AHIP
Center for Policy and Research

Trends and Innovations in Chronic Disease Prevention & Treatment

An Update on Medicare Advantage Plans

America's Health Insurance Plans

April 2008

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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.

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PART ONE

Overview: Key Trends in Chronic Care

"Without case management, I might be dead. If not, I would be alive but still thinking I was invincible. I no longer smoke, I take fewer medications, and I've lost weight. I check my blood sugar every day and intend to keep the weight off."

"If it wasn't for [my health plan], I wouldn't be alive today. I call [my nurse case manager] my angel. If it wasn't for her, I couldn't afford my medications. [The nurse case manager] gave me the courage to live in the future and put the bad behind me. She always makes me feel better when I talk to her..."

"I had a million questions. [My nurse case manager] answered them in a way that the doctors couldn't. My doctors had tried for 20 years to convince me to stop eating salt, but it never worked. Although I had never met [my case manager], she somehow got me to stop eating salt and take better care of myself in no time. I don't know how she did it. I owe it all to her."

"Thank you for all your help arranging hospice, and I'm sure for a lot of the behind-the-scenes work. Mom was well cared for, and everyone was great to her and my sisters and me. I appreciate your follow-up phone call and your genuine care and concern."

These are just a few of the comments that Medicare Advantage members are making about health plans' programs to address chronic conditions. This report provides additional perspective on the operation and impact of these programs nationwide:

- In Part One of the report, we describe the latest strategies that health plans are using to serve the needs of members with chronic diseases, including conditions such as diabetes, heart failure, chronic obstructive pulmonary disease, asthma, depression, bipolar disorder, chronic kidney disease, and hypertension. Wherever results are available, we review what has been achieved.
- In Part Two, we provide detailed descriptions of 18 disease management programs implemented by health insurance plans participating in Medicare Advantage.

Health Plan Strategies

Overcoming Language and Cultural Barriers to Care.

To help break down language and cultural barriers that may prevent members from obtaining effective diabetes care, ***Presbyterian Healthcare Services (PHS)*** hired a lay community health worker called a *promotora*. The *promotora*, who Presbyterian refers to as "the eyes of the physician, the ears of the nurse, and the heart of the clinic," works in a low-income, underserved community in the health plan's service area. The *promotora* speaks the same language, lives in the same neighborhood, shops in the same stores, attends the same church, and is concerned about the same issues as community residents. Her role is to visit patients' homes; provide information about recommended diet, exercise, and diabetes-related preventive care; call to ask about missed doctor's appointments and lab tests; and help patients access needed health and social services.

The *promotora* also can act as an interpreter during visits to health and social service practitioners. The *promotora* talks with patients outside of the medical setting, and she takes time to listen to their concerns. By maintaining ongoing, personal contact with members, the *promotora* builds strong bonds of trust that help motivate patients to follow treatment plans. In addition, the *promotora* is able to identify subtle changes in patients' health status and report them to other members of patients' care teams for prompt follow-up. Based on the success of the *promotora* initiative, several additional clinics in Presbyterian's network have proposed implementing the program in their communities.

RESULTS. PHS's diabetes care initiative, which included a variety of strategies in addition to the promotora's services, produced the following results:

- From 2002 to 2007, the proportion of Medicare beneficiaries with HbA1c readings above recommended levels or with no HbA1c test in the past year (defined as the "poor control rate") dropped from 36.5 percent to 12.2 percent.

As part of its health management initiative for members with chronic conditions, ***Health Plan of Nevada/ Sierra Health & Life (HPN/SHL)*** offers language translation services for all members with any of four chronic conditions (congestive heart failure, diabetes, pediatric asthma, and chronic obstructive pulmonary disease) whose health service use and/or lab test results suggest that they are at moderate or high risk of

complications and hospitalization. Members whose primary language is not English can consult regularly with nurse health coaches by phone in any of more than 100 languages. The languages most frequently requested are Spanish and Tagalog.

During these calls, nurses encourage members to schedule appointments for recommended care; provide guidance on taking prescribed medications appropriately; screen members for depression and link them with behavioral health professionals; and may refer members to case management staff. Case managers help members manage complex health care and social service needs, and they assess individuals' eligibility for public programs such as Medicaid and state pharmacy assistance programs. From January to October 2007, nurse health coaches made more than 370 calls in languages other than English.

RESULTS. HPN reported the following improvements from 2005 to 2006:

- The proportion of Medicare Advantage members with diabetes who had LDL cholesterol at recommended levels (i.e., below 100 mg/dL) increased from 55.2 percent to 58.4 percent.
- The rate of kidney disease screening for Medicare Advantage members with diabetes rose from 68.9 percent to 73.5 percent.

Because diabetes is especially prevalent in the Latino population, ***Aetna*** distributed diabetes member 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 with information on recommended diet, exercise, and preventive care for people with diabetes, along with a video called *Diabetes: A Guide for Hispanic Americans*. The video featured prominent Latino spokespeople explaining the services that people with diabetes could expect to receive during doctor visits and strategies for healthy eating.

Based on physician feedback about the usefulness of materials in Spanish for patients with diabetes, Aetna partnered with the American Diabetes Association in 2006 to distribute CD-ROMs in English and Spanish to all of its participating primary care physicians providing diabetes care. The CDs include patient tools such as blood glucose logs, recommended strategies for counting carbohydrates, and diaries for tracking diet and exercise. Physicians can print out and use materials on the CD as they see fit, for example, by reviewing them with patients during visits and/or giving them to patients to take home.

RESULTS. Aetna reported the following changes from 2004 to 2006 among members enrolled in the program:

- The proportion of Medicare Advantage members with diabetes whose cholesterol levels were below 100 mg/dL (defined as being "in good control") increased from 48.6 percent to 52.4 percent.
- The percent of Medicare Advantage members with diabetes who had HbA1c tests increased from 86.6 to 89.

Focusing on Special Needs.

To provide extra help for beneficiaries who have complex conditions and/or low incomes, some health plans have received approval from the federal Centers for Medicare & Medicaid Services (CMS) to offer Special Needs Plans (SNPs). SNPs are Medicare Advantage plans that are permitted to provide coverage designed specifically for three populations: beneficiaries eligible for both Medicare and Medicaid (dual-eligibles), beneficiaries with chronic conditions, and/or beneficiaries who are in nursing homes. SNP status makes it possible for health plans to offer benefits aimed at meeting extensive medical, social service, behavioral health, and, in some cases, financial needs.

Approximately 1,600 Medicare Advantage members participate in two initiatives offered by ***AMERIGROUP Community Care's*** Special Needs Plan for Medicare and Medicaid dual-eligible beneficiaries in Houston, TX: Geriatric Care Management Rounds and Enhanced Care Initiatives (ECI). Both programs provide comprehensive case management, and ECI focuses on members with the most complex needs. Beneficiaries enrolled in Geriatric Care Management Rounds receive regular phone calls from nurses, who check on their health status, ensure that they are taking medications as recommended, follow up with physicians to address medication-related or care issues, and help them access transportation and other community resources.

Members participating in Enhanced Care Initiatives receive regular in-person visits from case managers, who provide information about health conditions and medications and discuss symptoms and complications that need to be addressed. Case managers can help members obtain medical equipment, sign up for Meals on Wheels, and access financial assistance. They also can accompany members to doctor visits as needed. AMERIGROUP nurses and social workers serving beneficiaries in both programs meet weekly with the health plan's physicians, nurses, and pharmacists to discuss medical and social service challenges, as well as strategies to promote optimal care.

RESULTS. From the time that the two programs were implemented in the third quarter of 2006 to the same period in 2007, the following changes were reported among AMERIGROUP's SNP members in Houston:

- The number of hospital days per thousand members declined by 11 percent.
- The number of emergency room visits per thousand fell by 23 percent.
- Primary care visits per thousand members increased by 8 percent.
- Outpatient visits per thousand for behavioral health conditions increased by 54 percent.

More than 154,000 Medicare beneficiaries in 34 states and the District of Columbia are enrolled in SNPs established by the ***Evercare division of Ovations*** (a UnitedHealth Group company). Evercare offers SNPs for institutionalized individuals, SNPs for dually eligible Medicare and Medicaid beneficiaries, and SNPs for people with severe or disabling chronic conditions. Using nationally recognized guidelines for evidence-based care, Evercare is able to combine primary, acute, and long-term care services into a single system of care designed to close gaps in treatment of chronic and other conditions while slowing the progression of illness and disability.

Evercare's programs for institutionalized members include meetings with nurse practitioners, who conduct physical exams; take comprehensive medical histories; and assess cognitive functioning levels, limitations in activities of daily living, and nutritional needs. 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 as needed.

To help low- and moderate-income beneficiaries with chronic diseases live independently in their communities for as long as possible, Evercare covers a range of health and social services for chronically ill members through its Dual-Eligible SNPs and Chronic Care SNPs. For individuals with complex needs, nurses or social workers trained as care managers conduct comprehensive assessments and develop care plans to address medical, behavioral health, and social service issues. Depending on members' health status, care managers may conduct in-person evaluations of their home environments to check on safety issues and arrange for home modifications to prevent falls or improve accessibility. Evercare also coordinates with state Medicaid agencies, Area Agencies on Aging, and local consumer groups (e.g., the AARP, Alzheimer's Association, National Kidney Foundation) to implement programs that benefit SNP members.

As of February 2008, approximately 70,000 Medicare Advantage members with chronic conditions were enrolled in a SNP established by ***Care Improvement Plus***. The health plan provides customized support programs based on members' health conditions. For members with diabetes, the health plan does not require copayments for podiatry visits, and it provides plan options that include full coverage, with no copayments, for many commonly prescribed diabetes medications, including coverage through the Medicare Part D coverage gap. The health plan also covers transportation to doctor visits, as well as "diabetic shoes" for beneficiaries who have reduced sensation in their lower extremities.

Members with diabetes who are at high risk of complications receive in-person medical assessments and regular phone consultations with nurses specializing in diabetes care. Beneficiaries with diabetes who have reduced sensation in their feet receive devices they can use every day to check for foot infections. The device shines red on each area of the foot where it detects potential infection to alert members to follow up immediately with their podiatrists.

Providing Personalized Online Health Information.

Since January 2008, all members of ***HealthNow New York (HealthNow)*** have had access to Personal Care Advance, a customized, Web-based resource for health information. For each member enrolled in the program, HealthNow creates a Web page with information tailored to his or her health conditions and preferences. Based on analysis of claims data, HealthNow may include, for example, information on preventive care recommended for people with diabetes, strategies for addressing seasonal allergies, and/or reminders to have a flu shot.

If a member says during a conversation with a health plan nurse that he or she is trying to lose weight, HealthNow sends suggestions on diet and exercise to his or her personalized Web page. Members who indicate on health risk assessments that they are having difficulty quitting smoking will receive tips on smoking cessation and links to community resources.

If a member grants HealthNow permission to view his or her online personal health record (PHR), the health plan may send condition-specific information to the personalized Web page based on data in the PHR. HealthNow regularly updates each member's Web page with new, customized content.

Taking on Obesity.

Because many of its elderly members have chronic conditions and face challenges maintaining healthy weight, ***Humana*** partnered with ***Healthways*** in 2004 to provide the SilverSneakers® Fitness program to Medicare Advantage members. As of November 2007, more than 180,300 Medicare Advantage members were enrolled in SilverSneakers in 43 states and Puerto Rico.

The program combines exercise with social support to promote healthy living. 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. SilverSneakers participants have the opportunity to attend a variety of special events, including potluck meals, holiday celebrations, and birthday parties. Through these events, members can develop and maintain friendships with other program participants and extend their social support networks.

RESULTS. From 2006 to 2007, the following improvements occurred among Medicare beneficiaries enrolled in the program:

- The percent of individuals who said they were exercising three or more times per week increased from 67 to 84.
- The proportion of respondents who reported their health as "much better" or "somewhat better" than it was in the previous year increased from 39 percent to 41 percent.

Helping Members with Bipolar Disorder.

In 2007, ***Health Alliance Plan (HAP)*** began offering a phone coaching program for members discharged from hospitals with bipolar disorder. Each participant has four scheduled phone consultations with a social worker or psychologist over a two-month period. The calls focus on mood management; signs and symptoms of bipolar disorder; and relations with family, friends, and employers. HAP also sends each person in the program a chart for tracking moods on a continuum from depressed to manic, and the health plan encourages members to speak with their therapists if moods are close to one end of the continuum or the other. Members can contact the program's social workers and psychologists at any time during business hours or designated evening hours to ask questions or seek help.

Advancing the Quality of Care for End-Stage Renal Disease.

Recognizing that patients with end-stage renal disease (ESRD) often have complex needs that can be met most effectively by a team of clinicians specializing in ESRD care, ***WellPoint*** established an ESRD management program in 2001. The health plan initially offered the program in parts of New York, Connecticut, and Kentucky, and it plans to expand the initiative nationwide in 2008. In 2007, Medicare Advantage members comprised approximately 60 percent of the program's 140 participants. As of January 2008, 87 Medicare Advantage members with ESRD were enrolled.

As part of the program, nurse care managers set up the full range of medical, social, and behavioral health services that members need. For example, they may arrange for home health care, physical therapy, or occupational therapy. They help members find dialysis centers convenient to their homes.

Care managers communicate regularly with members' physicians about their health status, and in conversations with members, they seek to reinforce physicians' care plans. For example, they help patients choose healthy foods, understand how to take their medications correctly, and identify signs and symptoms of chemical imbalances (e.g., high potassium or calcium levels) that require prompt medical attention. Because patients with ESRD often have anemia, care managers ensure that they have regular blood tests, and they provide information and support to members on taking anemia medications as recommended.

Members admitted to nursing homes can continue to work with care managers, who can help with advance treatment planning and end-of-life care. Care managers provide information and support to family members throughout the treatment process. Patients usually are enrolled in the ESRD management program for several years.

RESULTS. An evaluation of the program found that from 2003 to 2006:

- The total number of hospital days per thousand for Medicare Advantage members participating in the program fell by 26 percent, from 12,738 to 9,426.
- The number of emergency visits per thousand among Medicare Advantage members in the program dropped by 7 percent, from 454 to 422.
- Total hospital admissions for participating Medicare Advantage members increased by 5 percent, from 1,605 to 1,688. WellPoint attributes this increase to early identification of ESRD complications. The reduction in hospital lengths of stay that occurred during the same time frame suggests that patients were treated promptly and effectively and thus avoided infections and further complications.

Improving Options for End-of-Life Care.

In response to the finding that people with terminal illnesses often do not have enough information about treatment options or support services, two health plans have pursued initiatives focusing on palliative care.

In ***Aetna's*** end-of-life program—which has served more than 1,000 Medicare Advantage members since 2005—nurses work with members who have terminal illnesses, along with their caregivers and physicians, to develop care plans based on individual needs. Members and their caregivers determine how often and for how long they would like to be in contact with nurse case managers. Most contacts are by phone, but some consultations can occur at home or in long-term care facilities as needed.

Aetna's nurses provide a wide variety of services to meet members' needs. These can include: coordinating medical and social services; offering information about treatment options and helping members make informed decisions about care; helping people understand their medications, manage pain, and cope with side effects; arranging for lodging near treatment sites; setting up delivery of durable medical equipment; helping members work with nutritionists to avoid weight loss; and setting up hospice care. Members and their families can contact Aetna nurses by phone on a 24/7 basis with questions or requests for help.

RESULTS. The program's results are as follows:

- Approximately 77 percent of terminally ill Medicare Advantage members enrolled in the program chose to participate in hospice. In contrast, an estimated 20 to 30 percent of Medicare fee-for-service beneficiaries who died during the same period participated in hospice.
- From 2005 through the first quarter of 2007, fewer than 10 percent of terminally ill Medicare Advantage members participating in the program died in hospitals. Surveys of the general population and of the seriously ill show that people overwhelmingly prefer to die at home.[1] A systematic review of international literature found that preference for home death ranged from 59 percent to 81 percent in the general population and from 49 percent to 90 percent among cancer patients.[2]

Kaiser Permanente's palliative care program was implemented as a randomized controlled trial among 300 members with terminal illnesses in Colorado and Hawaii from 2002 to 2004. The program included but was not limited to Medicare Advantage members; the mean age of participants was 74. As part of the program, an interdisciplinary palliative care team consisting of a nurse, social worker, and physician assessed patients' physical, medical, psychological, social, and spiritual needs. Core teams were expanded to include pharmacists, chaplains or spiritual counselors, dietitians, home health aides, occupational and speech therapists and bereavement coordinators as needed.

Based on the wishes of patients and their families, palliative care teams developed care plans that focused on enhancing patients' comfort, managing pain and symptoms, and improving quality of life. Physicians conducted home visits and were available, along with nurses, on a 24-hour, on-call basis. The program also provided advance care planning so that patients and their families could make informed decisions about care goals and end-of-life care. Patients in the control group received "usual care," which included home health and acute-care services, primary care, and hospice care according to their needs and based on Medicare home health care guidelines.

RESULTS. The study found that:

- Thirty days after enrolling in the program, 93 percent of participants in the palliative care group said they were very satisfied, compared with 80 percent of members receiving usual care.
- Ninety days after enrolling in the program, 93 percent of participants in the palliative care group said they were very satisfied, compared with 81 percent in the usual-care group.
- Thirty-six percent of members receiving palliative care were hospitalized, compared with 59 percent of members in the usual-care group.

[1] Dunlop, R.J., et al., 1989, cited in Gruneir, A., et al. (2007). Where people die: A multilevel approach to understanding influences on site of death in America. *Medical Care Research and Review*. 64(4). 351-378.

[2] Higgenson & Sen-Gupta, 2000, cited in Gruneir, A., et al. (2007).

Coaching Members on How to Improve Their Health.

Nurses are a crucial link in health plans' efforts to stay connected with their members. Health plans' nurse case managers who specialize in chronic care stay in touch by phone with individuals with chronic diseases who are most at risk of complications and hospitalization. Based on the individualized care plans that members develop with their doctors, nurses coach members on how to set goals for improving their health and well-being, and they support members in pursuing strategies to achieve these goals.

As part of the Connections Health Management program offered by ***Independence Blue Cross (IBC)***, members with any of five chronic conditions (asthma, diabetes, chronic obstructive pulmonary disease, chronic heart failure, and/or coronary artery disease) who are at high risk of complications or hospitalization receive phone calls from Health Coaches who are trained as registered nurses, dietitians, or respiratory therapists. Since the program's inception in 2003 through 2006, more than 47,000 Medicare Advantage members have consulted with the program's Health Coaches. Health Coaches' interactions with members are tailored to meet individuals' needs. Through a whole-person approach to coaching, they support individuals' efforts to reach their health care goals.

Coaches seek to ensure that members receive all of the treatments and procedures recommended for their conditions, and they may suggest referrals to behavioral health practitioners, case management services, smoking cessation, or other available health plan programs. On average, Health Coaches contact program participants at high health risk five to seven times per year, with variations according to members' preferences and needs.

RESULTS. IBC found that:

- In 2006, 87 percent of members in the Connections Health Management program said they were "satisfied" or "very satisfied" with it.
- From September 2005 to August 2006, annual growth in health care costs among all of IBC's Medicare Advantage members was reduced by 4 to 4.5 percent overall.

Nurses from ***Kaiser Permanente's*** Care Coordination program in Colorado make phone calls to members following discharge from a hospital, emergency room, or nursing home to assess their health status and needs. During these calls, nurses conduct complete reviews of patients' health status and physical symptoms, such as pain and breathing difficulties. They also ask members questions such as whether they have food in the house and whether they can walk, drive, read medication labels, and perform activities of daily living (i.e., bathing, dressing, eating).

Based on members' responses, care coordinators help them set care goals to improve their health status and quality of life. These goals could include, for example, taking medications correctly and ordering refills as needed; following recommended exercise plans; increasing caloric intake; and monitoring glucose levels regularly.

Once they have helped members set goals, care coordinators speak with members by phone on a regular basis to help them achieve these goals. Nurses also link members with services that they need, which could include home care, Meals on Wheels, transportation, financial assistance, and Alzheimer's support groups.

If it appears that members may qualify for public programs such as Medicaid, care coordinators link them with state agency staff who can help them fill out applications. Care coordinators communicate regularly with members' physicians, to keep them updated on changes in health status, needs for adjustments to care plans, and other member needs.

Approximately 3,500-4,000 Medicare Advantage members participate in the program each year.

RESULTS. Kaiser reported that:

- More than 90 percent of Kaiser Permanente members surveyed about the program said they were highly satisfied with its coordination of services and with the continuity of their care.
- From January through December 2006, the emergency room component of the program saved approximately $1 million.
- The program saved an estimated $3 million annually from 2004 to 2006.

Regence members who have missed multiple tests and procedures recommended for chronic care and/or have had multiple emergency room visits and hospital admissions receive calls from nurse disease managers, typically once a month but with intervals varying based on member needs. Nurses keep in touch with members for as long as necessary to help them access care that will improve their health status. Calls with Medicare Advantage members often last for a half-hour or more.

During these conversations, if disease managers determine that members have other unmet needs (e.g., difficulty affording medications, lack of transportation), they link members with community organizations that can help. Members can contact the program's nurses at any time during business hours and can remain enrolled in the program for as long as they wish.

As of April 2008, ***UCare*** nurses specializing in complex care follow up immediately with all members who have ER visits or inpatient admissions for diabetes care. Nurses contact these members by phone, typically once, but they can schedule additional calls as needed. During their conversations, nurses ask about factors that contributed to the medical emergency and whether members are facing barriers to treatment. They encourage members to follow up with their primary care physicians as soon as possible. In addition, nurses provide members with information about the condition and about effective diabetes care. They help "at-risk" members access diabetes-related preventive care services, and they coach them on diet, exercise, and medication issues to help them maintain blood sugar levels within recommended ranges. Nurses also help members with complex needs (e.g., those with multiple chronic conditions) connect with UCare's case management nurses or social workers.

RESULTS. UCare's diabetes care initiative was associated with the following changes from 2004 to 2006:

- The rate of hospital admissions among members with diabetes fell from 2.8 percent to 1.1 percent.
- The percent of members with diabetes who had emergency room visits for the condition declined from 2.8 to 1.7.

Using Information Technology to Drive Health Care Improvements.

Health plans are leveraging the power of information technology to closely track the health status of members with chronic conditions. Based on ongoing electronic monitoring, data collection, and analysis, health plan staff are able to take prompt action to improve members' care and well-being.

Blue Cross Blue Shield of Massachusetts (BCBSMA) provides electronic scales and tools for taking blood pressure and pulse readings every day to members with heart failure who meet specified criteria (i.e., based on assessment of their self-management skills, health status, and recommendations from their physicians). Results are transmitted in real time to BCBSMA nurses, who analyze the results and follow up with patients and their doctors if these readings suggest potential problems. For example, if a member with heart failure has gained two or three pounds within one day (an indication of fluid buildup that suggests circulation problems), nurses ensure that he or she contacts a doctor immediately for evaluation.

Physicians can refer patients to the home monitoring component of the program at any time, and they determine for each patient the specific readings and/or physiological changes that trigger notification for follow-up care. Of the 1,900 Medicare Advantage members participating in the program, 125 use electronic monitoring devices.

RESULTS. Since the program's inception in 2001:

- The quality of life among Medicare Advantage members (measured by the Minnesota Living with Heart Failure Quality of Life Survey, with lower scores indicating higher functioning levels) improved from a combined score of 16.4 on physical and emotional quality-of-life measures in 2001 to a combined score of 13.7 in 2004.

As part of its Practice Excellence[SM] program, ***Independent Health Association*** is using online data to improve care for nearly 20,000 Medicare Advantage members. Since 2003, the health plan has offered payment incentives to encourage physicians to submit data from patient records indicating whether patients have received recommended tests and procedures to improve diabetes care and reduce the risk of cardiovascular disease.

Staff in participating physicians' offices fill out online forms indicating whether patients have received screening tests, procedures, and medications that are recognized as indicators of effective, high-quality care for the targeted conditions. Physician incentive payments can total 10 to 15 percent of a physician's Independent Health revenue throughout their participation in the program.

Based on the data submitted, 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. Each participating physician receives a two-page report summarizing results, along with strategies for increasing the proportion of his or her patients who receive recommended services for the three conditions.

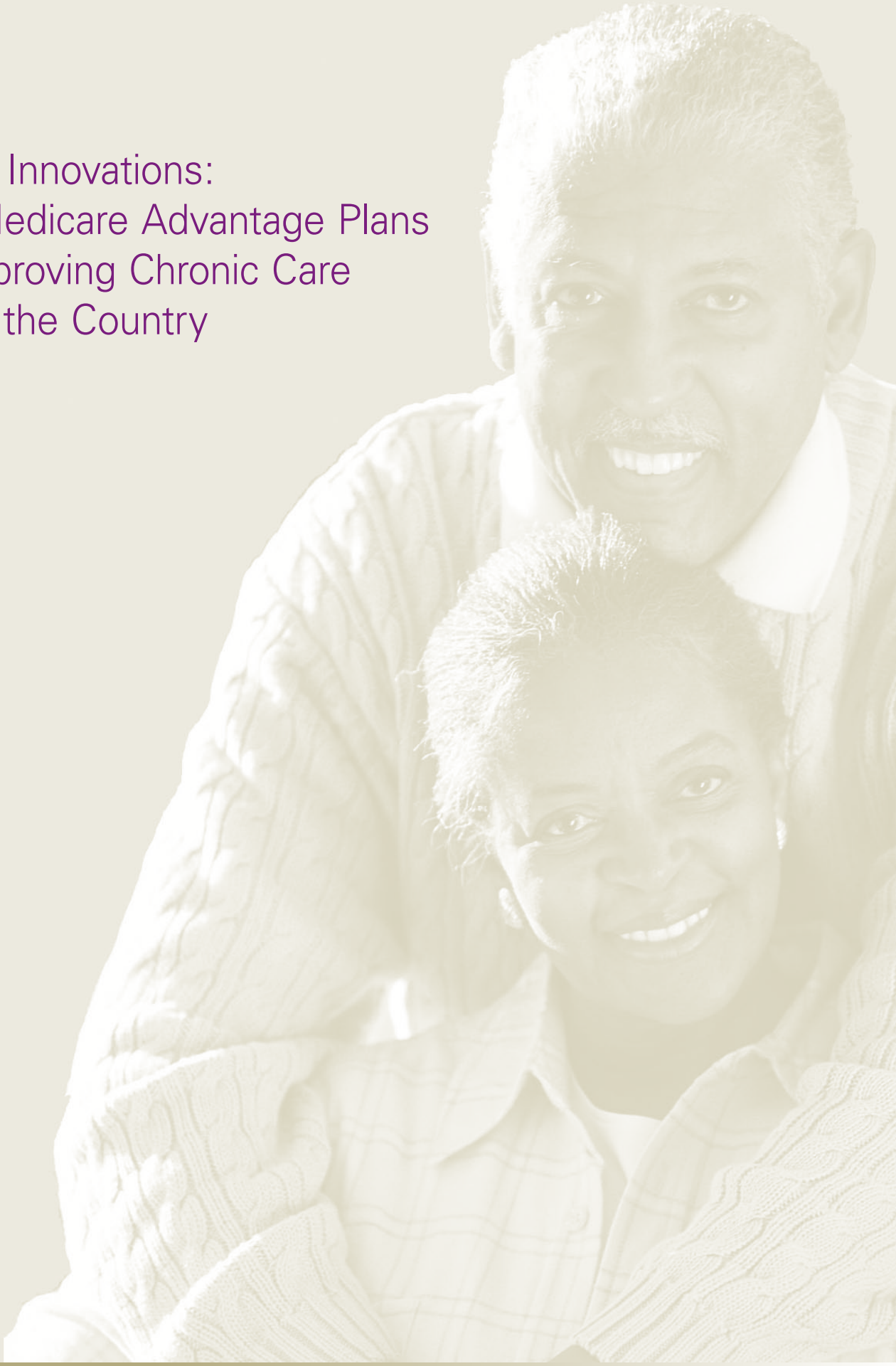
In December 2006, Independent Health launched a new program designed to reward physicians for improving the health status of its most severely ill Medicare Advantage patients with diabetes. Physicians receive incentive payments based on the level of diabetes complications (e.g., kidney disease, peripheral vascular disease, and/or retinopathy) among their patients (with higher incentive payments for physicians whose patients are more seriously ill) and on the extent to which these patients have HbA1c, cholesterol, and blood pressure readings within nationally recommended ranges. As of September 2007, approximately 630 physicians were participating in the program, which aims to improve care for 7,600 Medicare Advantage members with diabetes.

RESULTS. Since Independent Health added cardiovascular care to its Practice Excellence program in 2005, the health status of Medicare Advantage members has improved as follows:

- The percent of Medicare Advantage members with blood pressure readings at recommended levels has increased from 63 to 72.
- The proportion of Medicare Advantage members whose cholesterol levels are consistent with national guidelines has increased from 39 percent to 59 percent.

PART TWO

Recent Innovations: How Medicare Advantage Plans Are Improving Chronic Care Across the Country



Taking a Multi-Dimensional Approach to Diabetes Care

To address the high prevalence of diabetes, its potential complications, and the high cost of treatment, Aetna uses a broad range of strategies in its Integrated Comprehensive Diabetes program. Approximately 19,000 Medicare Advantage members receive the program's materials and services.

Information Tools, Access to Experts, and Reminders

All members with diabetes receive biannual newsletters and periodic mailings with information on multiple health conditions, including diabetes, asthma, health 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 provide a 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.

Health Coaching

Members at high risk of complications receive phone calls from nurse case managers trained as health coaches. Approximately 3,100 Medicare Advantage members with diabetes participate in health coaching. During initial calls, nurses 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 members with depression receive needed care.

Case managers contact members on a quarterly basis or more often if necessary to promote appropriate diabetes care. During these calls, nurses address individual needs that arise. For example, if a member's blood sugar level remains above recommended levels, the case manager may call him or her once a week to address underlying reasons and pursue strategies, such as changes in diet or exercise, to improve health. Nurse case managers can arrange for transportation to doctor visits and link members to sources of financial assistance as needed to help ensure that they receive recommended care. Members can contact their case managers at any time via a toll-free number.

Materials in Spanish

Because diabetes is especially prevalent in the Latino population, Aetna distributed diabetes member 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 that contained information on recommended diet, exercise, and preventive care for people with diabetes, along with a video called *Diabetes: A Guide for Hispanic Americans*. The video featured prominent Latino spokespeople explaining the services that people with diabetes could expect to receive during doctor visits and strategies for healthy eating.

Based on physician feedback about the usefulness of materials in Spanish for patients with diabetes, Aetna partnered with the American Diabetes Association in 2006 to distribute CD-ROMs in English and Spanish to all of its participating primary care physicians providing diabetes care. The CDs include patient tools such as a blood glucose log, recommended strategies for counting carbohydrates, and a diary for tracking diet and exercise. Physicians can print out and use materials on the CD as they see fit, for example by reviewing them with patients during visits and/or giving them to patients to take home.

Results

From 2004 to 2006:

- The percent of Medicare Advantage members with diabetes who had HbA1c tests increased from 86.6 to 89.
- The proportion of Medicare Advantage members with diabetes whose cholesterol levels were below 100 mg/dL (defined as being "in good control") increased from 48.6 percent to 52.4 percent.

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Providing Compassionate Care at the End of Life

Based on research showing that individuals with terminal illnesses often do not have enough information about treatment options, support services, palliative care, or pain relief, Aetna implemented the Compassionate Care initiative in 2004 as part of its Geriatric Case Management Program for Medicare Advantage members. The program has served more than 1,000 Medicare Advantage members since 2005. In addition, Aetna worked with several large national employers to implement a modified version of the program on a pilot basis to individuals with employer-sponsored coverage.

Developing Individual Care Plans

Based on claims analysis, review of ongoing care, and referrals from health care practitioners, Aetna's nurse case managers make phone calls to members with terminal illnesses and offer them the opportunity to participate in Compassionate Care.

Once members decide to participate in the program, case managers evaluate their needs and work with members, caregivers, and physicians to develop care plans based on individual needs. These may include palliative care, pain relief, emotional support services, and hospice care. Members and their caregivers determine how often and for how long they would like to be in contact with nurse case managers. Most contacts are by phone, but some consultations can occur at home or in long-term care facilities as needed.

Coordinating a Wide Range of Services

Nurses provide a wide variety of services to meet members' needs. These include: coordinating medical and social services; facilitating referrals to specialists and approvals for coverage; offering information about treatment options and helping members make informed decisions about care; helping individuals understand their medications, manage pain, and cope with side effects; arranging for lodging in the vicinity of treatment sites; arranging delivery of durable medical equipment; helping members work with nutritionists to avoid weight loss; and setting up hospice care. Members and their families can contact nurses by phone on a 24/7 basis with questions or requests for help.

Inspiring Thank-You Letters and Phone Calls

Since the program's implementation, Aetna has received many letters and phone calls from Medicare Advantage members and their families expressing high levels of satisfaction with the program and a great appreciation for the services it provides. Comments have included the following:

"How can we thank you for all you have done? We love you."

"You make the unbearable a little more bearable. God bless...you, you are credits to your profession."

"Thank you for all your help arranging hospice, and I'm sure for a lot of the behind-the-scenes work. Mom was well cared for, and everyone was great to her and my sisters and me. I appreciate your follow-up phone call and your genuine care and concern."

Results

From 2005 through the first quarter of 2007:

- Nearly 4,000 individuals completed the program.
- Approximately 77 percent of terminally ill Medicare Advantage members enrolled in the program chose to participate in hospice. In contrast, an estimated 20 to 30 percent of Medicare fee-for-service beneficiaries who died during the same time period participated in hospice.
- From 2005 through the first quarter of 2007, fewer than 10 percent of terminally ill Medicare Advantage members participating in the program died in hospitals. Surveys of the general population and of the seriously ill show that people overwhelmingly prefer to die at home.[3] A systematic review of international literature found that preference for home death ranged from 59 percent to 81 percent in the general population and from 49 percent to 90 percent among cancer patients.[4]

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[3] Dunlop, R.J., et al., 1989, cited in Gruneir, A., et al. (2007).

[4] Higgenson & Sen-Gupta, 2000, cited in Gruneir, A., et al. (2007).

Helping Members with Special Needs Achieve a Better Quality of Life

Recognizing that many low-income elderly members with chronic diseases have difficulty accessing medical, social, and financial services, AMERIGROUP Community Care added two new programs to its offerings for Medicare and Medicaid dual-eligible members of its Special Needs Plan (SNP) in 2006. The programs—Geriatric Care Management Rounds and Enhanced Care Initiatives (ECI)—together serve nearly 1,600 of AMERIGROUP's 5,000 dually-eligible SNP members in Houston, TX.

Benefits to Meet Special Needs

Low-income elderly beneficiaries often face multiple challenges, including: high rates of chronic illness; lack of transportation; unsafe home environments that create risks for falls; social isolation and lack of family support; and financial problems that make it difficult to pay for housing, heat, and air conditioning. Without professional help, many of these members "fall through the cracks," suffer repeated medical emergencies, and experience rapid declines in health.

AMERIGROUP's SNP programs are designed to provide the extra help and guidance that low-income, chronically ill members need to stay healthy. Because of the plan's status as a SNP for dual-eligible beneficiaries and as a contractor with the Texas Medicaid STAR+PLUS program, AMERIGROUP was able to combine comprehensive Medicare coverage (including coverage for services such as transportation to doctor visits and medical assessments) with STAR+PLUS Medicaid benefits such as social activities at adult-day health centers, personal attendant services to promote independent living, home modification, and pest-control services.

Intensive Case Management

Geriatric Care Management Rounds and Enhanced Care Initiatives both provide comprehensive case management. As part of both programs, nurses and/or social workers conduct full assessments of medical and social service needs; coordinate medical, specialty, and behavioral health care; and communicate with members' families and physicians to promote optimal care. In addition, depending on each member's needs, case managers also may help members obtain subsidies for housing, utilities, and prescriptions and ensure that they have emergency response devices in their homes.

To identify members who would benefit from the programs, AMERIGROUP conducts ongoing claims analysis. Dual-eligible members who have experienced falls or who have any of five health conditions—heart failure, diabetes that is not being treated effectively, hypertension, sickle cell disease, or coronary artery disease with a history of heart attack—receive calls from nurse case managers, who offer them the opportunity to participate in the Geriatric Care Management Rounds program.

Beneficiaries with more complex needs (defined as members with multiple health conditions addressed in Geriatric Care Management Rounds who have been hospitalized frequently and use medical equipment and prescription drugs extensively) are eligible to enroll in Enhanced Care Initiatives. ECI provides a more intensive level of case management to address a full range of medical, social service, and behavioral health care needs.

Geriatric Care Management Rounds

Beneficiaries in the Geriatric Care Management Rounds program receive regular phone calls from nurses, who check on their health status, ensure that they are taking medications as recommended, follow up with physicians to address medication-related or care issues, and help them access transportation and other community resources. Calls may be weekly, biweekly, or monthly, depending on members' needs. If beneficiaries in the program are hospitalized and/or disabled, nurse case managers conduct home assessments to determine their needs for personal attendant services, home health care, home modifications to promote safety, as well as physical, occupational, and/or speech therapy.

Once a week, AMERIGROUP nurses and social workers meet with a health plan pharmacist and the medical director to consult about members' care plans that they believe warrant extra attention. For example, if a member is not responding to his or her medications or is experiencing side effects, the medical director and pharmacist may suggest medication changes. In addition, the medical director may contact the member's physician to discuss care strategies.

AMERIGROUP closely monitors the health status of members in Geriatric Care Management Rounds and may enroll them in Enhanced Care Initiatives if their conditions become more complex.

Enhanced Care Initiatives

Beneficiaries enrolled in Enhanced Care Initiatives receive regular in-person visits as needed from case managers, who may be nurses or nurse practitioners. Many ECI members are socially isolated and/or homebound, and a significant number have behavioral health conditions. During these visits, case managers provide information to members about their health conditions and medications, and they discuss symptoms and complications that need to be addressed. Case managers also can help members access medical equipment, Meals on Wheels, and other community resources. They accompany members to doctor visits as needed.

Besides receiving guidance from case managers, ECI participants are encouraged to attend adult activity centers that offer exercise classes; primary and preventive care; and health education classes on topics such as nutrition, medications, and prevention of falls. Activity centers also hold a variety of social events and celebrations for members.

As in the Geriatric Care Rounds program, nurses and social workers serving beneficiaries in the ECI program meet weekly with AMERIGROUP's physicians, nurses, and pharmacists to discuss medical and social service challenges, as well as strategies to promote optimal care.

Results

From the time that the two programs were implemented in the third quarter of 2006 to the same period in 2007, the following changes were reported among AMERIGROUP's SNP members in Houston:

- The number of hospital days per thousand members declined by 11 percent.
- The number of emergency room visits per thousand members fell by 23 percent.
- Primary care visits per thousand members increased by 8 percent.
- The number of hospital admissions per thousand for behavioral health conditions decreased by 30 percent.
- Outpatient visits per thousand for behavioral health conditions increased by 54 percent.

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MASSACHUSETTS

Making New Connections with Heart Failure Patients

To improve the quality of life and prevent unnecessary hospital readmissions among members with heart failure, Blue Cross Blue Shield of Massachusetts (BCBSMA) implemented the Blue Care Connection for Heart Failure program for more than 1,900 Medicare Advantage HMO and PPO members in 2001. Every month, BCBSMA analyzes claims to identify members with heart failure diagnoses and enrolls them automatically in the program. Members have the opportunity to opt out at any time.

Upon enrolling a new member in the program, BCBSMA sends him or her a work book with information on a variety of issues related to heart failure, including recommended medications, diet and exercise to improve health, symptoms that warrant immediate medication attention, as well as strategies to address depression and stress.

Keeping in Touch to Offer Support and Advice

Nurses make initial calls to all program enrollees and ask a series of questions to assess their health status and needs. Based on responses to these questions, nurses make follow-up calls at appropriate intervals. For example, members with heart failure who are following diet and exercise programs, understand their medications, have had no hospital admissions, and have weight and blood pressure readings at recommended levels receive calls on a quarterly basis to determine whether they have questions, whether issues have arisen that warrant medical attention, or whether they need any type of assistance.

By contrast, members who have had several hospital admissions, are not sure they understand their medications, and are not following the diet recommended for individuals with heart failure, could receive calls on a daily or weekly basis until their conditions are stabilized. During these calls, nurses help members set and achieve goals—such as following diet and exercise plans and taking recommended medications—and they help coordinate all of the medical, behavioral, and social services that members need. These services include, for example, Meals on Wheels, transportation assistance, and financial assistance to pay for medications. Nurses also can help members prepare lists of questions to ask during doctor visits.

Home Monitoring for Real-Time Response to Symptoms

Depending on their health status, self-management skills, and physician recommendations, members who are receiving frequent calls from nurses also may have access to home monitoring devices that include electronic scales and tools to take blood pressure and pulse readings. Members take readings with these devices every day, and results are transmitted in real time to nurses, who analyze the results to identify potential problems. For example, if a member has gained two or three pounds within one day (an indication of fluid buildup that suggests circulation problems), nurses ensure that he or she contacts a doctor immediately for evaluation. Physicians can refer patients to the home monitoring component of the program as they see fit, and they determine for each patient the specific readings and/or physiological changes that trigger notification for follow-up care. Of the 1,900 Medicare Advantage members participating in the program, 125 use electronic monitoring devices.

Coordinating with Physicians

Nurses keep physicians updated regularly on the program's activities and on the health status of their patients who are participating. Nurses also meet periodically with physician groups that have large volumes of patients enrolled in the program and in BCBSMA's other chronic care initiatives. Nurses provide physicians with materials—such as condition-specific flow sheets to track patients' use of recommended services and office posters on the importance of regular blood pressure and cholesterol tests—to support evidence-based care.

Results

Since the program's inception in 2001:

- Approximately 95 percent of Medicare Advantage members participating in the program say they are "highly satisfied."
- The proportion of Medicare Advantage members taking medications recommended for heart failure (angiotensin converting enzyme inhibitors or angiotensin receptor blockers) increased from 83 percent in 2001 to 95 percent in 2005.
- The quality of life among Medicare Advantage members (measured by the Minnesota Living with Heart Failure Quality of Life Survey, with lower scores indicating higher functioning levels) improved from a combined score of 16.4 on physical and emotional quality-of-life measures in 2001 to a combined score of 13.7 in 2004.

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Expanding the Horizons of Chronic Care

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. HAP subsequently expanded the program to address all cardiovascular disease, as well as asthma, chronic obstructive pulmonary disease (COPD), depression, bipolar disorder, diabetes, hypertension, obesity, chronic kidney disease, low back pain, and osteoporosis. Medicare Advantage members comprise approximately 12 percent of the more than 100,000 people with asthma, coronary artery disease, congestive heart failure, COPD, depression, and diabetes enrolled in the program.

Sending Educational Materials and Reminders

All members with the specified conditions receive newsletters, reminders to have recommended tests and procedures, and other condition-specific information. In 2007, HAP enhanced the program to provide automatic phone reminders to members with diabetes who have not had indicated services and screenings (i.e., cholesterol tests, HbA1c tests, and dilated retinal exams) at recommended intervals.

Pursuing Goals and Action Plans to Improve Health

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 managed effectively receive phone calls from nurse case managers, who offer them the opportunity to participate in regular phone consultations to improve their health. Approximately 3,000 Medicare Advantage members participate in case management. Nurses contact program participants on a regular 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 (e.g., nutritionists, behavioral health professionals and pharmacists) and community resources (e.g., transportation services, Meals on Wheels) as needed.

Nurse case managers are notified automatically whenever a member is hospitalized due to a chronic condition so that they can follow up with the member immediately after discharge.

Adding Behavioral Health Experts to Chronic Care Teams

Recognizing that people with chronic conditions often suffer from depression and other behavioral health conditions, HAP enhanced the program in 2007 to add social workers and psychologists to the team of professionals providing regular case management services to members. This change was intended to broaden the range of behavioral health disease management services available to members beyond those related to depression. As part of this initiative, all members participating in nurse case management receive phone calls from behavioral health case managers, who assess for symptoms of depression. Individuals whose responses indicate a likelihood of depression, anxiety, or substance abuse are linked with behavioral health care providers.

Behavioral case managers can help facilitate behavioral health appointments and arrange for transportation to behavioral health visits. They follow up with members periodically by phone to determine whether they are keeping scheduled behavioral health appointments, taking medications as prescribed, and/or are experiencing side effects. The behavioral case managers can help members work with their physicians to resolve issues associated with side effects and modify medication regimens as needed.

Helping Members with Bipolar Disorder

Also in 2007, HAP added a program for individuals discharged from hospitals with bipolar disorder. Upon discharge, each of these members receives a letter from HAP with information about the program, and subsequently a behavioral case manager contacts him or her to offer the opportunity to participate. These case managers, who are social workers and psychologists, can help members make appointments for therapy and support them in following behavioral health treatment plans.

Subsequently, each program participant has four scheduled phone consultations with a behavioral case manager over a two-month period. These calls, which typically are about 45 minutes long, focus on mood management; signs and symptoms of bipolar disorder; and relations with family, friends, and employers. Each participant also receives a chart for tracking moods every day on a continuum from depressed to manic. HAP encourages members to speak with their therapists if moods are close to one end of the continuum. Members can also contact their behavioral case managers at any time during business hours or designated evening hours to ask questions or seek help.

continued ▸

Expanding the Horizons of Chronic Care (continued)

Inspiring Overwhelmingly Positive Feedback

Medicare Advantage members have had an overwhelmingly positive response to HealthTrack. They have shared comments such as:

> "If it wasn't for HAP, I wouldn't be alive today. I call [my nurse case manager] my angel. If it wasn't for her, I couldn't afford my medications. [The nurse case manager] gave me the courage to live in the future and put the bad behind me. She always makes me feel better when I talk to her. I think HAP is wonderful and I wouldn't change it for anything."

> "My case manager…was very helpful and informative regarding my cardiopulmonary disease. This is an excellent program! HAP's HealthTrack has helped me to monitor my vitals—heart/pulse/breathing—and learn more about my condition."

> "I had a million questions. [My nurse case manager] answered them in a way that the doctors couldn't. My doctors had tried for 20 years to convince me to stop eating salt, but it never worked. Although I had never met [my case manager], she somehow got me to stop eating salt and take better care of myself in no time. I don't know how she did it. I owe it all to her."

> "Without case management, I might be dead. If not, I would be alive but still thinking I was invincible. I no longer smoke, I take fewer medications, and I've lost weight. I check my blood sugar every day and intend to keep the weight off."

Results

Among members with heart failure who participated in case management from 2005 to 2006:

- The proportion of individuals with LDL-cholesterol levels below 100 mg/dL increased from 62 percent to 67 percent.
- The rate of using ACE inhibitors rose from 69 percent to 74 percent.

Among members with diabetes who participated in case management from 2005 to 2006:

- Use of cholesterol-lowering drugs increased from 35.4 percent to 68.3 percent.

Medicare Advantage members represented over 30 percent of all people participating in HealthTrack's case management initiative in 2007. Among Medicare Advantage members in case management from 2005 to 2006:

- The number of hospital discharges per thousand for individuals with heart failure fell by 19 percent.
- The number of hospital discharges per thousand for people with diabetes declined by 21 percent.

Among Medicare Advantage members working with case managers in 2007:

- Ninety-two percent said they were "satisfied" or "very satisfied with their nurse case managers.
- Eighty-eight percent said they would recommend the case management program to friends or family.
- Seventy-nine percent rated the program as "good" to "very good" for helping them improve their health.

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Closing the Gaps in Evidence-Based Medicine

To increase the use of effective services on an ongoing basis for members with diabetes, depression, asthma, chronic kidney disease, and cardiovascular conditions, 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.

As of September 2007, approximately 50,000 of HealthNow's Medicare Advantage members had one or more of the chronic conditions targeted through the program. Individuals with these conditions are enrolled in the program automatically unless they opt out. Medicare Advantage members comprise 59 percent of program enrollees with coronary artery disease, 18.5 percent of the program's members with diabetes, and 3.7 percent of the program's members with asthma.

Keeping Members Up-to-Date on Recommended Services

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 have not had, 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.

Health Coaching for Information and Access

In addition to receiving Gap Reports, program enrollees 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. A total of 1,600 Medicare Advantage members have received health coaching since the program's inception.

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, and/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.

During their conversations, case managers ask questions to identify symptoms of depression, and they refer members to their primary care physicians or to behavioral health specialists for follow-up. In subsequent phone calls, nurses encourage members to make and keep appointments for diagnosis and treatment of behavioral health conditions.

Promoting Use of Effective Medications

Also as part of the program, HealthNow reviews use of effective medications for individuals with asthma and/or depression. If individuals have not refilled prescriptions for treatment of either of these two conditions within 10 days of the refill due date, the health plan sends their prescribing physicians letters that discuss the benefits of continued treatment with these medications.

Entering a New Era of Web-Based Communication

Since January 2008, HealthNow has been offering all members a new program called Personal Care Advance, which provides customized Web pages with information tailored specifically to individuals' conditions and preferences. Based on analysis of claims data, HealthNow may include, for example, information on preventive care recommended for people with diabetes, strategies to address seasonal allergies, and/or reminders to have a flu shot. If a member says during a conversation with a health coach that he or she is trying to lose weight, HealthNow will send suggestions on diet and exercise to the member's personalized Web page.

Members who indicate on health risk assessments that they are having difficulty quitting smoking will receive tips on smoking cessation and links to community resources. Customized Web pages also include a "symptom-finder" with links to nationally recognized reference materials that help members identify next steps for seeking care. In addition, if members grant HealthNow permission to view their online personal health records (PHRs), the health plan may send information to their customized Web pages based on data entered into PHRs. HealthNow regularly updates each member's Web page with new, customized content. HealthNow plans to evaluate the program's impact on at least an annual basis.

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Closing the Gaps in Evidence-Based Medicine (continued)

Results

After receiving Gap Reports in September 2006 indicating a lack of recommended treatments and/or procedures for diabetes care, Medicare Advantage members' use of preventive care for diabetes increased by the following rates within a four-month period:

- 12 percent for HbA1c tests;
- 14.5 percent for dilated retinal exams; and
- 27 percent for LDL cholesterol tests.

Also from September 2006 to January 2007, after HealthNow mailed Gap Reports that highlighted missing preventive care services, mammography screening rates grew by 14 percent, and use of flu shots rose by nearly 40 percent among Medicare Advantage members.

Ninety-six percent of members who received health coaching in 2006 said they were highly satisfied with the information provided, found it to be helpful, and used it in conversations with their physicians.

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Pursuing Many Paths to Excellence in Chronic Care

To increase use of recommended care for individuals with chronic conditions, Health Plan of Nevada/Sierra Health & Life (HPN/SHL) and its physician group subsidiary, Southwest Medical Associates (SMA), developed the Health Management Program for individuals with congestive heart failure, diabetes, and pediatric asthma in 2002.

The initiative was expanded to include individuals with chronic obstructive pulmonary disease in 2005. In late 2006, Medicare Advantage members enrolled in SHL's health plans were added to the program. In 2007, more than 13,000 Medicare Advantage members participated in the Health Management Program; these members comprise about 50 percent of the program's total enrollment.

Promoting Education and Quality Care

All members with the targeted conditions are considered program participants unless they opt out. The participation rate has remained at nearly 100 percent since the program's inception.

Based on its tracking of service use in an electronic registry, HPN/SHL divides members into low-, moderate-, and high-risk groups based on their use of inpatient care, emergency room visits, 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/SHL's health education classes, as well as phone numbers for nurses who can answer their health-related questions. All members in all risk groups receive annual postcard reminders for flu shots, as well as disease-specific preventive care (e.g., eye exam reminders for members with diabetes).

Offering Guidance and Resources

Unless they opt out of the program, individuals at moderate and high risk of complications and hospitalization are eligible to receive periodic phone calls from registered nurses trained as health coaches. From January to October 2007, RN Health Coaches made more than 9,000 calls to HPN/SHL members. Approximately 80 percent of these calls (7,200) were with Medicare Advantage members.

Based on information in HPN/SHL's registry, health coaches encourage members to schedule appointments for recommended care, and they provide guidance on taking prescribed medications appropriately. Health coaches also may refer members to case management staff. Case managers help members manage complex health and social service needs, and they assess members' eligibility for public programs such as Medicaid and state pharmacy assistance programs. Nurses screen members for depression and can link them with behavioral health specialists.

Overcoming Language Barriers

In 2006, HPN/SHL began offering language translation services for all members eligible to receive health coaching. Members whose primary language is not English can opt to consult with health coaches in any of more than 100 languages. The most frequently requested languages are Spanish and Tagalog. RN Health Coaches made more than 370 calls in languages other than English from January to October 2007.

Providing Home Visits and Monitoring

Members with congestive heart failure who have specified health needs, such as difficulty following treatment plans and taking medications correctly, as well as those who have been hospitalized frequently, are assessed for participation in a home health program offered by HPN's affiliate, Family Healthcare Services (FHS). Members participating in the program receive regular home visits from nurses, who check for safety risks (e.g., loose rugs or stairs) and help arrange modifications as needed. Nurses also set up and use home monitoring systems to check patients' weight, vital signs, and other key health measures. Based on these readings, nurses follow up with individuals' physicians to discuss changes in health status and/or medications.

Offering Information Support to Physicians

Based on data from its registry, HPN/SHL sends primary care physicians 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. The reports compare individual physicians' performance in providing effective services to that of all other primary care physicians within the Southwest Medical Associates network and throughout the HPN/SHL network. Physicians are encouraged to follow up with patients who have not had treatments or procedures recommended for their conditions.

Results

From 2005 to 2006:

- The proportion of HPN's Medicare Advantage members with diabetes who had LDL cholesterol at recommended levels (i.e., below 100 mg/dL) increased from 55.2 percent to 58.4 percent.
- The rate of kidney disease screening for Medicare Advantage members with diabetes rose from 68.9 percent to 73.5 percent.

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Helping Seniors Get Fit in "Silver Sneakers"

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. As of November 2007, more than 180,300 Medicare Advantage members were enrolled in SilverSneakers in 43 states and Puerto Rico.

Complimentary Access to Fully Equipped Fitness Centers

SilverSneakers members have complimentary access to participating fitness 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. 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.

An Optional Self-Directed Walking Program

Individuals who do not live near partnering fitness centers can participate in SilverSneakers® Steps, a self-directed, pedometer-based physical activity program. 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.

Special Events and Celebrations

SilverSneakers participants 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.

Results

Nationwide surveys of program participants found that from 2006 to 2007:

- The percentage of respondents who reported their health as "much better" or "somewhat better" than it was the previous year increased from 39 to 41.
- The proportion of respondents who said they were exercising three or more times per week increased from 67 percent to 84 percent.
- The percentage of respondents who said they were lifting weights or doing strength training two or more days per week increased from 54 to 95.

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Independence Blue Cross, Health Dialog, and AccordantCare™

Pennsylvania, Massachusetts, and North Carolina

Keeping Members Connected with Quality Care

A Suite of Programs to Address Chronic Conditions

In response to the rising prevalence of chronic conditions and increased medical cost trends, Independence Blue Cross (IBC) collaborated with Health Dialog to launch the Connections℠ Health Management Program for members with asthma, diabetes, chronic obstructive pulmonary disease (COPD), chronic heart failure, and/or coronary artery disease in 2003. Since 2004, IBC has also provided a program to support members with end-stage renal disease (ESRD). 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 this program to include Crohn's disease.

Significant Medicare Advantage Enrollment

In 2006, more than 84,000 Medicare Advantage members with one or more of the five common chronic conditions were eligible to participate in the Connections Health Management Program. Independence identified more than 5,400 Medicare Advantage members for the Connections AccordantCare Program and over 600 for the ESRD program. Members eligible for any of the three programs are considered to be program participants unless they opt out. Opt-out rates range from three percent for the Connections Health Management Program to 15 percent for the ESRD Program.

Connections Health Management

For the Connections Health Management program, IBC analyzes individuals' hospital admissions, emergency room use, medication histories, and use of recommended care to determine their risk levels, and the health plan provides outreach suited to individual needs. 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, cholesterol tests).

Depending on their conditions, program enrollees at high risk of complications or hospitalization receive phone calls from Health Coaches who are registered nurses, dietitians, or respiratory therapists. Since the program's inception in 2003 through 2006, more than 47,000 Medicare Advantage members have consulted with Health Coaches. During their conversations with members, coaches assess members' needs, ask about lifestyle issues affecting their health, and determine whether they are using effective treatments and preventive care (e.g., controller medication for asthma, pneumonia shots).

Health Coaches' interactions with members are tailored to meet individuals' needs. Through a whole-person coaching approach, they support individuals' efforts to meet their health care goals. Coaches focus on closing any identified care gaps to help ensure that members receive all of the treatments and procedures recommended for their conditions, and they may suggest referrals to behavioral health practitioners, case management services, smoking cessation or other available health plan programs. On average, Health Coaches contact program participants at high health risk five to seven times per year, with variations according to member preferences and needs.

Connections AccordantCare

Based on monthly analysis of claims data, IBC identifies members with complex chronic conditions who could benefit from Connections AccordantCare. Nurse disease managers contact these members by phone to assess their medical needs. Unless they opt out of the program, individuals then have a series of follow-up calls on at least a quarterly basis with their nurses to review medications; receive help with following physicians' treatment plans; and learn how to avoid potential complications and safety risks. 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.

ESRD Program

Each month, IBC uses claims data to identify all members with end-stage renal disease (ESRD) who are receiving dialysis. Program enrollment staff contact members to engage them in the program, and subsequently nurses conduct clinical assessments and provide support and education to program participants. Nurses work closely with members' dialysis care teams to provide care and support for all needs related to ESRD and other health conditions.

Members can remain in the Connections programs for as long as they wish throughout their enrollment in IBC.

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Keeping Members Connected with Quality Care (continued)

Results

- In 2006, 87 percent of members in the Connections Health Management Program said they were "satisfied" or "very satisfied" with the program.
- From September 2005 to August 2006, annual growth in health care costs among all of IBC's Medicare Advantage members was reduced by 4 to 4.5 percent overall.
- Ninety-seven percent of members surveyed about the Connections AccordantCare program in 2007 said they were satisfied with the services provided by the program, and 92 percent of respondents said they were willing to recommend the program to others with similar conditions.
- In the 2007 survey, members were asked to rate their knowledge about their health conditions before and after their participation in the Connections AccordantCare Program. Sixty-seven percent of the members surveyed said their knowledge was "excellent" or "good" prior to joining the program, and 92 percent surveyed said their knowledge was "excellent" or "good" after joining the program.
- Ninety percent of members surveyed about their participation in the ESRD program in 2006 said they were satisfied with the assistance they received from nurses. The average overall rating for program nurses was 8.8 on a scale of 1 to 10 (with 10 being the highest).
- From July 2005 to June 2006, the ESRD program reduced annual growth in health care costs among Medicare Advantage members with ESRD by 6.1 percent. Use of inpatient care among Medicare Advantage members enrolled in the program was 17 percent below IBC's projections, and emergency room use among Medicare Advantage members participating in the initiative was 10 percent below projections.

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Using Data and Incentives to Drive Improvements

To help prevent potentially 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 and adult diabetes, and it was expanded in 2005 to include cardiovascular disease. Since its inception, the program has worked to promote improvements in chronic care for nearly 20,000 Medicare Advantage members.

Pay for Participation

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.

Office staff in participating physicians' offices fill out online forms indicating whether their patients have received screening tests, procedures, and medications that are recognized as indicators of effective, high-quality care for the three conditions. Physician offices return the data to Independent Health, which provides incentive payments that can total 10 to 15 percent of a physician's Independent Health revenue throughout their participation in the program.

Information Tools to Promote Excellence

Based on the data submitted, 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.

Incentives to Improve Health Status

In December 2006, Independent Health launched a new program designed to reward physicians for improving the health status of its most severely ill Medicare Advantage patients with diabetes. Physicians receive incentive payments based on the level of diabetes complications (e.g., kidney disease, peripheral vascular disease, and/or retinopathy) among their patients (with higher incentive payments for physicians whose patients are more seriously ill) and on the extent to which these patients have HbA1c, cholesterol, and blood pressure readings within nationally recommended ranges. As of September 2007, approximately 630 physicians were participating in the program, which aims to improve care for 7,600 Medicare Advantage members with diabetes.

Office Redesign for More Effective Care

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.

Results

Diabetes Care Improvement

Since the program's inception in 2003, the following improvements have occurred among Medicare Advantage members with diabetes:

- Rates of annual HbA1c and cholesterol testing have increased from 65 percent to 84 percent.
- Eighty-one percent have had annual foot examinations, compared with 44 percent in 2003.
- The rate of kidney function testing increased from 45 percent to 69 percent.
- The proportion of Medicare Advantage members with diabetes whose cholesterol readings are at recommended levels (less than 100 mg/dL) has increased from 30 percent to 48 percent.
- The percent of Medicare Advantage members with diabetes whose HbA1c levels are consistent with national recommendations (i.e., at less than 7) has increased from 31 to 41.

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Independent Health Association
New York

Using Data and Incentives to Drive Improvements (continued)

- The proportion of Medicare Advantage members with diabetes whose blood pressure readings are within nationally recommended ranges (i.e., below 130 mm/Hg) increased from 21 percent to 36 percent.

Cardiovascular Disease Prevention

Since the program's inception in 2005, the health status of Medicare Advantage members has improved as follows:

- The percent of Medicare Advantage members with blood pressure readings at recommended levels has increased from 63 to 72.
- The proportion of Medicare Advantage members whose cholesterol levels are consistent with national guidelines has increased from 39 percent to 59 percent.

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Taking a Team Approach to End-of-Life Care

In response to survey findings indicating that people overwhelmingly prefer to die at home, Kaiser Permanente implemented an in-home palliative care initiative from 2002 to 2004. The project was implemented as a randomized controlled trial for approximately 300 members with terminal illnesses in Colorado and Hawaii. The program included, though was not limited to, Medicare Advantage members; the mean age of participants was 74.

As part of the program, an interdisciplinary palliative care team—consisting of a nurse, social worker, and physician—assessed patients' physical, medical, psychological, social, and spiritual needs. The core team was expanded to include pharmacists, chaplains or spiritual counselors, dietitians, home health aides, occupational and speech therapists, and bereavement counselors as needed. Based on the wishes of patients and their families, palliative care teams developed care plans that focused on enhancing patients' comfort, managing pain and symptoms, and improving quality of life.

Round-the-Clock Access to Doctors and Nurses

Physicians conducted home visits and were available, along with nurses, on a 24-hour, on-call basis. The program also provided advance care planning so that patients and their families could make informed decisions about care goals and end-of-life care. All program participants received palliative care until death or transfer to hospice programs.

Patients in the control group received "usual care," which included home health and acute-care services, primary care, and hospice care according to their needs, based on Medicare home health care guidelines.

Enhancements to the Hospice Model

The project differed from hospice care in the following ways:

- Whereas individuals generally must have a prognosis of six months to live in order to participate in hospice programs, there was no such requirement in the Kaiser program.
- While individuals in hospice programs must agree to discontinue curative treatments in order to receive hospice care, individuals in Kaiser's program could choose to continue to receive such treatments.
- As part of the Kaiser program, palliative care physicians worked with patients' primary care physicians to coordinate care across treatment settings. Patients could maintain their primary care physicians while also receiving home visits from palliative care physicians.

Results

During the study period, from 2002 to 2004, the following statistically significant results were reported:

- Thirty days after enrolling in the program, 93 percent of participants in the palliative care group said they were very satisfied, compared with 80 percent of members receiving usual care. Ninety days after enrolling in the program, 93 percent of participants in the palliative care group said they were very satisfied, compared with 81 percent in the usual-care group.
- Twenty percent of members in the group receiving palliative care used the emergency room, compared with 33 percent of members in the group receiving usual care.
- Thirty-six percent of members receiving palliative care were hospitalized, compared with 59 percent of members of the usual-care group.
- Overall, health care costs for members in the palliative care group were 33 percent less than for those in the control group. The average health care cost per day for members in the palliative care group ($95.30) was significantly lower than that for members in the group receiving usual care ($212.80).
- Among study participants who died, 71 percent of deaths in the palliative care group occurred at home, compared with 51 percent in the usual-care group. After controlling for age, survival time, and medical conditions, participants receiving palliative care were 2.2 times as likely to die at home as those receiving usual care.

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Guiding Members on the Road to Independence

Upon finding that patients discharged from hospitals and nursing homes often had difficulty making the transition to living at home, Kaiser Permanente's Colorado region established the Chronic Care Coordination program in 2004. In 2006, Kaiser expanded the program to include all members who had used the emergency room three times or more within a three-month period.

An estimated 75 to 85 percent of the 4,700 members participating in the program each year are Medicare Advantage members. Approximately 55 percent of program participants have multiple chronic conditions (e.g., diabetes and hypertension), and 45 percent have experienced acute episodes of illness such as pneumonia and dehydration.

Quick Follow-up after Discharge

As part of the program, Kaiser's nurse care coordinators make phone calls to members following discharge from a hospital, emergency room, or nursing home to assess their health status and needs. During these calls, nurses conduct complete reviews of patients' health status and physical symptoms, such as pain and breathing difficulties. They also ask members questions such as whether they have food in the house and whether they can walk, drive, read medication labels, and perform activities of daily living (i.e., bathing, dressing, and eating).

Help with Goals

Based on members' responses, care coordinators help them set care goals to improve their health status and quality of life. These goals could include, for example, taking medications correctly and ordering refills as needed; following recommended exercise plans; increasing caloric intake; and monitoring glucose levels regularly. Once they have helped members set goals, care coordinators speak with members by phone on a regular basis to help them achieve these goals.

Links to Help

Nurses also link members with services that they need, which could include home care, Meals on Wheels, transportation, financial assistance, and Alzheimer's support groups. If it appears that members may qualify for public programs such as Medicaid, care coordinators link them with state agency staff who can help them fill out applications.

If members have been diagnosed with behavioral health conditions, care coordinators help them access Kaiser's behavioral health services.

Care Reminders and Communication with Physicians

As part of the program, nurses remind members to have recommended preventive care, such as mammography, Pap tests, and prostate cancer screening, as well as flu and pneumococcal vaccines. Care coordinators communicate regularly with members' physicians, to keep them updated on changes in health status, needs for adjustments to care plans, and other member needs.

A Flexible Time Line for Enrollment

Many patients with multiple chronic illnesses "graduate" from the program after a few months, once they have improved their ability to monitor their conditions and use effective care on an ongoing basis. Members with more debilitating conditions often remain in the program for two to three years, until they move to nursing homes or assisted living facilities.

Patients' needs following acute-care episodes vary widely. In some cases, care coordinators determine after a single consultation that members do not need further assistance. In other situations, they may work with members for two to three months to ensure that they are obtaining follow-up primary care and taking recommended medications.

Results

- A program evaluation that examined use of health services among members discharged from skilled nursing facilities in 2006 found that:
  - More than 90 percent of program participants said they were highly satisfied with the program's coordination of services and with the continuity of their care.
  - Approximately 2 percent of members in the Care Coordination program were admitted to the hospital during the year, compared to 14 percent of members not participating in the program.
  - The rate of emergency room use was 7 percent among program participants, compared to 16 percent for members not participating in the program.
- The program has saved an estimated $3 million annually from 2004 to 2006.
- From January through December 2006, the emergency room component of the program saved approximately $1 million.

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Reinventing Diabetes 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, multidimensional 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. Approximately 14,000 members participate in the program, 23 percent of whom are Medicare beneficiaries.

Giving Doctors Tools to Promote Recommended Services

All of PHS's Medicare Advantage members are patients of Presbyterian's physician group affiliate, Presbyterian Medical Group (PMG). PMG tracks information on members' use of diabetes-related health services 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.

Using a Team of Experts

Medicare Advantage members' primary care physicians coordinate care with multidisciplinary teams that work onsite at Presbyterian Medical Group. These teams include certified diabetes educators, pharmacy clinicians, nurse care managers, behavioral health counselors, and a lay community health worker called a *promotora*.

The *promotora*, who Presbyterian refers to as "the eyes of the physician, the ears of the nurse, and the heart of the clinic," works in a low-income, underserved community in the health plan's service area. The *promotora* speaks the same language, lives in the same neighborhood, shops in the same stores, attends the same church, and is concerned about the same issues as community residents. Her role is to visit patients' homes, provide information about recommended diet, exercise, and diabetes-related preventive care; call to ask about missed doctor's appointments and lab tests; and help them access needed health and social services.

The *promotora* also can act as an interpreter during visits to health or social service practitioners. The *promotora* talks with patients outside of the medical context, and she takes time to listen to their concerns. By maintaining ongoing, personal contact with members, the *promotora* builds strong bonds of trust that help motivate patients to follow treatment plans. In addition, the *promotora* is able to identify subtle changes in patients' health status and report them to other members of patients' care teams for prompt follow-up.

Nurse care managers coordinate with the *promotora*, track members' use of recommended diabetes-related services, and likewise refer beneficiaries to other team members as needed. For example, nurses may refer members to behavioral health counselors for treatment of depression or to pharmacists for more information about medications.

Health Coaching to Overcome Barriers to Care

Based on information from DocSite and from PHS's ongoing analysis of claims data, nurse care coordinators make phone calls to members 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.

Providing Extensive Help to Meet Multiple Needs

Individuals with multiple chronic conditions and/or those facing major barriers to effective care (e.g., members with no family support and those with cognitive impairments) receive intensive care management services. Depending on need, nurse case managers may conduct in-home assessments to identify safety risks (e.g., unsafe stairways) and arrange for modifications to promote healthy living environments. Case managers also may accompany members to doctor visits to help them communicate effectively and ensure that they understand treatment recommendations.

Recognizing and Rewarding Quality Care

As part of its plan-wide pay-for-performance initiative, PHS provides annual, lump-sum incentive payments to physicians based on nationally recognized indicators of quality care. These measures include 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 2006.

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Reinventing Diabetes Care (continued)

Using Hospital and Emergency Visits as Opportunities for Improvement

To help prevent 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. Care teams send test results to members' primary care physicians. PHS is expanding the initiative to other hospitals in its network.

Results

- From 2002 to 2007, the proportion of Medicare beneficiaries with HbA1c readings above recommended levels or with no HbA1c test in the past year (defined as the "poor control rate") dropped from 36.5 percent to 12.2 percent.
- In 2006, the number of hospital admissions per thousand among members receiving the PMG's team-based approach to diabetes care was 26 percent below that of members who did not receive care in sites using the team-based approach.

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Using a Three-Part Strategy for Improvement

In response to the high incidence of chronic disease among members, Regence implemented a disease management initiative for individuals with congestive heart failure, chronic obstructive pulmonary disease, asthma, diabetes, coronary artery disease, anxiety, and/or depression in April 2007. Medicare Advantage members represent 22 percent of the approximately 70,000 members enrolled in the program. Individuals with the targeted conditions are enrolled automatically unless they opt out (the program's opt-out rate is about 2 percent). Physicians can refer patients to the program, and members can self-refer.

Providing Information Support

Regence regularly analyzes claims to identify members with the targeted conditions, and it divides members into low-, medium-, and high-risk groups based on their use of recommended health services. Members are placed in the low-risk group if they are receiving effective care according to the medical evidence (e.g., members with diabetes are having regular HbA1c tests, individuals with coronary artery disease are having cholesterol tests, and members with depression are taking antidepressant medications as recommended). Regence sends these members newsletters about their conditions and offers them access to disease managers (who are nurses, social workers, and other behavioral health professionals) whom they can contact via a toll-free number during business hours to ask questions or request help.

Offering Health Coaching and Care Coordination

Regence places members in the "medium-risk" group if they are missing tests or procedures recommended for their conditions. Disease managers send these members reminder letters and encourage them to obtain recommended services. In addition, members in the medium-risk group can request assistance from disease managers. For example, if members have not filled prescriptions because they do not drive, disease management staff can link them with pharmacies that deliver. Members are paired with disease managers who have expertise in their primary diagnosis (e.g., a certified diabetes educator or a behavioral health practitioner), and disease managers coordinate care to ensure that members receive the full range of services needed to address all of their health conditions.

Addressing Unmet Needs

Members are in the high-risk group if they are using the emergency room and/or are being admitted to the hospital for their conditions. In some cases, these members have missed multiple tests and procedures that are recommended for their care. Nurse disease managers contact these members by phone, typically once a month, but with intervals varying based on members' needs. Nurses keep in touch with members for as long as necessary to help them access care that will improve their health status. Calls with Medicare Advantage members often last for a half-hour or more. During these conversations, if disease managers determine that members have other unmet needs (e.g., difficulty in affording medications, lack of transportation, poor nutrition), they link members with community organizations that can provide help. Members can contact the program's nurses at any time during business hours, regardless of whether they are enrolled in this component of the initiative.

Individuals can remain in Regence's disease management program for as long as they wish. An analysis of the program's results is expected by Summer 2008.

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Helping Patients with Diabetes Pursue a Path to Better Health

After successfully implementing a disease management program for Medicaid members with diabetes in 2004, UCare established a similar program for Medicare Advantage members in 2005. In 2006, approximately 3,500 Medicare Advantage members with diabetes were enrolled in the program, representing 53 percent of the program's total participation. Individuals dually eligible for Medicare and Medicaid comprise 13 percent of the program's enrollment.

The health plan analyzes claims on a regular basis to identify all members with diabetes, and it categorizes them as "low-risk" or "at-risk" based on their use of recommended care. A member is considered "low-risk" if he or she has had two HbA1c tests, a cholesterol test, a retinal eye exam, screening for kidney disease, and two visits to a primary care physician or endocrinologist for diabetes care within the past year. Members are placed in the "at-risk" group if they are missing one or more of these tests or visits.

Information Support and Rewards

UCare sends members of the "low-risk" group educational brochures and newsletters about diabetes and recommended care, as well as a phone card with 100 free minutes. In addition, members in both the "low-risk" and "at-risk" groups can access UCare's toll-free Diabetes Message Line at any time to ask non-urgent diabetes-related questions. UCare nurses return calls to the Message Line within one business day.

Customized Reports and Gift Cards

Besides receiving educational materials, members in the "at-risk" group receive customized Diabetes Care Reports on an annual basis that list all of the lab tests and visits recommended for diabetes care; the date of their most recent visit or screening; and a check box with the designation "needed" or "done" to indicate whether they have had the lab test or visit as recommended in the past year. UCare also provides vouchers for members to take to doctor visits along with the customized reports. Members are encouraged to discuss the reports with their doctors and have doctors sign the vouchers upon members' completion of all of the recommended services for diabetes care. Each member who mails a signed voucher to UCare receives a $10 gift card for Target.

Communication with Primary Care Clinics

When a UCare member is hospitalized or visits the emergency room (ER) for diabetes-related care, UCare sends a report to the member's primary care clinic about the visit or admission, along with a list of the medications he or she has taken for diabetes and other health conditions in the past two months. The reports include a note encouraging the clinic to follow up with members to ensure that they receive effective diabetes care.

Health Coaching and Case Management

As of April 2008, UCare nurses specializing in complex care follow up immediately with all members who have ER visits or inpatient admissions for diabetes care. Nurses contact these members by phone, typically once, but they can schedule additional calls as needed. During their conversations, nurses ask about factors that contributed to the medical emergency and whether members are facing barriers to treatment. They encourage members to follow up with their primary care physicians as soon as possible. In addition, nurses provide members with information about the condition and about effective diabetes care. They help "at-risk" members access diabetes-related preventive care services, and they coach them on diet, exercise, and medication issues to help them maintain blood sugar levels within recommended ranges. Nurses also help members with complex needs (e.g., those with multiple chronic conditions) connect with UCare's case management nurses or social workers.

Results

Overall, the following results have been attributed to the program's activities:

- Thirty-one percent of members with diabetes in the "at-risk" group in 2006 moved to the "low-risk"category in 2007.
- The rate of inpatient admissions among members with diabetes fell from 2.8 percent in 2004 to 1.1 percent in 2006.
- The percent of members with diabetes who had emergency room visits for the condition declined from 2.8 in 2004 to 1.7 in 2006.

Among members in the "at-risk" group who responded to a satisfaction survey in 2006:

- Eighty-seven percent said that the program's Diabetes Care Reports were helpful to them.
- Eighty-one percent said that since receiving the reports, they were more aware of their diabetes care.
- Eighty-nine percent said they were satisfied with the program's educational mailings.

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OVATIONS
A UnitedHealth Group Company

Breaking New Ground in Community and Long-Term Care

A Flexible Program for Beneficiaries with Special Needs

To improve the quality of care and health outcomes for individuals with special needs, the Evercare division of Ovations (a UnitedHealth Group company) offers programs with a strong focus on care coordination for individuals in nursing homes and those with chronic diseases living independently in their communities. These programs are available to Medicare beneficiaries through Evercare's Special Needs Plans (SNPs), which include SNPs for institutionalized individuals, SNPs for dually eligible Medicare and Medicaid beneficiaries, and SNPs for people with severe or disabling chronic conditions.

Through its SNPs, Evercare is able to focus its clinical expertise and benefit design on caring for members with specific medical and social service needs. More than 154,000 Medicare beneficiaries in 34 states and the District of Columbia currently are enrolled in Evercare's SNPs. Using nationally recognized guidelines for evidence-based care, Evercare is able to combine primary, acute, and long-term care services into a single system of care designed to close gaps in treatment of chronic and other conditions while slowing the progression of illness and disability.

Coordinating Care in Nursing Homes

As of January 2008, more than 29,000 Medicare beneficiaries in nursing homes were enrolled in Evercare's institutional SNP. 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

Evercare's programs for institutionalized members include meetings with nurse practitioners, who conduct physical exams; take comprehensive medical histories; and assess cognitive functioning levels, limitations in activities of daily living, and nutritional needs. Nurse practitioners also review medications to identify duplicative prescriptions and the potential for adverse interactions. Based on the information gathered through this process, nurse practitioners work with members' physicians to develop plans of care for all conditions identified.

Regular Visits with Nurse Practitioners

Following their initial assessment visits, nurse practitioners schedule appointments with institutionalized beneficiaries as needed to identify changes in health status; review the effectiveness of their initial Evercare treatment plans; assess 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- and moderate-income beneficiaries with chronic diseases live independently in their communities for as long as possible, Evercare covers a range of health and social services for chronically ill members through its Dual-Eligible SNPs and Chronic Care SNPs. As of January 1, 2008, these plans served a combined total of 125,000 members.

Customized Care Plan

As part of this initiative, Evercare conducts initial health assessments to review members' medical histories and assess their functioning levels and needs. For individuals with complex needs, nurses or social workers trained as care managers conduct additional assessments and develop care plans to address medical, behavioral health, and social service issues. 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.

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Breaking New Ground in Community and Long-Term Care (continued)

Home Visits
Depending on members' health status, care managers may conduct in-person evaluations 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 care managers at any time to ask questions or obtain help with medical, behavioral health, or social service issues.

Partnering with Community Groups
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 develop programs tailored to individuals with special needs. In addition, Evercare's care managers assess members' eligibility for a variety of programs and can help them access Medicaid benefits, home heating assistance, prescription drug subsidies, and/or other types of assistance.

Evercare expects to report results of initial quality evaluations by the National Committee for Quality Assurance (NCQA) in late 2008.

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Teaming Up to Improve Kidney Disease Care

Recognizing that patients with end-stage renal disease (ESRD) often have complex needs that can be met most effectively by a team of clinicians specializing in ESRD care, WellPoint established an ESRD management program in 2001. The health plan initially offered the program in parts of New York, Connecticut, and Kentucky, and it plans to expand the initiative nationwide in 2008. In 2007, Medicare Advantage members comprised approximately 60 percent of the program's 140 participants. As of January 2008, 87 Medicare Advantage members with ESRD were enrolled.

Coordinating a Full Range of Services

WellPoint seeks to identify patients for the program as soon as they are referred for dialysis. The health plan analyzes claims regularly and takes referrals from hospital discharge planners and physicians. Nurse care managers contact new dialysis patients by phone to assess their needs. Subsequently they work to set up a full range of medical, social, and behavioral services to meet these needs. For example, they may arrange for home health services, physical therapy, or occupational therapy; help members find dialysis centers convenient to their homes; help ensure that patients are making and keeping follow-up appointments with primary care physicians and nephrologists; and help patients locate transportation as needed. Care managers ask questions to screen for depression, and they help members connect with primary care physicians, social workers, psychologists, and/or psychiatrists to obtain treatment.

Communicating with Physicians

Care managers communicate regularly with members' physicians about their health status, and in conversations with members, they seek to reinforce physicians' care plans. For example, they help patients choose healthy foods, understand their medications and take them correctly, and identify signs and symptoms of chemical imbalances (e.g., high potassium or calcium levels) that require prompt medical attention.

Promoting Effective Preventive Care

Nurse care managers also remind patients to have regular preventive care, such as flu and pneumonia shots, as well as procedures recommended for their conditions (e.g., eye and foot exams for members with diabetes). Because patients with ESRD often have anemia, care managers ensure that they have regular blood tests, and they provide information and support to members on taking anemia medications as needed.

Providing Long-Term Support as Needed

Depending on individuals' health conditions and living arrangements, nurse care managers may perform home safety visits. For example, they may recommend removal of throw rugs or installation of grab bars to help prevent falls. Care managers keep in touch with ESRD patients on an ongoing basis throughout their treatment. Members admitted to nursing homes can continue to work with care managers, who also can help with advance treatment planning and end-of-life care. Care managers provide information and support to family members throughout the treatment process. People usually are enrolled in the ESRD management program for several years.

Results

Among Medicare Advantage members enrolled in the ESRD management program, from 2003 to 2006:

- Total number of hospital days per thousand fell by 26 percent, from 12,738 to 9,426.
- The number of emergency visits per thousand dropped by 7 percent, from 454 to 422.
- Total hospital admissions increased by 5 percent, from 1,605 to 1,688. WellPoint attributes this increase to early identification of ESRD complications. The reduction in hospital lengths of stay that occurred during the same time frame suggests that patients were treated promptly and effectively and thus avoided infections and further complications.

From 2005 to 2007:

- The rate of participation in advance care planning (e.g., deciding on treatments to receive if hospitalized and arranging for end-of-life care) among all patients enrolled in the program increased from 3 percent to 91 percent.
- The percent of ESRD patients with diabetes enrolled in the program who had dilated retinal exams increased from 68 to 91.

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Making Special Needs the Top Priority

Based on positive results of programs that XLHealth had implemented as a provider of disease management services, the company established Care Improvement Plus, a Special Needs Plan (SNP) for Medicare beneficiaries with chronic conditions (heart failure, diabetes, end-stage renal disease (ESRD), and/or chronic obstructive pulmonary disease) in 2006. As of February 2008, approximately 70,000 Medicare beneficiaries were enrolled.

Because of its status as a Medicare Advantage Special Needs Plan—in which all members have chronic conditions—Care Improvement Plus offers a benefits package tailored to the unique needs of Medicare beneficiaries with chronic conditions, and it has made disease management a primary focus.

Diabetes Care

Care Improvement Plus provides customized support programs based on members' health conditions. For example, for members with diabetes, the health plan does not require copayments for podiatry visits, and it provides plan options that include full coverage, with no copayments, for many commonly prescribed diabetes medications, including coverage through the Medicare Part D coverage gap. The health plan also covers transportation to doctor visits, as well as "diabetic shoes" for beneficiaries who have reduced sensation in their lower extremities.

Identifying Patients at High Risk of Complications

Upon enrollment in the health plan, members receive "welcome" phone calls from nurses, who administer health risk assessment surveys by phone to determine their health status. Nurses ask beneficiaries with diabetes if they had foot problems—such as ulcers, blisters, or wounds—and whether they ever have had an amputation. Members who answer "yes" to any of these questions are considered to be at high risk for additional diabetes complications. Care Improvement Plus also conducts regular claims analysis to identify members with diabetes who are experiencing foot problems.

Providing Foot Check-Ups and Coordinating with Physicians

Members with diabetes who are at high risk of complications receive a variety of personalized services. For example, when a member is at high risk of developing foot ulcers and/or amputation, nurses help schedule visits with primary care physicians, podiatrists, and/or vascular specialists. Nurses also conduct in-person evaluations for these members, either at one of the health plan's evaluation centers or in members' homes, depending on individual needs. As part of the evaluation process, nurses conduct physical examinations, take medical histories, and test sensations in members' feet to identify blockages and other circulatory problems.

Based on findings from these exams, Care Improvement Plus sends each beneficiary a customized "Ask Your Doctor" letter with suggestions for issues to discuss with primary care physicians. At the same time, the health plan sends the member's PCP a letter describing the member's conditions and referencing nationally recommended standards of care.

Providing New Tools and Health Coaching

Beneficiaries with diabetes who have reduced sensation in their feet receive devices they can use every day to check for foot infections. The device shines red on each area of the foot where it detects potential infection to alert members to follow up immediately with their podiatrists.

Beneficiaries with diabetes who are at high risk of complications also receive regular phone calls (at least monthly and more often as needed) from nurses who specialize in diabetes care. Nurses provide information and reminders about regular testing of their blood sugar levels, blood pressure, and cholesterol levels. They help members access care from endocrinologists; send diabetes-related information based on members' needs and requests; and screen members for depression. Beneficiaries showing signs of depression are linked with the health plan's social workers, who can help them access the behavioral health services they need. Care Improvement Plus's nurses also can help members to access transportation and/or apply for Medicaid and financial assistance as needed.

Providing Education to Members at Low Risk of Complications

When the health plan's health risk assessment analysis identifies a beneficiary with diabetes as having a low risk of complications, it sends the member a free glucometer and personal care kit with brochures, flyers and other educational materials about diabetes. Based on claims data, these members also receive customized information about their other health conditions, as well as personalized "Ask Your Doctor" worksheets to bring to physician visits. Care Improvement Plus monitors claims on an ongoing basis. If a member in the "low-risk" category begins to experience additional health problems, a nurse contacts him or her and offers the opportunity to enroll in the high-risk component of the program.

Results

Care Improvement Plus will report initial program results in 2009.

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