

DM DISEASE MANAGEMENT ADVISOR™

Physicians need DM in medical home model

Collaborative effort between docs, industry expected

There are signs that the advanced medical home concept is gaining steam: The increasing drumbeat emanating from physician groups, the reported success of Medicare's Physician Group Practice (PGP) demonstration projects, and two documents released in December 2007 that noted the benefits of having PCPs at the center of patient care. "People are realizing that if you are going to have any way of controlling the costs of healthcare and costs of premiums for people, we have to find effective ways to treat chronic illnesses," says **David S. Herr, MD**, chief medical officer at Rocky Mountain Health Plans in Grand Junction, CO. "This is really a win-win approach. You are promoting the idea of more care for your patients, not limiting care. You're giving the care when it's most effective, and with a healthier patient, you're avoiding a higher hospital cost later."



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MEDICARE DISEASE MANAGEMENT SECTION

p. 1 Fielding the unanswered questions

The questions about the market value and the cost of providing healthcare for those over 65 years of age with multiple chronic comorbid conditions are much more complex than when Medicare was launched 40 years ago.

The two documents released in December that promoted the medical home model are:

1. DMAA: The Care Continuum Alliance's *Advancing the Population Health Improvement Model*, which supports a system in which the patient-physician relationship is at the center of a "comprehensive, coordinated team approach." (See "DMAA backs medical home tenets" on p. 3.)
2. The Commonwealth Fund's report *Bending the Curve: Options for Achieving Sav-*

ings and Improving Value in U.S. Health Spending, which highlights several cost-saving ideas and notes that a medical home with "a per-member per-month fee for care management services in addition to usual fee-for-service payments" and "additional quality- and efficiency-based incentives" could save \$60 billion in five years and \$193.5 billion in 10 years in national health expenditures. Most of the savings would come from a decrease in hospital and physician expenses resulting from "higher-quality and more-efficient care delivered by medical homes."

The medical home movement is full steam ahead, which makes one wonder: What will happen to the DM industry if the medical home concept becomes the norm?

DM leaders say the medical home does not signal the end of DM companies, but instead DM will play a major role in the concept.

The advanced medical home concept with care coordination in the physician's practices is quite a different model than DM, but **Gordon Norman, MD, MBA**,

"DM has about a 15-year learning curve of developing techniques for improving population health that is not going to be learned or adopted overnight by primary care physicians."

—Gordon Norman, MD, MBA

Medical home model

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chair-elect of DMAA and executive vice president and chief science officer at Alere Medical, Inc., in Reno, NV, says the medical home is not a substitute for the DM industry; rather, DM is a complementary tool that physicians will need.

“DM has about a 15-year learning curve of developing techniques for improving population health that is not going to be learned or adopted overnight by primary care physicians,” says Norman, who describes his vision of the medical home this way: care coordination services funneling through a single focus and point of contact

(the physician) so the patient doesn’t have to become a healthcare expert to chase down all the information from separate sources.

Vince Kuraitis, JD, MBA, principal of Better Health Technologies in Boise, ID, says the medical home model has the potential to become “a blending of the best of both worlds” that will include doctors properly reimbursed for care coordination that is supported by DM’s infrastructure, such as call centers, predictive modeling software, diabetes educators, and remote monitoring.

Rick Kellerman, MD, board chair of the American Academy of Family Physicians and a practicing family physician in Wichita, KS, says DM and PCPs working in “parallel universes” is a “waste of money.”

The patient-centered medical home is supported by physician organizations, such as the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. The four groups released a joint statement in support of the concept in March 2007 that described care in the medical home this way:

- The patient is in control of care with a strong ongoing relationship with the PCP
- The physician oversees a team of individuals who collectively care for the patient
- Care coordination allows the patient to receive the proper care when it is needed

“We know many patients change behaviors just on the recommendation of their physician,” says Kellerman. “There’s great value in having a physician who provides most of the care that most of the patients need most of the time and helps coordinate and integrate their care across the healthcare system when they go to the hospital or see a consultant. Having that integration function is important and improves quality and controls costs.”

A common complaint among physicians is that DM companies do not communicate with them. Kellerman says greater communication is needed in the medical

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home. “We’re all going to have to align in terms of helping patients manage their own illnesses,” he says.

Although pediatricians have been talking about the medical home idea since the 1960s, particularly for children with severe disabilities, new technology that allows for greater care coordination is making DM interested in the medical home model.

Ariel Linden, DrPH, MS, president of Linden Consulting Group in Hillsboro, OR, says a new chronic care model via the medical home concept could actually benefit DM. With the physician in control of managing chronically ill patients, DM won’t have to prove ROI.

“There are some very positive benefits for the disease management industry,” says Linden. “First of all, it gets away from the ROI argument. [In the medical home

model, DM companies] would no longer be on the hook for that. They are there to support the physician. If the physician can manage patients better and keep people out of the hospital, they will benefit financially from the payer. That said, the program fees will have to be low enough to entice a physician to use these services.”

Kellerman says the medical home is needed because the country’s healthcare system is “behind the eight ball.” He likened attempting to change healthcare to trying to turn the Titanic.

“The baby boomers are starting to retire, there’s more chronic disease, costs are out of control, we’re in a global environment, there are so many reasons to change the system, and yet there is incredible inertia that prevents change,” he says. “Inertia is the major barrier.” ■

DMAA backs medical home tenets

DMAA: The Care Continuum Alliance added its voice to the advanced medical home model discussion with the release of its paper *Advancing the Population Health Improvement Model* in December 2007.

DMAA’s statement offers a model with an integrated, physician-guided delivery system with reimbursement for targeted improvement goals for population-based chronic care that mirrors much of what has been backed by physician organizations. (For the list of key components of DMAA’s Population Health Improvement Model, see the sidebar on p. 4.) DMAA’s population health improvement is based on three core components:

1. Central care delivery and leadership roles of the PCP
2. Importance of patient activation, involvement, and personal responsibility
3. Patient focus and expanded care coordination provided by wellness, disease, and chronic care management programs

Gordon Norman, MD, MBA, chair-elect of the DMAA board, a member of the Physician Engagement

Committee, which developed the paper, and executive vice president and chief science officer at Alere Medical, Inc., in Reno, NV, says the advanced medical home discussion is an “opportune time to talk about how we can help realize that vision with the learned skills, tools, techniques, and intellectual properties that [DM has] developed in the last 15 years.”

Norman says the paper is not a major change in focus for DMAA. “I think it really codifies a lot of things we have been saying and believing for some period of time but just haven’t been organized and put on paper. For as long as I have been involved in disease management, I think most of us believed physicians, and particularly primary care physicians, are central to our ability to impact population health,” he says.

Norman says DMAA developed the principles to clarify its perspective, open dialogue between the DM industry and others in healthcare, and inform physicians about DM’s potential role in improving care via the advanced medical home.

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DMAA

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Norman says the medical home theory is still in the discussion stage and it's premature to define what will comprise a medical home. He adds the concept will also differ by the locale, type, and size of an organization; community resources; and the patients being served.

"I think that it's a good thing that we not start with a rigidly defined model but try lots of different formulations and learn which seem to be most suitable under what circumstances," he says.

One of the reasons the medical home has become such a hot topic is the expected PCP shortage. DMAA's model promotes group visits, remote patient monitoring, and telehealth, which Norman says could help resolve some of the shortage concerns.

"Under those circumstances, everything we can do to extend the reach and touch of the primary physicians that we have is going to be very important. There are roles that nonphysicians can play in terms of monitoring patients remotely and working with physicians that can multiply their ability to manage a population. I think those will become more prominent," he says.

One of the sticking points that needs resolution is physician reimbursement for leading care coordination via the medical home.

Norman says PCPs already perform some of those duties but are not being reimbursed. In order for the

medical home to become the norm, the physicians will need to get paid for those services.

Although DMAA's model doesn't promote a specific reimbursement model, the proposal stipulates the need for increased reimbursements for services.

However, in order for physicians to receive higher reimbursements, Norman says, physicians will have to prove success in clinical process and outcomes indicators, assessment of patient satisfaction, function status and quality of life, economic and care utilization indicators, and effect on known population health disparities.

"There is no free lunch in healthcare in America," says Norman. "I think the bar will be raised on tracking, measuring, and quantifying outcomes of care far beyond what exists already. That's a good thing."

Norman says DMAA's model is an attempt to show that DM and physicians are complementary partners in population health improvement.

He adds that both sides shouldn't "get caught up in quibbles over who's getting what portion of the healthcare premium. It's really about who is best situated to serve efficiently in a role of population health improvement, and neither of us can succeed, I think, as we might without utilizing the skills, tools, perspectives, and abilities of the other." ■

DMAA's Population Health Improvement Model

The following are the key components of DMAA: The Care Continuum Alliance's Population Health Improvement Model:

- ▶ Population identification strategies and processes
- ▶ Comprehensive needs assessments that assess physical, psychological, economic, and environmental needs
- ▶ Proactive health promotion programs that increase awareness of the health risks associated with certain personal behaviors and lifestyles
- ▶ Patient-centric health management goals and education, which may include primary prevention, behavior modification programs, and support for concordance between the patient and the PCP
- ▶ Self-management interventions aimed at influencing the targeted population to make behavioral changes
- ▶ Routine reporting and feedback loops, which may include communications with patients, physicians, health plans, and ancillary providers
- ▶ Evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall population health

Medical home concept still fuzzy

The advanced medical home has gained traction, and the phrase has made its way into legislation and the industry's lexicon, but it is still largely a concept with inconsistent definitions. **Vince Kuraitis, JD, MBA**, principal of Better Health Technologies in Boise, ID, says when it comes to the medical home, "the devil is in the details."

"What I'm observing is a bandwagon effect of everyone now saying they have a medical home, and there's no definition or standards as to what constitutes a medical home. There are many unresolved, unknown implementation issues that have yet to be worked through, and it is going to take a while to figure those out," Kuraitis says, adding that the National Committee of Quality Assurance's guidelines released in November 2007 were a step in the right direction.

Gordon Norman, MD, MBA, chair-elect of DMAA: The Care Continuum Alliance and executive vice president and chief science officer at Alere Medical Inc., in Reno, NV, says DMAA is meeting with national physician organizations to discuss how DM and physicians can work collaboratively.

After all parties can agree upon the definition of a medical home, Kuraitis says the next issue will involve payment models. In joint principles released by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association in March 2007, the groups provided a payment structure based on a framework that:

- Reflects the value of the physician and nonphysician staff patient-centered care management work that falls outside of the face-to-face visit
- Pays for services associated with care coordination within a given practice and between consultants, ancillary providers, and community resources
- Supports adoption and use of health IT for quality improvement
- Enhances communication access, such as secure e-mail and telephone consultation

- Recognizes the value of physician work associated with remote monitoring of clinical data using technology
- Allows for separate fee-for-service payments for face-to-face visits
- Provides for physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting
- Allows for additional payments for achieving measurable and continuous quality improvements

"Until we get some sense of [the payment structure] and the standards that go up around that, we're still just talking about a concept that is pretty fuzzy," says Kuraitis. "I haven't seen any proposals from the doctor organizations saying the medical home fee should be X dollars per month. It's going to take a while to work through that, and it's both a political and analytical process."

Another area that needs resolution is establishing accountability for improving population health with a set of objective measures that mark progress, says Norman.

If PCPs want to get paid for care coordination, Norman says they will need to demonstrate clinical health improvements as well as cost savings. "Every quid has a pro quo," he adds.

Rick Kellerman, MD, board chair of the American Academy of Family Physicians and a practicing family physician in Wichita, KS, says demonstration projects and state and federal legislation will ultimately flesh out the definition of a medical home. "We will have more data for demonstration projects and at some point come to a tipping point that the medical home is accepted and that we need payment reform to support it," he says. ■

Questions? Comments? Ideas?

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Rocky Mountain gives PCPs tools, learning, reimbursement

Rocky Mountain Health Plans is not new to the medical home concept. The Grand Junction, CO, health insurer implemented a chronic care model in primary care offices four years ago focused on diabetic patients in Mesa County, a largely rural section of western Colorado.

In Rocky Mountain's project, **David S. Herr, MD**, chief medical officer at Rocky Mountain Health Plans, says the PCP plays a key role in coordinating care.

"With the chronic care model, what we are trying to do is to give physicians more tools so they can do more effective case management in the medical home setting," says Herr.

Rocky Mountain Health Plans' project includes four chronic care training sessions for physicians and office staff based on the Institute for Healthcare Improvement's program. After the initial training, representatives from the offices meet on a monthly basis to share successes, failures, ideas, and data. "We have some interesting discussions. I think that, in general, drives things in the right direction," says **Philip J. Mohler, MD**, of Family Physicians of Western Colorado, also in Grand Junction. Mohler is one of the approximately two-thirds of Mesa County PCPs who are taking part in the project.

The program's foundation is coordinating the patient's care in the primary care office, emphasizing patient self-management, creating registries to understand patient population and those who need care, setting up office processes and patient flow, and communicating with patients before and after visits. To get the process started, Rocky Mountain Health Plans paid participating physicians a \$30 case management fee per diabetic patient per quarter.

Family Physicians

Of the 1,800 Rocky Mountain patients throughout Mesa County who are enrolled in the project, 300 are served by Family Physicians of Western Colorado, a practice of 15 physicians. Not all of Family Physicians' patients are Rocky Mountain members, but the office resolved the

issue of equity by agreeing that all diabetic patients would receive the same level of care regardless of health plan, which included an RN, electronic medical record, and preplanning letter.

As part of the chronic care program, Family Physicians hired an RN to handle care coordination. Since implementing the program, Mohler says, the physicians have seen improvements in hemoglobin A1c figures and blood pressure, and patients come in more regularly because of the proactive communication with office staff members.

Health disparities, so common in healthcare, also melted away. "When you break it down by line of business, by Medicare, Medicaid, or commercial, our Medicaid patients do just as well as our commercial members and Medicare members," says Mohler, who also works part-time for Rocky Mountain.

Another benefit associated with the program is the technological advances within the patient registry. Physicians are able to print a report that allows patients to review their A1c, blood pressure, and LDL numbers. "Most doctors use it as a teaching tool," says Mohler.

The first two years showed improved outcomes, but Family Physicians made a change. The physicians reluctantly agreed they simply couldn't afford the nurse.

"The bottom line was that after we paid that RN . . . we were losing \$30,000 a year," says Mohler, adding physicians each underwrote the program \$2,000 annually.

A little less than three years ago, Family Physicians moved forward without the RN and her duties were spread out throughout the staff. Now, office employees fill out preplanning letters and reports. Mohler says the program is sustainable and the costs are now a wash.

Starting this year, Rocky Mountain is adding cardiovascular disease to the chronic care program. The focus is on a subset of patients who are nondiabetics with a history of cardiovascular disease. Herr says physicians will identify patients around measurable outcomes, and will focus on the high-risk population who may have already suffered a heart attack. ■

MEDICARE

DISEASE MANAGEMENT

Physicians say any new payment must be aligned with services provided

Many unanswered questions

A lot has changed in the delivery of healthcare since the 1960s when Medicare was born. Now in 2008, the questions about the market value and the cost of providing healthcare for those older than 65 with multiple chronic comorbid conditions are much more complex.

The questions abound: How much is chronic care management worth? Is there a clear ROI? What should government payers such as Medicare and Medicaid pay doctors to manage the care of older, sicker patients with multiple conditions? Should CMS scrap the fee-for-service (FFS) Medicare system altogether? Should risk adjustment methods be incorporated into a revised payment system? What is the cost of managing chronic care elderly patients? Will all doctors be able and willing to take on more centralized care as promoted by the patient-centered medical home? Where do DM companies fit into a new payment structure? Will their voices be heard in the ongoing discussions about a new payment model?

“Fundamentally, [physicians] are a cottage industry right now,” says **David Weber, MD**, CEO of Wenatchee (WA) Valley Medical Center. “We are paid for piecemeal work, and there are little or no incentives to curtail services or keep patients out of the hospital,” he says.

Weber is a member of the American Medical Group Association, an Alexandria, VA-based group that primarily represents multispecialty physician practices

across the country. Weber says he supports the concept of a patient-centered medical home but wonders whether there will be enough incentive—and enough physicians—to make it a reality.

The American College of Physicians (ACP) in Washington, DC, has been a driving force behind the implementation of a medical home.

“Nobody knows the answer to the question of how much this new model would cost until we get real data,” says **Michael Barr, MD, MBA, FACP**, vice president of ACP’s Department of Practice Advocacy and Improvement. “We expect that a new payment model will include some form of risk adjustment payments,” he says.

Barr is organizing a 10-month study of the cost of the patient-centered medical home that began in November 2007 and is being funded by the Commonwealth Fund’s Patient-Centered Primary

“We expect that a new payment model will include some form of risk adjustment payments.”

—**Michael Barr, MD, MBA, FACP**

Care Initiative. He says the main goal of the study is to identify incremental costs of building a medical home in a variety of practice settings, including Medicare populations.

“We don’t expect specific numbers, but we do hope to pull together information on the incremental costs of delivery and some payment options,” says Barr.

The Commonwealth Fund, based in New York City, supports independent research of healthcare issues. In December 2007, the group published a report that analyzed 15 potential savings options that could reduce

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Physicians

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Medicare spending. The report places a strong emphasis on the need to improve Medicare reimbursements to PCPs who support enhanced services, such as care coordination and care management, says **Cathy Schoen, MS**, the group's senior vice president for research and evaluation.

If all Medicare FFS beneficiaries were enrolled in a medical home, this approach could result in net health system savings of \$194 billion, according to the report.¹ Schoen says the Commonwealth Fund and its research partner, The Lewin Group, are continuing to study how the medical home and other policy options can affect Medicare and Medicaid cost savings and will "review in greater detail specific ways to spur savings."

IT is a key factor in cost savings, says **Anthony Shih, MD, MPH**, assistant vice president of the Commonwealth Fund. Shih oversees the Program on Quality Improvement and Efficiency. "There is likewise substantial evidence that the greater role of doctors [in chronic care management] results in better health outcomes and lower costs," he says.

Shih and Schoen say that a primary problem with the current FFS system is that payment incentives are not aligned to promote better care and lower costs.

Payment options

A variety of payment options have been studied for the past several years in demonstration projects funded by CMS and other government agencies. Payment has varied widely, as have chronic care services. The Community Care of North Carolina Medicaid demonstration paid \$2.50 per member per month.

Pay-for-performance demonstrations, including the Physician Group Practice (PGP) Demonstration, based incentive payments on a percentage of cost savings rather than paying physicians for specific services. These demos began in April 2005. During the first year, two practice sites met eligibility criteria for cost-saving paybacks. Each of the 10 participating sites developed its

own quality improvement efforts. CMS has stated that it is pleased with the overall results of the PGP demonstration and has extended it for one year beyond its scheduled April 2008 end date. All 10 participating group practices have been asked to continue in the demonstration.

The After Discharge Care Management of Low Income Frail Elderly (AD-LIFE) trial began in January 2003 and was scheduled to end in 2006, but has been extended to 2009. It is funded by the Agency for Healthcare Research and Quality. The most anticipated outcome of this study was the cost of individualized comprehensive care management of Medicare beneficiaries enrolled in the demonstration.

Kyle Allen, DO, medical director of Summa Health System Post Acute and Senior Health Services in Akron, OH, and head of the AD-LIFE project, says the anticipated costs of a comprehensive care plan for post-hospital discharge at the beginning of the trial were between \$2,100–\$2,500 per member per month. The goal of comprehensive care management is to lower overall Medicare costs by decreasing hospital readmissions and emergency department visits.

Most recently, a group of physicians presented the outline of a Medicare payment system that is based on Ambulatory Patient Groups (APG) rather than current procedural terminology (CPT) codes. APGs were first implemented in 1995 in an Iowa Medicaid contract with CMS and have been revised several times (most recently in 2007). APGs are based on the patient's diagnoses, not on procedures that the physician completes during an office visit as in CPT codes.

Where does DM fit in?

Barr says that one of the reasons why there are so many payment methods being studied is because the model that CMS ultimately chooses for its Medicare and Medicaid beneficiaries will likely be one that is copied by commercial payers.

“There is no doubt that the current payment system is broken, but we don’t want to replace it with something that doesn’t work in the long run,” he says.

There is also some skepticism about the practicality of only one new payment model. “Surely, we will not have one monolithic model,” says **Gordon Norman, MD, MBA**, chair-elect of DMAA: The Care Continuum Alliance in Washington, DC, and executive vice president and chief science officer at Alere Medical, Inc., in Reno, NV. “Any change in the payment model needs to consider the extent to which physicians can be self-sufficient in their practices.”

Norman says the alliance sees the role of DM as strongly supportive of physicians as partners in providing care to chronically ill patients. He says that the promotion of the patient-centered medical home has given the false impression that DM is in competition with the proposed new model. In December 2007, DMAA announced its support of a model for an integrated, physician-guided delivery system for population-based chronic care. The model calls for payment for cognitive services, care coordination, referral activities, and adherence to evidence-based clinical practice guidelines.

“Any new payment model will fly or die over time depending on accountability for services provided,” says Norman. “We will continue to be a player with CMS in developing policy and new payment models. We want to leverage what DM has learned into any new payment model.”

He says the DM industry is still closely watching the major Medicare DM initiative, Medicare Health Support, to determine whether and how this FFS DM effort has improved care and cut costs. “There is a lot invested in not throwing out the baby with the bath water. We have yet to determine what is working in this demonstration, but we do now suspect that the initial ambitions were too grandiose,” he says. Of eight companies that began this demonstration in 2005, only three remain, and cost savings have been hard to quantify.

Pay for performance

One of the 10 potential options considered by the Commonwealth Fund in its report is pay for performance. **Leslie Norwalk**, CMS’ acting administrator, said in July 2006 that the PGP demonstration “provides new evidence that paying for quality of care instead of volume of services results in better outcomes and cost savings. It is the right thing to do.”

“If you look at pay-for-performance programs, there is a proliferation of different payers, different payment thresholds, and formulas,” says **Douglas Carr, MD**, medical director of the Billings (MT) Clinic, one of the 10 CMS PGP Demonstration sites. “It is hard to get individual doctors behind one particular plan, especially if they have a sense that you are just trying to game the system.”

Savings in these demonstrations is based on total Medicare Part A (inpatient) and Part B (outpatient) claims data. The government’s actuaries determined that the smallest difference that can be viewed as not having been caused by a normal variation is 2% and, therefore, set a 2% threshold for determining annual Medicare savings. Expenditures are risk-adjusted concurrently. This demonstration is a non-enrollment model based on actual utilization of physician services and includes a control group.

CMS announced the results of the first year of the demonstration in July 2006. Two physician groups demonstrated \$9.5 million in savings to the Medicare program. All of the 10 sites improved quality based on CMS-defined quality measures.

Carr says that PCPs want to provide more comprehensive services to patients but are currently caught in the “trap of billable hours.” As for DM programs, Carr says, most physicians prefer to develop their own in-house efforts if possible. “Using outside vendors is a disconnect with the provision of care to the patient and a break-even financially at best,” he says. ■

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P4P has its drawbacks

It's not the performance of certain clinical practice standards that really matters; rather, it's the patient outcomes.

That has long been the argument of some health-care experts who question the growing use of pay-for-performance (P4P) programs, particularly in older and sicker patient populations such as Medicare.

The American College of Physicians (ACP) has now joined in that sentiment and goes a step further. "Whether the measures pertain to checking on rates of performing tests or on performance on achieving certain goal values, mismatched perceptions between physicians and their patients, deselection of certain patients who might make physicians' performance look bad, and 'playing to the measures' are all dangers [of pay-for-performance programs]," says **Richard Neubauer, MD**, a member of ACP's Ethics, Professionalism and Human Rights Committee. Neubauer coauthored a position paper for the professional society that was published in early December 2007.¹

"Pay-for-performance programs should not use incentives that encourage physicians to discriminate against a class or category of patients [for example, elderly patients with multiple chronic medical problems]," he says. Rather, "incentives should encourage physicians to care for the sickest and most vulnerable patients."

ACP commissioned the paper because of the growing use of pay-for-performance programs despite what the group charges is "little evidence on their potential unintended consequences and effects on the doctor-patient relationship." The group's concerns hold true for virtually all pay-for-performance programs that are in effect today, including ones such as the Medicare Physician Group Practice Demonstration, which has been deemed highly successful.

Neubauer is particularly skeptical of claims that pay for performance is a good way to manage the care of Medicare patients with multiple comorbid conditions.

P4P concerns

The College of Physicians, along with other medical societies representing PCPs, is strongly advocating for implementation of a patient-centered medical home. The group says pay for performance has inherent conflicts with the ultimate goal of the medical home, namely performance that is totally patient centric.

"As an organization of professionals dedicated to the care and best interests of patients, the ACP believes that pay-for-performance movements can lead to better healthcare," says Neubauer. "But we are concerned about using a limited set of clinical practice parameters to assess quality, especially if payment for good performance is grafted onto the current payment system, which does not reward robust comprehensive care," he says.

Although the CMS has several demonstrations that include pay-for-performance incentives, **Linda Magno**, the agency's director of demonstrations has said recently at public meetings that one of the failures of DM in fee-for-service Medicare (e.g., the Medicare Health Support Demonstration) is that providers have failed to adjust the traditional DM model that is aimed at one disease for the Medicare population that has a high incidence of multiple disease states.

DM providers should put more emphasis on quality indicators than on clinical practice guidelines alone, says **Cynthia Boyd, MD, MPH**, assistant professor at Johns Hopkins University School of Medicine's Division of Geriatric Medicine and Gerontology in Baltimore. Quality indicators emphasize the assessment of burdens, risks, and benefits of complex therapies for older, sicker patients rather than on defining quality as attaining an adherence rate to standards that may not apply to a particular patient, she says. ■

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Finding at-risk patients

Survey-based predictive modeling goes beyond claims

Most DM organizations use the rearview mirror approach when trying to intervene with at-risk members.

This is done when DM companies review medical and pharmacy claims as a way to catch at-risk patients before they become costly, but **Alfred Lewis, JD**, executive director at Disease Management Purchasing Consortium International, Inc., in Wellesley, MA, says the claims-based approach “simply does not work.”

“Generally speaking, I am of the opinion that you need to know much more about people than what’s in the claims,” he says. Reviewing medical claims data alone indicates who has received services, but not who is at risk of costly healthcare services in the near future. **Ariel Linden, DrPH, MS**, president of Linden Consulting Group in Hillsboro, OR, says relying solely on claims data is insufficient as an identifying methodology because:

- Those who were hospitalized in 2007 are unlikely to be rehospitalized this year
- Those who were not hospitalized in 2007 could wind up having a lengthy stay this year

Reasons for success

Here are four examples as to why health perception surveys boost predictive accuracy:

1. Surveys reveal not only those needing interventions but also which members are willing to make changes
2. Information comes directly from members, which leads to more stable and reliable data
3. Results and reporting are immediate, and populations can be profiled across demographic, geographic location, age, gender, etc., so that additional programs and services can be developed
4. High engagement rates are achieved because the right people are targeted

Source: The Haelan Group’s Predictive Modeling and Finding and Intervening with the High-Cost Healthcare Consumer white paper.

- New members in a health plan do not have any claims data to feed into the predictive model

As a result, these models significantly underpredict high-cost individuals and overpredict low-cost individuals. Linden, instead, suggests a hybrid approach that includes survey-based predictive modeling coupled with claims data review.

“There are several [health risk assessment] tools that have good accuracy at identifying people who are at risk of a near-term hospitalization,” says Linden, pointing to the probability of repeated admissions (PRA) tool, which identifies seniors at risk of hospitalization. “People think [claims-data analysis] using a predictive model is a good standard, and it’s not. It’s far from it. That’s one of the major reasons why disease management does not prevent avoidable hospitalization. They miss most of the people who are actually going to get admitted.”

One of the pioneering programs that developed a survey-based predictive model is One Care Street, which was developed in the mid-1990s by Julie Meek, DNS, founder of The Haelan Group in Indianapolis, and now chief science officer at CareGuide in Coral Springs, FL. CareGuide now runs One Care Street, which includes a health perception survey, health coaching, and claims data review.

The goal of the program is to gauge whether a person is going to need expensive medical care within the next six to 12 months.

Finding those most at risk of expensive medical care benefits everyone. “Everybody wins [when healthcare costs are under control]. Society wins, the employer wins, and certainly the person and the family win,” says **Jim Kerr**, vice president of business development at CareGuide.

The multiple-choice questions in One Care Street’s health perception surveys (one geared to preretirees and

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Predictive modeling

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one for the senior population) go beyond asking about a person's condition and diseases. They touch upon their emotional and mental state, health habits, and feelings toward their health and status.

Although basic health risk assessments predict early morbidity and mortality, health perception surveys ask the person about current health issues and focus on clinical risk factors and disease conditions. A properly worded health perception survey determines a person's emotional state and response to illness and stresses. One Care Street also gauges whether a person is a good candidate for coaching, says Kerr.

"A typical [health risk assessment] is going to find what people's health issues are. That's not nearly as important as determining how concerned they are about those issues," says Lewis. "If you can figure out who is starting to panic about the health habits that they have developed, you'll be more likely to find people who are willing to change them but don't know how to go about changing them."

According to CareGuide, One Care Street's 45-question health perception surveys capture 63%–67% of

at-risk people rather than 10%–15% using the standard DM approach of analyzing claims.

After the respondents complete the survey, CareGuide uses its predictive algorithm to find out whether the person is at risk and would be receptive to coaching. In a matter of a few weeks, coaches contact those deemed at risk (those who take the survey are also informed that they can utilize coaching if they believe they need it). Kerr says the quick turnaround allows CareGuide to reach out to at-risk people before their condition deteriorates.

The coaching goes beyond the usual tenets of healthy living; it touches upon real-life topics. For instance, the coaches are trained in problem-solving skills and motivational interviewing, an intervention technique that helps people change their behavior.

Linden says implementing motivational interviewing and hiring the right coaches with the proper training are important for a successful program. Lewis concurs, adding that motivation is more important than dissemination.

"What has been learned the last several years is it's not about the dissemination of the information. It's

Keys to success

Jim Kerr, vice president of business development at CareGuide in Coral Springs, FL, says there are three elements needed to create a successful survey-based program:

1. Incentive design
2. Communication
3. Leadership support

Kerr says 90%–95% of companies that partner with CareGuide offer incentives to take health perception surveys.

Ariel Linden, DrPH, MS, president of Linden Consulting Group in Hillsboro, OR, says it's important to develop incentives depending on the population. Some of the successful incentives have included discounted copays and deductibles, gift cards, and drawings for a Hawaiian trip, a big-screen TV, and iPods. "No two populations respond the same to incentives," says Linden. Communication can include mailings,

on-site talks with employees, videos, meetings to spark interest, and question-and-answer sessions.

The importance of getting leadership support cannot be overstated. A leadership's backing is more than just getting an okay. Kerr says the clients that have enjoyed the best results were companies that embraced the idea from top to bottom. Not getting a company's leadership behind a program is a recipe for disappointing results, says Kerr. Linden adds one more key to success: communicating with PCPs.

Unless commercial DM makes a serious attempt to engage with physicians, Linden says, the industry will miss a critical piece in properly identifying people at risk of a near hospitalization. Physicians know better than anyone who can benefit from DM, but vendors have historically chosen the path of least resistance and relied on the patient's claims to identify them rather than get physician buy-in, says Linden.

about motivation, and motivation is much harder than disseminating information," says Lewis.

CareGuide's health coaches spend an average of two to two and a half hours on the phone over a two- to four-month period in an attempt to improve the at-risk person's level of perceived health.

Rather than mailing everyone the same letter, giving them identical refrigerator magnets, and reading from a script about how to live healthy, the coaches teach the at-risk people how to react in different situations. For example, rather than eating a candy bar when stressed, the coaches may suggest listening to a favorite song or taking a walk and revisiting the problem in 10–15 minutes.

Kerr says training is continuous for nurses, who know the different benefit structures for each person so they can refer people to available services if needed.

The combination of health perception surveys and

coaching appears to be working. CareGuide trumpets a 74% engagement rate versus the industry standard of 15%–20%. "Our engagement is so high because the predictive model is so good. We're calling people who want the help and need the help," says Kerr.

According to CareGuide, employers who have used One Care Street have cut healthcare costs. For instance, MacAllister Machinery, a heavy equipment supplier in Indianapolis, saw healthcare costs drop 7% from 2005–2006 and another 4% from 2006–2007. In the year before signing up for One Care Street, MacAllister faced a 14.5% increase from 2004–2005, according to CareGuide.

In early 2007, CareGuide also reported that a review of 10 clients showed an overall ROI of 8:1. The clients chosen had two full years worth of data, so CareGuide was able to properly analyze the results. CareGuide plans additional studies for the first and second quarters of 2008. ■

Study finds pharmacist program improves diabetes

Pharmacists performing medication therapy management (MTM) services improved diabetic patients' hemoglobin A1c levels, according to a study released by the University of Oklahoma Health Sciences Center's (OUHSC) College of Pharmacy in Oklahoma City.

Lourdes G. Planas, RPh, PhD, an assistant professor at the University of Oklahoma and an author of the nine-month study *Evaluation of a Community-Based Diabetes Management Program among HMO Enrollees*, says the results show the effectiveness of MTM programs and how pharmacists can play a role in improving health outcomes. (See "Impact on patients" on p. 10.)

With the popularity of MTM services and pharmacists' larger role in the Medicare Modernization Act, Planas tells her students it's a great time to be a pharmacist. "We have the opportunity for pharmacists to be providers of MTM services. That right there is an opening for a key role to demonstrate to the rest of the healthcare world that pharmacists can make a difference in patients' lives.

I think pharmacists are generally underutilized for their skills and their training. There are just a lot of things pharmacists can do to help patients and help physicians."

Daniel J. Cobaugh, PharmD, FAACT, DABAT, director of research and program development at the Bethesda, MD-based American Society of Health-System Pharmacists (ASHP) Research and Education Foundation, which funded the study, says the results highlight the "critical role for the pharmacists to play in effecting outcomes." These positive outcomes show managed care companies that an MTM program can save money for a diabetic patient's care. "There is a real opportunity for pharmacists to impact therapeutic, safety, and humanistic outcomes," he says.

Planas says the study began with Kimberly Crosby, PharmD, BCPS, who works as a clinical pharmacy services coordinator for USA Drug (formerly May's Drug Stores) in the Tulsa, OK, area and as a clinical assistant professor at the University of Oklahoma College of Pharmacy. Crosby

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Pharmacist program

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wanted to evaluate her MTM services at USA Drug, and Planas and Kevin Farmer, RPh, PhD, agreed to conduct the study with Crosby. The study's investigators reached out to the ASHP foundation, which provided funding. Cobaugh says the ASHP foundation funded the study because it focused on the foundation's two priorities: advancement of optimal patient medication outcomes and expansion of pharmacists' direct patient care roles.

The investigators also received the okay from CommunityCare HMO in Tulsa, which covers more than 100,000 public employees in Oklahoma, to let its members take part in the study. The six pharmacists from USA Drug who took part in the MTM program attended a three-day training program that focused on diabetes standards of care, including therapy, patient monitoring, and testing equipment to measure A1c, glucose, and low-density lipoprotein levels. To take part in the study, patients needed a hemoglobin A1c greater than 7%. The HMO notified those eligible, and the patients who volunteered were randomly assigned to either an intervention group or control group. Those in the intervention group received diabetes MTM services on a monthly basis, including:

- ▶ Pharmacists checked the patients' A1c and lipid levels, blood pressure, and conducted a comprehensive medication assessment
- ▶ Pharmacists communicated recommendations to the patients' PCPs via phone or fax

Meanwhile, those in the control group received A1c monitoring every three months and were given recommendations that they could give to their doctors. Both groups received a glucometer and were trained in its use.

Planas says a large part of the MTM pharmacists' role was resolving drug therapy problems. She says pharmacists identified 315 drug therapy problems during the 289 patient visits. Pharmacists couldn't change the medication dosage so they contacted the physicians of those patients needing drug therapy changes. Planas says having pharmacists as part of the healthcare team helps in

the area of medication because of the changing nature of pharmaceuticals. "It's really nice to have pharmacists who are up to date and medication experts and can be very skilled in an area like diabetes," she says.

Limitations

Planas says the study's limitations included the small sample size, an enrollment limited to HMO enrollees with diabetes, its limited access to medical records, and the lack of face-to-face interaction with physicians.

The sample size was only 38 in the intervention and 27 in the control group at the start. That number dropped further with only 24 in the intervention and 19 in the control group who completed the nine-month program. Planas says those who dropped out couldn't commit to the study.

As the program is expanded, Planas says investigators may soften the monthly consultation requirement depending on the patient's condition. That could help with keeping people in the program, says Planas.

Investigators deemed the clinical portion of the study a success, and Planas says investigators will soon analyze quality of life and financial data. When reviewing an MTM program's costs, Planas says analyzing total costs—rather than drug costs—is critical. "[Patients in an MTM program] are getting new meds, so of course drug costs are going up, but are the medical costs going down more than the Rx drugs are going up? I think that one big thing is to look at total costs," she says. ■

Impact on patients

Mean A1c levels	Baseline	After nine months
Intervention group	7.63	6.95
Control group	7.74	7.98
Percent of patients at goal A1c level (< 7.0)		
Intervention group	33%	58%
Control group	16%	11%

Source: Evaluation of a Community-Based Diabetes Management Program among HMO Enrollees.

Pharmacists play greater role in patient care

Many pharmacists are more than just experts in dispensing medication and have taken a bigger role in the care of patients.

Through medication therapy management (MTM) programs, pharmacists advise patients about medication use, lifestyle, diet and exercise, A1c monitoring, cholesterol education, and foot and eye exams. Several pharmacists are also certified diabetes educators.

“We are seeing a dramatic rise in pharmacists seeking residency training at the end of their education,” says **Daniel J. Cobaugh, PharmD, FAACP, DABAT**, director of research and program development at American Society of Health-System Pharmacists Research and Education Foundation in Bethesda, MD. “We are seeing an increased involvement in pharmacists in the care of patients with diabetes.” Given the aging population facing chronic diseases and the predicted PCP shortage, there is an opportunity for pharmacists to go beyond the traditional role of dispensing medication, he says.

Cobaugh says he expects the pharmacist’s role will continue to evolve. One only has to look at the changes in the pharmacy field over the past 40 years and the pharmacists’ larger role in the Medicare Modernization Act. He expects pharmacists will provide direct patient care in emergency departments, ambulatory clinics, hospitals, and community pharmacies.

“Across the profession of pharmacy, there are opportunities for change. I think we’re going to witness greater change as the use of medications becomes more and more complex,” he says.

If pharmacists play a larger role in healthcare, the next step is a reimbursement structure that properly compensates pharmacists for the added work. **Lourdes G. Planas, RPh, PhD**, an assistant professor at the University of Oklahoma Health Sciences Center’s (OUHSC) College of Pharmacy in Oklahoma City, says the investigators in her study *Evaluation of a Community-Based Diabetes Management Program among HMO Enrollees* partnered with an HMO because of the reimbursement question.

“There needs to be a model that compensates the pharmacist for providing services that were described in this study. Currently, reimbursement for pharmacists is primarily tied to medication product, and pharmacists need to be recognized as providers so they can bill for and be reimbursed for their services,” says Cobaugh.

It’s not just pharmacists who are promoting the idea of MTM. The importance of pharmacists in patient care is also gaining traction in managed care. In speaking about DMAA: The Care Continuum Alliance’s support of the advanced medical home, **Gordon Norman, MD, MBA**, chair-elect of DMAA and executive vice president and chief science officer at Alere Medical, Inc., in Reno, NV, says pharmacists can serve as a valuable member of the health team. “There can be some very creative roles for pharmacists and pharmacy techs to be educating patients about medications, side effects, alternatives, affordability, how to remember dosages, long-term adherence strategies, etc.,” he says.

MTM pharmacists have new tools to help them too. For example, the FDA cleared over-the-counter sales of CONFIDANT’s chronic disease management product in December 2007 (see the article on p. 12). **Thomas E. Wall**, vice president of business development and marketing at CONFIDANT, says pharmacists are playing a significant healthcare role. “In some ways, it’s kind of returning to the days of old when the corner pharmacist was a confidant of the individual and a trusted healthcare adviser. You can see a lot of the pharmacy organizations going into the clinic business and healthcare business in a big way because there’s an immense demand for it,” says Wall. On the other hand, there are those who view MTM pharmacists as yet another chef spoiling the broth by stretching into physicians’ territory.

Planas says what those in healthcare should view as important is the care of the patient, not a profession’s boundaries. “It’s all to help the patient. These pharmacists help the physicians help the patients. I think if we can keep that attitude, it works for everyone,” she says. ■

FDA gives CONFIDANT over-the-counter approval

Medication therapy management (MTM) pharmacists received an over-the-counter tool to help their chronic care patients when the FDA cleared Durham, NC-based CONFIDANT for over-the-counter sales of its chronic DM product in December 2007.

CONFIDANT, a developer of mobile communication solutions focused on DM, received approval for its phone-based product that allows patients to self-manage their condition while providing better data to both traditional and nontraditional caregivers.

“As it exists today, [diabetic patients] are very much alone and on their own trying to manage their disease,” says **Thomas E. Wall**, vice president of business development and marketing at CONFIDANT.

Diabetic patients often handle the day-to-day oversight of their disease alone. CONFIDANT’s program allows a daily review of the patient’s health status, which creates a support system.

Patient data sent wirelessly from a cell phone can be reviewed through the CONFIDANT portal or by accessing personal health record or electronic medical record systems.

CONFIDANT’s program includes three steps:

1. Users open the CONFIDANT application on their cell phone, wirelessly collect measurements from their home glucometer, blood pressure cuff, and/or weight

scale; answer questions about diet, exercise, and medication routine; and then upload the information to the server.

2. The data are analyzed, monitored, and stored on the server, and users receive real-time, confidential, personalized feedback to help them understand their status. The patient, patient’s guardian, doctor, pharmacist, and/or caregiver has secure access to the readings.
3. From a library of thousands of messages, CONFIDANT provides coaching, positive reinforcement, and reminders to help the user stay on point and maintain positive behaviors.

Using wireless Bluetooth technology means the patient doesn’t manually log in the information, which eliminates errors and potential for fibbing. “It’s real important that the data is accurate and is also simpler in that you don’t have to take information from one device and put it into another,” says Wall.

The product originally received FDA clearance in 2005. Wall says CONFIDANT is talking to several pharmacies about using the product as a complementary tool to general care and MTM. The company is also looking to expand its product to congestive heart failure and asthma patients. ■

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