



# Health Insurance Plans' Innovative Initiatives to Combat Cardiovascular Disease



Fall 2012





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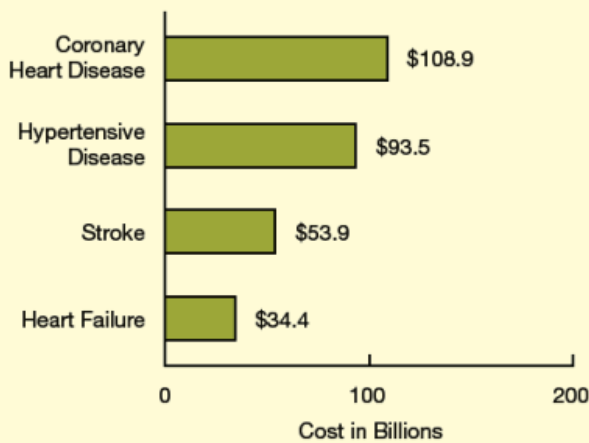
Cardiovascular disease (CVD) is the leading cause of death in the United States, with more than one in four people dying from heart disease every year. People of all backgrounds are affected, and heart disease is influenced by many factors. Research shows a clustering of these factors puts people at increased risk for poor health outcomes.

Health plans target risk factors individually, through programs to help individuals understand and adhere to medication regimens for hypertension, diabetes, and managing cholesterol; tobacco cessation programs; and weight management programs; and provide disease management (DM) programs that target the cluster of conditions and risk factors related to heart disease. These DM programs, including programs for heart disease and related risk factors, help patients manage their conditions through linking them with case managers that can help them organize their medications and prescriptions, health coaches and nurses advise them on lifestyle changes such as healthy eating and exercise, and in general improve their knowledge and skill set around managing their condition.

The infrastructure for improving population health that health plans have in place is unique to the health care system. Health plans have the ability to assist individuals in improving their health across the spectrum—from before they make that first doctor appointment through all of the specialists they see to manage a chronic disease. Physicians can track patients that come into their office, but health plans work with patient populations, including those who do not frequently use the health care system. Through health risk assessments (HRAs), health plans identify health risks and conduct outreach to individuals to provide them with tailored programs that best meet their personal needs.

## Managing CVD also imposes a cost burden on individuals and society

Estimated Direct and Indirect Costs of Major Cardiovascular Diseases, United States, 2010



Source: Heidenreich PA, Trogon JG, Khavjou OA, Butler J, Dracup K, Ezekowitz MD, et al. Forecasting the future of cardiovascular disease in the United States: a policy statement from the American Heart Association. *Circulation* 2011;123(8):933-944.

Heart disease disproportionately affects African American and Hispanic men and women, and AHIP and our member plans are playing a key role in initiating and leading change in the collection of data on race, ethnicity, and primary language; cross-cultural communication training of health care professionals; improvements in clear health communication; development of quality improvement programs to reduce disparities; and measuring progress over time.

A concerted focus on four interventions called the ABCS: **A**spirin use, **B**lood pressure control, **C**holesterol control and **S**moking cessation, could save hundreds of thousands of lives a year. The profiles in this report provide a sample of some of the innovative trends in health plan initiatives to fight heart disease through incorporating the ABCS.

## Featured AHIP Member Plans

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### **Aetna**

Aetna is one of the leading diversified health care benefits companies in the United States, serving approximately 37.2 million people with information and resources to help them make better informed decisions about their health care. Aetna offers a broad range of traditional and consumer directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, and medical management capabilities and health care management services for Medicaid plans. Its customers include employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units, and government-sponsored plans in the United States and internationally.

### **AmeriHealthMercy**

The AmeriHealth Mercy Family of Companies is the leading organization of Medicaid managed care plans and related businesses in the United States. Touching the lives of more than 4 million members, AmeriHealth Mercy is an expert and industry leader in Medicaid, State Children's Health Insurance Programs (SCHIP), and other publicly funded insurance programs. AmeriHealth Mercy's programs offer improved health outcomes for members and have saved taxpayers millions of dollars. AmeriHealth Mercy has a variety of programs and capabilities to meet the special medical and social needs of underserved populations and to satisfy complex state and federal requirements.

### **Blue Cross Blue Shield of Massachusetts**

Blue Cross Blue Shield of Massachusetts is the leading private health plan in the Commonwealth—a not-for-profit company with a proud history of community and health care leadership. Their highest priority is to make quality health care affordable for individuals, families and employers who have made them the health plan of choice in Massachusetts. Blue Cross Blue Shield of Massachusetts is an independent licensee of the Blue Cross Blue Shield Association.

### **CIGNA**

CIGNA, a global health service company, is dedicated to helping people improve their health, well-being, and security. CIGNA Corporation's operating subsidiaries provide an integrated suite of medical, dental, behavioral health, pharmacy, and vision care benefits, as well as group life, accident, and disability insurance, to approximately 47 million people throughout the United States and around the world.

### **Health Net**

Health Net, Inc. is a publicly traded managed care organization that delivers managed health care services through health plans and government-sponsored managed care plans. Its mission is to help people be healthy, secure and comfortable. The company provides health benefits to approximately 6.0 million individuals across the country through group, individual, Medicare (including the Medicare prescription drug benefit commonly referred to as "Part D"), Medicaid, Department of Defense, including TRICARE, and Veterans Affairs programs.

### **HealthPlus of Michigan**

For more than 30 years HealthPlus has been dedicated to improving the health of the communities in which it lives and serves. With offices in Flint, Troy and Saginaw, HealthPlus provides health benefits to more than 200,000 satisfied members throughout Michigan and the Midwest.

## Featured AHIP Member Plans (cont'd)

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### **Highmark, Inc.**

One of the leading health insurers in Pennsylvania, Highmark Inc. has a mission to provide access to affordable, quality health care enabling individuals to live longer, healthier lives. Based in Pittsburgh, Highmark serves 4.8 million people through the company's health care benefits business. Highmark contributes millions of dollars to help keep quality health care programs affordable and to support community-based programs that work to improve people's health. Highmark Inc. is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

### **Humana**

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. By leveraging the strengths of its core businesses, Humana believes it can better explore opportunities for existing and emerging adjacencies in health care that can further enhance wellness opportunities for the millions of people across the nation with whom the company has relationships.

### **Kaiser Permanente**

Kaiser Permanente, America's largest not-for-profit health plan, is headquartered in Oakland, California. Kaiser Permanente serves the health care needs of nearly 8.7 million members in nine states and the District of Columbia. It encompasses the not-for-profit Kaiser Foundation Health Plan, Kaiser Foundation Hospitals and their subsidiaries, and the private Permanente Medical Groups.

### **UnitedHealthcare**

UnitedHealthcare provides a full spectrum of consumer-oriented health benefit plans and services to individuals, public sector employers, and businesses of all sizes, including more than half of the Fortune 100 companies. The company organizes access to quality, affordable health care services on behalf of more than 26 million individual consumers, contracting directly with more than 570,000 physicians and care professionals and nearly 4,900 hospitals to offer them broad, convenient access to services nationwide. UnitedHealthcare is one of the businesses of UnitedHealth Group (NYSE: UNH), a diversified Fortune 500 health and well-being company.

### **Universal American**

Universal American, through its family of healthcare companies, provides health benefits to people with Medicare. They are dedicated to a Healthy Collaboration, working together with healthcare professionals in order to improve the health and well-being of its members. Universal American's family of companies offers affordable healthcare products and programs, including Medicare Advantage plans and traditional health insurance. The prescription drug benefits for its Medicare Advantage plans with prescription drug coverage are administered by MemberHealth®, LLC, a pharmacy benefits management company (PBM).

### **WellPoint**

WellPoint, an independent licensee of the Blue Cross and Blue Shield Association, serves members as the Blue Cross licensee for California; the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as the Blue Cross Blue Shield licensee in 10 New York City metropolitan and surrounding counties and as the Blue Cross or Blue Cross Blue Shield licensee in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), and Wisconsin. In a majority of these service areas, WellPoint does business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield or Empire Blue Cross Blue Shield (in the New York service areas) with more than 33.5 million members in its affiliated health plans, and a total of more than 69 million individuals served through all subsidiaries.

## Aetna Study: *Disease Management to Promote Blood Pressure Control Among African Americans*

A 2010 Aetna study published in the journal *Population Health Management* looked at disease management (DM) to better control blood pressure among African-American members who were diagnosed with hypertension. African Americans have a higher prevalence of hypertension and poorer cardiovascular and renal outcomes than white Americans. The study examined whether a “culturally competent” telephonic nurse DM program is more effective than a standard “light-support” DM program to improve blood pressure (BP) control.

The answer? Yes. The study concluded that a culturally competent DM program can improve patient compliance and reduce systolic blood pressure. In this case, “cultural competence” meant employing nurses with culturally oriented training, the use of culturally sensitive materials, and regular outreach to members’ physicians.

For this project, a prospective randomized controlled study (March 2006—December 2007) was conducted, with 12

months of follow-up on each subject. A total of 5932 health plan members were randomly selected from the population of self-identified African Americans, age 23 and older, in health plans, with hypertension; 954 accepted, 638 completed initial assessment, and 485 completed follow-up assessment.

The intervention consisted of telephonic nurse DM (intervention group) including educational materials, lifestyle and diet counseling, and home BP monitor vs. home BP monitor alone (control group). Measurements included proportion with BP < 120/80, mean systolic BP, mean diastolic BP, and frequency of BP self-monitoring.

Results revealed that systolic BP was lower in the intervention group (adjusted means 123.6 vs. 126.7 mm Hg,  $P=0.03$ ); there was no difference for diastolic BP. The intervention group was 50% more likely to have BP in control (odds ratio [OR]=1.50, 95% confidence interval [CI] 0.997–2.27,  $P=0.052$ ) and 46% more likely to monitor BP at least weekly (OR

1.46, 95% CI 1.07–2.00,  $P=0.02$ ) than the control group.

A nurse DM program tailored for African Americans was effective at decreasing systolic BP and increasing the frequency of self-monitoring of BP to a greater extent than home monitoring alone. The authors concluded that recruitment and program completion rates could be improved for maximal impact. (*Population Health Management* 2010;13:65–72)

### **Why focus on racial and ethnic equality in health care?**

Aetna pioneered its work in racial and ethnic equality in health care in 2002 with the award-winning step to begin the voluntary collection of race and ethnicity data from members. To date, the company has more than six million currently active members who have volunteered this information. Eliminating disparities in health care can lead to better health outcomes for these populations.

## AmeriHealthMercy: *PerformPlus* Cardiology Program

The *PerformPlus* Cardiology program is a shared savings model that is built upon Accountable Care and Medical Home concepts and it is intended to foster a true collaborative partnership in patient care. The program is a balanced scorecard of quality and efficiency metrics delineated by key performance pillars on which physician incentives are based. Peer and trend-based performance metrics are aligned to actuate efficient use of resources, promote quality care & outcomes, and reduce unnecessary or redundant care.

Quality performance pillars include American Medical Association-based metrics such as:

- ▶ ACE/ARB Therapy for Coronary Artery Disease
- ▶ Antiplatelet Therapy
- ▶ Event Cholesterol Test

- ▶ LDL Lowering Drug Therapy
- ▶ Lipid Test
- ▶ ACE/ARB Therapy for Heart Failure
- ▶ Beta Blocker Therapy for Systolic Heart Failure
- ▶ LVEF Assessment
- ▶ Warfarin and other approved anticoagulants

The Medical Home recognition component of *PerformPlus* includes an incentive for Smoking Cessation and Lifestyle Counseling as well as Electronic Medical Record capability and proper care and triage for all patients presenting with chest pain.

Efficiency performance pillars include 3M's "Potentially Preventable Readmission" rates, Ambulatory Care Sensitive Admission rates, Inpatient Admission rates and level 1 & 2 Emergency Room utilization.

A prospective bonus pool threshold is based upon a percentage of baseline annual compensation and categorical metrics are calibrated to reward and encourage incremental improvement within an aggregate pre-determined budget. Top-tier providers are sectioned within each respective category and supplemental bonus opportunities awarded for statistically significant achievement relative to top-tier baseline.

The *PerformPlus* program is being piloted with Keystone Mercy Health Plan's largest Cardiology group (for patients 21 and older) and the expected return on investment is approximately 2.7 to 1, assuming a median tier performance. This program is a true step in the right direction for improving outcomes and quality of care for cardiovascular disease patients.





## Blue Cross Blue Shield of Massachusetts *MyBlueHealth<sup>SM</sup> and Blue Care Connection<sup>®</sup>*

Blue Cross Blue Shield of Massachusetts *MyBlueHealth<sup>SM</sup>* program helps members who want to get in better shape, stop smoking, or simply improve their overall health and wellbeing. *MyBlueHealth<sup>SM</sup>* helps participants reach their individual health improvement goals by providing them with personal wellness plans and valuable tools designed to address each individual's specific health needs.

The first step in participating is to complete the Health Assessment. Health Assessment results are used to create a Personal Health Report. This report not only provides participants with an easy-to-understand explanation of their health status and any health risk factors they may have, but it also helps *MyBlueHealth* create individualized, tailored personal wellness plans for each participant.

Depending on the health risks identified by the health report and the specific goals included in the personal plan for health, participants have a variety of tools and support to help them achieve their health goals. These include:

- ▶ Online health coaching
- ▶ Personal wellness plans for exercise, nutrition, and stress management
- ▶ Healthy change guides related to smoking, emotional health, weight management, and managing blood pressure and cholesterol
- ▶ Tracking tools to monitor factors that influence health, such as exercise, nutritional intake, and health screening results
- ▶ Family wellness plans to encourage healthy eating and physical activity for children

- ▶ More than 1,000 healthy articles and recipes

- ▶ Online community support

Members who are living with a chronic condition may be able to benefit from participating in a *Blue Care Connection<sup>®</sup>* Disease Management program. These comprehensive, health management programs are designed to help members with chronic conditions, including diabetes and conditions related to cardiovascular disease, understand the day-to-day management of their condition, support their physician's plan of care, and improve their quality of life. Disease Management programs provide individual self-assessment and educational tools, and, when appropriate, support by phone that enables participants to take a more active role in their own health management.

Each *Blue Care Connection<sup>®</sup>* Disease Management program is designed to:

- ▶ Increase participants' understanding of their condition
- ▶ Improve their ability to follow the treatment plan
- ▶ Help reduce complications
- ▶ Deliver educational materials, including a quarterly newsletter, self-care goals agreement, and care reminder cards
- ▶ Offer 24-hour access to a dedicated toll-free number, and online educational support

### **Provider Engagement**

Blue Cross Blue Shield of Massachusetts (BCBSMA) has for several years partnered with physician groups and hospitals in Massachusetts in a new contract model that rewards quality and efficiency, rather than quantity of services. This is known

as the Alternative Quality Contract. The health care groups participating in this model have significant financial incentives to improve performance on a number of quality measures related to cardiovascular health. These include process measures (such as insuring that cholesterol levels (LDL) for members with coronary artery disease and diabetes are measured at recommended intervals). In addition, the incentives are triple weighted for measures of clinical outcomes, including maintaining patients' blood pressures and cholesterol levels in recommended ranges. The results seen from implementing this new reimbursement model have been startling. Performance on these key measures of quality related to cardiovascular health improved 2-3 times as much as did the performance of our overall network, with a number of groups achieving maximum levels of performance, including with the clinical outcome measures.

### **Member Engagement**

Many employers working with BCBSMA have now adopted incentives for their employees to take control of their health. They are measured on their success with regard to key behaviors related to cardiovascular health, such as blood pressure control, cholesterol control, medication adherence, and smoking cessation. These incentives may take the form of reduced premium contributions or financial awards for achieving goals.

## CIGNA's Chronic Condition Support Program: *Your Health First*

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CIGNA's Chronic Condition Support Programs provide assistance based upon medical, behavioral and lifestyle factors associated with chronic conditions.

Traditionally the industry has focused on the individual's health needs one at a time, or correlated care across different programs. CIGNA now has the ability to look at individuals holistically, weaving together services and support to meet each person's needs through one program.

In 2010, CIGNA launched Your Health First, a holistic approach to chronic care, with program expansion in January of 2011. Your Health First is built on CIGNA's unique, behavioral-based health coaching

model. Simply telling people with heart disease to take their medicines, exercise, and eat a healthy diet doesn't make them more compliant. However, developing a relationship with someone as an individual who happens to have heart disease enables a coach to learn what motivates that person. Understanding what drives that individual's behavior helps the coach focus on what specific lifestyle and health care changes can help that person achieve improved health outcomes.

Individuals identified with one of the following chronic conditions are eligible for chronic condition support designed to help the individual develop a personal health plan specific to their health needs.

- ▶ Asthma
- ▶ Coronary Artery Disease
  - Acute Myocardial Infarction
  - Angina
  - Congestive Heart Failure
- ▶ COPD (Emphysema and Chronic Bronchitis)
- ▶ Diabetes (Type 1 & 2)
- ▶ Depression
  - Anxiety
  - Bipolar Disorder
- ▶ Heart Disease
- ▶ Low Back Pain
- ▶ Metabolic Syndrome/Weight Complications
- ▶ Osteoarthritis
- ▶ Peripheral Artery Disease

## Health Net: *Targeting Weight Management and Tobacco Cessation*

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Health Net's multifaceted *Fit Families for Life—Be in Charge!* program aims to work with providers to educate and connect members to programs and services that help them make healthier food choices and increase physical activity. The *Fit Families for Life—Be in Charge!* program offers providers resources to meet the U.S. Preventive Services Task Force recommendations on obesity screening and counseling, and NCOA's HEDIS priorities.

The *Home Edition* program is one of a number of member-based offerings under the *Fit Families for Life—Be in Charge!* program. It is a five-week, home-based family intervention program that promotes healthier lifestyles. Through goal-setting strategies, participants receive guidance for making better food choices and increasing physical activity. A program workbook covers topics such as how to read a nutrition facts label, tips for adding fruits and vegetables to everyday meals, family involvement in the kitchen, tips for eating out, and aerobic exercise options.

A healthy recipes cookbook and DVD accompany the workbook—each offering visual references to healthier meals and

nutrition concepts. The DVD provides multiple easy-to-follow exercise segments designed to accommodate various levels of physical ability. The program workbook, cookbook and DVD are also available to members and the community through a three-week community classroom format, whereby trained classroom facilitators educate participants about how to incorporate healthy eating and active living strategies into their family lifestyle. Providers can also work with HealthNet to offer a class series at their office.

### **Quit for Life**

Recognizing the link between smoking and cardiovascular disease, *Quit For Life* (QFL) is a telephone-based program where members are assessed and counseled via telephone by a trained tobacco cessation counselor. Members often self refer or are referred by their physicians. Once enrolled, a counselor assesses the member's enthusiasm to actively participate in the program and his/her readiness to quit, as well as medication recommendations. Benefits offered to QFL participants include:

- Four scheduled outbound telephonic

- counseling sessions with a trained tobacco cessation specialist; the ability to make unlimited inbound calls; nicotine replacement therapy (NRT) medications; a 26 week follow-up evaluation and a QFL Quit Guide workbook.

The *Quit For Life* Program is advertised to members and providers through their respective newsletters, updates, and web sites, along with flyers and pre-recorded messages on the member services line and on the Health Education Information Line. Outreach calls are also made to Health Net members that are identified as smokers through the *Be in Charge!*<sup>SM</sup> *Asthma Program*, or that are utilizing smoking cessation medication and are not enrolled in the *Quit For Life* Program.

Members are assessed upon enrollment and are reassessed six months later by telephone survey. Members are considered to be of "quit" status if they have been smoke free for one month or more. Health Net also provides two incentive raffles: one to increase enrollment and the other to encourage program completion. Throughout 2010, there was a 31% completion rate and a 25% quit rate.



## HealthPlus of Michigan: *Focus on Hypertension*

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HealthPlus recognizes the substantial deadly and costly effects of hypertension that is left untreated or treated sub-optimally. It also recognizes the challenges that health plans face in developing initiatives to improve the management of hypertension due to the fact that blood pressure (BP) is not reported in claims data. HealthPlus developed an intervention utilizing BP obtained through electronic medical records (EMR) to a) identify members with elevated BP, b) assess patient compliance with treatment, and c) inform physicians of non-compliance and/or patient BPs that remain high.

The goal of the work group initiative was to communicate to physicians a panel of their hypertensive patients and a call for action to assess the efficacy of current medication regimens, patient lifestyle changes, diet, and medication compliance. HealthPlus formed a work group comprised of disease management nurses, pharmacists, and an informatics analyst. The objective was to develop an intervention utilizing BPs obtained through EMR to identify members

whose BP was  $\geq 140/90$ . Once identified, compliance with antihypertensive therapy was evaluated from claims data. Non-compliance was defined as MPR (medication possession ratio)  $< 80\%$ . The group developed criteria to report member-specific data that indicated potential non-compliance with medication or an absence of prescription claims for antihypertensive medication with a BP result  $\geq 140/90$ , or compliance with medication but a BP result still  $\geq 140/90$ .

### **Intervention evaluation and outcomes**

A total of 3,467 reports have been sent to physicians since implementation of the *Focuses on Hypertension Initiative* in 2010. Physicians are asked to respond to the report with their intended course of action. The average response rate has improved to 28%. To date, the report has resulted in 373 members being contacted by their physicians to return to the office for evaluation of their hypertension. Physicians have also reported adding or changing medication for 83 members in response to the report. Outcomes evaluation available

three months post-intervention has revealed 27% of members achieved a BP at target goal  $< 140/90$ .

The *Focus on Hypertension* intervention enlists numerous managed care precepts including efforts to prevent illness by managing existing risk factors and partnering with primary care physicians to monitor patient care and treatment compliance. HealthPlus is enlisting additional organizations to participate in the project as their EMR technology becomes available to expand the program. The intervention earned an *Innovations in Health Care* award from the National Kidney Foundation of Michigan in 2011. The initiative has demonstrated that using EMRs to capture blood pressure results is an effective way for managed care organizations to identify members with elevated blood pressure and provide a timely report to physicians that is actionable, sustainable and replicable.

## Highmark's Cardiovascular Programs

*These Highmark programs have been in place for over five years.*

### **Encouraging Use of Beta-Blocker Treatment after a Heart Attack**

Highmark's program for Encouraging Use of Beta-Blocker Treatment after a Heart Attack reaches members through mail outreach services, telephonic outreach services, and use of web-based wellness programs. The program involves network physicians through pay-for-performance incentives, promotion of guidelines, and support of patient data registries.

Highmark's results have demonstrated improved health outcomes for all covered populations and the most recent reports indicate compliance rates rose up to twenty-three percentage points over three years.

#### **Importance of Measures**

Each year, an estimated 785,000 Americans will suffer a myocardial infarction. Of these, 470,000 will have had at least one heart attack before. Of those aged 45 and older, who have an initial heart attack, 19% of men and 26% of women will die within one year. The benefits of beta-blocker therapy for secondary prevention are well established. The American Heart Association and the American College of Cardiology strongly recommend long-term beta-blocker treatment, initiated as early as possible following a heart attack, and continued indefinitely, to reduce reoccurrence and mortality for all patients without a contraindication.

This measure accounts for the percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July

1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.

Member interventions over the last year have consisted of continued mailings of post AMI education, a Blues On Call® Condition Management Program for Coronary Artery Disease (CAD) that includes health coaching and education related to diet, cholesterol management, exercise, and proper medications, including beta-blockers, and web-based programs. There is also a medication reconciliation component and targeted outreach to high-risk CAD Medicare Advantage members.

Provider interventions over the last year included a SMART™ Registry and mailings alerting clinicians to a gap in the members care, annual adoption and approval of Chest Pain Clinical Practice Guidelines, and the financial incentives rewarding practitioners for providing appropriate care to members post AMI.

### **Highmark's Program for Controlling High Blood Pressure**

Highmark's program for controlling high blood pressure reaches members through telephonic outreach services and partnerships with community wellness programs. Through pay-for-performance incentives, promotion of guidelines, and patient education material, the program engages in-network providers. Highmark's results have improved for all covered populations and the most recent reports

indicate compliance rates rose about six percentage points over three years.

High blood pressure affects 1 in 3 Americans and is a major risk factor for heart disease, stroke, and kidney disease. Of those affected, 1 in 5 is unaware that they are hypertensive.

This measure identifies the percentage of enrolled members aged 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year. Blood pressure is considered under control if it is less than 140 mm Hg systolic/ 90 mm Hg diastolic.

Member interventions over the past year have included health coaching, educational mailings and a CAD Condition Management Program, web and community-based programs, a six week community-based lifestyle improvement program providing education on nutrition, exercise, stress management and social support, a hospital-based treatment program (the Dr. Dean Ornish Program for Reversing Heart Disease), and targeted outreach to high risk seniors.

Provider interventions over the past year have a toolkit for talking with patients, promotion of Hypertension Clinical Practice Guidelines on Highmark's Provider Resource website, promotion of and Continuing Medical Education (CME) opportunities, as well as the QualityBLUE Physician Pay-for-Performance Best Practice Clinical Quality Measure – Controlling High Blood Pressure.

## Humana: *Heart Safety Outreach and Education*

Humana is proud to participate in the Million Hearts initiative, a significant focus of the health plan's National Quality Strategy. Humana programs focus on patient safety and education to improve cardiovascular health.

### Heart Safety Outreach

Medication Safety is a key element of the Partnership for Patients. While that initiative addresses hospital medication safety, Humana has developed programs to improve patient safety and appropriate medication adherence more broadly, including:

1. Voice Activated Technology (VAT) outreach to high-risk patients with cardiovascular disease and diabetes to provide information on the medications to the member. These calls allow for a "warm transfer" of the member to live Health Planning and Support consultants and to pharmacy consultants.
2. An innovative statement called SmartSummary<sup>®</sup> that provide member claim information but also offers a list of the member's current medications with photographs to allow the senior to identify their current medications visually. This service is for Humana Medicare Advantage and Prescription Drug Plan members.
3. Electronically-triggered communications are sent to members who are not adhering to their medications for chronic cardiovascular or related conditions such as diabetes, hypertension, elevated lipids, and coronary artery disease. This program is available to all Humana fully insured and Medicare Advantage members.

### Review to Improve Safety with Cardiac Procedures

The risk of injury during and after percutaneous cardiac procedures is up to 11 percent in various studies. These procedures include placement of pacemakers as well as elective cardiac catheterizations. While such procedures can be medically necessary, many are performed without an evidence-based rationale.

Humana provides a review with oversight by a board-certified cardiologist to reduce the inappropriate cardiac device implantation that is not based upon evidence-based medicine. This safety precaution for elective procedures is expected to reduce morbidity and mortality. A cardiologist is available for peer-to-peer review to provide information not found in medical records.

### Education

Humana has created a robust education and engagement program for Medicare Advantage members, called Humana Active Outlook<sup>®</sup>. The program includes an award-winning magazine, classes, and social opportunities. Among Humana Active Outlook's heart education offerings:

#### ▶ HAO Magazine: Spring, 2011— Theme: Outsmarting Heart Disease and Diminishing Diabetes.

Mailed in March 2011 to 1,443,421 member households, with a total member reach of 1,730,300. Content covers topics such as cardiovascular issues due to long-term sleep loss, stopping smoking, getting preventive screenings, and preventive approaches such as dental hygiene.

#### ▶ Live It Up! Digest: Spring, 2011— Theme: Living with and Managing Heart Disease or Diabetes

Mailed in March, 2011 to 552,441 member households, with a member reach of 662,238

Members receiving **LIU!** Digest have been diagnosed with a chronic condition such as heart disease. Content covered specific steps to take to improve heart health, such as reducing belly fat, getting preventive screenings, understanding medicines, and learning about medical advances in heart disease treatment.

#### ▶ Humana Active Outlook Classes and Seminars—

Classes have been attended by thousands of members and cover a range of heart health-related topics such as reducing cholesterol, controlling blood pressure, understanding how the heart works, and preventing heart disease.

### Humana's Goals In Support of the Million Hearts Initiative

Humana strives to reduce heart disease in its members in all ways possible, and has concentrated its efforts in these areas:

- ▶ Improve access to appropriate care for patients with heart disease;
- ▶ Improve patient safety through use of Humana's technologies to reduce medication or procedure-related complications;
- ▶ Reduce conditions or injuries acquired through treatment by eliminating invasive procedures that are not evidence-based;
- ▶ Educate members to help prevent heart disease and improve quality of life of those who are already have heart conditions.



## Kaiser Permanente: *ALL/PHASE Initiative*

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Kaiser Permanente's ALL/PHASE protocol utilizes low-cost and generic medications and clinical interventions to reduce heart attacks, and has been successfully implemented in Kaiser Permanente communities, including those served by safety net organizations. The ALL Initiative (**A**spirin, **L**isinopril and **L**ipid-lowering medication) was implemented to reduce heart attacks and strokes by aggressively enrolling patients with heart disease or patients who are at least 55 years old with diabetes, in a therapeutic program that included the use of these three medications. The organization's PHASE

program (**P**reventing **H**eart **A**ttacks and **S**trokes **E**veryday) enhances ALL by adding a beta blocker and emphasizing healthy lifestyle changes. Research has shown that bundling two low-cost, generic heart drugs—a cholesterol-lowering statin and a blood pressure-lowering drug—prevents heart attack and stroke.

Realizing the benefits for its members and community partners, Kaiser Permanente awarded Community Benefit grants to share this initiative with safety net clinics. Those grants led to the implementation of ALL in five community clinics in Southern

California, and the use of PHASE in seven community clinics and four public hospital and health systems in Northern California. Since launching the program with community clinics, public hospitals and health systems in California in 2005, there are now 46 locations using this program in ambulatory clinics and community health center settings across the country. Kaiser Permanente provides guidance to health care workers throughout the implementation of ALL/PHASE and opportunities to study Kaiser Permanente practices on-site.

## UnitedHealthCare: *Long-Standing Collaborations and Quality Initiatives*

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UnitedHealthCare (UHC) has long been committed to a goal of reducing CVD across the nation by working with medical societies, physicians, hospitals and organizations that share this goal by following proven evidence based clinical guidelines for managing heart disease. Through the United Health Foundation, UHC partners with the American Public Health Association and Partnership for Prevention, to produce an annual assessment of the nation's health that shows successes and challenges on a state-by-state basis. Now in its 22nd year, America's Health Rankings focuses on addressing the risk factors for cardiovascular disease, including smoking, obesity, and diabetes.

UHC has collaborated with the American Heart Association (AHA) on multiple fronts to promote the prevention, early identification and management of heart disease and stroke. This collaboration includes encouraging hospitals to adopt the *AHA Get With The Guidelines* program for managing patients with heart disease and stroke. Other activities UHC is involved in with the AHA include *Go Red for Women*; *Annual Heart Walk*; *Mission Lifeline* program; and Clinical Guidelines for managing cardiovascular disease.

Collaborations with the American College of Cardiology (ACC) include a number of projects to promote the development and

use of clinical guidelines for managing patients with cardiovascular disease and to encourage the adoption of the ACC's Appropriate Use Criteria. UHC has provided grant funding to the ACC Foundation, and has made participation in the ACC's National Cardiovascular Data Registry for Cath PCI a mandatory requirement for participation in UHC's Premium Cardiac facility designation program. Furthermore, UHC has incorporated the actual hospital clinical outcomes registry data into the Premium Facility designation program's measurement and scoring criteria.

UnitedHealth Group is also involved in a community-based collaboration with the YMCA and Walgreens, aimed at tipping the scales against the epidemic of diabetes, prediabetes, and obesity in the U.S., both major risk factors for heart disease. The Diabetes Prevention and Control Alliance is anchored by two innovative programs including the Diabetes Prevention Program, which is designed to help people at risk for diabetes prevent the disease through healthy eating, increased activity, and other lifestyle changes, and the Diabetes Control Program, which help people with diabetes better control their condition through education and support from trained pharmacists. UnitedHealth Group covers these services at no charge to plan participants enrolled in employer-provided health insurance plans.

The program uses a group-based lifestyle intervention designed especially for people at high risk of developing diabetes. In a group setting, a trained lifestyle coach helps participants change their lifestyle by helping people eat healthier and increase their physical activity, and learn about other behavior modifications over the 16-session program. After the initial 16 core sessions, participants meet monthly for added support to help them maintain their progress. Results-based incentives help drive performance. For example, a lifestyle coach from the YMCA receives a higher payment for helping an individual achieve greater weight loss, as well as reimbursement for each patient's participation.

The Diabetes Prevention and Control Alliance launched in April 2010 and roll-out will continue nationally through 2011 and 2012. UnitedHealth Group employees have access to the programs as they roll out in each market. In addition, UnitedHealth Group has entered into an agreement with Minnesota-based health insurer Medica to offer the programs to a wide range of the company's employer-sponsored plans in Minnesota.

The Alliance programs will be available to other insurance companies and employers as well. To learn more, visit [www.unitedhealthgroup.com/diabetes](http://www.unitedhealthgroup.com/diabetes).

## Universal American's *Healthy Collaboration Model Fosters Innovations in Heart Attack and Stroke Prevention*

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Universal American's approach to improving the healthcare outcomes of its members begins with the *Healthy Collaboration* model. In *Healthy Collaboration*, the health plan provides its physicians, particularly at the primary care level, with a robust set of patient analytics to facilitate well-informed primary care and the comparative tools necessary for physician groups to benchmark their patient outcomes. The program gives primary physicians the option to participate in aggressive and transparent gain-sharing arrangements that incentivize physicians to innovate and drive improvements across their practices. A set of care management interventions—including an annual health risk assessment, post-acute discharge support, health coaching for targeted populations, and connections with social services when needed—complements the medical services provided by the health plans' physicians. Finally, the benefits packages are designed to incentivize members toward healthy behaviors, including: \$0 copay for primary care visits and low co-pays for cholesterol

control drugs, Lipitor and Crestor.

By design, *Healthy Collaboration* allows physicians to innovate when working with different populations and chronic conditions. Due to the prevalence and importance of heart attack and stroke, several participating physician groups have chosen to implement practices that focus on these problems and the underlying conditions that lead to them.

Below are two examples of the approaches that participating physicians are championing through *Healthy Collaboration*. The health plan participates with physicians in examining the outcomes of these efforts and, if they are judged successful, the plan will create the incentives and educational forums necessary to promote the adoption of these best practices across physician groups.

Under the leadership of Dr. James "Larry" Holly, Southeast Texas Medical Associates (SETMA) physicians have implemented a performance dashboard for each practice physician in which physicians are measured against each other across a

variety of quality of measures, including HEDIS measures. The dashboard creates transparency for each physician and facilitates discussions with outliers. Dr. Holly participated in a CMS-sponsored Medical Home assessment, to analyze patterns of care, health outcomes, and costs of care for Medicare fee-for-service (FFS) beneficiaries receiving healthcare services from clinical practices that are National Committee for Quality Assurance (NCQA)-recognized medical homes. SETMA is generally outperforming national benchmarks across an array of measures.

*Memorial Clinic Associates*: Led by Dr. Miguel Franco, Memorial Clinic Associates focus on HEDIS measures that include: blood pressure, cholesterol and diabetes checks, and screenings. Through the use of E-health records, they document high-risk factors such as tobacco use, which trigger physicians to offer counseling and tailored patient education materials.



## WellPoint's *Fitbit* Pilot Study

WellPoint is piloting an innovative new program, *Fitbit*, to help members at risk for heart disease and other chronic conditions improve their health through increasing physical activity and achieve healthier weight through the use of computer-assisted accelerometers/pedometers and comprehensive lifestyle-management health coaching.

The pilot study has four specific aims:

- ▶ To assess if an accelerometer/pedometer device, the Fitbit Tracker, used by itself or in combination with telephonic lifestyle-management coaching, results in greater daily activity levels among users versus people who neither use a Fitbit Tracker nor receive coaching.
- ▶ To assess the effectiveness of the Fitbit Tracker alone and in combination with coaching among plan members with and without chronic health conditions.
- ▶ To determine how long participants persist in daily physical activity.
- ▶ To develop profiles of the participants who benefit most from the use of a pedometer/accelerometer alone and in combination with coaching interventions designed to increase daily physical activity.

The pilot involves 1,500 WellPoint members who are recruited via email, the health plan's web site, and WellPoint customer worksites. Participants must have a body mass index (BMI) greater than 28 (a BMI of greater than 25 is considered overweight, while a BMI

of 30 or greater is classified as obese). Half of the participants (750 people) are currently diagnosed either with certain "Category 1" medical conditions including asthma, diabetes, coronary artery disease, congestive heart failure; OR with two or more of the "Category 2" conditions including hypertension, hyperlipidemia, knee pain, depression, or arthritis.

The other half of the participants must have no diagnosis of any Category 1 medical condition and no more than one Category 2 medical condition. Participants in this intervention group ("Fitbit Tracker Only") will receive a Fitbit Tracker, a web-enabled pedometer with additional capabilities. It can be worn loosely in a pocket or clipped to clothing and is small enough to be discreet.

The Fitbit Tracker plus telephonic coaching intervention includes everything in the Fitbit Tracker only group plus personalized lifestyle coaching provided by Anthem Care Management. The health-coaching program addresses three critical parts of successful lifestyle modification and maintenance: mind, body, and nutrition. Telephone coaching will be used to engage participants and help them achieve their goals. The frequency of participant contact and type of coaching focus will be individually tailored to each participant depending on the participant's risk factors and willingness to take part. Primary outcome measures of the study include physical activity levels, quality of life measures, BMI, absenteeism, health care utilization, and health care costs.

Preliminary data from Fitbit has shown that users who live sedentary lifestyles increase their activity levels by 50% after using the Fitbit Tracker for 12 weeks. Before more results are in, the member testimonials are compelling:

*One of my employees...started wearing their Fitbit while sleeping. They realized their sleep efficiency was 48%! That basically means they thought they were getting 7-8 hours a night when in reality it was 3-4. So, they made an appointment with their physician who did a sleep study and found that they have SEVERE obstructive sleep apnea. Physician is providing recommendations on treatments, therefore he will start to get more and better sleep. What a great testimony started by the Fitbit!"*

*"I would like to thank you for providing me with a Fitbit. The last 12 weeks have changed my life from sedentary and discouraged to active and positive about my weight loss goals. As an RN, I have always had the dietary knowledge but could never put it together with exercise so that I would see positive results. The Fitbit combines all of the information so that you can see what you are doing and adjust the numbers by being more active and balancing your diet easily. When I started, I couldn't imagine how the little gadget could help but it has proven to be exactly what I needed to see results."*





America's Health  
Insurance Plans

601 Pennsylvania Ave., NW  
South Building  
Suite Five Hundred  
Washington, D.C. 20004

202.778.3200  
[www.ahip.org](http://www.ahip.org)