Relevance to Population

Chronic Obstructive Pulmonary Disease (COPD) affects more than 12 million people in the United States, making it the 4th leading cause of mortality and the 2nd leading cause of disability. It is predicted that these statistics will increase 30% by 2020 due to the aging population and prevalence of tobacco use (Buist 2005). In 2012, COPD was one of the top 10 diagnoses for inpatient admissions of UPMC Health Plan members. Although COPD cannot be cured, use of the following evidence-based guidelines for management of COPD can control symptoms, slow disease progression, and improve quality of life. The prevalence rate for COPD at UPMC Health Plan in 2012 was 3.71% percent for all products; 23.12% for SNP and 13.49% for Medicare.

Definition

COPD is a common preventable and treatable disease, characterized by chronic airflow limitation that is usually progressive and associated with an enhanced chronic inflammatory response in the airways and the lungs to noxious particles or gases. Exacerbations and comorbidities contribute to the overall severity in individual patients. (GOLD 2013)

The chronic inflammatory response in the airways may lead to parenchymal tissue destruction with enlargement and loss of elasticity in the alveoli (emphysema), and disruption of the normal repair and defense mechanisms, resulting small airway fibrosis.

Extra-pulmonary manifestations of COPD, including nutritional abnormalities, weight loss, skeletal muscle dysfunction, and increased risk for cardiovascular disease, may also affect the prognosis in individuals with COPD.

Clinical Indicators Measured by UPMC Health Plan

1. The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis. -HEDIS®
2. The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter during the measurement year and who were dispensed appropriate medications:
   - Dispensed a systemic corticosteroid within 14 days of the event -HEDIS® AND
   - Dispensed a bronchodilator within 30 days of the event. -HEDIS®

Population Covered by Guideline: All adult members with stable COPD and acute exacerbations of COPD.

Goals of Therapy for COPD Management

- Reduce risk: Prevent disease progression, prevent and treat exacerbations, reduce mortality
- Reduce symptoms: Relieve symptoms, improve health status and exercise tolerance

Diagnosis of COPD

- Clinical indicators for considering the diagnosis of COPD include any of the following in an individual over age 40 years (GOLD 2013):
  - Persistent dyspnea that progresses over time and is typically worse with exercise
  - Chronic cough that may be intermittent and may be unproductive
  - Any pattern of chronic sputum production
  - Exposure to risk factors: tobacco or other smoke, occupational dust and chemicals
• Spirometry is required for the diagnosis of COPD (GOLD 2013 & Qaseem 2011)
  o Use of spirometry to screen for COPD is only recommended in symptomatic patients
    (evidence does not show benefit of treatment for COPD before the onset of symptoms)
  o Spirometry should be performed after an adequate dose of a short-acting inhaled bronchodilator to minimize test variability
  o A post-bronchodilator fixed ratio of $FEV_1/FVC < 0.70$ confirms the diagnosis of COPD
  o Post-bronchodilator $FEV_1$ is used to assess the severity of airflow obstruction in COPD
    (see table below)

<table>
<thead>
<tr>
<th>COPD Severity Category</th>
<th>Degree of Airflow Limitation</th>
<th>$FEV_1$ (% predicted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I: Mild</td>
<td>Mild</td>
<td>$FEV_1 \geq 80%$</td>
</tr>
<tr>
<td>II: Moderate</td>
<td>Worsening</td>
<td>$50% \leq FEV_1 &lt; 80%$</td>
</tr>
<tr>
<td>III: Severe</td>
<td>Further worsening</td>
<td>$30% \leq FEV_1 &lt; 50%$</td>
</tr>
<tr>
<td>IV: Very Severe</td>
<td>Severe</td>
<td>$FEV_1 &lt; 30%$</td>
</tr>
</tbody>
</table>

COPD Treatment - Smoking Cessation: KEY POINTS

Smoking cessation is the single most effective intervention to prevent COPD and to slow its progression (GOLD 2013 and Qaseem 2011)

Brief Strategy to Help Patients Willing to Quit Smoking (GOLD 2013):
  o **ASK**: Systemically identify all tobacco users at every visit
  o **ADVISE**: Strongly urge all tobacco users to quit
  o **ASSESS**: Determine willingness to make a quit attempt
  o **ASSIST**: Aid the patient in quitting
  o **ARRANGE**: Schedule follow-up contact

COPD Treatment - Assessment for Therapy: (refer below to “Recommendation of the 2013 GOLD COPD Guideline”)

• The following should be assessed to guide therapy for patients with COPD:
  o Current level of patient’s symptoms
  o Severity of spirometric abnormality
  o Risk of COPD exacerbation
  o Presence of comorbidities

COPD Treatment – Pharmacotherapy: KEY POINTS (GOLD 2013)

• General considerations:
  o Pharmacotherapy can improve symptoms, health status and exercise tolerance, and reduce the frequency and severity of exacerbations.
  o No medications for COPD have been shown to modify the long-term decline in lung function.
  o Each pharmacologic treatment regimen should be individualized according to severity of symptoms, risk of exacerbations, drug availability, and the patient’s response.
• Bronchodilators:
  o Inhaled bronchodilators are central to COPD management, either as needed or on a regular basis to prevent or reduce symptoms.
  o Long-acting bronchodilators (LABD) are convenient and more effective at producing maintained symptom relief than short-acting bronchodilators.
  o There is no evidence to recommend one class of LABD over another – initial selection of an inhaled long-acting beta₂ agonist or anticholinergic bronchodilator should depend on the patient’s perception of symptom relief.
  o Combined use of either short or long-acting beta₂ agonists and anticholinergic inhalers may be considered if symptoms are not relieved with single agents.
  o Short-acting bronchodilators are preferred in treating acute COPD exacerbations.

• Corticosteroids: (GOLD 2013)
  o Long-term treatment with inhaled corticosteroids plus LABD is recommended for patients with severe/very severe COPD and frequent exacerbations.
  o Long-term monotherapy with inhaled or oral steroids is not recommended in COPD.
  o Long-term inhaled steroid therapy increases risk for pneumonia and fractures.
  o Oral prednisolone 30-40mg/day x 10-14 days is recommended for acute exacerbations.

• Selective Phosphodiesterase 4 Enzyme Inhibitor (PDE4): (GOLD 2013)
  o Roflumilast (Daliresp) plus LABD may be used to reduce exacerbations in severe/very severe COPD with chronic bronchitis and frequent exacerbations. (GOLD 2013)
  o PDE 4 inhibitors should always be combined with at least one LABD.
  o Roflumilast should be avoided in underweight patients.
  o Roflumilast and theophylline should not be given together.

• Mucolytic therapy: (GOLD 2013)
  o Routine use not recommended in COPD based on very small demonstrated benefits.

• Antibiotic therapy: (GOLD 2013)
  o Prophylactic, continuous use of antibiotics is not recommended in COPD.
  o Antibiotics (5-10 day course) are indicated for treating infectious exacerbations of COPD when there is increased dyspnea, increased sputum volume and purulence or require mechanical ventilation.

### 2011 ACP, ACCP, ATS, ERS Guideline Update (Qaseem 2011):

<table>
<thead>
<tr>
<th>Guideline Update: Recommendations for Treatment of Stable COPD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Description</strong></td>
</tr>
<tr>
<td>Asymptomatic, with or without airflow obstruction</td>
</tr>
<tr>
<td>Stable symptomatic COPD</td>
</tr>
<tr>
<td>Stable symptomatic COPD</td>
</tr>
<tr>
<td>Stable symptomatic COPD</td>
</tr>
<tr>
<td>Stable symptomatic COPD</td>
</tr>
</tbody>
</table>
Recommendation of the 2013 GOLD COPD Guideline:

- GOLD recommends placing patients into 4 treatment categories (A, B, C, D) based on the following:
  - Validated patient questionnaires to assess symptoms in COPD patients, using the:
    - Modified British Medical Research Council (mMRC) Questionnaire: measures 5 levels of breathlessness and predicts future mortality risk (copd.about.com/od/copdbasics/a/MMRCdyspneascale.htm)
    - OR
    - COPD Assessment Test (CAT): 8 item measure (score 0-40) of health status impairment in COPD. (www.catestonline.org)
  - Spirometric severity level (mild, moderate, severe, or very severe)
  - Assessment of exacerbation risk (based on the previous number of exacerbations per year).

- GOLD association between Symptoms, Spirometric Classification, and Exacerbation Risk:
  - **Patient Group A** – Low Risk, Less Symptoms: Mild or moderate airflow obstruction and/or 0-1 exacerbations/year, and mMRC grade 0-1 or CAT score < 10.
  - **Patient Group B** – Low Risk, More Symptoms: Mild or moderate airflow obstruction and/or 0-1 exacerbations/year, and mMRC grade ≥ 2 or CAT score ≥ 10.
  - **Patient Group C** – High Risk, Less Symptoms: Severe or very severe airflow obstruction and/or ≥ 2 exacerbations/year, and mMRC grade 0-1 or CAT score < 10.
  - **Patient Group D** – High Risk, More Symptoms: Severe or very severe airflow obstruction and/or ≥ 2 exacerbations/year, and mMRC grade ≥ 2 or CAT score ≥ 10.

<table>
<thead>
<tr>
<th>Initial Pharmacological Management of COPD* (GOLD 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Group</strong></td>
</tr>
<tr>
<td>A</td>
</tr>
<tr>
<td>B</td>
</tr>
<tr>
<td>C</td>
</tr>
</tbody>
</table>

*continued*
### Non-Pharmacological Treatment of COPD – KEY POINTS:

- **Influenza and pneumococcal immunization** should be offered to every COPD patient. (GOLD 2011)

- **Physical Activity**: is recommended for all patients with COPD:
  - Evidence for benefit is extrapolated from pulmonary rehabilitation studies.
  - Pulmonary rehab benefits may be sustained if exercise training is maintained at home.

- **Pulmonary Rehabilitation**:
  - All patients who get short of breath when walking at their own pace on level ground should be offered pulmonary rehabilitation. (GOLD 2013)
  - Pulmonary rehabilitation should be considered for COPD patients who have dyspnea or other respiratory symptoms, reduced exercise tolerance, restriction in activities from their disease, or impaired health status. (American Thoracic Society)
  - Benefits of pulmonary rehabilitation (level A evidence) (GOLD 2013):
    - Improved exercise capacity
    - Reduced the perception of breathlessness
    - Improved health-related quality of life
    - Reduced hospitalizations and the number of days in the hospital

- **Long-term Oxygen Therapy**:
  - Oxygen (O\textsubscript{2}) therapy (> 15 hours/day) has been shown to increase survival in patients with hypoxemia.
  - Continuous O\textsubscript{2} therapy should be prescribed in COPD patients with severe resting hypoxemia (PaO\textsubscript{2} \(\leq 55\) mmHg/SaO\textsubscript{2} \(\leq 88\%\) on room air) (strong recommendation). (Qaseem 2011)

- **Non-invasive Ventilation (NIV)** (e.g., CPAP, BiPAP): (GOLD 2013)
  - NIV with long-term oxygen therapy may be considered in patients with stable severe COPD and pronounced daytime hypercapnea.
  - It may improve survival but not quality of life
  - In patients with both COPD and sleep apnea, there are clear benefits from CPAP in both survival and risk of hospital admission.
• Lung Volume Reduction Surgery (LVRS): (GOLD 2013)
  o Patients should be referred to the LVRS coordinator (412-647-5266) for more detailed radiographic, cardiac, and exercise evaluation to determine candidacy.
  o Removing hyper-inflated parts of the lung improves respiratory muscle function, increases elastic recoil pressure of the lung, and improves expiratory flow rates.
  o LVRS is most effective among patients with severe, predominantly upper-lobe emphysema and low post-rehabilitation exercise capacity prior to treatment; benefits include:
    ▪ Reduction in COPD exacerbations
    ▪ Improvement in survival in selected COPD patients compared to medical therapy (54% vs. 39.7%).
      ➢ There was no survival benefit in similar patients with high post-pulmonary rehab exercise capacity, although exercise capacity and quality of life improved.
      ➢ LVRS had higher mortality vs. medical therapy in severe COPD with FEV1 ≤ 20% predicted and homogenous emphysema or DL_CO2 ≤ 20% predicted.

• Lung Transplantation: (GOLD 2013)
  o In appropriately selected patients with severe COPD, lung transplantation has been shown to improve quality of life and functional capacity.
  o Criteria for referral for lung transplantation include COPD with a BODE Index* > 5
  o Criteria for listing a COPD patient for lung transplantation include a BODE Index of 7-10 and at least one of the following:
    ▪ History of exacerbation associated with acute hypercapnea (PaCO2 > 50 mmHg)
    ▪ Pulmonary hypertension, cor pulmonale, or both despite oxygen therapy
    ▪ FEV1 < 20% predicted with either DL_CO2 < 20% predicted or homogenous distribution of emphysema

* BODE Index – A multidimensional grading system for COPD, which has been shown to be superior to FEV1 in predicting all cause and respiratory related death in COPD. It assigns points based on severity of dysfunction for FEV1, distance walked in 6 minutes, MMRC** dyspnea scale, and BMI.

** Modified Medical Research Council (MMRC) Dyspnea Scale – A grading system to assess a patient’s level of dyspnea, as follows:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description of Breathlessness</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I only get breathless with strenuous exercise.</td>
</tr>
<tr>
<td>1</td>
<td>I get short of breath when hurrying on level ground or walking up a slight hill.</td>
</tr>
<tr>
<td>2</td>
<td>On level ground, I walk slower than people of the same age because of breathlessness, or have to stop for breath when walking at my own pace.</td>
</tr>
<tr>
<td>3</td>
<td>I stop for breath after walking about 100 yards or after a few minutes on level ground.</td>
</tr>
<tr>
<td>4</td>
<td>I am too breathless to leave the house or I am breathless when dressing.</td>
</tr>
</tbody>
</table>
### Pharmaceutical Interventions for Inhaled Agents and Dosing Information (GOLD 2011)

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
<th>Drug Category</th>
<th>Dosing Information &amp; Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beta&lt;sub&gt;2&lt;/sub&gt;-Agonists, Short-acting</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albuterol (Salbutamol)</td>
<td>Ventolin HFA&lt;sup&gt;®&lt;/sup&gt;, Proventil HFA&lt;sup&gt;®&lt;/sup&gt;, Proair HFA&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Short-acting β&lt;sub&gt;2&lt;/sub&gt; agonist</td>
<td>2 puffs as needed every 4-6 hours</td>
</tr>
<tr>
<td>Levalbuterol</td>
<td>Xopenex HFA&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Short-acting β&lt;sub&gt;2&lt;/sub&gt; agonist</td>
<td>2 puffs every 4-6 hours (theoretical benefits over Albuterol not demonstrated; 3&lt;sup&gt;rd&lt;/sup&gt; line after Albuterol &amp; Ipratropium in COPD)</td>
</tr>
<tr>
<td>Terbutaline</td>
<td>Brethine</td>
<td>Short-acting β&lt;sub&gt;2&lt;/sub&gt; agonist</td>
<td>5 mg three times a day, taken P.O.</td>
</tr>
<tr>
<td><strong>Beta&lt;sub&gt;2&lt;/sub&gt;-Agonists, Long-acting</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arformoterol</td>
<td>Brovana&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Long-acting β&lt;sub&gt;2&lt;/sub&gt; agonist</td>
<td>15 mcg via a standard jet nebulizer connected to an air compressor twice a day</td>
</tr>
<tr>
<td>Salmeterol</td>
<td>Serevent Discus&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Long-acting β&lt;sub&gt;2&lt;/sub&gt; agonist</td>
<td>1 puff BID; higher and longer bronchodilation effect than other β&lt;sub&gt;2&lt;/sub&gt; agonists</td>
</tr>
<tr>
<td>Formoterol</td>
<td>Foradil&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Long-acting β&lt;sub&gt;2&lt;/sub&gt; agonist</td>
<td>1 puff BID; similar to Salmeterol, but has quicker onset of action</td>
</tr>
<tr>
<td>Indacaterol</td>
<td>Arcapta Neohaler</td>
<td>24-hour long-acting β&lt;sub&gt;2&lt;/sub&gt; agonist</td>
<td>75 mcg once daily, dry powder capsule for inhalation with the Neohaler</td>
</tr>
<tr>
<td><strong>ANTICHOLINERGICS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ipratropium</td>
<td>Atrovent&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Short-acting anticholinergic</td>
<td>2-4 puffs QID; maintenance only, not PRN for acute symptoms</td>
</tr>
<tr>
<td>Tiotropium</td>
<td>Spiriva&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Long-acting anticholinergic</td>
<td>1 capsule inhaled daily; replaces Ipratropium</td>
</tr>
<tr>
<td>Aclidinium&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Tudorza&lt;sup&gt;TM&lt;/sup&gt;</td>
<td>Long-acting anticholinergic</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td><strong>Combination short-acting beta&lt;sub&gt;2&lt;/sub&gt;-agonists plus anticholinergic in one inhaler</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albuterol + Ipratropium&lt;sup&gt;[&lt;small&gt;1&lt;/small&gt;]&lt;/sup&gt;</td>
<td>Combivent&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Short-acting β&lt;sub&gt;2&lt;/sub&gt; agonist + short-acting anticholinergic</td>
<td>2 puffs QID; greater bronchodilation inhaled in combination, but similar effect probably achieved by doubling the dose of each drug</td>
</tr>
<tr>
<td><strong>METHYLXANTHINES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aminophylline</td>
<td></td>
<td>Methylxanthines</td>
<td>300-600 mg every 6 to 8 hours dependent on weight and tolerability</td>
</tr>
<tr>
<td>Theophylline (SR)</td>
<td>Theo-Dur, Theo-24</td>
<td>Methylxanthines</td>
<td>300-600 mg once or twice daily depending on the formulation, weight, and tolerability</td>
</tr>
<tr>
<td><strong>INHALED CORTICOSTEROID</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beclomethasone</td>
<td>Qvar&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Inhaled Corticosteroid</td>
<td>1-8 puffs (40-320mcg) twice daily</td>
</tr>
<tr>
<td>Budenoside DPI</td>
<td>Pulmicort&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Inhaled Corticosteroid</td>
<td>1 – 8 puffs (180-1440 mcg) daily divided in 2 doses</td>
</tr>
<tr>
<td>Flunisolide&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Aerobid&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Inhaled Corticosteroid</td>
<td>2 – 8 puffs (500 – 2000 mcg) daily divided in 2 doses</td>
</tr>
</tbody>
</table>

*continued*
### Pharmaceutical Interventions for Inhaled Agents and Dosing Information (GOLD 2011)

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
<th>Drug Category</th>
<th>Dosing Information &amp; Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluticasone 44</td>
<td>Flovent 44®</td>
<td>Inhaled Corticosteroid</td>
<td>2 – 6 puffs (88 – 264 mcg) daily divided in 2 doses</td>
</tr>
<tr>
<td>Fluticasone 110</td>
<td>Flovent 110®</td>
<td>Inhaled Corticosteroid</td>
<td>2 – 16 puffs (220 – 1760 mcg) daily divided in 2 doses</td>
</tr>
<tr>
<td>Fluticasone 220</td>
<td>Flovent 220®</td>
<td>Inhaled Corticosteroid</td>
<td>2 – 8 puffs (440 – 1760 mcg) daily divided in 2 doses</td>
</tr>
<tr>
<td>Mometasone†</td>
<td>Asmanex®</td>
<td>Inhaled Corticosteroid</td>
<td>1-2 puffs (220-440 mcg) once or twice daily</td>
</tr>
<tr>
<td>Ciclesonide†</td>
<td>Alvesco®</td>
<td>Inhaled Corticosteroid</td>
<td>1-4 puffs (80mcg-320mcg) twice daily</td>
</tr>
<tr>
<td>Fluticasone 100 + Salmeterol 50</td>
<td>Advair 100/50®</td>
<td>Combination long-acting β₂ agonist + Inhaled Corticosteroid</td>
<td>1 puff (100 mcg Fluticasone + 50 mcg Salmeterol) every 12 hrs</td>
</tr>
<tr>
<td>Fluticasone 250 + Salmeterol 50</td>
<td>Advair 250/50®</td>
<td>Combination long-acting β₂ agonist + Inhaled Corticosteroid</td>
<td>1 puff (250 mcg Fluticasone + 50 mcg Salmeterol) every 12 hrs</td>
</tr>
<tr>
<td>Fluticasone 500 + Salmeterol 50</td>
<td>Advair 500/50®</td>
<td>Combination long-acting β₂ agonist + Inhaled Corticosteroid</td>
<td>1 puff (500 mcg Fluticasone + 50 mcg Salmeterol) every 12 hrs</td>
</tr>
<tr>
<td>Formoterol/ Budesonide</td>
<td>Symbicort®</td>
<td>Combination long-acting β₂ agonist + Inhaled Corticosteroid</td>
<td>2 puffs(80-160mg/4.5mg) twice daily</td>
</tr>
</tbody>
</table>

**System Corticosteroids**

| Prednisone | Deltasone | Corticosteroid | Variable dosing, short term use if exacerbation to shorten recovery time |
| Methyl-prednisolone | Medrol | Corticosteroid | Variable dosing, short term use if exacerbation to shorten recovery time |

**Phosphodiesterase 4 Enzyme (PDE4) Inhibitor - systemic/oral therapy**

| Roflumilast | Daliresp | PDE4 Inhibitor | 500 mcg once daily, taken P.O. |

*=not listed in GOLD treatment guidelines

*It is important to note, the pharmacy coverage can vary based on the members plan. Therefore it is recommended that the office confirm coverage through the pharmacy to determine covered plan benefits.*

For additional information go to [www.upmchealthplan.com](http://www.upmchealthplan.com)


### Additional Resources for UPMC Health Plan Members

- **MyHealth Advice Line** is staffed by experienced Registered Nurses and is available 24/7 to provide telephone support to members. Call 1-866-918-1591. TTY/TDD users should call 1-866-918-1593.
- **Health Coach Programs** provide intensive case management for members with specific chronic illnesses or conditions. The programs are built upon best practices and accepted clinical guidelines and include:
Diabetes
Respiratory
  • Asthma
  • COPD
Behavioral Health
  • Depression
Cardiovascular
  • Heart failure
  • Coronary artery disease

• Additional Health Coach Program information available to members and providers by calling:
  1-866-778-6073.

• Additional Health Condition Management Programs include:
  • Hypertension
  • Hyperlipidemia
  • Low Back Pain
  • ESRD
  • Wound Care
  • Oncology
  • Rare & Chronic Conditions
  • Attention Deficit/Hyperactivity Disorder (ADHD)
  • Anxiety Disorders
  • Substance Abuse

• Online interactive preventive health programs and resources are available in partnership with WebMD at
  www.upmchealthplan.com
  • MyHealth Ready to Quit™
  • MyHealth Step Up to Wellness™
  • MyHealth Eating Well™
  • MyHealth Weigh to Wellness™
  • MyHealth Less Stress™
  • MyHealth OnLine Emotional Health Program™
Scientific Evidence Sources


