Veteran DM provider builds on early success

Pioneering Medicaid DM program produces robust outcomes

If all goes as planned, and Nashville, TN-based Healthways successfully acquires LifeMasters Supported Selfcare, Inc. early next year, it will gain significant entry into the fast-growing Medicaid DM market, an arena where LifeMasters had been a major player for some years. LifeMasters, based in South San Francisco, CA, currently has ongoing projects with Medicaid programs in Georgia, Texas, and Florida. In fact, the company just unveiled four-year outcomes for one of its first public-private partnerships, a program targeted toward Medicaid recipients in northern Florida.

In that program, LifeMasters has worked with Florida’s Agency for Health Care Administration (AHCA) to manage more than 11,500 beneficiaries with CHF and related co-morbidities including diabetes, COPD, and hypertension. It’s a high-risk, hard-to-reach population, but a joint analysis of the program’s impact suggests that the approach has not only significantly reduced hospitalizations, it has also produced improvements in functional status, treatment compliance, and provider adherence to national guidelines.

Early surprises

Florida has been one of the pioneering states with respect to DM, and the contract with LifeMasters was among the state’s first collaborations with a DM vendor. Consequently, many of the early lessons on how to effectively deliver services to disadvantaged, chronically ill patients have been learned in the process of implementing this program. For example, while disease managers anticipated that finding and engaging Medicaid recipients in the program would be challenging, there have been some surprises.

“What is sort of counterintuitive in this population is that once we do find people and connect with them, they are more likely than the people in commercial populations to want to participate in the program,” emphasizes Christobel Selecky, executive chairman of LifeMasters. “In many cases we are the first people who have ever reached out to these people ... and they are often very excited about the opportunity to have someone help them out and engage them in the system. So our rates of engagement in this population are actually higher than they are in the commercial population.”

Over the course of implementing the program, disease managers have learned to take advantage of whatever level of engagement is agreeable to the recipient, even if the connection is initially quite lim-
ited. “If we can’t get someone engaged at the level we want, we still find it important to have some level of connection with them because we are always looking at their claims information … and looking for reasons that they might want to be engaged,” explains Selecky, noting that recipients are often more willing to participate in the program following a hospitalization or other exacerbation of their disease.

Another surprise has been the extent to which Medicaid recipients elect to communicate with the program via the Internet. “We provide recipients with scales and BP cuffs, and we teach them about the importance of weighing themselves, taking their BP, and paying attention to symptoms like shortness of breath, swelling, and weight gain,” notes Selecky. Participants are then instructed to regularly communicate that information to the program, either by phone or through the program’s web page. Developers are not sure why, but they have found that a higher rate of Medicaid recipients are using the Internet to communicate this information than in their commercial populations.

Whether the information is communicated by phone or the Internet, a computerized process then analyzes the data against nationally recognized thresholds to determine whether a participant requires intervention. In cases where attention is needed, the system automatically alerts the person’s LifeMasters nurse to give the individual a call and/or take whatever action is required.

**Relationship-building**

Some aspects of the program, as originally designed, have become standard practices across the industry. For example, the focal point of the intervention is each participant’s relationship with a personal nurse. “That nurse’s responsibility is to educate the participant about their condition, help them set goals for changing their lifestyle … and then work with the participant to encourage lifestyle change,” adds Selecky. Goals are individualized but often pertain to issues such as weight loss, symptom management, stress reduction, and physical activity.

Another “founding principle” of the program is to support the doctor-patient relationship, according to Selecky. Consequently, while physicians receive “exception reports” whenever a program nurse discovers that there has been an exacerbation of a patient’s condition, the intervention is primarily focused on the participant. For example, if a nurse discovers that a participant is not on a particular drug that is recommended by standardized guidelines, she will attempt to address the situation by educating the participant about those recommendations, and urging the participant to discuss the matter with her physician. “It is very important that we are not seen as the police or an intermediary,” stresses Selecky. “It is not our job to question the physician’s treatment plan.”

In fact, in many instances, one of the first tasks a personal nurse will undertake with a Medicaid
participant will be to help that individual select a PCP, or a provider who will be most responsible for coordinating the person’s care. “Often, these patients are seeing four, five, or even six physicians for several different conditions that are not on a common medical system,” explains Derek Newell, senior VP of client relationships for LifeMasters. “In this situation, we work with the participant and coach them on selecting one physician to be their main contact.”

In cases where multiple providers are involved, and it is not entirely clear which provider is most responsible for coordinating a patient’s care, LifeMasters uses algorithms embedded within its computer platform to ascertain which physician is in the best position to oversee care. “We will look at the data and say that, given the patient’s complexity and morbidity profile, and his utilization pattern, we think that this particular physician is the focal point of his care for the things that are driving the most expense,” notes Newell. “We will recommend that physician to the member, and also focus our outreach and attention on that particular physician.”

**Positive outcomes**

The four-year analysis of the program, conducted by LifeMasters and AHCA, suggests that the many interventions included in the approach have paid off in improved clinical and financial outcomes. The data show that hospital admissions declined by more than 25%, use of recommended drugs improved substantially, and self-perception of both physical and mental functioning improved among participants in the program. *(See Figure 1 on pages 62-63.)*

While these data are encouraging, developers have gained valuable insight on additional steps that could offer even greater benefits. “As we move into larger and larger Medicaid populations, we see a very significant amount of depression and other psychological disorders,” explains Newell. “There is a special need in this population where up to 10% of hospitalizations are because of psychological issues, so we are right now exploring enhancements in our model related to helping people manage mental illness, and depression in particular.”

Further, as states become more experienced with DM, many of them are moving toward programs that have more of a multi-disease focus. At this point, it is unclear what action ACHA will take when the CHF program comes up for renewal in September, but Selecky emphasizes that LifeMasters is adept at managing several conditions. “Just because this is a CHF program doesn’t mean that all we manage is CHF,” she says. “The people who are selected to participate in the program have CHF, but they have multiple co-morbidities, and this is a full-person focused program.”

**Editor’s note:** For more information about the programs offered by LifeMasters Supported Selfcare, Inc., visit the organization’s web site at www.lifemasters.com.
Omaha company capitalizes on the potential of self-care to drive down costs

In a nation burdened with lifestyle-related chronic disease, there is little question that one key to controlling health care costs is figuring out how to actively engage patients in the management of their own health. Disease managers across the country are hard at work on this problem, but one organization that has been focused on the issue since 1998 is Omaha, NE-based SimplyWell LLC, a company formed by orthopedic surgeon James Canedy, MD, to address escalating health care costs and what Canedy viewed as serious deficiencies in preventive care.

While the company works primarily through employers, the approach focuses on developing individualized care strategies for each participant, typically through a combination of lifestyle coaching, education, and DM. Health care professionals are actively engaged in the model, but the chief aim is to help individuals become proficient in their own self-care, regardless of their risk profile.

Armed with data showing that the model has been able to improve outcomes and deliver an ROI, SimplyWell now has clients in 49 states and 13 countries, and it is currently piloting a new version of the approach that it hopes to make available to individual physicians interested in doing more to nurture optimal self-care in their own patients.

Getting started

The idea for SimplyWell began to take shape when Canedy was participating in a health advisory group in Washington, DC, in the mid to late 1990s. “I came home with the concern that we were going to see large growth in health care costs, which we have, and that we really weren’t meeting the mark in preventive management for patients,” he explains. Consequently, Canedy and his associates interviewed insurance companies, employers, hospitals, and patient groups to gather insight on what it would take to address these problems. The earliest form of SimplyWell was built from there.

“We created this theory in 1998, and we needed to test it, so we tested it in a paper model where we had paper health risk assessments (HRAs), written reports that we would mail, classroom education, and a nurse call-in feature, but it was not an integrated or an automated platform at this stage,” he says. “Once we showed positive results from a risk and from a cost standpoint, we invested in an Internet-based platform, and moved the program to that application.”

Data capture and analysis

Even in its current form, however, the program is more than a web-based application. While participants may, indeed, begin their involvement with the program by filling out a personal health history and an HRA online, they also undergo a health screening that typically takes place at the employer site. “We will gather clinical metrics such as height, weight, and BP, and we will gather two vials of blood on each participant,” explains Michelle Baade, director of business development for SimplyWell. “By essentially doing a mini-physical, we are getting information specific to their health status today, and that information is all auto-populated into a personal health record.”

Once the self-reported data and the information from the health screening have been collected and analyzed, participants are stratified into three risk categories. (See Figure 1.) The program gener-
ates an online report and action plan for each participant that focuses on tasks related to preventive care management, education, and self-monitoring.

**Intervention activities**

An individual who is categorized as being “within guidelines” is directed toward activities that will help the person maintain his or her good health, emphasizes Baade. This could include reminders to undergo recommended screening procedures, nutritional guidance that may include references to specific education modules within the SimplyWell platform, and advice pertaining to physical activity.

Alternatively, participants who are categorized as being “at risk” are directed toward activities aimed at minimizing risks that have been identified through the initial screenings. Individuals who are overweight, for instance, receive action plans that focus on activities designed to help them reduce and better manage their weight. Individuals with high cholesterol levels or other lab values that are outside normal range will be directed to consult with their personal physician.

Individuals at highest risk -- those with established chronic disease -- receive the most intensive support and guidance, although Baade emphasizes that all three categories of participants receive some level of telephonic coaching. “The first level of participants receives two outbound phone calls per year; the second category or risk management group receives four phone calls per year, and participants categorized in the third risk level can receive phone calls as frequently as monthly,” she explains. “The personnel that make those calls are RNs with ten or more years of experience, and they have at their fingertips DM guidelines, and evidence-based decision-tree medicine, so they are well-equipped to provide the appropriate guidance to people at all three levels.”

**An emphasis on self-care**

Regardless of a participants’ risk stratification levels, they are encouraged to maintain regular preventive screenings and checkups; they are directed to their own personal action plan library that is automatically populated with education modules that pertain to the individual’s specific risk profile; and they are encouraged to do some level of personal self-monitoring.

“An individual who is diabetic would be checking his blood sugars on a regular basis, and he would be able to document that. And if his BMI indicates that he needs to focus on weight management, then he will receive a chart to be able to do that as well,” explains Baade. Participants can also choose from a robust list of health tracking tools that pertain to everything from blood pressure and exercise to specific DM programs.

Further, Baade emphasizes that SimplyWell will design a program that is based on a particular population’s characteristics and needs. “Once we come on site and collect the data, and evaluate their claims, we may find that lung cancer is a great concern,” she says. “Then, we will incorporate into the plan design a tobacco cessation program.”

**Clinical and financial reporting**

The company has kept ongoing data on what
Baade refers to as its alpha site, a population that has been engaged with the SimplyWell program for more than seven years. According to these statistics, the program has been highly effective at gradually reducing the number of participants with 3, 4, or 5 risks to the point where most of the participants now have three or fewer risks. (See Figure 2 on page 64.)

Additionally, according to self-reported data, the program’s 24-hour nurse line and an online self-care guide have enabled a growing percentage of participants to avoid unnecessary ER visits or trips to their physician’s office. (See Figure 3 on page 65.) “Our value proposition is that you trade an $800 ER visit for just a few dollars by educating that individual,” stresses Baade. “There is a lot of unnecessary waste within the system, so we ask individuals if these tools help them make better decisions about accessing the health care system at appropriate points.”

From a cost standpoint, Baade points out that the program delivers an increased ROI with each additional year of participation with a 6:1 return by year 5. (See Figure 4 on page 65.) She notes that participants in the SimplyWell program consistently consume fewer health care resources than those who choose not to participate. (See Figure 5 on page 65.)

“What is key here is that over 50% of the population is participating in the study,” she stresses, noting that this high level of participation proves the results are not simply an artifact of self-selection. “Actuarially, once we get beyond 50% of the population, we are able to demonstrate that we are impacting the population by reaching into that second risk-stratification level where individuals have more risk.”

**Beyond health care costs**

Virtually all employers are interested in lowering or controlling health care costs, but some administrators also believe this type of benefit sends a message to employees that the company is concerned about their well-being. “We like the fact that it is open to all of our employees to get real-time feedback on their health with the testing, and also the fact that we can continue to educate our people on ongoing health concerns that may affect them,” explains Warren Speed, a senior VP with Jackson, MS-based Parkway Properties, Inc, a real estate investment trust that has offices in nine states.

While it is still too soon to gauge any population-based results from the program, there is strong evidence that the company’s employees are buying into it. According to Speed, a full 66% of the employee base participated in the program last year. “We offer a half-day off for employees that take part in the initial screening and blood draw, and then if they participate in the health education modules, they will receive another half-day off later in the year,” he explains. “That has worked pretty well.”

**New program for physicians**

After several years offering the employer-based program, Canedy is now in the process of perfecting a program that physicians can offer to their own patients. It’s an attempt to help clinicians meet the increasing demands on their time, and to anticipate the types of resources they will need to most effectively negotiate the trend toward pay for performance.

“If a physician is working with an insurance company that has financial incentives in place for meeting certain boundaries in diabetic management, they can pull out all the information [they need],” explains Canedy, noting that the approach is now being piloted in the Midwest as a benefit that patients would pay for through an annual fee to their physicians. “Instead of waiting for disaster, physicians would like to be proactive,” he says. “We are very excited about where we are headed with this.”

**Editor’s note: For more information on SimplyWell, visit the organization’s web site at www.simplywell.com, or call Michelle Baade at 402-559-6769 or 877-991-9355.**

**Tackling the epidemic from all angles**

**Kaiser moves obesity to the top of its clinical priority list**

Armed with mounds of data showing just how dearly the obesity epidemic is costing the country and its citizens, California-based Kaiser Permanente has embarked on a comprehensive strategy designed to tackle the problem from all angles and provide clinicians with an array of resources they can use to help patients get a better handle on their weight. It’s a daunting challenge, but the sheer number of individuals impacted by excess weight has pushed the issue to the top of Kaiser’s clinical priority list. (See Figure 1 on page 67.)

“We don’t have BMIs (body mass indexes) on all our members yet, but we have estimated that out of our 8.5 million members, about 4.4 million are overweight or obese. So clearly this is not a problem that we can ignore, or that will go away today or tomorrow,” stresses Trina Histin, PhD, project director for Kaiser’s Weight Management Initiative. “If you look at the incidence of [other major chronic diseases], they are clearly overshadowed by overweight and obesity, and there are some real connec-
tions between the risk factors associated with obe-
sity and the kinds of things we are seeing in our
population in terms of diabetes, heart disease, and
chronic pain.”

Kaiser’s initiative is just a few years old at this
point, and Histin emphasizes that the organization
is still experimenting with different technologies
and strategies that offer promise in helping patients
to modify their lifestyles and slim down. However,
the initiative’s core components are in place, and
developers are buoyed by early outcomes that sug-
gest Kaiser’s multifaceted approach to the problem
may well be critical to success over the long term.

**Time for action**

Taking on any health issue requires financial
resources, but Histin emphasizes that with the obe-
sity epidemic, the cost of doing nothing is stagger-
ing. That message is underscored in a presentation
Histin delivers outlining Kaiser’s approach. She
cites evidence that health care costs are significantly
higher for patients with BMIs over 30, and that obe-
sity adds considerably to the cost of taking care of
patients who already have a chronic disease. In
Kaiser’s own disease registries for diabetes, CAD,
and CHF, Histin offers data showing that patients
who are obese cost $3,000 to $5,000 more per year
than patients who are not obese. (See Figure 2.)

To begin to tackle the issue in an evidence-
based fashion, Kaiser has established a policy
emphasizing that clinicians should screen all adult
patients for obesity, then those patients should be
risk-stratified and offered appropriate interven-
tions. (See Figure 3.) Under this approach, all
patients -- whether they are overweight or not --
will receive some lifestyle guidance, and addi-
tional interventions are added for individuals at
higher risk levels. These may include some form of
behavior change therapy, pharmaceutical interven-
tion, or bariatric surgery for those at highest risk.

 `'Don’t lose that momentum’`

There is no question that clinicians are often
reluctant to discuss weight with their patients,
but Histin says there is ample evidence showing
that just taking that first step of having a discus-
sion can make a significant impact. “There have
been a number of studies showing that, on aver-
age, patients are about 2.8 times more likely to

![Figure 1: Kaiser Permanente’s Clinical Priority Areas](source)

![Figure 2: Incremental Cost of Obesity in Chronic Condition Cohorts](source)

![Figure 3: A Suggested Approach to Treatment Options](source)

![Figure 4: Clinician-Patient Communication](source)
engage in weight loss attempts if they are advised to do so by their provider,” she says. (See Figure 4 on page 67.) “The obvious next step is to make sure they are referred to programs so that you don’t lose that momentum.”

Contending that no one approach will work for everyone, Kaiser has established a number of programs and resources that clinicians can use with overweight patients. Programs are modified to apply to different populations, and they vary in some respects from region to region, but the overall focus is the same. “What is common across all of them is a core curriculum encouraging healthy eating and active living, as well as figuring out ways for emotional release,” explains Histin. “Usually these programs are led by a health educator, and often times they bring in a registered dietitian or behaviorist.”

**Web-based interventions**

In addition to the more traditional lifestyle management programs, Kaiser has also implemented a number of web-based resources for both clinicians and patients. For example, clinicians

![Figure 5: Supporting the Clinician -- KP HealthConnect](source)

![Figure 6: Average Weight Loss (lbs) at 3- and 6-months (baseline BMI ≥ 30)](source)

![Figure 7: Outpatient Visits Over Six Months by Treatment Group](source)

![Figure 8: Balance™ Produces Recognized Positive Health Benefits](source)
have access to weight management guidelines, research, diagnostic codes, and counseling protocols though Kaiser’s electronic medical record. (See Figure 5 on page 68.) For patients, Kaiser has partnered with Ann Arbor, MI-based HealthMedia to deliver programming to members who prefer a web-based intervention, either as an alternative to traditional programming or in addition to other weight management interventions.

The web-based approach uses computerized, artificial intelligence to essentially emulate what a nurse counselor would do if she were working with a patient on a one-to-one basis, explains Ted Dacko, HealthMedia’s president and chief executive officer. “We use the Internet to interview each individual participant using sophisticated technology. Then we apply behavior change models to individually build a plan for each person based on their stage of change, their motivation, their self-confidence, their perceived severity, perceptibility, and barriers,” he says. “It is actually like they are getting a personalized program written by a medical professional to teach them how to lose weight.”

The HealthMedia program, called Balance, relies on self-reported data to monitor health status and progress, but because the program is computerized, it is a simple matter to track and report on outcomes over time. Histin reports that in a randomized controlled trial that compared members enrolled in Balance with members who were given information on how to access weight management-related content through the Kaiser web site, the Balance participants lost about three more pounds at six months than members in the comparison group. (See Figure 6 on page 68.) Further, Histin adds that that 12-month outcomes show that the weight loss in the Balance group was sustained, and overall health care utilization was lower in this group as well. (See Figure 7 on page 68.)

To date, 75,000 Kaiser members have gone through the Balance program, and the organization has continued to see positive outcomes in both the general population and in individuals with chronic disease. (See Figure 8 on page 68.) Histin adds that more than half of all the Balance participants have lost weight, a full 47% of participants dropped by one BMI point, and 16% of participants dropped a full BMI stratification level. Of the participants with BMIs over 30, 27% lost at least 5% of their baseline weight, and 10% of them lost at least 10% of their baseline weight.

**Worksite wellness**

Working with individual employer-purchasers to implement the Balance program, the approach has produced documented improvements in productivity as well as an ROI, Histin tells DMA. “We know that not only is this good for our members, but we can also take it into the worksite,” she says. “The online program is very portable, so we can tailor it for the purchaser and get good outcomes.”

While Kaiser has had good success with the web-based approach, Histin acknowledges that many challenges remain. For example, she emphasizes that Kaiser needs to focus more attention on engaging physicians in the process so that they will refer more patients to the program, and there is also room for further innovation with regards to member engagement.

Overall, however, no one at Kaiser is complaining. “We found that when you use the right model to implement with the right intensity, it seems to be effective at getting employees enrolled into the program,” she says. “We also found that people lost weight on the program, and their weight loss accompanied a decrease in productivity losses.”

Effective clinical management is central to Kaiser’s initiative, but Histin emphasizes that it is just one part of a larger strategy the organization considers essential to addressing the obesity epidemic. “We decided from the start to take a public health approach to obesity because you cannot silo this within the medical system. It really needs to be a total approach,” she explains. For example, Kaiser is actively involved with research on obesity and weight management, and in promoting sound public health policy. Additionally, Kaiser in involved in community education projects that include reaching out into the schools to encourage children to be more active in looking after their own health.

“Our ongoing policy is we really can’t expect to be healthy if our members live and work and go to school in communities that are unhealthy. That underscores our weight management work.”

**Editor’s note:** For more information on HealthMedia’s web-based DM and health promotion programs, visit the organization’s web page at www.healthmedia.com. Information about Kaiser Permanente can be accessed at www.kaiserpermanente.org.

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**A new quest to pinpoint high quality, cost-efficient chronic care standards**

Improving care of the chronically ill in this country is not necessarily a matter of allocating more dollars to the problem. In fact, there is now fresh evidence that facilities and regions that spend the most on caring for chronically ill patients tend to have poorer outcomes than low-cost facilities and regions. This, at least, is the startling conclusion of a new study undertaken by the Center for the Evaluative Clinical Sciences (CECS) at Dartmouth Medical School in communities that are unhealthy. That underscores our weight management work.”

**Editor’s note:** For more information on HealthMedia’s web-based DM and health promotion programs, visit the organization’s web page at www.healthmedia.com. Information about Kaiser Permanente can be accessed at www.kaiserpermanente.org.
School in Hanover, NH.

In the Dartmouth Atlas Project, investigators studied the records of 4.7 million Medicare enrollees who passed away between 2000 and 2003 and had at least one of 12 chronic conditions. What they found were huge variations in cost and quality -- sometimes even within the same healthcare system. In fact, the authors conclude that Medicare could have saved as much as $40 billion, or nearly one-third of what the agency spent on care for these patients over the four-year time frame, if all the regions studied practiced at the same high-quality/low-cost standards established by the Salt Lake City, UT region -- one of a handful of regions identified as performing at a high level on cost as well as quality.

As a result of these findings, study authors are calling for an overhaul in the way America manages chronic illness, and they are providing policy makers, providers, and patients with a powerful tool to guide them toward more cost-efficient, high-quality care.

**Drilling down**

With support from Princeton, NJ-based Robert Wood Johnson Foundation, the Dartmouth Atlas Project has been compiling reports on variations in health care resources and utilization for 13 years. However, investigators point out that this latest edition of the Atlas represents a major advance over previous editions because it has drilled down to the individual hospital level, offering detailed insight on how virtually all of the nation’s acute care hospitals and their associated physicians manage chronic illness.

“The information reveals what we believe are striking variations and unacceptable patterns in variation and should lead to reconsideration of how chronic illness is managed as a longitudinal or as a population-based strategy that does not depend entirely on the acute care hospital to perform rescue care,” stresses John Wennberg, MD, MPH, a principal investigator on the study. “What we find is that some states, regions, and hospitals are more efficient than others, use fewer resources while providing patient care of equal or better quality, and we believe that these efficient hospitals should stand as benchmarks to be strived for by providers and by public policy because the implication in terms of overall resource utilization is extraordinarily significant.”

In compiling their database, researchers looked at the care individuals received during the last two years of life, taking into account such factors as physician visits, referrals to specialists, quality and intensity of care, days spent in the hospital, and the rate of ICU admissions. “This is not just end-of-life care we are looking at; it is actually a pattern of practice of how chronic illness is managed over time by providers in different communities,” emphasizes Wennberg. “Further, care of chronically ill patients in the last two years of life accounts for about one-third of Medicare’s total spending, so what happens in this period of life is extremely important in terms of Medicare’s budgets and its projections for growth and spending.”

By making the data available to providers, policy-makers, and patients in a searchable database, investigators believe the effort can be mobilized into an engine pushing for more high-quality, cost-efficient care. “Sometimes you will see in the data incredibly long periods of hospitalization, lots of intensive care, and in light of the overall finding that more is not better, this creates an opportunity for a real choice, we think, among patients,” adds Wennberg. “For policy-makers, we believe the data displays extraordinary opportunities to improve efficiency in health care by promoting patterns of practice similar to highly respected, low-utilization providers such as the Mayo Clinic in Rochester, MN, or Intermountain Healthcare in Salt Lake City, UT.”

**High variations in spending**

Analyses conducted from the Dartmouth Atlas highlight a number of issues of particular concern. For example, investigators found that America’s large academic medical centers exhibit just as much variation in cost and quality as the rest of the country’s medical institutions. Further, they noted that even in large metropolitan areas where health care spending tends to be relatively high, there is considerable variation in health care spending -- sometimes even within the same hospital system.

Using the Dartmouth Atlas to look at facilities within the New York Presbyterian Hospital System, for instance, investigators found that inpatient reimbursements at Wyckoff Heights Hospital during the last two years of life were almost three times higher than those at other hospitals in the system.
than the U.S. average. (See Figure 1 on page 70.) In contrast, inpatient reimbursements at New York United Hospital were only 30% higher than the national average.

**Questionable returns**

“The key question that is raised by this data is: What are the benefits of the increasing utilization found at some of the higher-intensity hospitals in the U.S.?” says co-author **Elliott Fisher**, MD, MPH, senior associate at the VA Outcomes Group, and professor of medicine and community and family medicine at Dartmouth Medical School. “We know now from numerous studies that have been published over the last four years, and reinforced by some of the findings from the current Atlas, that the higher spending -- the greater use of the hospital as the site of care -- is not associated with better care or better outcomes. In fact, it tends to be worse.”

This finding appears to be counter-intuitive, but Fisher contends that the high-spending facilities and regions tend to spend their dollars on the types of care that do not necessarily offer clear-cut benefits such as more days spent in the hospital at higher intensity, more physician visits, and more referrals to different types of specialists. “We have good data now showing the technical quality of care -- whether patients receive the appropriate medicines when indicated. And the technical quality of care is lower in the high-spending health care systems,” he says, noting that mortality is also 2% to 5% higher in these systems. “We think the most likely reason for these poorer health outcomes in the higher spending regions and hospitals is a consequence of poor communication when there are multiple physicians involved, and more medical errors as a result of this fragmented care that patients are receiving.”

**A call for standards**

Both investigators agree that a big part of the problem is a general lack of standards in caring for the chronically ill. “Maybe we have put too little emphasis on developing scientifically valid clinical pathways for managing chronic illness outside of the hospital,” notes Wennberg. “There are a few places where this is happening such as Group Health Cooperative in Seattle, the Mayo Clinic in Rochester, MN, and Intermountain Healthcare in Salt Lake City, UT, but there is a big gap. And the evidence of the lack of standards is the extent to which practices vary within the academic medical centers.”

By making the latest edition of the Dartmouth Atlas available, the authors are hopeful that policy makers and providers can take steps toward improving chronic care management in their own settings by modeling the health care practices of the best systems. Adds Fisher, “We are unlikely to solve the problem of chronic care in this country if we leave in place our overbuilt acute care sector. We need to re-emphasize the development of chronic care management for primary care, and think about how we can improve the management of care at the end of life.”

**Editor’s note:** For more information about the Dartmouth Atlas, visit www.dartmouthatlas.org.

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**Net Watch**

**New web resource for cardiology patients**

Concerned that cardiology patients often have difficulty recalling information and instructions given to them during visits with their physician, developers at Duke University Heart Center have created a special section on their website that will allow patients to review the latest information about their heart condition and get detailed descriptions of medical tests and treatment options.

To encourage patient use of the web resource, physicians have been equipped with pre-printed forms that list the various heart disorders, tests, and treatments. During their discussions with patients, physicians can simply check off the tests and treatments that have been reviewed so that patients can then go to the website, register, and get more information about what was discussed during the clinic visit. For example, if a patient has been scheduled to undergo a cardiac catheterization, the patient can go to the website and review what he is supposed to do prior to the procedure, and get detailed information on what the procedure entails as well as what he can expect afterwards.

In addition to providing immediate information, the site also has interactive capabilities. For example, patients who have registered at the site will receive e-mail notifications when new guidelines or other information is available on a particular issue or condition of special interest to them. For more information about the resource, visit www.dukeheartcenter.org.

**Online screening survey takes aim at decreasing colorectal cancer deaths**

Gastroenterologists at Chicago, IL-based Rush Medical Center have unveiled a free, online educational tool designed to help patients ascertain...
whether they are at risk for colorectal cancer. The interactive tool, available at www.RushHealthAssociates.com, includes a brief questionnaire about health history, and it assesses each person’s need for further evaluation.

The tool is designed, in part, to help clinicians counter the view by many individuals that they are simply not at risk for the disease. In fact, although colorectal cancer is highly preventable when caught early, it is the second leading cause of cancer-related deaths in this country for both men and women combined. Experts agree that the most important first step in battling the disease is to undergo recommended screening at the appropriate age. Developers are hopeful that the online screening survey will prompt more patients to do so.

New pay-for-performance resource just released from NHI

Pay-for-performance incentive programs have quickly gained traction in the healthcare marketplace as payers, employers, and provider organizations continue to search for methods that align the goals of each stakeholder. The results of early efforts have been impressive in terms of outcome and quality gains, improvements in preventive care and guideline adherence, reductions in utilization and costs, and real dollar rewards for the providers involved.

But making P4P work takes more than a simple carrot, and the design of performance-based incentives is critical to long-term success. That’s why National Health Information has released “Pay-for-Performance in Action: Achieving Outcomes Improvement Through Quality-Based Incentives.”

This new special report takes P4P from the planning committee to the real world, with detailed case studies of pay-for-performance programs, their success strategies and mistakes, as well as their results and plans for future changes and improvements.

This 60-page report will give you valuable advice, guidance, and insight into the key factors that will drive the success of your performance-based incentive efforts:

• Incentive criteria and rewards;
• Creating solid payer-provider partnerships;
• Acquiring and sharing credible data and profiling reports;
• Using EMRs to drive quality;
• P4P in Medicare and Medicaid;
• Getting physician buy-in;
• And much more!

“Pay-for-Performance in Action: Achieving Outcomes Improvement Through Quality-Based Incentives” is available for just $99 plus $5.95 shipping and handling. To order, call 800-597-6300 or send payment to NHI, P.O. Box 15429, Atlanta, GA 30307; to order online or view a full table of contents, go to http://www.nhionline.net/products/improvement7.htm. All orders must be prepaid and are fully protected by NHI’s 100% money-back guarantee.