

DM DISEASE MANAGEMENT ADVISOR™

**Clinical trials and ROI methodologies
are still on the drawing board**

DM programming moves from the Internet to mobile phones for added impact

One of the primary keys to effectively managing chronic disease is getting patients to the point at which they take charge of their own health. But this is a tall order, especially with diseases as complicated and labor-intensive as diabetes. Just getting people to test their blood sugar on a regular basis can be a huge challenge when they have busy jobs and lifestyles that require them to be constantly on the move.

For all of these reasons, several healthcare technology companies are focused on developing applications that can deliver core DM tasks via mobile phones. The capabilities of these new offerings range from being able to exchange data and other information with patients on an almost real-time basis wherever they are located

to being able to use specially equipped mobile phones to actually test blood sugar and transmit those readings to a central location. And mobile phones are not just being used to manage diabetes; they are being deployed in weight-management clinics and asthma programs, as well as other settings.

Although many of these applications are already on the market, many more are in various stages of development and pilot testing, and healthcare analysts believe that

“Both employers and payers are looking to drive down their costs, and diabetes is obviously high on their list of chronic diseases because of the costs and crossover implications to other diseases and the amount of resources [it requires].”

—Kathi O’Neill

the purely Internet-based DM programs will soon be looking to mobile phones for added power and reach.

Mobile phone applications draw interest

One organization that is keeping a close eye on developments with mobile phones is the Juvenile Diabetes Research Foundation (JDRF). The idea of arming youngsters and teens with cell phones equipped with glucometers or communications tools designed to help them track their sugar and manage their disease is immediately appealing, because younger diabetics are unlikely to resist the allure of a cell phone.

Further, any step toward easing the burden of managing a disease such as diabetes is worth exploring, explains **Aaron Kowalski, PhD**, the research director of JDRF’s Artificial Pancreas Project, an effort focused on building a system whereby a continuous glucose sensor automatically triggers an insulin pump as needed without the patient having to intervene. Kowalski envisions that



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some of the technology needed for a so-called closed-loop system could ultimately be consolidated onto a cell phone. "It is something that is high up on our radar screen," he says, noting that consolidation, convenience, and ease-of-use are very important with diabetics. "It falls under the umbrella of new technologies that we are interested in."

Although the JDRF has not yet funded any studies involving cell phone applications, a number of options are already on the market, and more will soon be available. For example, by the end of this year, Palisades

Park, NJ-based HealthPia America plans to introduce its GlucoPhone, a cell phone that is equipped with a glucometer so that patients can test their blood glucose levels wherever they are and then transmit the readings to a centralized Web location. "It is an automatic transfer to the Web site, so the patient doesn't have to worry about writing it down, or worry about [his or her] computer crashing, or whether [he or she] has the correct software involved," explains **Kathi O'Neill**, president of HealthPia America. O'Neill explains that patients have access to their individual data, but they can also give their providers access through the use of a user ID and password.

In addition to these capabilities, the company is currently pilot testing a program whereby HealthPia transmits a text message to a parent or guardian whenever new blood glucose data from the person's child reach the HealthPia Web site. And O'Neill points out that there is obvious potential in using the GlucoPhone system in pay-for-performance programs in which providers are compensated for their management of chronic disease.

"Both employers and payers are looking to drive down their costs, and diabetes is obviously high on their list of chronic diseases because of the costs and crossover implications to other diseases and the amount of resources [it requires]," says O'Neill. "It consumes 2.4 times the resources of any other chronic illness."

New studies to focus on efficacy

Confidant, a software company based in Research Triangle Park, NC, is already on the market with mobile phone applications that can retrieve data from off-the-shelf home-monitoring devices—such as glucometers, blood pressure cuffs, and scales—and then transmit those data to the company's server, where they are interpreted based on treatment regimen thresholds that have been set for the individual ahead of time.

"Then messaging comes back [to the patient] in virtual real time to help the person understand where they are in terms of managing their disease, as well as to give

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some positive reinforcement,” says **Tom Wall, MBA**, vice president of business development and marketing for Confidant. “Essentially, it is using a mobile phone as a health coach and sort of the center of a support system.”

Wall emphasizes that the messaging built into the software is designed not to tell patients the obvious—that their sugar levels are high, for example—but rather to give them some context that will help them change behavior patterns.

“What we do is look for trends in the data, so, for instance, what a diabetic may not know is that they have a pattern of readings at a certain time of the day,” Wall says. “In some cases, they don’t remember when they last tested, let alone what their last reading was, so rather than reporting that they just posted a 300 reading, we would say that they are consistently high in the mornings, or that they have issues around weekends.” In addition, Wall points out that the software facilitates graphic representations of trends, so that patients can view their data in any number of ways.

Although the patient is getting regular feedback, the caregiver—which may be a provider, DM company, case manager, or payer representative—will receive notices if the patient falls out of certain parameters that have been established ahead of time. In response, Wall notes that the caregiver can send a text message to the patient or give him or her a phone call with specific instructions.

The company is working with a variety of DM companies, payers, and provider groups that are interested in using the phone applications to stay in close touch with chronically ill patients and help them better manage their disease. For example, the company just announced that it is working with Honolulu-based Ho’okele Personal Health Planners, a company that offers a suite of services designed to help chronically ill patients better manage their disease and navigate the

complicated healthcare system. Other customers include a weight-management clinic in North Carolina that is using Confidant applications to stay on top of patients once they have left the clinical setting. “They have participants who come to their campus, spend two to four weeks, and lose a considerable amount of weight, but their issue is that when the patients go back to their routines at home, they lose that structure,” says Wall. “They are using our product in conjunction with some other service offerings they have so that, when people leave the campus, they can take our product home with them and stay connected.”

To date, Confidant has completed several small trials and pilot studies that have been mainly focused on usability and comfort with the technology. However, Wall explains that the company is now in the process of implementing larger pilots that will compare patient groups that have access to the Confidant applications with control groups engaged in usual care. The focus of these studies will be to establish not just comfort with the technology, but also efficacy in terms of clinical outcomes and financial impact.

Patient engagement is critical

San Francisco-based BeWell Mobile Technology offers services that are somewhat similar to Confidant’s, although rather than communicating directly with other devices, BeWell’s programming relies exclusively on patient-reported information. Established in 2004, BeWell offers two main products: its Diabetes Assistant and Asthma Assistant programs—software applications that are customized to address the needs of a particular patient population.

“Our job is to figure out what the clinical team is trying to do clinically so that we can then support that with our technology,” says **Peter Boland, PhD**, business development director at BeWell. “So it really gets down to understanding what are the underlying drivers, the underlying symptoms, and the underlying triggers that relate to [the condition and population.]”

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By mapping out all of the various symptoms and issues that are important to a clinical team to monitor and manage in a given population, Boland says BeWell can then design the software so that it regularly prompts patients to provide feedback about these matters of concern.

Once the patient has inputted his or her responses, the data are transmitted to the BeWell server, where they are analyzed according to parameters that have been established ahead of time by the clinical team. The analyzed data are then transmitted to the caregiver server so that care managers can see which patients are most at risk for exacerbations and therefore require priority attention. "This gives the nurse case manager information on how to organize [his or her] day and [his or her] time and what needs to be done in terms of intervention," says Boland.

In addition to keeping caregivers apprised of the clinical matters that they have stipulated, patients receive almost instantaneous feedback every time they submit answers to questions, says Boland. This information ranges from motivational messaging and education about their condition to trend reports that provide a

graphic representation of the data that have been collected for the past week or month.

"What we are really trying to do is get people to self-manage their disease. That is the real key, and that means they have to have more information about their illness and what they can do about it, and they have to be motivated," says Boland. "We are not just talking about avoiding the ER but [making sure that patients] are on top of their illness, managing their condition, and leading full and productive lives. There are very tangible rewards."

Although BeWell has customers already using both of its initial applications for patient care as well as for research purposes, Boland acknowledges that the pathway to reimbursement is a continuing challenge.

"We are in discussions with some very large DM vendors, and what it comes down to is the ROI," he says. "They just don't have the sense yet of just how powerful this ubiquitous technology can be in healthcare. We are trying to amass the documentation to answer those questions." ■

Reimbursement remains a stumbling block to comprehensive care

New centers aim to provide DM-style, multidisciplinary care to people with ADD/ADHD

The conditions most often referred to as attention deficit disorder (ADD) and attention deficit hyperactive disorder (ADHD) affect anywhere from eight million to 12 million Americans, according to some estimates. However, a large percentage of these individuals has never received a proper diagnosis, and many experts suggest that even those in treatment for the condition are often receiving less than optimal care.

Part of the problem is that both children and adults with ADD/ADHD often have other, related problems as well, ranging from specific learning disabilities to behavioral health problems such as depression and anxiety.

In most of these cases, treatment requires much more than a visit to the doctor's office or a prescription or two. Rather, it may also require ongoing involvement on the part of teachers, coaches, therapists, and other specialists.

Given that these needs do not fit easily into the traditional healthcare delivery model built around 20-minute office visits with a single provider, a group of specialists has begun to offer an alternative approach that attempts to deliver under one roof all of the different forms of care that a person with ADD/ADHD might need. Now available in four cities, with plans for rapid expansion in the near future, ADD Health and Wellness

Centers are not only attempting to give patients and their referring providers the kind of multidisciplinary approach to treatment that guidelines recommend, but also collecting the kind of data that the company's founders hope will soon give providers more definitive answers about the types of therapies that are most effective for this unique population of patients.

Care is fragmented

The healthcare challenges that go along with ADD/ADHD are strikingly similar to the difficulties associated with other chronic conditions that require multidisciplinary care, according to **Robert Baurys**, who is now the CEO of ADD Health & Wellness Centers but previously built a company focused on providing care to patients with fibromyalgia and fatigue. "Like our previous business, the number of people who are diagnosed, or are in the process of being diagnosed or misdiagnosed is almost identical," he says. Further, he emphasizes that in both cases, the highly fragmented nature of healthcare in this country is a huge obstacle to effective treatment.

With respect to ADD/ADHD, Baurys points out that it is typical for there to be several practitioners who don't talk to each other working with a family. "It is an enormous disconnect, and our firm belief is that people are willing to pay a premium if services are very coordinated and customized to their needs."

Whether the approach will be successful remains

to be seen, but Baurys points out that the four ADD Wellness Centers now open in Boston, Dallas, Austin, and Houston, have amassed a caseload of 700 patients in a little more than five months. And although referrals are coming from traditional providers, school guidance counselors, and even employers, the lion's share of families working with the centers comprises families who initiated contact themselves.

An accurate diagnosis is essential

It seems logical that the first step in working with a new patient is getting an accurate diagnosis, but this is a task that is not always done well in the community, according to **Theresa Lavoie, PhD**, the director of psychology services at ADD Health & Wellness Centers. "For us, that means understanding what symptoms are [attributable] to ADHD and which symptoms aren't," she says, noting that many conditions, such as sleep disorders, for example, are associated with attention difficulties but are not ADHD. "Additionally, very often what is co-occurring with ADHD, such as depression, anxiety, or a learning disability, is overlooked and not treated."

To get an accurate diagnosis, Lavoie explains that most patients will undergo a comprehensive neuropsychological evaluation, a process that includes a variety of standardized tests and procedures designed to give clinicians a good sense of an individual's cognitive and

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behavioral abilities. “This always begins with an extensive assessment of someone’s history, so we are looking at clinical history, family history, medical history, academic history, and a general sense of current functioning,” says Lavoie, noting that this initial phase of the evaluation is typically conducted by a psychologist or social worker.

Some patients will not need any further evaluation, but in many cases, patients will then be referred on to a neuropsychologist, who will administer an extensive battery of tests to, among other things, identify discrepancies between an individual’s capabilities or IQ and his or her academic or work-related performance. “[This part of the evaluation] also looks at attention very thoroughly,” adds Lavoie. “We are looking at sustained attention, divided attention, the ability to shift one’s attention, auditory attention, and visual attention.” This is particularly important, she stresses, because many people with ADD/ADHD have difficulty with organization, time management, problem solving, and higher-order reasoning.

Treatment planning emphasizes strengths

The results of the neuropsychological evaluation will determine what interventions come next for most patients. In the case of children or teenagers, Lavoie notes that these interventions often include contacting the school system to request certain accommodations and working with parents to help them understand their child’s needs both in the classroom and at home. Additionally, many patients are referred to a physician for further evaluation—especially in cases in which the psychologist or neuropsychologist believes that medication may offer some benefits.

“Very often, parents are resistant [to putting their child on medication],” says Lavoie, but she still often makes the referral so that parents can, at least, become more educated about when medications can be helpful or not helpful, and get their concerns addressed.

In addition, Lavoie points out that physicians also conduct nutritional assessments, offering families guidance about dietary strategies that can help patients

compensate for their difficulties with attention. For example, although skipping breakfast can affect anyone’s energy level, Lavoie stresses that these difficulties are exacerbated in a person with ADHD. Similarly, she explains that by guiding families toward more proteins and less carbohydrates, patients can avoid some of the spikes in energy, characteristic of some people with ADHD, that are typically followed by emotional valleys or what Lavoie refers to as “crashes.”

Beyond the initial evaluations and consultations, Lavoie notes that most patients continue to come to the ADD Health & Wellness Centers as often as once or even twice a week for therapy or coaching or to attend regular support group meetings. In many cases, these activities are aimed not so much at providing treatment but rather at helping patients develop strategies they can use to overcome the obstacles that go along with ADD/ADHD.

Lavoie refers to the larger process surrounding these activities as asset-based treatment planning. “What we are talking about is helping people understand what their strengths are and how to use them to maximize their performance, achieve their goals, and to function most effectively,” she says.

This may involve helping a child or teenager break down large tasks into small pieces that they can accomplish over time. In the case of an adult, it may involve assistance with career planning.

Interestingly, although most people associate ADD/ADHD with children, Lavoie estimates that 40% of the company’s patients are adults. Many of these individuals have difficulty holding a job, and others may be highly successful at work but have experienced years of difficulty with managing relationships in their personal lives.

Curiously, Lavoie notes that a high percentage of the adult patients who come to the centers for help are entrepreneurs. “If we have a group of 10 people, in almost every instance, seven or eight will be self-employed,” she says. “They may be very successful but struggling with an aspect of ADHD.”

Adults with ADHD come with complications

Treating adults with ADD/ADHD often comes with extra layers of complications, according to **David Rabiner, PhD**, a senior research scientist at Duke University in Durham, NC, who has done extensive work focusing on interventions for ADHD. "For many adults, they didn't just develop ADHD; they have had it throughout their lives, and in the absence of any treatment, that often leads to a variety of difficulties," he says, noting that issues such as depression, anxiety, and substance abuse are not uncommon in these individuals, and they need to be addressed along with the core ADHD.

In addition, Rabiner points out that clinicians usually don't have the same kind of insight into how the person has functioned throughout his or her life or access to as many sources of information with an adult patient. "When you are [dealing] with a child, you often know how they are doing because you have the child there, and you are speaking to their parents and teachers," says Rabiner. "But when you are speaking to a 25- or 35-year-old adult, your only source may be that adult."

Despite a growing awareness of ADD/ADHD in adults, Rabiner suggests that internists may not be as attuned as pediatricians are to the problem. And he notes that there is no question that there is a large population of undiagnosed adults who could benefit from treatment.

Consequently, although Rabiner is not involved with the ADD Health & Wellness Centers, he believes that the idea of offering a cadre of care services and interventions, all coordinated from a central location, is attractive in the case of both adults and children.

"In many communities, if parents want to get good, state-of-the-art evaluation and treatment for their child with ADHD, they just don't know where to go," he says. "There are some pediatricians who do an excellent job with this, but there are others who just don't have the time or experience to do that, and there are many kids with ADHD who have more complex kinds of cases where a multi-model approach that incorporates a number of different interventions may be quite necessary."

Outcomes data will offer specifics

Finding state-of-the-art care is difficult in many communities, but the biggest obstacle to effective diagnosis and treatment of ADD/ADHD may well be the reimbursement policies of payers.

Although some children with less complex cases respond well to medication or straightforward behavioral therapy, Rabiner points out that few traditional practitioners have the time to carry out the kind of thorough, comprehensive approach to evaluation and treatment recommended in guidelines that have been established by the American Academy of Pediatrics.

Although the ADD Health & Wellness Centers do not submit claims but rather provide clients with the appropriate paperwork to handle that aspect themselves, Lavoie acknowledges that clients have had great difficulty obtaining reimbursement for neuropsychological evaluations and some of the other services as well. Also, Baurys points out that clients with preferred provider organization coverage tend to have better success at obtaining out-of-network reimbursement for services than do clients with HMOs.

However, by collecting and publishing outcomes data, Baurys is hopeful that traditional payers will ultimately see value in the multidisciplinary approach offered through the centers. To assemble these data, personnel from the centers plan to test clients at no charge every 90 days, looking at parameters that correlate highly with attention as well as depression, anxiety, quality of life, and self-reported symptoms.

When this information is reported in conjunction with financial data, Baurys believes that traditional payers will take notice.

"When people come to us . . . we see how many tests they have had, how many times they have been to different therapists, and how many medications they have changed back and forth. You just see an enormous waste in the system," he says. "I think as we publish our outcomes data, and we can show specifics . . . about what people are getting, we will have a much firmer foot to stand on in terms of validating [our position] in the marketplace." ■

Strategies aim to support PCPs and target gaps in care

Medicaid programs find opportunities for improvement in complex patient populations

Aged, blind, and disabled (ABD) Medicaid beneficiaries are among the most complicated and expensive patients to manage. Although they account for less than one-third of all Medicaid enrollees, they are responsible for nearly three-quarters of the agency's healthcare spending. However, this population also presents multiple opportunities for cost savings, according to **Melanie Bella**, senior vice president of the Center for Health Care Strategies (CHCS) in Hamilton, NJ. Speaking during a teleconference cosponsored by CHCS and the Government Innovators Network at Harvard University's John F. Kennedy School of Government in Cambridge, MA, Bella stressed that realizing sustained financial benefits from this population requires strategic vision rather than simply slicing reimbursements and services.

"These [strategies] are not getting at the root cause of spending, which really has to do with utilization, whether it is misuse, overuse, or underuse of services," she said. However, what can work, according to Bella, are quality improvement interventions that are targeted toward the true drivers of healthcare spending in this population. And as subsequent speakers at the conference illustrated, this is where effective case finding, DM,

and comprehensive solutions can make a significant dent in both clinical and financial returns.

P4P program drives improved outcomes

The teleconference "Medicaid Best Buys: Managed Care Models for Aged, Blind, and Disabled Beneficiaries" was held on May 29 and was the fourth in a series of CHCS-sponsored presentations focused on disseminating strategies that the organization believes can offer the most powerful returns—from both clinical and financial standpoints.

David Kelley, MD, MPA, chief medical officer for Pennsylvania's Department of Public Welfare, outlined several strategies that his state has implemented as part of Access Plus, a fee-for-service program operating in 42 rural counties and covering about 290,000 lives. "In this model, we are trying to establish for both kids and adults a medical home," said Kelley, describing the program as an enhanced primary care/case management model. However, because the population includes a high percentage of recipients with chronic diseases and other complex healthcare needs, a primary focus of the model is to provide support, in terms of specialty care and care coordination, to PCPs who are the centerpiece of the medical home concept.

Consequently, the state has put in place a complex case management unit, including 24 full-time RNs, to help manage and coordinate care for those patients with highly complex needs. In addition, the state is working closely with McKesson Health Solutions, a Broomfield, CO-based DM vendor that is providing services to patients with diabetes, coronary artery disease, CHF, asthma, chronic obstructive pulmonary disease, and the array of comorbidities that typically go along with these diseases.

"McKesson mainly uses a telephonic model [originating] from both Colorado and Pennsylvania, but there are

Figure 1

Clinical Results 12 Months

- Asthmatics taking inhaled corticosteroids increased from 60% to 67%
- Heart Failure patients monitoring weight daily increased from 42% to 74%
- COPD patients able to recognize disease exacerbation increased from 32% to 63%
- Consumers with Coronary Artery Disease
 - Taking aspirin increased from 79% to 85%
 - BP systolic <140 increased from 83% to 94%
 - Statin use increased from 80% to 88%
- Diabetics with LDL < 100 increased from 15% to 33%
- Diabetics taking aspirin increased from 36% to 61%

Source: Office of Medical Assistance Programs, Pennsylvania Department of Public Welfare.

also community-based nurses involved as well as community-based, nonclinical care coordinators in the field to help coordinate services," said Kelley. "The other thing that is very important in working with McKesson is the coordination between their DM nurses and our special needs unit nurses, because many times, they are handing off cases to one another."

To get providers engaged in the DM process, McKesson also oversees a pay-for-performance (P4P) program that applies chiefly to PCPs who provide a medical home for Access Plus patients. "We are paying providers to assist with DM enrollment and for identifying appropriate candidates for DM," said Kelley. In addition, providers can receive P4P funds for encouraging patients to participate in DM, for participating in care plan development, and for completing certain disease-specific evidence-based care practices.

"We pay for the additional effort that we know goes on in the care of very complex patients," said Kelley. And 12-month data suggest that the approach is delivering improved clinical outcomes on a number of measures. (See **Figure 1** on p. 80.)

In addition, Kelley noted that half of all DM participants dropped from level three, the highest severity level of illness, to level one or two. And he pointed out that conservative calculations suggest that one-year cost-savings from the DM program are in the \$27 million range. "We feel confident in that number. We feel [it represents] true cost savings attributable to the DM population," said Kelley, adding that the ROI was about 1.3.

IT system links critical data sources

Noting that the typical ABD high-utilizer has no PCP or medical home and frequently uses the ER for primary care, it is easy to see how expenses pile up for these complex patients, particularly when you consider that there is often very little information linking these various points of utilization and no integration of pharmacy, laboratory, or behavioral health data, explains **Coleen Kivlahan, MD, MSPH**, senior vice president of medical affairs for Schaller Anderson, Inc., an Arizona-based healthcare

company that manages more than 100,000 ABD recipients in several states. This is precisely why Schaller Anderson decided to invest heavily in IT with the aim of finding out who these patients are and where opportunities exist for improved care coordination, added Kivlahan.

The process begins with predictive modeling software that Schaller Anderson uses in concert with pharmacy data, and a series of risk tools to identify which patients are at highest risk. "We are looking at 12-month claims costs across the board, including labs, durable medical equipment, procedures, and pharmacy. And then, finally, we look at care gaps or evidence-based care concerns or considerations for these patients," said Kivlahan, noting that all of this information is then consolidated on a single IT system. (See **Figure 2** below.)

The analysis ultimately ranks all members in a searchable database so that health planners can focus in on high-risk patients, particular patient populations, or groups of patients with specific characteristics. Further, Schaller Anderson has implemented a tool that alerts care managers every time a member is in the hospital. "The combination of predictive modeling and this [prediction tool] in the hospital gives us a great sense for what is happening to all of our members in real time," said Kivlahan.

Generated from all of this information are care plans

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Figure 2

Our Predictive Modeling tool includes:

- **Predictive Risk Score** -- Multiple factors, including the Medicaid Rx, a pharmacy based risk adjustment tool, are used.
- **Chronic Care Risk Stratification** -- Members are stratified on the basis of their compliance or adherence to program goals and outcomes, and ranked by the risk of future avoidable costs that each enrollee represents.
- **Co-morbidity** -- Each member is assigned additional algorithm weight if a significant co-morbid condition is identified. Predictive Pathways uses the Charlson Index to identify and apply additional diagnostic weight for those conditions having significant morbidity implications.
- **Impact Rating** -- A member's primary condition is assessed and scored based on the possible level of impact from care management on the member's financial and clinical outcomes.
- **12-Month Claims Cost** -- A rolling 12 months of claims cost (pharmacy, medical, DME, procedures, lab, etc.) (excluding trauma and maternity) is calculated. Cost is stratified into high-cost, moderate and low-cost enrollees, with higher weights given to those members having higher accumulated costs.
- **Care Gaps** -- The presence or absence of evidence-based effective interventions for each of the four conditions in disease management: CHF, COPD, Diabetes and asthma.

Source: Schaller Anderson, Inc., Phoenix.

Medicaid

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that target interventions and clinical tasks toward those patients most in need of these services. Kivlahan noted that the care plans are made available electronically to both providers and patients. In addition, at two sites, Schaller Anderson has begun to make available to providers and patients summaries of the predictive modeling analyses so that they can incorporate care plan changes, and have them disseminated to all of the appropriate stakeholders, with approval from patients.

Kivlahan did not have any outcomes to share about the approach, but she noted that Schaller Anderson hopes to eventually further enrich its data resources with self-reported information about functional status and quality-of-life indicators. “We would also love to see expansions in social and behavioral health indicators collected on all of these members, and we have begun to do that now in several states,” she added.

Support for PCPs is the priority

With just 230 employees, Portland, OR-based CareOregon is a tiny health plan with limited resources. Consequently, rather than providing financial incentives for providers, the plan has taken a different tack in engaging providers to manage the complex ABD population in its CareSupport program. “For us, it has been really important to create partnerships and relationships with our PCP base to create medical homes and to really convince them that they can deal with this complex population,” explained **David Labby, MD, PhD**, medical director of CareOregon.

To do that, Labby explained that the plan focuses much of its energy and resources on supporting PCPs by providing them with care coordination assistance and by taking steps to activate patients. “A lot of our patients aren’t treatment ready; they don’t know how to do a doctor visit, and they don’t know how to do self-management,” said Labby. “So a lot of the coaching and engagement that we do is actually to get them to take advantage of what would be a medical home.”

To support providers, the health plan has brought in pharmacists, social workers, and what they call health-care guides—nonclinicians who implement patient reminder calls and other administrative tasks that do not require clinical skills—in order to create multidisciplinary teams capable of managing complex patients. “We have teams with all of these components assigned to clinics so they know the nurse to call or the social worker to call,” said Labby. “We want to be sort of an extension of the PCP office.”

The plan has implemented rounds whereby the multidisciplinary teams regularly discuss cases and conduct assessments. Initially, these rounds were “clunky” and inefficient, but by standardizing procedures, Labby noted, the plan has streamlined the process to the point at which the teams can now review several patients very quickly. In fact, the plan has attempted to standardize as many processes as possible, including the assessment that patients go through when they are identified for being included in the CareSupport program. “It takes about 40 minutes, but we go through all the domains [outlined in the chronic care model] to understand what their drivers of risk are because we are looking for modifiable risk,” he says.

Through this process, what the plan has learned is that some of the major drivers of risk are related to problems with decision-making and memory. Consequently, Labby said, a major focus of the health plan has been to guide people toward effective decision-making and to give them strategies that can help them remember important self-care tasks.

By helping patients to overcome such barriers, Labby noted, the plan is freeing up providers to focus on medical care. And he pointed out that early data suggest that the approach is resulting in significant cost reductions. “It is our feeling that the closer we get to integrating with the provider office and the more we support what they are doing, the more effective we will be,” he said. “We are now trying to figure out ways in which we can move the case management process actually into the provider office [as well].” ■

Group leaders hope to nurture innovative reforms at the state and national levels

Broad-based coalition aims to make chronic disease a top priority for policymakers and presidential candidates

Chronic disease is taking a devastating toll on this country, causing seven of every 10 deaths and accounting for 75% of the \$2 trillion spent each year on healthcare, according to the Centers for Disease Control and Prevention. And a new, broad-based coalition is warning that this burden will only increase unless steps are taken to transform the current healthcare delivery model from one that focuses on acute care to a system that emphasizes prevention.

The Partnership to Fight Chronic Disease (PFCD), a group representing more than 50 organizations from healthcare, labor, and business, is launching an aggressive campaign aimed at nurturing innovative solutions to the problem at both the state and national levels, and making sure that the issue is a centerpiece of the debates leading up to the next presidential election.

Leadership is critical

Leading the coalition's effort is **Richard Carmona, MD, MPH, FACS**, the 17th Surgeon General of the United States, and **Kenneth Thorpe, PhD**, chair of the Department of Health Policy & Management in the Rollins School of Public Health at Emory University in Atlanta and a former White House health policy advisor. But the group also includes representatives from provider organizations, healthcare insurance companies, pharmacy associations, the DM industry, and labor groups. Although there are areas of disagreement among many of the participating organizations, they have nonetheless reached consensus about a number of specific goals.

"One is for the [presidential] candidates to talk about the cost of healthcare and then have them put into place proposals that attack the real, true problems," says Thorpe, noting that the PFCD wants to see specific proposals for curbing the prevalence of chronic disease, and system reforms that will address the need for health information technology as well as fundamental changes in the

healthcare delivery model. "The idea is to see if we can have an influence on the construction of the healthcare reform proposals, or at least the way [policymakers and candidates] think about it," he says. What is clear is that the delivery model and the payment system currently in place are not effective for managing patients with multiple conditions, he adds.

Further, Thorpe notes that it will take leadership to lay out what the best delivery model should look like and how the country should pay for it. "It is not going to evolve on its own," he says. "Leadership has got to come out of Congress and the President, and the reform changes have to be driven through the Medicare program and then secondarily through the Federal Employees Health Benefit Program. That way, you can leverage the changes to the commercial market nationwide."

Early intervention worth considering

Success in managing chronic disease in the Medicare population is important, but policymakers should also consider the clinical and financial opportunities presented by addressing chronic disease at an earlier stage, according to **Tracey Moorhead**, the president and CEO of the Disease Management Association of American (DMAA), another group that is participating in the PFCD.

"Medicare is, I believe, playing catch-up with DM programs that have been proven successful in a variety of state Medicaid programs and populations and also certainly in the commercial sector," she says. "We have any number of case studies and peer-reviewed literature in commercial populations and also a growing body of evidence that some of the very innovative state Medicaid DM programs are showing that DM is an effective intervention for both improving healthcare outcomes and reducing healthcare costs in unique populations."

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Moorhead adds that she believes many of these successes can be transferred to appropriate segments of the Medicare population.

Conventional wisdom would suggest that prevention programs implemented at the pediatric stage stand the best chance of improving outcomes and controlling costs. The problem is that there are no data to support this supposition, notes Moorhead. "The type of dynamic, financial, long-term scoring model that you would need to estimate that isn't currently used by the federal government," she says.

However, without long-term data about early intervention, the evidence is clear that chronic disease is often preventable. Consequently, Moorhead would like to see policymakers address the need for more preventive interventions and education. "Helping people to understand the need for—and how to live—a healthy lifestyle would be an excellent first step," she says.

For example, Moorhead would like to see coverage for regular screenings for diabetic conditions, education for healthy behaviors, and recognition that DM programs that affect the prevalence and severity of chronic disease can influence clinical outcomes as well as costs.

Support builds for medical home concept

Consensus is building among coalition members that the medical home concept—an approach that prioritizes coordination of care from a central, primary care base—offers the best approach toward prevention and effective management of chronic disease, according to Thorpe. He points out that provider groups such as the American Academy of Family Physicians and the American College of Physicians favor the approach, because it integrates the PCP into the delivery model.

However, he acknowledges that this type of model simply doesn't exist today, because the system of reimbursement does not support it and the technological tools are not in place to give the physicians the ability to effectively manage such a model. "It has to have some

leadership saying that this is the best practice model, and we want to have it widely diffused," he says.

Moorhead emphasizes that DMAA supports the concept as well, noting that every patient, and particularly those with chronic diseases, should have a medical home. "Our concern as an organization representing the DM industry is that many of these patients see five, six, or more physicians of varying specialties, and the role of DM is to play the coordinator . . . to insure that all of the players on a healthcare team serving one patient are coordinated and communicating," she says.

Thorpe says the problem with current DM programs is that they tend to work around the PCP, and as a consequence, physicians are highly resistant to such efforts. However, Moorhead maintains that most of the prominent players in the DM arena now fully appreciate the importance of establishing a collaborative relationship with the physician, and they are actively engaged in nurturing such relationships. "The medical home should reside with the physician," she says.

States offer an immediate opportunity

In addition to making sure that the presidential candidates address healthcare reform, the PFCD is also working to establish state chapters to nurture many of the reform efforts that have already begun at the state level.

Thorpe points out that policymakers in Vermont have taken steps to promote adoption of the medical home practice model on a statewide basis. And other states such as New Jersey and Illinois are considering similar reforms. "There are governors out there saying that they need help in trying to figure out how they are going to control health care spending," he says. "They are moving on this, so we think by establishing state chapters we can have an immediate impact." ■

Editor's note: For more information about the PFCD, visit www.fightchronicdisease.org.