Health plans bringing in DM services

Displeased with the money they’re paying to DM vendors and dissatisfied with DM’s results, more health plans are moving those services in-house.

For example, a pair of Minnesota health plans announced in April that they’ll offer DM services. Blue Cross Blue Shield of Minnesota in St. Paul and Medica in Minnetonka, MN, are part of a trend that is moving health plans into the DM space.

Those who support in-sourcing DM services say internal programs allow for flexibility, faster interventions, and can cut costs. Those who side with outsourcing point to DM vendors’ extensive knowledge and product line.

Randall Williams, MD, CEO of Pharos Innovations in Northfield, IL, says many employers and health plans are questioning the value and place of traditional DM because it hasn’t always fulfilled the promise of saving money. “There is no doubt in my mind that the industry is undergoing a seismic shift away from outsourcing programs to third parties ... and has begun to reinvigorate internal building or assembling of disease management programs,” Williams says. “Others are exploring outsourcing to physicians directly under pay-for-performance or medical home reimbursement models.”

There is a trend toward greater in-sourcing, but Ian Duncan, FSA, MAAA, president of Solucia, Inc., in Farmington, CT, says he’s surprised there hasn’t been an even larger in-sourcing movement. One of the largest expenses for a health plan is paying for DM, says Duncan, adding that he doesn’t understand why more health plans don’t explore offering services in-house.

“It seems that the outsourced DM industry that took off around 2000 has managed, despite the fact that it is expensive and has difficulty demonstrating successful ROIs, to keep a very strong hold on health plans and employers,” he says.

George Bennett, chair and CEO of Health Dialog in Boston, uses a nautical analogy to describe the current in-sourcing versus outsourcing situation.

“Strong currents and high winds always favor the effective navigator,” Bennett says. “The care management industry has been characterized by strong currents and high winds for a decade. Current sailing conditions include the fact that many large health plan payers are changing the mix of in-sourcing and outsourcing services they are using to meet their customers’ care management/disease management needs.” Third-party care management/DM firms must understand “the strong currents and high winds and ... navigate with the trends rather than sail upstream,” he adds.

For example, one way to stay on course is to license...
Health plans < continued from p. 1

intellectual property to help plans carry out their in-sourcing strategies and provide outsourced services to those who want them.

The trend is not just with health plans looking to in-source, but health plans with DM programs seeking services from outside vendors, says Alfred Lewis, JD, executive director of Disease Management Purchasing Consortium International, Inc., in Wellesley, MA. Lewis says the current climate shows both sides of the in-sourcing/outsourcing debate think the grass is greener on the other side.

Lewis says health plans are looking outside their companies because they’ve found that hiring call center nurses is more difficult than expected, there are lengthy accreditation processes that health plans must undertake to provide DM services, and health plans usually have different hours than what is needed for call center nurses. Adding night nurses raises HR and security issues, too, Lewis says.

“This is just one example of the many logistical details that no one thinks of when deciding to in-source,” he says.

However, Premila Kumar, MD, PAHM, manager of care management at Horizon Blue Cross Blue Shield of New Jersey in Newark, hasn’t seen those issues at her health plan. “I don’t think there are any drawbacks in administering programs in-house,” she says.

In addition to health plans in-sourcing DM programs, Kumar says she sees insurers develop hybrid models in which they in-source some services and outsourc others.

Competitive advantage

Bennett says care management, which runs the gamut from chronic illness to other conditions, has become an important part of the competitive landscape, and many health plans now view care management as a strategically important component of their service offerings.

“They are very interested in having a mix of care management services that can give them a competitive edge. The right mix of services is still in question. Different firms answering the question in different ways is creating a lively, competitive landscape,” says Bennett.

He says some health plans are creating their own care management programs, and some benefit from intellectual property from third-party vendors while using their own staff. “Most are mixing and matching the various in-sourcing and outsourcing options. For a health plan to not have a care management function in 2008 to help people better navigate the healthcare system puts them at a serious competitive disadvantage. They have to have presence in this arena given that there is signif-
icant and growing evidence that it has a high impact,” says Bennett. Kumar says in-sourcing DM gives a health plan such as Horizon better control of its members. If a health plan signs up with a DM vendor, the plan is bound by contract limitations. By in-sourcing services, the health plan can change programs, look for gaps in member care, and provide interventions without having to go through a vendor. One example is Horizon’s home telemonitoring program for HF patients, which was expanded to include diabetes patients and may soon be further expanded to patients with obesity, says Kumar.

> continued on p. 5
BCBS of Minnesota creates in-sourced health management model

To gain more control of the health of its members, Blue Cross Blue Shield (BCBS) of Minnesota in St. Paul will sever ties with Healthways and begin offering most of its DM services in-house in January 2009.

David Plocher, MD, chief medical officer and senior vice president of health management and informatics at BCBS of Minnesota, says outsourced DM vendors simply do not have the relationships with providers that health plans enjoy. “We have a responsibility to help our members improve their health status as much as we can, and an outsourced company doesn’t have our linkages to providers and, so, when we want to collaborate with providers, we need to be in charge of the health management programs,” he says.

Plocher says BCBS’ new offerings are not a “me-too approach,” but one in which new features can potentially help all members, not just those with chronic diseases. BCBS will offer Whole Person Health Support, a health management program that goes beyond traditional DM. The health plan says Whole Person Health Support is more expansive than DM in the areas of identification and stratification, consent and engagement, and integration. “We use entirely different methods to find people. We want to concentrate on finding people who really need to be found and whose course we can modify and who are ready to change behavior,” says Plocher.

The health plan is also using advanced claim pattern software that filters claims to find gaps in care, such as failures in medication refills and testing; reviews referrals; biometric screening; hospital discharges; and health risk assessments.

Plocher says the switch to in-sourcing will allow the health plan to revamp the health management programs rather than negotiating changes with a vendor. “The owner, the health plan, always wants control, flexibility, and speed. That’s easier to manage when it’s an in-house–owned program.”

Bringing the majority of DM services in-house in January 2009, BCBS also hopes to gradually in-source additional programs later. Two programs that will remain outsourced for now are an online health assessment and a nurse triage line. Plocher says BCBS also believes that in-sourcing more DM services will allow it to offer Whole Person Health Support at a lower price than the traditional DM program. BCBS will hire 80–100 employees to handle the DM services, a majority of whom will staff a nurse call center. Plocher adds the health plan is investing in technology for the call center and decision health platform.

Plocher, who consulted for Healthways until 2001, has been involved with the DM industry for nearly 15 years. In addition to Plocher’s experience, BCBS, as a health plan, was an early leader in turning its focus to disease and health management. Its experience in health management grew significantly starting in 2002, including working with Healthways on several DM programs.

At one point, BCBS had more than 250,000 members enrolled in a variety of DM programs. This gave Plocher and his team knowledge about what works with DM models. In addition, BCBS built and operated its own HF program for Medicare members, which was recognized by CMS as a highly successful model.

This experience gave BCBS the experience and foundation to create the next generation of health management programs it is bringing to the market, Plocher says.

He says BCBS will educate members about the program changes through outreach and on-site tours. “It’s a large communication effort to reorient our purchasers, because this really does change the game from the old days of marketing one disease program at a time.”

Plocher says bringing the DM services in-house and providing a larger health management program will help BCBS members. “It’s easier for us to deliver Whole Person Health Support with our in-sourced programs because we don’t have handoffs, we don’t have data being sent to outsourced companies. It’s fully integrated,” he says.

“It’s easier for us to deliver Whole Person Health Support with our in-sourced programs because we don’t have handoffs, we don’t have data being sent to outsourced companies. It’s fully integrated.”

—David Plocher, MD
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“That is something we can do by looking [at] and analyzing the data from time to time, and we have better control. If a vendor is [offering DM services], it’s limited by the contract’s outline,” says Kumar.

Don Hawley, chief strategy officer at Health Dialog in Boston, doesn’t fault health plans for examining the numbers or bringing DM services in-house. In the current climate, DM vendors should embrace health plans in-sourcing DM and find ways to add value to those programs.

“We work hard to help our clients structure solutions that reflect their view of the best mix of in-sourced services and outsourced services. In our view, the mix often changes over time,” Hawley says.

Smaller health plans outsourcing

Bennett says big health plans tend to use a mixture of in-sourced and outsourced solutions, but that health plans with less than 500,000 members are mostly outsourcing care management/DM programs.

Health Dialog, with outsourced services that are now available to more than 24 million people, has not seen a drop in outsourced business in recent years. In fact, its licensing business for large plans that want to in-source and its outsourcing businesses have grown. Bennett estimates that Health Dialog will grow about 30% this year, breaking the $300 million mark.

Bennett says the company is growing despite in-sourcing because it offers its intellectual property and outsource services à la carte rather than only offering bundled outsourced services.

The firm is as interested in licensing intellectual property as it is in outsourcing. The health plan client can decide whether to use its own staff (in-source) or Health Dialog’s staff (outsource).

In fact, Bennett estimates that only 30% of Health Dialog’s costs are associated with call center nurses. A large fraction of the firm’s resources are focused on predictive modeling, reaching and engaging members, developing sophisticated software tools, and licensing intellectual property.

“If you are a third-party vendor and your definition of care management is narrow, then you will experience more stress in the near term than if you define your service offerings more broadly,” says Bennett about DM’s need to go beyond the strictly call center nursing model.

Bennett says Health Dialog broadcasts the availability of its support services to members of a client’s served population. The firm also has an extensive library of predictive models, which allows them to take a half-mil-

Upcoming audioconference


This 60-minute audioconference will focus on the importance of health literacy and how to properly educate and engage members. It will offer strategies to help healthcare professionals deliver information to consumers that will engage them and enhance compliance outcomes. Participants will learn how to:

➤ Identify the scope of the current health literacy issue
➤ Recognize the importance of developing universal health literacy standards
➤ Formulate a plan for presenting a business case for health literacy to leadership
➤ Implement a health literacy program that reaches members regardless of background or education level
➤ Recognize what to expect in the future with health literacy

For more information, visit www.hcmarketplace.com and click on Managed Care and then Audioconferences, or call customer service at 800/650-6787.

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Health plans < continued from p. 5

lion people and find the 15,000 members who are at risk of “falling into the vortex” of the intense use of healthcare services, says Bennett.

Once the high-risk individuals have been identified, Health Dialog also has cost-effective reach-and-engage tools to help convince the high-need individuals that they could benefit from health coaching support (e.g., online and telephonic).

The outreach tools include segmentation approach-

Difficult to duplicate?

The debate between DM vendors and health plans offering DM falls along the lines of which offers the better products. Each side claims the other has trouble duplicating its products and services.

DM vendors say they have extensive knowledge in areas of data collection, measurement, technology, decision aid, and other tools.

In response, health plans claim that in-sourcing DM allows them greater flexibility and control of their members, they have better relationships with physicians through other health plan business, and they experience a shorter turnaround time to receive claims data, which allows them to contact at-risk members faster. There is also no hassle with having to negotiate contract changes when DM is done in-house, they say.

The future

Bennett says the future of in-sourcing versus outsourcing will depend on the evolving strategies of the large health plans. He observes that decisions to in-source or outsource are often reversed after several years.

However, in his view, as long as there are health plans with fewer than 500,000 lives, the care management/DM outsourcing model will grow and prosper, he says.

Lewis expects to see more health plans test in-sourcing, but he’s not sure it will be successful.

“I think you’ll continue to see a slow trend toward more in-sourcing that will ultimately reverse itself when people sort of throw in the towel and start getting their first outcomes and realizing they don’t have anything to show [from in-sourcing DM services],” says Lewis.
CMS demonstration targets younger seniors

Five demonstration projects are accepting participants in a three-year program to gauge whether preventive services reduce costs and chronic disease among younger Medicare beneficiaries.

CMS’ Senior Risk Reduction Demonstration (SRRD) is quite different from the Medicare Health Support (MHS) project, which will end this year after CMS officials reported disappointing cost savings.

Although MHS dealt with the sickest diabetes and CHF patients, SRRD is slated to focus on younger seniors, aged 67–74, across multiple risks (see “Health risk categories in SRRD project” on p. MDM 2).

“This is a much wider net in terms of the population we’re working with because it’s a national random sample of beneficiaries. While there may be some participants with multiple chronic conditions, this service provides a lighter touch, focusing on self-management rather than traditional disease management,” says Julia Portale, senior director of Pfizer Health Solutions, Inc., in New York City. Pfizer is one of two companies to take part in MHS and SRRD (Health Dialog is the other).

“[SRRD is] trying to understand how people can take care of themselves and be as effective as they can managing their health,” she says.

The demonstration’s goal is to see whether health promotion, health management, and disease prevention programs that have been developed in the private sector can work within the Medicare population to achieve high participation rates, receive positive reviews from beneficiaries, reduce health risk factors, improve beneficiaries’ health, and save money for Medicare.

According to CMS, SRRD is “based on evidence that CMS gathered as part of its Healthy Aging Project, which showed that effective risk reduction programs, beginning with the administration of a Health Risk Appraisal (HRA) and including evidence-based and tailored behavior change follow-up interventions, exert a beneficial effect on behavioral, physiological, and general health status outcomes.”

“I think what is interesting about it is that it is a lighter touch than traditional disease management, so it’s really about focusing on people’s ability to change their lifestyle to maximize their health,” says Portale.

Including Pfizer Health Solutions, the five organizations taking part in SRRD are:

➤ Health Dialog Services Corp. in Boston
➤ Focused Health Solutions in Deerfield, IL
➤ HealthPartners Health Behavior Group in Bloomington, MN
➤ StayWell Health Management in St. Paul, MN

Don Hawley, chief strategy officer at Health Dialog, says his company was interested in taking part

> continued on MDM p. 2
in SRRD because it dovetails with its Medicare and healthy living programs. “We basically have taken the programming that we already provide to the substantial number of Medicare beneficiaries in our current program and adapted it into the shape that the demonstration requires.”

In the SRRD project, Pfizer will work with Green Ribbon Health (created by Pfizer and Humana to provide programs in the MHS program), which will handle the social work for more intense participants, Health Fitness Corporation, which will provide health coaching, and two Aging and Disability Resource Centers, which offer social services and financial counseling.

The centers were originally created to provide a one-stop shop to help consumers make decisions regarding long-term care options and have now expanded to provide information and assistance, including Medicare Part D and health promotion programs. Portale says having the local organizations on board combines the agencies’ more personal connections with a large scale, lighter touch.

Portale says Pfizer’s demonstration project will incorporate the company’s existing experience in health promotion into the new programs, including experience from its employee wellness program, Healthy Pfizer. She says the demonstration will be an opportunity to analyze what works and whether chronic disease self-management strategies are effective across multiple disease states in a light-touch model.

Hawley says it’s best to track the entire population rather than placing beneficiaries into disease-state silos. “As health needs change, we want to support [members] as they migrate from one segment to the next. It’s those moments of transition and change that are the most ripe for intervention and readiness for support. Our entire design and our whole program is around support, across the whole continuum. This is something we endorse.” Portale says Pfizer saw SRRD as a way to expand services across all levels of health. Pfizer has offered traditional DM programs and end-of-life services, and SRRD is a way to see whether the New York-based company can reach Medicare beneficiaries to slow disease progression and reduce costs. “It is an area that we have interest in and think it is the wave of the future in terms of being able to reduce costs and improve health,” says Portale.

Pfizer’s HRA will “determine participants’ risk for disease and will create tailored interventions to start improving participants’ health.” With that information, Pfizer will connect beneficiaries in the standard and

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**Health risk categories in SRRD project**

The Senior Risk Reduction Demonstration (SRRD) will address the following health risk categories simultaneously:

- Physical inactivity/lack of exercise
- Poor nutrition
- Smoking/tobacco use
- Excessive tobacco use
- Excessive alcohol consumption
- High BP
- High blood glucose levels
- High total cholesterol
- Overweight/obese
- Inappropriate use of clinical preventive services
- Depression
- High stress
- Lack of general well-being
- Burden of providing caregiving
- Social isolation
- Lack of motor vehicle/home safety
- Falls (preventable accidents)
- Polypharmacy/medication issues

Source: Senior Risk Reduction Demonstration vendor solicitation notice.
enhanced intervention arms of the project to proper health coaching and community resources, encourage increased engagement with doctors, and promote adherence to physicians’ treatment plans.

Portale says DM companies can effectively reach out to senior populations. Pfizer learned that even the sickest individuals can change their health with the right tools. “It was rewarding to see those changes in people with multiple health issues, and we thought SRRD would be a good opportunity to try to get people on the front end to prevent some of those conditions,” says Portale.

Unlike other demonstrations that focus on a specific disease state or geographical area, SRRD cuts across health status and location. For example, the pilot phase of the program has participants in 47 states, Portale says. Hawley says CMS will compare participants with ones from more densely populated areas to see whether beneficiaries benefit from living in areas with more resources.

**Capitation fee**

Medicare will assign approximately 15,000–17,000 randomly selected beneficiaries to each vendor for recruitment into the demonstration. About 85,000 fee-for-service Medicare beneficiaries will take part in the project.

CMS will pay the five organizations on a monthly per-beneficiary capitation fee with the understanding that each company must accept a 10% withholding of its fee each year of the demonstration and as much as 15% during the course of the demonstration. The organizations must reach budget neutrality.

Hawley says Health Dialog has designed a program that will at least reach that goal. “It’s hard in a three-year trial, when a lot of the population is healthy, to be able to see the payoff of healthy living support, because a lot of that stuff gets deferred beyond the scope of the study. I think the value of these kinds of work will have a tail on it that will go beyond the scope of the study,” he says.

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**More is not best**

*Report: Better practice patterns would save Medicare billions*

With healthcare spending expected to reach $4 trillion annually by 2017, chronic disease accounting for 75% of healthcare costs, and CMS testing ways to improve outcomes and lower costs, the Dartmouth Institute for Health Policy and Clinical Practice is suggesting more care does not equal better quality.

The most recent edition of the Dartmouth Atlas Project of Health Care (DAP), *Tracking the Care of Patients with Severe Chronic Illness*, states Medicare could save tens of billions of dollars annually if it followed the practice patterns of a facility such as the Mayo Clinic in Minnesota.

The report suggests that physicians are prescribing too many services and notes the differences between how particular regions handle end-of-life care for chronic illness patients. The authors say the cost differences coupled with the lack of better outcomes and quality shows policymakers must review the healthcare system. “The opportunity lies in the potential gains in efficiency that could be achieved if higher spending regions or hospitals adopted the practice patterns of the most efficient U.S. regions,” according to the report.

The Dartmouth project began in 1993 to study healthcare and measure variations in resources and utilization by geographic areas. The research has more recently expanded to report on resources and utilization among patients at specific hospitals. “The extent of variation in Medicare spending, and the evidence that more care does not result in better outcomes, should lead us to ask if some chronically ill Americans are getting more care than they or their families actu-
ally want or need,” said Risa Lavizzo-Mourney, MD, MBA, president and CEO of the Robert Wood Johnson Foundation, a healthcare advocacy organization, in a statement.

Medicare, according to the DAP, encourages the overuse of acute care hospital services and the proliferation of medical specialists because of misplaced financial incentives, especially for treating chronically ill patients.

In the report, the Dartmouth authors studied chronically ill patients, including patients with cancer, CHF, and chronic lung disease.

One way to improve care, according to the DAP, is through the medical home model, which places the primary care provider at the center of a patient’s care coordination.

The model has gained popularity; for example, it is the template for CMS’ Physician Group Practice (PGP) demonstration project. CMS has praised the results, citing two groups earning performance payments for quality and efficiency of $7.3 million as part of their share of the $9.5 million savings in the Medicare program. Two other groups also met all 10 diabetes clinical quality measures in the PGP project.

“Medicare policy, including reimbursement, should support ‘organized’ systems of effective care management, with a strong primary care component,” lead author John Wennberg, MD, said in a statement. “The federal government should also support better research into clinical practices for managing chronically ill patients.”

The study’s authors found that the patients studied cost healthcare $289 billion from 2001–2005, but if the spending per patient mirrored Mayo’s home region of Rochester, MN, Medicare could have saved $50.1 billion, or 17.3%. The report also compared Mayo with UCLA Medical Center to show how increased services raise costs but do not improve outcomes. For example:

- UCLA spent more than $93,000 per patient in the last two years of life, whereas the Mayo Clinic spent $54,432
- In the last six months of life, chronically ill patients at UCLA had more than twice as many physician visits as those at Mayo and spent almost 50% more days in the hospital
- UCLA uses 1.5 times the number of beds and almost twice as many physician FTEs than Mayo Clinic in managing similar patients

According to the DAP, higher end-of-life costs did not equal better outcomes. In fact, mortality was slightly higher in the higher-cost regions following acute myocardial infarction, hip fracture, and colorectal cancer diagnosis, and healthcare providers adhered to process-based quality measures at a lower rate.

Patients in high-cost areas also reported worse access to care and greater waiting times, and the report found no difference in patient-reported satisfaction with care.

The DAP says two factors are driving decisions about care:

- Doctors and patients believe that more services equal healthier patients.
- Based on that belief, it is the supply of beds and treatments and specialists—not the person’s health status—that determines how many services are used. The supply of services creates its own demand, so regions with more resources have more usage and higher costs.

The Dartmouth conclusion also questions whether the country faces a physician shortage and says that not overusing acute care hospitals would save money and could help resolve the shortage of RNs.

“In light of the evidence that regions and academic medical centers with greater use of physician labor in managing chronic illness incur higher costs and have slightly worse outcomes, the assertion that the nation faces a physician shortage warrants critical examination,” according to the report.
Silverlink HealthComm Behavior Index shows disconnect

Health plans can improve the effect of their communication to members and, in turn, drive appropriate healthcare behaviors that will improve health outcomes and lower healthcare costs.

Recent research from Silverlink’s HealthComm Behavior Index shows a link between healthcare communication and satisfaction, personalization, and behavior change.

Further, the study found that most Americans are lukewarm about their health plan’s communication, and some segments claim that the outreach is not helping them take action on their health or improve their lifestyles.

Silverlink Communications in Burlington, MA, a healthcare communication company with more than 50 clients representing more than 150 million lives, kicked off its quarterly index as a way to measure the effectiveness and behavioral impact of healthcare communication.

Stan Nowak, Silverlink’s CEO, says there is no other organization compiling this kind of data, particularly surveys that measure the relationship between healthcare communication and satisfaction, personalization, and behavior change—and compare these dimensions over time. Silverlink’s SAVS 5.0 Technology Platform’s automated communication system contacted almost 50,000 commercially insured adults in the United States between February 12–19. Of the 1,254 who started the survey, 1,176 completed it (nearly 94%).

If a health plan was the caller, only 30%–40% would have participated, says Jack Newsom, senior director of Adaptive HealthComm Science at Silverlink.

In addition to screening and demographic questions, the survey, which took five to eight minutes, asked participants 10 questions focusing on personalization, satisfaction, and action.

Respondents, who were either commercially insured or seniors in Medicare Advantage plans, answered each question by rating their health plans’ communication on a scale of 1–5 (see “Communication breakdown” on p. 8).

Nowak says the index shows that health plans have a significant opportunity to much more effectively connect with their members to drive behavior change.

“What we have been talking about a number of years now is, clearly, a high degree of personalization in your communications will increase satisfaction and then the effectiveness, and I think that was borne out by this work,” says Nowak.

Silverlink found that respondents consistently rated the satisfaction and personalization of their health plans’ communication in the mediocre range. Areas in which health plans could improve are helping members improve their health and adopt a healthier lifestyle.

The index’s first results show five items that might interest health plans and DM organizations:

- Americans are unenthusiastic about healthcare communication
- There is a correlation between a person’s satisfaction and the personalization of healthcare communication
- A person’s health status—not demographics—is a better predictor as to whether a person takes action
- Unhealthy people are the least satisfied with their healthcare communication
- Seniors are especially pleased with their healthcare communication

Although health literacy is often stated as a barrier to health, Silverlink’s index reports that a person’s health status is more important than demographics in the area of engagement. “One thing that jumps out to us is that

> continued on p. 8

“>The most important thing, in my view, is the actions of the patient themselves. This will be the single largest driver for reducing health plan expenses over the next several years.”

—Stan Nowak
folds in poor health, that are more in need of services, are ones who feel the least personal communications, and are the least likely to take action," says Newsom.

Newsom says seniors are often positive about their healthcare and health status. Susan Frankle, director of corporate communications at Silverlink, says, “I think the interesting piece of it was how people rate their health status. It’s relative to their peers and age bracket.”

Nowak says health plans should not link all seniors into one group. Instead, healthcare needs to think of

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**Silverlink** <continued from p. 7>

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**Communication breakdown**

**Respondents are lukewarm on healthcare communications:**

**Average rating**

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**Unhealthy respondents have lower scores across all questions:**

**Average rating by health status**

**Source:** Silverlink Communications, Burlington, MA.
seniors more granularly. “What we have learned over time is all seniors are not created equal,” he says.

Communication is an area of opportunity for health plans, Nowak says, adding that health companies don’t usually create a companywide communication program, but they allow individual departments to communicate with members.

This can create disjointed member outreach that is repetitive and not coordinated, which not only doesn’t help members, but is also wasteful, says Nowak.

“The more personalization, I think, you’re going to increasingly see yields of higher impact,” explains Nowak.

Nowak provides an example of personalized member communication: flu shot clinics.

Rather than contacting a member and suggesting he or she get a flu shot, Nowak says a health plan or DM company could more effectively target the individual with specific information.

For example, a health plan could contact a person for a flu shot reminder, provide a personalized message about why that person should receive a flu shot, and provide a list of flu shot clinics taking place in the person’s community.

Silverlink officials say they will conduct the index quarterly to gauge the progress of healthcare communications. They also hope to offer the services to clients so they can gauge their communication against the national average.

Nowak says creating personalized communication that engage members and spark them to action is the right way to connect and activate members.

Health plans and DM organizations should understand that member satisfaction and personalized communication translate into member action.

Creating a personalized companywide communication program provides health plans and DM companies a chance to target the critical and costly unhealthy segment. “The most important thing, in my view, is the actions of the patient themselves. This will be the single largest driver for reducing health plan expenses over the next several years. We need that patient to take action based on the communications,” says Nowak.

### Improving communication

The following are four ways to improve healthcare communication:

- Create a companywide communication program
- Focus on those who are the most unhealthy
- Don’t inundate members with redundant information, but create a system to track each member’s communication
- Personalize the message to the individual

### Beyond the bottom line

**DM/wellness companies looking at health coaching programs’ effectiveness**

A growing number of health management companies are going beyond simply measuring outcomes and are looking under the hood of their health coaching programs to make sure their offerings are actually causing the intended results.

**Ariel Linden, DrPH, MS**, president of Linden Consulting Group in Hillsboro, OR, says exploring the actual nuts and bolts of a health coaching program shows a company where its program is making gains and engaging members and highlights areas of concern. If a company cannot show improvements in patient activation, Linden says he isn’t confident that companies can accurately attribute its health coaching programs to a positive outcome.

Linden says he sees more interest in the DM space on this kind of view, but the majority of DM programs are still not properly reviewing their programs and,
Bottom line  < continued from p. 9

subsequently, not providing the best health coaching. As a health service researcher, Linden says he is just as interested in those kinds of causal pathways as he is the bottom line.

Linden and Susan Butterworth, PhD, director of Oregon Health & Science University’s Health Management Services in Portland, run a program that performs stem-to-stern review of health coaching programs.

One way to review a health coaching program is by randomly selecting calls between coaches and patients using measures to review whether a coach is proficient in motivational interviewing—Motivational Interviewing Treatment Integrity Code—and how the patient is progressing in his or her health—Patient Activation Measure (PAM).

That’s not to say that any person can listen to a call and effectively track motivational interviewing techniques. That kind of expertise takes training and knowledge. By reviewing calls, Butterworth says she is able to accurately weigh whether the intervention is effective and is responsible for patient and bottom-line improvements.

Companies can use these methods to conduct regular review of their programs and consider their effectiveness.

Through the process, Butterworth also reviews hiring, materials, training groups, managers, and how they support the coaches. After a thorough review, Butterworth says its gives her more confidence that the intervention caused the results.

Chris Delaney, CEO of Insignia Health in Portland, OR, says the PAM effectively segments a population based upon levels of activation and the performance of nearly 100 self-management behaviors, helping coaching programs achieve higher levels of member activation, reduce unwarranted utilization, and allocate resources more effectively.

The 10- and 13-question PAM, which is used in about 15 countries, segments people into four levels:

- Level 1 (starting to take a role in their healthcare): 10%–15% of adults
- Level 2 (building knowledge and confidence): 25%–30% of adults
- Level 3 (taking action in their healthcare): 32%–37% of adults
- Level 4 (maintaining behaviors): 20%–24% of adults

Delaney says the PAM, developed by Judy Hibbard, DrPH, and her colleagues at the University of Oregon, offers a wealth of insight not found in other measurement tools, such as health risk assessments (HRA).

Although many HRAs have dozens of questions that gauge a person’s health status and functioning, these assessments do not tackle the underlying drivers to health—the self-management competencies that are largely responsible for health status and future risk.

“We’re trying to capture the insights most relevant to effecting behavior change, and we think we have that in the Patient Activation Measure,” he says.
**Motivational interviewing**

Linden says motivational interviewing training is key. Ongoing training—not just sessions when a person is hired—ensures that health coaches use proper methods.

For health coaches to engage and activate people with chronic disease goes beyond having call center nurses with clinical backgrounds.

Without the proper training, the medically trained often do not know how to bring about change. One way to do this is to show empathy and not try to force someone to make a change. Nurses shouldn’t push patients before they are ready. “Empathy happens to be one of the most important traits,” says Linden.

**Avoid these health coaching mistakes**

One common mistake that health coaching nurses make is that they give patients information or advice before they are ready to make a health change, says Susan Butterworth, PhD, director of Oregon Health & Science University’s Health Management Services in Portland, OR. Nurses should assess a person’s readiness to change. “When a person shows resistance, instead of backing off and reading that as ‘I need to change my approach,’ [untrained nurses] push harder,” Butterworth says of health coaches who are not following motivational interviewing principles.

“There are studies that show that that kind of resistance, where someone is pushing on someone to make that change, and the person is giving you the ‘yeah, but’ dance ... that actually predicts negative clinical outcomes,” says Butterworth. “So, in a sense, [when a coach pushes too hard], that’s not just neutral, they are doing harm.”

If a patient is showing resistance, Butterworth says, a coach should explore the person’s ambivalence and find out what is holding the person back. She says people want to be healthy but, for many, that’s difficult to do. It’s like cleaning the garage, she says. You know you should do it, but there are plenty of good reasons to delay the chore.

“The only thing that makes it different is that with cleaning out the garage, you’re not going to die from it,” she says. Butterworth says it’s difficult for many because people have used unhealthy habits such as cigarettes as a coping mechanism. In effect, by pushing a person away from tobacco, you are removing a crutch. “What we do is help them to explore what they would like to do, and then, once motivated, we help them find a plan that helps them address those barriers and helps give them substitutes [to the crutches].”

Butterworth says health coaches can’t help people change until those people stop resisting and start talking about how they might benefit from changing their behaviors. Instead of reciting barriers to health, the people begin to discuss ways to improve their behaviors.

“What makes a really good collaborative team is when the coach comes in with their expertise, but they acknowledge that the patient has just as much to do with solving the problem, and they work together to solve the problem,” says Butterworth.

Another mistake call center nurse systems make is that they spend too much time following a script rather than teaching nurses how to effectively talk to patients. “I’m pretty anti-script, because scripts are antithesis to the whole notion of being with the patient where they are in their state of readiness to change,” says Butterworth.

**Chris Delaney**, CEO of Insignia Health in Portland, OR, says a critical way to bring activation is to “start where the patient is” and through gaining knowledge and confidence. “If you lack confidence, you’re not going to be terribly motivated,” he says.
One DM company that created a health coaching program with motivational interviewing is DaVita-Village Health in Vernon Hills, IL, a DM company that focuses on end-stage renal disease.

Andrew Hayek, president of DaVita-Village Health, says his company implemented the programs to help members with such areas as staying current on flu shots. The coaches are able to explore why some members may reject flu shots, such as a friend’s negative experience with the shot. The coaches find the root cause and then explore the best way to resolve that barrier, such as interaction with a physician. This kind of health coaching requires asking open-ended questions and a heavy dose of listening, Hayek says, adding that DaVita-Village Health’s leadership changed to motivational interviewing for its health coaches in 2007 because they believed it would work in its patient population. The company’s nurses focus on helping patients who are at risk of a near-term hospital admission. Hayek says the company has not had the program in place long enough to have specifics about how it has affected patients and costs.

“I think that our experience is too new to draw conclusions that should be applied elsewhere. However, our thinking and our work has reflected that patients’ decisions play a role in care, and that thoughtfulness of getting to root cause as to why patients may make decisions that results in less-than-best practices being delivered is important,” he says.

Wellness book publishes in June

Preorder your copy of Integrating Wellness into Your Disease Management Program, Second Edition, published by HCPro, Inc., today. The book, scheduled to publish in June, will help your organization discover ways to improve health while saving money for clients (in both productivity and health costs). The authors, John Harris, MEd, FAWHP, chief wellness officer and senior vice president of Healthways, and Dexter Shurney, MD, MBA, MPH, senior vice president and chief medical officer of Healthways, are at the forefront of the health management movement. The following actionable items you will learn from this book include:

➤ Discovering ideas to implement wellness programs
➤ Constructing smart predictive models that combine claims data review with health surveys that find people who are at risk and willing to make a change
➤ Developing effective coaching techniques and creating incentives that spark healthy living
➤ Creating wellness programs that are effective and contain costs

A key component to offering a successful wellness program is targeting individuals who are either at risk or want to improve or maintain a healthy lifestyle. Integrating Wellness into Your Disease Management Program will deliver cost-effective methods to identify the best candidates for wellness incentives through health risk assessment surveys, help people who want to be healthy reach their goals, and educate others to develop healthy habits and create a healthier lifestyle. Integrating Wellness into Your Disease Management Program will show you how to motivate individuals ready to make a change by connecting them through:

➤ Effective health coaching practices
➤ Targeted e-mails
➤ Interactive Web sites
➤ Engaging programs in the workplace

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