

# DM DISEASE MANAGEMENT ADVISOR™

## Remote services offer advantages

### Telemedicine offers new alternatives for behavioral healthcare delivery

It took several years for the Fuqua Center for Late-Life Depression at Emory University in Atlanta to implement its telemedicine strategy. But with support from the state and the help of videoconferencing technology set up in more than 30 locations, psychiatrists at the center began seeing older patients remotely in September 2006.

The Fuqua Center is not alone in its efforts. More and more healthcare organizations and policymakers are turning to telemedicine for potential solutions to the ever-growing challenge of treating patients with depression who live in rural or remote areas.

Such efforts range from simply using the telephone to deliver psychotherapy and psychosocial support, to laying sophisticated fiber-optic lines for videoconferencing so that patients in outlying areas can receive specialty care from

providers who may be hundreds of miles away. Obtaining reimbursement for such approaches remains a stumbling block in many cases, but progress has been made on that front in recent years, and evidence is mounting that at least some of these applications offer important advantages over the traditional in-person encounter.

## Videoconferencing removes stigma of visit

For the Fuqua Center, videoconferencing was a viable solution to treating patients who lived too far away to regularly come in for treatment or who were embarrassed about doing so.

“The goal of the Fuqua Center is to provide psychiatric care for elderly adults with mental illness and to decrease stigma,” says **William McDonald, MD**, a professor in the department of psy-

**“What really works in medicine is presenting . . . your patient’s problems that you have been trying to figure out for the past six months, and then having an expert explain what is going on and develop a treatment plan with you.”**

—William McDonald, MD

chiatry at Emory and the director of the Fuqua Center. That’s a challenge because there are few psychiatrists in most of rural Georgia, he says. “There may be one mental health center somewhere, but it is very, very rare to have psychiatrists in rural parts of Georgia. In fact, there is not a lot of psychiatric care even in the medium-sized cities.”

So Fuqua attempted to make care more accessible with help from the state. The state provided the fiber-optic lines needed to establish the telemedicine connection and the coordinators in each of the outlying areas necessary to facilitate encounters with patients. “The coordinator in a [particular] community might get a call



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from a doctor who says he needs his patient seen by a psychiatrist," McDonald says. "The coordinator then sets everything up. She gets the patient's records to us and gets the patient to the site with a nurse [at the scheduled time], so that makes it relatively easy."

Having support staff at the local site is critical, McDonald emphasizes, because most primary care doctors do not have the time or resources to set up a videoconference visit. However, McDonald stresses that working with providers on a consultative basis has tremendous potential.

"What really works in medicine is presenting . . . your patient's problems that you have been trying to figure out for the past six months, and then having an expert explain what is going on and develop a treatment plan with you," McDonald says. "You [work with an expert on these cases] a few times, and then you can do it on your own. So our goal is not really to make money off this, but to train these rural doctors in order to develop psychiatric care in these rural areas."

In addition to training providers in rural areas how to offer psychiatric care, the program at the Fuqua Center also has removed some of the stigma that people often associate with mental healthcare by making it available in a traditional medical setting. "Many older Americans have this odd idea about what goes on in psychiatry offices, but to actually go to a medical place, and have a nurse there who takes your [blood pressure] and presents you to a doctor, that has actually worked very well," McDonald says. "It makes it much closer to a medical visit [in the patient's eyes]."

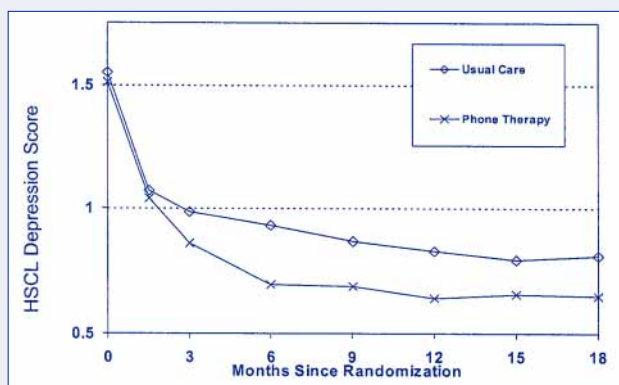
There are some disadvantages to Fuqua's videoconferencing approach. Technical glitches sometimes disrupt the audio/video connection, and older patients sometimes have difficulty hearing, a problem often compounded by the involvement of speakers and microphones.

The approach is still relatively new, but physicians who have referred patients to the program seem happy with it, as indicated by the fact that they continue to send more and more patients.

McDonald says he believes that as more practitioners and patients participate in the process, the approach will prove its value—both from a clinical and financial standpoint.

"In these rural populations, there will be real cost savings because there is plenty of evidence to show that patients with depression have much higher healthcare utilization, not just for mental health, but for all sorts of health," he says. "Older depressed patients are much more likely to go to the ER complaining of chest pain

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**Figure 1**

Source: Ludman E, Simon G, Tutty S, et al. "A Randomized Trial of Telephone Psychotherapy and Pharmacotherapy for Depression: Continuation and Durability of Effects." *Journal of Consulting and Clinical Psychology* 2007, 75 (2): 257–266.

[and other problems]. So there is very good evidence that a little money spent in treating depression can actually decrease overall costs."

### Phone-based psychotherapy delivers results

Another form of telemedicine—psychotherapy offered via the telephone—also appears to offer benefits, according to a study published in the April 2007 *Journal of Consulting and Clinical Psychology*. In that study, researchers from Seattle-based Group Health followed nearly 400 adult patients diagnosed with depression and placed on antidepressant therapy. Half of the group received brief, telephone-based psychotherapy soon after beginning their medication regimens; the other half received usual care.

Clinical improvement, as measured by the Hopkins Symptom Checklist (HSCL) Depression Scale, occurred in both groups. But within three months, the group receiving phone therapy showed more improvement than the usual care group, and this improvement was sustained for more than a year.<sup>1</sup> (See **Figure 1** above.)

At 18 months, 77% of those who received phone therapy reported that their depression was much or very much improved, whereas only 63% of those receiving usual care reported similar improvement.

The lead author of the study, **Evette Ludman, PhD**, a researcher with Group Health, notes that the telephone

gave the patients flexibility and required less time and effort on their part than traditional psychotherapy, but the psychotherapists had to work especially hard to reach patients. "Therapists are usually trained to set up an office and wait for people to come. In our setting . . . sometimes they had to call 20 times before they reached somebody," she says. "We learned that we need very energetic therapists who are willing to put in the amount of outreach effort needed and not take it personally [when patients fail to respond]."

The therapists also need to be available on nights and weekends, when people typically have the most time to devote to a phone-therapy session. And even those conditions aren't ideal, because there can be myriad distractions going on in the background at a patient's home. "That can mean screaming children, television—a variety of things—and it takes some getting used to," Ludman says. However, she stresses that this may actually benefit the patients because they are learning to incorporate depression-fighting techniques in their real world.

Interestingly, some of the therapists felt that the fact that patients did not see them in person offered a comfort level or a level of anonymity that made the patients more accepting of the therapy. "It made people almost more willing to open up," Ludman says. "We thought about sending pictures of the therapists to people so that they could have someone to imagine they were meeting, but then we realized something was working in our favor."

One curious result from the study was that medication adherence was only slightly better in the phone-therapy group than the usual care group. In previous studies, patients receiving telephone follow-up have consistently had better adherence rates than patients in usual care. Ludman suggests that this may be because medication monitoring and follow-up have improved in usual care in recent years. She also points out that this makes it much more likely that it was the psychotherapy—and not the medication—behind the improved clinical results in the phone-therapy group. "We wanted to see if psychotherapy added to the medication, and given in a real-world,

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primary care setting, would provide an added benefit," she says. "And we really think [that it did]."

### Remote services need reimbursement

Next on the agenda for Ludman and colleagues is a cost-effectiveness analysis of the approach, from which they hope to be able to make a strong business case for phone psychotherapy. As it stands now, although Medicare will pay for the type of telemedicine visits that McDonald and other psychiatrists are providing in Georgia, there is no similar reimbursement mechanism for phone-based psychotherapy.

However, Ludman is optimistic that this will soon change. "I think there will be increased recognition of all types of remote services—Internet-delivered and telephone-delivered. I think we are on the cusp of a change there," she says. ■

### Reference

<sup>1</sup> Ludman E, Simon G, Tutty S, et al. "A Randomized Trial of Telephone Psychotherapy and Pharmacotherapy for Depression: Continuation and Durability of Effects." *Journal of Consulting and Clinical Psychology* 2007, 75 (2): 257–266.

## Psychological barriers interfere with telemedicine applications in older populations

Healthcare organizations and providers interested in implementing a telemedicine application for senior patients would be well-advised to get input from those patients before moving forward, according to a new report by the New Millennium Research Council (NMRC), a think tank based in Washington, DC. The report, *Overcoming the Psychological Barriers to Telemedicine: Empowering Older Americans to Use Remote Health Monitoring Services*, reviews existing literature on the subject, and suggests that older Americans often have different concerns related to telemedicine than younger generations.

For example, Americans older than age 60 are much more hesitant to use computers or Internet-based applications than younger Americans and tend to have heightened concerns about confidentiality and privacy. "One of the big concerns people have relates to transmitting personal demographic information or health records online," says **Matt Bennett**, executive director of NMRC. "People are worried that their information is going to go out there onto the Internet, and that someone is going to get their hands on it and use it for nefarious purposes."

The report suggests that older Americans also worry that a telemedicine application may somehow interfere with the personal relationship they have with their provider or the clinic staff with whom they are used to interacting. "What we found in some of the literature is that people have the fear that they

will become socially isolated [if a telemedicine application is implemented], and they don't understand that it is actually a way to avoid isolation," Bennett says.

Some of these psychological barriers will resolve themselves over time as the baby boomer generation ages; baby boomers tend to be much more comfortable with computers and technology than their parents. But that's still a little way off.

In the meantime, telemedicine applications are more likely to be successful if providers spend time and effort educating and training senior patients on the front-end, the report suggests. "It is a matter of making the patients aware of what the technology can and can't do, and what the benefits are for them," he says. "It is investing in systems that are simple to use, that patients can understand without too much [explanation], and setting up support networks so that if [patients] are using something they don't understand or there is a technical glitch, they can easily get access to support."

The report goes one step further, suggesting that older individuals or peers actually offer this user education and support. Such a tactic can make the older patient more open to learning about how to use a new application and less embarrassed about asking questions.

Visit NMRC's Web site at [www.thenmrc.org](http://www.thenmrc.org) to access the full report.

## **Experts point to timing, cultural values, and provider involvement as critical to success**

# **Surefire strategies to boost DM enrollment and retention**

Getting and keeping patients enrolled in DM programs has always been a challenge. But the advent of phone-call screening mechanisms such as caller ID, and the tendency of many people to rely on their cell phones rather than hard-wired phones, has made this task doubly difficult. However, there are strategies that can help healthcare organizations overcome such obstacles and establish lasting relationships with the people who can most benefit from DM interventions.

Although DM enrollment tactics always need to be customized to fit individual organizations and patient populations, experts in this field stress that the same key considerations apply in most situations. Further, regardless of the method used to reach a patient, the timing of this connection is almost always central to whether or not that participant will enroll and engage.

### **Timing and training make a difference**

It is critical to act upon referrals for DM quickly—particularly because claims data, which often identify patients as eligible for a DM program, are already dated by the time an actual referral is made. **Debra Leon**, president of Wheeling, IL-based Health Contact Partners, Inc., an independent call center, spoke about the importance of “cycle time” at HCPro’s March 13 audioconference “Enroll, Engage, and Retain: Strategies to Boost Disease Management Program Participation.”

“If a member has an event that puts him in the hospital or qualifies him for a program, obviously he is going to be more [motivated] to join the program if you can reach him within thirty days,” she says, noting that cycle time is the time period between receipt of a referral and completion of the enrollment process. “For most programs, the goal should be to [reach and enroll] identified patients within 10–14 days. Seven to 10 days is ideal.”

Leon emphasizes that enrollment success can be enhanced if you send potential enrollees a card or a letter

in the mail, introducing the program and encouraging inbound calls, prior to your first phone call. “That is very helpful to people who need to know who you are,” she says. Leon emphasizes that outbound calls should be made almost immediately after that letter or card is received. “Complete the first call to everyone on your list within three business days,” she says. “If there is a two-to three-week gap, it is a meaningless effort. You have wasted the letter. They are going to forget you.”

Organizations that don’t have the manpower to look up incomplete or incorrect phone information about potential enrollees should consider using an outside vendor, according to Leon. Similarly, she advises organizations to get the help they need in order to make contact with all potential enrollees quickly.

If the people making the enrollment phone calls are nurses or other clinical professionals, that will add credibility to the encounter. However, Leon suggests that the more important consideration is making sure that these individuals have the training and skill set to perform a function that is similar to high-level customer service.

Further, she stresses that the enrollment team needs top-level support for its success. “If upper management does not see the enrollment/engagement piece as critical, and they will not invest in the training and resources needed to make it successful, that will be a barrier,” adds Leon.

### **Listen for subtle clues**

Often, the people who stand to benefit most from DM intervention are the hardest to reach because of language barriers, odd work hours, limited access to—or comfort with—technology, or geographic isolation, according to **Brenda Schmidt, MS, MBA**, the managing director at Phoenix, AZ-based Diversity Wellness, a company that specializes in reaching out to diverse populations—especially in Latino communities. Schmidt, who also spoke at

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the HCPro audioconference, notes that in order to reach diverse populations, you need to dig beyond the simple, demographic details. "It is very easy to look at age, gender, race, ethnicity, and even job type. What is less obvious, but very key to the engagement process is literacy level, preferred language, and the preferred way of getting information—things that aren't [readily] available to an enrollment person when they are looking at a census," says Schmidt. "So the enrollment/engagement process needs to start very, very early in digging deeper into some of these issues."

In particular, she notes that language specificity is a huge challenge among Latino populations because a Spanish word that may mean one thing to a person of Mexican descent may mean something completely different to someone of Puerto Rican or Central American descent. Consequently, important health messaging can be completely misconstrued or misunderstood if the person doing the outreach fails to appreciate these differences.

Similarly, whether or not a person can read has a strong bearing on how you can most effectively communicate with him or her, but Schmidt notes that alert outreach personnel can usually discern this information by listening for subtle clues. "When we do an outbound phone call around literacy level, we don't

ask the individual whether he or she can read these materials. We ask them whether they would prefer for us to read the materials to them, or to review the material with them," says Schmidt, noting that this method enables enrollment personnel or nurse counselors to ascertain literacy status without causing embarrassment or discomfort.

### Consider cultural values

Although increasing numbers of Americans are turning to the Internet for health information, that is not necessarily a valid trend among certain ethnic populations. For example, Diversity Wellness did a survey among Latino women who had access to high-speed Internet applications and found that fewer than 2% use the Internet to obtain health information. Consequently, a Web-based outreach or intervention would not be successful in this population. Other cultural groups may have different preferences. The bottom line, notes Schmidt, is that it is important to find out about such preferences before launching an outreach effort.

Similarly, she emphasizes that it is critical to understand that cultural beliefs can play a strong role in health behavior. The more outreach workers understand about these beliefs, the better able they will be to reach a population. For example, she notes that many

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cultures have a sense of fatalism with regard to their health. If a person's grandfather and father have diabetes, he or she may feel it is inevitable that they will get the disease as well. Obviously, an enrollment effort that makes no attempt to acknowledge this underlying belief has little chance of success with this individual.

Sometimes it is a matter of understanding the hierarchy of the family (i.e., just one spouse making all the decisions for the family) that is critical, and other times the cultural nuances of a particular population may have the biggest impact. But Schmidt emphasizes that you need to have more than the basic details. "During that first enrollment call, if the individuals do not perceive that the person on the phone has an appreciation or understanding of them, they will not enroll," she says.

One strategy that has worked well for Diversity Wellness is finding people within a social network or worksite to champion a program and engage others. Such champions need to come from the culture or community that you are trying to reach, but they can be invaluable in providing support and validation for the DM effort. "They can create that trust and relationship base that makes the program more high-touch," notes Schmidt. "The more high-touch you make it, the greater the participation will be."

### Get the clinician involved

If you can loop a patient's provider into the enrollment process, you can dramatically improve your success with DM enrollment, according to **Ray Fabius, MD**, president of Chadds Ford, PA-based CHD Meridian Healthcare, which operates more than 215 worksite-based healthcare centers. In a recently published study coauthored by Fabius, investigators found that this approach resulted in a 76% enrollment rate as compared to the typical rate of 25% that is achieved through conventional enrollment methods.<sup>1</sup>

The study involved nearly 2,000 Goodyear Tire & Rubber Company employees and their dependents, who were identified through informatics as good candidates to participate in a DM program focused on improving control of diabetes, hypertension, and CAD. "After we

stratified the worthy population to engage in a DM program, we actually reviewed the list with the trusted clinician[s] at the workplace so that they also could have some input on patients who might be missing, or patients who may have been rated lower or higher than they should be through our informatics process," says Fabius. "Then we looked at [the clinicians'] schedule of appointments. Any patients who we were interested in inviting to participate in our integrated DM program—who were scheduled to have an appointment within the next 60 days—were flagged to be introduced to the program and invited to participate during the actual visit."

Targeted patients who did not already have scheduled visits received an outbound call from one of the clinicians at the health center. Whenever possible, he notes that the call was made by a clinician who had already established a relationship with the patient.

In either case, once a patient agreed to participate in the DM program, a member of the DM telephonic team initiated an outbound call to the individual to get him or her started. However, Fabius emphasizes that investigators did not consider patients true participants until they completed a telephonic assessment, which is part of the DM program.

### Approach affects engagement and retention

The approach was not only successful at engaging participants in DM. In a second evaluation that will be published soon, data will show that after several months, engagement in the CHD Meridian program fell by just 6%. Additionally, Fabius anticipates that outcomes data resulting from the active engagement in DM will be positive as well. "As you might expect, the cohort of patients who agreed to participate in the program were in general more expensive to the employer than the patients who elected not to participate, but over the study period, those two cohorts switched," he says. "The cohort that has been participating in our integrated DM program has, on average, become less expensive than the cohort that decided not to participate."

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Fabius acknowledges that by providing full-service, primary care at the worksite, the company may have advantages that traditional, off-site care services may not have. For example, all the physicians and ancillary staff members work for CHD Meridian and follow a single formulary and benefits plan.

Further, by practicing at the worksite, the clinicians have ample opportunity to establish strong relationships with their patients.

However, the healthy enrollment numbers produced by the approach suggest that engaging clinicians in the DM process early on can deliver important dividends.

"This has really been a challenge for DM programs," he says. But to get around it, program developers went to

great lengths to make sure clinicians understood the workings of the integrated DM program—even going so far as to introduce the clinicians to the group of telephonic care management nurses that would be working with them.

The message to clinicians was that there was a program available that could supplement what they do. "By sponsoring the value of the program to their patients, the engagement rate was really solidified," Fabius adds. ■

### Reference

<sup>1</sup> Frazee S, Kirkpatrick P, Fabius R. "Disease Management Engagement Rates: Leveraging the Trusted Clinician." *Disease Management February 2007.*

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## Psychosocial issues loom large in effort to improve birth outcomes

# Aggressive outreach and intervention deliver major dividends regarding at-risk pregnant women

Pregnancy-related care is a huge cost driver for most Medicaid healthcare organizations. High-risk deliveries are particularly expensive, especially considering the cascade of costs that goes along with admission to the neonatal intensive care unit (NICU). Policymakers know that early intervention can go a long way toward preventing birth complications, but making that happen in a transient, disadvantaged population is no easy task.

It's a problem the Monroe Plan for Medical Care, based in Rochester, NY, decided to take on, beginning in late 1997. Since then, the health plan has put together a multipronged approach that has not only gotten huge numbers of providers to participate, but also has made a major dent in the health plan's NICU costs.

### Quality improvement efforts

Working with the Hamilton, NJ-based Center for Health Care Strategies (CHCS), a nonprofit organization

focused on improving healthcare quality for Medicaid recipients, Monroe started by developing a way to better identify pregnant women early on; the plan made it mandatory for providers to fill out and return a prenatal registration form for any pregnant woman they treated.

"We paid our providers \$30 for the submission of this form, and the 'stick' that we used was a potential denial of reimbursement for prenatal care if it was not submitted," says **Joseph Stankaitis, MD, MPH**, chief medical officer at the Monroe Plan for Medical Care, who spoke at a March 21 audioconference sponsored by CHCS that focused on care-management strategies for high-risk asthma and high-risk pregnancy.

The threat of denied reimbursement boosted submission rates of the forms from 3% to greater than 90%, but in many cases, the submission was too late, with the health plan receiving the forms a week or two before delivery. "You really have to know who is pregnant early

enough in order to intervene for those who are at high risk," Stankaitis says. "It really doesn't help if you find out that someone was pregnant . . . by receiving the claim for the delivery. There is very little you can do to affect the outcome."

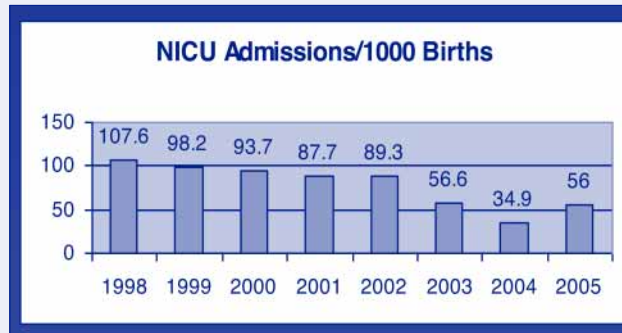
To try to get the forms filled out earlier, health plan administrators held face-to-face meetings with the providers and their staff members to explain the purpose behind the prenatal registration forms. They also implemented a tiered reimbursement process whereby providers who submitted the forms in the first trimester would receive \$50 per form, those who submitted in the second trimester would receive \$30 per form, and those who submitted in the third trimester would receive \$20 per form. This plan, which started in 2001 and remains in effect today, has kept first trimester form submission rates well over 60%, he notes.

In addition to ramping up its efforts to identify pregnant women earlier, the Monroe Plan also took steps to improve the stratification process that categorizes pregnant women into different risk groups. This helped bring attention to some behavioral health issues that were falling through the cracks. There was no coordination "between the prenatal staff and the behavioral health staff in terms of addressing issues that had to do with mental health or chemical dependency problems that were identified on [the prenatal] forms," Stankaitis says. To address this problem, the health plan formalized a process requiring both behavioral health and medical staff members to review all prenatal registration forms.

### Psychosocial issues take a toll

With identification and stratification processes in place, the Monroe Plan turned its attention to outreach and intervention. "What we found from our own birth-outcomes database was . . . a high correlation of poor birth outcomes with women who are socially isolated, have unstable home environments, or experience spousal abuse," Stankaitis says. As a result, the plan added a social worker to its staff and implemented a social outreach program specifically focused on working with women

**Figure 2**



*Analysis of NY State SPARCS Data Demonstrated No Concurrent Changes in NICU Admission Rates in Upstate New York for Medicaid During These Years*

*Source: The Monroe Plan for Medical Care, Rochester, NY.*

who face these types of psychosocial issues.

Fortunately, the health plan administrators at Monroe didn't have to start from scratch with their program. The type of approach they had in mind already existed in the Rochester, NY, region in the form of a grant-funded program offered through Strong Memorial Hospital's social work division. Called Baby Love, the program reaches out to women through social workers and paraprofessionals, or nonclinicians who then identify areas of need and link the women with resources and support. Monroe contracted with Baby Love to provide outreach services to women identified as having significant psychosocial risks.

"It is a home visiting program, so we will go to them, and the initial visit will be with a social worker and an outreach worker," says **Kelly Petzing, LMSW**, a supervisor with the Baby Love program. "The social worker does a full psychosocial assessment and then comes up with a plan for whatever we might be able to do to help."

That aid might be something as seemingly simple as driving the women to their medical appointments. For women who have no source of transportation, it's a huge help. Additionally, the health plan has learned that the travel time shared by the outreach worker and the client can be particularly productive.

"What the outreach folks do is allow the individuals to really talk about issues that they probably wouldn't talk to their providers about," says Stankaitis, who referred to

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## Aggressive plan < continued from p. 57

this space and time in the vehicle as a “safe zone.”

“A lot of things get uncovered, and there are incredible moments in terms of finding out what is going on, and also teachable moments, too, in terms of enhancing what is the right thing to do in terms of care. Having that connect—engaging the patient—that is where it is all at.”

In addition to providing transportation, outreach workers might assist the women in obtaining food, clothing, baby supplies, or any other basic items they may need. The social worker also may provide referrals for substance-abuse treatment or other types of specialty care. “Pretty much anything that might be identified as an issue for the family we will try to address, and then we stay involved throughout the pregnancy,” Petzing says. “The outreach worker will do regular visits, usually about every two weeks or so, just to continue building that relationship and working on whatever is identified as a need for that family.”

### Pilot program shows promise

Typically, Baby Love will stay involved with the family long enough to do a postpartum visit, and conduct a final assessment to determine any additional needs that require attention. “We want to make sure the mom has her postpartum visit and that the baby has the first couple of pediatric visits, and then we will refer the family on to other programs if there are ongoing needs,” Petzing says.

Program administrators always attempt to pair clients with outreach workers who have similar cultural or community ties. For example, Spanish-speaking outreach workers are available to work with women of Hispanic heritage.

And Baby Love piloted a program with the Monroe Plan in which pregnant African-American teens were paired with African-American women who had previously been pregnant teens themselves, and who had overcome the obstacles involved. “They really served as tremendous role models and offered a vision of hope for some of these girls . . . and it really worked well,” says Stankaitis.

### Approach delivers improved outcomes

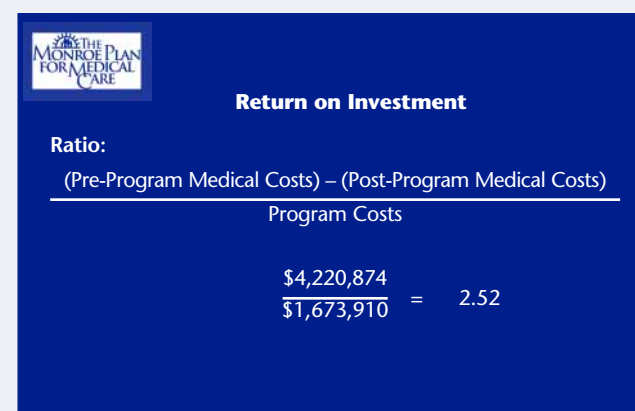
Since the Monroe Plan’s quality improvement efforts began in 1997, there has been gradual improvement in NICU admission rates per 1,000 births. But the most dramatic reduction in NICU admissions—a drop of more than 30 NICU admissions per 1,000 births—occurred in 2003, one year after implementation of the Baby Love outreach program. (See **Figure 2** on p. 57.)

“Clearly, we think that has made a huge difference for us and is probably the major driver for our outcomes here,” Stankaitis says.

There also has been a difference in terms of dollars. He points out that the effort has delivered an ROI of \$2.52, meaning that for every dollar the health plan has spent on the intervention, it has saved more than \$2.50. (See **Figure 3** below.)

In reviewing the health plan’s success, Stankaitis underscores the value of working with community-based organizations and services. “Don’t try to duplicate existing services. It doesn’t make any sense to do that,” he says. “We tried to do some of our own social outreach early on . . . but really, if you have someone in your community already doing this, and they’ve got a lot of experience and know how to manage the system better than you can, don’t duplicate it. Work with them.” ■

**Figure 3**



Source: *The Monroe Plan for Medical Care, Rochester, NY.*

## Consortium aims to guide patients and providers toward better blood sugar control

# New report calls for action on diabetes and its complications

A new report is, once again, sounding the alarm about the state of diabetes care in this country. And this time, the sheer magnitude of the costs and complications associated with diabetes has stunned even specialists who spend every day caring for patients with the disease.

Among other staggering statistics, *The State of Diabetes Complications in America* points out that the country spent nearly \$23 billion in 2006 just on the costs associated with treating the complications of the disease. Further, the healthcare costs of people with complications from type 2 diabetes are three times higher than that of the average American who has not been diagnosed with the disease.

Unveiled in April at the annual meeting of the American Association of Clinical Endocrinologists (AACE) in Seattle, the report is an urgent warning to providers and patients that they are not doing enough to get the disease under proper control. Further, it marks the beginning of a campaign that AACE and partnering organizations hope to use to bring more attention to the problem.

### Ample room for improvement

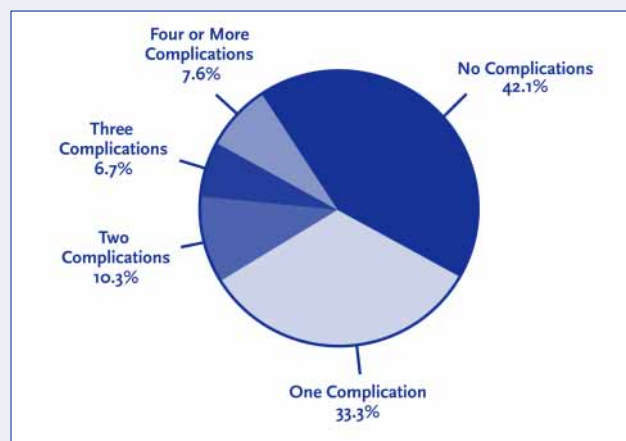
“The earlier you intervene, and the more aggressively you intervene, the lower the risk is of developing complications,” noted **Daniel Einhorn, MD, FACP, FACE**, the secretary of the board of directors at AACE, speaking at the organization’s annual meeting. “What is remarkable about this report is that, despite knowing this, and despite having the tools to control blood glucose, we are still getting this high burden of complications.”

To that point, not only is diabetes the leading cause of new blindness in people ages 20 to 74, but nearly half of all people diagnosed with diabetes have eye damage. In addition, diabetes is the most common cause of kidney failure, accounting for 44% of new cases in 2002. And the disease is responsible for more than 60% of noninjury-related foot amputations, even though comprehensive foot care can prevent a large percentage of amputations.

“We have a new report that clearly tells us we are not getting the job done well enough,” Einhorn said.

In breaking down the costs and prevalence statistics associated with all the major complications from diabetes, the report uses data from the National Health and Nutrition Examination Survey conducted by the National Center for Health Statistics at the Centers for Disease Control and Prevention, and the Medical Expenditure Panel Survey, a collection effort of the Agency for Healthcare Research and Quality, which is cosponsored by the National Center for Health Statistics.

**Figure 4: Prevalence of multiple complications among people with type 2 diabetes**



Source: State of Diabetes Complications in America. American Association of Clinical Endocrinologists.

### Diabetics have more complications

Highlighting some of the report’s findings, **Willard Manning, PhD**, a professor in the department of health studies at the University of Chicago, noted that 57.9% of diabetics have one or more complications from the disease. (See **Figure 4** above.) “These numbers are just incredible in terms of their implications for quality of life, mortality, and healthcare costs,” Manning said.

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## Diabetes

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But those numbers aren't even the worst of it. The cost estimates associated with the disease and its complications are actually quite conservative, he said. "They don't include all of the other economic costs and human costs that are associated with the disease and its complications. What's missing from this [report] are the things that are related to reduced employment, drops in productivity, increases in disability, and of course, the very substantial costs associated with premature mortality."

The report breaks down the complications associated with diabetes into two categories—microvascular and macrovascular. In terms of numbers, the microvascular complications, including kidney disease, retinal disease, and foot problems, are particularly striking, Manning said. (See **Figure 5** below.)

For example, the report suggests that nearly a third (27.8%) of all diabetics will develop kidney disease as opposed to only 6.1% of people who do not have diabetes. And foot problems occur in more than twice as many diabetics (22.8%) as nondiabetics (10%). "I had always known that type 2 diabetics

have more complications than the general population, but I never quite appreciated until the report came out how big the disparity is between diabetics and nondiabetics," he said. "In some cases, we are talking about factors of two, three, and four. That is an enormous difference."

### Road maps guide treatment

With funding support from GlaxoSmithKline, a Diabetes Complications Consortium is now in place to promote awareness of the results of AACE's report, and to help people with type 2 diabetes reduce their risk of complications. Members of the consortium include the Amputee Coalition of America, the National Kidney Foundation, the National Federation of the Blind, and Mended Hearts, Inc. (a support group for heart-disease patients and their families).

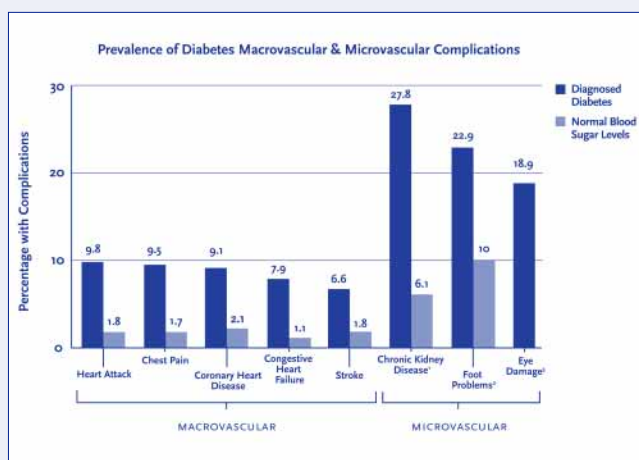
In addition, through its Web site, AACE is distributing diabetes road maps to guide clinicians toward evidence-based treatment of the disease. "It is really an approach to help the medical community achieve good glucose control, and what it suggests are what medications can be used at what point and at what combination," Einhorn said.

As it stands now, clinicians are using the tools available to treat diabetes too late, and the evidence shows that what is needed is earlier and more aggressive intervention, he noted. In fact, AACE is mounting a separate effort aimed at intervening with people before they have even developed the disease.

"We hope to move the discussion to an earlier [stage] of the illness where it is much more treatable and much more manageable . . . You can't choose to not deal with this. The only question is whether you deal with the diabetes up-front or, rather, you deal with it later on, as complications. And that is a message that I think has not been heard clearly enough," Einhorn said. ■

*Editor's note: For more information about the report and the Diabetes Complications Consortium, visit the group's Web site at [www.stateofdiabetes.com](http://www.stateofdiabetes.com).*

**Figure 5: Prevalence of complications in people with type 2 diabetes vs. people with normal blood sugar**



Source: *State of Diabetes Complications in America*. American Association of Clinical Endocrinologists.