

MDISEASE MANAGEMENT ADVISOR™

Study: Wellness works Comprehensive program brings modest ROI

A recent study of workers at health insurer Highmark, Inc., shows that a comprehensive employee wellness program results in a positive ROI.

"The Impact of the Highmark Employee Wellness Programs on Four-Year Healthcare Costs" was published in the February *Journal of Occupational and Environmental Medicine*, which is the official journal of the American College of Occupational and Environmental Medicine. The study specifically researched whether Highmark's employee wellness program saved the company money.

The researchers found healthcare expenses per person per year were \$160 lower for wellness program participants than nonparticipants. Inpatient expenses were also \$183 lower per year for participants. The estimated net savings from the program was \$1.3 million, producing an ROI of 1.64:1, according to Highmark.

Ron Z. Goetzel, PhD, research professor at the Emory University Rollins School of Public Health's Institute

for Health and Productivity Studies in Atlanta and vice president of health and productivity research at Thomson Healthcare in Washington, DC, was a coauthor of the study. He says the study, and others that have been done over the past 20 years, shows that evidence-based health promotion programs that reach large numbers of employees at worksites can translate to health-care cost savings and productivity improvements.

Brian Day, director of advanced analytics at Pitts-

burgh-based Highmark, says the study was performed to review whether the company's employee wellness program is worth the money invested. Day says the study reaffirms the Highmark leadership's advocacy for wellness programs.

"My opinion is because it shows there is an ROI, I believe the company will continue to invest in wellness programs and look at how the ones we have now can be improved and added upon," says Day. "If you're above breaking even and still providing benefits for members, then you are doing a good thing."

But savings can't be expected right away. "Wellness is one area that you are not going to see immediate results. If you put it into place and expect changes in six months or a year, you're going to be disappointed. You need to be committed to it and you will see results. Wellness works," Day says.

Highmark, which employs about 12,000 workers, began offering a comprehensive employee health promotion program in 2002. Highmark's program offers health risk assessments (HRA), online programs in nutrition, weight, and stress management, tobacco-cessation

"If you're above breaking even and still providing benefits for members, then you are doing a good thing."

—Brian Day



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programs, on-site nutrition and stress classes, individual nutrition and tobacco-cessation coaching, biometric screenings, and campaigns to increase fitness participation and awareness of disease prevention strategies. Highmark employees also have access to employee fitness centers in Pittsburgh and Camp Hill, PA, site of another Highmark office.

Additionally, there is a 10,000 Steps Program, in which employees receive pedometers and a book to help them record the number of steps they take daily. Nearly 10,000 of Highmark's employees participated in the wellness program between 2002 and 2005.

The cornerstones of the wellness program are the HRA and biometric screenings, which check employee cholesterol, glucose, and blood pressure. Using the data from those two sources, the program personalizes the wellness message for each employee.

Because the study focused solely on ROI, Day says researchers did not explore the health effect of the biometric screenings. But he believes the screenings did improve results. "We were seeing an incremental improvement over time for the participants versus the non-participants in preventive screening. It would logically follow that the biometric screening would also improve, but that is something that will be left to an analysis to fully determine."

In the study, researchers compared wellness program participants to nonparticipants. However, because of the wellness program's popularity, study authors found there weren't enough nonparticipants who could be matched to participants. Instead, they created a supplemental pool of nonparticipants with Highmark coverage who did not use wellness programs offered to employer clients (or benefit from the Highmark leadership's focus on wellness) and selected those from industries similar to Highmark's, such as financial, real estate, and insurance. This allowed the researchers to separate study participants into two groups of 1,892 people (participants and matched nonparticipants).

Day says Highmark's employees are not different from similar industries' employees in terms of health status. Goetzel says many in healthcare work long hours, suffer from high stress, and eat a poor diet, but there is an opportunity to improve employee health. "Certainly, working in healthcare companies should prompt employees to have a greater focus on health. It's much more central to what they are all about," says Goetzel.

The study is an improvement over other wellness studies because researchers controlled for self-selection bias by matching up Highmark employee program

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participants as closely as possible to nonparticipants from other employers in similar industries, Goetzel says. “What we have done here is to match participants in the program to very, very similar people who did not participate in the program, so essentially we were able to follow two groups of people over time ... and see what their healthcare and cost experiences were like,” he says. “It was a more accurate depiction of what the true differences between program participants and nonparticipants might be and how these differences translate to savings.”

To calculate the program savings, researchers collected program expenses by combining fixed and variable costs, such as costs of the HRAs, fitness centers, and programs. They compared these totals with the costs of healthcare provided to employees drawn from medical claims data. (For a breakdown on program costs, see “Costs of wellness program at Highmark, Inc.” on p. 4.)

In addition to comparing participants and nonparticipants, researchers divided the former into categories

based on the types of wellness programs they used:

- **HRA only**—Employees who completed an HRA but did not participate in other wellness programs
- **HRA and other**—Employees who completed an HRA and participated in online, group, or individual health improvement sessions
- **HRA and fitness center**—Employees who completed an HRA and used the fitness center

Those in the program-specific groups “experienced slower healthcare cost increases than for nonparticipants,” but the differences were only “statistically significant for those who used an HRA and the fitness center,” the study stated. The differences between groups may not have been significant because of sample size, according to the study.

“Examining the three subsets of program participants, we found a slower rate of growth in healthcare costs for participants vs. nonparticipants, regardless of whether

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Seven aspects of a successful wellness program

Ron Z. Goetzel, PhD, who coauthored a review of employee wellness programs at Pittsburgh-based Highmark, Inc., cites the following seven items as necessary to achieving a successful program:

1. Health risk assessment (HRA). HRAs provide immediate feedback to program participants and highlight areas that need improvement, allow a company to reach out to people who need help, and provide an effective measurement tool.

2. Triage methods. It’s important to have good methods for triaging people into risk-reduction programs.

3. Good incentives. “Incentive structures that seem to be working more effectively are those where you reduce participants’ medical premiums if they engage in programs.”

4. Theory-based behavior change methods. “There is a whole body of literature in the social-psychology domain that shows how to change people’s behaviors more effectively than just telling people to change their behavior.”

5. Tailored communication. Adjust communication to fit participants’ preferred learning styles, such as one-on-one

coaching, mail, telephone, or e-mail. “A program that doesn’t engage a large proportion of the population in some form or fashion is not going to be successful.”

6. Measurement and evolution by building metrics.

This data allows you to analyze and fine-tune wellness programs.

7. Leadership support. “[Leaders] need to model healthy behaviors. They can’t say, ‘Everyone live a healthy lifestyle, I’m going to continue to live my unhealthy lifestyle.’ ”

Once the wellness program is established and employees take part, the next question is: How does a company define a successful wellness program? Goetzel says a 2%–5% improvement in most risk factors and a 2%–5% reduction in healthcare utilization is sufficient to deem a program a success.

“What that means is that you don’t need to get everyone to quit smoking and lose weight and start running. A relatively small change in the health-risk profile of employees will actually achieve dramatic improvements in healthcare utilization costs and productivity,” says Goetzel.

Wellness works < continued from p. 3

employees only completed an HRA; participated in coaching, online, group or individual programs; or visited a fitness center along with engaging in other wellness programs," wrote the authors.

Researchers found the largest growth in participation was in fitness center use, which jumped from 21.5% in 2003 (when the Pittsburgh center opened) to 46.5% in 2005 (when both fitness centers were open). Online program participation also increased from 11% in 2002 to 27% in 2005, and individual nutrition coaching increased from 1% in 2002 to almost 6% in 2005.

Day says communication with employees through an Intranet site, coupled with executive leadership and the greater wellness movement within the United States, were the reasons why program participation increased. The outreach appears to have worked, given that participation didn't involve only healthy individuals, but also people with chronic conditions. "We had some very high-risk and sick individuals that participated in the wellness programs, which tells us that people recognized the benefits of using wellness programs. It's not just those who want to stay in shape," says Day.

Two areas the study did not take into account were employee productivity and absenteeism. Many researchers have used those figures as a way to test the benefit of wellness programs, but Day says Highmark did not have that information. He believes the ROI is probably underestimated because the researchers did not take those costs into account. Day says Highmark did complete an additional study in 2007, which reviewed self-reported sick days against those who participated in the employee wellness program. Highmark found that participants in the wellness program were absent a half-day less than those not in the program. "That kind of gave us an idea that we were having some effect on productivity," he says.

Day says Highmark wants to further explore the wellness study results to gauge the effectiveness of specific programs. Highmark will promote the findings as an example of how wellness programs work. "What we want to try to do is talk to the employers and sell it to them, so to speak, so they start to buy into wellness and put it into effect for their employees ... We will likely consider rolling out some of the things that we found effective in this study," he says. ■

Costs of wellness program at Highmark, Inc.

Editor's note: Here's a look at the breakdown in annual program costs for Highmark's wellness program, along with the cost per participant and net savings.

	2002	2003	2004	2005	Average
HRA and incentive	\$243,731	\$143,111	\$140,785	\$142,605	\$167,558
Online	\$1,142	\$1,372	\$1,300	\$2,575	\$1,597
Group	\$1,544	\$3,077	\$3,010	\$0	\$1,908
Nutrition coaching	\$66	\$740	\$1,585	\$3,420.00	\$1,453
10,000 Steps	\$0	\$2,441	\$3,851	\$2,061	\$2,088
Highmark Challenge	\$0	\$0	\$348	\$2,766	\$799
Maintain Don't Gain	\$0	\$0	\$182	\$192	\$94
Total wellness program costs	\$246,483	\$176,343	\$181,000	\$204,577	\$202,101
Cost per participant	\$130.28	\$135.34	\$138.38	\$150.98	\$138.74
Net savings	\$87,398	\$157,538	\$152,881	\$129,304	\$131,780

Source: "The Impact of the Highmark Employee Wellness Programs on Four-Year Healthcare Costs," Journal of Occupational and Environmental Medicine, February 2008. Inflation-adjusted to 2005 dollars.

'Til death do us part

OptumHealth creates lifetime PHR

OptumHealth's recent announcement about lifetime personal health records (PHR) suggests Americans may soon add another certainty to the Benjamin Franklin adage about death and taxes.

While the healthcare industry watches Google and Microsoft's entry into the PHR arena, OptumHealth has created a lifetime PHR program that allows consumers to maintain and update their online health record regardless of employment, health plan, or doctor changes.

More than 21 million consumers from sister company UnitedHealthcare and OptumHealth's private employers or payers can access their PHRs through the company's free, secure consumer Internet portal, HealthAtoZ.com.

Those who later leave OptumHealth's care will still have free access to their PHR via the Web site, their health insurers will no longer populate the electronic record with claims data, but individuals can continue to self-enter information into their PHRs.

In addition, anyone with Internet access can self-enter and create his or her own PHR at www.healthatoz.com for free.

Harlan Levine, MD, chief medical officer at OptumHealth Care Solutions in Golden Valley, MN, says the lifetime PHR is an example of the company's "consumer empowerment" focus. Levine says PHRs play a critical role in healthcare, especially as care and society become more fragmented.

"The personal health record can be the central location to consolidate all that information to help [consumers] move through the healthcare delivery system," Levine says, "and help ensure they are not prone to medication errors or gaps in care because of the disruption of data flow."

Levine says a barrier to greater PHR use is that consumers view them as temporary tools because PHRs usually aren't transferable if the consumer changes health plans, jobs, or physicians. He says OptumHealth's lifetime PHR eliminates that issue.

"There is tremendous value in managing healthcare through a personal health record, but what has been challenging in the industry is adoption," says Levine. "[The lifetime PHR] is part of a broader strategy to make this more appealing and to overcome the barrier that this is a short-term solution as opposed to information that a consumer can access anytime—essentially a lifetime benefit."

The electronic PHR through OptumHealth can be populated with claims data, such as hospital and doctor visits, immunizations, lab results, and prescriptions, as well as information from health risk assessments. PHR users can also self-enter information, including family history, previous medical history, or a living will, and can track their sugar levels, weight, diet, and other health-related data.

Levine believes that having prepopulated information will spark potential users to take part. "I think the fact that you're not starting from scratch and information is being input into the personal health record makes it much more likely that the consumer will go to the personal health record, because the hardest part is getting started," he says.

Joseph C. Kvedar, MD, founder and director of the Center for Connected Health in Boston, would like to see proactive and engaged PHR users. The center is a division of Partners Healthcare that is applying communications technology and online resources to improve access to and delivery of quality patient care. With current warnings about physician shortages and baby boomers approaching their senior years, Kvedar says having an active, educated patient involved in his or her care is vital.

Healthcare companies shouldn't merely populate PHRs with claims information, says Kvedar. They should encourage consumers to take ownership. "The approach I like better is to motivate patients to input their own

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Lifetime PHR

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data, because by enabling patients to collect and better understand their own health data, we can push or pull them into the self-care mode. To succeed, we need patients to be much more aware and involved in the self-management of their health," says Kvedar.

Kvedar expects the movement toward greater PHR integration will come because of economics, not patients. Payment reform, in which healthcare providers are held accountable for quality of care rather than number of transactions, will make tools such as PHRs more important. "The pain point, no matter how you look at it, is the cost of care," he says.

Users have the ability to grant PHR access to doctors, nurses, loved ones, or anyone involved in their healthcare.

Of course, any time computer databases are involved, one of the first concerns is privacy. The World Privacy Forum released a consumer advisory February 20 about "the potential privacy risks in personal health records every consumer needs to know about."

The report warned consumers that some PHRs can compromise consumer privacy. Levine says OptumHealth addresses those concerns through password protection and encryption technology to help protect patients' information.

In addition to the PHR, OptumHealth's Web site includes a symptom checker, health assessment, personalized dashboard, nurse chat, online health coaching, calculators, and health-related articles. The symptom checker was created with the assistance of the company's nurses, who provide clinical guidance to callers on a daily basis.

"We believe that consumers need a trusted source for health content, and for that reason, the health content we deliver has been vetted through an in-depth review process," says Levine.

The health information is also specifically geared toward the individual, based either on self-selected areas of interest or health risk assessment results. Using that

information, the Web site presents topic-specific articles or information about health programs. "The goal is to make it relevant to the individual," explains Levine.

Levine says the lifetime PHR is important to OptumHealth from a strategic point of view. "This is an opportunity to create tremendous value. As people adopt and use personal health records more, we will have broader capabilities to alert them to, and make available to them, programs that can support their healthcare needs," he says.

Ann Fleischauer, director of communications at OptumHealth, believes people will take charge of their healthcare through their PHR. She foresees patients bringing a printed copy of their PHR with them to the doctor. This not only will help the patient, but the doctor as well.

Levine believes that within three to five years, the information in PHRs will become much more relevant to busy physicians taking care of more patients. "Physician adoption will then catalyze broader consumer utilization," he says.

Since OptumHealth created its first PHR in 2005, the company has been updating and improving the document. With the lifetime PHR now in place, company officials expect that progression will continue.

"As the industry continues to move forward, and consumers have growing needs and become more engaged and empowered in their own healthcare, our site will continue to evolve, and we will continue to make value-based enhancements," says Levine. ■

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MEDICARE

DISEASE MANAGEMENT

South Carolina pilot

CMS program offers PHRs to Medicare population

Senior citizens and computers are not usually thought of as allies, but a new CMS pilot project is testing personal health records (PHR) in the Medicare population.

The pilot project, which will run through September with the possibility for an extension, will offer PHRs to 100,000 beneficiaries in Medicare's fee-for-service program in South Carolina.

Medicare will populate the PHRs by importing two years of claims data, including diagnoses, procedures, tests, and hospitalizations. The project will not initially include pharmacy claims, although individuals will be able to add their prescriptions into the tool.

The PHRs are being offered by HealthTrio in Centennial, CO, which already provides these tools to more than 100,000 individuals through their employers. The contract is being managed by QSSI, which has partnered with Palmetto GBA and IBM.

"This is a tremendous opportunity for CMS to show that they are very interested and very aware of how to help [Medicare beneficiaries] gain information and knowledge [about their healthcare]," says **Dave Syposs**, vice president of product marketing and sales support at HealthTrio.

Lorraine Tunis Doo, senior policy advisor for the Office of eHealth Standards and Services at CMS, says the project is part of a larger initiative in which the federal agency is developing the framework for an infrastructure to support PHRs, and is currently evaluating the many important issues that affect adoption,

including privacy, security, and data standards. Doo says CMS plans to work with vendors on PHRs, rather than create its own version.

"We are evaluating how Medicare can provide access to its (claims) data to beneficiaries who want to have their own PHR," says Doo.

HealthTrio spent several months working with QSSI to develop a PHR that seniors would want to use on a regular basis. "Things that were required were to make it easier to navigate and for visual effect. The product we developed is specific to that population," says Syposs.

The PHR pilot will use a number of different outreach initiatives to educate seniors

about PHRs, including community events and working with caregivers, advocates, and associations. The next edition of Medicare handbooks will provide information about PHRs, and CMS' Web site has FAQs and general information about PHRs.

"We will continue to work with the Office of External Affairs [at CMS] to identify appropriate and creative ways to educate beneficiaries about PHRs, including collaboration with those community resources who have access to, and are trusted by, seniors," says Doo.

Doo says CMS will gauge regular utilization and perceived value as guideposts to whether the South Carolina PHR project is successful. The project is the second CMS PHR initiative for Medicare beneficiaries. The other project kicked off in June 2007 and

The project is part of a larger initiative in which [CMS] is developing the framework for an infrastructure to support PHRs.

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CMS program < continued from MDM p. 1

included four insurers offering Medicare Advantage/Part D plans that had existing PHRs.

There are now seven plans participating in that project, and CMS expects to evaluate that pilot within the next few months.

CMS will report the findings to the American Health Information Community and U.S. Department of Health and Human Services Secretary Mike Leavitt by the end of the year, according to Doo.

Joseph C. Kvedar, MD, founder and director of the Center for Connected Health in Boston, a division of Partners HealthCare that is applying communication technology and online resources to improve access to and delivery of quality patient care, says a successful

PHR with engaged consumers requires users who have the time, technology expertise, and interest in their health to closely monitor the PHR. Seniors may have the time and interest in their health, but many don't have computer access or the computer skills necessary to maintain a PHR.

Kvedar suggests that as younger generations with computer experience grow older, PHRs will gain in popularity.

"There's a much larger group of seniors that are afraid of computers ... It's going to require a few more years of maturing and graying of the computer-friendly generations to get a significant uptick," he says. ■

SNP Medicare expansion continues

Editor's note: This is part one of a two-part series exploring Medicare special needs plans (SNP).

Special needs plans—including chronic condition special needs plans (C-SNP)—continue their rise in the Medicare market in 2008, with a growth rate of 60% and the advent of the country's first such plan developed specifically for beneficiaries with Alzheimer's disease.

In late December 2007, CMS announced that it is working with the National Committee for Quality Assurance (NCQA) on quality measures for Medicare SNPs. These structure and process measures were scheduled to be released by NCQA March 15. (See "CMS/NCQA propose SNP quality measures" on p. 4 of this **Medicare Disease Management** supplement.) What makes SNPs a successful business model for DM in the Medicare population, and what have the successful SNPs learned? Offering an SNP is seen as a good business investment, but a risky one.

"These are the beneficiaries that are costing Medicare the most because they have multiple chronic conditions," says **Fred Dodson**, executive vice president of Care Improvement Plus, the C-SNP run by XLHealth, headquartered in Baltimore. Beneficiaries who enroll in the C-SNP have one or more of four chronic conditions: diabetes, chronic heart failure, chronic obstructive pulmonary disease, and/or end state renal disease.

"Two of our key focus areas are managing members appropriately in order to maximize the quality of their lives and reviewing documentation to ensure appropriate reimbursement," Dodson says.

His company places a strong emphasis on documentation and coding, in addition to offering what Dodson calls "an attractive product that brings disease management into a Medicare Advantage plan."

Dodson says proper coding is particularly important when a beneficiary has more than one chronic condition and underlying disease problems that must be

consistently documented from year to year in order to obtain appropriate reimbursement from Medicare. "If a member with diabetes has retinopathy, for example, we have to make sure that our documentation shows these diagnoses each year," he says.

Even two years ago, says Dodson, the C-SNP in particular was an unknown concept. But XLHealth leaders saw it as a way to get a leg up on the competition and began offering it to a small number of beneficiaries in eight counties in Maryland. In 2007, Care Improvement Plus expanded into three additional counties in Maryland, as well as statewide preferred provider offerings in three designated CMS regions:

1. Missouri and Arkansas
2. Texas
3. South Carolina and Georgia

Also, in 2007, CMS began reimbursing all SNPs at 100% risk-adjusted payments. The total number of plan options grew from 43 in 2006 to 241 in 2008. As for Care Improvement Plus, the total enrollment numbers increased from just under 500 in 2006 to approximately 75,000 at the end of 2007. "We anticipate that our growth rate will stabilize this year. However, we have continued to make strides in new enrollments thus far in 2008 within our existing service areas," says Dodson.

An advantage for SNPs over other Medicare DM offerings is the flexibility. The legislation that created SNPs allows plans to target beneficiaries with specific conditions and build benefit packages tailored to those conditions.

In a traditional Medicare Advantage model, benefits are created for a broader population and not designed around a specific chronic condition, says **Harry Leider, MD**, XLHealth's chief medical officer.

Care Improvement Plus offers seven benefit packages. Coordinated care and DM modalities are included in each option.

The SNP model provides an opportunity for better

integration of DM efforts, says Dodson, compared to working with fee-for-service beneficiaries, such as those in Medicare Health Support or another pilot program.

According to a recent CMS announcement, the Medicare Health Support pilot program has not met certain criteria and will end in 2008. "In a fee-for-service environment, the provider is trying to infiltrate from the periphery; whereas in a SNP model, the beneficiaries are plan members and as a result providers can more easily gather important medical and health-related data to stratify and manage members effectively," Dodson says.

Role of independent brokers

Dodson says the company has learned that the success of SNPs is also tied to the role of the independent broker and how well the brokers know the Care Improvement Plus product. "Broker education is critical industrywide," he says. "We are one of the few plans that didn't delegate this responsibility outside the organization."

Brokers should know every aspect of the C-SNP benefit, including the different drugs covered in the Medicare Part D prescription drug benefit offered through Care Improvement Plus.

Care Improvement Plus offers a prescription drug benefit that centers on chronic DM, Dodson says.

Prescription drugs that members need to best manage their chronic disease, but that may not be available in generic, are incorporated into the Care Improvement Plus formulary.

For example, top diabetes drugs, such as Metformin, Avandia, and Actos, are often used in combination. They are expensive and could well put the Medicare beneficiary over the \$2,510 limit that triggers the "donut hole" in coverage.

"Adding these drugs to the formulary and offering low to no copay levels for certain disease state medications has been a distinct advantage for our members," says Dodson.

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Expansion continues < continued from MDM p. 3

The drug benefit and other C-SNP offerings have clearly provided much richer services than enrollees had under previous Medicare coverage, says Dodson.

“The challenge for knowing how well disease management strategies are faring in this market is that we have little to benchmark against,” he says. “We believe

that we will continue to improve quality and lower costs in 2008.”

Editor’s note: Next month, we will feature the first Medicare Advantage SNP specifically for people with chronic disease and dementia. ■

CMS/NCQA propose SNP quality measures

CMS has asked the National Committee for Quality Assurance (NCQA) to develop a set of structure and process measures for special needs plans (SNP).

“This is a first step in evaluating the quality of care that it provided to Medicare beneficiaries who are receiving care from these new Medicare Advantage plans,” says **Kerry Weems**, CMS acting administrator. CMS data shows that there were 470 SNPs covering more than one million beneficiaries in 2007; a total of 760 SNPs have been approved for 2008.

The quality measures will examine how SNPs set up case management programs for members with complex needs and how they act to improve clinical care and the patient experience, Weems says.

In addition to quality and process measures, CMS will require that SNPs report 13 HEDIS measures to assess performance. These must be reported by June 30 and include:

- ▶ Colorectal cancer screening (except for SNPs under PPO contracts, because these measures rely on medical record review)
- ▶ Glaucoma screening in older adults
- ▶ Spirometry testing in the assessment and diagnosis of chronic obstructive pulmonary disease (COPD)
- ▶ Pharmacotherapy for COPD exacerbation (first-year measure is optional for all Medicare Advantage reporting)
- ▶ Controlling high blood pressure (except PPO contracts)
- ▶ Persistence of beta blocker treatment after a heart attack
- ▶ Osteoporosis management in older women

- ▶ Antidepressant medication management
- ▶ Follow-up after hospitalization for mental illness
- ▶ Annual monitoring for patients on persistent medications
- ▶ Potentially harmful drug-disease interactions
- ▶ Use of high-risk medication in the elderly
- ▶ Board certification

NCQA President **Margaret O’Kane** says that NCQA’s geriatric measurement advisory panel will help develop the structure and process measures in the following areas of care: integration of benefits and services, case management, care transitions, member experience, and clinical quality improvement.

The accreditation organization released the proposed standards for public comment in December 2007 and planned to announce proposed final requirements to CMS by March 15.

Final requirements and data collection tools will be available to SNPs in mid-April, with submission due by June 30.

Every SNP benefit package with an effective date of January 1, 2007, will be required to submit HEDIS results, and every benefit package, regardless of start date, must report quality and process measures.

O’Kane also says that NCQA will conduct training sessions over the Web to inform SNPs about pertinent information regarding the process for submitting data through NCQA’s data collection tools and the requirement for SNP evaluation.

Dates and times for training are available on the NCQA Web site at www.ncqa.org.

DM to the rescue?

Countries look to United States for chronic disease programs

With the rest of the world facing many of the same chronic diseases as the United States, DM organizations have stretched beyond this country's borders to help other nations fight life-threatening ailments.

A month doesn't pass without at least one U.S. DM company announcing a global expansion. Over the past few months alone, Aetna Global Benefits (AGB) announced it was making its DM services available to international members, U.S. Preventive Medicine promoted its expansion to the United Kingdom, and Health Dialog added France to its international work in the UK and Germany.

Martha Temple, AGB president, says other countries are facing similar health issues as the United States. "Chronic diseases are increasing throughout the world. Every system is feeling the strain of chronic disease," Temple says.

George Bennett, chairman and CEO at Health Dialog, says the idea of health management has taken hold. People now see that the patient's care outside the physician's office is a critical piece of healthcare. "The idea has emerged now and is alive all over the world," he says.

Health Dialog

One of the leaders in the international—as well as U.S.—DM space is Health Dialog, based in Boston. Health Dialog opened its first international office in the UK in 2005 when the company won a predictive modeling contract with the UK's National Health Service (NHS). After laying that foundation, Health Dialog worked with the country's Primary Care Trusts (PCT), geographic units that provide healthcare, to establish telephonic support for chronic diseases.

Although there were initial concerns as to whether the reserved British would open up about their health via telephone, Bennett says that has not been a problem. "We are finding that interest in telephonic support seems to be fairly universal," he says.

Bennett says the company provides many of its U.S. offerings to UK consumers as well. Health Dialog is one of 14 companies that qualified for NHS' Framework for procuring External Support for Commissioners (FESC), which is a federal stamp of approval that allows PCTs to choose from government-approved companies. Bennett says working with the trusts and UK government is not a large departure from dealing with the myriad U.S. health plans, because no U.S. client provides the same services in the same way.

"It was business as usual for us to do an adaptation of that," says Bennett. "Health Dialog's characteristic is to always figure out where the client is and meet them there. We are a pretty adaptive bunch."

In Germany, Health Dialog is not employing its own nurses but providing programming and training for German companies employing nurses.

"Basically, the German model is to support them in their efforts, where they supply the labor and we are supplying the intellectual property in the form of software and analytic insights to help them, which seems like a good model for us in the non-English-speaking countries, at least in the short term," says Bennett.

Health Dialog continued its international expansion in February with the announcement that the largest primary care health insurer in France had selected the Boston company to support France's first whole-person care management pilot program.

Caisse Nationale de l'Assurance Maladie de Travailleurs Salaries (CNAMTS), which covers 85% of the French population (about 50 million lives), will target

"Worldwide services for care management is embryonic but promises to be enormous over the next 10–15 years."

—George Bennett

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Chronic disease programs

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136,000 diabetics living in 10 of the country's 97 *departements*, which are political and geographic areas in France.

Health Dialog will provide CNAMTS with services and methodology for developing and implementing a program that will include DM, decision support, and general health and wellness. The U.S. company will train CNAMTS nurses, who will provide telephonic health coaching. Accenture, a global management consulting, technology services, and outsourcing company based in Paris, which previously worked with Health Dialog in Germany, will assist in the implementation of support materials and outreach efforts that require translation and customization.

Bennett says Health Dialog's expansion isn't over yet. The company is also speaking with representatives from Japan, China, Canada, Australia, and Switzerland. Health Dialog is primed for further growth with British United Provident Association's (BUPA) recent purchase of the company. The UK's leading provider of private

healthcare insurance and services, BUPA has facilities in 18 countries, with international employees who coordinate services in 180 to 200 countries. In fact, the majority of BUPA's revenue comes from outside the UK, says Bennett.

Bennett says BUPA has "an enormous presence and experience adapting to other countries." Having BUPA as its owner will enable Health Dialog to extend to other areas, he says.

Although Health Dialog continues to look beyond the nation's borders, Bennett says the company's priority is still the United States. "The U.S. will be our principal focus, but we are now working out an international expansion plan, and the intent is how fast can we grow internationally without distracting the U.S. resources," he says. Bennett expects DM to continue to stretch across the globe, as well as become a larger aspect of U.S. healthcare. "Worldwide services for care management is embryonic but promises to be enormous over the

Socialistic systems welcome DM

DM companies that have expanded beyond U.S. borders have found a welcoming home in countries with socialized healthcare programs.

A benefit to working with socialized programs is that DM companies don't have to promote their programs to many health plans and employers. **George Bennett**, chairman and CEO at Boston-based Health Dialog, says those systems allow a company to work with an individual governmental department. Plus, a government is more apt to take a long-range view of a DM program than an employer, who may want immediate results.

"I think the socialized medical systems are a better environment to learn how to do longitudinal population health management than the U.S. is," says Bennett.

Some examples of socialized healthcare systems are in Canada, Israel, and Cuba, but the country that has reached out the most to U.S. DM companies is the UK. Fourteen companies received the country's stamp of approval with

the designation of Framework for procuring External Support for Commissioners. The designation allows the UK's Primary Care Trusts to choose from those companies without having to conduct exhaustive research into the background of each.

Frederic Goldstein, president and COO at Jacksonville, FL-based U.S. Preventive Medicine, whose company is expanding into the UK, believes U.S. DM companies and socialized healthcare systems can create a healthy marriage. "I think I see more interest from both sides. They're interested in some of the techniques and approaches in the U.S., in addition to U.S. DM companies' interest in trying to meet that need," says Goldstein.

Whether a socialized system is best remains one of the most heated debates in healthcare, and the DM companies involved in international projects are not taking sides. Instead, Bennett says foreign socialized healthcare programs work well with DM. "I think the socialized medical systems are one of the biggest boons to U.S. DM," he says.

next 10–15 years. The U.S. is going to be much bigger as well,” says Bennett.

Aetna Global Benefits

AGB, which is the largest U.S.-based provider of expatriate benefits, recently announced it is providing its DM services to international members. AGB is focusing on the ailments that officials have found most prevalent in the expatriate population: diabetes, coronary artery disease, and asthma. “We are seeing that members are now more willing to travel the world with chronic diseases they have under control or a family member [who] has a chronic disease,” says Temple. “We’re seeing a rise in those diseases within our population.”

AGB is working with Aetna domestic to take advantage of the latter’s tools. The international arm of Aetna is taking that information, translating the materials, and making changes relative to a country’s standards of care.

In addition to the expatriate DM program of 350,000 members, AGB has a relationship with the NHS in the UK and has been approved as a provider within the FESC. AGB works with PCTs to help them analyze care management programs. Aetna has a UK office of approximately 20 people. In 2007, the company purchased Goodhealth Worldwide, an expatriate carrier with locations around the world, to complement its business. “What we are finding is that programs we have developed in the U.S. are applicable around the world,” says Temple.

U.S. Preventive Medicine

While the above two companies have laid roots outside this country, U.S. Preventive Medicine is just now looking to expand to the UK from its new headquarters in Jacksonville, FL. **Frederic Goldstein**, president and COO at U.S. Preventive Medicine, says the company plans to open the Centers for Preventive Medicine with iHealth UK Ltd. in that country.

In addition, U.S. Preventive Medicine purchased Specialty Disease Management Services in late 2007, which Goldstein says will help the company in its expansion.

“That gave us obviously a much more solid platform to build on in the experience that we can take to these countries and show them demonstrated results and success,” he says.

Goldstein says the UK is a prime area for DM programs. The daily newspapers feature articles about childhood obesity, and Prime Minister Gordon Brown has made converting the country’s health system to more of a prevention model a priority.

Goldstein says DM is resonating globally as nations face chronic diseases similar to those in the United States. Countries see that U.S. DM programs could help them with their health problems.

“Many of these government-funded programs have struggled because of bureaucracy or the ways the system is set up. [DM programs] are free-market ideas that could help them out,” says Goldstein. ■

Connecting with consumers

Companies find inspiration in other industries

Health plans spend \$9 billion each year communicating with members, but most of it doesn’t reach the right consumers and engage them.

Stan Nowak, CEO and cofounder of Silverlink, a healthcare communications company with 50 clients representing 150 million lives, based in Burlington, MA, is not sure healthcare is spending its communications money as effectively as it could.

In the not-too-distant past, healthcare companies did not view member engagement with as much focus as they do today.

“The time is now to treat member communications more strategically. Now members are making more choices and have increased financial responsibilities,” says Nowak.

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Inspiration

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Silverlink

Nowak says one of the biggest drivers of the change within healthcare from a business-to-business to a consumer focus came with the Medicare Modernization Act in 2003. Consumers increasingly have more say as to which services to choose, and health plans and DM companies need to offer services that engage consumers, he says.

But health plans have not been using communications as much as they could to promote their services and improve the member experience. According to a recent Forrester's North American Technographics Customer Experience Online Survey, consumers ranked medical insurance providers below many other industries—such as retailers, investment firms, insurance companies, and Internet service providers—in terms of customer experience.

Rather than continuing that dissatisfied customer trend, Silverlink—which offers communication solutions in numerous areas, such as Medicare, Medicaid, population health and DM, managed care, pharmacy benefit management, and medical supplies—is looking beyond healthcare for inspiration. Silverlink officials have tapped into the experience of consumer-based industry leaders, such as American Express, Capital One, and Harrah's Las Vegas.

Those industries have invested hundreds of millions in analytics and engage potential customers by segmenting and personalizing the outreach. By leveraging that consumer data and behavior, those companies are leading their industries, according to Silverlink.

Silverlink believes it has created a way to more effectively reach and engage members. Building upon the company's automated phone system, Silverlink announced improvements in March that merge decision science methodologies and analytics with personalization technology. The three-tier approach is:

- ▶ **Adaptive HealthComm Science**, which includes decision science methodologies, an iterative process, and continual integration and optimization

- ▶ **SAVS 5.0 Technology Platform**, which offers flexible architecture and extreme personalization; rapid program development; and visibility, measurement, and control
- ▶ **Expertise and service delivery**, including communication, healthcare, and consumer-marketing expertise

The idea behind Adaptive HealthComm Science is to drive consumers' actions in a personalized way that adapts and improves with each iteration. This is done through the SAVS 5.0 Technology Platform, which provides memory, on-call calculations, and dynamic pathing to enable the delivery of highly personalized, HIPAA-compliant, and interactive communications programs, according to Silverlink.

The new technology allows Silverlink to offer programs to clients through a multichannel approach, rather than merely automated calls. "That core capability is able to build things very quickly without programming; that allows us to microsegment populations and to move a population of a million people in any direction. That is what the consumer industry has learned in the past two decades," says Nowak.

The platform applies real intelligence and allows Silverlink to personalize communication. For example, the technology tracks call times to figure out when a customer is usually home. It also follows a person's health status, including collecting clinical data, over a set amount of time and escalates the call to a nurse if there is a continuing problem.

The platform allows Silverlink to change the message according to by age, sex, location, or other subgroup.

The Adaptive HealthComm Science program also allows Silverlink to take a health plan's customers and find the proper communication program.

That communication change could be as simple as changing the caller's accent. "We found a thing like using a Southern accent in certain ZIP codes improves

the yield on programs by 40%. It really blew us away," says Nowak.

By looking at the microsegments' demographics, Silverlink can assign the right voice based on the age and gender mix and even modify the script for a lower language level. "Our latest technology allows us through a single call program to create the best experience based on the segment you belong to," says **Margot Walthall**, director of product marketing at Silverlink.

Nowak says Silverlink is now able to conduct constant experiments to find best communication practices for each microsegmented population. "As we were building this capability, we talked to people who run these functions at large companies, like American Express, who have been doing things like this for 15–20 years now. They will tell you the same thing ... You look at what your population shows you, you measure it, and that's how you define what the interventions are."

Some may possess a negative view toward automated calls, but Nowak says they actually should be a "key component of communication strategy."

"The data now shows that the response rate for automated interactive calls is dramatically higher than any other form of communication," says Nowak.

Nowak says Silverlink's new offerings merge health-care with the best consumer engagement sciences. "We're taking disciplines from 20 years of customer marketing science and combining that with some of the predictive modeling capabilities that have been built in health-care," he says, "and then combining that on a highly flexible platform designed for adaptive control that allows us to get much smarter and drive much higher instances of behavioral change."

HealthMedia

Many employers with wellness programs barrage employees with health-promoting posters and incentives, but HealthMedia doesn't think that's the best way to reach and engage consumers. To engage a population in company wellness programs, businesses need executive sponsorship, appropriate resources, a strategic plan,

proper incentives, consumer-friendly access, and intervention strategies that fit the readiness of the population.

"We know that when behavior change happens, it reduces risk, which reduces costs," says **Alicia Rinaldi, MPH**, manager of participation strategy at HealthMedia in Northborough, MA, which combines technology and behavioral science to help clients—including Kaiser Permanente, Cleveland Clinic, and eight Blue Cross Blue Shield organizations—and partners with APS Healthcare, Health Dialog, and Wellsource. Rinaldi presented a free HealthMedia-sponsored Webinar January 31 on maximizing participation and outcomes in health management initiatives.

Many companies don't get the wellness program participation they expect because they don't learn about their employee population, says Rinaldi. She suggests that companies need to avoid the *Field of Dreams* mistake—"If you build it, they will come"—which is believing that everyone will get involved merely because a program is available.

Before implementing programs, companies need to reflect and ask:

- What are we trying to achieve?
- What are our goals and objectives?
- How will they be measured?
- What is our focus? Some examples might include reducing healthcare costs, improving productivity, increasing member satisfaction, changing behavior, and improving health.

"The process is about taking a step back to know not only where you are, but where you want to go," says Rinaldi.

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Questions? Comments? Ideas?

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Inspiration

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Once a game plan is chosen and goals and objectives are created, HealthMedia suggests companies implement a 12-month action plan that allows them to review progress throughout the year.

Once the game plan is set, the company will need to use intelligent recruitment by creating an individualized wellness program. This is done in large part through a health risk assessment (HRA), which collects health information from an individual and gauges that person's desire to change his or her lifestyle.

Rinaldi says an important part of communication is not bombarding people with too much information. The wellness program should tackle each problem separately and provide personalized information on each area of concern.

This kind of initiative has been successful for HealthMedia clients. Rinaldi highlights an example of recommended changes that worked with a healthcare system, including moving from a gift card to a benefit-based incentive, promotional integration with a communitywide health and wellness Web site, and tailoring communications to individuals who completed health risk assessments (HRA). (For examples, see "Best practices for effective incentives" to the right.)

What the healthcare system found was that program participation increased from 1,307 in the year prior to

HealthMedia's work to 9,374 in the next year, a participation increase of 7.2 times.

Even a minor change can engage employees, such as improving online access. HealthMedia recommended Kaiser Permanente do just that by changing its Web site to include behavior change programs on the home page. This allowed for easy access and reduced barriers. Kaiser Permanente reported a twofold participation increase from just that improvement.

When creating an incentive plan, HealthMedia suggests a plan that moves from extrinsic to intrinsic motivation, such as encouraging employees to complete HRAs that will be used to tailor communications.

"This is a really exciting strategy to look at how we are mining data wisely to send individual-salient messages," says Rinaldi. ■

Best practices for effective incentives

HealthMedia suggests companies use the following practices when creating wellness program incentives:

- ▶ Provide immediate gratification
- ▶ Add value in self-select awards
- ▶ Tie incentives to follow-up activities to collect outcomes
- ▶ Use internal companywide performance metrics/bonuses, which will help build a culture of wellness

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