



# **Health Plan Achievement Awards**

**2003 & 2004**



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## New York HPA Health Plan Achievement Awards

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With their focus on prevention and intervention, health plans have been at the forefront of initiatives to identify ways to improve patient care and generally enhance the overall health and well being of their members and communities. Recognizing that New York's health plans are engaged in a wide array of innovative programs, the New York Health Plan Association Council created the Health Plan Achievement Awards to publicly acknowledge plans' outstanding efforts and spread the word about these programs.

There are two categories for the annual Health Plan Achievement Awards:

- ★ Health Plan Patient Care Improvement Initiative — Awarded for a program developed by a health plan to initiate improved patient care within its membership.
- ★ Health Plan Community Leadership — Awarded for excellence demonstrated by a health plan in addressing community needs.

All submissions were reviewed by a panel of independent judges who considered the following criteria:

- ★ Leadership — Demonstrated by identifying a need and developing a plan to implement change that will result in improvement. Efforts could include forging partnerships with businesses, government, and other community groups in the implementation of program strategies.
- ★ Commitment — Program commitment is illustrated by a plan demonstrating a substantial depth of understanding of the needs to be met by the project and, where applicable, the community the plan serves. Reviewers were asked to evaluate the duration of the program and any continuing efforts.
- ★ Impact — As demonstrated through statistics measuring improvements in the area being addressed, or in the case of longer-term intractable issues, by the number of people served or participating as evidenced by positive feedback from the constituency being served or by the indications of improved quality of life.
- ★ Innovation — A demonstration that the plan has been creative in its approach to solving an area of need or providing a service to the community. The plan has also been creative in forging partnerships as well as gaining support from the population identified for assistance.
- ★ Replication — The program can serve as a model for the development of other similar programs throughout the state and/or country.
- ★ Acceptance — The program has achieved a high level of community acceptance. This can be documented through letters or other evidence of community participation in support of the program.

The program was created in 2003 and repeated in 2004. In total, 12 plans submitted 34 programs for consideration.

## **2003 Award Winners**

Top honors in the patient care improvement category went to GHI (Group Health Incorporated) for its Positive Actions Towards Health — or P.A.T.H. — program that targets patient-level interventions with the goal of detecting and reducing gaps between evidence-based clinical care and actual care provided to patients. Hudson Health Plan's Prenatal Care Initiative, which successfully standardized the data collection process and resulted in more accurate and complete reporting of prenatal care, received first place in the community leadership category.

Because of the high caliber of the programs and the close scoring by the judges also recognized programs in each category to receive honorable mentions. For patient care, HIP Health Plan of New York was recognized for its Geriatric Case Management Program that seeks to improve or maintain functional status of Medicare+Choice members, facilitate the delivery of health care services and enhance quality of life for these members. Oxford Health Plan's Asian Initiative, which after identifying an underserved Chinese population, created a special program in the heart of Chinatown to provide appropriate health information and health care services, and ultimately improved care delivered to this population, was cited for community leadership.

## **2004 Award Winners**

The patient care improvement award went to MVP Health Care in 2004 for its Back Care Program, developed to provide members suffering from chronic low back pain individualized disease management interventions as well as population targeted educational information. Aetna received first place in the community leadership category for its Racial & Ethnic Disparities initiative, which uses data collection to foster better understanding of disparities among racial and ethnic groups, to target education, outreach and quality improvement efforts, and to support community-based initiatives.

In the second year of the program, Hudson Health Plan's Facilitated Enrollment Electronic Application and CarePlus' Healthy Beginnings educational initiative received honorable mention awards for community leadership. For patient care improvement, Independent Health's Medicaid Mammography Outreach effort and Preferred Care's Medicine Bag Review program were given honorable mentions.

The following pages offer a summary of all the programs submitted in both 2003 and 2004.

**Patient Care Improvement Initiatives**

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### *Migraine Intervention Program*

Migraine headaches affect 28 million people nationwide. They account for \$1 billion in direct medical costs and an additional \$13 billion in lost productivity.

Faced with the task of helping health plan members reduce high emergency room and pharmacy utilization rates, Aetna set out to determine if it could improve clinical management and decrease utilization of unnecessary and possibly discretionary services among high-utilizing migraine patients through a simple educational intervention. The program was developed in collaboration with GlaxoSmithKline, and was designed to decrease utilization of unnecessary services and increased use of appropriate medication.

Participants for the migraine intervention program were identified through Aetna's extensive database that integrates medical and pharmacy claims data. Using a combination of predictive modeling and risk stratification processes, Aetna was able to identify 7,432 members most at risk for incurring migraine-related events.

Working with GlaxoSmithKline, which provided its trademarked MIGRAINE MATRIX® materials as well as clinical input, Aetna medical directors customized a suite of informational tools for members and physicians, and implemented a focused education intervention program. Aetna mailed the targeted members a MIGRAINE MATRIX® toolkit consisting of informational booklets, headache diaries and action plans, as well as tip sheets on migraine medication, avoiding the emergency room and controlling rebound headaches.

The results over a six-month period were rewarding, showing a decrease in emergency room, outpatient and inpatient care, as well as an increase in compliance with appropriate medication. Emergency room cases related to migraine decreased by 23 percent. Outpatient cases related to migraine decreased 25 percent. Inpatient utilization related to migraine decreased 18 percent. Overall members filled fewer prescriptions, and the prescriptions filled for appropriate migraine medication increased by 13 percent. The end consequence was improved quality of care for members with migraine headaches and reduced expense for employers.

Aetna's approach was innovative in the way it mobilized information to identify a specific sub-set of members who suffered the most, used the most services and were most likely to benefit from educational intervention. This ability to intervene only where it mattered most and would have the most impact, was a hallmark of the program's success. Based on these initial results, Aetna has now expanded the program and instituted it nationwide.

### ***Provider Incentive Program***

Physician partners have the greatest impact on medical utilization and quality of care delivered to patients in the United States healthcare system. Since the inception of managed care health plans, a variety of financial mechanisms have been created and deployed in an attempt to modify physician behavior. The intent of these mechanisms is to align the behavior and performance of physician partners with the published standards of quality care and reduce inefficient use of services in the health care system. There continues to be a need to create new methods to provide incentives to providers in private practice and facility environments that reward performance and motivates providers to modify practice patterns. These practice patterns occur in two dominant locations; ambulatory visits to practitioner offices and facility based procedures, typically hospitals.

BlueCross BlueShield of Western New York and BlueShield of Northeastern New York are utilizing the Provider Incentive Program to provide financial incentives and rewards for provider performance. The program, designed to target key performance measures and supply financial incentives, was deployed in the two health plans in January 2002, with the hospital incentives added in January 2003.

The Provider Incentive Program was modeled on another innovative program, the Care Management Incentive Program, which was first initiated in 1997 for primary care physicians. The revised program included specialty care physicians and hospitals, and established specific quantified goals for clinical and satisfaction measures. Physician clinical performance measures are those found in the Health plan and Employer Data Information Set — HEDIS — and include; cervical cancer screening, breast cancer screening, diabetic eye examination, HbA<sub>1c</sub> testing, childhood immunizations and well child visits. Hospital performance measures are unique to each facility but include activities such as appropriate medications upon discharge, infection and mortality rates, eliminating low volume procedures and planning for computerized physician order entry.

Approximately three quarters of the clinical measures have shown improvement and reached statistical significance across the last 4-year period data. Cervical cancer screening improved 9.1 points over 5 years. Breast cancer screening performance displayed a 2.1 point positive trend in the 5-year period. The performance measure for HbA<sub>1c</sub> in the diabetes population improved 2.8 points 2002 compared to 2001. The 6 component childhood immunization measure improved 36.3 points over the 5-year period while the well child visit rate for members under 18 in the three age brackets improved 12.8 points, 8.1 points and 13.7 points respectively over the 5-year period.

Hospital facilities have also demonstrated dramatic improvement in a majority of clinical improvement areas. The support and visibility of the provider incentive program has allowed hospital staff to dedicate resources and improve health outcomes for our health plan members.

## Capital District Physicians' Health Plan (CDPHP)

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### *Peak Asthma Performance*

Asthma, a chronic condition affecting the lungs and airways, affects approximately 20 million Americans. While asthma cannot be cured, for most patients it can be controlled. An effective asthma health management program has the potential to improve quality of life and decrease medical services for those suffering with the disease. The Capital District Physicians' Health Plan (CDPHP) developed its comprehensive asthma management program, Peak Asthma Performance, with the goal to decrease asthma morbidity, as measured by adherence to National Institute of Health asthma guidelines, and decrease utilization of asthma-related health care services. CDPHP partnered with participating practitioners to increase member and practitioner knowledge regarding appropriate use of anti-inflammatory medications and the program also provides patient education tools aimed at empowering members with asthma to take an active role in the control of their disease.

Member education is available at multiple levels of intensity. An annual mailing gives an overview of the most important aspects of asthma self-management. It also, encourages members to assess personal readiness to change and make important self-management decisions. Member newsletters include articles on asthma, treatment options, and schedules of educational classes. All members with a claim history of asthma receive additional mailings, including a semi-annual newsletter that emphasizes avoidance of triggers, the benefits to development of an action plan with practitioner input, and the importance of medication compliance.

Members who frequently fill rescue medication prescriptions without also filling those for long-term anti-inflammatory medications are targeted for additional outreach. For this population, classes are offered in person, by consultation via telephone, or in recorded format. These members also receive a packet including written information, a video, a peak flow meter and a spacer. Practitioners are notified when members receive educational services so that they can reinforce the importance of self-management during office visits.

Also through the Peak Asthma Performance program, primary care practitioners receive roster listings twice a year of their members with asthma and any dates of emergency room visits or inpatient services related to asthma. This helps practitioners identify a need for further education or for an adjustment of medication. Claims are monitored to promote rapid identification of members who require emergency or inpatient services for asthma, with identified members sent a follow up letter reminding them of educational services provided by CDPHP and, again, primary care practitioners notified so they can review those members' current action plans and make necessary adjustments.

Since 1999, Peak Asthma Performance has helped educate more than 1,600 members. Statistics gathered from 2000 to 2002 have demonstrated steady improvement in asthma management and control.

## Capital District Physicians' Health Plan (CDPHP)

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### *Pressure Wise*

Hypertension is a major disease afflicting more than 50 million people, or 1 in 4 adult Americans. Cardiovascular morbidities associated with long-standing uncontrolled hypertension are congestive heart failure, coronary artery disease, renal disease and stroke, which combine to cause half of all deaths in the United States. For patients with hypertension, educational interventions can effect improvement in the process and outcomes of care delivery.

CDPHP's Pressure Wise program seeks to improve the care of its members with hypertension through increased compliance with standardized hypertension practice guidelines to achieve increased control of the condition, thereby reducing potentially serious complications of uncontrolled blood pressure. Related goals of the program are to reduce member behaviors that may contribute to hypertension and potentially more serious cardiac disease, and to empower members to make lifestyle modifications that can directly improve their quality of life.

Pressure Wise is designed to provide various levels of intervention based on a member's individual readiness to change. Potential program members are identified via claim analysis. Target population includes all members (Commercial, Medicaid, Medicare and Family Health Plus) age 18 and over with a claims history of hypertension. These members receive annual educational mailings that include content on the importance of controlling blood pressure and on changes that an individual can implement in order to take control of their own health. Information about how to make and sustain change are also included along with a quality of life survey designed to serve as an impetus to start members thinking about their hypertension and its intangible impact on their lives. Members also receive a semi-annual newsletter focusing on important aspects of hypertension control and periodic invitations to attend hypertension management classes where they are taught to monitor their own blood pressure using a blood pressure cuff and receive information about lifestyle changes. To date more than 2,200 plan members have attended these classes. Also through the Pressure Wise program, twice a year practitioners receive rosters, listing all of their members with hypertension and their dates of visits. Members are also stratified by disease severity, and high-risk members with target organ disease are identified.

A study of the program done in 2003 shows percentage of members with hypertension who had blood pressure recorded at every office visit in the reporting year increased from 76% in 1999 to 96% in 2002. During that same period, members with hypertension who had controlled blood pressure, defined as <140/<90, increased from 44% to 58%. The increased documentation of blood pressure values and increased percentage of members who are controlled, as well as the maintenance of high self-reported quality of life further demonstrates that CDPHP's extensive member and practitioner outreach efforts have resulted in measurable improvement.

## Capital District Physicians' Health Plan (CDPHP)

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### *Smoking Cessation*

About 8.6 million people in the United States have at least one serious illness caused by smoking and approximately 440,000 people each year die of a smoking-attributable illness. In 2003, medical costs related to smoking were \$75 billion.

Faced with those numbers, CDPHP developed its Smoking Cessation program to encourage and help members attempting to quit smoking. Through this comprehensive program, the plan partners with members to provide optimal support for smoking cessation efforts.

The program includes a payment mechanism to reimburse primary care physicians and OB/GYNs who conduct smoking cessation educational visits. Members with prescription drug coverage are allowed to fill smoking cessation prescriptions without attending a smoking cessation program and prescriptions can be filled for a 24-week period once a year for up to three years. This new policy was mailed to practitioner offices, along with an "Ask Me How to Quit" button, and the policy modifications were also noted in the practitioner newsletter. In order to preserve the important link between administration of medication and provision of educational services, CDPHP identified a series of "stage of change" behavior modification booklets that could be mailed out to all members who fill prescriptions for smoking cessation medications. For the Medicaid population, information available from the state includes over the counter smoking cessation aids as well.

Follow-up surveys were sent to members to measure the effectiveness of the interventions. Based on survey responses, CDPHP reported 78 members used pharmaceutical aids only, of which 30 (38%) were successful in quitting; 10 members attended classes only, of which 6 (60%) reported having quit smoking; and 22 members attended classes and used pharmaceutical aids, of which 9 (41%) reported they were not smoking. The survey also found that practitioners had discussed risk factors associated with smoking with 94% of the participants and 47% reported that they had been offered counseling by their practitioners.

Based on these figures, the plan determined members who attended smoking cessation classes had the highest level of success in quitting, followed by members who both attended class and used prescription deterrents. Clearly, no one methodology works for all smokers, and multiple quit attempts may be needed in order to reach maintenance.

Future plans include development of a newsletter that can be used to support members who are trying to quit smoking. In order to continue to expand the availability of educational services, CDPHP plans to continue to partner with employer groups to make smoking cessation counseling available on-site to increase access and participation.

## Capital District Physicians' Health Plan (CDPHP)

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### *Weigh 2 Be*

Obesity is a growing health concern, impacting an ever-increasing segment of the American population. Overweight and obesity are associated with heart disease, type-2 diabetes, stroke, arthritis, breathing problems, certain types of cancer, and psychological disorders such as depression. According to the Surgeon General, 61% of adults in the United States were overweight or obese in 1999 and it is estimated as many as 300,000 deaths each year in the United States are associated with obesity. The economic cost of obesity in the United States was about \$117 billion in 2000.

CDPHP historically sought to address the problem of obesity and related conditions through several hundred free wellness seminars offered to members annually. These include topics on nutrition, weight loss and healthy eating. Additionally, visits to a nutritionist are covered when medically necessary.

In 2003, CDPHP launched the Weigh 2 Be program in order to offer enhanced support to members ready to take an active role in weight reduction. The program is designed to appeal to members who are ready to transition to the "action" phase as well as to support those already taking action who may be struggling with maintenance. Members enrolled in Weigh 2 Be receive targeted educational mailings that contain information on nutrition, portion size and exercise. Also included is a listing of wellness classes and a wellness discount brochure. Additional program aids include an offer for a discounted pedometer and pocket weight control organizer. All members enrolled in this program are entitled to a 50% reimbursement upon completion of a ten-week Weight Watcher's program.

To date, more than 4,600 members have enrolled in the Weigh 2 Be program and nearly 670 members have completed a 10-week session at Weight Watchers. A follow up survey conducted in 2003 found that 61% of survey respondents had lost weight, with an average weight loss of 12.35 pounds, 59% had enrolled in Weight Watchers and 53% initiated an exercise program. Those responding reported that the most useful components of the program were the Weight Watchers brochures, information on stress, walking, nutrition and portion size, and the weight control organizer. Overall, 72% reported being very or somewhat satisfied with the Weigh 2 Be program.

## Elderplan

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### *ActiveHealth Management CareEngine Service*

Elderplan is a nonprofit Social Health Maintenance Organization (HMO) that serves approximately 14,000 senior citizens in Greater Metropolitan New York City. As a social HMO, Elderplan offers a rich benefit package — including prescription drugs, home care, transportation and home-delivered meals — that exceeds those offered by Medicare and traditional Medicare HMOs. The additional benefits are designed to help the elderly live safely in their own homes and communities, and avoid or delay placement in skilled nursing facilities. The benefits are particularly attractive to patients who are chronically ill, with these patients comprising 35% of Elderplan’s membership.

To better serve its chronically ill population, Elderplan partnered with ActiveHealth Management, an information-driven care management and data analytics company, utilizing the CareEngine Service software tool to track various patient data and develop a complete patient profile. The software compares the pattern of each patient’s care, applies a comprehensive set of evidence-based clinical rules and then generates patient-specific care improvement recommendations, which are communicated to the patient’s physicians to help prevent avoidable clinical complications and hospitalizations.

While benefiting patients, the system is also beneficial to physicians because it enables them to be more proactive with their patients, assisting them to provide accurate treatments and preventive measures. Moreover, as patients with chronic illnesses tend to be cared for by multiple doctors, the CareEngine tool creates a bridge between providers as well as a connection between providers, the patient and the plan. This three-way partnership results in enhanced communications that helps ensure improved quality of care.

During the first year of use, the ActiveHealth Management CareEngine tool identified nearly 4,500 significant clinical issues for almost 2,900 Elderplan members. As a result of these findings, providers were able to intervene and ensure patients received appropriate services and treatments. This timely intervention was responsible for significant savings by avoiding hospitalizations. Analysis of the first year of the program found that savings realized as a result of the improved care delivered to patients far exceeded the costs of the software.

## Elderplan

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### *Palliative Care*

Traditional approaches to managing the conditions of the elderly with frailty and morbidity are often times ineffective. In 2002, Elderplan developed Palliative Care as an innovative approach to this issue. The initiative is a specialized care management intervention for plan members living with advanced chronic illness such as cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) or stroke. It is designed to enhance the existing care management services by integrating palliative care into members' chronic care benefits. The goal of Elderplan's palliative care service is to expand the depth of its continuum of services to more effectively meet the needs of its growing chronically ill population, in an approach that is both patient-centered and economically responsible.

The palliative care service is comprised of an interdisciplinary team consisting of one nurse and two social workers. The team works collaboratively with the members' primary care providers and specialists, vendors, community service agencies, families and caregivers, and of course, the members to develop and implement holistic palliative care plans. The service incorporates other important interdisciplinary aspects, such as psychosocial, mental health or alternative therapies/complementary medicine. The team uses specialized assessment tools, care planning documents and other materials to meet Elderplan's specific operational and performance needs.

Three separate analyses have been conducted on the impact of Palliative Care Service, using claims, utilization and assessment tool data. Elderplan reported that participants in the Palliative Care Service program were better at managing pain, gained the ability to perform more activities safely and experienced an improved quality of life.

## Fidelis Care New York

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### *Fidelis BabyCare*

It has long been documented that poor socio-economic status as well as race and ethnicity are linked with low utilization of prenatal services. Low utilization of prenatal services, in turn, results in high incidence of complications at birth.

Through community needs assessments and analysis of claims data, Fidelis Care recognized the same correlations among its own members. Fidelis responded to the need of this population by developing the BabyCare program, designed to enhance access to prenatal services and, ultimately, improve health outcomes.

Through BabyCare, which is both educational and preventive in nature, pregnant members are afforded the opportunity to participate in a coordinated health program that begins in the prenatal period and continues through the postpartum office visits. The program, which is available to all Fidelis members including those enrolled through Medicaid, Child Health Plus and Family Health Plus, is staffed by dedicated health and disease state management associates and a clinical director who work together to identify members and then manage those members' care throughout her pregnancy. In addition to improving access to medical and social services in general, BabyCare also helps to identify high-risk cases. For these cases, a case manager works with the patient and obstetrician to develop an individualized care plan that takes them through delivery and beyond.

In 2003, more than 6,000 women were enrolled in the BabyCare program and more than 13% of these women accessed prenatal services in the first trimester. Based on enrollment in the program through the first half of 2004, the total number of women reached was projected to surpass 2003. While the growth in enrollment was encouraging, more important was the fact that the percentage of those accessing prenatal care during the first trimester had risen to 16%. Another important indication of the program's impact is the fact that although the percentage of high risk pregnancies remains unchanged, there has been a significant decrease in the percentage requiring care in the neonatal intensive care unit — roughly 4% in 2003 versus 2% in the first half of 2004.

### *P.A.T.H. — Positive Actions Toward Health*

GHI, through its preferred provider organization (PPO) operations, is aware that the positive aspects of open access and flexibility of choice can also lead to disjointed care and potential lapses in communication. In addition, the increasing complexity of today's health care system can create serious gaps in the continuity of care. The Positive Actions Toward Health — or P.A.T.H. — program is designed to improve member health through a supportive collaboration with network providers and the provision of timely treatment improvement suggestions on a patient-specific basis. Objectives of the program include: correction of medical errors of omission and commission, reduction of the overall illness burden and improved health of the covered population, decreased utilization of health care services in the covered population when that utilization is medically inappropriate or avoidable by preventing a complication or the progression of disease, and improved compliance with current national clinical guidelines.

P.A.T.H detects and reduces gaps between evidence based clinical care and actual care provided to patients. The program targets patient-level intervention through two basic processes. First, the aggregation of all available clinical information compiled from different resources (lab results, medical, hospital, and pharmacy claims). Second, comparing patient level care to a digitized summary of relevant up-to-date medical knowledge.

The P.A.T.H. program utilizes the CareEngine tool, developed by ActiveHealth Management, to aggregate diverse data to create a complete patient profile. CareEngine compares the pattern of each patient's care against an extensive array of clinical algorithmic rules. When an apparent departure from optimal clinical care is detected, a Care Consideration recommendation is generated and transmitted to the P.A.T.H. clinical staff via an interactive, secure Web-based portal. Recommendations are ranked according to complexity and urgency. Cases of the highest complexity and urgency generate an immediate outbound call from a GHI medical director to the member's physician. Less severe or complex cases generate a letter or phone call from a clinician to the member's physician.

The P.A.T.H program also includes a Clinical Stratification Identification (CSID) process, which validates the presence of specific diseases, stratifies and assigns a patient-specific value/risk score based on disease severity and the presence of co-morbidities. CSID also provides an "impact ability" score that prioritizes interventions and predicts the relative likelihood of patient benefit from disease management services. P.A.T.H. clinical staff facilitate improved decision making through discussion and consultation of patient-specific errors of omission and commission in care, which are communicated directly to the treating physician. Physicians are provided with specific references to medical literature that support the recommended intervention. Telephonic communication is followed-up with a letter to the treating physician reiterating the Care Consideration recommended and clinical rationale. The letter also re-confirms the physician's ultimate decision-making authority and

encourages provider feedback. The program includes tracking to determine if the recommendation was implemented.

In addition to positive patient feedback that confirms the benefits of the program interventions, providers also report positive experience with P.A.T.H. Of the providers responding to a satisfaction survey, 100% agreed that the information they received was “useful in developing a plan of care,” and 83% responded that the P.A.T.H. program provided “long term benefits to improve the communication of health care information.”

Data supporting the P.A.T.H. program show implementation of the highest urgency recommendations has increased over time from 26% in 2001, the first year of the program, to 94.4% in 2003. The program also resulted in actual medical savings of \$2.45 per member per month (PM/PM) for 2001 and \$2.84 PM/PM for 2002.

### *Discharge to Home Initiative*

As America's population of frail elderly and chronically disabled continues to grow, so too, does the demand for health care services that meet the special needs of these populations. Generally, people wish to remain in their homes and communities as long as they possibly can. This has resulted in an increased reliance on long term home care services. Managed long term care programs, which coordinate all of the health, medical, social, and long term care needs of members through a single case manager who follows the individual across all settings and sites of care, offer a unique alternative model of care that make possible for people to remain in their communities.

Even though at least 25% of people 65 years and older will at some point in their lives require a skilled nursing facility, for many people, living in a residential facility long term is not a preferred option. While most nursing homes give good care, the loss of control and dignity of the residents, and the fact they are not with family and friends in the environment they know best, is more often than not unsatisfactory to the member. While managed long term care has been viewed for a long time as a way of enabling people to remain in their own homes, it soon became clear that these programs also offered a special opportunity to assist people in returning to their own homes following a nursing home stay.

GuildNet, a 4-year-old managed long term care program for Medicaid eligible people who are blind or visually impaired and who live in their own homes in Manhattan, Queens, Bronx or Brooklyn, developed a patient care improvement initiative to increase the success of nursing home discharges back to the community. The program works by analyzing the processes in place, re-deploying resources, and educating referral sources in order to improve patients' transition from facility to community.

Several aspects of the Discharge to Home Initiative are described below. We believe that these efforts are the leadership modeling which make this a unique effort, yet replicable, in other home based programs. Specific components of the initiative included collaboration between nursing home partners and GuildNet to achieve optimal physical and emotional status of the member at time of discharge as well as special outreach by GuildNet to other nursing homes interested in collaboration. Also contributing to the success of the program was extensive cooperation between the New York City Human Resources Administration, the nursing home provider and GuildNet to ensure as seamless a process as possible and internal GuildNet system and practice changes — including additional resource allocations — to facilitate the discharge and transition.

The results of this initiative have been very favorable to both the enrollee and to GuildNet, with nearly 80 members receiving services at home in a coordinated, cost effective manner and with their quality of life enhanced and their feelings of satisfaction high. Measurable results of the Discharge to Home Initiative include: substantially decreased hours of care given per month by personal care workers following a patient's discharge; readmissions to

the nursing home dropped dramatically as did hospitalization rates within 120 days. However, perhaps the most positive result is the continued satisfaction of the member, family, referral sources and staff members of GuildNet. The member goes home and regains some measure of control in their lives. Staff are pleased that they do not have to deal with various problems of re-hospitalization and/or readmission to the nursing home. Families are increasingly involved in responsibilities of care for their loved ones.

### *Diabetes Health Management Program*

Analysis of claims data identified that approximately 3% of HealthNow's managed care population had a diagnosis of diabetes. Moreover, many of those were non-compliant with recommended monitoring services to improve the levels of control of their disease. In response to this deficiency, HealthNow developed the Diabetes Health Management Program to improve the quality of life for members with diabetes by improving physician practice patterns and patient compliance. The Diabetes Health Management Program encourages members to take charge of their diabetes through self-care management and support of their health care team (primary care physician, endocrinologist, diabetes educator, nutritionist, pharmacist and their health plan).

The program stratifies members based on their level of risk and are provided with diabetes program materials and interventions designed to educate members about the need to properly manage diabetes and prevent long term complications. Members are encouraged to complete a quality of life survey so that their specific needs can be met, reminder mailings are sent to members who have not had the recommended testing within the past 12 months, automated voice call reminders and a one-to-one diabetes counseling program are also available. In addition, educational mailings, sponsored by Pfizer Pharmaceuticals, are provided and articles about diabetes are published in the member newsletter.

Members who have been identified from a daily inpatient census report as having a hospital admission for diabetes complications are sent a letter explaining the program and receive additional educational materials including a resource booklet that lists "Alive and Lively" education and nutrition programs available in the community, educational pamphlets, a description of diabetes program, Web site information, a meal planner, a diabetes health record pocket card, an introduction to diabetes booklet, "Chicken Soup for the Soul-Living with Diabetes" booklet, and "How to talk Diabetes with your doctor" booklet.

HealthNow also developed provider programs and interventions under the Diabetes Health Management Program. Physicians are provided with a semi-annual report to assist in managing their patients with diabetes. The mailing includes a letter and a health maintenance/educational counseling flow sheet for each diabetic member identified. Wellpoint Pharmacy provided a continuing medical education (CME) learning materials and HealthNow distributed diabetes awareness posters to the top 300 providers in each market. The plan's physician newsletter included an article describing the program to assure all participating providers are educated regarding the Diabetes Health Management Program.

More than 17,000 members have been served by the program.

### *Diabetic Foot Ulcer Management*

With the rising prevalence of diabetes and peripheral vascular disease, medical literature is filled with reports of increased rates of amputation procedures. Most primary care physicians and general surgeons lack the specialized expertise to treat wounds in the setting of peripheral vascular disease. Medical literature shows that amputation is the first of a downward spiral of medical encounters resulting in loss of functional status and a cascade of medical expenses. Interventions that prevent amputation not only save limbs, but improve quality of life of members at risk for amputation and reduce costs.

To address these issues, HIP Health Plan of New York developed the Diabetic Foot Ulcer Management program. A major goal of the program is identifying criteria defining “wound care center of excellence,” based on the collaboration of national leaders in the field. The program utilizes a case management model and the use of centers of excellence for treatment of the most severe cases. A case manager offers his/her services while the patient is cared for in the traditional delivery system. For patients accepted into the program, the nurse seeks to optimize adherence to the medical care plan, reduce barriers to care and build the trust of the patient and provider. Members with wounds exhibiting no, or slow healing, are eligible for referral to a center of excellence after a discussion with the provider.

To support these processes, a data collection form, developed by the nurse case managers in collaboration with the providers of care, is the standard reporting device for wound care. This tool provides the critical data sets necessary to evaluate the member’s progress, and is the basis of discussion with both provider and member around care plans and compliance. The collected data are effective in alerting all team members — physicians, case managers and member — when a change in care or referral is appropriate.

The Diabetic Foot Ulcer Management program has focused on difficult cases, and in many cases has been successful in completely healing long-standing wounds. Plans for expansion of this program include using claims data to identify members at-risk for foot ulcers to permit earlier identification and implementation of a preventive foot care program. HIP plans to improve data reporting through implementation of an Internet-based data transfer system capable of transferring wound information and digital photographs.

## HIP Health Plan of New York

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### *Geriatric Case Management*

Medical care of elderly residing in the community is a challenging process. This is especially true for individuals who have several co-morbidities, multiple medications, age-related changes, difficult travel requirements and psychological issues. With more than 104,000 Medicare members, HIP Health Plan of New York developed a plan for Geriatric Case Management (GCM). The program aims to improve or maintain functional status and quality of life of Medicare+Choice (now called Medicare Advantage) members residing in the community. Problems that can be successfully addressed by GCM include depression, Alzheimer's, falls, decline in functional status and polypharmacy, which refers to problems that can occur when a patient is taking more medications than are actually needed.

Each month HIP's Medical and Quality Informatics Department generates a report of Medicare members identified by a utilization-based clinical algorithm. The algorithm takes into account recent hospitalization, emergency room visits, multiple medication use and office visits, as well as diagnostic information recorded as part of these claims and encounters. The identified high-risk members receive priority attention including outreach calls and services from GCM staff. Each member is reviewed for potential inclusion in the program and the primary care provider is notified by letter when his/her member is enrolled in GCM. In addition, medical directors at designated health centers receive a monthly report of their patients currently enrolled in GCM. A nurse and social worker collaborate to identify specific needs of a given member and coordinate the communication and delivery of these services. This team remains involved in the coordination of services until a stable pattern has been attained, with essential components of interventions being care planning (community resources, entitlement programs, hospice), health education (chronic illnesses, aging issues, home safety, medications, nutrition, long term planning), advocacy and care coordination.

From inception of the GCM program in April 2001, more than 3,400 Medicare+Choice members have been enrolled. The program's impact has been evaluated twice, with the first evaluation showing GCM participants had 213 fewer claims and \$434,789 lower cost less than a control group during a 6-month follow-up. On average, GCM cases had 3.33 fewer claims and cost \$6,794 less than controls during 6 months of follow-up. The second efficacy study yielded similar results, with GCM cases an average of 15.1 fewer claims per member and average costs that were \$7,857 less than controls during the 6-month study period. GCM cases also had 49% fewer inpatient claims and shorter average lengths of stay (1.3 days less) compared to the controls. All of this provides evidence the program appears to achieve its combined goals of admission reductions, reduced lengths of stay and reductions in professional claims.

### *Healthy Living with Chronic Conditions*

Chronic diseases are the leading killers in the United States, accounting for more than 70% of all deaths in the nation and over 60% of total medical expenditures. For the past three years, HIP Health Plan of New York has encouraged its members with chronic disease to live more healthy lives through its Healthy Living with Chronic Conditions program. This initiative educates and empowers people with chronic conditions to better manage their overall health and well being. The primary goal of the program is to provide the maximum number of program participants with the necessary tools to establish and work toward goals for healthy living, thereby improving their overall wellness. Through a series of workshops, participants learn how to control pain, deal with depression, fight fatigue, manage stress, improve goal setting and develop problem-solving skills.

Workshops are modeled after the Chronic Disease Self Management Program developed by Stanford University's School of Medicine. During 2002, more than 100 people participated in thirteen self-management classes in four boroughs of New York City and Long Island. These courses were led by a team of eighteen volunteers. Additionally, the program trained leaders from five grass roots community organizations, who in turn taught this program to their constituents. Throughout the year, HIP provided free-of-charge training to 10 non-profit organizations wishing to offer this course. Program participants learn how to take small steps toward positive changes and healthier living, building their confidence and ability to manage their day-to-day living activities.

In 2003, HIP presented the initial findings of a preliminary study of the effectiveness of the Healthy Living with Chronic Conditions Workshop at the American Association of Health Professionals annual meeting in Atlanta, Georgia. In the study, based on a sampling of 47 participants from classes in 2001, participants reported that they were more able to perform activities of daily living and had higher degrees of self-efficacy.

Recognizing the impact this workshop has realizing its potential to improve the wellness of the greater community, the HIP Foundation partnered with various non-profit community organizations to offer the Healthy Living with Chronic Conditions to their constituents. Over the past year, HIP has sponsored replication of the program with more than 15 different non-profit organizations in the New York area.

## Hudson Health Plan

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### *Increasing Primary Care Services for Special Care Adults*

More than 50% of Hudson Health Plan's special care adult members are mentally/behaviorally disabled. Because the New York State Medicaid program carves-out services for mental/behavioral care and due to minimal tracking for this population, Hudson Health Plan (HHP) realized that primary care utilization was not being monitored.

Seeking to address this problem, HHP developed a program to increase the frequency of visits to primary care providers (PCP) and primary dental providers (PDP) for its members receiving Supplemental Security Income (SSI) benefits. The overall goal of the project is to increase primary care penetration for both medical and dental care for adults 18 years of age and older who receive SSI benefits and who have not had a primary care provider visit in the last year or a primary dental care visit in the last two years.

HHP's first priority was to identify 100% of current adult SSI members enrolled for three or more months in the health plan who did not access their PCP or PCD within the targeted time period. Once identified, the goal was to increase the PCP penetration rate from 68% to 80% and the PCD penetration rate from 42% to 60%. Additionally, HHP staff began building a system to track primary care visits and other interventions with members.

Research yielded 609 members in need of either PCP and/or PDP visits. These members were then mailed a postcard, printed in English and Spanish, with an "800" telephone number to call. This mailing resulted in 184 members, nearly 31% of those identified, contacting HHP. At that point of contact, the importance of PCP/PDP visits and the need to schedule in the next two months were emphasized, and a \$10 phone card incentive was described. A follow-up letter and visit verification form were then mailed.

For enrollees who did not respond to the postcard after two weeks, a letter with more details, including information on the phone card incentive, and a visit verification form were sent to the member. This outreach resulted in an additional 7% member phone response. HHP's bilingual staff then called the remaining members who had not responded, yielding an additional 32% success rate.

Statistical evaluation reported improvements in member communication and in member care for special care adults. The program communicated with 56% of members, producing valuable information for patient care. Office visits increased from 209 in 2002, to 395 in 2003. HHP plans to continue its outreach program to further identify and improve care for special care adults.

## Independent Health

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### *Medicaid Mammography Outreach*

Breast cancer is the most common cancer in women in the Western world. While breast cancer mortality has improved substantially in white women during the past decade, research shows mortality among African-American women has remained fairly constant. This is attributed to the fact that while African-American women have a lower incidence of breast cancer, their mortality rates are higher because the cancer is often detected at later stages when it is more aggressive and more difficult to successfully treat.

One of the most effective methods to detect breast cancer remains mammography screening. Although effective, the method remains underused. In particular, low-income women use breast cancer detection screenings the least, resulting in lower survival and higher mortality in this group than in the remainder of the population. Recognizing that women of color and women living in poverty often face enormous barriers to accessing preventive services, Independent Health set out to create a program for its Medicaid population designed to facilitate access to screening, thereby improving screening rates and raising the potential for detection for this population.

Independent Health first set out to determine the barriers women in the Medicaid population face to having regular mammography screenings. A focus group of targeted Medicaid members found that while almost all had basic knowledge of the mammogram procedure and knew that the screening was free, most desired more information about what follows after interpretation of the test results. Perhaps not surprisingly, the greatest barrier to getting a mammogram is fear of the unknown, resulting in procrastination and excuses. Other barriers identified included transportation issues, scheduling of appointment times and a sense that providers needed better training in communicating with women and multicultural populations.

Armed with this information, Independent Health designed a Medicaid Mammography Outreach Pilot program, aimed at providing culturally appropriate education about breast health and mammography. The outreach pilot also arranged transportation for members in need and partnered with mammography sites to facilitate appointment schedules. Members who signed up for an appointment received personalized reminders — a mailing approximately a week before their scheduled appointment and a phone call one day prior to the appointment.

Independent Health's outreach pilot was successful in overcoming some barriers to screening, lack of transportation in particular. However, although significantly more women identified through the Medicaid Mammography Outreach Pilot received the important screening test — 54.5% of those in the outreach program versus 10.9% of Medicaid recipients not in the program — the overall screening rate remains low. Additional approaches, including monetary incentives to motivate women to get screened, had little success in overcoming barriers such as fear.

## Independent Health

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### *Physician Incentive Project: Diabetes*

Independent Health provides coverage for many members living with diabetes. Research has determined that active disease management can greatly increase members' ability to perform daily tasks and, in turn, greatly increase quality of life. To help support active disease management for its members, Independent Health developed the Physician Incentive Project: Diabetes.

The initiative aims to improve health in the community through leadership in managing and developing innovative quality health care systems. The project demonstrates significant improvements in health status of diabetics by promoting strategies to improve systems within physicians' offices.

Independent Health's Physician Incentive Project: Diabetes was begun in 2002. The collaborative program brought Independent Health together with two network hospitals and 22 physicians within Niagara County. Project meetings with hospital administrators and participating physicians facilitated coaching sessions, clarification on self-medical record review and peer discussion and learning. The hospitals, health plan and physicians collaborated to create a subset commonly invested in improvement within a defined population.

Independent Health provided each physician with a registry of diabetic patients and individual patient survey forms to document comprehensive diabetes care. The project required the physicians to do a self-review of medical records using the survey forms. The self-assessment covered three timed intervals: baseline, measuring retrospective review of care for 2001; interim, measuring care July 2001 through June 2002 reflecting process changes; and final care measuring during 2002.

In addition, physicians and their office teams were coached to implement intervention strategies to improve office systems and care. Strategies include: a copy of WNY diabetic guidelines for all office staff, staff member designated as project leader for each office, coaching on effective usage of diabetic registry, flagging of medical records for diabetic patients, and development of a process to notify patients of missed appointments.

Physicians in the project were reimbursed according to improvements, which were based on a HEDIS scale from 1 to 10. Eight physicians (38%) with the average score greater than 6.86 received full reimbursement. Two physicians (9%) scored an average greater than 6.25 received 50% reimbursement. Three physicians who demonstrated 50% improvement received 25 % incentive payments.

Based on the success of the program, Independent Health plans to expand the project to 2,900 eligible physicians and will continue to strive to promote chronic disease management in the future.

## **MVP Health Care**

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### ***Back Care Program***

Lower back pain is a chronic condition affecting more than 15% of the United States population. MVP Health Care has taken an innovative approach to addressing this need by developing a disease management program for members with chronic lower back pain.

The goals of the program include increasing the use of conservative approaches such as activity and self-care as first line treatment, improving behavior modification and helping members understand perceptions of disability. Additional goals are avoiding extensions of injury through work/activity modification and conditioning, preventing back surgery, encouraging appropriate use of pain management medications, providing early interventions/referral to pain management programs, decreasing hospitalizations and ER visits, decreasing the utilization of CT and MRI imaging, and reducing lost work time.

MVP's Back Care Program is modeled after its asthma and diabetes management programs, both of which have experienced high levels of success and acceptance. Members are identified for participation in the program by meeting one of the following criteria: at least two encounters with a diagnosis of low back pain at least 10 weeks apart, self-referral, practitioner referral, or MVP staff referral. Identified members are then sent a health risk assessment survey. Based on survey results, members are assigned risk scores that predict their health care usage in the next six to nine months. Members who completed the survey also receive customized educational materials based on their responses, a back care workbook on how to reduce back pain (e.g. through exercise, stress reduction, etc.), and an action plan to document their health improvement activities and track progress.

When members are identified as high-risk, an MVP nurse calls the member to review their survey results and determine how the program will best meet their needs. The nurse tailors the education to meet an individual's needs by focusing on the topics flagged on the person's survey. Survey topics include: physical symptomatology, barriers to compliance with recommended care, emotion, functional ability and behavior change. In addition, the nurse educates the member on the anatomy of the back and helps him/her to understand where the pain may be coming from. The nurse may contact the member's practitioner(s) to discuss his/her treatment plan and goals in order to assist the practitioner in educating the member.

MVP produced a bi-annual newsletter for the Back Care Program and mailed it to the 1,800 members in the program. Members are also encouraged to enroll in the Personal Health Improvement Program (PHIP), a series of six weekly two-hour classroom sessions conducted by health care professionals that highlight the "mind-body connection" and how moods and behavior can affect one's body and health. MVP also offers classes throughout its service area to give all members with persistent back pain the opportunity to learn in a classroom setting. Currently MVP is in discussion with a regional physical therapy practice to provide classes covering the various topics such as anatomy of the spine, proper alignment,

causes of back problems, correct posture and body mechanics, effects of nutrition, smoking and fitness on the back and ways to reduce the risk of further injury.

MVP evaluated the success of the program by assessing members' perception of their low back pain using a visual analog scale, which is a numerical score between one and ten. The average score for members upon enrollment in the program was 4.75. The average score decreased more than two points, to 2.7, after the initial three months of the program. Member feedback demonstrates the success of the program in improving and maintaining back care.

## Oxford Health Plans

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### *Living with Diabetes*

Diabetes is the fifth leading cause of death by disease in the United States. People with diabetes are at higher risk for heart disease, blindness, kidney failure, extremity amputations, and other chronic conditions. Direct medical and indirect expenditures attributable to diabetes in 2002 were estimated at \$132 billion.

In 1997, Oxford Health Plans developed the Living with Diabetes program to meet the needs of its members identified as high risk. The program seeks to educate and motivate members with diabetes so they acquire the skills, knowledge and ability to effectively manage their disease. A primary path to achieve this goal is member empowerment and physician involvement, with emphasis on creating ongoing dialogue between the member and their physician that will continue beyond the member's involvement with the program. Since developing the program, Oxford has expanded it to cover all 51,000 members diagnosed with diabetes.

The majority of members selected for the Living with Diabetes program are identified through laboratory data reports. Selected members are then stratified according to glycosylated hemoglobin (HbA1c) and those in each stratification level receive different interventions. Interventions increase in intensity the higher the member's HbA1c value. Level IV members receive pro-active telephonic educational outreach, while Level I members receive an annual reminder of the elements of good diabetes care. Level II and III members receive a series of 12 monthly mailings from the Diabetes Control Network, sponsored by Pfizer Pharmaceutical, each focusing on a different aspect of diabetes care.

Oxford also offers other programs for members with diabetes. There is a Newly Identified Member Mailing program for those who have been diagnosed with diabetes in the previous quarter as well as newly enrolled members with an existing diagnosis of diabetes. The Options for Living with Diabetes program is a seven-week self-management program that provides members an opportunity to learn about diabetes and to share ideas about self-care, focusing on a variety of topics such as nutrition, exercise and medication compliance. In an effort to reach the Asian population, Oxford collaborates with its Chinatown Health Clinic, providing diabetes screening educational materials in Chinese. Oxford also developed the Diabetes Best Practice Program for members who have historically been non-compliant with their physician's recommendations to become actively engaged in managing their own conditions, to help motivate these members to receive the care they need.

In addition to member programs, Oxford developed programs for physician education. In 2002, Oxford distributed Clinical Practice Guidelines, designed by the American Diabetes Association. Each year, Oxford also provides a Physician Report Card Mailing with an attached list showing their patients who have been identified as having diabetes, their latest HbA1c and date, their latest LDL-C value and other information to aid in the care of those patients.

Oxford evaluated the impact of Living with Diabetes based on improvements in HEDIS Comprehensive Diabetes Care indicator rates. In 2002, 39% of Oxford members with diabetes were considered to have poor blood sugar control, compared with 66% four years ago. Oxford reported a 14% increase in the number of members with diabetes receiving the appropriate cholesterol screenings over the last four years. This number translated into 58% of members maintaining the appropriate cholesterol screenings, compared to 23% in 1999. In addition, Oxford reported a 24% increase in the number of members receiving the proper screenings for kidney disease.

## Preferred Care

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### *Medicine Bag Review Program*

Preferred Care is committed to actively caring about its members and making it simple and easy to stay healthy. This includes helping the plan's Medicare Advantage members to remain independent by reducing preventable illnesses and injuries.

National data suggests that older adults consume 30% of all prescription medications and attempt to further improve their health by taking over-the-counter medications, vitamins and herbal supplements. These additional substances are not typically consumed with the knowledge of the member's physician nor are they tracked in a pharmacy database. However, these substances can create drug-to-drug interactions and or drug-to-disease interactions that can reduce the effectiveness of prescription medications and contribute to the incidence of falls, injuries and hospitalizations.

Preferred Care initiated the Medicine Bag Review Program in 2000 by partnering with a highly-respected regional grocery chain, Wegmans. The goals are to reduce the number of illnesses and injuries brought on by adverse reactions to medications and increase medication compliance.

The goals of the program are accomplished through a free, face-to-face interview with members identified as high risk and a pharmacist trained in geriatric pharmacology. The pharmacist reviews all substances for potential interactions, provides a summary to the member, and notifies the physician of any contraindications. The pharmacist also assesses the member's understanding of the correct administration of prescription medicines and identifies generic alternatives as available.

Between 2000 and 2003, 1,053 members have participated in Preferred Care's Medicine Bag Review Program, and 233 potentially adverse interactions have been identified. Member satisfaction has ranged between 85% and 96%. Compliance with medication regimens improved between 6% and 7%. These reviews and ensuing counseling have resulted in improved quality of life, fewer medicine-related injuries and better compliance with pharmacological treatment plans.

## Vytra Health Plans

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### *Tobacco Free Teens*

Smoking is the leading preventable cause of death and disability in the United States. It is estimated that every day more than 3,000 12-17 year olds in the United States become smokers. That's more than a million new teenage smokers a year. Despite increasing costs of cigarettes and greater public awareness of health risks, tobacco use among teens is still an issue. Results of the Youth Tobacco Survey in Suffolk County 2000-01, prepared by the Suffolk County Department of Health Services, found that in the 30 days preceding the survey, 32% of middle school and 42% of high school smokers reported smoking on school grounds. Most smokers begin using tobacco before the age of eighteen, and half before the age of fifteen.

Vytra Health Plans' Tobacco Free Teen initiative was designed to help physicians prevent many of their teen patients from starting to smoke and to help others to quit. Literature has shown that smokers who try to quit are more successful if they have the support of their physicians. Vytra's program focused on providing education, tools and resources to physicians who treat adolescents.

Tobacco Free Teens was set up as a pilot initiative by Vytra in 2001, targeted to 263 doctors in 80 physician groups that treat about 50% of Vytra's membership. The intervention utilized an existing Department of Health (DOH) survey of risk behaviors, already determined to be well received and acceptable to adolescents, parents and clinicians, that physicians gave to their adolescent patients. The survey then became a springboard for discussion between physician and patient, encouraging dialogue about healthy lifestyle choices. Physicians were also given information to help them determine the best medical treatment for their patients as well as a comprehensive packet of resource materials to assist patients.

The intervention program was successful, with results exceeding expected goals. Before beginning the Tobacco Free Teen program, 15% of the plan's adolescent population was screened for tobacco use. The screening rate for 2001 was 33.63%, more than double the baseline rate. The program also helped to raise awareness and provided education about the dangers of tobacco and the need for medical intervention and/or counseling to parents of teens. Vytra has been an active member of the Tobacco Action Coalition of Long Island and the Tobacco Free Teen initiative dovetails with the plan's existing comprehensive Tobacco Free Program.

**Community Leadership Initiatives**

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### *Racial & Ethnic Disparities in Health Care*

People of diverse racial and ethnic backgrounds suffer from certain diseases at up to five times the rate of the rest of the population. Yet, as documented by the Institute of Medicine's report, *Unequal Treatment*, racial and ethnic minorities receive lower quality health care than non-minorities, even when insurance status, income, age and severity of conditions are comparable. Seeking to address this critical health disparities issue, Aetna developed a coordinated, multidimensional program composed of research, education, member service, data collection, direct health care and general awareness initiatives.

In planning since 2001, Aetna launched the first NYS health plan evidence-based initiative to identify disparities in healthcare in January 2003. The first step in the initiative is to identify the potential for problems. Through April 2004, Aetna had collected voluntarily provided race and ethnicity information from over 340,000 Aetna members, with a reporting rate of 80%. A secondary data collection initiative, in partnership with the American Medical Association, collected similar information on the plan's network of physicians. Once the information was collected, all individually identifiable information was made confidential and privacy protected.

Coupled with Aetna's predictive tools, the plan uses these data to identify disparities, support and encourage new research and test new approaches to reduce disparities. Administrative data are used to identify members with any of 67 chronic diseases or medical conditions that may benefit from disease management programs. For example, Aetna's diabetes management program found that Hispanics and African Americans were significantly less likely than whites to report having a dental exam, flu or pneumonia shot or check their glucose levels daily in the past year. With these facts in hand, Aetna was able to educate customers and target disease management and other new initiatives, including demonstration initiatives through the Aetna foundation. Similar successful interventions include Aetna's Breast Health Initiative, which identifies African-American and Hispanic/Latina women 40 and older who have not obtained screening mammograms, and provides targeted outreach via telephone contact by bilingual nurse case managers to assist these women in getting care, or the Maternity Management Education Program that identified 3,500 African American members at high risk of premature labor and delivery, providing them with education and case management services, and a Cervical Cancer Prevention Program for Vietnamese American Women that includes Vietnamese language materials and public service announcements and community education for a population that has historically shunned these medical services, resulting in significant and persistent increases in preventive screening and women's health services for this population.

Another avenue to addressing disparities in health care is the building of community partnerships to reduce disparities. Aetna empowers its local employees to actively engage their local communities to address issues of disparities through recognition and support of voluntarism and encouraging employees to work with communities to promote competitive

applications for foundation disparities grants. In 2003, Aetna funded more than \$325,000 in initiatives related to health disparities reductions throughout New York State.

Equally important to the effort to reducing disparities is workforce cultural competence. In 2003, Aetna engaged in both internal and external initiatives to strengthen its health care workforce's cultural competence. Within Aetna nearly 90% of physicians and nurses completed cultural competency training in 2003, with over 75% reporting that the training, improved their interactions with members. In 2004, trainees will receive ongoing reinforcement. In addition, among Aetna's non-clinical workforce, diversity courses have been taken by thousands of Aetna employees. In addition, Aetna's foundation has supported cultural competence training and training curricula development. In 2002, for example, Aetna funded the National Coalition of Ethnic Minority Nurses Association to increase the number of people of color in the nursing profession. In May 2004, Aetna supported a patient-based approach to cross-cultural care in Manhattan, which provided training to more than 1,550 clinicians. In 2003, Aetna also funded the New York Based Equitable OB/GYN Care cultural competence curriculum development and pilot in three locations in New York State by ACOG.

One of Aetna's goals is to serve as a catalyst for researchers at the nation's leading academic institutions to take a closer look at variations in health status and health care delivery among racial and ethnic populations. In 2004, Aetna funded the Children's Defense Fund to identify and eliminate disparities in health for minority children. Other supported research includes medical school funding to assess the impact of cultural competency training to identify patient-provider communication skills to improve depression and chronic pain care and outcomes for African Americans. Aetna has also invested in the Center of Excellence on Health Disparities at Morehouse School of Medicine, the National Conference for Community and Justice's Conversation on Race, Ethnicity and Culture, and in planning initiatives for four historically black medical colleges' research to address racial and ethnic disparities.

Through its innovative program, Aetna has been recognized as a leader for removing obstacles and working to ameliorate the results of racial and ethnic disparities in our health care system. Aetna has also received extensive recognition and awards for its efforts and leadership.

## Affinity Health Plan

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### *Lead Screening in Targeted Communities*

The Community Health Institute (CHI) is a separate research and program department of Affinity Health Plan, focusing on identifying and developing projects that improve public health in the communities Affinity serves — the five boroughs of New York City and the five surrounding counties (Nassau, Suffolk, Westchester, Orange, and Rockland). The CHI lead screening initiative seeks to raise lead testing rates in targeted, high-risk communities in New York City. This grant-funded initiative takes a focused approach to increasing lead screening rates, recruiting Affinity providers and encouraging them to adopt a relatively new and easy “fingerstick” method of screening a child for lead.

The CHI lead screening initiative developed out of a pilot project begun by Affinity in 2001 to raise lead screening rates in Orange County. Several high blood lead level results in the county prompted Affinity to pursue adoption of the capillary testing method with primary care providers in Orange County. The notable success of that early pilot program prompted the broader effort and the application for grant funds to make it a community initiative. To identify high-need communities, CHI worked closely with the NYC Department of Health’s Lead Poisoning and Prevention Program to select 5 high-risk/high-needs neighborhoods for the project: Harlem, Greenpoint/Williamsburg, Downtown/Park Slope/Brooklyn Heights, and Flatbush in Brooklyn, and West Queens. Each of the selected neighborhoods has low lead screening rates for children relative to the city-wide average, or a high rate of elevated blood lead levels, or both of these conditions.

The initiative sought to achieve four basic objectives: 1) identify targeted areas of focus for the project; 2) identify and recruit via phone and mail Affinity primary care providers (PCPs) to participate in the project; and 3) enroll Affinity PCPs in the project and arrange for participating PCP offices to receive materials from MedTox; and 4) track the results. The project promotes use of a simpler capillary lead testing method that can be performed in physicians’ offices. CHI found through discussions with members, PCPs, and city officials that one of the biggest obstacles to higher lead testing rates was the fact that many physicians referred patients to an outside lab for a lead test; many parents simply did not take their child to get the test.

Physicians recruited to participate in the project are encouraged to adopt capillary lead testing, a simple fingerstick method that enables physician or other medical office staff to collect blood samples in the office rather than sending patients to another location to be tested. CHI has worked closely with a laboratory vendor, MedTox, who provides all the materials needed for the capillary lead test to doctors’ offices free, including the mailers to send the samples to the lab. MedTox tests the sample and faxes the lab results to the doctor, and sends a monthly summary report to CHI as well.

In addition to provider recruitment, CHI also held a number of lead screening events in the identified neighborhoods across the city, screening over 300 children for lead during the past year. An important feature of this initiative is that it serves not only Affinity members, but all children in the targeted communities — the initiative encourages physicians to test every child who comes into their office who needs a lead test. (Affinity reimburses providers for performing the capillary lead test on Affinity members through its usual procedures, and grant funds are used to reimburse providers for non-Affinity members.)

CHI's lead screening initiative has evolved considerably since the initial grant award in June 2003. CHI identified an important community health issue, and applied and received a grant to promote the capillary lead testing method in targeted, high-risk communities across the city. The project takes an innovative approach in trying to address a community need, going into the community to conduct lead screenings on the streets where they live and work and conduct their daily activities. These community events help to raise awareness of the need for lead testing and, ultimately it is hoped, will prompt more primary care providers to adopt the capillary lead testing method. Capillary lead testing offers a simple, easy way to test children in doctors' offices and not send them to another site to be tested, and can thus go a long way towards raising lead testing rates for plans and providers.

### *Leap and Learn*

Childhood obesity has become a national epidemic, with at least one of every five children overweight. Over the last two decades, the number of overweight children has doubled. Although children have fewer weight-related health problems than adults, overweight children are at risk of becoming overweight adolescents and adults. Overweight adults are at risk for health problems including heart disease, diabetes, high blood pressure, stroke, gallbladder disease, osteoarthritis, sleep apnea, and some forms of cancer.

The Leap and Learn Healthy Choices project addresses childhood obesity by teaching children the importance of healthy food choices and healthy alternatives to sedentary behavior. The goals of the program include exposure and introduction to healthy behaviors, building and expanding on the knowledge created by healthy habits, and mastering these learned skills. The initiative provides and encourages the necessary knowledge and skills to establish and maintain physical fitness, participate in physical activity and maintain personal health. It also teaches children about the relationship between behaviors and healthy development and enables them to understand human growth and development.

BlueCross BlueShield implemented the Leap and Learn program in the kindergarten of three Buffalo-area schools. At the program's inception each participant was weighed and measured. Over the course of ten weeks, participants' lunchtime food choices were tracked at three separate times. Students also received 30-45 minutes of instruction from MUSE teaching artists once a week, learning a song and dance focused on healthy messages. (MUSE teaches through oral tradition, using auditory skills to learn songs, dances and games.) Participants also received a CD with the song on it as well as a T-shirt and program workbook. The program culminated with activities that included parents participating in the performing the Leap and Learn Superkids song and children preparing and serving their parents healthy fruits and vegetables.

## **BlueCross BlueShield of Western New York/BlueShield of Northeastern New York**

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### ***Walking Works***

America is spending more than ever on preventable health problems such as heart disease, osteoporosis, Type 2 diabetes and arthritis. According to research from BlueCross BlueShield's Healthcare Affordability Campaign, more than 60% of Americans are overweight or obese, 60% of adults do not engage in the recommended amount of physical activity and approximately 25% of American adults are not active at all. The Department of Health and Human Services estimates that increasing regular, moderate physical activity among the 88 million inactive Americans over the age of 15 might reduce annual healthcare costs by as much as \$76.6 billion.

The Walking Works program was developed in response to the increased trends of poor heart health, obesity, chronic illness and physical inactivity. Objectives include integration of the walking program with BlueCross BlueShield's (BCBS) national health care cost campaign, facilitating local outreach, building consumer understanding of the role of personal responsibility on health care management, building public belief that BCBS health plans are committed to helping members maintain good health, and improving the health of members and the community-at-large.

Walking Works was introduced to BCBS employees with support from the office of the president and senior management. Then all officers and directors were educated about the personal responsibility concept and asked for their support as leaders and role models. Articles were launched on the corporate Intranet to let employees know why walking works. A special employee walk launched Walking Works across all divisions coinciding with a national walk on Capitol Hill. A special after-work walk was added in Buffalo to coordinate with sponsorship of the walking trails for the Art on Wheels local cultural/travel initiative.

Employees were given the option to track steps using either a pedometer or a special 10K a Day Web site. Throughout the summer BCBS employees logged 22,674 miles, which is enough miles to walk around the world. In Buffalo, the number of walkers rose from 1,500 in 2002 to 4,000 in 2003, and money raised through community walk events increased from \$150,000 to 400,000. In the Albany market, walkers increased by 700, raising the number to more than 4,000, and \$500,000 was raised for sponsored events.

To initiate the program in the public sector, BCBS's health promotions and sales staff initiated an outreach to two select employer groups in Buffalo and Albany as a way to encourage worksite health. Through the Community Relations programs, BCBS introduced Walking Works to the community-at-large at events, including the American Heart Walk and America's Walk for Diabetes. In the future BCBS will target select employer groups, increase media and public relation through Web and newsletter materials, add a disease management team, offer pedometers at a discounted rate to members, and offer a child-friendly pedometer when Walking Works is launched in schools.

## CarePlus Health Plan

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### *Healthy Beginnings Program*

At The Little School at CarePlus, the plan seeks to enrich the lives of children and their families through interactive and fun Keep Me Healthy classes designed to increase health literacy. These health and early childhood development classes are held weekly at 2 of its community office sites and involve children from infancy through 3 years of age and their parents or caregivers. Each weekly class focuses on a new health or development topic such as home and fire safety, the importance of immunizations, lead poisoning prevention and dental health. With the use of songs, story time and arts and crafts, young children learn the importance of health care at a level they can understand. These classes also provide parents or caregivers with valuable information that they can apply to their family's daily lives by focusing on the benefits of preventative health. The classes and presentation format establish a rapport between parents/caregivers and CarePlus staff. Guest speakers from the community such as New York City firemen and local pediatricians provide first hand knowledge about their respective areas of expertise. CarePlus welcomes all of its members in the community to participate in these classes and encourages its providers to refer families for enrollment.

Healthy Beginning classes were initiated in September of 1998 designed to promote cognitive, language, social and emotional development for children. The classes consisted of story time and arts and crafts. The class was held once a month in community day care centers. In 2001, CarePlus brought the Healthy Beginnings classes into their community offices and increased the number of classes to three times per week. From 2001-2003, the classes continued to provide information primarily pertaining to child development. In July of 2003, CarePlus reassessed the Healthy Beginning classes in light of the needs of the community and its members. Through comments in the suggestion boxes in the centers, CarePlus members within the community expressed their desire to learn more about preventive health care measures. As a result, CarePlus redesigned the classes to better serve the community by delivering more focused health messages in an environment friendly to both children and their parents or caregivers. CarePlus's Healthy Beginnings classes were renamed Keep Me Healthy classes with the implementation of the new health curriculum.

The new curriculum allows the Keep Me Healthy classes to utilize a playgroup setting for children and their family members to interact with one another while providing beneficial information. The Little School's Keep Me Healthy classes are held 3 days per week with 3 age-specific classes held per day. The early morning class is for children ages 6 months through 1 year; the mid-morning class is held for children ages 1 through 2 years; the afternoon class is held for ages 2 through 3 years. Each class follows the same format. Children are greeted with a "welcome circle" where they join together with the teachers to sing opening songs. The class topic is then presented to the children and their parents/caregivers. Following the topic discussion, the class sings songs related to that particular topic and then stories supporting the weekly topic are read. The class then moves over the children's table where children and their parents/caregivers create a custom-

designed art project that reflects the weekly topic. For example, a healthy smile poster is created by students during the Dental Health topic.

The Keep Me Healthy classes also target the parents/caregivers by providing them with information pertaining to their health. Children are most often accompanied by mothers, but frequently are brought to the class by other family members such as fathers, aunts, or grandparents. Pamphlets about certain preventive tests that pertain to the health of the adult caregivers, such as cancer screening tests, mammograms and pap smears, are available in the classroom from the CarePlus staff. Each series of classes devotes one session to the topic of family health. This class, entitled Healthy Families, stresses the importance of preventive health care for all caregivers particularly since they are vital to the family unit.

### *Care for the Caregiver Initiative*

The enormous role that caregivers play in society is frequently undervalued and often overlooked. Through research, corporate membership analysis, health service professionals interviewed, corporate member requests and input, analysis of caregiving services available and focus groups, it was apparent that the most overlooked patient in society is often the 'CAREGIVER' themselves. These caregivers are often "silent patients" who too often do not receive the assistance and support their role requires. To bring focus, attention and potential sources of assistance to the caregiving population, HIP sponsors a theatrical presentation entitled "CARING for ME; CARING for YOU" an entertaining exploration of the challenges of caregiving.

The Integrative Wellness department, through Care for the Caregiver, aims to create "awareness", "acceptance", "action" and "abundance" for the caregiver community. This initiative facilitates community-based organizations in raising their constituencies' awareness of the important and often unconsidered role of caregivers, while exposing the need for all of us as caregivers to realize that in order to help others, we must first help ourselves. It uses drama and discussion to foster acceptance that caregiving is a role that often masks the hidden patient (the caregiver), which can lead to many present and future difficulties, health issues and burdens. The initiative provides resources for action through presentations by support organizations during a reception period. Supplementary literature and resource material is also available to attendees.

The theatrical setting provides a platform in which the topic of CAREGIVING can be explored in a safe and secure venue for this dialogue. Performances contain professional (Broadway) actors. The show is accompanied by a dedicated playbill for the event honoring the hosting organization.

In 2002 there were 6 performances, reaching 1,028 people. In 2003, Care for the Caregiver was performed 19 times, reaching more than 4,000 people — an increase in exposure of almost 400%.

In the future, HIP plans to create a TV quality (multi-camera) video to make this performance available to a wider audience. To further promote Care for the Caregiver, HIP is arranging theatrical licensing of the production for local theatrical organizations with discussion guides. HIP is also developing a Resource Kit for Caregivers and plans to develop a working model for respite relief, along with a written discussion guide and employee caregiving support groups for caregivers in the workplace.

## HIP Health Plan of New York

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### *Clara Barton High School for Health Professions Partnership*

Clara Barton High School for Health Professions is located in the Crown Heights section of Brooklyn, New York and offers specialized academic medical and business programs. With the many changes in the health care industry over the last two decades, HIP identified a need to enhance the existing health careers program. HIP determined that to insure students are able to apply current educational and occupational skills upon graduation, the school had to introduce new areas of concentration and strengthen its current offerings.

HIP's primary goal is to enhance the Health Careers Program of Clara Barton High School for Health Professions, providing the faculty and students with hands-on, professional medical information on diverse opportunities within the current and emerging health care industry. The goals are achieved through a series of workshops, financial and technical assistance, and on-going program support.

This partnership directly impacts the 2,200 students who attend Clara Barton High School. In the future, these students will impact thousands of people in the communities where they will deliver healthcare. Since the inception of the partnership in 1995, HIP has offered numerous programs including Principal for a Day, School-to-Work, Scholarships, Arts and Education, Health Information Practicum Day, Faculty Day at HIP, and Sophomore and Senior Day at HIP.

HIP plans to continue its relationship with Clara Barton, with upcoming projects focused on improving the professional development of the faculty of the Health Careers Program by providing faculty with course studies, seminars, workshops and materials that will aid them in meeting the demands of today's emerging health careers in a managed health care setting. HIP also plans to expand the school's association with health care facilities to provide more opportunities for clinical training, internships and job placements. In addition, HIP will offer other resources such as health career fair, enhanced virtual enterprise program, and a reference library of health information for both faculty and students.

## Hudson Health Plan

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### *Facilitated Enrollment Electronic Application*

Hudson Health Plan (HHP) is a not-for-profit Prepaid Health Services Plan (PHSP) operating in Westchester, Rockland, Sullivan, Dutchess, Ulster and Orange Counties. As one of New York's first PHSPs, HHP has long been a leader in advocacy, operational effectiveness, and clinical quality in New York State-sponsored managed care programs (Medicaid, Child Health Plus and Family Health Plus).

Facilitated Enrollment (FE) was implemented in New York State in June 2000 to combine the eligibility screening and enrollment process for three programs – Medicaid, Child Health Plus, and the Woman, Infant and Children programs (Family Health Plus was later added to the program). However, there were many barriers to overcome. The eight-page “Growing Up Healthy” (now “Access NY”) application required complex calculations and extensive documentation. Manually transcribed data needed to be entered into computer systems three times. Illegible entries, miscalculations and missing documentation resulted in rejected applications and delays in approval.

HHP realized that information technology was the key to improving the FE process. To ensure that community-wide needs were met, HHP staff decided to create an electronic application that could be used by any FE agency, of any size, to automate the eligibility verification and enrollment process. HHP developed FEEA, a Facilitated Enrollment Electronic Application, which is easily interfaced with other systems and networks and can be used in small PC-based environments. HHP's overall goal is to widely distribute FEEA to address inefficiencies in the FE system, reduce costs and ensure that all eligible individuals are added to the health insurance rolls as soon as possible.

To develop this software application, HHP partnered with other managed care organizations (MCOs), community based organizations (CBOs) and a county Department of Social Services (DSS). Today, FEEA is in use in multiple sites and HHP is testing electronic transmission between a collaborating MCO and its local DSS. HHP is also working to install FEEA at various organizations and government agencies that have requested assistance in managing the FE system in New York State.

## Hudson Health Plan

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### *Prenatal Care Initiative*

In 1999, Hudson Health Plan (HHP) discovered inconsistencies between scores for early entry into prenatal care, reported by the New York State Department of Health (DOH) in its QARR process, and data the health plan collected for claims. In order to improve prenatal care HHP developed the Prenatal Care Initiative, a three phase program that aims to determine true rates of early entry into prenatal care, increase the rate of entry into prenatal care in the first trimester and expand the studies and their impact statewide.

After a detailed study, HHP staff determined that the data discrepancies were due to significant underreporting of prenatal care by HHP's contracted hospitals on birth certificate surveys that are forwarded to the Bureau of Vital Statistics. Once accurate data were received it became clear that many members were not entering prenatal care during the first trimester. In order to understand this, HHP staff designed and conducted a barrier study among enrollees, at the same time conducting a companion study, targeting 28 obstetrical providers to determine barriers to early prenatal care. Both providers and health plan members cited the same barrier to early prenatal care: lack of insurance. HHP staff developed an action plan to address this issue on a large scale. Efforts included outreach to and educating enrollees about the importance of early prenatal care as well as the existence of free programs that provide care. The plan also worked to identify and involve other stakeholders, conducted a statewide barrier survey, identified existing government-funded programs for pregnant women, documenting program eligibility requirements and timelines, benefits for mothers and their babies, provider reimbursement, and overlapping or conflicting processes that might impede access. These findings were then disseminated to members, providers, advocacy groups, regulators and legislators.

Concurrent with this analysis, HHP staff worked with EMS, a company that offers an electronic maternity case-management program, to increase functionality of the software package. This resulted in the development of the "Barrier Wizard". The Barrier Wizard presents a series of questions that the case manager must ask each prenatal care patient. The system is user-friendly and ensures that all information is collected at the point of contact. This software then provides numerous reports about each patient's experience, including a full assessment of barriers to care.

As a result of this program, HHP identified the rate of prenatal care among its members, barriers to care and drastically improved its QARR score. In 1999 HHP's QARR score was 69, while the state average was 63. In 2002 HHP scored 90, while the state average was 78. This improvement is largely a result of the Prenatal Care Initiative.

## Oxford Health Plans

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### *Asian Initiatives*

In reviewing social and demographic information, Oxford discovered that the health needs of the Asian community, in particular the Chinese, were not being met for reasons including language barriers, distrust and lack of education. After reviewing results from the study, Oxford discovered that the Chinese community has little knowledge of the American health care system, was unaware of Chinese-specific diseases, paid little attention to preventive care and often opted to see a doctor only when really sick. In response to this issue Oxford Health Plan formed Asian Initiatives in 1994, to provide access to affordable, quality health plan services for Asian-Americans through qualified Asian physicians and superior in-language customer service support. The initiatives also strive to provide culturally sensitive educational materials and innovative programs to promote health and wellness throughout the community.

To alleviate this population's fears and reservations about accessing health care services and providers in the United States, Oxford worked closely with Chinese-American Medical Society (CAMS) to create a network of Chinese-speaking physicians and establish a positive reputation in the community. CAMS helped Oxford build relationships with quality, board-certified Chinese-speaking physicians, and a long-term partnership with the Chinese-American Independent Practice Association (CAIPA). Throughout the past nine years, Oxford's Asian Initiatives have organized innovative services that have provided information and tools to improve the health and wellness of Chinese and Korean communities. Oxford offers many services such as: Walk-In-Centers (Chinatown and Queens), Chinese & Korean Service Hotline, Health Seminars, and Social Security Seminars. In addition, Oxford also offers various Health Educational Awareness Programs.

Oxford's current Asian membership is over 33,000, but the impact of the Asian Initiative in the community extends far beyond their base of members. Tangible impacts of the initiative are evaluated on a program-by-program basis, and by the volume of visitors to the walk-in-centers and the number of calls received by customer service hotlines. In 2002, walk-in-centers served 22,306 customers and Chinese & Korean Customer Service Hotlines answered 46,765 calls.

These successful results are an indication of the acceptance of the initiatives by the underserved Asian community. In the future, Oxford plans to continue developing innovative approaches to improving healthcare within a culturally sensitive setting.

## Preferred Care

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### *You're In Charge!*

Consistent with national statistics, the majority of Preferred Care members have at least one chronic illness. To meet their needs Preferred Care developed You're in Charge! The mission of the program is to help older adults "take charge" of their health by increasing understanding of the medical conditions they can manage, to prevent health problems and improve and maintain independence through lifestyle changes. Curricula are designed to identify potential health risks, provide information to help improve knowledge related to aging and chronic illness, teach skills that enhance self-management, and assist members to set personal goals and develop action plans.

You're in Charge! recruited an advisory board composed of a culturally diverse group of members. The advisory board provides direction and insight into the development and implementation of interactive preventive/wellness programs and the various partnerships for support services. All programs and services are selected based on their ability to address the physical, emotional, intellectual, spiritual, social and vocational aspects of wellness for older adults.

You're in Charge! offers more than 30 wellness programs, nine of which specifically address chronic illness. Programs include: Body in Motion (physical activity for older adults), Eating Well, Aging Well, Living a Healthy Life with a Chronic Condition, Skills for Successful Living with Type-2 Diabetes, Food Fluid and Feelings (nutrition for people with congestive heart failure), Safe Stepping Fall Prevention Workshop, Medicine Bag Review, Learn the Computer, and Preferred Care Gold Volunteer Program. In order to improve program access for members and other in the community, Preferred Care developed flexible educational programs that can be taken on the road and presented in various settings through community partners, or at home through interactive materials and telephonic support.

Members who participated in You're In Charge! praised it with a 96.7% satisfaction rating in 2000. A program evaluation was administered focusing on behavioral change to determine the impact of You're In Charge! According to participants: 86% became more aware of factors that affected their health, 82% learned more about a healthy lifestyle, 74.4% felt they had more confidence in making changes to improve their health, 51.1% felt more confident they could communicate with their physician regarding the care of their health, 69.5% set one or more personal goals to improve their health, and 57.5% took steps toward meeting their goals.

## Vytra Health Plans

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### *SPF 2003*

Vytra Health Plans' mission is "to add measurable value to our customers and earn trust by contributing to their health improvement and security." A definite synergy exists between this mission and supporting physical fitness and god health education for individuals.

Vytra has identified growing health shortcomings in the marketplace that could be attributed to lifestyle choices. The plan's solution is the combination of altruistic programs that raise awareness of and encourage a healthier lifestyle to members of our community. A cornerstone of these programs is the SPF program — in this case the "Summer Protection For" 2003.

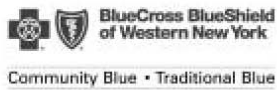
According to the Centers for Disease Control and Prevention, skin cancer is considered the most common form of cancer. More than one million cases of skin cancer were diagnosed in the United States in 2002. With Long Island comprising approximately 1% of the nation's population, it is estimated there are about 10,00 skin cancer cases per year on Long Island. Most types of skin cancer are curable if diagnosed early and treated promptly. Another growing problem on Long Island is Lyme Disease. Long Island, especially Suffolk County, has a very high rate of Lyme Disease.

Introduced in 1997, the SPF program has educated tens of thousands of Long Islanders about the importance of prevention and encourages them to take the necessary precautions to enjoy their time outdoors safely. Working in partnership with the New York State Department of Parks, Recreation and Historic Preservation and other community organizations, the initiative combines health education, summer safety and outreach activities. Believed to be the only program of its kind in the nation, the SPF program uses Vytra employee volunteers to distribute sunscreen and educational material at state parks and other locations throughout the region.

Vytra's SPF program distributes 50,000 samples of sunscreen annually, along with educational information on summer protection. Although difficult to measure clinical impact of a community programs such as SPF, the Suffolk County Department of Health has reported a steady declining trend in cases of Lyme Disease over the past several years. The number of reported cases fell from 645 in 1999 to 500 in 2000 and 417 in 2001. It is reasonable to conclude that repeated educational messages contribute in some way to the trend. Vytra plans to continue its SPF program, to continue educating the population about summer safety and helping those using Long Island's beaches and parks to safely enjoy the outdoors.







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