

# MDISEASE MANAGEMENT ADVISOR™

**Another year, another glowing report**

## CMS trumpets PGP demonstration successes

The 10 groups participating in CMS' Physician Group Practice (PGP) demonstration project received a total of \$16.7 million for improving quality and efficiency of care during the project's second performance year, according to CMS. Four groups—Dartmouth-Hitchcock Clinic in Bedford, NH, The Everett (WA) Clinic, Marshfield (WI) Clinic, and the University of Michigan Faculty Group Practice in Ann Arbor—earned a combined total of \$13.8 million in performance payments. However, even with that windfall, groups involved in the project say the bonuses do not offset the costs associated with the program.

PGP, the first pay-for-performance initiative for physicians under Medicare, creates incentives for groups to coordinate care delivered to Medicare patients and rewards them for improving quality and cost efficiency.

The 10 physician groups represent 5,000 physicians and 224,000 Medicare fee-for-service beneficiaries.

(For a complete list of participating groups, see "Physician Group Practice participants" on p. 3.)

All of the groups improved quality of care for chronically ill patients by achieving benchmark or target performance on at least 25 out of 27 quality markers for patients with diabetes, CAD, and CHF. Five of the groups reached benchmark quality performance on all the quality measures, according to CMS. (For a list of the 32 measures in the project, including measures that are being implemented in year three, see "Quality measures for the Physician Group Practice demonstration project" on p. 4.)

**"The goal is to support the providers' practice and make it easier for the patient and the provider to accomplish the care needs the patient has."**

—Theodore A. Praxel, MD

Additionally, all 10 groups increased their scores on at least 19 of the 27 measures in year two. The groups placed their incentive payments at risk for performance on all the 27 quality measures under CMS' pay-for-reporting Physician Quality Reporting Initiative (PQRI). Five groups earned 100% of their PQRI payments, and the others received at least 96%.

CMS is so pleased with PGP's results, it has extended the project to a fourth year.

"We are paying for better outcomes, and we are getting higher quality and more value for the Medicare dollar," **Kerry Weems**, acting administrator of CMS, said in a prepared statement.

"And these rules show that by working in collaboration with the physician groups on new and innovative ways to reimburse for high-quality care, we are on the right track to find a better way to pay physicians," Weems says.

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### MEDICARE DISEASE MANAGEMENT SECTION

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Educating physicians about statins resulted in more physicians prescribing the drugs and saved money by averting major coronary events, according to a study of an MTM program.

HCP Pro

## PGP

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## Marshfield Clinic

For the second consecutive year, Marshfield (WI) Clinic met quality measurements and saved CMS money. Because of its successes in year two, Marshfield Clinic will gain \$5.78 million. (CMS will withhold 25% of that amount until the end of the project.)

**Theodore A. Praxel, MD**, medical director of quality improvement and care management at Marshfield Clinic, says Marshfield's programs are based on getting the right care at the right time at the right place. "The clinic as a whole is quite proud of the results of meeting all the quality metrics and the performance payment. I think it speaks well for the physicians and staff efforts to further improve the quality of care we give our patients," Praxel says.

As part of the project, Marshfield Clinic expanded its anticoagulation care management program across the entire 43-site system, developed a heart failure care management program, enhanced its electronic health record (EHR) to expand care management and coordination, promoted its 24/7 nurse advice line, and developed clinical practice guidelines and monitored population-based clinical performance through clinic storyboards.

"The goal is to support the providers' practice and make it easier for the patient and the provider to accomplish the care needs the patient has," Praxel says.

During year two, Marshfield Clinic also rolled out electronic provider reminders (called iList, for intervention list) that flag patients who need monitoring. For example, if the system did not contain records of a recent foot exam or A1C test, the system would notify the provider of the gap in care.

"This allows the practices to reach out and proactively contact those patients," Praxel says, adding that the program promotes a better use of physician and patient time.

Marshfield Clinic has had an EHR for more than 20 years, and the network is now completely paperless. Praxel says physicians bring a tablet computer to patient visits and can make notes, review lab results, and see x-ray images and interpretation on the tablet computer.

The nurses have the same access to records as the physicians, which allows them to view the patients' medications and review their full care. This provides the nurse with a view of the whole patient and not just a particular disease, Praxel says.

The EHR is one reason for the project's success. Marshfield Clinic has improved efficiency by reducing the number of retests. Going paperless helps providers avoid communication breakdowns.

For example, the technology is also used in the anticoagulation program, Praxel notes. "For those care management programs in which nurses interact with the patients, those notes are almost real-time transcribed and updated to the record, so when the patient comes in, the provider

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has the record. In addition, there is an e-mail notification to the provider so they can look at the entry to see if there was any change, which promotes a continuous healing relationship," he adds.

Praxel says one issue is that many of Marshfield's care models, such as the anticoagulation and heart failure management programs and 24/7 nurse line, are not reimbursed by CMS, despite their importance for care coordination between office visits.

Praxel suggests changes to the reimbursement system to pay for these kinds of services.

Although Marshfield will receive \$5.78 million for performance year two, Praxel says the bonus does not cover the program's costs. He says it's difficult to determine the project's full costs because the network has spread the program through its entire patient population.

Praxel echoes those who spoke glowingly of the demo's learning opportunities through partnerships with the other PGP projects.

The groups met for a monthly phone meeting to discuss effective care processes and review standards and approaches. The clinic learned from other PGP groups about risk stratification of patients and using care management approaches to take care of patients with complicated diseases.

"There has been a sharing between the groups of the different formats that people might use, different data displays, different ways to help educate the providers and the patients, and that has all been very educational," Praxel says.

Praxel and others involved in the project say CMS does not provide information in a timely manner. For example, CMS did not release data from the demo's second year until midway through performance year four. "We really can't do anything about performance year three. That's done already," he says.

Praxel adds that without actionable rapid information, the network can't intervene. "I think that's one of the things I have learned for our own providers as well. The sooner we can give them actionable information, the more useful it is to them," he says.

**St. John's Health System**

St. John's Health System, a Springfield, MO, faith-based integrated health system that includes six hospitals, a health plan, and 70 locations in southwest Missouri and northern Arkansas, scored 100% on the quality measures during year two. St. John's used a patient registry that is designed to track information,

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**Physician Group Practice participants**

Facility	Location	Achieved all 27 quality markers	Performance payments for saving enough and improving quality
Billings Clinic	Billings, MT		
Dartmouth-Hitchcock Clinic	Bedford, NH		Yes
The Everett Clinic	Everett, WA		Yes
Geisinger Health System	Danville, PA	Yes	
Middlesex Health System	Middletown, CT		
Marshfield Clinic	Marshfield, WI	Yes	Yes
Forsyth Medical Group	Winston-Salem, NC	Yes	
Park Nicollet Health Services	St. Louis Park, MN		
St. John's Health System	Springfield, MO	Yes	
University of Michigan Faculty Group Practice	Ann Arbor, MI	Yes	Yes

Source: CMS.

## PGP

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identify gaps in care, and ensure that appropriate and timely care is provided to the 31,000 Medicare beneficiaries in its 62,000-patient system.

The registry includes a visit planner that allows physicians to track a to-do list for each patient visit, such as reminders about tests and interventions. The planner includes one-page summaries for each patient with demographic and clinical information.

Although the registry is not an EHR per se, **James T. Rogers, MD**, St. John's primary care department chair, says the homegrown product has some of the same characteristics as an EHR.

Rogers says the healthcare system created its own database because it was unable to find an EHR it could use for the demonstration project.

Rogers says St. John's avoided the temptation to develop a complex database and instead created a program that physicians, providers, and office staff members could integrate into their work flow. St. John's information technology staff built a system that feeds laboratory, scheduling, and billing data into one database.

The database was limited to the 32 quality measures in the PGP and allows report generation so the system can review data long-term. "As opposed to a lot of price tags, we built this for a lot less than finding something out there and trying to retrofit it," Rogers says.

The system also implemented a case manager in the emergency department to collaborate with the system and community services to provide transition planning; a heart failure team that coordinates heart failure care, provider education, and improve outcomes; and groups that focus on diabetic retinal eye exams and mammography and colorectal cancer screenings.

Rogers says St. John's almost backed out of the PGP project. When the project was first announced, CMS initially issued fewer quality measures and did not put limits on savings, he says.

"The reason we decided to continue is that it forces us to do better in quality," Rogers says, adding that the system realized there might be a chance it would not gain any bonuses at all. "We're putting in about a half-million a year on our budget to try to make this thing

### Quality measures for the Physician Group Practice demonstration project

The table below shows the quality measures the 10 groups involved in the Physician Group Practice demonstration project are trying to meet.

Diabetes mellitus	Heart failure	Coronary artery disease	Preventive care
<ul style="list-style-type: none"> <li>➤ HbA1c management</li> <li>➤ HbA1c control</li> <li>➤ BP management</li> <li>➤ Lipid measurement</li> <li>➤ LDL cholesterol level</li> <li>➤ Urine protein testing</li> <li>➤ Eye exam</li> <li>➤ Foot exam</li> <li>➤ Influenza vaccination</li> <li>➤ Pneumonia vaccination</li> </ul>	<ul style="list-style-type: none"> <li>➤ Left ventricular function</li> <li>➤ Left ventricular ejection fraction testing</li> <li>➤ Weight management</li> <li>➤ BP screening</li> <li>➤ Patient education</li> <li>➤ Beta-blocker therapy</li> <li>➤ Ace inhibitor therapy</li> <li>➤ Warfarin therapy for patients</li> <li>➤ Influenza vaccination</li> <li>➤ Pneumonia vaccination</li> </ul>	<ul style="list-style-type: none"> <li>➤ Antiplatelet therapy</li> <li>➤ Drug therapy for lowering LCL cholesterol</li> <li>➤ Beta-blocker therapy—prior myocardial infarction</li> <li>➤ BP</li> <li>➤ Lipid profile</li> <li>➤ LDL cholesterol level</li> <li>➤ Ace inhibitor therapy</li> </ul>	<ul style="list-style-type: none"> <li>➤ BP screening</li> <li>➤ BP control</li> <li>➤ Plan of care</li> <li>➤ Breast cancer screening</li> <li>➤ Colorectal cancer screening</li> </ul>

Source: CMS.

successful, and we haven't recouped any of that investment yet," Rogers says.

### The Everett Clinic

The Everett (WA) Clinic scored 96% on quality for management of diabetes, CAD, and CHF in the PGP project's year two and will receive \$250,000, after reportedly saving CMS nearly \$1.6 million.

Through the project, The Everett Clinic offers electronic patient reports to PCPs to use with diabetes, heart disease, and hypertension patients, as well as mammogram, Pap smear, and colonoscopy screening, provides on-site coaching for hospitalized patients and caregivers to help them through the healthcare system during and after hospitalization, implements a program in which physicians see patients within 10 days after unplanned hospital admissions, and partners with local providers to deploy palliative care programs in PCPs' offices to improve end-of-life care.

**James Lee, MD**, assistant medical director at Everett, says the clinic moved from paper to full EHR during the second performance year of the PGP project. Lee says Everett Clinic did not use outside vendors, but instead created its electronic programs and performed DM functions within the network.

Lee says having an outside vendor can add a layer of complexity and might delay care. He says the most important thing he has learned about the demonstration is that to deliver high-quality, efficient care, a system needs to use a common platform through an EHR.

"A systematic approach to disease management and preventive services is crucial. In addition, a coordinated care model, irrespective of the care setting, prevents unnecessary hospitalizations," Lee says.

The EHR is the glue of the project's integrated process, he adds.

Everett Clinic created a real-time electronic database that includes hospital admissions and discharges so that care coordination could take place. Nurses and office staff members can use this information to arrange discharge follow-up. While the patient is in the examining

room, DM prompts and reports from the EHR remind physicians and staff members about any overdue preventive screening services or necessary laboratory tests. This allows staff members to order these items and frees up physician time.

"The whole care model revolves around electronic health records gluing different clinical pieces together to enhance face-to-face experience during an office visit," Lee says.

The clinic also added a hospital coach—a nurse with 30 years of experience—who visits Medicare patients at a local hospital. She speaks with them about barriers or challenges that could cause a problem during the transition from the hospital to home.

Lee says the program has been a tremendous help for patients. "On an emotional level, patients really appreciate someone from their doctors' office visiting them at the hospital. Patients feel connected and are more willing to talk about their challenges and difficulties," he says.

And there are other added benefits to the hospital coach program. Lee says the nurse can identify whether patients understand why they are hospitalized, their medications, what to do after discharge if problems arise, and whether they have scheduled a doctor's appointment after discharge.

"Those are the four key educational components we can introduce into these visits that are elements of good care transition, and I believe a robust discharge process prevents unnecessary visits back to the hospital and the emergency room [after discharge]," Lee says, adding that a key to the project's success is having an open and constant dialogue among all stakeholders in the local care delivery system.

This is important not only in the PGP project; DM could learn from the success. Any dialogue to improve chronic care should center on patients and explore both medical and social challenges.

"The community partnership is so important. Physician offices should use all available community resources to improve patient care," Lee says, adding that Everett

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**PGP***< continued from p. 5*

Clinic lost \$7.6 million caring for its 25,000 Medicare patients in 2007.

The \$250,000 that Everett Clinic will receive via the second year's success is not enough to make up for this loss of revenue, Lee says.

**Billings Clinic and Park Nicollet Health Services**

Pharos Innovations, LLC, a Northfield, IL-based technology company that offers chronic care management programs, assists Billings (MT) Clinic and Park Nicollet Health Services in St. Louis Park, MN, in the heart failure portion of the demonstration. In year two, Pharos worked with 500–600 patients for each network.

Pharos' telephonic Tel-Assurance program captures daily patient information, identifies which patients need interaction, and feeds the data back to physicians and care managers.

This allows them to catch potential health problems before they spiral out of control.

**Randall Williams, MD**, CEO of Pharos, says the biggest challenge was getting the patients engaged. In year two, Williams says Pharos staffed enrollment and retention efforts. He says keys to engaging the HF population are getting physician buy-in and connecting with patients while they are in the hospital.

"Part of the magic is that by helping co-opt the physician in endorsing the program to the patient, we have a running start in getting the patient in the program," Williams says. "Secondly, we capture some of these patients during hospitalization, so they are a little more motivated in not making that happen again."

Williams adds that Pharos has worked with behaviorists and social workers to effectively reach people. The outreach team tells the patient they are calling from the provider organization rather than a DM company or health plan, which helps the patients feel a closer connection.

Pharos has also used local mail distribution and phone number banks help connect with people. Williams says

Pharos' work paid off, as Billings and Park Nicollet promote 85%–90% participation rates.

"Both of our clients experienced consistent and compelling reduction in all-cause hospitalization for the patients who were enrolled in our programs. They were able to reduce admissions by about one patient admission per enrollee per year," Williams says.

One challenge is that provider organizations are often not equipped to perform chronic care coordination, so Pharos has helped them develop processes for this, he says.

"We learned the power of cooperating or collaborating with provider systems to do care management. We have also learned about the challenges of doing that. From the standpoint of the power of doing it, we have found that the robustness of clinical information goes dramatically beyond what is available by claims data to target the right patients for intervention," says Williams.

An issue cited by those involved in the PGP project is CMS' bonuses. Williams says the delay in getting paid by CMS prevents individual networks from expanding their services in the project. He says it can take up to three years from the time the networks incur costs to receive their CMS bonuses.

"It's a pretty brutal financial arrangement, though on the surface it sounds great," Williams says of the \$16.7 million CMS paid in bonuses for year two.

Pharos is talking to the two networks about expanding its Tel-Assurance program to COPD and diabetes patients, and a third project site, Forsyth Medical Group in Winston-Salem, NC, signed up Pharos to perform heart failure interventions following the end-of-performance year two.

Although there have been recent questions about the effectiveness of DM (most notably in the Medicare Health Support demonstration project), Williams says DM works if it's delivered in the right way, such as the programs in the PGP. ■

# MEDICARE

## DISEASE MANAGEMENT

### MTM program increased statin use

**Initiative averted major coronary events, saved money**

Educating physicians about statins resulted in more physicians prescribing the drugs and financial savings from averted major coronary events, according to a study of a medication therapy management (MTM) program. The study, "Effect of an Intervention to Increase Statin Use in Medicare Members Who Qualified for a Medication Therapy Management Program," was published in the August *Journal of Managed Care Pharmacy*. It looked into Carlsbad, CA-based Prescription Solutions' MTM program for Medicare Advantage Prescription Drug Plans patients. MTM programs are a key part of Medicare Part D—the idea is to use the expertise of pharmacists and pharmacy benefit managers to educate beneficiaries and the healthcare industry as a whole.

#### Number of members needed to treat to avoid one major coronary event

Measure	Result
Number of interventions needed to produce one statin initiation	20
Number needed to treat with statins to avoid one major coronary event	11
Number of interventions needed to avoid one major coronary event	220

Source: "Effect of an Intervention to Increase Statin Use in Medicare Members Who Qualified for a Medication Therapy Management Program," *Journal of Managed Care Pharmacy*.

In the study, Prescription Solutions, a pharmacy benefit management company that provides prescription drug benefits for commercial, Medicare, and government health plans, employers, and unions, mailed educational materials to prescribers to increase statin use among members with diabetes or CAD who had not filled prescriptions for statins in the previous six months. The study sought to

**"If you involve the physician in a respectful manner and get them on board, your intervention, as we have proven, will go farther."**

—Brian K. Solow, MD, FAAFP

estimate the potential cost savings of such a program.

The study found that the MTM program and greater use of statins saved an estimated \$12,323 in cardiovascular costs for 220 members who received the program intervention. In a four-month follow-up period, 12.1% of members whose prescribers received the intervention began taking statins. The report also found that 11 members would need to be treated with a statin medication for a median of 5.4 years to avoid one major coronary event. (See "Estimate of costs avoided during a 5.4-year period" on **MDM** p. 2.)

"As a result, it would be necessary to conduct the intervention with prescribers of 220 members to avoid one major coronary event," wrote the researchers.

**Brian K. Solow, MD, FAAFP**, vice president and medical director of clinical services at Prescription Solutions, says statins have significantly reduced the risk of death and major coronary events and reduce the risk of a second heart attack. However, only about one-third of

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## MTM program

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patients hospitalized after a heart attack receive statins at discharge. Two factors account for this, Solow says. Doctors are busy and may forget to prescribe statins, and medication compliance with statins is difficult.

Researchers identified 1,340 members and 1,275 prescribers for the intervention. Prescription Solutions then mailed a patient-specific report to prescribers that showed which members under an individual physician's care could benefit from statin therapy. The mailing also included a section for prescriber feedback and a prescriber educational booklet.

Solow says the study focused on prescribers rather than patients because physicians have the most effect in this kind of intervention. He adds that member- and nurse-targeted intervention statin initiation programs have not been as successful as prescriber-targeted programs. "If you involve the physician in a respectful manner and get them on board, your intervention, as we have proven, will go farther," Solow says.

How does an MTM program effectively engage prescribers when physicians are already busy and

inundated with other information? Solow says step one is to respect the physicians, who are the ultimate caregivers.

He says an MTM outreach program can do this by offering accurate information through claims data and make only evidence-based recommendations.

This physician-targeted intervention is only one of Prescription Solutions' MTM programs. The company has also seen success in a geriatric prescription monitoring program that has reduced the risk of inappropriate medications being prescribed for those aged 65 and over.

The program identified nearly 13% of the 1.3 million program enrollees who had at least one prescription claim for a drug they should avoid. Through an

### Estimate of costs avoided during a 5.4-year period

Costs	Results
Costs of a major coronary event	\$28,990
Statin use to prevent one major coronary event	\$16,335
Program cost	\$332
Total cost to prevent one major coronary event	\$16,667
Costs avoided by conducting the intervention	\$12,323

Source: "Effect of an Intervention to Increase Statin Use in Medicare Members Who Qualified for a Medication Therapy Management Program," Journal of Managed Care Pharmacy.

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educational mailing to physicians, Prescription Solutions was able to resolve about 66% of the conflicts, Solow says. Given the proven benefits of statins and the results from this study, he believes there will be more studies focusing on education, adding that the MTM program shows that pharmacy benefit managers can help ensure appropriate, safe, and effective use of prescription drugs. A pharmacy benefit manager isn't

there to limit drugs to clients, but to focus on quality and total patient care.

The study highlights the importance of ongoing education, Solow says. Pharmacy benefit managers are there to be "an adjunct partner with health plans in the care of the patient and, by doing so and accepting some of these processes, they can help their client and their overall health costs." ■

### **CMS demonstration project**

## **VillageHealth pleased with ESRD program**

Traditionally, CMS has not allowed Medicare beneficiaries with end-stage renal disease (ESRD) to enroll in Medicare Advantage (MA) plans, but an ongoing demonstration project is testing the effectiveness of DM models in improving quality of care for ESRD patients. CMS' ESRD Disease Management Demonstration includes organizations that provide services for dialysis patients, such as:

- ▶ DaVita's VillageHealth, which partnered with Long Beach, CA-based Scan Health Plan, an MA HMO that serves nearly 105,000 people in Southern California
- ▶ Fresenius Medical Care North America, a dialysis provider, which has partnered with several companies through its wholly owned subsidiary Fresenius Medical Care Health Plan to offer services to ESRD patients in Philadelphia, Pittsburgh, Dallas, Houston, San Antonio, Boston, New York City, San Diego, and Nashville
- ▶ Evercare, a managed care organization, which partnered with DaVita to operate sites in Atlanta and Tucson, AZ

The organizations receive the same risk-adjusted ESRD capitation payment as the MA program overall—with separate rates for dialysis, transplant, and posttransplant modalities. The ESRD payment amount can be reduced by 5% depending on performance on

quality measures, according to CMS. **Kerry Willis, PhD**, senior vice president of scientific activities at the National Kidney Foundation in New York City, says CMS spends billions on dialysis, and the federal agency has been focusing on improving dialysis care. In fact, studies have shown the average dialysis patient incurs costs of about \$70,000 per year. (See "Pharmacy program with DM component targets CKD" in the January **DMA**.)

"There has been a huge upsurge the last 10 years trying to understand and trying to really constitute the best practices and the best therapies in this population," Willis says.

Health plans usually only pay for dialysis for a short time before Medicare picks up the tab. Willis says some private insurers have been implementing proactive programs to catch at-risk patients before they spiral into dialysis. These kinds of interventions are being tried by several healthcare organizations that are hoping to stop the deterioration to ESRD.

"Where health plans have been very active is in trying to devise strategies to reduce the progression of kidney disease so they don't wind up with patients on dialysis," Willis says, adding that about 70% of patients on dialysis regress to that level because of uncontrolled type 2 diabetes or hypertension, and 40% of patients with uncontrolled type 2 diabetes have kidney damage.

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## ESRD program

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Many with ESRD did not get their BP or blood sugar under control, and that led them on the road to dialysis, he says.

DaVita, through its VillageHealth program, has been serving about 420 Scan Health Plan members with ESRD since the start of the project at the beginning of 2006. **Chris Mayne**, regional operations director at VillageHealth in San Bernardino, CA, says DM programs for the ESRD population make sense.

Mayne says CMS recently sent DaVita data from the first 18 months of the project (January 2006–June 2007). “We learned we do make a difference in the outcomes that are most meaningful in that population,” he says about the demonstration data, which have not been publicly released by CMS.

VillageHealth is offering the same programs it provides to its other ESRD patients, including a 24/7 nurse case manager, who Mayne says is the primary DM arm of the programs. The case manager has a portfolio of patients with whom he or she meets at least once per month.

Mayne says one reason DM is appealing to this population is that many ESRD patients visit dialysis facilities three times per week for three or four hours. Having the patients at the centers makes it easier for the case managers to stay connected with patients, he says.

“That means that we know, for the most part, where they are, so it’s easier to meet with them and do what we can do to help them,” Mayne says. He says DaVita’s programs include intervention, care coordination, and patient activation. The intervention program helps ESRD patients handle their other health problems and comorbidities, such as diabetes and hypertension.

ESRD patients may have various doctors’ appointments because of these additional health problems. The case managers in the project help the patients coordinate their appointments.

“The VillageHealth nurse is at the center of it. It’s coordinating with the patients, coordinating with the doctors, and coordinating with the dialysis facility,” Mayne says.

Patient activation begins with engagement, which starts with building a rapport with the patients. Gaining trust can take time.

Beyond building the patient’s trust, the case managers also need to build relationships with physicians and show them that the ESRD program is valuable.

“From there, it’s learning what is the right methodology and frequency of communication they prefer. Not every physician is the same in that manner. But we’re all here to get the best results for the patient so, in the end, it ends up being one big clinical team, and that includes the dialysis facility as well,” Mayne says.

The health status of ESRD patients makes care difficult. “The biggest challenge is that the patients have so many things that are going on with them clinically. It’s how do you focus on the really important few that are going to make a difference for the patient,” Mayne says.

A recent study found that the prevalence of kidney disease has increased from one in every 10 adults to one in every seven or eight.

This figure is expected to rise because of higher rates of obesity, diabetes, and high BP, coupled with aging baby boomers, according to the National Kidney Foundation.

“I think it’s unquestionably been a struggle because the dialysis population has grown, but we have seen new therapies, lots of new research, and I think that we can all take pride in the fact that the mortality rates in the dialysis population are starting to come down. I think that we are making progress, and the goal is obviously to provide an opportunity for these patients to live long and live well,” Willis says.

The ESRD demonstration project is slated to end in 2009. ■

**First in nation****College announces chronic care degree program**

A Philadelphia university will soon become the nation's first to offer a chronic care management degree program and a doctorate in population health.

The Jefferson School of Health Policy and Population Health (JSHPPH) will open its doors in 2009 with three master's degree programs in public health, health policy, and healthcare quality and safety, as well as certificate programs in health policy and healthcare quality and safety. The quality and safety program will only be the second such program in the nation, following the program at Northwestern University School of Medicine.

In 2010, the school will add master's and certificate programs in chronic care management and a doctorate in population health/health policy. Private sector certificates in chronic care management are available, but this is a first for a university, says **David B. Nash, MD**, chair of Jefferson Medical College's department of health policy in Philadelphia. Jefferson decided to take on the topic because of the need for education about population health and healthcare's consumer movement, Nash says.

Although many have promoted the need for chronic care management, Nash says there is limited training in DM practices and interventions, adding that it's no longer possible to achieve clinical excellence, to educate medical health professionals, and to serve the community without making health policy and population health a central focus.

Nash says the chronic care management program will help graduates assume leadership roles in managed healthcare, DM organizations, integrated healthcare delivery systems, community-based service or advocacy organizations, public service, and ambulatory settings.

The program will prepare graduates to:

- Develop, implement, and evaluate coordinated, system-based strategies to effectively prevent and manage complex health conditions of patients
- Promote patient engagement through shared decision-making

The school's instructional format will be a blend of online and traditional approaches that officials say they believe will suit the student population.

The degree programs will emphasize fieldwork, experiential learning, and interprofessional collaboration.

The courses will focus on disease prevention, protection against environmental hazards, healthy behavior promotion, and system changes to support healthy lifestyles.

Course content will cover topics such as the medical home, electronic medical records, the rise in consumerism, chronic care management, workplace wellness, case management, and prevention.

**Why is a school needed?**

Chronic disease accounts for 75% of all healthcare spending and affects an estimated 133 million people in the United States, close to half of the population, according to Jefferson.

And that doesn't count nonmedical costs, such as presenteeism and absenteeism. According to Jefferson, chronic disease accounted for 80% of healthcare spending in Pennsylvania in 2007. In addition, four out of every five hospitalizations, 76% of physician visits, and 91% of all filled prescriptions are due to chronic disease, it states.

Nash says healthcare is in a crisis, and chronic illness is an epidemic. Healthcare leaders need information on quality and safety improvement and the challenges related to access, coordination, disparities, and cost. They must also address affordability, accessibility, efficiency, productivity, quality, and safety. The aging of the U.S. population, coupled with a shortage of trained professionals with specialized expertise, creates a need for population health, he says.

During an earlier strategic planning process, Thomas Jefferson University identified population health and

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## Chronic care

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health policy as one of five key strategic priorities. Nash says the university created a task force that researched the topic and ultimately presented a plan to the Jefferson board July 28.

Nash says the new program doesn't need expensive equipment and laboratory space like other medical schools, so the new school is actually a low-cost, low-risk, high-visibility opportunity. "Those are the kinds of things leaders like," he says.

Jefferson will link the new school closely with Jefferson's *Disease Management* journal, which will now

**The change to population health is part of a larger movement within the industry.**

be called *Population Health Management*, and the annual colloquium, which will be renamed the

Population Health Colloquium. "I think it's a reflection of our new thinking about the new school and where the field is going," Nash says.

The change to population health is part of a larger movement within the industry. DM companies have transitioned from caring solely for the chronically ill to the larger population. The Disease Management Association of America changed its name to DMAA: The Care Continuum Alliance because of the change in focus from disease management to population health.

### Excitement about new school

**Thomas Wilson, PhD, DrPH**, epidemiologist of Trajectory Healthcare, LLC, and founder and board chair of the nonprofit Population Health Impact Institute (PHII) in Loveland, OH, supports the new school and the college adopting the term population health. Academic institutions usually use the phrase public health for these kinds of programs, but many associate the word public with only government-based programs, Wilson says.

"I think, as we all know, a population health strategy—where decisions must be based on evidence—can be done

by a public agency or can be done by private agencies," says Wilson, who has a doctorate of public health from UCLA and who founded the PHII four years ago.

Wilson says he hopes the new school focuses on an expansion of epidemiology, the science on which public health is based. "I think science should be the basis of the whole program: the bride, not the maid of honor," he says about the school's focus, adding that population health strategy is a continuous quality improvement process and isn't definitive, like physics.

"Everybody wants the final answer. We learned a long time ago in epidemiology that, for the most part, the answer you get from science is better than the answer you get from pulling something out of the air. But levels of certainty exist in science, and most of it is not definitive. Thus, most rational debates around population will be informed by social values, ethics, and economics, too," Wilson says.

Although the phrase population health is more popular now than when Wilson founded PHII, he says there is still education needed. Some people think population health means health programs for the entire population, but it also involves targeting specific subpopulations, he says. ■

### New degree programs

Master's programs*	Doctoral programs
<ul style="list-style-type: none"> <li>▶ Public health (existing)</li> <li>▶ Health policy</li> <li>▶ Quality and safety</li> <li>▶ Chronic care management</li> </ul>	<ul style="list-style-type: none"> <li>▶ PhD in health policy or population health sciences</li> <li>▶ Doctorate in health policy</li> </ul>

\*Certificate programs will be offered in each area, and new dual degrees will be added.

Source: Jefferson Medical College, Philadelphia.

## Medical home

# Physician practices will need DM/population health

DM/population health organizations will experience changes and opportunities in the medical home, said speakers at a September DMAA: The Care Continuum Alliance Webcast.

Paul Grundy, MD, MPH, director of IBM's healthcare, technology, and strategic initiatives and chair of the Patient-Centered Primary Care Collaborative (PCPCC) in Washington, DC, and Bruce Bagley, MD, medical director for quality improvement of the American Academy of Family Physicians in Leawood, KS, spoke during the Webcast.

The two men were scheduled to take part in the keynote address for DMAA's annual forum, which was postponed because of Hurricane Ike. DMAA instead hosted a Webcast with the two speakers. (DMAA has rescheduled its conference to November in Florida.)

The momentum of the medical home movement has involved several healthcare players—employers, payers, PCPs, and the DMAA.

Although some in DM/population health are concerned about what the medical home might mean to the industry's future, Tracey Moorhead, president of DMAA: The Care Continuum Alliance in Washington, DC, said DM/population strategies are an important component to the medical home, and physician practices will need the industry's expertise to implement the medical home.

Grundy said IBM became interested in changing healthcare delivery because the company was spending \$2 billion for healthcare, and its employees were getting little benefit. In fact, the nation's healthcare is "garbage," he said, because there is simply not enough emphasis on prevention and connecting the many players in the system. What IBM and other large employers want is a coordinated healthcare system.

"What we do now is so grossly unacceptable in terms of [not] putting the patients in the center of what needs to

be done. The money aside, what we do now is atrocious to our patients," Grundy said.

Grundy said the U.S. healthcare system focuses on the disease rather than the patient. It also doesn't reward physicians for keeping patients healthy. He said the United States spends twice as much as any other developed nation on healthcare, and the country has the highest teen pregnancy and abortion rates of those nations, as well as the highest infant mortality rate. Only half of the U.S. population is getting the necessary preventive services and exams, Grundy said.

Part of the problem is that the system has disempowered the patient-doctor relationship and does not allow for coordination. Physicians are not communicating with one another through a network that would avoid unnecessary costs and protect patients from potential medication errors, Grundy said. For example, having a patient visit five different specialties that are not communicating about the patient's care is wrong, according to Grundy. "As a buyer of care and the son of a father and mother that are desperately in need of care, it's unacceptable, it's immoral, it's wrong. We need to address this in a fundamental way," Grundy said. He said payers need to take a leadership role and change the way they pay for healthcare.

For example, rather than reimburse for a patient's leg amputation, payers need to pay physicians to prevent patients from having that amputation through preventive services, he said, adding that the current payment structures are flawed and "economic incentives significantly influence healthcare in frequently perverse and completely unintended ways." Grundy said the flaws in the payment structure include:

- **Salary:** Problems with productivity
- **Fee for service:** Problems with overuse
- **Capitation:** Problems with under use
- **Pay for performance:** Problems with ignoring the healthcare not attached to payment

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## Medical home

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Grundy said what is needed is a blending of payment structures. The PCPCC has recommended the following three-part payment methodology:

- A monthly care coordination payment for physician's work that falls outside of face-to-face visits and for the health information technologies needed to achieve better outcomes
- A visit-based fee-for-service component that is recognized for services that are currently paid under the present fee-for-service payment system
- A performance-based component that recognizes achievement of service, patient centeredness, quality, and efficiency goals

Bagley said he believes a PMPM coordinated care fee, coupled with incentives for providing quality care, is needed. "A blended payment makes a lot of sense," he said.

In addition to a new payment structure, Bagley said primary care practices need to become places of continuing, comprehensive, and personal care. This means a change from the individual physician as the sole leader of

the practice to a team of people who work to provide care coordination. That approach must involve a real team in which each player, from the physician to the office staff members, shares responsibility for quality and care.

Bagley said a successful medical home includes:

- A team approach to care
- Registries for the top diagnoses
- Active care coordination
- Built-in quality systems and measurements
- Partnership with community resources
- Advanced patient education and self-management support
- Service orientation
- Information technology support

Bagley said there are new opportunities for DM/population health companies in the medical home. (See "Opportunities for DM/population health" in the left column.) Those companies will need to change their focus from helping the individual patient coping with chronic illness to assisting the primary care practice in helping patients cope with chronic illness, he said.

DM and primary care practices have been disconnected historically, but the medical home will bring coordination between the two, he said.

Practices will also have to integrate DM/population health into practice flow. Bagley acknowledged that this change is a big shift for DM/population health and primary care practices.

Bagley said primary care practices have not been optimally using community resources such as DM and population health organizations.

But physicians will need to use those companies that have experience in patient registries, patient self-management, health coaching, and 24/7 nurse lines in the medical home. "We have to encourage offices to use those resources when it's appropriate," he said, adding that there are some services that practices will need to outsource. ■

### Opportunities for DM/population health

Bruce Bagley, MD, medical director for quality improvement of the American Academy of Family Physicians, said DM/population health will be critical in the medical home model at a September DMAA: The Care Continuum Alliance Webcast.

Bagley said that DM/population health companies are needed for the following functions:

- Support for office transformation
- Training office staff members for registry and care coordination functions
- Patient self-management support
- Providing needed communitywide care coordination services
- 24/7 nurse help line

## Weight loss helps type 2 diabetes patients

Losing weight has long-range health benefits for type 2 diabetes patients—even if the person regains the weight, according to a Kaiser Permanente Northwest study.

People who lost weight soon after a type 2 diabetes diagnosis were in better control of their BP and blood sugar, the American Diabetes Association's *Diabetes Care* reported in a September article about the study, "Weight Change in Diabetes and Glycemic and Blood Pressure Control."

**Gregory A. Nichols, PhD**, investigator at Kaiser Permanente in Portland, OR, and coauthor of the study, says engaging a patient with a recent type 2 diabetes diagnosis is important, but a weight loss at any time is beneficial. This is especially true for the more than 20 million people in the United States with type 2 diabetes, most of whom are overweight or obese.

"The main surprise is the benefit remained, even though, on average, they gained the weight back," Nichols says. "Weight loss, whenever it happens, or even attempts at weight loss, are worth doing."

The study is the first to show the health benefits of losing weight even if the patient experienced weight gain later, Nichols says.

The study followed 2,574 adults with type 2 diabetes for four years. Those who lost weight, usually within an average of 18 months after diagnosis, were twice as likely to achieve their BP and blood sugar targets compared to those who didn't lose weight.

The researchers found that the initial period after a diabetes diagnosis is "of particular interest because this may be a time of heightened patient and clinical interest in patient behavior change."

"We've known for a long time that weight loss is an important component in diabetes treatment and prevention," **Adrienne Feldstein, MD, MS**, an investigator at Kaiser Permanente's Center for Health Research in Portland, OR, and the study's lead author, said in a statement. "Now it appears there may be a critical window of

opportunity following diagnosis in which some lasting gains can be achieved if people are willing to take immediate steps toward lifestyle changes."

In the study, most patients remained at about the same weight during the first three years, but a small group of 314 patients lost an average of 23 pounds. That group was more likely to meet BP and glucose targets during the fourth year, even though most of them had regained their weight. Previous research had looked at only two points in time—the start and end of the survey. However, with Kaiser Permanente's electronic medical record (EMR), researchers were able to keep track of patients' weight throughout the project.

Kaiser Permanente's EMR is physician-populated and has completely replaced paper charts. Anything that happens during a healthcare encounter goes into the EMR, including weight, labs, and pharmacy data. Patients have access to most of the EMR except for the doctors' notes, Nichols says.

With the EMR in place, researchers received real-time data for weight, glycemic, and BP control and associated demographic and comorbidity factors. Kaiser Permanente also has a diabetes registry within the EMR, which reminds physicians of evidence-based recommendations, such as medications and tests. At the end of the study, most of the patients were near the same weight as at the beginning of the study.

This means that if not for the EMR, researchers would have just checked patients' weight at the beginning and end of the observation period and not realized the weight loss during the process. Researchers would not have discovered the benefit of weight loss without the EMR, Nichols says.

### Study included four groups

Researchers investigated weight gain and loss patterns the first three years and then glucose control tests and BP readings in the fourth year.

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## Diabetes patients

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After first excluding patients who had conditions that might lead to unintentional weight change, such as cancer and pregnancy, the researchers divided the more than 2,500 new diabetes patients into weight-trajectory groups: higher stable weight, lower stable weight, weight gain, and weight loss. They also excluded 3,833 patients with a severe illness or condition, including cancer and pregnancy.

The researchers found that the higher stable weight and lower stable weight groups maintained their weights, whereas the weight gain patients increased from an average of 107.8 kg at the beginning to 114.7 kg at 18 months, followed by a weight loss and ending near the baseline.

The weight loss group began at an average of 109.3 kg, lost weight to 98.6 kg at 18 months, and then regained back to near the baseline weight. The study found that:

- ▶ The weight loss group had the lowest percentage of people with above-goal HbA1c and BP
- ▶ The weight loss group was less likely to have above-goal HbA1c than the other groups
- ▶ The higher stable weight group was 1.7 times more likely to have above-goal HbA1c than the weight loss group
- ▶ The lower stable weight group was 1.5 times more likely to have above-goal HbA1c than the weight loss group
- ▶ The weight gain group was 1.8 times more likely to have above-goal HbA1c than the weight loss group

“The weight loss group, on average, began regaining at about 18 months. This suggests that the first months post-diagnosis may provide a window to capitalize upon patient and clinician motivation by actively applying weight loss interventions. However, additional support for maintaining weight loss will be important,” the authors wrote.

### Kaiser Permanente programs

Kaiser Permanente offers diabetes education classes to those diagnosed with the disease. Patients learn about

appropriate diet, exercise, the importance of monitoring blood sugar, and potential complications of the disease. Nichols says between 75%–80% of the patients in this study attended the free diabetes education classes.

Kaiser Permanente also offered weight loss classes called Freedom from Diet for a nominal fee. Very few patients in the study attended these classes, says Nichols.

Researchers did not investigate whether either of these programs—or any program, for that matter—particularly helped patients.

Previous studies have shown the benefits of nutritional counseling and food diaries, but this study did not separate out these programs.

Nichols says clinicians played an important part, because they were the ones who worked with patients and educated them about diabetes and weight loss benefits. A kind word from a physician goes a long way, he says.

“Physicians are busy, not just at Kaiser, but everywhere. It’s easy for them to focus on biology and laboratory and pharmacy, and sometimes forget about the patient interaction that is really important to people’s health,” Nichols says.

### Why was there a benefit?

Nichols says there are two hypotheses for why patients still experienced benefits even after regaining the weight: The positive effects are long-lasting because of the patients’ metabolic memory, or the study did not last long enough, and there might be a reduction in health benefits in a fifth year.

“We have seen in other clinical trials that well after the trials have stopped that a group that was treated intensively to lower their blood sugar had longer-term benefits, even if their treatment starts to equalize later. Those who got into good control early did better 10 to 15 years out in terms of cardiovascular disease and things like that. It’s possible that that’s what we’re seeing here,” Nichols says. ■