Aetna's Program in Health Care Disparities:
The Diabetes Pilot Program

The Disparities Solutions Center

INTRODUCTION

Among health plans, Aetna has distinguished itself as a national leader in the area of identifying and addressing racial and ethnic disparities in health care. Under the leadership of Chairman Dr. John Rowe, Aetna's Task Force on Racial and Ethnic Disparities in Health Care was formed in 2002 to address gaps in its members' access to quality care and to oversee its newly established program in Health Care Disparities. This program is described as a "coordinated, multidimensional program in health disparities comprised of a variety of research, education, customer service, data collection, direct health care and general awareness initiatives" that is aimed at addressing perceived disparities in health care among its clients.[1, 2] The program comprises a major race-ethnicity data collection initiative, the Aetna Foundation's Regional Grant Program, education and training programs on cultural competency for physicians and health care leaders, Member Health Education Tools, and enhanced disease management programs. Aetna subsequently embarked on a series of activities that focus on improving the quality of care delivered to their minority members, including an African American Pre-Term Labor component of Aetna's Moms-to-Babies maternity management program; a Breast Health Initiative to improve mammography rates among African American and Latina women; and a Diabetes Disease Management Program to address disparities in diabetes that were identified internally. These are all part of a Chairman's Initiative that is guided both by an internal working group on disparities and an external, national Racial and Ethnic Disparities Expert Panel. In 2004, Aetna also joined the National Health Plan Collaborative (funded by the Robert Wood Johnson Foundation and the Agency for Healthcare Research and Quality)—a group of nine health plans working in partnership to address racial/ethnic disparities in health care.

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➤ At A Glance

ORGANIZATION
Aetna, Inc (Health Plan)

TOPIC
Improving the quality of diabetes care for African Americans and Latinos

ACTIVITY
Disease management program

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ISSUE SPOTLIGHT

Disease management is a well recognized and commonly used strategy to improve quality of care. Among several efforts to identify and address disparities, Aetna implemented a pilot program focused on meeting the needs of minority patients within their Diabetes Disease Management Program. This pilot was initiated after research showed that minorities (African-Americans and Hispanic/Latinos) within an ongoing standard diabetes disease management program had lower levels of glycosolated hemoglobin testing and lipid testing—key process measures in the care of diabetics. After interviewing minority patients to identify the barriers they faced in managing their diabetes, Aetna incorporated strategies to address issues of low health literacy among some of its members and cultural competence among some of its providers. This case study examines the experience of a culturally competent diabetes disease management pilot program.

MOTIVATION AND DRIVING FORCES

A New Direction

The arrival of Dr. John Rowe in September of 2000 marked a new era at Aetna—one focused on improving member access to quality care; a major component of this included identifying and addressing racial and ethnic disparities in health care. Motivated by his familiarity with the issue of disparities and his experiences both as a health care provider in Boston and a hospital president in New York City, Dr. Rowe created a Chairman's Initiative focused on disparities first led by Patricia Hassett, Chief of Staff, Office of the Chairman, and now by Laura Donna, Head of Enterprise Initiatives. Dr. Rowe identified two themes that he wanted to emphasize when he came to Aetna:

➤ Disparities is a quality of care issue that should be integrated into the organizational structure and functions and should lead to ongoing racial and ethnic data collection and quality improvement programs designed to eliminate disparities.

➤ The company should respond to the diversity of its members by implementing cultural competency programs for Aetna clinicians.

Key themes identified by Dr. Rowe:

- **Disparities reduction is integrated with quality of care**
- **Importance of increasing cultural competence**

Prior to beginning the Initiative, and in an effort to better understand the issue, Dr. Rowe asked for data on quality, stratified by race and ethnicity, and discovered that Aetna did not collect this information from its members routinely. After a process that included a review of the legal issues and concerns related to collecting this information, in 2002, Aetna staff embarked on a new race and ethnicity data collection effort of its membership. Dr. Rowe was interviewed by the Wall Street Journal for an article on the program. In response to a question about whether he was concerned that the motivation for collecting this information would be perceived as discriminatory, he stated that "knowing the subsets of his enrolled members had higher risk of diseases and poor outcomes and not doing anything about it, was itself racist."[3] In effect, the opportunity to clarify the company's position in the lay press helped to "immunize" both Dr. Rowe and Aetna from unwarranted criticism. Not only was the article and their approach favorably received at the national level, but Dr. Rowe said "it also made it safe for others to get into the water, as Aetna proved collecting this data wasn't the third rail that many perceived it was."

Good Medicine and Good Business

"When we paid attention to this issue, and began collecting race and ethnicity data, we unleashed a capacity within the organization," Dr. Rowe states. Many within Aetna were excited about the company's ability to identify and address racial and ethnic disparities in health care. Collecting general data was not good enough, though, and Aetna asked its diabetes disease management contractor to stratify its quality measures for members by race and ethnicity. Disparities in quality by race and ethnicity were found, with minorities being less likely to have received glycosolated hemoglobin or cholesterol testing, or to have had the influenza vaccination. This was the motivation for the Diabetes Pilot Program described here, part of a broader Aetna disparities initiative to address disparities.

Ultimately, Dr. Rowe feels that addressing racial and ethnic disparities in health care is "good medicine and good business." He said that "addressing disparities is a quality improvement issue, and therefore in line not only with good medical practice, but also with solid business principles that include knowing your customers and providing them with excellent services." In addition, he feels that Aetna has distinguished itself in the marketplace as one of a few large health plans that can assure large employers that the company is tackling disparities, and provides the best service for an increasingly diverse American workforce. Although no formal return on investment has been calculated, at this time the primary benefit—in addition to providing higher quality care to members—is market distinction.

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>
> **– JOHN ROWE, M.D.**

PROGRAM DESCRIPTION

Name of Program: Diabetes Disease Management Pilot

Approach for Addressing Disparities: Targeted Intervention

Motivation for Condition Selection: Diabetes is a common chronic disease for which Aetna routinely examines quality measures, including screening and laboratory values; higher prevalence among minority populations.

Target Population: African Americans and Latinos with diabetes who were active members of disease management services in 2005 and who had no claims for influenza vaccination, glycosolated hemoglobin testing, and cholesterol (LDL) screening from July 1, 2004 to July 13, 2005. Non-Hispanic Whites were not included in the Pilot. Members must have been continuously enrolled for 18 months (12 months prior to intervention and 6 months post intervention). Case finding for the disease management program was accomplished via a "health profile database" which requires 3 different claims for diabetes among 4 different databases (hospital, pharmacy, outpatient, and labs).

Project Goals: To improve rates of utilization of preventive services, including cholesterol screening and glycosolated hemoglobin testing.

Background: Aetna authorized the voluntary collection of race and ethnicity data for all members in 2001. The data were collected on health plan members using a variety of self-reporting approaches, including during enrollment; as input into the Aetna Navigator website (used by enrollees); and as part of disease management calls made to patients as part of this intervention (also voluntary). Aetna has collected race and ethnicity data on approximately 3 million of 15 million active medical members, and 80-90% of those who have the option of providing their race and ethnicity on the enrollment forms have done so. Only a select few employees at Aetna have access to the race and ethnicity data. Each request for analysis must be approved by a review process and committee that includes an attorney, the head of informatics, the head of quality, and the head of the disparities initiative. No information on income or other measures of socioeconomic status are collected.

Disease management for diabetes at Aetna has been provided by an external vendor. A 2003 survey by researchers at Emory University found racial and ethnic disparities in the management of diabetes among members in the Aetna Diabetes Disease Management program. Subsequently, an analysis of barriers conducted by these researchers identified limited health literacy and health numeracy as potential barriers to receiving preventive services among this group of minority members.[4] In 2005, Aetna implemented a Diabetes Disease Management Pilot to address these gaps identified by Emory University and to determine appropriate ways to improve self-management of the disease. Data from Aetna's Health Analytics team revealed that 13% of African American and Latino members lacked a glycosolated hemoglobin test and 17% lacked an LDL test in the past year.

Process and Intervention: The usual disease management protocol prior to the intervention included a monthly telephone call from a registered nurse who would review the patient's clinical record and discuss progress. In addition, the patient received an informational newsletter about diabetes twice a year as well as an influenza vaccination reminder. The diabetes pilot was designed to offer a number of enhanced services, including efforts focusing on the vendor's clinical staff, the patient's physician, and the patient.

1. The Disease Management Vendor:

- ➤ Developed an Enhanced Coaching Telephone Call Script and Protocol: The script for calls to members in the disease management program was revised to target those with lower health literacy and numeracy skills.
- ➤ Received Cultural Competency Training: Brief training in cultural self-awareness, as well as practical tips for communicating with minority patients were provided.

2. The Patient's Physician:

- ➤ Received a targeted mailing: The mailing included patient specific data, a copy of the educational materials that were sent to the patients, and a link to the Department of Health and Human Services Office of Minority Health Cultural Competency Training for Family Physicians was provided (although there was no method of verifying whether the physicians voluntarily enrolled in the training program).

3. The Patient:

- ➤ Received a targeted mailing (in English and Spanish): This mailing was sent to minority patients in the disease management pilot program. It included The National Institutes of Health's ABC (HbA1c, Blood pressure control, Cholesterol management) Booklet[5]—materials that emphasize the importance of glucose, cholesterol and hypertension screening and management for diabetics (written at the 5th grade level). Materials on the importance of influenza vaccination were also added to the mailing in September 2005. Patients were instructed to bring these materials with them the next time they saw their physician.
- ➤ Receive a targeted call: Patients received "out of cycle" calls by the vendor (outreach calls above and beyond standard disease management protocol) to further address any issues or barriers they were facing.

Cost: There was no marginal cost to Aetna for implementing the diabetes pilot beyond the costs associated with their overall program on disparities reduction. Because of the size of their contract with the disease management vendor, Aetna was able to negotiate the addition of the enhanced intervention at no increase in fee. The cost to the vendor was approximately $125,000 and included direct staffing costs (labor + benefits), outbound call attempts and the successful calls for the campaign calls, and the cost of printing and mailing the (A1c & LDL) letter.

PROGRAM RESULTS

The pilot enrolled 226 members who had not received glycosolated hemoglobin testing and 294 members who had not received LDL testing during the 12-month baseline. Aetna then tracked receipt of testing among pilot participants via insurance claims during the period July 15, 2005 – December 31, 2005. Although influenza materials were included in the patient education packets, Aetna did not attempt to track receipt of influenza shots because insurance claims are considered to be an unreliable source of information. By the end of the study period, 37.8% of pilot enrollees had received cholesterol screening and 38.1% had received glycosolated hemoglobin testing.

SUSTAINABILITY AND NEXT STEPS

Although still evaluating the outcomes of the Diabetes Pilot, there have been many lessons learned that will assist Aetna in their ongoing effort to address disparities. Many of these have been shared publicly as part of their participation in the National Health Plan Collaborative that is focused on disparities in diabetes care. Another Aetna pilot project currently underway addressing disparities in hypertension through culturally competent disease management should provide additional lessons as well. This program will compare a standard quality improvement approach to one that is more targeted toward minorities and follows the same principles as the Diabetes Pilot.

In the future, Aetna will be revamping their approach to disease management programs. New efforts in this area will be broadened, and will focus on members with multiple conditions (moving away from the simple, single disease approach). They will focus on all members, but data collected will be stratified by race/ethnicity to monitor for disparities, and the interventions will be informed by the lessons learned in the diabetes pilot. For example, all patient information will be targeted at a basic level of health literacy, and cultural competence training will be required for all staff engaged in the disease management programs. In summary, the program on diabetes will not only be sustained, but in essence will be “new and improved” and will be applied more broadly to other conditions. Routine collection and stratification of data by race and ethnicity will allow for close monitoring of progress related to disparities in health care.

Cultural competence training will be required for all staff engaged in the disease management programs.

LESSONS FOR THE FIELD

- Once disparities are identified, it is helpful to conduct a barrier analysis to determine what specific challenges and issues minority patients may be facing that contribute to differences in quality of care. This information can be used to shape interventions.
- Cultural competency training holds promise as one part of a multi-tiered intervention, but the quality of the program, and its uptake, is an equally important consideration. It is important, however, to embed principles of cultural competence (including addressing health literacy) into multiple parts of the intervention, not just in the training of health care providers and coaches.
- While gaining a better understanding of return on investment of these efforts is planned for the future, efforts to reduce racial and ethnic disparities appears to have value at Aetna in terms of differentiating the company's image in the marketplace.
- In the process of analyzing their data, Aetna discovered some discrepancies between self-reported utilization and claims data, with some of the disparities identified from interviews with disease management members not being verified by the claims data. One explanation may be that diabetes tests were in fact performed, but without a thorough explanation to patients, or perhaps the issues were explained but not understood. More needs to be learned about how vulnerable populations understand the care that is provided to them.
- A limitation of the pilot is that the evaluation lacked a valid control group. For example, it would have been advantageous to randomize enrollees into an intervention group and a non-intervention group to see if some of the gains during the study period would have occurred anyway. It would also be helpful to have comparative data on non-Hispanic white members with diabetes.

CRITICAL SUCCESS FACTORS

- The collection of race and ethnicity data is possible and practical from both legal and economic perspectives, and forms the foundation for all efforts to address disparities. Without this data, it is impossible to determine if any racial/ethnic group is receiving disparate quality of care.
- Addressing disparities through a quality improvement framework is promising, and can be viewed as good medicine and good business.
- Leadership, structure, and a willing organization are key elements in creating and developing an agenda to address racial/ethnic disparities in health care.

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FOR FURTHER INFORMATION

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AETNA TIMELINE:

1982

- Launches the Aetna Foundation

2001

- Authorizes race and ethnicity data collection
- Establishes the colorectal cancer partnership with the American Cancer Society and provided culturally appropriate education in 6 languages

2002

- Launches the internal task force on disparities, which Dr. John Rowe chaired
- Begins collecting race and ethnicity data from members
- Adds outreach to prevent preterm labor for African Americans
- Launches the breast health ethnicity disease interventions for African Americans and Latinos
- Launches the external advisory board for race and ethnicity disparities

2003

- Initiates collection of race/ethnicity data in Diabetes Disease Management Program
- Starts DocFind and makes it available in Spanish
- Initiates Quality Interactions Cultural Competence Training program for all internal medical directors and case managers
- Joins the National Health Plan Learning Collaborative (focused on diabetes)

2004

- Initiates Marriott Pilot for Health Literacy
- Accepts race/ethnicity data from the Aetna navigator
- Extends regulatory approval for data collection
- Identifies diabetes disparities in disease management population; intervention (described in this case study) and analysis begins
- Receives award from Disease Management Association of America for their disease management efforts

2005

- Patricia Hassett publishes article in Health Affairs summarizing Aetna efforts
- Completes barriers analysis of hypertension control for African Americans
- Collects data on Breast Health Initiative