

## PLENARY SESSION 3: HEALTH POLICY 2004. IMPROVING OUTCOMES THROUGH RESEARCH AND PRACTICE

### A. HOW WE REALLY SERVE ALL PEOPLE, OR DO WE?

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More than 45 million persons in the United States lack health insurance, and an estimated 80 million persons lived without health insurance at some point during the last year. People who do have health insurance face increasing copays, and for most US workers, losing their job means losing health insurance. The United States spends more than twice as much per person on health care than other developed nations, but these other nations provide health care for all their residents. The insurance industry began in the United States more than 200 years ago, with hospital care for seamen paid by compulsory wage deductions. The modern insurance industry began to develop in 1929 with the formation of BlueCross. In the 1970s and 1980s, enrollment in managed-care plans surged in response to rising healthcare costs. In the 1940s, businesses began to provide health insurance as a benefit of employment. The Medicare/Medicaid legislation passed in 1965 represented the first attempt by the US government to improve healthcare through insurance coverage. Medicare part A covers hospitalization guaranteed to all. Medicare part B covers most of the outpatient needs as purchased by the individual. The most glaring omission from Medicare was for prescription drugs, and awkward attempts to resolve this omission continue even today.

In 1960, the Office of Economic Opportunity was founded in response to inequalities in education and job training. In 1965, the legislation was amended to fund "neighborhood health centers." In 1967, the Public Health Services Act was amended so that the

Department of Health and Human Services could fund community health centers, and these funds had to be used for direct delivery of health services. Federally qualified health centers assess payment status by using federal poverty guidelines. For persons at or below 100% of the poverty level, a nominal fee may be assessed for services, but this fee is not bookable. Between 101% and 200% of the poverty level, a discount may be applied, and above 200%, regular charges apply. See Table 1 for some statistics from health centers on a national level compared to centers in North Carolina (which represents one of the southeastern states, the poorest area of the country) and one specific center in North Carolina, Lincoln Community Health Center (LCHC). Community health centers provide services to people in need, but these figures show that large numbers of uninsured and underinsured patients exist.

Nationally, health centers have a good record in mammography screening, improving birth outcomes, childhood immunization rates, and other indicators. The centers work collaboratively with other agencies in their communities, such as health departments and social services. One of the more productive screenings conducted at LCHC in the last 2 years has been prostate cancer screening. It took place on a Friday and Saturday and involved LCHC, Duke Medical Center, and the Cancer Society. Nurses from both Lincoln and Duke participated in both sessions. This year, more than 250 men were screened at each screening. If any positive result was found on manual or PSA screening, follow-up was performed regardless of the patient's insurance status. This example of cooperation is needed for successful screening as well as the outreach that can be done through meaningful collaboration. Outreach to the community is achieved in many ways, through health fairs, screen-

**Table 1. Comparison of health center statistics on a national, state, and center level. 2003 Data**

Characteristic	National	North Carolina	LCHC
Grantees (N)	>890	23	1
Population served (N)	15 million	>261,000	35,165
Ethnicity			
African American	24.1	40.8	59
Hispanic	35.4	28.5	27
White	36.2	26.7	8
Other	4.6	NA	NA
Insurance status			
Uninsured	39.3	49.6	74
Medicaid/SCHIP	75.8	24.6	17
Medicare	7.2	10.5	5
Private insurance	14.8	14.7	3

ings, and education, but more can be accomplished by working in collaboration with other agencies.

Best practices are determined by the management staff of the center with oversight by a board that is composed of at least 51% of actual users of the service. The Bureau of Primary Care has been very supportive in this area and has shown leadership in promoting best practices. The Bureau initiated collaboratives in the late 1990s; the first was in diabetes, and it established guidelines for the centers that participated, including desired goals for hemoglobin A<sub>1c</sub>, foot care, eye exams, and self-management. Regional team meetings promoted cooperation and exchange of information among the participants, and it forced involved centers to think about the delivery of health care and its organization, not only for diabetes, but in terms of general organization. Collaboratives now include other diseases.

The increasing number of uninsured patients is an increasing financial worry for health centers. The uninsured patient population of health centers increased by 11% in 2003. While state economies are slowly improving, health centers still see Medicaid eligibility cutbacks, residual cuts, and cuts in direct funding, all of which impede access to affordable health care. Thirty-one states are providing funding to health centers,

for a total of more than \$220 million. At least two states—Texas and Georgia—have reduced Medicaid eligibility for residents. In Texas, sources estimate that 8,000 women will lose their Medicaid coverage each month. In Georgia, eligibility reductions have caused 12,000 pregnant women and 1,700 elderly and disabled adults to lose Medicaid coverage. Eleven states have made changes to their enrollment processes that will likely impede access to care for vulnerable populations, who often rely on health centers for care: Alaska, Colorado, Georgia, Kentucky, Massachusetts, Nevada, Maine, Minnesota, Oregon, South Carolina, and Texas. At least 10 states have reduced Medicaid benefits: Indiana, Maine, Michigan, Minnesota, New Mexico, Ohio, Oregon, South Carolina, Texas, and Utah. Ten states increased cost-sharing, through copayments for Medicaid patients, and 11 states increased cost-sharing, mainly through premiums for children enrolled in state health insurance programs. This loss of insurance coverage increases the burden on health centers already struggling to keep their doors open and maintain their quality of care.

As was noted in the *New York Times*, “What is needed to control the costs and provide basic health and hospitalization coverage for all Americans is an

independent agency that would set national healthcare policy, collect medical fees, pay claims, reimburse doctors fairly, and restrain runaway drug prices: a single-payer system that would eliminate the costly, inefficient bureaucracy generated by thousands of different plans.” This idea is not so radical. A single-payer system already exists—in the form of Medicare.

## B. MEETING HEALTHY PEOPLE 2010 GOALS: AETNA'S RESPONSE TO THE INDUSTRY CHALLENGE

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### HEALTHY PEOPLE 2010 GOALS

The Healthy People 2010 initiative set forth two primary goals. The first goal is to help persons of all ages increase life expectancy and improve their quality of life. The second goal is to eliminate health disparities among different segments of the population. In order to help meet these goals, Aetna has developed several programs and initiatives.

### HEALTHY BODY, HEALTHY WEIGHT PROGRAM

Focus on obesity is one of the biggest challenges faced in healthcare today in terms of improving overall quality of life as well as reducing morbidity and mortality. Looking at obesity trends in adults and children, no segment of the population is spared the risk and morbidity associated with obesity, although higher prevalence is seen in Black women. A marked increase is seen in prevalence of obesity in children and adolescents. The costs of obesity are tremendous, both in terms of direct pharmacy costs, as well as costs of increased comorbidities and certainly in terms of re-

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duced quality of life. Diabetes and coronary artery disease represent two of the top causes of death in Americans, and both are directly correlated with the obesity epidemic.

In response to these challenges, Aetna has created programs that are responsive to specific patient needs as well as programs that are based on known, evidence-based practices and support efficient use of healthcare services. Aetna's Healthy Body, Healthy Weight Program is designed on the principle that weight loss is voluntary; only those who are ready to change will participate and are more likely to succeed. The program design incorporates existing community resources and partners with employers as an important building block to a successful program. Participation in the program is voluntary, but incentives are provided to increase enrollment and encourage success. Patients are targeted early, before costly comorbid conditions can develop, and they are provided with tools to enhance behavioral and lifestyle changes.

Aetna has a number of technological tools available and provides them to participants in the weight-loss program. These tools include web-based health risk assessment and identification of potential comorbid conditions. Pharmacy claims data are used to identify possible cost-savings solutions. Aetna also partners with physicians to manage patients' obesity and other disease states. Worksite partnerships are another critical area since so many Americans receive health insurance through their employers. Aetna provides workplaces with "healthy choice" lists for cafeterias and vending machines, nutritional and weight-loss posters, menu leaflets with ethnic diets, and on-site body mass index (BMI) calculator tools.

Incentives are built into Aetna's program. These incentives are based on participation rather than outcome and are strategically implemented at three, six, and nine months to reduce attrition and encourage success. Incentives provided

include pedometers, coupons for community-based weight management programs, and possible financial incentives. The program is one year in duration and is accessed online or over the telephone. Risk stratification into low-, intermediate-, or high-risk groups is based on BMI and comorbidities; all content is health literate and culturally appropriate. Participants in the low-risk group (BMI < 29 with no comorbidities) are provided with nutritional education, menus, and information on a tailored exercise program. These participants receive a phone call from a nurse and a letter regarding medication options. Their primary care provider (PCP) receives a letter regarding program participation and medications. They are followed up in 6 months and receive a total of five "touchpoints," or contacts from Aetna to encourage participation and success. Participants in the intermediate-risk group (BMI = 30–34.9 with comorbidities and no hospitalizations) receive all of the amenities that the low-risk population receives, with the addition of increased phone calls from a weight-loss therapist (once per month for three months, then once every three months for a year). These participants receive an increased number of touchpoints: 10.

High-risk members (BMI  $\geq$  35 with comorbidities and hospitalizations) have access to all of these amenities, with the addition of follow-up calls from the nurse to the participant's PCP to discuss medications and comorbidities, increased calls from weight-loss therapist, and therapist always available via 800 number. The total number of touchpoints for this population is 25.

Outcome measures for this program are behavioral assessment, satisfaction, weight and amount of weight loss, BMI, medication use and adherence, physician visits, exercise, blood pressure, lipid and glucose levels, and others.

The program offers a number of benefits to both participants and also to Aetna. Participants receive education

and nutritional, ethnically appropriate menus. Benefits to Aetna are reduced pharmacy costs, decreased use of medical services, and less need for bariatric surgery.

### WOMEN'S HEALTH 2004

Another of Aetna's programs to reach Healthy People 2010 goals is the Women's Health 2004 program. Sample initiatives include Moms-to-Babies, Ethnic Disparity Initiatives, and Women's Health Online.

The Moms-to-Babies high-risk disease management program attempts to reduce the morbidity associated with preterm delivery to mothers and infants. This program leverages technology to provide women with the ability to enroll as early as possible, since early registration makes an enormous difference in providing women with the prenatal care they need. In general, early satisfaction data show that members are very satisfied with the program, case management, and educational materials. The program has resulted in decreased neonatal intensive care unit (NICU) days and lower NICU costs, which indicates that fewer infants are in need of intensive care. Employers are encouraged to participate in Moms-to-Babies; Aetna provides newsletter content, web enrollment posters, in-services, a presence at employer health fairs, and customized sponsor materials.

Ethnic Disparity Initiatives have focused on two groups at particularly high risk: African-American women and Latina women. For African-American maternity risk management programs, all African-American women are identified as high risk. In addition to Moms-to-Babies mailings, African-American women receive a booklet entitled, "Generations: a Pregnancy Guide for Women of African Descent." A breast cancer and ethnic disparities initiative focuses on African-American and Latina women to encourage mammography screening

and reduce morbidity. Materials are available in English and Spanish, and staff are bilingual. Of the total population, 100% received outreach from a nurse, and 52% agreed to have a follow-up mammogram.

## ADDRESSING HEALTH DISPARITIES

Addressing health disparities requires data for analysis to identify where disparities are occurring, determine what solutions can be offered, and target and deliver programs. Disparities in health care are viewed at Aetna as a quality imperative as well as a business imperative. Community-level interaction and involvement in solutions are critical to reduce health disparities. Aetna was the first plan to collect data on race and ethnicity, and have proactively addressed

challenges including effectively mitigating any questions of data abuse, ensuring appropriate use and access to data, and using data to develop specific programs. Key activities in addressing health disparities include voluntary data collection from members and network physicians. Aetna also has required internal clinical cultural competency training, and programs are developed to improve health outcomes in targeted areas. Data are also collected on physician ethnicity and language preference in order to allow patients to choose a provider with whom they can feel comfortable and participate in their own health care.

## SUMMARY

Aetna is involved in the struggle to reduce health disparities and improve the overall health status of persons living

in the United States. Aetna has been effective in using data wisely and leveraging available information resources to target specific programs to specific ethnic groups and to make sure that all patients have access to high-quality, evidence-based clinical care.

## C. IMPROVING CARDIOVASCULAR HEALTH OUTCOMES THROUGH USE OF EVIDENCE-BASED RESEARCH

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Please see complete article, *Improving Cardiovascular Health Outcomes Through the Use of Evidence-Based Medicine*, published under Original Reports: Heart Disease in this supplement.