

DM DISEASE MANAGEMENT ADVISOR™

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XLHealth launches the eighth and final program in Tennessee

Pharmacists assume high-profile role in MHS program

While all eight of the Medicare Health Support programs are targeting a similar population of beneficiaries with diabetes and/or heart failure, and each program must meet the same set of criteria established by CMS, there is nonetheless considerable variation in program content and design. This is particularly obvious in Baltimore, MD-based XLHealth's entry to the field, the eighth and final Medicare Health Support program now underway in Tennessee.

While the program makes judicious use of home monitoring technology, it is also placing a priority on regular in-person assessments. Further, given the complexity of the medication regimens many of these chronically ill patients must endure, program designers have integrated pharmacy consultations into the mix, believing that the approach will pay off in improved adherence to guidelines, better patient compliance, and reduced medication errors. The program's design can offer important lessons for not only MHS program planners, but for anyone applying DM strategies to a similar population.

Inside This Month...

- **Don't overlook the value of low-cost, telephone-based interventions.** A new study shows that phone-based DM approaches can be highly effective at reaching disadvantaged populations. In this case, trained prevention care managers made outreach calls to boost screening rates in women who were clearly due for testing. Investigators believe the approach could effectively be used to promote other health care services as well Page 53
- **Use the simple tools at your disposal to battle metabolic syndrome.** It's the fastest growing disease in the Western world, but practitioners are having little success doing battle against metabolic syndrome -- that constellation of symptoms that warns of more serious complications down the road. However, an expert on the disease from Baylor College of Medicine in Houston, TX, has outlined a host of simple strategies that practitioners can use today to make headway against this menacing problem Page 56
- **New ideas focus on redesigning primary care.** Spurred in part by mounting evidence that mediocre care is the rule rather than the exception, a number of health care experts are pointing to primary care as the ideal place to initiate change. In fact, some suggest that this is the ideal place to deliver traditional DM services -- particularly in light of the fact that as the population ages, chronic disease is on the increase. Find out how some leading voices in the debate hope to re-tool primary care so that it can deliver much more in the way of ongoing care and support Page 58

Relationship building

The XLHealth program was launched in mid-January, beginning with outreach calls to the 20,000 beneficiaries CMS has identified for intervention. During this initial contact, nurses invite the beneficiaries to participate in the program and proceed to conduct health risk assessments with those who agree to go forward. All the participants are then directed to one of six assessment centers XLHealth has established in Tennessee to support the program. Here, they undergo a face-to-face meeting with either a local care manager or a personal support nurse, who conducts further evaluations as part of the health risk assessment process.

"We will use this time to do some coaching and to begin to build a relationship with them," explains David Hollis, MD, XLHealth's chief medical officer for the Tennessee program. "We think it is important to have a local community relationship with the participants in addition to any telephone coaching calls that might be done."

Also, during this initial assessment all patients are offered a free digital retinal photography screening with the use of a digiscope, and all the diabetics exhibiting signs or symptoms of periph-

eral vascular disease are offered free diabetic shoes with orthotics to fit in them. Hollis notes that these steps were integrated into the assessment process to specifically address the high incidence of amputations and diabetic retinal disease in Tennessee.

"We have already done over 500 digiscope exams, with almost 10% of those people having an urgent need to see an ophthalmologist, so we are preventing blindness," he says. "And diabetes is the leading cause of amputations, so by aggressively managing these people we are reducing the amputations and keeping patients out of hospitals and nursing homes."

In an effort to identify wounds at the earliest possible stage, diabetic patients are being equipped with a temperature probe and instructions for self-monitoring. "What we encourage them to do on a daily basis is to measure the tem-

perature in five places on each foot," notes Hollis. "What we are looking for is a temperature of about 90 degrees in any of those places, or a four degree difference between the two feet. It has been shown clearly that the breakdown of tissue that would lead to an ulcer, which could ultimately lead to an amputation, is preceded by a change of temperature in the area."

Self-management support

A variety of other devices and tools are being made available, depending on patient needs. These include glucometers, BP cuffs that automatically record BP readings, and telemetry scales that automatically transmit a patient's weight and information regarding symptoms to a monitoring center where the readings are reviewed on a daily basis.

Figure 1: Sample Patient Reports

The figure displays two sample reports from XLHealth. The left report is a letter to a participant, and the right report is a 'Your Blood Sugar' report card.

Letter to Participant:

Dear Participant,

Congratulations on being selected for the Medicare Disease Management Program. You are excited to begin working with you toward better health.

Within the next week, an XLHealth representative will call you. Until then, you can become familiar with the program by reviewing the Demonstration Program Welcome Kit.

- Program Overview Brochure**—Get to know the health care team you'll work with, and the tools you can use to take control of your health.
- Patient Responsibilities Sheet**—Ensure that you are meeting your responsibilities by carefully reviewing the tasks expected of you as a participant.
- The Program Experience: One Patient's Story**—Learn how the program changed one patient's life.
- Caregiver: How You Can Help Brochure**—Let your family members know about the kit's other materials so that he or she may help you.
- Sample Goals Report**—Make healthy changes to your lifestyle. Your program nurse gives you. He or she will review this report with you.
- XLHealth Magnet**—Use this as a helpful reminder to call us with questions or concerns.

You can also expect to receive these important items in the next few weeks:

- Membership ID Card**—Present this card every time you visit a hospital or emergency room.
- Pharmacy Benefits Brochure**—Learn how to use your benefits to receive your enhanced prescription drug coverage.

Your program benefits will go into effect on the first day of the month you feel free to call us at 1-888-993-3444 if you have any questions.

Let us congratulate you again on your selection into the Medicare Disease Management Program, and we're glad you can be part of it.

Sincerely,
Your Care Team at XLHealth

The Warehouse at Camden Yards • 351 West Camden Street, Suite 100 • Baltimore, MD 21201
410.625.2200 • Fax 410.625.2244 • www.xlhealth.com

Your Blood Sugar Report Card:

Member Name : JOHN DOE Physician : ROBERT SMITH, MD
Member ID : 123456789-01 Assessment Date : 01/02/2003
Member Phone : (555) 123-4567

GLUCOSE MONITORING - BLOOD SUGAR CONTROL

2 HgA1c Blood Tests in Last 12 Months (Yes)	<input checked="" type="radio"/>	3
HgA1c Blood Test Result <= 7.0 (Yes)	<input checked="" type="radio"/>	3
Your HgA1c Results from 09/02/2003 : 5.8 Standard : 7.0		
Uses a Glucose Meter (Yes)	<input checked="" type="radio"/>	3
Routine Visits with Primary Care Physician (Yes)	<input checked="" type="radio"/>	3

CARDIO - HEART GOALS

Routine Visits to Primary Care Physician (Yes)	<input checked="" type="radio"/>	3
HDL Cholesterol at Goal >40 AND Total Cholesterol at Goal <200 (Yes)	<input checked="" type="radio"/>	3
Results: HDL = 47 / Total Cholesterol = 165		
Triglycerides at Goal < 150 (No)	<input checked="" type="radio"/>	1
Triglycerides = 190		
LDL < 100 (Yes)	<input checked="" type="radio"/>	3
LDL Value : 80 (Fasting : No)		
Fasting Cholesterol Re-Checked or Confirmed by Physician (Unknown)	<input type="radio"/>	4
Takes Low Dosages of Aspirin (Yes)	<input checked="" type="radio"/>	3

CLINICAL DEPRESSION GOALS

Appointment with a Health Professional (consult your physician) (Unknown)	<input type="radio"/>	4
Zung Test Score Less than 50 (Unknown)	<input type="radio"/>	4
Your Zung Test Score : (No Entry)		

Legend:

- 1 Needs Immediate Attention
- 2 Needs Attention
- 3 Goal Obtained
- 4 Insufficient Information

Source: XLHealth.

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"There are some heart failure patients who don't need a telemetry scale, but we give them a nice scale with large numbers," explains Hollis. "We believe all heart failure patients should weigh themselves daily, so we always make sure they have a scale in their homes with instructions to contact us if they have gained a specified amount of weight."

Patients receive additional support through personalized reports that spell out their responsibilities for self-management and make specific recommendations for steps they can take to improve their health. (See Figure 1.)

To insure that participants are able to take advantage of the program's services, developers have gone to great lengths to identify and address any barriers that might arise. Hollis notes that in some cases, this is simply a matter of providing basic services. "There is not a lot of public transportation in Tennessee that is real convenient, even in the larger cities, and the result is that we found transportation to be a barrier to patients visiting their physicians and coming to our assessment centers," he explains. "When we are talking to a participant, and they say they can't make it to an assessment center because they don't have any way, then we will step in. We will provide transportation to physician visits as well the assessment center. We are willing to do both if there is a significant need."

Pharmacy consultations

One of the most unique aspects of the XLHealth program is the integration of pharmacists into each participant's care team. In fact, once individuals have undergone an initial assessment at an XLHealth assessment center, they are typically referred to a pharmacist for an in-person consultation. Program designers have facilitated this service by partnering with LaFrance, Inc., the parent company of Super D Drugs, and CVS/Pharmacy.

"We offer each participant the opportunity to spend 30 to 40 minutes with a pharmacist in a consultation room at one of the drug stores," explains Hollis, noting that participating pharmacists have access to each patient's medication information through XLHealth's technology platform. "We initially do a medication review in our office and put some of that information in the system. The pharmacist can see that information, but then they collect some of their own information as well. They look at the medications and try to gauge participant compliance; they look at whether there are any side-effects that are occurring; and they look at omissions and commissions -- whether the patient is on the appropriate medications, based on standardized guidelines."

In cases where the pharmacist finds an opportunity for improvement, an intervention

letter is dispatched to the patient's physician for further review. "We are trying to look at the guidelines and make sure patients are on the right medications, when indicated," stresses Hollis. "Physician judgment comes in and we let the physician make the final decision, but we do think [the pharmacist consultations] are important because we know that about half of all patients who take medications on a chronic basis are not compliant with their medications within 30 days. There are a lot of different reasons for that, and we try to work with [the physicians and the patients] to improve compliance."

Two weeks following an initial pharmacist-patient consultation, the pharmacist calls the patient at home to check on how things are going with the medication regimen. "We have an option built in whereby if the pharmacist determines that he or she needs a second visit with a patient, or one of the telephone nurse coaches determines that the patient needs another visit, we will schedule one." Hollis notes that while follow-up "visits" with the pharmacist are often conducted by telephone, program staff encourage patients to do the initial consultations in person.

Medicare Disease Management latest product from NHI

"Land grab."

That's how a top executive with a leading disease management company recently described what DM and provider organizations are gearing up for as the ongoing Medicare-sponsored disease management demonstration projects -- designed to test DM concepts with the Medicare FFS population -- begin to document their results.

It is just a matter of time now until 15 million Medicare recipients become fair game for DM providers, and your competitors are racing to stake their claim in this massive new market.

Your organization must begin preparing NOW to make sure you get your share of this massive marketplace, and to make sure you are ready for the many clinical, operational, regulatory, and business challenges you are sure to face.

That's why National Health Information is offering a free trial to our newest newsletter, *Medicare Disease Management*, the first and only publication devoted to helping plans and providers successfully navigate this uncharted territory. Each monthly issue is filled with detailed clinical guidance, success strategies and case studies, business models, contracting opportunities, compliance advice, proven program management initiatives, and much more! Our veteran team of journalists and DM experts gives you a key competitive edge in the battle for market share -- and in the struggle for positive outcomes and ROI in the senior population.

We are offering our customers a \$50 discount and a three-issue free trial subscription. To request a free trial, order online at www.nhionline.net/products/mdm.htm or call 800-597-6300.

Preparing for a new role

To gear up for the XLHealth program, participating pharmacists underwent 30 hours of training that dealt with cardiovascular health and diabetes, according to **Jeff Gross**, director of patient care for CVS Pharmacy. "In addition to that, we had on-site training around process and administrative tasks related to the consulting services. And there was also a series of conference calls that XLHealth conducted to help the pharmacists understand the special areas of focus, based on the data that XLHealth got from Medicare," he explains.

The consultations are primarily designed to deal with issues around safety, compliance, understanding side-effects, and identifying any duplicate or missing therapies, Gross explains. "The consultations are really to help the patients understand what is typically a pretty large number of medications that they are having to manage between actual prescriptions and even some over-the-counter medications they might be taking."

From CVS's standpoint, the XLHealth pro-

gram is an opportunity to demonstrate the kind of value a community pharmacist intervention can bring to DM. Gross maintains that that the approach is an ideal fit for some populations.

"When you get patients with ten or more medications, you are getting to a level of complexity that extends beyond the training of an RN, and yet pharmacists are the experts in medications," he says, noting that CVS is hopeful its pharmacists' expertise will be evident in the clinical and financial outcomes generated by the XLHealth program. "Among all the Medicare Health Support programs, this is the only one that has a community pharmacist role ... and we are certainly hopeful that if XLHealth produces the best health outcomes, lower costs, and essentially higher quality, that among the points of differentiation will be the fact that the [organization has] carved out a role for the community pharmacist."

Editor's note: For more information about XLHealth, visit the organization's web address at www.xlhealth.com. ❖

A word of caution when considering technology-based DM applications for senior populations

No one doubts the potential of information technology to boost health care quality and efficiency, but any expenditures along these lines will be wasted if patients and providers are not comfortable with the applications or the devices. In fact, such concerns are of paramount importance when dealing with senior populations because a significant percentage of older patients have little, if any, experience with computers or Internet-based applications.

"We found that for a majority of seniors, even the most simple functions of logging into a system and remembering a four-character password were initially very daunting," observes **Lorenzo Moreno**, PhD, MSc, a senior health researcher at Princeton, NJ-based Mathematica Policy Research who is involved with evaluating a telemedicine intervention targeted toward diabetic Medicare beneficiaries living in medically underserved areas of New York. "Anything that relies on the Internet or web-based applications is probably going to be a challenge, particularly for people who have never used computers before or are just beginning to use computers."

In light of the implementation barriers he experienced with the telemedicine demonstration, Moreno has prepared a brief that addresses the issues health care organizations should consider before implementing a technology-based DM intervention within a senior population. Initially, he recommends assessing the technological skills of the target population. "There are two potential ways to do that. One is to use a patient registry in which information about the level of education or the last place of employment can provide clues regarding what sorts of skills a population may have with regards to information

technology," he says. "Also, the manufacturers or developers of these technologies are doing this kind of usability testing, but it is not necessarily clear that this information is being made available to the people purchasing the technology."

Moreno emphasizes that the needs and skills of the health care providers who would potentially be interacting with these applications must also be given strong consideration. "If the technology is not user-friendly to the patients, this is going to create a lot of frustration among the providers. It will require them to be answering technical questions that they might not necessarily be prepared to respond to. They could spend a substantial portion of the encounter addressing technical questions rather than delivering care," stresses Moreno. "We think that the system design has to incorporate the provider perspective and user perspective -- not only the technical designer perspective."

Facility with computers and other new technologies will undoubtedly increase in the coming years, but for the time being, Moreno suggests that more traditional tools are a better fit with senior populations. For example, he notes that interactive voice response systems are well-accepted and understood by seniors. Likewise, simple monitoring tools that require users to answer questions about their health status by pressing two or three buttons also work well in older populations; typically, these devices send the information to a monitoring center via phone lines. A third option that works particularly well for delivering health education involves use of a simple DVD. Adds Moreno, "Seniors know how to use the appliances to run DVDs, and there is an explosion in these types of interactive applications that allow the user to get information about their condition."

Telephone-based intervention shows promise in boosting screening rates

There is no question that new technologies are helping disease managers become more productive and efficient in reaching out to greater numbers of patients, but such approaches often offer little value to low-income groups who have little or no experience with computers or Internet-based applications. Fortunately, however, there is new evidence that, when used appropriately, the telephone can be highly effective at reaching such populations and motivating them to take better care of their health.

In searching for better ways to increase cancer screening for low-income and minority women in New York City, researchers from Hanover, NH-based Dartmouth Medical School found that targeted phone calls delivered by trained personnel could significantly boost the number of women taking advantage of mammograms, colorectal screenings, and Pap tests. In fact, the results from the study are so impressive that researchers are now testing the approach in a broader population where existing infrastructure and personnel will be used to implement the telephone-based intervention. Further, investigators believe that the low-cost approach can eventually be expanded to include many other types of preventive services as well.

Appealing approach

Well-aware that disadvantaged populations are adversely impacted by the morbidity and mortality associated with cancer, and that patients in this population are often not diagnosed until cancer is well advanced, researchers wanted to identify a method that could successfully boost screening rates in low-income and minority groups. The study population consisted of women served by 11 community health centers for the underserved in New York City.

Investigators wanted to test the efficacy of a telephone-based intervention primarily because, in many delivery systems, the resources needed for telephone outreach are already in place -- typically to promote such services as well-child visits and childhood immunization.

“The idea of initiating a series of

supportive phone calls from someone who was well-trained and well-aware of barriers had a lot of appeal,” explains **Allen Dietrich**, MD, the principal investigator on the study and a professor of community and family medicine at Dartmouth Medical School. “Looking ahead to the next stage, we figured if we could do this in a research study, there were established infrastructures to which we could translate this methodology so that it could be sustained outside of the research study.”

Prevention care managers

Armed with data from a previous study that identified the chief reasons why women fail to take advantage of cancer screening services, investigators recruited bilingual women -- mostly college graduates -- who they could train to serve as prevention care managers (PCMs). The PCMs would then reach out by telephone to women due for any of the three targeted cancer screenings, and then help them overcome barriers to receiving the needed screenings.

In the first session of the two-day training period, the trainees were briefed on the disparities that exist regarding cancer screening in low-income groups, and the recommendations for screening issued by the U.S. Preventive Services Task Force. Further, they received detailed descriptions of what is involved with undergoing each of the targeted screening procedures so they would be well-equipped to answer any patient questions about the procedures. “We

Figure 1: Types of Support Provided by Prevention Care Managers to Patients*

Type of Support	Patients Receiving Support (n = 696)
Educate and increase awareness, n (%)	
Mail clinician recommendation letter to patient	328 (47.1)
Mail activation card to patient	328 (47.1)
Mail screening test-specific educational material to patient	313 (45.0)
Schedule, remind, and access advice, n (%)	
Schedule screening appointments	148 (21.3)
Provide appointment reminders	208 (29.9)
Call patient	132 (19.0)
Send patient reminder letter	130 (18.7)
Schedule appointment with primary care provider	68 (9.8)
Give patient access advice	16 (2.3)

* All patients assigned to the intervention group are included in this intention-to-treat analysis.

Source: Dietrich A, Tobin J, Cassells A, et al. Telephone Care Management to Improve Cancer Screening Among Low-Income Women. *Annals of Internal Medicine* 2006; 144:563-571.

really wanted them to understand that we were using this strategy to facilitate change, and that they were the change agents,” explains **Andrea Cassells**, MPH, a co-author of the research and director of clinical affairs for the Clinical Director’s Network, a non-profit group based in New York City that focuses on developing research and educational activities in community health centers.

Hands-on training

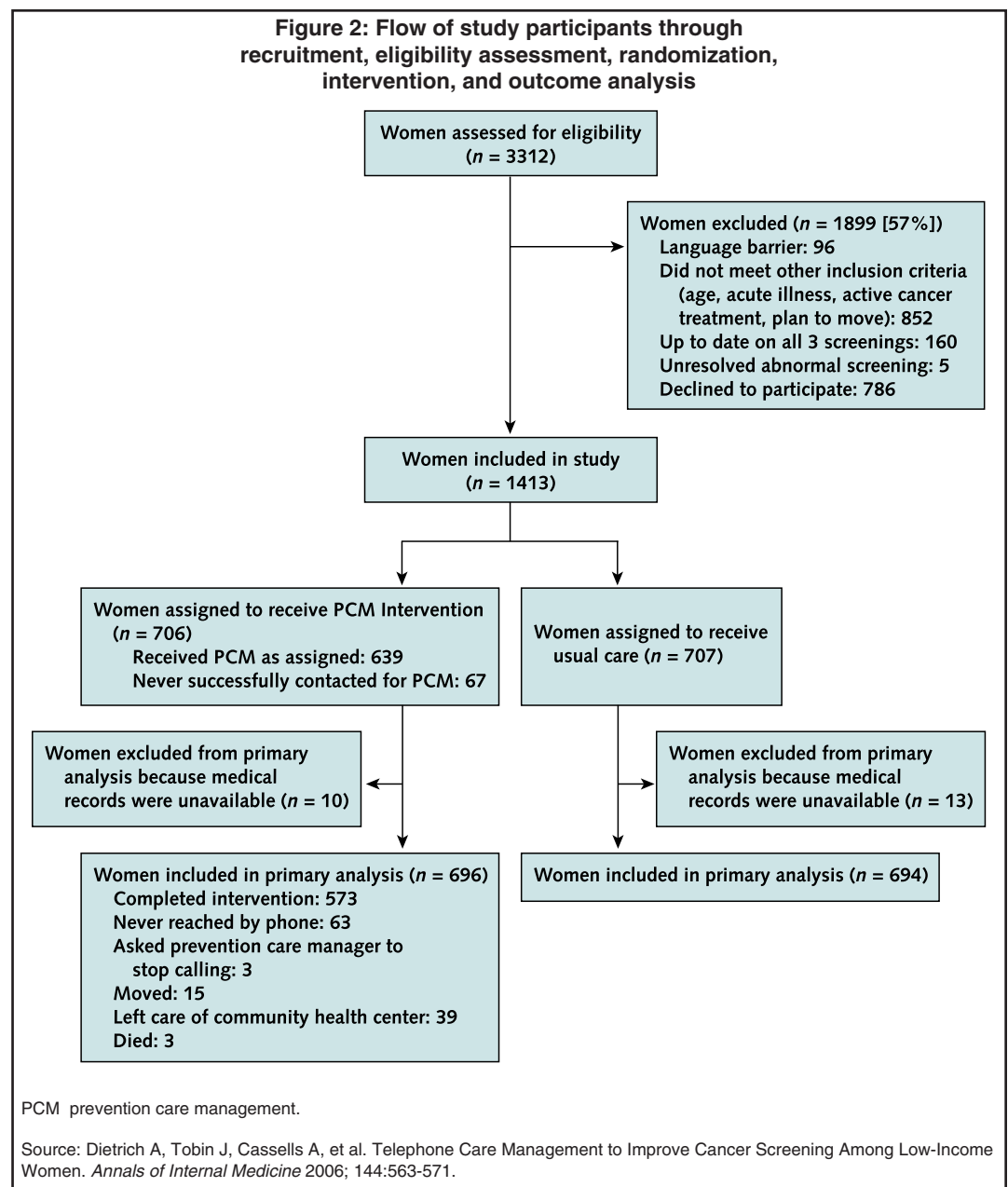
The second phase of the training involved more hands-on, interactive learning, emphasizes Cassells. “We developed a series of scripts to facilitate the calls,” she says, noting that the scripts were based on prior research looking into the various barriers women from the targeted population typically faced. “The [trainees] went through the different scripts and did some role-playing to make sure they had a comfort level with making the calls.”

Over the course of the intervention, the prevention care managers received weekly feedback on their performance in making the calls, and the scripts were continually tweaked to accommodate new situations that would arise. “As we went along, we discovered additional barriers, so we had to develop scripts for those as well,” adds Cassells.

All of the women targeted to receive calls had previously agreed to participate in the study and to have their chart reviewed so investigators could determine what, if any, cancer screening procedures they should undergo, according to guideline recommendations. The PCMs were then given this information so they could

specifically address the procedures needed when they made outreach calls. (See **Figure 1** on page 53.)

While carrying out these calls, one of the most common barriers cited by the targeted patients was the lack of a recommendation or referral from their PCP to undergo the screening procedure. “Many of these women had chronic conditions such as diabetes, hypertension, or asthma ... so the prevention issues would invariably fall to the bottom of the plate,” notes Cassells. “A woman would come in with diabetes, and the provider would focus on making sure her diabetes was being well-managed, so even though she needed a mammogram or a referral for a colonoscopy, these weren’t addressed.”



Intervention strategies

To address this issue, the prevention care managers sent out pink “activation cards” to the patients listing the specific screening procedures they needed. The information was listed in English on one side of the card and in Spanish on the other side to get around language barriers. The patients were then instructed to take these cards with them to their next office visit.

“This was to address the issue of helping the doctor see that the patient was in need of screening, but we also used this strategy because we found that a lot of women were faced with not being able to communicate with their providers,” notes Cassells. “Many of the Spanish-speaking women felt that even though there might be an interpreter present, they really weren’t communicating, so the cards helped them to overcome that gap.”

In addition, to overcome the lack of a provider recommendation or referral, the prevention care managers worked with the community health centers to send letters to the women -- signed by their providers -- recommending that

they receive the needed screening procedure. Adds Cassells, “The women would see that their clinician wanted them to have this test, and that helped them to follow through.”

Knowledge gap

Another barrier that came up frequently during the outreach calls was a lack of knowledge or understanding about the screening tests being recommended. This was particularly true with the various tests used to screen for colon cancer, explains Cassells. Many of the women could simply not fathom the process of testing their stool, and others had never heard of colonoscopy. In these cases, the prevention care managers would thoroughly explain the testing procedure, mail educational materials to the women, and then follow up with a repeat phone call in two or three weeks. “Once we followed up with them, a lot of the women would then indicate that they now understood the test and felt that they could go ahead and proceed with the procedure,” says Cassells.

To deal with the issue of competing priori-

Figure 3: Proportion of Women Up to Date for Cancer Screening*

Measurement Period	Intervention Group (n = 696)	Usual Care Group (n = 694)	Difference (95% CI)†
Mammography			
Baseline, %	58	60	-0.02 (-0.07 to 0.03)
Follow-up, %	68	58	0.10 (0.05 to 0.15)
Change from baseline (CI), percentage points	0.10 (0.05 to 0.15)	-0.02 (-0.08 to 0.02)	0.12 (0.06 to 0.19)
Papanicolaou test			
Baseline, %	71	70	0.01 (-0.04 to 0.06)
Follow-up, %	78	70	0.08 (0.03 to 0.12)
Change from baseline (CI), percentage points	0.07 (0.03 to 0.11)	0.00 (-0.03 to 0.05)	0.07 (0.01 to 0.12)
Any colorectal screening			
Baseline, %	39	39	0.00 (-0.05 to 0.05)
Follow-up, %	63	50	0.13 (0.08 to 0.18)
Change from baseline (CI), percentage points	0.24 (0.20 to 0.29)	0.11 (0.08 to 0.16)	0.13 (0.07 to 0.19)
Up to date for 1 or more screening			
Baseline, %	86	86	0.00 (-0.03 to 0.04)
Follow-up, %	91	87	0.04 (0.01 to 0.08)
Change from baseline (CI), percentage points	0.05 (0.02 to 0.08)	0.01 (-0.02 to 0.04)	0.04 (0.00 to 0.08)
Up to date for 2 or more screenings			
Baseline, %	61	61	0.00 (-0.06 to 0.05)
Follow-up, %	75	62	0.13 (0.08 to 0.18)
Change from baseline (CI), percentage points	0.14 (0.10 to 0.18)	0.01 (-0.04 to 0.05)	0.13 (0.00 to 0.08)
Up to date for 3 screenings			
Baseline, %	21	22	-0.01 (-0.06 to 0.03)
Follow-up, %	43	30	0.13 (0.07 to 0.20)
Change from baseline (CI), percentage points	0.22 (0.18 to 0.27)	0.08 (0.04 to 0.12)	0.14 (0.08 to 0.20)

* This analysis is based on unadjusted rates.

† All values in this column are percentage points.

Source: Dietrich A, Tobin J, Cassells A, et al. Telephone Care Management to Improve Cancer Screening Among Low-Income Women. *Annals of Internal Medicine* 2006; 144:563-571.

ties, the prevention care managers typically used motivational interviewing techniques and continuous encouragement to convince the women that they needed to take care of themselves in order to take care of their families or whatever other goals they were focused on accomplishing.

Additionally, when access barriers were apparent, the prevention care managers would go ahead and make appointments for the women. They then coordinated with the participating health centers to send the fecal occult blood test cards directly to the women so that they did not have to schedule an extra appointment to receive the cards. In some cases they were able to arrange for the centers to establish open-access hours when patients could simply show up and receive the screening procedures without a prior appointment.

Promising results

Investigators compared the group of women targeted for intervention by the PCM with a matched group of women with similar characteristics.¹ (See Figure 2 on page 54.) While women in the intervention group received, on average, four telephone calls from a PCM, women in the control group received a brochure about the screening procedures and a single phone call, informing them what screening tests they were overdue for and recommending that they discuss the issue with their physician.

Following the 18-month study period, data analyses show that the PCM intervention had a significant impact on screening rates for all three tests. (See Figure 3 on page 55.) When compared to the control group, researchers found that screening rates increased by 12% for mammography, 7% for Pap tests, and 13% for colorectal screenings in the intervention group.

While the PCM intervention was clearly effective in the context of this study, investigators are eager to test the approach in more of a real-world setting where participants do not have to agree in advance to receive the calls, and where women due for screening procedures can be identified through administrative data rather than time-consuming chart reviews.

Fortunately, they will not have to wait long; the National Cancer Institute has already approved funding to test the approach on a larger scale. "We will be working with three to four Medicaid managed care organizations in New York, NY to train their outreach staff to conduct this intervention," notes Cassells. "The Medicaid managed care arena is already set up to make outreach calls, so we plan to build on that. The infrastructure is already there."

Reference

1. Dietrich A, Tobin J, Cassells A, et al. Telephone Care Management to Improve Cancer Screening Among Low-Income Women. *Annals of Internal Medicine* 2006; 144:563-571. ❖

A call to action on the world's 'fastest growing disease entity'

An arsenal of strategies available to do battle with metabolic syndrome

The dangers associated with the epidemic of obesity in this country are well-understood; practitioners know that excess weight heightens the risk of heart disease, hypertension, diabetes, and many other diseases. However, this knowledge has thus far failed to make a meaningful impact on care. To the contrary, the incidence of overweight and obesity is growing by one percentage point each year in this country, and already two-thirds of the population is overweight or obese.

Why are health care providers throwing up their hands in the face of such a gathering storm? Perhaps the reason is because any sensible solution to the problem requires lifestyle modification, and many practitioners are skeptical about their ability to help patients make difficult changes. However, there is plenty of evidence to

suggest that physicians are, in fact, ideally suited to be the messenger in this instance because patients tend to give their instructions a good deal of authority. Furthermore, physicians are well-positioned to implement the kind of incremental changes that can ultimately lead to significant risk reduction.

Establish realistic goals

Nowhere is America's weight problem more obvious than in the alarming incidence of metabolic syndrome -- the constellation of risk factors characterized by a large waist circumference, elevated BP, high plasma levels of triglycerides, low plasma levels of HDL cholesterol, and impaired glucose tolerance. "It's the fastest growing disease entity in the world, and it is something that needs to be recognized and dealt with by physicians and other health care professionals," according to **John Foreyt**, PhD, the director of the behavioral medicine research center at Baylor College of Medicine in Houston,

TX. "We never saw this when we were kids. It is a new disease, and it is the result primarily of a lot of us getting so fat, so the obesity is driving the insulin resistance which is driving the metabolic syndrome."

To help physicians effectively address the problem, Foreyt has developed a "toolbox" of lifestyle intervention strategies that busy physicians can incorporate into their practice.¹ He emphasizes that the first and most important strategy is to establish realistic goals that a patient has a good chance of being able to achieve. For example, he points out that while many patients aim to lose 50 lbs or 100 lbs very quickly, they are likely to fall short, resulting in feelings of failure. Foreyt suggests beginning with a more modest goal of 8% weight loss -- a smaller achievement, but one that can boost self-efficacy and set patients up for subsequent achievements.

Make patients aware

Physicians should also think about ways to raise patient awareness of metabolic syndrome and how various lifestyle choices impact the course of the disease. This can be accomplished by instructing patients to weigh themselves every day, use a food diary to record what they eat, and by having patients keep a log that keeps track of their physical activity.

Such approaches go hand-in-hand with goal setting, notes Foreyt, because patients can strive toward a goal of exercising 30 minutes a day or, using a pedometer, they can build up to 10,000 steps a day. "That is five miles or 500 calories, which results in a one-pound weight loss in a week," he says. "The idea is that we all burn about 5 calories a minute as soon as we get up and start walking."

A third essential task in making progress against metabolic syndrome is to confront barriers that prevent patients from making needed lifestyle changes. This is a matter of addressing any issues from a problem-solving point of view and helping patients come up with ways to overcome these obstacles, notes Foreyt. For example, if a patient is not making the necessary changes in his diet, the practitioner should work with the patient to find out what specific issues are in the way, and then develop some practical solutions. Patients who must eat at restaurants frequently, for instance, may want to call ahead to make sure healthy food choices will be available. In other cases, it might make sense for patients to bring specific types of meals to work every day, or to stock up on some sensible evening snacks if nighttime snacking is a problem.

Finding the time to exercise is another com-

mon barrier that physicians can often help patients resolve with simple, practical solutions. Furthermore, problem-solving almost always comes into play in the event of relapses. Physicians can help patients understand that relapses need not sabotage their efforts, and they can help them devise individualized coping strategies.

Address stress management

Given that stress often interferes with attempts at lifestyle change, Foreyt emphasizes that physicians should consider having a discussion with patients about what triggers stress in their lives, and how they can mitigate the problem. "There are many techniques, and it would be easy for the physician to teach a patient stress management strategies," emphasizes Foreyt, noting that one ideal approach is physical activity.

It may also be beneficial to engage in what Foreyt refers to as cognitive restructuring, a method of helping people to think more positively and realistically about themselves. This can be accomplished by having patients develop self-enhancing thoughts and beliefs that support or encourage their efforts to exercise and make dietary changes. For example, if a patient resolves to walk 30 minutes after dinner every day, and he repeats that affirmation to himself repeatedly, it can be a strong impetus for continuing the activity.

Getting a patient to think positively is important, but that patient's chances for success in any lifestyle change effort will be enhanced if he has a support system to provide ongoing encouragement. Consequently, physicians should discuss this issue with patients, and encourage them to think about ways to develop such a system at home, in the office, and/or by joining a support group. Colleagues or family members who share the same concerns can be especially beneficial in sustaining efforts toward lifestyle change.

Put it in writing

Taking into account that you have worked with the patient to establish realistic goals that are achievable, take the next step by having the patient confirm that he or she agrees to make specific changes in behavior before the next visit. This can be a verbal commitment, but Foreyt advises putting the agreement in writing in the form of a simple contract.

"The doctor has a piece of paper where the patient signs it and the doctor signs it," he explains. The agreement may state that the

patient agrees to walk for 20 minutes three days per week, to add a vegetable to the evening meal, or to cut desserts from three times a week to twice a week.

A tailored approach

Studies suggest that weight loss medications have, at most, a modest impact, but they are beneficial in some cases, and physicians should consider pharmacotherapy as one more option at their disposal in working with patients who need to lose weight.

“What you are really looking for is a tai-

lored approach to help raise awareness, confront barriers, and overcome any specific problems, using a variety of approaches,” explains Foreyt. “The idea is that one approach will not fit all patients ... so you need to tailor the program to the patient as far as eating healthy, exercising, and managing weight. That is the bottom line, and that is how you treat metabolic syndrome.”

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RAND study citing ‘mediocre’ care fuels debate

Momentum builds for linkage between DM, primary care

Despite the vigorous debate over pay-for-performance and other incentive methods aimed at driving quality, there is mounting evidence that the vast majority of people in this country are receiving, at best, only mediocre care. A recent study conducted by the RAND Corporation, for example, pointed out that most people -- regardless of race, income, or insurance status -- experience significant deficits in recommended care.¹ The problem is most troubling in chronically ill populations, where following care guidelines is critical to averting exacerbations of existing conditions. There are numerous contributing factors behind this sad state of affairs, but a growing chorus of experts is suggesting that any viable solution must begin with a total redesign of the way primary care is delivered in this country.

Critics point out that internists and family practitioners are increasingly preoccupied with acute problems, leaving little time for the kind of health promotion, education, and preventive steps that could ward off the development of chronic disease down the road. Further, they argue that most PCPs lack the training and/or support to optimally manage the increasing numbers of people already impacted by chronic disease, even though a majority of these individuals receive the bulk of their care in a primary care setting.

Addressing such fundamental problems will not be easy, but groups are beginning to come forward with ideas on how to refashion primary care so that it is capable of delivering a much more comprehensive suite of services directly linked to patient needs. Among other things, some are arguing that rather than or in addition

to farming out DM to third-party vendors, it is part and parcel of what needs to take place in primary care.

A ‘leaky boat’

The RAND study looked at preventive services and care for 30 acute and chronic conditions that are considered to be the leading causes of death and disability. And, perhaps astoundingly, the researchers found that participants only received about 55% of the recommended care services. Further, these significant gaps existed across all socio-demographic groups.

“What our study showed was that we are all in the same leaky boat, basically. Everybody, whether they are rich or poor, black or white, insured or uninsured, is getting the same mediocre care,” stresses **Steven Asch**, MD, the lead author of the study from RAND, and on staff at the Veterans Affairs of Greater Los Angeles Health Care System. “We looked at basic, bread and butter, routine services for people ... and what we found was that the kinds of things that help you get in the door like insurance and being well-off don’t seem to help very much once you get in the door.”

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A system 'designed to fail'

One of the primary barriers to quality care that the researchers identified is the fragmentation of the health care system. "It is so disjointed that it is very difficult for even well-meaning patients and physicians to get the care they need," notes Asch, pointing out that in most settings no one person is charge of a patient's care. "A patient might get his heart care from one physician and his arthritis care from someone else, and there is no easy way for those doctors to communicate with each other on a real-time basis."

Further, while adoption of the electronic medical record (EMR) and other modes of information technology are essential to improving efficiency and timely care delivery, Asch emphasizes that technology is not the total answer. He suggests there also needs to be a mechanism for measuring quality, and for holding people accountable for outcomes. Adds Asch, "The current system is essentially designed to fail in its current incarnation. Neither patients nor physicians are getting the help they need."

Higher demands, greater rewards

Recognizing that such problems are only going to intensify as the population ages and chronic disease becomes even more prevalent, the American College of Physicians (ACP) is calling for a revolution in the concept of primary care.

"Managing older patients with chronic disease requires involvement over time, and the office visit is only a piece of the activity," explains **William Golden**, MD, FACP, chair of ACP's Board of Regents, and an internist and geriatrician based in Little Rock, AR. "With the advent of EMRs and e-mail, and with the need for frequent blood monitoring and improved compliance from patients with increasingly complex drug regimens, we think that physicians should be expected to, and rewarded for, more comprehensive care of their patients -- a task that extends to activities in between office visits."

The ACP is looking at different models of care delivery, but it has already endorsed the concept of the advanced medical home, a model of care that utilizes a team approach to deliver ongoing care and support. Under this concept, practices are organized around the needs of patients. "This could be in some ways almost like a DM-type model where the physician's office can monitor and encourage compliance with a complex regimen, and also help the patient obtain necessary services through either social agencies or sub-specialist referrals," notes Golden.

Golden stresses that physicians need to think more in terms of population-based care where, instead of looking at just one diabetic patient, for example, physicians monitor how well they are taking care of all 50 of their diabetic patients. "It's really a kind of comprehensive re-look at what we expect out of a practice, and an attempt to make sure that physicians have the tools to do that kind of job."

The ACP acknowledges that achieving real change in the way primary care is delivered will also require fundamental alterations in the way internists are trained and reimbursed. And the organization has just unveiled policy papers that address each of these concerns. Additionally, to move the group's ideas forward, ACP has created a Center for Practice Innovation.

"We will be looking for model practices to try out these concepts and report on their experiments so that we can share the data with members," says Golden. "We would like to see efficient, evidence-based practices that are patient-centered. And that is easy to say, but to execute is always a bit of a trick."

Help needed from policy makers

A number of health experts believe the ideal place to implement the chronic care model is in primary care, according to **Julie Schmittiel**, PhD, an investigator with Kaiser Permanente's Northern California Division of Research, who has studied the relationship between the chronic care model and certain types of primary care delivery.² However, she points out that a majority of practices lack the tools and/or resources to take on this larger role.

"If you look at what is out there in terms of health promotion and health education, the overall levels are not very impressive, so a lot of those basic things that you need to implement this kind of care are not there right now."

Schmittiel envisions the ideal primary care practice as one that is the nexus for all of a patient's care needs. "This type of practice really tries to be the place where all other care springs from," she explains. "This is the place where you learn about health education classes, and this is where you get your HbA1c monitored. And as soon as you are diagnosed with a chronic disease, you are not sent to a specialist or care manager unless that care manager is really integrated into the system."

To nurture this kind of care, Schmittiel emphasizes that primary care practices are going to have to get away from their acute care focus, but she agrees that they will have to have help from policy makers. "If we really believe that primary care is the nexus [for all other care activi-

ties], then we have to start thinking that way and setting up our system of incentives accordingly.”

Editor's note: For more information on the American College of Physicians' efforts to revamp primary care, visit the organization's web site at www.acponline.org.

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National Health Information has released a timely special report providing detailed guidance on the use of predictive modeling in disease management and other health-related applications.

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