hospitals or used emergency rooms for their conditions in the past year. Based on this information, HealthNow sends members Gap Reports twice a year that list recommended treatments and/or appointments that they are missing, compare their most recent lab test results with recommended results for their conditions, and encourage them to contact their physicians. HealthNow also sends these reports to members' physicians and suggests that they follow up with patients to provide recommended care.

Case Management

In addition to receiving Gap Reports, members identified through claims analysis as having multiple complex conditions, emergency room visits, and/or hospital admissions receive phone calls from nurse case managers, who provide health coaching and help address their needs. For example, case managers may provide members with information about their conditions and effective treatments, help them make appointments for needed services with specialty physicians and physical therapists, arrange for transportation to doctor visits, help them access needed medications, or coordinate installation of home medical equipment. Case managers also link members with community-based services (e.g., Meals on Wheels, support groups) as needed. Depending on members' preferences, case managers may send them brochures, videotapes, or DVDs providing information about their conditions. They also update members' physicians about the services their patients are receiving, and they coordinate care as needed.

Additional Outreach to Members with Depression

To provide increased support to members with depression as a primary diagnosis and those with depression in conjunction with other health conditions, HealthNow partnered with Health Integrated, Inc. to launch a pilot program in 2006. The program seeks to inform and motivate members to modify their behaviors so that they can pursue physicians' treatment plans and gain the skills and confidence needed

Closing Gaps in Care for Members with Chronic Conditions or ADHD (cont'd)

HealthNow
HealthNow New York Inc.

to address their conditions effectively. Program participants have regular phone consultations with behavioral health professionals trained as care coaches.

During their conversations with members, coaches help individuals set goals for following medical and behavioral health treatment plans, provide guidance on strategies to reach these goals, and address unmet health care needs. For example, if a care coach finds that a member with depression is not taking prescribed medications due to side effects that have not been discussed with his or her physician, the coach seeks the patient's consent to relay the information to the physician, who can modify doses or prescriptions as needed. Subsequently, the coach encourages ongoing communication with the care team and provides support for following the treatment plan. Coaches also can help members write down goals they would like to achieve during upcoming therapy appointments and make lists of questions to discuss during upcoming doctor visits.

Typically, members are enrolled in the program for 9 to 12 months. Based on results of the pilot, expected in 2007, HealthNow and Health Integrated will decide whether to expand the program to the health plan's entire membership.

Guidance on Attention Deficit Hyperactivity Disorder

In response to the increased prevalence of attention deficit hyperactivity disorder among children, HealthNow developed a program in 2004 to ensure that they receive treatment consistent with medical evidence. The health plan sends all network pediatricians copies of the American Academy of Pediatrics' clinical practice guidelines on ADHD diagnosis and treatment. Guidelines include having children with questionable behaviors evaluated by behavioral health specialists and ensuring that children diagnosed with ADHD take medications if they meet specified criteria. The health plan also has developed a parent guide on how to address ADHD successfully at home and in school. The guide is available in hard copy and on the health plan's Web site.

Besides providing physicians and parents with written information on ADHD, HealthNow has partnered with child psychiatrists in two of its service areas to provide expert consultations on individual cases. In Western New York, network pediatricians can refer members to child psychiatrists at the University of Buffalo for behavioral evaluations on an expedited basis. In Northeastern New York, child psychiatrists are available to consult by phone with HealthNow's network physicians.

Results

HealthNow will evaluate the impact of the Health Management and ADHD programs on health care quality, costs, and member satisfaction beginning in the second quarter of 2007.

For more information, contact:

Lynda Karig Hohmann, Ph.D., M.D., M.B.A.
Medical Director
HealthNow New York
30 Century Hill Drive
Latham, NY 12110
(518) 220-4722
hohmann.lynda@healthnow.org

Sheila M. Gould, R.N.B.C., C.P.H.Q.
Corporate Director, Healthcare Quality Improvement
HealthNow New York
1901 Main Street
Buffalo, NY 14208
(716) 887-6948
Gould.sheila@healthnow.org

Ellen E. Grant, Ph.D., L.C.S.W.-R
Vice President
Behavioral Health, Wellness & Health Promotion
HealthNow New York
1901 Main Street
Buffalo, NY 14208
(716) 887-7933
Grant.ellen@healthnow.org

Health Alliance Plan
Michigan

A High-Tech and High-Touch Approach to Chronic Care

PROGRAM AT A GLANCE

Goal ▸ Improvethe health of individuals with cardiovascular disease, asthma, depression, diabetes, hypertension, and obesity and prevent unnecessary complications.

Key Strategies

- Send online reminders to physicians when members have not had recommended preventive care.
- Offer health coaching to help members establish care goals, pursue action plans to achieve them, and access other services and community resources as needed.
- Offer members with heart failure and diabetes the chance to participate in daily in-home monitoring using electronic devices that allow nurses and doctors to address health problems quickly.
- Arrange for pharmacists to contact members who are not taking recommended medications to answer questions, discuss possible side effects, and address concerns about affordability.
- Conduct group classes with trained facilitators, who help members create action plans to improve health, develop the skills needed to address their conditions effectively, and recognize symptoms that warrant immediate medical attention.

Results in Brief

- Among members with congestive heart failure who received health coaching, the percent of individuals with LDL-cholesterol levels below 100 mg/dL increased from 61% in 2003 to 70% in 2005.
- In a 2005 survey of program participants with congestive heart failure:
  - Ninety-six percent of respondents rated the helpfulness of program information as "good" to "excellent."
  - Ninety-eight percent of respondents said they were somewhat to very likely to recommend the program to others.

FROM CONCEPT TO ACTION

HAP's HealthTrack Program

In response to the rising prevalence of heart failure among its members, Health Alliance Plan (HAP) launched HAP's HealthTrack in 2004. The program promotes use of effective care on a regular basis to avoid unnecessary complications that can lead to hospital and emergency room use. In 2005, HAP expanded the program to address all types of cardiovascular disease, as well as asthma, depression, diabetes, hypertension, and obesity.

To identify individuals with these conditions, HAP analyzes medical, lab, and pharmacy data, along with claims for emergency room use and inpatient care once a month. As part of this analysis, HAP determines whether members have had tests, procedures, treatments, and medications that have proven effective in improving health. The program provides a full spectrum of services, ranging from wellness and preventive care, to nurse case management and assistance from clinical pharmacists and behavioral health specialists. Health care practitioners, employers, and family members provide referrals to the program, and individuals can self-refer.

Wellness and Preventive Care

Educational Materials and Classes

All members with the specified conditions receive newsletters, reminders to have recommended tests and procedures, and other condition-specific information. In addition, members can access a variety of information on HAP's Web site (www.HAP.org/healthtrack), including educational brochures; a comprehensive medical library called My Health Zone®; planning tools to support healthy lifestyle changes; health risk assessments; and programs to facilitate weight loss, smoking cessation, improved nutrition, and stress management.

Besides providing written materials and online resources, HAP offers members the opportunity to enroll in the PATH (Personal Action Toward Health) program, a six-week chronic disease self-management program developed at Stanford University. The program consists of six group classes with trained facilitators, who help participants take action to improve their health and well-being (e.g., by exercising, changing thought patterns, and communicating as needed with physicians).

Preventive Care Reminders for Physicians

As part of its monthly analysis of claims data, HAP determines whether members have had preventive services (e.g., mammography, Pap tests, cholesterol testing, prostate cancer screening) at recommended intervals. If not, HAP's Member Health Manager system places red "clipboard" icons in the eligibility records that physician offices check for payment purposes in conjunction with each visit. Clipboards serve as

reminders for physicians to provide or arrange for preventive care services as soon as possible.

Care for Individuals with Gaps in Chronic Care

Phone Consultations with Nurses

Members with chronic conditions who have missed recommended treatments or whose lab tests or claims for hospital and/or emergency room visits suggest that their conditions are not being treated effectively receive phone calls from nurse case managers, who offer them the opportunity to participate in regular phone consultations to improve their health.

Nurses contact program participants on an ongoing basis (often weekly or biweekly at the outset) to assess their needs; help them set goals; develop action plans to meet these goals; and provide referrals to other professionals and community resources as needed. For example, nurses may refer members with diabetes to nutritionists for help with developing healthy menus, arrange transportation to doctor visits, or refer individuals with depression to behavioral health specialists. Nurses also can help members develop lists of questions to ask during doctor visits.

Individuals generally work with nurse case managers for three to four months. Once members complete this component of the program, HAP continues to monitor their claims and lab data to identify any significant declines in health status or gaps in care. If necessary, nurses contact members again to address these issues.

The Health Buddy® System

In addition to providing ongoing support from nurse case managers, HAP offers members with heart failure and diabetes the opportunity to undergo daily in-home monitoring with the Health Buddy,® an electronic device that asks questions once a day about symptoms, behavior, and knowledge related to their condition (e.g., whether members with heart failure are feeling dizzy, have gained weight, or are eating high-salt foods). Health Buddy® transmits the answers to nurse case managers, who review them and follow up with members and/or their physicians to address issues (e.g., significant weight gain, dizziness) before they lead to complications.

Clinical Pharmacy Assistance

Also as part of HAP's HealthTrack, individuals with the specified conditions whose lab test results or claims data suggest that they are not taking prescription drugs as recommended receive calls from clinical pharmacists. Pharmacists answer their questions, explain the benefits of taking medications as prescribed, discuss possible side effects, ask how well their current prescriptions are working, and address affordability issues. Based on these conversations, pharmacists may contact members' physicians to suggest changes in doses or medications, and they can link members with pharmaceutical assistance programs as needed.

Feedback to Physicians

In support of physicians' efforts to provide effective care, HAP provides its physicians online reports listing patients with chronic conditions who have not had treatments and procedures recommended by the medical evidence. The reports include comparative data on delivery of recommended services for all HAP physicians. The reports include comparative data on delivery of recommended services for all HAP physicians.

Nurse case managers send physicians copies of members' case management plans, updates on members' progress, and letters notifying them when members complete the program. Case managers contact members' physicians to alert them of changes in health status that may warrant immediate attention.

Results

Health Care Quality and Outcomes

Among members with congestive heart failure who received nurse case management:

- Use of Angiotensin converting enzyme (ACE) inhibitor medications and Angiotensin II receptor blocker drugs (ARBs) as recommended increased from 38% prior to the program's implementation in 2003 to 78% in 2005.
- The percent of individuals with LDL-cholesterol levels below 100 mg/dL increased from 61% in 2003 to 70% in 2005.

Member Satisfaction

In a 2005 survey of HAP HealthTrack enrollees with congestive heart failure:

- Ninety-six percent of respondents rated the helpfulness of program information as "good to excellent."
- Ninety-eight percent of respondents said they were somewhat to very likely to recommend the program to others.

Health Care Costs

- From 2003 to 2005, the number of inpatient admissions among HAP members with congestive heart failure declined by 65%, from 2,773 per thousand to 979 per thousand.
- In 2005, total health care costs for HAP members with congestive heart failure were $72 per member per month—3% lower than projected. The program's estimated return on investment was 1.7:1.

For more information, contact:

Richard Precord, M.S.W.
Director, Clinical Care Management
Health Alliance Plan
2850 West Grand Boulevard
Detroit, MI 48202
(313) 664-8230
rprecord@hap.org

Health Plan of Nevada

Nevada

Partnering with Members and Physicians to Promote Effective Care

PROGRAM AT A GLANCE

Goal ▸ Increase use of recommended care for individuals with chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), diabetes, and pediatric asthma.

Key Strategies

- Send members annual reminders to have preventive care services, such as flu and pneumonia shots.
- Offer members with congestive heart failure optional home visits from nurses and tele-monitoring to regularly check vital signs, weight, and health status.
- Provide health coaching to help members schedule appointments for recommended care, take medications appropriately, and access behavioral health care as needed.
- Offer group sessions in which parents of children with asthma at high risk of complications review children's treatment plans with health professionals and learn how to use peak flow meters.
- Appoint physician "champions" for diabetes care within affiliated physician group clinics to keep staff up-to-date on effective care strategies.

Results in Brief

- Among members with employer-sponsored coverage, the percent of individuals age 18 and older with diabetes who had HbA1c tests increased from 72.8% in 2003 to 83.5% in 2006.
- Use of controller medications among Medicaid beneficiaries ages 5-9 with asthma rose from 63% in 2005 to 86.4% in 2006.

FROM CONCEPT TO ACTION

A Multi-Part Initiative

To increase the use of recommended care for individuals with chronic conditions, Health Plan of Nevada (HPN) and its physician group subsidiary, Southwest Medical Associates (SMA), developed a multi-part initiative for individuals with congestive heart failure, diabetes, and pediatric asthma in 2002. The program expanded to include individuals with chronic obstructive pulmonary disease in 2005.

HPN and SMA use electronic registries to track members' use of effective treatments and procedures (e.g., controller medications for asthma, HbA1c and cholesterol tests for individuals with diabetes and CHF). HPN provides information and services based on individuals' risk of complications and/or hospitalization. In addition, the health plan provides participating physicians with patient-specific, actionable information; performance incentives; and continuing medical education to encourage them to provide care according to nationally recognized and evidence-based clinical practice guidelines.

Alternative Services Based on Risk

HPN divides members listed in the registry into low-, moderate-, and high-risk groups based on their prior history of inpatient hospitalizations, emergency department and outpatient visits, and/or lab test results. All members with the targeted conditions receive introductory packets with disease-specific brochures, general information about the program, listings of HPN's health education classes as well as phone numbers for nurses who can answer their health-related questions.

Once a year, the health plan sends members in all risk groups postcard reminders for flu immunizations, pneumonia shots, and other preventive care (e.g., dilated eye exams for individuals with diabetes) recommended for individuals with the targeted chronic conditions. Members can opt out of the program at any time.

In addition to receiving written materials, members at moderate risk of hospitalization and complications can receive a variety of condition-specific services. For example, members with asthma may receive telephone calls or letters from their primary care physicians to explain their diagnoses, describe the effective use of medications, and encourage them to schedule regular primary care visits.

Depending on their specific health needs, some members with congestive heart failure are eligible to be assessed for participation in a home health program offered by the health plan's affiliated home health company, Family Healthcare Services (FHS). Individuals referred to the program receive home visits from nurses, who evaluate their home environments for safety and appropriateness for tele-monitoring, their ability to follow treatment plans, and willingness to participate in the program.

Home care nurses visit and monitor the health status of program participants regularly through tele-monitoring systems to check their weight, vital signs, and health status. Nurses follow

Partnering with Members and Physicians to Promote Effective Care (cont'd)

SINCE 1982
HEALTH PLAN OF NEVADA, INC.
a subsidiary of Sierra Health Services, Inc.

up with members' physicians as needed (e.g., to address declines in health status or to discuss changes in medications or doses).

Unless they opt out of the program, individuals at high and moderate risk of complications and hospitalization receive periodic telephone calls from registered nurses trained as health coaches. Based on information in HPN's registry, health coaches encourage members to schedule appointments for recommended care, and they provide guidance on taking prescribed medications appropriately.

The frequency of telephone calls is based on members' risk levels. Health coaches also may refer members to case management staff, who assess members' eligibility for public programs (e.g., Medicaid, state pharmacy assistance programs) as needed. Nurses also screen members for depression and can link them with behavioral health specialists.

Twice a year, parents of children with asthma who are in the high-risk category have the opportunity to attend group sessions where health professionals (e.g., nurses, pharmacists, health educators) review children's treatment plans and demonstrate the use of peak flow meters to measure lung capacity. Following these sessions, members meet with their children's pediatricians, who discuss treatment plans in greater detail and explain strategies for effective asthma care (e.g., how to avoid situations that trigger symptoms and how to respond in a timely manner if symptoms occur).

Promoting Physician Involvement

Reports with Actionable Information

Based on data from its registry, HPN sends PCPs quarterly reports that document their patients' use of recommended treatments and procedures, as well as the frequency of patients' hospital stays, outpatient visits, and emergency room visits for the targeted conditions. In addition, the reports compare individual physicians' performance in providing effective services to that of all other primary care physicians within SMA and throughout HPN's network. Based on this information, physician office staff can contact patients to schedule appointments for recommended care.

Physician "Champions"

To promote the program's success, primary care physician "champions" for diabetes care are appointed within each SMA clinic. An endocrinologist affiliated with SMA shares the latest information on effective diabetes care with PCP champions on a regular basis so that they can keep their staffs up to date. This mentoring process lays the groundwork for ongoing clinical and operational improvements.

Rewarding Success

Each quarter, SMA holds an awards dinner to recognize participating clinics whose patients have achieved specified health outcomes. Individual physicians are rewarded if at least 70% of their patients with diabetes have been screened for kidney disease, have HbA1c levels below 9, and have cholesterol levels below 130 mg/dL. Similar programs may be implemented in the future for pediatric asthma, CHF, and COPD.

Educational Sessions

Each month, SMA offers continuing medical education classes that often focus on the four targeted conditions, and the medical group periodically conducts "lunch-and-learn" sessions to discuss new information or research related to these conditions. Twice a year, SMA holds asthma and diabetes "summits," which are half-day programs in which clinical experts and health care providers discuss the latest research, appropriate use of medications, and effective treatment strategies.

Results

Diabetes

Among HPN members with employer-sponsored coverage, the proportion of individuals age 18 and older with diabetes who had recommended preventive care increased as follows from 2003 to 2006:

- The percentage of members who had HbA1c tests increased from 72.8% to 83.5%.
- The proportion of individuals who had LDL-cholesterol tests rose from 75.2% to 91.5%.
- The percent who received screening for kidney disease grew from 49.4% to 62.8%.

Asthma

From 2005 to 2006, use of controller medications among HPN members ages 5-17 with asthma rose as follows:

- The percent of children ages 5 to 9 with employer-based coverage who used the medications rose from 71.6% to 93.5%.
- The rate among children ages 10-17 with employer-based coverage increased from 62.5% to 85.6%.
- The proportion of Medicaid beneficiaries with asthma ages 5-9 using the treatments increased from 63% to 86.4%.
- The rate among Medicaid beneficiaries ages 10-17 rose from 56.8% to 70.3%.

For more information, contact:

Jenny DesVaux Oakes
Assistant Vice President, Public and Community Relations
Health Plan of Nevada
P.O. Box 15645
Las Vegas, NV 89158
(702) 242-7155
jennypr@sierrahealth.com

Highmark Blue Cross Blue Shield and Health Dialog

Pennsylvania and Massachusetts

Staying On Call For Chronic Care

PROGRAM AT A GLANCE

Goal ▸ Ensurethat individuals with diabetes, congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, and/or asthma receive coordinated care consistent with the medical evidence.

Key Strategies

- Use an interactive voice response phone system to check members' health status, determine whether they have questions, and provide information on recommended care.
- Offer health coaching to help members set goals to improve health; access community resources; and obtain additional medical and/or behavioral health services to meet their needs.
- Send primary care physicians regular updates on members' chronic conditions, medications, work with health coaches, and check the status of progress in obtaining recommended care.

Results in Brief

- Ninety-two percent of program participants surveyed in 2005 said they were satisfied or very satisfied with the program.
- Among the health plan's PPO members enrolled in the program from 2003 to 2004, the percent of individuals with congestive heart failure who took beta-blockers as prescribed grew from 60% to 69.4%.

FROM CONCEPT TO ACTION

A Streamlined Approach

To create a more streamlined approach to chronic care, Highmark Blue Cross Blue Shield worked with Health Dialog to create the Blues On Call℠ program in 2001. The program combines five separate disease management initiatives into one program to ensure that individuals with diabetes, congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, and/or asthma receive coordinated, effective care consistent with the medical evidence.

Identifying Members Who Can Benefit

Highmark BCBS and Health Dialog analyze medical and pharmacy data on a monthly basis to identify members with any of the five conditions who have not had recommended treatments and screenings. The health plan also reviews hospital admission and discharge data each day to identify members with the conditions who have been hospitalized, and it refers members to the program based on responses to health risk assessments that individuals can complete online at any time. Health care practitioners and case managers refer members to the program, and individuals can self-refer. By analyzing members' prior use of health services, Highmark BCBS predicts their risk of complications and/or hospitalization within the coming year, and the health plan provides information and services tailored to members' needs.

Outreach Based on Risk of Complications

Mailings, Outreach Calls, 24-Hour Nurse Line

Once they have been identified for the program, members with any of the five conditions receive condition-specific mailings periodically throughout the year. For example, Highmark BCBS sends notices reminding members to have recommended preventive care services (e.g., flu shots, eye exams for members with diabetes), as well as postcards suggesting that they speak with physicians about medications proven to be effective for their conditions (e.g., beta-blockers following heart attack, controller medications for asthma).

Besides sending mailings and reminders, Highmark BCBS uses an interactive voice response (IVR) phone system to contact members at moderate risk of complications periodically to determine whether their risk levels have increased. During these calls, Highmark BCBS asks whether members have questions about their health (e.g., whether they believe their diabetes is under control, whether they know how to address symptoms effectively), provides information about recommended care, and asks if they would like to consult with a Health Coach.

Health Coaching

Members who have been hospitalized for their conditions, who have not had recommended treatments or procedures (e.g., beta-blockers following heart attack, controller medications for asthma), or who indicated during IVR outreach calls that their conditions were not under control and/or that they would like additional assistance receive periodic phone calls from nurses, respiratory therapists, or dieticians trained as Health Coaches. During these calls, Health Coaches use a shared decision-making® approach to help members develop goals (e.g., losing weight, quitting smoking, taking medications as recommended) for improving health. Health Coaches contact members periodically to assess their progress in meeting these goals, and they help them find community resources

(e.g., nutrition counseling programs, smoking cessation classes, exercise classes, support groups, and workplace employee assistance programs) to support their efforts. Health Coaches conduct screenings to determine whether members have additional health conditions (e.g., depression, hypertension, high cholesterol), and they help members access medical and/or behavioral health services to address unmet needs. Health Coaches also send members written materials, videotapes, and DVDs to provide information and decision support. The frequency of contact varies depending on members' needs and preferences.

Coordination with Case Management

Health Dialog's Health Coaches coordinate with Highmark's case managers on a daily basis and refer members with several chronic conditions and/or complex needs (e.g., due to recent trauma) to case management. Case managers follow up with members to provide support with a broad range of medical, health benefit, and social service issues (e.g., arranging for home care services, installation of medical equipment, assistance with advance directives).

Case managers may work with members for several days, several months, or more, depending on individual situations. Once members' case management needs have been met, Health Coaches follow up with members periodically to help them maintain optimal health.

Regular Updates for Primary Care Physicians

Several times per year, Highmark BCBS sends every primary care physician in its network a SMART™ Registry report that includes a list of each patient's chronic conditions and medications; an indication of whether he or she is working with a Health Coach; and the status of his or her progress in receiving all recommended care (e.g., HbA1c tests for individuals with diabetes, blood pressure and cholesterol tests for members with coronary artery disease). Each report includes charts displaying information at the patient level and for the physician's entire practice. Patient-specific reports are formatted for easy placement in medical charts.

Highmark BCBS's nurses follow up with physicians by phone or in person, depending on physicians' preferences, to explain the reports and help them modify office operations as needed (e.g., by implementing phone reminder systems) to ensure that individuals with chronic conditions receive care consistent with the medical evidence.

Results

Member Satisfaction

In a 2005 survey of Blues On Call participants:

- Ninety-two percent of respondents said they were satisfied or very satisfied with the program.
- Ninety-two percent said they were highly satisfied with their Health Coaches.
- Ninety-seven percent said they would recommend the program to others.
- Eighty-six percent said that speaking with Health Coaches had a positive effect on the quality of care that they received from their health care practitioners.

Quality of Care

Among Highmark BCBS's PPO members enrolled in Blues On Call from 2003 to 2004:

- The percent of individuals with coronary artery disease who had cholesterol tests increased from 51.2% to 55.6%.
- The proportion of members with diabetes who had HbA1c tests rose from 58.3% to 63.1%.
- The percent of members with congestive heart failure who took beta-blockers as prescribed grew from 60% to 69.4%.

Financial

- Cost savings attributable to Blues On Call represent 1-3% of total health care costs for all Highmark members.

For more information, contact:

Patricia Neurohr
Director, Clinical Program Management
Highmark Blue Cross Blue Shield
120 Fifth Avenue, Suite P4420
Pittsburgh, PA 15222
(412) 544-2202
patricia.neurohr@highmark.com

Kiran Ganda
Manager, Marketing
Health Dialog
60 State Street, 11th Floor
Boston, MA 02109
(617) 406-5239
kganda@healthdialog.com

HIP Health Plan of New York

New York

Forging a Path to Independence for Frail Elderly Members

PROGRAM AT A GLANCE

Goal ▸ ImproveMedicare beneficiaries' health and functional status.

Key Strategies

- Offer regular phone consultations with nurses, who help ensure correct use of medications, help members make lifestyle changes to improve health, coordinate care as needed, and provide information on home safety issues.
- Provide assistance from social workers, who help members complete applications for public programs; find senior center activities in their communities; and access legal, financial, and end-of-life planning services.
- Update physicians regularly about the program; inform them when their patients enroll; and encourage them to collaborate with the program's nurses and social workers.

Results in Brief

A case-controlled study of 121 individuals enrolled in the program for six months in 2004 found that the number of inpatient admissions among participants was 49% less than the number of admissions among a control group.

FROM CONCEPT TO ACTION

Identifying Elderly Members at High Risk of Hospitalization

Recognizing that a small portion of Medicare beneficiaries accounted for the majority of health care costs, in 2001 HIP Health Plan of New York (HIP) added a Geriatric Case Management (GCM) program to its ongoing initiatives for elderly members. The program addresses many issues often facing frail, elderly individuals, including age-related physical changes, lack of social support, difficulties with transportation, and confusion about complex medication regimens.

The program's goal is to improve beneficiaries' health and functional status so that they can live more independently in the community.

To identify individuals who could benefit from the program, HIP analyzes claims data (to determine which members with chronic conditions are most likely to develop complications or be hospitalized in the future) and takes referrals from community agencies, primary care physicians, and health plan medical management staff. Program participants have conditions such as heart and lung disease, depression, arthritis, dementia, and Parkinson's disease.

Regular Phone Calls with Nurses and Social Workers

Geriatric nurse case managers make initial phone calls to members to describe the program and offer the opportunity to enroll. If individuals decide to participate, case managers conduct structured interviews that focus on the individuals' medical histories, use of prescription and over-the-counter medications, nutrition, exercise, smoking habits, and functional status.

After speaking with nurses, program participants receive calls from social workers, who assess their financial need, determine eligibility for public programs, evaluate their formal and informal support systems, and identify needs for services such as Meals on Wheels, low-cost transportation, and adult day care. Social workers also screen members for depression and can provide referrals to behavioral health specialists.

Subsequently, members receive regular phone calls from nurses and social workers at least once a month and more often as needed. To help members address their chronic conditions effectively, nurses review their medications, determine whether they are being taken correctly, and assess the potential for adverse interactions. Nurses contact the members' physicians as needed to address these issues. In addition, they help members make lifestyle changes in such areas as exercise and diet to improve their health.

Nurses provide members with information about age-related changes, factors specific to their chronic conditions, and home safety. They also coordinate members' primary, specialty, and home care if needed. To supplement and reinforce their health care teaching, nurses send members written materials on topics relevant to their conditions. All materials are available in both English and Spanish, at either third- or sixth-grade reading levels.

Social workers serve as member advocates as needed, for example, by helping them complete applications for Medicaid and other public programs, find senior center activities in their communities, and access legal, financial, and end-of-life planning services. GCM's nurse case managers and social workers communicate regularly to ensure that program participants receive services

in a timely and coordinated manner. Members are enrolled in the program for an average of three months.

Communication with Physicians

HIP regularly provides information about the program to primary care physicians and encourages them to work collaboratively with GCM nurses and social workers. The case management team sends letters to physicians notifying them when their patients enroll in the program. In addition, nurses and social workers collaborate with members' physicians on an ongoing basis (e.g., to ensure that members take medications as recommended).

The GCM director meets with HIP's participating medical groups periodically to provide information about the program, answer questions and encourage physicians to refer their elderly patients with chronic conditions. HIP's Web site includes a description of the program, and the health plan's physician newsletter has featured articles about it.

Results

Approximately 450 members are enrolled in the GCM program at any one time, and the average age of program participants is 79.5 years. A case-controlled study of 121 individuals during a six-month period in 2004 found that:

- The number of inpatient admissions among GCM participants was 49% less than the number of admissions among a control group.
- Average hospital lengths of stay were shorter (1.3 days less) among participants than in the control group.

For more information, contact:

Ronald Maiorana
Senior Vice President for Public Affairs
HIP Health Plan of New York
55 Water Street
New York, NY 10041
(646) 447-6269
rmaiorana@hipusa.com

Horizon Blue Cross Blue Shield
New Jersey

Providing a Continuum of Care to Meet Member Needs

PROGRAM AT A GLANCE

Goal ▸ Improve health and prevent unnecessary complications among members with chronic conditions and those with complex needs following hospitalization.

Key Strategies

- Use an interactive voice response (IVR) phone system to remind members with diabetes, asthma, and/or coronary artery disease to have recommended preventive care.
- Offer health coaching to help members develop goals to improve health; pursue action plans to meet goals; find affordable medications, transportation, child care, and/or housing; link with community organizations for additional support; and obtain behavioral health care as needed.
- Call and visit individuals with end-stage renal disease regularly to ensure that they receive all needed services in a timely manner.
- Provide case management to help members with complex needs access services such as home care, private-duty nursing, transportation, installation of home medical equipment, and end-of-life care.

Results in Brief

Among program participants with asthma, the number of emergency room visits fell by 49% from 2004 to 2005, and the number of inpatient admissions declined by 51%.

FROM CONCEPT TO ACTION

Health and Wellness Education Programs

To improve members' quality of life and reduce the need for hospitalization and emergency room use, Horizon Blue Cross Blue Shield of New Jersey (Horizon BCSBSNJ) established the Health and Wellness Education Programs in 2003.

The programs focus on care for nine chronic conditions (hepatitis C, end-stage renal disease (ESRD), multiple sclerosis, chronic obstructive pulmonary disease, heart failure, coronary artery disease, diabetes, asthma, and obesity), and they provide case management for individuals with complex needs following major acute care episodes (e.g., individuals who have had hospital stays longer than 10 days for acute care or multiple hospital admissions within 90 days).

Horizon BCBSNJ identifies members who can benefit from the programs by analyzing medical and pharmacy claims and responses to health risk assessments (HRAs) that individuals complete upon enrollment. Physicians refer patients to the program, and individuals can self-refer. Based on its analysis of claims and HRAs, Horizon BCBSNJ divides members into risk groups according to their predicted likelihood of hospitalization or emergency room use in the upcoming year. Horizon BCBSNJ automatically enrolls all individuals eligible for the program and gives them the opportunity to opt out.

Educational Materials

All program participants receive condition-specific informational mailings on a quarterly basis. These include calendars with reminders to have recommended tests for their conditions (e.g., HbA1c blood level tests for diabetes, cholesterol and blood pressure tests for individuals with coronary artery disease); refrigerator magnets with tips on healthy meal planning; and newsletters and brochures with information and preventive care recommendations from organizations such as the National Kidney Foundation; American Heart Association; National Heart, Lung, and Blood Institute; American Diabetes Association; and National Institute of Diabetes & Digestive & Kidney Diseases. These materials list Horizon BCBSNJ's toll-free number that members can call to ask questions and seek assistance from professional care specialists.

Reminder Calls

To supplement the programs' educational materials, in 2005, Horizon BCBSNJ began using an interactive voice response system to make phone calls reminding all members with diabetes, asthma, and/or coronary artery disease to have preventive care tests and procedures at intervals prescribed by nationally recognized clinical practice guidelines.

Every six months, Horizon BCBSNJ contacts members who have not had the recommended care to remind them to schedule appointments and take prescribed medications. For example, Horizon BCBSNJ would call a member who has not filled a beta-blocker prescription following a heart attack to

ask whether he or she plans to fill the prescription. If the individual says "No," he or she would hear a message about the benefits of beta-blockers following heart attacks and would be encouraged to contact a health care practitioner to learn more about the medication. In addition, the negative response would trigger an alert for a professional care specialist to contact the member, encourage him or her to fill the prescription, and address any barriers to taking it on a regular basis.

Regular Phone Consultations with Care Specialists

Individuals at high risk of complications and/or hospitalization have the option of consulting by phone on a regular basis with professional care specialists. Care specialists identify and address gaps in members' knowledge about their conditions; help them develop goals to improve their health status; and help them follow action plans to meet these goals. Action plans may include working with behavioral health coaches, attending smoking cessation classes, modifying diets, increasing exercise, and/or monitoring vital signs every day.

Care specialists coordinate with Horizon BCBSNJ's social workers to help members find affordable medications, transportation, medical equipment, child care, and/or housing. They also link members with community organizations to access other resources and programs (e.g., support groups, reading programs for individuals who are blind). Care specialists ask questions to screen members for depression and can refer them to behavioral health specialists. The frequency of these calls varies depending on member needs and can range from weekly to quarterly.

On-Site Assistance for Members with End-Stage Renal Disease

When a Horizon BCBSNJ member begins dialysis treatment, a care specialist with nephrology experience contacts the member and the dialysis facility to arrange a meeting. During a series of monthly visits and regular phone calls with members, care specialists seek to ensure that they receive all of the services they need in a timely manner.

Care specialists provide members with educational materials, and they review lab test results to monitor key health status indicators. Care specialists discuss these results regularly with patients and their treatment teams to improve members' well-being and promote positive health outcomes.

Case Management

Besides providing care for individuals with chronic conditions, Horizon BCBSNJ's Health and Wellness Education Programs refer members to case management if they have experienced catastrophic events or have complex needs following major acute care episodes. Depending on member needs, case managers can arrange for and coordinate services such as home health care, private-duty nursing, transportation, installation of home medical equipment, authorization for inpatient or outpatient services, and end-of-life care.

Communication with Physicians

Because health care practitioners' involvement is critical to the success of the Health and Wellness Education programs, Horizon BCBSNJ communicates regularly with members' primary care physicians. Each year, the health plan sends physicians lists of their patients enrolled in the programs, as well as copies of program materials upon request.

Professional care specialists contact physicians as needed to discuss issues related to members' medications (e.g., potential adverse reactions, multiple medications and/or changes in health status that require follow-up). Care specialists also ask physicians to fill out and fax back forms to track member progress in obtaining recommended tests and treatments.

Horizon BCBSNJ encourages physicians with high volumes of patients who have not had recommended treatments and screenings to attend its annual disease-specific seminars during evening hours in multiple locations throughout the state. Physicians earn continuing medical education (CME) credits for their attendance.

Results

- As of January 2006, approximately 114,000 members were enrolled in Horizon's Health and Wellness Education programs.
- Among members enrolled in the asthma program, the number of emergency room visits fell by 49% from 2004 to 2005, and the number of inpatient admissions declined by 51%.
- Among members enrolled in the diabetes program, the number of emergency room visits decreased by 2% from 2004 to 2005, and the number of inpatient admissions fell by 6%.
- Annual member surveys consistently have found that approximately 75% of members are satisfied with the programs.

For more information, contact:

Premila Kumar
Senior Clinical Manager, Health and Wellness Education Programs
Quality Management and Clinical Innovations
Horizon Blue Cross Blue Shield of New Jersey
Three Penn Plaza East- PP 13N
Newark, NJ 07105
(973) 466-5390
premila_kumar@horizonblue.com

Humana Inc.
Kentucky

Guiding the Way to Good Health With Personal Nurses

PROGRAM AT A GLANCE

Goal ▸ Improve health and well-being among members at risk for adverse health events and/or hospitalization.

Key Strategies

- Offer members the opportunity to consult regularly with Personal Nurses, who can identify needs and help individuals set goals to improve health, pursue action plans to achieve goals, and discuss alternatives to unhealthy activities.
- Allow members to contact Personal Nurses for help with health care, lifestyle, or health benefit issues.

Results in Brief

In a 2006 survey of members using the Personal Nurse service, 99% of respondents said their conversations with Personal Nurses had affected their thinking about health goals.

FROM CONCEPT TO ACTION

The Personal Nurse® Service

In response to employer requests for initiatives to help employees navigate the health care system, Humana created the Personal Nurse service in January 2003. Personal Nurses help members identify their health and lifestyle goals, create action plans to achieve them, and link members with resources to facilitate the process.

Identifying Members

Humana analyzes medical, lab, and pharmacy claims on a monthly basis to identify patterns of health care use that ultimately could lead to adverse health events and/or hospitalization. These include: being newly diagnosed with a health condition; having a recent hospitalization or emergency room visit; having gaps in primary care physician visits for specified time frames; not taking prescribed medications; and/or having numerous doctor visits to address a condition.

Individual conditions and patterns of care are weighted for severity (i.e., a new diagnosis of diabetes is weighted more highly than a diagnosis of seasonal allergies) to create an overall "severity score" for each member. Members with scores above a specified threshold receive phone calls from Personal Nurses trained in health coaching and motivational interviewing.

Health Coaching

During the first conversation, the Personal Nurse asks each member a series of open-ended questions about health status and goals for improving health. Personal Nurses provide condition-specific health assessments to determine members' needs related to each of their conditions, and they help them address these needs.

For example, Personal Nurses speaking with parents of children with asthma may encourage them to have regular pediatrician visits, provide referrals to pediatric asthma specialists, and/or direct them to the National Heart, Lung, and Blood Institute's Web site. Personal Nurses speaking to individuals newly diagnosed with breast cancer may provide information about treatment options and link them with local support groups.

If members express interest in making lifestyle changes to improve health, Personal Nurses coach them in pursuing action plans that may include eating healthy diets, exercising regularly, checking blood sugar levels, and taking medications as prescribed. Personal Nurses help members develop strategies to cope with impulsive thoughts (e.g., the temptation to light a cigarette in stressful situations) and discuss alternatives to unhealthy activities (e.g., chewing gum rather than smoking, using relaxation techniques to reduce stress).

Personal Nurses generally do not contact members' physicians. Rather, they encourage members to contact their physicians if they have questions or concerns about treatment, and they help them make lists of questions to bring to doctor visits. If members express interest in saving money on health care, Personal Nurses provide them with information about lower cost-sharing levels for choosing generic drugs, in-network hospitals, and participating physicians.

Individuals generally have three to five scheduled 20-minute conversations with Personal Nurses over a six- to nine-month period. Each member can contact his or her Personal Nurse at other times through a toll-free number to ask questions or seek help with health care, lifestyle, or health benefit issues.

Results

In a 2006 survey of Humana members using the Personal Nurse service:

- Ninety-nine percent of respondents said their conversations with Personal Nurses had affected their thinking about health goals.
- Eighty-nine percent said their discussions with Personal Nurses had helped them feel more comfortable when speaking with their physicians.

For more information, contact:

Chase Braden
Director of Sales for Clinical Programs
Humana Inc.
500 West Main Street
Louisville, KY 40201
(502) 580-1833
cbraden@humana.com

Independence Blue Cross
Pennsylvania

Helping Members Connect to Effective Care

PROGRAM AT A GLANCE

Goals
- **Improve health and prevent unnecessary complications and hospitalization among members with chronic conditions.**
- **Help members facing major treatment decisions understand their options and make informed choices.**

Key Strategies

- Remind members to schedule treatments and procedures recommended for their conditions.
- Offer health coaching to help members understand and follow treatment plans and provide referrals to behavioral health, smoking cessation, or other services to meet members' needs.
- Contact individuals making major treatment decisions and provide information about different options based on the medical evidence.
- Coordinate with dialysis care teams to ensure that members with end-stage renal disease receive care and support for all of their needs.

Results in Brief

- Eighty-seven percent of members surveyed about the Connections Health Management Program in 2005 said they were "satisfied" or "very satisfied" with health coaches' services, and 90% said they would recommend the program to others.
- From 2003 to 2004, the number of inpatient days for privately insured HMO and PPO members with chronic conditions who participated in the program was 13% to 18% less than expected.
- The program has reduced annual growth in total medical costs, excluding pharmacy, by an estimated 1.5-3%.

FROM CONCEPT TO ACTION

The Connections℠ Suite of Programs

In response to the rising prevalence of chronic conditions and increased treatment costs, Independence Blue Cross (IBC) collaborated with Health Dialog to launch the Connections℠ Health Management Program in 2003.

The program includes three components: (1) disease management for members with asthma, diabetes, chronic obstructive pulmonary disease (COPD), chronic heart failure, and/or coronary artery disease; (2) round-the-clock telephone access to health coaches to obtain information about health topics; and (3) decision support for members facing important choices among treatment options for conditions such as breast cancer, prostate conditions, back or knee pain, and depression.

In 2004, IBC launched the Connections℠ Kidney Program (CKP) in partnership with RMS to support members with chronic kidney failure, and in 2005, IBC added the Connections℠ AccordantCare™ program for individuals with any of 15 complex chronic conditions (e.g., multiple sclerosis, seizure disorders, Parkinson's disease, lupus, sickle cell anemia, and/or rheumatoid arthritis). In 2006, IBC expanded the program to include Crohn's disease. Connections AccordantCare helps members learn more about their conditions and gain the skills needed to follow physicians' treatment plans.

Connections Health Management Program

All eligible members first receive a mailing welcoming them to the Connections Program. To identify members with specific chronic conditions, IBC works with Health Dialog to analyze data on a monthly basis from medical, pharmacy, lab, and radiology claims; lab test results; and information from health risk assessments. Health care practitioners and case managers also may refer members to the program, and individuals can self-refer.

Each member eligible for the program is considered to be a participant unless he or she opts out. IBC stratifies the population based on members' risk levels to determine the level of outreach best suited to individual needs. The health plan determines individuals' risk levels through predictive models using data on past hospital admissions, emergency room use, medication histories, and use of recommended care. Individuals are considered to be in the high-risk group if they have not had treatments or procedures that medical evidence indicates are effective for their conditions and/or if their patterns of health care use suggest that their future medical costs are likely to be high.

Mailings, Reminders, and Access to Health Coaches

All participants identified with one or more of the chronic conditions targeted through the program receive mailings with condition-specific information, along with reminders to schedule treatments and procedures recommended for their conditions (e.g., flu shots for members with any of the chronic conditions, cholesterol tests for individuals with chronic heart failure and/or coronary artery disease). In addition, all members, regardless of whether they have chronic conditions, have access to health coaches by phone on a 24/7 basis to discuss any health care topic.

Ongoing Health Coaching

Depending on their conditions, program enrollees at high risk of complications or hospitalization receive phone calls from health coaches who are registered nurses,

dieticians, or respiratory therapists. During these calls, coaches assess members' needs, ask about lifestyle issues affecting their health (e.g., diet, exercise, smoking), and determine whether they are using effective treatments and preventive care (e.g., controller medications for asthma, flu and pneumonia shots).

Health coaches' interactions with members are tailored to individual needs and goals, and they support individuals' efforts to meet these goals. Coaches encourage members to follow up regularly with health care practitioners, and they help members understand and follow physicians' treatment plans.

Health coaches may help members develop lists of questions to ask during doctor visits. They focus on closing any identified "care gaps," to ensure that members receive all of the treatments and procedures recommended for their conditions, and they may suggest referrals to behavioral health care practitioners, case management services, smoking cessation programs, or other health plan programs to address their needs. On average, health coaches contact members at high risk five to seven times per year; however, the frequency varies based on member preference and need.

Enhanced Decision Support

IBC offers enhanced support for individuals facing treatment decisions related to a variety of medical conditions, including benign uterine conditions, prostate conditions, ovarian cancer, breast cancer, and depression, as well as decisions about bariatric surgery, joint replacement, or back surgery. When claims analysis indicates that a member is in a potential "decision window," IBC contacts the individual by phone or mail to encourage consultation with a health coach to discuss treatment options.

Coaches use a model of "shared medical decision making" that helps members work with their doctors to understand treatment options and make informed health decisions. During their conversations with members, health coaches may offer to send them 30- to 45-minute videotapes produced by the Foundation for Informed Medical Decision Making. Videos discuss the pros and cons of alternative treatment options based on the medical evidence. Coaches follow up with members to ensure that they received the videos and answer any additional questions.

Connections AccordantCare

To identify members with complex chronic conditions who can benefit from Connections AccordantCare, IBC analyzes claims data on a monthly basis. Once individuals are identified with complex conditions, they receive initial calls from nurse disease managers specializing in their conditions to assess their medical needs.

Unless individuals opt out of the program, disease management nurses subsequently schedule follow-up calls to review medications recommended for their conditions; help them follow physicians' treatment plans; and discuss how to avoid potential complications and safety risks. Program participants receive monthly newsletters with information about their conditions, effective treatments, and recent research findings, and they can access condition-specific information on Accordant's Web site.

Connections Kidney Program

Every month, IBC uses claims data to identify all members with end-stage renal disease (ESRD) who are receiving dialysis. Program enrollment staff contact these members to engage them in the program. Subsequently, experienced dialysis nurses called health services coordinators (HSCs) meet with members at their dialysis sites or at home to discuss the program and conduct clinical assessments.

Based on results of these assessments, Connections Kidney Program HSC's coordinate with their dialysis care teams to provide care and support for all of their needs related to ESRD and other health conditions. As part of the process, the health plan provides individual patient reports and practice-level data on outcomes on a quarterly basis to each member's PCP and kidney specialist, as well as to dialysis centers.

Results

- The program has reduced annual growth in total medical costs, excluding pharmacy, by an estimated 1.5-3%. In the program's first year, total medical costs for individuals participating in the Connections Health Management Program were 1.5% to 2% less than projected costs in the program's absence. In its second year, the program continued to reduce annual growth in medical costs for program participants by 2.5 to 3% below projections.
- IBC attributes the savings largely to reductions in avoidable hospital admissions and outpatient services. For example, from 2003 to 2004, the number of inpatient days for privately insured HMO and PPO members with chronic conditions who participated in the program was 13% to 18% less than expected.
- Eighty-seven percent of members surveyed about the program in 2005 said they were "satisfied" or "very satisfied" with health coaches' services, and 90% said they would recommend the program to others. Seventy-eight percent of members with chronic conditions perceived the quality of care received from their health care practitioners as "better" or "much better" as a result of their having worked with coaches.
- In 2006, approximately 2,000,000 IBC members participated in Connections Health Management, including more than 220,000 members with chronic conditions.
- As of April 2006, approximately 12,000 members with complex chronic conditions were enrolled in the Connections AccordantCare program, and approximately 500 members with ESRD received services through the Connections Kidney Program.
- In 2006, IBC's Connections Programs were awarded the Disease Management Leadership Award for Outstanding Health Plan from the Disease Management Association of America.

For more information, contact:

Esther Nash, M.D.
Senior Medical Director – Population Health and Wellness
Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103
(215) 241-4653
Esther.Nash@ibx.com

Kaiser Permanente
California

Going ALL Out to Prevent Heart Attacks and Stroke

PROGRAM AT A GLANCE

Goal ▸ Ensurethat all members with coronary artery disease and/or those over age 55 with diabetes regularly take three medications—aspirin, lisinopril, and lovastatin (ALL)—to prevent heart attack and stroke.

Key Strategies

- Arrange for clinical pharmacists to contact members who are not using recommended care for the two conditions to describe the benefits of aspirin, lisinopril, and lovastatin and encourage them to schedule appointments to obtain prescriptions and/or lab tests as needed.
- Offer group sessions for members with the targeted conditions who are not taking the ALL medications or who have not had recommended lab tests, to answer questions, address concerns, and provide prescriptions.
- Have physicians send letters to patients at risk of heart attack or stroke, to encourage them to take the ALL medications as prescribed and/or to schedule office visits to obtain prescriptions.

Results in Brief

From 2002 to 2005, the percent of members with coronary artery disease and/or those over age 55 with diabetes who took the ALL medications as recommended increased from 49% to 67%.

FROM CONCEPT TO ACTION

The ALL Initiative

Based on strong evidence from the medical literature indicating that a combination of three medications—aspirin, lisinopril, and lovastatin (ALL)—could reduce the risk of heart attack and stroke for individuals with coronary artery disease and for people over age 55 with diabetes by more than 70%, Kaiser Permanente established the ALL Initiative in 2002. The program seeks to ensure that every Kaiser Permanente member in these two groups takes the three medications on an ongoing basis.

Encouraging Regional Innovation

Kaiser Permanente regions throughout the country have set goals to increase use of ALL medications among members, typically by 5-10% per year, and each region has flexibility to design its own programs to meet the goal. Teams of nurses, physicians, and administrators in each Kaiser region serve on an ALL Implementation Network and have quarterly conference calls to compare best practices and learn from each other's experiences. Each Implementation Network member is responsible for submitting data from the medical groups in his or her region indicating utilization rates of ALL medications among the members for whom they have life-saving potential.

Kaiser Permanente regions use a variety of approaches to promote the ALL initiative, including: a clinical pharmacist program; a multi-disciplinary team approach; a member group meeting series; a physician support model; and a physician letter campaign. Each of these programs is described below.

Phone Consultations with Pharmacists

In the Colorado region, clinical pharmacists review data from Kaiser's electronic medical records on members' diagnoses and lab tests to determine whether individuals with coronary artery disease and members over age 55 with diabetes are taking the ALL medications.

Pharmacists contact members in these groups who are missing any one of these drugs, as well as those who have not had recommended lab tests to monitor the two conditions (e.g., HbA1c or LDL-cholesterol) or whose lab results suggest that their conditions are not being treated effectively. During these phone calls, pharmacists describe the benefits of the ALL medications and encourage members to schedule appointments with their doctors to obtain prescriptions and/or lab tests as needed. Pharmacists also contact members' treating physicians via e-mail to suggest that they would be appropriate candidates for using ALL.

Multi-Disciplinary Teams

In the Hawaii region, clinics have formed multidisciplinary teams—comprised of physicians, nurse practitioners, medical assistants, and diabetes health educators—who review members' records to identify members who could benefit from the ALL medications. Physicians make decisions about which patients could most benefit, and other members of the team contact members by phone to discuss the medications' life-saving potential, help them schedule appointments, and answer their questions.

Group Sessions

Also in Hawaii, Kaiser offers group sessions for members with the targeted conditions. Kaiser staff contact members who are not taking the ALL medications, who are missing recommended lab tests, or whose lab tests suggest that they are at risk of complications and invite them to informational sessions on the benefits of ALL. During these sessions, nurse practitioners and/or physicians

answer members' questions, address any concerns they have, and write prescriptions for the medications. Members also are encouraged to share their experiences and address each other's questions.

Additional Staff Support for Physicians

In the Richmond area of Northern California, Kaiser provided medical groups with additional staff who were assigned full-time to the ALL project. Medical assistants reviewed members' electronic records to identify individuals with the two targeted diagnoses who were not taking ALL medications, who were missing lab tests for the conditions, or whose lab results suggested that they would benefit from treatment. The assistants contacted these members by phone to discuss the benefits of the medications and of regular testing and to help them schedule lab tests or doctor's appointments as needed.

Physician Letter Campaigns

In Southern California, physicians review patient records to identify individuals at risk of heart attack and stroke who could benefit from ALL. They send these patients letters that emphasize the medications' track record in saving lives, encourage them to take the ALL regimen as prescribed, and/or to schedule office visits to discuss the medications and obtain prescriptions. Physicians often add handwritten messages to the letters to help build rapport with patients.

Results

- From 2002 to 2005, the percentage of Kaiser Permanente members with coronary artery disease and/or those over age 55 with diabetes who took the ALL medications as recommended increased from 49% to 67%.
- In recognition of the ALL Initiative's innovative strategies and successful results, Kaiser Permanente won the AHIP Foundation's Innovation and Excellence Award for Chronic Care in 2006.

For more information, contact:

Michelle Wong
Care Management Consultant
Kaiser Permanente Care Management Institute
One Kaiser Plaza
Oakland, CA 94612
(510) 271-2386
Michelle.wong@kp.org

MVP Health Care
New York

Keeping Members with Diabetes on Track with Effective Care

PROGRAM AT A GLANCE

Goal ▸ Improve health among members with diabetes and prevent unnecessary complications.

Key Strategies

- Offer health coaching to help members make lifestyle changes—such as eating healthy diets and increasing exercise—to improve health.
- Use a phone system with speech recognition to remind members with diabetes to have recommended tests, encourage them to schedule appointments, and provide positive reinforcement for using effective care.
- Give physicians tools to enhance diabetes care, such as clinical information sheets that indicate patients' use of diabetes medications and recommended tests; clinical practice guidelines; exam room posters; and sample letters to patients.

Results in Brief

- From 2000 to 2005, the proportion of individuals with diabetes who had annual LDL-cholesterol tests increased from 81.3% to 93.6%.
- From 2004 to 2005, the percent of members with the condition whose LDL-cholesterol levels were below 100 mg/dL increased from 36.7% to 43.9%.

FROM CONCEPT TO ACTION

Reducing Unnecessary Complications

To promote effective diabetes care on an ongoing basis and prevent long-term complications, MVP Health Care established the Diabetes Care Program in 1997. MVP identifies members who can benefit from the program by analyzing medical, lab, and pharmacy claims on a quarterly basis and by reviewing member responses to its health risk assessment surveys on an ongoing basis.

A Two-Tiered Approach Based on Risk

MVP includes members in the program's high-risk component if they have been hospitalized for diabetes, have used the emergency room for the condition, have HbA1c blood level readings of 8% or higher, and/or whose health risk assessment responses indicate that diabetes interferes with their daily activities and/or that they do not monitor their blood glucose levels. Health care practitioners can refer members to the program, and members can self-refer.

Health Coaching

Members identified as high-risk receive phone calls from registered nurses, who explain the program and offer the opportunity to participate. Individuals enrolled in the program have a series of phone conversations with health coaches with expertise in diabetes care to help meet their needs and improve their health.

For example, health coaches discuss the benefits of regular preventive care for diabetes (e.g., LDL-cholesterol testing, HbA1c tests), help them set goals for lifestyle changes (e.g., healthy eating, increased exercise) to improve health, and work with them on action plans to achieve their goals. Coaches also send members fact sheets from the American Diabetes Association (ADA) on a variety of topics tailored to their needs and interests.

The frequency of calls varies based on member needs, and often they occur every two to three weeks. Individuals spend an average of four to six months in the high-risk component of the program but can continue to contact their health coaches as needed after its completion.

General Informational and Complimentary Items

All members enrolled in the program receive *Diabetes News*, a biannual newsletter focusing on topics such as diet, stress management, and traveling with medications.

In addition, MVP offers each member with diabetes a glucose meter and a free, one-year membership to the American Diabetes Association. The membership includes a subscription to the ADA's monthly magazine, *Diabetes Forecast.*

Customized Outreach Calls

In 2005, MVP partnered with the Eliza Corporation to create a phone-based outreach program to remind members with diabetes to have recommended preventive services. All members with diabetes receive phone calls to determine whether they have had recommended HbA1c blood level tests, LDL-cholesterol screenings, foot exams, eye exams, and microalbumin tests within the past year.

MVP sends information to Eliza in advance to indicate which members have had particular tests, so that each call can be customized to focus only on those tests that the health plan's records indicate the member is missing. Using speech recognition technology, the call provides member-specific feedback according to individual responses. For example, if members indicate that they have not had dilated retinal exams, they receive information about the exams'

benefits, and they are encouraged to schedule appointments with eye care specialists. If members say that they have had the recommended tests, they receive positive reinforcement.

During these calls, members also have the opportunity to complete MVP's health risk assessment survey, which asks about the extent to which diabetes interferes with daily activities and whether members are feeling depressed. Depending on their responses, members may receive the phone number for MVP's behavioral health program, or they may be referred to the health coaching component of the program.

Targeted Mailings

Twice a year, based on analysis of claims data and responses to outreach calls, MVP sends educational information to individuals who have not had recommended diabetes tests. For example, between August and November 2005, MVP sent mailings to members who had not had dilated eye exams or microalbumin tests in the previous 12 months. Each mailing included a letter, an article on dilated eye exams, a form that an eye care practitioner could use to send exam results to the member's primary care physician, and an article on microalbumin testing.

Once a year, MVP also sends each member with diabetes a check list with his or her most recent dates for HbA1c, LDL cholesterol, and microalbumin tests, and dilated eye exams. The check list describes the recommended intervals for these tests, along with a grid for tracking progress in completing them. MVP offers free gifts to members whose physicians verify that they had all of the recommended preventive care services for the year.

Members who have not taken cholesterol-lowering medications as recommended receive a different version of the check list with tips on remembering to take recommended medications, reminders to contact their physicians within three months of beginning new medications, and recommendations for regular office visits and follow-up with primary care physicians.

Physician Tools

To help physicians provide optimal diabetes care, MVP provides information, tracking tools, and patient education materials.

Clinical Information Sheets for Diabetes Care

Once a year, MVP sends "clinical information sheets" with up-to-date information on patients' use of diabetes-related services to members' primary care physicians and endocrinologists. The sheets, which can be placed in members' charts for easy reference, include the following information: cholesterol-lowering medications being taken; the extent to which members have taken medications as prescribed; hospitalizations and/or emergency room visits for diabetes in the past year; and primary care physician visits in the past six months. Dates and results for members' most recent retinal exams, hemoglobin A1C tests, microalbumin tests, and LDL-cholesterol screenings are also included on the sheets.

MVP also sends a one-page report to each member's primary care physician summarizing his or her responses to the questions on diabetes-related tests and health status that were asked in the phone-based outreach component of the program. Physicians can place these reports in member charts for follow-up and tracking.

Quality Improvement Manuals

Each year, MVP sends each physician in its network a CD-ROM containing the text for its *Physician Quality Improvement Manual*. The 2005 version included a variety of tools to enhance diabetes care:

- A flow sheet for tracking members' use of recommended tests and procedures;
- A reference sheet listing effective diabetes medications and recommended doses;
- An information sheet that physicians can use to explain dilated retinal exams to members;
- A poster explaining foot exams for diabetes;
- A tracking sheet to document foot exams;
- A list of resources and classes for individuals with diabetes;
- A sample letter to patients beginning medication regimens for chronic conditions;
- Clinical performance measures for diabetes care developed by the Physician Consortium for Performance Improvement;
- Tools for measuring and tracking body mass index;
- Guidelines for adult diabetes care developed by the Westchester New York Diabetes Coalition;
- The New York Health Plan Association's smoking cessation guidelines; and
- Patient education materials.

Results

From 2000 to 2005:

- The percent of members with diabetes who had annual HbA1c tests increased from 80.9% to 88.3%.
- The proportion of individuals with the condition who had annual LDL-cholesterol tests increased from 81.3% to 93.6%.

From 2004 to 2005:

- The percentage of members with diabetes whose LDL-cholesterol levels were below 100 mg/dL increased from 36.7% to 43.9%.
- The percent of individuals with the condition who had dilated eye exams increased from 58.1% to 59.2%.

For more information, contact:

Deborah Chambers
Director, Quality Improvement
MVP Health Care
625 State Street
Schenectady, NY 12305
(518) 388-2264
dchambers@mvphealthcare.com

Jana Altieri, R.N., M.S.
Quality Improvement Program Manager
MVP Health Care
625 State Street
Schenectady, NY 12305
(518) 388-2363
jaltieri@mvphealthcare.com

Presbyterian Healthcare Services
New Mexico

Finding Many Ways to Excellence in Diabetes Care

PROGRAM AT A GLANCE

Goal ▸ Improvethe health status of members with diabetes.

Key Strategies

- Use an online registry to track members' diabetes-related health services.
- Offer health coaching to help individuals with diabetes live healthy lifestyles.
- Provide case management to help individuals with complex needs take actions such as modifying home environments to promote safety, enrolling in Meals on Wheels programs, and setting up systems for correct medication use.
- Provide incentive payments to encourage physicians to provide effective diabetes care.
- Work with hospital staff to ensure that members with diabetes who use hospital facilities receive recommended monitoring and testing.

Results in Brief

From 2002 to 2005, the percent of Medicare beneficiaries with diabetes who had HbA1c readings above recommended levels dropped from 20.7% to 11.5%.

FROM CONCEPT TO ACTION

Addressing Gaps in Care

Upon finding that no single approach was effective in addressing gaps in care for members with diabetes, Presbyterian Healthcare Services (PHS) revamped its diabetes disease management program in 2004 to create a new, multi-faceted program. The new approach includes: online tracking; care coordination; case management; diabetes education; a pay-for-performance initiative; and a team-based system to improve hospital care for individuals with diabetes.

Online Tracking

PHS analyzes medical, lab, and pharmacy data on a quarterly basis to identify members with diabetes who can benefit from the program, and the health plan receives referrals from health care practitioners and nurse care coordinators. Within the health plan's affiliated physician group, Presbyterian Medical Group (PMG), information on members' use of diabetes-related health services is tracked in an online registry, called DocSite. Prior to office visits for individuals with diabetes, physician office staff download reports from DocSite that identify gaps in members' use of recommended care, such as HbA1c blood level testing, eye and foot exams, cholesterol testing, and kidney disease screening. These reports are placed in members' charts so that physicians can review them and discuss next steps during office visits.

In physician offices within its independent practitioner network, the health plan tailors tracking efforts to the characteristics and capabilities of individual practices. For example, PHS often provides physician groups with lists of their patients who are missing recommended tests and procedures for diabetes care, and staff in individual offices follow up as needed.

Care Coordination and Case Management

Based on information from DocSite and from PHS's ongoing analysis of claims data, nurse care coordinators contact members by phone who have not had tests and procedures recommended for diabetes care. During these calls, nurses identify members' needs, help them overcome barriers to following physicians' treatment plans (e.g., lack of transportation, inability to afford medications), and provide coaching to help them live healthy lifestyles. For example, care coordinators work with members on diet and exercise plans for weight loss, and they can refer individuals to local smoking cessation programs. In addition, nurses link members with community-based services (e.g., support groups, pharmacy assistance programs, local senior citizen centers) to meet their needs.

Care coordinators contact members' physicians if necessary, for example, to report significant changes in individuals' health status, discuss adverse reactions to medications, or suggest changes to medication regimens to improve health. The frequency of care coordinators' contact with members varies based on individual needs and may range from biweekly to quarterly. Individuals may remain in the program for several months or for more than a year.

Individuals with multiple chronic conditions and/or those facing major barriers to effective care (e.g., elderly members with no transportation or family support, members with cognitive impairments that make it difficult to keep track of medications and physician appointments) receive intensive case management services. Depending on need, nurse case managers may

conduct in-home assessments to identify safety risks (e.g., loose rugs, unsafe stairways) and arrange for modifications to promote healthy living environments (e.g., by setting up systems for correct medication use, enrolling members in Meals on Wheels programs to promote healthy diets). Case managers also may accompany members to doctor visits to help them communicate effectively and ensure that they understand treatment recommendations. Time frames for participation in case management can range from one day to two years.

Diabetes Education

To help prevent diabetes complications, PHS's care coordinators refer patients with HbA1c test results above specified thresholds to certified diabetes educators. In one-on-one meetings with members, diabetes educators discuss lifestyle changes (e.g., quitting smoking, improving diet, increasing exercise) to improve health. They also conduct screening for depression and refer members to behavioral health professionals as needed.

Members may meet with diabetes educators for up to 10 hours over a 12-month period. The health plan is developing strategies (e.g., changes in payment methods) to increase the availability of diabetes educators within its independent practitioner network, particularly those in underserved areas.

Periodic Mailings

Besides conducting ongoing tracking and follow-up to improve care for individuals with diabetes, PHS sends members with diabetes a variety of general and targeted mailings at least once every quarter. For example, the health plan sends mailings to all members with diabetes encouraging them to visit their primary care physicians regularly and to have recommended eye exams, foot exams, and HbA1c blood testing. In 2005, PHS sent targeted mailings to individuals with diabetes who had not had dilated retinal exams in the past year to encourage them to visit eye care professionals.

In 2006, PHS began sending home testing kits to members with diabetes who have not had HbA1c tests in the past year. The kits provide simple instructions for taking blood tests to measure HbA1c levels, and they include pre-addressed, postage-paid envelopes for sending blood samples to a designated lab for analysis. PHS offers WalMart gift cards to encourage Medicaid members to use and return the kits.

Information Support and Pay-for-Performance

In support of physicians' efforts to provide high-quality diabetes care, PHS sends all of its participating primary care physicians copies of nationally recognized clinical practice guidelines for diabetes and lists of local diabetes-related services such as community-based exercise programs and support groups.

As part of its plan-wide pay-for-performance initiative, PHS provides annual, lump-sum incentive payments based on nationally recognized indicators of quality care, including the percentage of physicians' patients with HbA1c levels above specified thresholds (defined as the "poor control rate") and improvements in the percent of physicians' patients with HbA1c readings above these levels. The health plan provided additional awards for excellence in diabetes care to several high-performing primary care physicians in 2005.

Hospital-Based Teams

To help avoid adverse events and improve health outcomes among hospital patients, PHS implemented a two-part team initiative at the largest hospital in its network (Presbyterian Hospital in Albuquerque, NM). In the first component of the program, nurses and physicians monitor blood sugar levels of intensive care unit patients with diabetes on a frequent basis, and they adjust insulin doses as needed to maintain blood sugar readings at healthy levels.

For the second portion of the program, the hospital created a policy directing hospital staff to provide HbA1c tests to all PHS members with diabetes who use the emergency room, receive outpatient services, and/or are admitted for inpatient care. Members' care teams send test results to individuals' primary care physicians. PHS currently is expanding the initiative to other hospitals in its network.

When members with diabetes are discharged from hospitals, PHS nurse care coordinators contact them by phone to review their treatment plans, encourage them to fill their prescriptions, and ensure that they schedule appointments for follow-up care.

Results

From 2002 to 2005, the percent of privately insured members, Medicare, and Medicaid beneficiaries with HbA1c readings above recommended levels (i.e., the plan-wide "poor control rate") dropped significantly:

- Among members with private coverage, the rate dropped from 37% to 31.7%.
- The rate declined from 20.7% to 11.5% among Medicare beneficiaries.
- For Medicaid beneficiaries, the proportion decreased from 58.6% to 46%.

For more information, contact:

Susan Dezavelle, R.N.
Disease Management
Presbyterian Health Plan
2501 Buena Vista SE
Albuquerque, NM 87106
(505) 923-8117
sdezavel@phs.org

Charles Baumgart, M.D.
Senior Medical Director
Presbyterian Health Plan
2501 Buena Vista SE
Albuquerque, NM 87106
(505) 923-5766
cbaumgar@phs.org

Optima Health
Virginia

Taking a Team Approach to Care for Asthma, Diabetes, and Sickle Cell Disease

PROGRAM AT A GLANCE

Goal ▸ Improvethe quality of life for members with asthma, diabetes, and sickle cell disease.

Key Strategies

- Conduct home visits to help members with asthma modify home environments to reduce symptoms.
- Offer members with diabetes free cooking classes and supermarket tours to help them choose healthy foods; provide instructions on taking insulin shots; and coordinate with physicians to monitor responses to insulin treatment.
- Refer members with sickle cell disease to a specialist who can coordinate care and offer home care nursing to administer intravenous treatments.
- Combine separate departments into a single unit to promote a team approach to chronic care.

Results in Brief

- From 1997 to 2004, use of emergency rooms among members with asthma who had private coverage declined by 7.7%, and it fell by 5.4% for Medicaid beneficiaries.
- From 1999 to 2004, the number of hospital admissions for members with diabetes who had private coverage fell by 25.3%.
- From 2003 through May 2005, the number of emergency room visits for individuals with sickle cell disease fell by 64% per member per month, and the number of physician office visits rose by 7%.

FROM CONCEPT TO ACTION

Enhancing Quality of Life

To address the major impact that asthma and diabetes were having on the quality of life and health care costs for its members, Optima Health established asthma and diabetes disease management programs in the late 1990s. In response to the growing incidence of sickle cell disease in its service area, Optima added a care coordination program for members with the condition in 2003.

For all of these programs, Optima analyzes pharmacy, lab, and medical claims data to identify members' risk of developing complications associated with emergency room visits and hospital admissions. The health plan divides them into categories of low, moderate, and high risk so that they can receive services tailored to their level of need. Subsequently, Optima contacts members by phone to describe the programs developed for their conditions and offer the opportunity to participate.

Providing Resources and Reminders

Optima sends informational flyers, newsletters, brochures, and reminders for preventive care to program participants with asthma or diabetes who are at low risk of complications. Optima also provides these members with a toll-free number they can call to speak with Personal Service Coordinators to answer their questions and/or provide coaching on how to make lifestyle changes to improve health. These coordinators have experience in customer service, as well as specialized training in coaching for behavior modification to improve health.

Health Coaching

For program participants with asthma or diabetes who are at moderate risk of complications, Optima offers personal coaching by phone with Personal Service Coordinators, who contact members regularly based on need, at frequencies ranging from once a day to once a year. The coaching involves offering suggestions and encouragement to help members make lifestyle changes that will improve their well-being. Coordinators do not provide medical advice but help ensure that members receive the medical information and care they need.

Life Coaching

Asthma

For program participants with asthma who are at highest risk of complications, Life Coaches (who are home care professionals with specialized training in asthma care) conduct home visits to identify factors (e.g., long-haired pets) that worsen asthma symptoms. Coaches then work with members to help them modify their home environments (e.g., taking action to control pet dander) to eliminate these irritants. In addition, Life Coaches coordinate with members' primary care physicians to develop effective care plans.

Care plans for asthma emphasize the importance of taking preventive medications on a regular basis to avoid severe asthma symptoms that require use of "rescue" medications. Life Coaches contact members at agreed-upon intervals, help them follow care plans, and address their questions and concerns.

In communities where Life Coaches are not available, Optima's nurse case managers conduct coaching over the phone on a regular basis to help

program participants follow physicians' treatment plans, understand their medications, and access medical and other services they may need (e.g., transportation, health education, or smoking cessation classes). Case managers may contact members' physicians to discuss medication changes or other medical issues that need attention.

Diabetes

Optima offers program enrollees with diabetes who are at the highest risk of complications the opportunity to meet in group settings in their primary care physicians' offices with nurse health educators. During these meetings, Life Coaches—who are nurses with specialized training in care for diabetes—explain lifestyle changes (such as diet and exercise) that members can make to improve their health, and they offer members the opportunity to meet with nutritionists.

Optima also offers these members free cooking classes and supermarket tours to help them choose healthy foods. Life Coaches teach members how to take insulin injections, and they coordinate with members' physicians to closely monitor members' response to insulin treatment so that physicians can adjust medication doses quickly if necessary.

In communities where Life Coaches are not available, Optima provides program participants with diabetes who are at highest risk of complications the same types of nurse coaching services as those available to members with asthma.

Specialized Treatment and Home Care Nursing

Virtually all members with sickle cell disease are at high risk of complications, and many have used emergency rooms as a regular source of care. To help ensure that these members receive effective care on an ongoing basis, Optima established a program in the Hampton Roads, Virginia area—which has the highest concentration of its members with sickle cell disease—to provide specialized nursing and physician care. Optima case managers refer program participants to an internist specializing in sickle cell treatment, and it provides the physician with an on-staff nurse to coordinate the care of members with the disease. Optima also offers these members the option of home nursing care to administer intravenous (IV) hydration treatment and/or pain medications as needed. Home care nurses also can help members alter their activities, for example, by making changes to reduce stress, avoiding cold weather, and maintaining adequate hydration, to improve their health and well-being.

Results

Asthma

- From 1997 to 2004, the number of hospital admissions for members with asthma who had private coverage fell by 31.0%, and admissions for Medicaid beneficiaries with asthma fell by 26.2%. Emergency room use for members with asthma who had private coverage declined by 7.7%, and for Medicaid beneficiaries with asthma, it fell by 5.4%.
- In recognition of these results, Optima received The National Environmental Leadership Award in Asthma Management from the U.S. Environmental Protection Agency in 2005.

Diabetes

- From 1999 to 2004, the number of hospital admissions for members with diabetes who had private coverage fell by 25.3%. During the same period, the number of emergency room visits for Medicaid beneficiaries with diabetes fell by 38.3%.
- In 2005, Optima's Life Coach Program for members with diabetes received the Disease Management Association of America's Recognizing Excellence Award for Best Provider Engagement Initiative.

Sickle Cell Disease

- Since the program's inception in 2003 through May 2005, the number of emergency room visits for individuals with sickle cell disease fell by 64% per member per month, and the number of inpatient admissions fell by 32% per member per month. Because the program encouraged members with sickle cell disease to follow up regularly with their health care practitioners, the number of physician office visits within this population increased by 7%.
- In 2006, the Sickle Cell Disease Management Program received the Disease Management Association of America's Recognizing Excellence Award for Best Medicaid Disease Management Program.

Transforming Traditional Approaches

While these results are encouraging, it became clear to senior staff over time that greater coordination and integration of Optima's chronic care programs would make them even more successful. Therefore, Optima began planning a major overhaul of its approach to chronic care in mid-2005. Traditionally, the major components of chronic care initiatives had been handled by three separate departments: Disease Management, Medical Management, and Behavioral Health. However, this separation sometimes created challenges in coordinating and communicating about treatment plans. As a result, Optima decided to combine the three divisions into a new integrated care delivery team called Clinical Care Services.

New Model of Care

The new unit will use one model for Optima's chronic care programs and will include disease-specific approaches for each condition. Having disease management, medical management, and behavioral health professionals working together in one unit will help ensure ongoing communication and coordination among primary care physicians, specialist physicians, behavioral health specialists, nurses, case managers, and Personal Service Coordinators.

For example, under the new model, case managers working with members who have diabetes or asthma and who see signs of depression will more easily be

Taking a Team Approach to Care for Asthma, Diabetes, and Sickle Cell Disease (cont'd)

able to find behavioral health specialists, confer with them on a timely basis to develop care plans that address both the medical and behavioral issues, and follow up as needed to make sure that both issues are being addressed on an ongoing basis.

To ensure that needs specific to different populations are addressed effectively, the new unit will include separate teams for Medicare, Medicaid, and privately insured members. This approach will allow Clinical Care Services teams to evaluate the characteristics of their member populations more effectively, set appropriate goals and measures for improvement, and develop teams of clinical experts best-suited to meet members' needs.

Retooling for Rapid Response

Under its new approach to chronic care, Optima will continue effective strategies already implemented to identify members most likely to develop complications that lead to emergency room visits and hospital admissions. Ongoing communication between members and professionals on the Clinical Care Services Team will supplement the data provided through claims analysis to identify problems as early as possible so that solutions can be implemented quickly.

The new Optima model of clinical care delivery began in early 2006 with a pilot project focused on specific employer groups. Optima is measuring the pilot's impact on pharmacy costs, total health care costs, health care processes and outcomes, and behavioral outcomes (e.g., taking medications as prescribed, eating healthy foods, exercising regularly). Depending on the pilot's results, which will be available in 2007, the initiative may be expanded to the entire membership.

For more information, contact:

Karen Bray, Ph.D., R.N., C.D.E.
Vice President, Clinical Care Services
Optima Health
4417 Corporation Lane
Virginia Beach, VA 23462
(757) 552-7198
KJBRAY@sentara.com

Sterling Life Insurance
Washington

STERLING HEALTH PLANS
Real People. Wise Choices.℠

Helping Medicare Beneficiaries Navigate the Way to Good Health

PROGRAM AT A GLANCE

Goal ▸ Improvethe quality of life for Medicare beneficiaries and help them navigate the health care system.

Key Strategies

- Develop case management plans to improve members' health and well-being.
- Help members take medications correctly and cope with side effects.
- Link members with community resources such as Meals on Wheels programs, support groups, and transportation assistance.

Results in Brief

- Beneficiaries surveyed about their satisfaction with the program in 2006 rated it an average of 4.8 on a scale of 1 to 5.

FROM CONCEPT TO ACTION

Case Management

To improve Medicare beneficiaries' quality of life and to help them navigate the health care system, Sterling Life Insurance Company established the Care Coordination Program in 2000. The program provides services to beneficiaries with chronic conditions, such as chronic heart failure, diabetes, chronic obstructive pulmonary disease, and depression, and to those who need assistance following major acute-care episodes, such as surgery, heart attack or stroke.

Sterling analyzes hospital admission records, health risk assessments, claims, and data from nurse advice line calls to identify individuals who could benefit from the program. Based on review of these members' medical histories, registered nurses help develop lists of individuals to contact. Nurses send introductory letters and call potential participants to describe the program's benefits and offer the opportunity to participate. Members also may self-refer.

Regular Consultation

Once members have chosen to enroll, nurse care coordinators contact them by phone to discuss their medical histories, prescribed medications, sources of social support, and barriers to effective care (e.g., difficulties with transportation, inability to afford medications). Based on this information, care coordinators develop case management plans to improve members' health and well-being. Care coordinators send copies of these plans to members' primary care physicians, whom they contact as needed while their patients are enrolled in the program.

In a series of regularly scheduled phone calls generally occurring over six to 12 months, nurse care coordinators address issues highlighted in individuals' case management plans. For example, they provide members with information about their conditions, discuss how to recognize signs and symptoms that require immediate medical attention, and help them make lists of questions to discuss during doctor visits. Care coordinators review members' medications, describe how to take them correctly, help them cope with side effects, and contact their physicians if necessary to suggest changes in prescriptions or dosages.

A Broad Range of Services

Besides addressing medical issues, nurse care coordinators help members with a variety of lifestyle and social service needs. They provide coaching on diet and exercise, and they provide referrals to community resources such as weight loss and smoking cessation programs, Meals on Wheels services, support groups, and transportation assistance. Nurse care coordinators typically speak with members at least every two weeks during their first few months in the program and then on a monthly or quarterly basis depending on member needs.

Results

- Approximately 800-1,000 Medicare beneficiaries participate in the Care Coordination program each year. In 2006, beneficiaries surveyed about their satisfaction with the program rated it an average of 4.8 on a scale of 1 to 5.

For more information, contact:

Sandy Harnden-Warwick
Manager, Medical Management
Sterling Life Insurance/Olympic Health Management
2219 Rimland Drive, Suite 100
Bellingham, WA 98226
(360) 392-9157
sandy.harnden-warwick@sterlingplans.com

Tufts Health Plan
Massachusetts

TUFTS Health Plan

Providing Intensive Care for Members with Complex Needs

PROGRAM AT A GLANCE

Goal ▸ Improve physical and mental health for individuals with chronic and complex conditions, including those with cancer diagnoses, as well as those undergoing hip, knee, or back surgery.

Key Strategies

- Help members understand their prescribed medications, physicians' plans of care, and opportunities to improve health and well-being.
- Help individuals overcome barriers to care, such as financial need and lack of transportation.
- Arrange for home health care, end-of-life planning, and hospice care as needed.
- Provide members information before and after hospitalization to support safe and effective transitions from inpatient to outpatient care.

Results in Brief

- Program participants surveyed about their physical and mental health status in 2004 and 2005 showed improvement in all eight of the survey's measures, including assessment of physical functioning, pain, and overall health, as well as social, emotional and behavioral health and well-being.
- From 2004 to 2005, hospital admissions were 15% below the levels projected for the program's enrolled population.

FROM CONCEPT TO ACTION

Tufts Health Priority Care™

To improve the quality of life and address rising health care costs for individuals with complex medical conditions, Tufts Health Plan implemented Tufts Health Priority Care in 2002. Program participants include individuals with chronic and complex conditions such as cancer, hemophilia, multiple sclerosis, trauma injuries, and transplants; as well as those planning hip, knee, or back surgery.

In 2005, Tufts Health Plan partnered with American Healthways and expanded the program to include members with diabetes, coronary artery disease, chronic obstructive pulmonary disease (COPD), heart failure, and asthma.

On a monthly basis, Tufts Health Plan analyzes medical and pharmacy claims to identify members with these conditions whose hospital admissions, emergency room visits, medical care, and prescription drug use indicate that they may be at risk for future hospitalization or extensive medical care. Health care practitioners and case management staff identify individuals for the program, and members can self-refer. Tufts Health Plan's nurse case managers contact members by phone to discuss the program's services; assess their medical needs and their interest in pursuing strategies to improve health; and offer the opportunity to enroll. Once individuals have agreed to participate, nurse case managers contact their physicians to review their treatment plans.

The Intensive Care Unit of Medical Management

In light of the one-on-one, intensive level of service that case managers provide, the health plan refers to Priority Care as "the intensive care unit of medical management."

Initially, nurses may speak with members newly enrolled in Priority Care every day, and subsequently, calls may be scheduled on a weekly or bi-weekly basis. Members can use a toll-free number to contact case managers at any time to ask questions or seek assistance.

Case managers support physicians' plans of care, for example, by helping members understand prescribed medications and by suggesting strategies to cope with side effects. Nurses provide regular feedback to primary care physicians and specialists, and they hold conference calls with multiple health care practitioners to discuss individual cases if necessary. They also send copies of their correspondence with members to the individuals' physicians.

Besides providing members with information about their health conditions and offering strategies to identify and prevent complications, case managers help them overcome barriers, such as financial need or lack of transportation, that make it difficult to obtain needed care. Case managers link individuals with community resources (e.g., support groups, programs providing home-delivered meals) that help improve their quality of life. They can refer members to workplace employee assistance programs for counseling and/or to behavioral health specialists to address their needs on an ongoing basis. Depending on members' needs, nurses also can arrange home health and help with end-of-life planning or hospice care.

Providing Intensive Care for Members with Complex Needs (cont'd)

TUFTS Health Plan

Hospital Planning and Follow-Up

Post-Discharge Phone Calls

As part of the program, nurse case managers contact members with any of the targeted conditions who are discharged from hospitals to help them understand their discharge instructions and medications and ensure that they visit their primary care physicians for follow-up care.

Care Coordination for Joint and Back Surgery Patients

The program also seeks to improve coordination of care for individuals scheduled for hip, knee, or back surgery. Nurse case managers contact these members prior to surgery to ask about current and anticipated health care needs (e.g., physical therapy, home care visits, rehabilitation).

Case managers then coordinate with health plan staff and health care practitioners to ensure that services are provided in a timely manner. They remain in contact with members after their surgery to address their questions and concerns, and, depending on members' conditions, they may arrange pre- or post-surgery home visits to identify and eliminate safety risks. For example, they can help members modify their home environments to avoid falls, and they may provide guidance as needed on using stairs and showers safely.

Results

From 2004 to 2005:

- Program participants surveyed about their physical and mental health status showed improvement in all eight of the survey's measures, including assessment of physical functioning, pain, and overall health, as well as social, emotional and behavioral health and well-being.
- Ninety-seven percent of members enrolled in the program said they were satisfied with it.
- Hospital admissions were 15% below the levels projected for the program's enrolled population.
- The number of inpatient days for program participants was 20% below projections.

For more information, contact:

Catherine Grant
Manager, Media Relations
Tufts Health Plan
333 Wyman Street
Waltham, MA 02454
(781) 466-9022
catherine_grant@tufts-health.com

WellPoint, Inc.
Virginia

Teaming Up to Improve Complex Care

PROGRAM AT A GLANCE

Goal ▸ Ensurethat members with chronic and complex conditions receive effective care on an ongoing basis.

Key Strategies

- Offer health coaching to help members understand medication instructions, set lifestyle goals, follow physicians' care plans, obtain referrals for specialty care, and access transportation as needed.
- Provide members with a toll-free number to contact health coaches with questions about care or benefits.

FROM CONCEPT TO ACTION

The ComplexCare Program

In response to finding that a small percent of members accounted for the vast majority of health care costs, WellPoint and its subsidiary, HMC, developed ComplexCare in 2004. The program helps members avoid preventable, high-cost conditions and episodes of care by ensuring that they receive effective treatments and health services on an ongoing basis. The program is not specific to any one condition, though many of the members enrolled have chronic conditions such as cancer and fibromyalgia.

Identifying Members

On an ongoing basis, WellPoint analyzes data related to hospital admissions, emergency room visits, lab results, use of high-cost imaging procedures, prescription drug use, and responses to health risk assessments, to identify care patterns indicating that members would be appropriate candidates for the program. For example, if members regularly see three or more doctors, have more than three emergency room visits within six months, or have more than two hospital admissions within a three-month period, WellPoint flags their records for follow-up.

Health Coaching

Once members have been identified through this process, nurse "health coaches" contact them by phone to offer the opportunity to enroll. By providing a variety of information and services to program participants, nurses help enrollees understand medication instructions, set lifestyle goals, and follow physicians' care plans. They also help members obtain referrals for specialty care, home health, and durable medical equipment, and they can assist with arranging transportation for doctor visits as needed.

Nurses set up calls with program participants at intervals based on need, and they check on individuals' health and well-being at least once every six weeks for up to a year. Members can use a toll-free number to contact nurses with questions about their care or benefits at any time during business hours.

The ComplexCare program uses a team approach, in which nurses, medical directors, pharmacists, dieticians, social workers, respiratory therapists, exercise physiologists, and health educators use motivational interviewing to help members set goals for improving health and pursue strategies to reach these goals. Nurses serve as members' primary contacts and coordinate with other professionals on the team to support member needs and help them follow physicians' care plans.

For more information, contact:

Stacy Brinkley
Vice President, Marketing
Health Management Corporation
6800 Paragon Place, Suite 500
Richmond, VA 23230
(804) 354-2109
sbrinkley@choosehmc.com

CHAPTER 5

Providing Medication Management and Case Management in Priority Areas

Heart disease is the number one cause of death in the United States.[1] The medical evidence is clear, however, that two strategies—treating individuals with beta-blocker medications following heart attacks and reducing cholesterol levels—significantly reduce the risk of repeat heart attacks, stroke, and heart disease-related deaths.[2] Health plans are well-positioned to coordinate with health care practitioners to ensure that individuals who are hospitalized with heart and circulatory conditions receive life-saving preventive care and medications in a timely manner. The initiatives profiled in this section illustrate that these efforts are paying off, with consistently high rates of beta-blocker use following heart attacks, double-digit increases in cholesterol screening rates, and reductions in individuals' cholesterol levels to recommended ranges.

The medical evidence is clear that two strategies—treating individuals with beta-blocker medications following heart attacks and reducing cholesterol levels—significantly reduce the risk of repeat heart attacks, stroke, and heart disease-related deaths.

[1]NCQA. Cholesterol management screening and control. www.ncqa.org/somc2001/CHOLESTEROL/SOMC_2001_CHM.html.

[2]National Quality Measures Clearinghouse. Cholesterol management for patients with cardiovascular conditions: Percentage of patients who had a low-density lipoprotein cholesterol (LDL-C) screening performed and the percentage of patients who have a documented LDL-C level less than 130 mg/dL and less than 100 mg/dL. www.qualitymeasures.ahrq.gov/summary/summary.aspx?doc_id=5763

Howard, P.A., & Ellerbeck, E.F. (2000). Optimizing beta blocker use after myocardial infarction. *American Family Physician*. http://findarticles.com/p/articles/mi_m3225/is_8_62/ai_65864173.

Blue Care Network of Michigan

Michigan

Getting a Perfect Score in Post-Heart Attack Care

PROGRAM AT A GLANCE

Goal ▸ Ensurethat all members who have heart attacks receive prescriptions for beta-blockers within seven days of hospital discharge and that they continue taking the medications for at least six months.

Key Strategies

- Contact individuals within seven days of hospital discharge following heart attacks to verify that beta-blockers were prescribed.
- Offer case management to help members develop care plans, access services such as rehabilitation and smoking cessation programs, and live healthy lifestyles to reduce heart attack risk.
- Coordinate care with hospital staff to promote timely and effective treatment for heart attack patients.

Results in Brief

From 2004 to 2006, 100% of members who had heart attacks received beta-blockers within seven days of their hospital discharge.

FROM CONCEPT TO ACTION

Promoting Beta-Blockers

Based on evidence that beta-blockers improve health and reduce mortality rates among individuals who have experienced heart attacks, Blue Care Network of Michigan began the Beta-Blocker Quality of Care Initiative in 2002. The program is for all Blue Care Network (BCN) members age 35 and older who are admitted to acute care hospitals due to acute myocardial infarction (AMI).

The goal is to ensure that each member with a diagnosis of AMI receives a prescription for a beta-blocker within seven days of hospital discharge, unless he or she has other conditions for which treatment with beta-blockers would be harmful (e.g., asthma, low blood pressure, history of adverse reaction to beta-blockers), and to ensure that each of these members continues taking beta-blockers for at least six months.

Working with Physicians and Hospital Staff

Blue Care Network analyzes hospital authorizations to identify members who have been admitted to hospitals with diagnoses of acute myocardial infarction. When a member is discharged from the hospital, a nurse care coordinator works with the hospital's clinical review staff to determine if the member has been prescribed a beta-blocker or if he or she has conditions for which beta-blockers should not be used. Care coordinators forward the information to the health plan's nurse case managers. Case managers contact the primary care physicians or cardiologists of heart attack patients who did not receive beta-blocker prescriptions to ask why physicians did not initiate treatment and determine if the members have other conditions that would be adversely affected by beta-blockers.

Offering Case Management

Within seven days, case managers contact members who are discharged from hospitals with AMI diagnoses to evaluate discharge plans and verify that beta-blockers have been prescribed or that they should not be used. During these phone calls, case managers assess members' understanding of the prescribed medications, the effectiveness of beta-blockers and the instructions received upon discharge.

In addition, the case managers provide members with information on risk factors for heart disease and on the importance of having annual cholesterol tests, quitting smoking, and losing weight. They discuss strategies for stress management, identify members' other health conditions relevant to their treatment and ask if members would like to participate in BCN's case management program.

Nurses call members enrolled in case management on a regular basis, or as needed, to ensure that they have follow-up visits with their physicians and to help coordinate additional services, such as cardiac rehabilitation and smoking cessation programs. In addition, nurses work with members and their physicians to develop care plans and to provide information on how members can reduce their risk for subsequent heart attacks and live healthier lifestyles.

During their conversations with members, case managers ask questions to identify signs and symptoms of depression, and they can provide referrals to behavioral health specialists. Case managers determine whether members have had recommended screening tests and treatment, if needed, for high cholesterol. They also encourage members to schedule appointments for cholesterol testing, and they contact physician offices to ensure screening occurs.

If case managers are unable to reach members by phone, they send letters on a regular basis reminding members to take beta-blockers as prescribed, have recommended screening tests, and consult regularly with their physicians. Members' primary care physicians and specialists receive copies of all letters sent to members.

BCN nurses monitor medical and pharmacy claims of all members who have heart attacks for at least six months after hospital discharge. Nurses remind individuals to take beta-blockers and obtain their recommended care.

Providing Resources for Members and Physicians

Besides providing case management, Blue Care Network offers members and physicians general information on effective post-heart attack treatment. The health plan posts a monthly newsletter on cardiovascular disease on its Web site (www.MiBCN.com), along with links to other sites providing heart disease information, such as the American Heart Association. Case managers send brochures on the effectiveness of beta-blockers with a recommendation that members continue lifelong treatment.

Blue Care Network's participating physicians can access nationally recognized clinical practice guidelines for post-heart attack treatment on the physician site at www.MiBCN.com, in the physician newsletter, and in the health plan's physician manual.

Promoting a High Level of Performance

Blue Care Network conducts ongoing tracking to promote a high level of performance among staff conducting beta-blocker program activities. The health plan produces weekly reports listing all members discharged after heart attacks, and it tracks staff timeliness in identifying members, referring them to case managers, and contacting members within the appropriate time frames. In addition, Blue Care Network created a work group to identify barriers to effective follow-up. Based on discussions at work group meetings, BCN made changes to its standard operating procedures to ensure case managers and other staff begin working with these members within a week of hospital discharge.

BCN also conducted regular meetings with staff of major network hospitals to explain the beta-blocker program and foster collaboration to promote timely and effective treatment. As a result, several hospitals revised their discharge summary forms and changed other discharge procedures to ensure heart attack patients are discharged with beta-blocker medications.

Results

The proportion of Blue Care Network's heart attack patients receiving beta-blockers within seven days of their hospital discharge has remained at 100% for three consecutive years (2004- 2006). In 2006, BCN expanded its reporting to include members with AMI diagnoses who received ongoing beta-blocker treatment for six months following hospital discharge. Results will be available by late 2007.

For more information, contact:

Diane Bridgeman
Director
Medical Management — Mail Code C336
Blue Care Network of Michigan
20500 Civic Center Drive
Southfield, MI 48076
(248) 799-6767
DBridgeman@bcbsm.com

Blue Care Network of Michigan

Michigan

Guiding Members to Lower Cholesterol

PROGRAM AT A GLANCE

Goal ▸ Ensurethat members discharged from hospitals following heart attacks, angioplasty, and bypass surgery, as well as those with circulatory system disorders, have LDL-C cholesterol tests and LDL-C cholesterol levels below 100 mg/dL.

Key Strategies

- Send all members discharged from hospitals with heart and circulatory system conditions reminder letters encouraging them to have their LDL-C cholesterol measured.
- Contact members by phone to reinforce the importance of LDL-C cholesterol testing and discuss the need to maintain cholesterol levels within a certain range to promote heart health.
- Contact members' physicians by phone as needed to ensure that patients with heart and circulatory system conditions receive cholesterol screening.
- Offer health coaching to help members whose cholesterol readings are above 130 mg/dL make lifestyle changes to reduce their cholesterol levels.

Results in Brief

- From 2002 to 2005, the proportion of members with heart conditions who had annual cholesterol screenings increased from 72.8% to 83.2%.
- The proportion of members with the targeted conditions whose LDL-C cholesterol levels were below 130 mg/dL rose from 56.9% in 2002 to 69.3% in 2005.

FROM CONCEPT TO ACTION

Taking an Aggressive Approach

In light of the strong evidence that early and aggressive treatment of high cholesterol is effective in preventing coronary artery disease, Blue Care Network of Michigan implemented a cholesterol management program in 2002 for any member discharged from a hospital after a heart attack, angioplasty, or bypass surgery. Beginning in July 2005, Blue Care Network expanded the program to include members discharged with circulatory system disorders (e.g., blocked arteries, blood clots).

The program's goal is to ensure that each of these members receives LDL-C cholesterol screening and lowers his or her LDL-C cholesterol to levels below 130 mg/dL. In 2006, the LDL-C target was changed to levels below 100 mg/dL, in compliance with revised heath care standards. Blue Care Network identifies members for the cholesterol management program through review of inpatient admissions and claims analysis.

Reminder Letters and Case Management

Blue Care Network sends all members discharged with heart and circulatory system conditions reminder letters encouraging them to have their LDL-C cholesterol measured. In addition, nurse case managers contact members by phone, to reinforce the importance of LDL-C cholesterol screening and to provide education on the need to maintain cholesterol levels within a certain range to promote heart health. If health risk assessments or analyses of health plan data show that members have not had the recommended screening, nurses make follow-up calls and send written reminders to members and their primary care physicians.

Case managers contact physicians by phone, as needed, to verify that the test was conducted and remind doctors to rescreen members who have been taking cholesterol-reducing medications for specified time periods. If pharmacy claims analysis shows that a member with an LDL-C level above 130 mg/dL is not taking cholesterol-reducing medication after physicians have received phone calls and written communications from nurse case managers, Blue Care Network's medical director contacts the member's physician to discuss the case.

In addition, BCN's nurse case managers contact all members whose cholesterol levels are above 130 mg/dL and offer them the opportunity to enroll in case management. Program enrollees receive regular phone calls from nurse case managers who provide coaching on diet, exercise, and other lifestyle changes to reduce cholesterol levels. Coaching continues until the member's cholesterol level stabilizes below 130 mg/dL.

Results

- From 2002 to 2005, the proportion of members with heart conditions who had annual cholesterol screenings increased from 72.8% to 83.2%, and the proportion of these members with LDL-C cholesterol levels below 130 mg/dL increased from 56.9% to 69.3% in 2005. (Note: Because the specifications for cholesterol monitoring and levels changed in 2006, data on results beyond 2005 are not comparable.)
- In 2006, 87% of members with heart or circulatory system disorders had annual cholesterol screenings, and 73% of these members had LDL-C levels below 130 mg/dL.

For more information, contact:

Diane Bridgeman
Director
Medical Management — Mail Code C336
Blue Care Network of Michigan
20500 Civic Center Drive
Southfield, MI 48076
(248) 799-6767
dbridgeman@bcbsm.com

BlueCross BlueShield of Tennessee

Tennessee

Extending the Lives of Heart Attack Patients with Effective Care

PROGRAM AT A GLANCE

Goal ▸ Increaselife expectancies for members who have heart attacks and prevent repeat heart attacks.

Key Strategies

- Contact heart attack patients within seven days of hospital discharge to ensure that they are taking aspirin and beta-blockers as recommended.
- Conduct subsequent calls to promote continued use of aspirin and beta-blockers, provide support and assistance, and encourage members to follow up with their physicians.
- Contact physicians as needed to identify reasons for not prescribing beta-blockers and provide copies of nationally recognized clinical practice guidelines for post-heart attack care.

Results in Brief

In 2004, 89.8% of members who had experienced heart attacks were taking beta-blockers 60 days following discharge.

FROM CONCEPT TO ACTION

Helping Heart Attack Patients Live Longer

To prevent repeat heart attacks and increase life expectancies for heart attack patients, BlueCross BlueShield of Tennessee implemented the AMI Beta-Blocker Pharmacy Care Management Program in 2003. Every day, the health plan analyzes hospital preauthorization data to identify members with inpatient admissions for acute myocardial infarction, or heart attack.

Regular Contact with Nurses

Within seven days of discharge, nurse care coordinators contact members by phone to confirm their diagnoses, determine whether they are taking aspirin and beta-blockers as recommended, and ask about any medication side effects or financial issues that may be preventing them from taking the medications.

Based on the answers to these questions, nurses provide informational materials and discuss strategies to address medication side effects. Nurses conduct follow-up calls at least every 60 days, and more often if needed, to determine whether members are taking recommended medications and whether they are experiencing symptoms related to their condition. Nurses provide support and assistance as needed, and they encourage members to follow up regularly with their physicians.

Communication with Physicians

If nurses determine that members have not been prescribed beta-blockers as recommended, they contact members' physicians to determine why, and they ask physicians whether they are familiar with clinical practice guidelines for heart attack patients developed by the American College of Cardiology and the American Heart Association. Nurses send doctors copies of these guidelines upon request.

In some cases, nurses find that members were discharged from hospitals by medical staff who were not their regular physicians and who were unaware of the effectiveness of beta-blockers. In these cases, nurses follow up with patients' cardiologists to ensure that beta-blockers are prescribed unless patients have other conditions for which taking them would be harmful.

Results

- In 2004, 89.8% of BlueCross BlueShield of Tennessee's members who had experienced heart attacks that year were taking beta-blockers 60 days after hospital discharge. The health plan currently is evaluating results of its beta-blocker program in 2005.

For more information, contact:

Lelis Welch
Senior Manager, Utilization Management Program Development
BlueCross BlueShield of Tennessee
801 Pine Street, 4G
Chattanooga, TN 37402
(423) 535-7906
Lelis_Welch@BCBST.com

Jackie Flowers
Manager, Specialty Programs
BlueCross BlueShield of Tennessee
801 Pine Street, 1G
Chattanooga, TN 37402
(423) 535-7687
Jacqueline_Flowers@BCBST.com

America's Health
Insurance Plans

601 Pennsylvania Ave., NW
South Building
Suite Five Hundred
Washington, D.C. 20004

202.778.3200
www.ahip.org