Quality improvement positively affects clinical and financial outcomes

Patient- and provider-focused interventions get results in behavioral health patients

Studies suggest that nearly half of all physician office visits involve an underlying behavioral health issue. Further, there is no question that a large percentage of patients with a behavioral health condition seek treatment from a PCP rather than a mental health professional. However, many traditional providers feel ill-equipped or uncomfortable treating behavioral health disorders—a reality that often results in patients being undertreated or treated inappropriately for their behavioral health issue. And the inevitable result of substandard care is increased utilization, with little to show for it.

Given that this problem is well recognized, some organizations have developed novel solutions that are delivering promising results. For example, a number of state Medicaid programs are benefiting from an analytic approach developed by White Plains, NY–based Comprehensive NeuroScience (CNS) that provides decision support to providers with the aim of bringing their prescribing of behavioral health medicines in line with evidence-based guidelines. Alternatively, CIGNA Behavioral Health (CBH), based in Eden Prairie, MN, is reporting favorable clinical and financial results from a patient-directed intervention aimed at preventing ER visits and hospital admissions among patients at high risk for such utilization because of their behavioral health diagnosis.

Intervention delivers dividends

With the intention of preventing readmissions, CBH spent years investigating methods of interacting with patients who had been hospitalized with a behavioral diagnosis. “We studied things such as mailing them letters, creating Web reminders, and a whole host of options,” explains Jodi Aronson Prohofsky, PhD, LMFT, senior vice president of clinical operations at CBH. “But what we found really worked best was having a one-to-one, dedicated care advocate to help them understand their disease, their issues, what was [affecting] them, and what could cause a decompensation.” In addition, Prohofsky notes that the advocate could help patients navigate the system, especially during times of crisis.

Investigators first tested the approach in the context
of a small pilot at a single site, and what they discovered was that not only did the care-advocate intervention decrease readmissions, it also had a positive effect on member satisfaction and staff satisfaction, says Prohofsky. She explains that staff appreciated the ability to follow patients on a more longitudinal basis.

At the conclusion of the pilot, CBH expanded what it now calls its Intensive Care Management (ICM) program to its entire book of business and launched a larger study aimed at taking a closer look at what factors the approach was affecting. For this yearlong study, investigators looked at 286 participants in the ICM program who had a primary behavioral diagnosis as well as underlying medical comorbidities. In addition, every participant had at least one inpatient psychiatric hospital admission. Outcomes from this intervention group were then compared with outcomes from a matched control group of 517 CBH members who did not participate in the ICM program.

Investigators analyzed a full year of medical, behavioral, and pharmacy utilization data for participants in the intervention and control groups. What they found was that the intervention group significantly outperformed the control group on a range of measures including a 53% reduction in hospital admissions, a 52% reduction in ER visits, a 13% decrease in nonmental health outpatient visits, and per-patient savings of $3,134. In addition, medication compliance among intervention group participants increased by 14.9%, and total outpatient costs remained flat from preenrollment to postenrollment.

(See Figure 1 on p. 99.)

Care advocates connect with patients

The study targeted individuals with both behavioral diagnoses and medical comorbidities because investigators wanted to document the effect the program can have on both behavioral and medical health. “As we were beginning to work with people, and we were keeping them compliant with their behavioral program, we were finding that they were naturally taking that compliance to their medical program,” says Prohofsky, noting that the care advocates help patients understand the importance of coordination of care.

However, Prohofsky says that a medical comorbidity is not a requirement for enrollment in the ICM program, which is primarily concerned with the behavioral health issue. Further, although the program targets members who have undergone an inpatient psychiatric admission, it also utilizes predictive modeling to identify and enroll members who are at risk for a first inpatient admission.
Even though care advocates primarily communicate with patients by phone, Prohofsky explains, they have a high degree of success in making an initial connection with patients because they make every effort to reach patients while they are still hospitalized or while they are in the doctor’s office on an outpatient visit. “Then we send the individual a follow-up letter to remind them [of] why we spoke, or if we couldn’t reach them, why we are trying to make contact,” she says. “And then from there, once the patients get connected with their care advocate, they are told that this is the person who will work with them from here on forward.”

The care advocates—typically psychologists, social workers, mental health counselors, and nurses—stay in contact with patients on a weekly or even daily basis, as needed, explains Prohofsky, noting that they schedule their phone appointments at the convenience of the individual. During these conversations, the advocate will work toward making sure that the member understands his or her diagnosis and medications. In addition, the advocate will help the member to identify early warning signs of difficulty so that he or she can take steps to address them before they become crises. Further, Prohofsky explains that the advocate and the patient will work together to identify a support system as well as important phone numbers that the member can call if he or she needs help. “It doesn’t replace the therapeutic

> continued on p. 100

**Figure 1: Standard MM.4.10**

<table>
<thead>
<tr>
<th>Pharmacy Compliance</th>
<th>Total Outpatient Costs</th>
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<td>Study Group</td>
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<tr>
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<td>Compliance with Non-Pharm Meds</td>
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<th>Inpatient Utilization</th>
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<td>Study Group</td>
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<td>Total Inpatient Costs</td>
<td>$2,182</td>
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<tr>
<td>Inpatient Admits</td>
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Source: CIGNA Behavioral Health, Eden Prairie, MN.
relationship or the medical relationship, but it becomes yet another relationship for the members, and we find that they are quite connected to it,” says Prohofsky.

When issues arise, such as a troubling side effect that is preventing the member from taking medications as prescribed, the advocate will encourage and prepare the member to discuss the issue with his or her provider. If this approach fails, either through misunderstanding or other barriers, the advocate will work directly with the clinician to resolve the problem. Prohofsky says that these contacts are usually well-received by providers, because they often have no idea that the patient stopped taking the medication or that there was even a problem.

Typically, as patients develop more knowledge and self-confidence in managing their behavioral health, contacts with the care advocate will begin to decrease, and eventually the patients will graduate from the program. However, Prohofsky notes that there is no firm timetable as to when graduation occurs. “Members have their advocate’s name and number, and they can reactivate the advocate at any time they feel they need to in the future,” she says.

Program focuses on prescribing

Although the ICM program includes some interaction with providers, it is primarily a patient-centered intervention. Alternatively, the approach developed by CNS is focused exclusively on the provider, but it too is delivering impressive results in many of the 25 state Medicaid programs the company is working with.

The program goes by different names in different states, but CNS refers to it as the Behavioral Health Pharmacy Management Program. Using a set of 150 different algorithms, the approach involves evaluating all pharmacy claims for mental health medications in order to identify practices that are inconsistent with evidence-based guidelines. When a potential problem or inconsistency is identified, CNS contacts the provider to let him or her know about the issue.

“We send a notice to the physician basically saying [what we have observed], and here is a 90-day history on the patient, and here are some things that we recommend that you consider,” explains Richard Surles, PhD, senior vice president of care management technologies at CNS. Surles says the company understands that there are often special considerations that go into prescribing, so CNS is simply asking providers to review the information that the company has provided. “We start out with a letter that has backup information. If the physician doesn’t respond, we have the ability to do a psychiatric peer-to-peer consultation [by phone],” says Surles, noting that the discussion always pertains to use of the medication rather than the patient.

In many cases, Surles explains, these communications deal with prescribing that is above or below recommended dosing levels, premature switching from one medication to another, or the prescribing of multiple medications from a single class. However, he adds, a large percentage of the notifications provide important information to the provider that he or she would not otherwise know about, such as duplicative prescribing of medications by different doctors who are seeing the same patient or the failure of patients to refill their medications as directed by their provider. “We get very good feedback from pediatricians and PCPs because generally they are out there by themselves, and many times we are bringing things to their attention that they have not thought about,” says Surles.

QI intervention affects costs

Although the program was developed as a quality improvement initiative, Surles acknowledges that most customers come to CNS because they are concerned about spiraling costs related to behavioral health medications. “Antidepressants are mostly generics now, but the big expense comes from the typical antipsychotics, bipolar medications, and, interestingly enough, drugs for children,” says Surles, noting that both stimulants and
There is a growing consensus among business and healthcare policy experts that the steep hikes in health-care costs that we have seen in recent years are economically unsustainable, and that the only way to get healthcare spending under control is by implementing fundamental changes in the way we fund and deliver care. Further, it’s clear that the heart of the problem is the escalating incidence of chronic disease in this country and the substandard care that chronically ill patients routinely receive. Study after study suggests that most people receive only about half of the care that is recommended for their conditions, and this inevitably leads to a vicious cycle of spending as preventable complications develop, making care and treatment increasingly expensive.

It’s a complicated problem, but at least it now has the full attention of business leaders, policymakers, and providers. This was evident as key representatives from all of these sectors recently shared their concerns and ideas about potential solutions in a summit sponsored by the Intel Corporation titled “Chronic Care at the Crossroads: Exploring Solutions for Chronic Care Management.” The meeting, held in Washington, DC, on July 17, facilitated a wide exchange of proposals about chronic care management.

Experts agree that chronic care management is essential to controlling costs

Key stakeholders debate the best pathway to healthcare reform

According to data released by several state customers who are working with CNS, the program has delivered significant dividends. In Missouri, for example, state investigators report that in a study comparing 1,911 intervention participants with a matched control group, hospital admissions declined by 43% in the intervention group and just 0.1% in the control group. In addition, there was a $1,238 decrease in costs per person in the intervention group and a $312 per-person decrease in the control group. The study period compared data from six months preintervention to six months postintervention.

In Oklahoma, investigators report that the program has helped to keep costs related to behavioral health medications relatively constant when most states are seeing steep hikes. However, Nancy Nesser, PharmD, JD, pharmacy director of the Oklahoma Health Care Authority, explains that there have been other advantages as well. “We decided to [offer the program in 2004] as an alternative to putting restrictions or prior authorization [requirements] on the antipsychotic medications,” she says. “We as an agency didn’t feel that going through the restriction process was the most beneficial thing to do for our patients, and so we opted to go an educational route.”

There are nearly 56,000 adults and 39,000 children taking behavioral medications within Oklahoma’s Medicaid program, so the program affects a significant number of recipients. Further, Nesser notes that there is evidence that providers who have received program notifications regarding their prescribing tend to change their prescribing patterns to be more in accordance with evidence-based practice over the longer term.

In Oklahoma and many other states, the CNS program is funded through grants from Eli Lilly and Company, although it is not known how long this funding will continue. In the meantime, CNS has begun to expand the program beyond the Medicaid arena. “We are moving to Medicare Advantage [programs] and also Medicare Part D, and so that is a major change for us,” explains Surles. “We have put a lot of time and effort into improving our elderly program, not only updating our indicators but also adding a falls prevention component based on the combinations of medications that can produce dizziness and nausea—symptoms that can lead to falls and injury.”

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Chronic care management  < continued from p. 101

how to refashion a system largely focused on acute care into one that promotes wellness and prevention.

Costs continue to escalate

Intel Corporation’s interest in sponsoring the summit came, not only from the fact that the company is working on a number of technological innovations related to management of chronic disease, but also because it is providing healthcare benefits to 55,000 employees in this country, noted Craig Barrett, chairman of the board of Intel, in his opening remarks. “We [at Intel] spend somewhere in the range of 600 million dollars [on healthcare] today. By the end of the decade that probably will be closer to a billion dollars a year on healthcare costs,” he said. “And anything that we spend on healthcare detracts from what we can do from a product development standpoint.”

Further, Barrett noted that he is troubled by the fact that the health reforms proposed by most of the presidential candidates deal almost exclusively with how to insure the 45 million people in the country who are now without coverage. “Not many people are talking about what to do in detail to change the way healthcare is delivered, or much about changing the cost of the healthcare system,” he said. “As the baby boomers age and we get more and more people over the age of 60, costs are going to increase. The issue is what can we do about it?”

One of the biggest problems is that the current healthcare delivery system is not geared toward preventing chronic illness or taking care of the chronically ill, and yet chronic illness accounts for as much

Caregivers: The second victims of chronic disease

The contributions of informal caregivers toward supporting the chronically ill take a huge toll on the caregivers’ own health and well-being, said Janice Kiecolt-Glaser, PhD, director of the division of health psychology in the department of psychiatry at Ohio State University College of Medicine. Kiecolt-Glaser spoke at “Chronic Care at the Crossroads: Exploring Solutions for Chronic Care Management,” a summit sponsored by the Intel Corporation on July 17 in Washington, DC.

The significant physical and mental repercussions that go along with the caregiving role are not well recognized, said Kiecolt-Glaser, who has performed extensive research into the effect of caregiving. She noted that it further compounds the problem of escalating healthcare costs. “Caregivers suffer enormously. They really are the second victims,” she said. “Caregivers don’t respond to influenza and pneumococcal vaccines as well as noncaregivers, so it means [that] they are going to be at risk for those diseases.”

Similarly, Kiecolt-Glaser noted that wounds don’t heal as rapidly in caregivers as in noncaregivers, and they are at greater risk for a whole host of chronic problems, frailty, and functional decline. “What makes it even worse is that when we study caregivers after they have stopped caregiving, we think they are going to recover,” she said. “But in fact they don’t. It appears that there may be premature aging of the immune system, and this may be because caregivers have lost part of their lives.” Kiecolt-Glaser added that at least one study shows that caregivers have a 63% higher mortality rate than noncaregivers during a four-year period.

Despite the significant sacrifices that caregivers must make, the people who take on these responsibilities typically go without recognition by the healthcare system, said Suzanne Mintz, president of the National Family Caregivers Association and a longtime caregiver herself. “There is pretty much a lack of respect in the system for the role of the family caregiver, when in fact we are very critical to the healthcare team and already save the system close to $3 billion a year by conservative estimates,” she said.

Also important to factor into the equation is the reality that industry loses as much $33 billion per year to lower productivity and employees having to leave the work force to take on a caregiving role, added Mintz. “There are costs to everybody.”
as 70%–80% of healthcare spending, according to Mark McClellan, MPA, MD, PhD, a former CMS administrator and a former FDA commissioner. “Our healthcare system is really designed to focus on acute illness and exacerbations of problems rather than on keeping people healthy in the first place. So that is the fundamental change we need to make, and the benefits of this change would truly be tremendous,” said McClellan.

For example, according to the Centers for Disease Control and Prevention, most of the diabetes and heart disease in this country are preventable through behavioral steps, said McClellan. “If we had been able to hold obesity levels . . . to the same level that they were in 1987, our healthcare costs today would be at least 10% lower,” he said. “That would be $200 billion per year that could go further toward keeping our costs down or helping people get access to quality care.”

Further, McClellan noted that once people become chronically ill, the healthcare system fails to provide adequate treatment and support. “A lot of the responsibility for trying to help people comply with medications and get the support services they need doesn’t even fall within the scope of the way we think about healthcare. It falls on family members and informal caregivers, so we need to rethink all of this.” (See sidebar on p. 102.)

**Huge obstacles remain**

One of the big pieces missing from the current system is the ability to get paid for providing coordination of care, according to Michael O’Dell, MD, chair and director of the family medicine department and residency program at North Mississippi Medical Center in Tupelo. “A lot of us are trying to change. There is clear recognition that our healthcare system is broken, and there is widespread support among providers for change in the system,” he said. “The problem you get into is that you have to see 24 patients a day before you actually start putting money in your own pocket to take home to your family, and when you are running at that kind of pace . . . it is awfully difficult to carve out time [for care coordination].”

In fact, McClellan noted that physicians all across the country are taking steps to implement beneficial reforms such as establishing disease registries, implementing IT into their practices, and forming integrated methods of delivering care or focusing on prevention. However, he added that there are huge obstacles. “All of these things in our current healthcare reimbursement environment typically cause [providers] to lose money,” he said, noting that physicians lose money when they order fewer tests or when they don’t need to see their patients as frequently, and hospitals lose money when they don’t need to treat patients as intensively or when they take steps that reduce the rate of readmissions. “Until we do a better of job of supporting [preventive] care, it is going to be very difficult for providers who want to do the right thing to be able to get the financial support they need to do it.”

There is no question that calling for reform is much easier than making it happen in an environment where multiple stakeholders have their own agendas, but Barrett suggested that the business community may be in the best position to usher in reform. “Systems only change rapidly when the people who have the buying power demand that they change,” he said. “No one has really picked up the issue of how do you get better healthcare, more efficiency, more productivity, and higher quality at the same or lower cost.”

Barrett noted that CMS pays for as much as 50% of the healthcare provided in this country, but added that the agency’s hands are largely tied by the legislative process. Although CMS is conducting numerous pilots and demonstrations related to chronic care delivery, Barrett said the agency cannot move as quickly to implement change as private payers. “I am disappointed in the other half of the payers,” he said. “The business community has been absolutely AWOL in this discussion until recently.”
For years, the way providers have assessed the risk of fracture in aging patients is by looking at bone mineral density (BMD), as measured by bone densitometry. But consensus is emerging that a much better way to assess fracture risk is by taking into account BMD measures or T-scores in combination with other key risk factors, especially age and previous fractures. In fact, investigators report that at least some clinical guidelines will soon recommend that clinicians adopt a new approach toward assessing risk that uses a formula that considers several different weighted risk factors to estimate what they are calling absolute fracture risk.

The new approach will first be outlined by the World Health Organization (WHO) in a technical document that the organization is expected to publish by the end of this year. But experts tell DMA that prominent U.S.-based organizations such as the National Osteoporosis Foundation (NOF) will quickly follow WHO’s lead in publishing guidelines of their own that are reflective of WHO’s work.

The move in this direction is based on years of extensive research into the various factors that contribute to the risk of fracture, and it is expected to trigger a significant change in the way providers determine when and whether to prescribe treatment for patients who exhibit signs of bone-thinning disease. Although providers will still have to rely on their clinical skills to make individualized treatment decisions, experts familiar with the new approach tell DMA that it will offer improved guidance about how to proceed.

**New approach is an improvement**

Currently, providers generally use T-scores to determine whether to prescribe treatment that can enhance bone preservation. This is based on cut-points that WHO established in 1994 in order to have operational definitions for osteoporosis, low BMD or osteopenia, and normal BMD. The problem with these definitions, however, is that they don’t tell the whole story, according to Ethel Siris, MD, director of the Toni Stabile Osteoporosis Center at Columbia University Medical Center in New York City and president of NOF.

“While it is true that whether a person is 50, 70, or 90 years of age, if [he or she has] a T-score of -2.5 or -3, [his or her] risk of fracture is much higher than if [his or her] T-score is -2 or -1.7 . . . It is also true that if you have a 50-year-old with a T-score of -2.5 at the spine, which would be called osteoporosis, [his or her] 10-year risk of fracture turns out to be lower than that of a 70-year-old who has a T-score of -2, which would be called osteopenia,” explains Siris.

Studies show that older age significantly enhances the risk of fracture in both women and men, and there are other factors that enhance risk as well, but these factors are not reflected in T-scores. Consequently, what the concept of absolute fracture risk does is take into account these other risk factors so that the provider can make better treatment decisions, says Siris. “Now that we have a lot of good treatments, we really need to do a better job of assessing the true risk in order to assure that those at highest risk get treated,” she says, adding that the new approach also enables healthcare organizations do a better job of allocating their resources.

**Clinical skills still required**

To determine a patient’s absolute fracture risk, a weighted algorithm will be used to arrive at a person’s 10-year risk of fracture. To simplify this process for providers, Siris anticipates that software will be made available that can be loaded directly onto bone densitometry machines so that the appropriate calculations can be made while the patient is undergoing a bone density scan. The process will require the technologist to ask...
the patient a few questions so that other key risks will be factored into the equation along with the patient’s BMD measurement.

In addition to the BMD measurement, the two most important factors are whether a patient has suffered a previous fracture and older age. Other factors that heighten fracture risk include tobacco use, family history of hip fracture, rheumatoid arthritis, and excessive use of alcohol.

Although the specifics of the new algorithm have not yet been published, Siris says that the approach will make it much harder for a provider to fail to treat a person who has recently broken a hip. “The hip fracture will be weighted so heavily that the person could wind up, correctly, with maybe a 25% or 30% 10-year risk of another fracture,” says Siris, adding that today, providers may neglect to treat such a patient if he or she has a T-score that does not meet the current definition of osteoporosis. “The very highest-risk patients—those who have had a fragility fracture—would score very high on [the algorithm] so that it would be almost malpractice not to treat them.”

In addition to making it much more likely that the people at highest risk receive treatment, Siris expects that the new approach will also eliminate at least some of the confusion among providers concerning what to do about osteopenia, which signifies a BMD level that is below normal but not to the level of osteoporosis. “If you have a 50-year-old patient who has a T-score of 1.9 at the hip and no other fractures, the patient’s 10-year fracture risk may be relatively low,” notes Siris. On the other hand, she notes that a 73-year-old patient with the same T-score is likely to have a fracture probability that puts him or her above the treatment threshold because of his or her age and osteopenia.

Siris emphasizes that although the algorithm to determine absolute fracture risk will provide guidance to physicians, it will not tell them how to treat or what, if any, agent to use. In addition, she stresses that it does not take every possible circumstance into account. “What do you do if you have a 70-year-old patient who has a pretty decent T-score, but [he or] she falls down a lot?” says Siris, noting that falls and many other issues are not part of the algorithm. “The doctor is still going to have to use judgment, but for a great many providers, the algorithm will be very helpful as a broad approach.”

**Provider education is critical**

Of course, the algorithm can only apply to patients who undergo bone densitometry. Medicare covers the procedure for all women 65 or older. But according to CMS, in 2005 only about 20% of patients who were eligible for bone densitometry actually received it, says Meryl LeBoff, MD, director of the Skeletal Health and Osteoporosis Center at Brigham and Women’s Hospital in Boston. In addition, LeBoff explains that many younger women with various risk factors—such as a history of anorexia, athletic amenorrhea, or use of certain drugs such as glucocorticoids—should undergo BMD testing as well, but the number of referrals for such tests is nowhere near where it should be.

“Bone density exams are widely available in major academic medical centers, cities, and outpatient settings, so I don’t know why doctors are not ordering these tests,” says LeBoff, adding that 40% of women over the age of 50 will sustain an osteoporotic fracture. “Physicians do far better with a patient who comes in with cardiac symptoms, so it is a matter of increasing awareness and education about the importance of bone health and the health consequences of osteoporotic fracture.”

LeBoff is hopeful that the new approach toward assessing absolute fracture risk will offer the added benefit of enhancing the visibility of bone health in women as well as in men, although bone loss tends to develop at a later age in men. “[Men] are [also] at risk of a fracture,” she says, noting that 29% of hip fractures occur in men.
Experts maintain that self-management is critical to success

Tiered approach to chronic pain targets suffering

Chronic pain, or pain that continues for at least three months, is a key driver of healthcare utilization. Yet there is little to show for much of this spending, because the individuals suffering from chronic pain often fail to receive the relief they are seeking, even after repeated visits to their provider and/or the ER. It’s a situation that typically leaves patients, providers, and payers frustrated with the results, even while the cycle of repeated utilization continues.

Part of the problem is that nonmalignant chronic pain, or chronic pain that is not associated with cancer, is tricky for the provider to pin down given that there are often few objective findings to rely on in diagnosing such a condition. Successful treatment of the condition may have more to do with alleviating a person’s suffering than actually removing the pain, a concept that may be entirely foreign to both patients and providers.

Despite these complexities, Oakland, CA–based Kaiser Permanente has developed a comprehensive, multilayered approach to chronic pain that developers believe offers all stakeholders a much better outcome than they have traditionally received. At the heart of the program is the idea that chronic pain should be viewed like the other major chronic diseases in the sense that self-management skills are critical to getting the condition under control.

A cure for pain is elusive

Speaking at a Webinar sponsored by Ann Arbor, MI–based HealthMedia on July 26, Andrew Bertagnolli, PhD, a care management consultant at Kaiser’s Care Management Institute, explained that both provider and patient education about the key differences between acute pain and chronic pain are critical to a successful outcome. “We know that immobilization and rest are actually counterproductive in the management of chronic pain. While they can be very helpful with acute pain, [with chronic pain] the muscles decondition, and this may end up causing the pain to flare up, so there is a lot of education that needs to happen at all levels,” he said.

Further, although acute pain tends to get better over a short period of time, he noted that some people must learn to manage chronic pain for the rest of their lives. “The way you would expect a person with diabetes to learn how to manage [his or her] diabetes through a number of avenues, looking at diet, exercise, medication, and monitoring, we would expect someone with chronic pain to learn to manage [his or her] condition as well.”

Given that a cure is often elusive for chronic pain, the approach that Kaiser has implemented focuses on what Bertagnolli referred to as the ripple effects of the condition. These include a diminished activity level, mood disorders such as depression and anxiety, sleep disturbance, and problems with relationships on the job or at home.

In fact, when working with patients, Bertagnolli uses a diagram that has a small circle in the center that represents their physical pain. Surrounding the central circle are outer circles that represent all of the ripple effects that enhance suffering, as represented by the enlarging circle. (See Figure 2 on p. 107.)

When Bertagnolli explains to patients that he has interventions that can help them with all of the ripple effects, essentially diminishing their suffering to the small central circle that represents physical pain, he said they are almost always eager to go forward. “That is how I engage people to get into trying some different approaches to pain management that aren’t focused on alleviation of their physical systems,” he said. “What we know is that evidence shows that it is really about self-management and learning new ways of dealing with pain.”

Self-management is the key

Similar to the way that diabetics or asthma patients are often triaged into different treatment programs based on their acuity level, Bertagnolli explained that Kaiser
has established three care management levels for the 12% of its population that has been diagnosed with chronic pain. For example, level one patients, who represent about 59% of the chronic pain population at Kaiser, have the least impairment in terms of physical and psychological functioning as well as lower self-reported pain ratings, so they receive care primarily through their PCPs.

Level two patients, representing about 35% of Kaiser’s population with chronic pain, are assigned to care managers, and they work with an interdisciplinary team of pain management experts focused on helping the individuals to manage their pain better. Typically, Bertagnolli noted that level two interventions last about six months, after which the patients are sent back to primary care.

Level three patients represent about 6% of Kaiser’s chronic pain population. These patients are usually so severely impaired by their pain that they are unable to work or are working very minimally, noted Bertagnolli. They too receive a care manager and work with an interdisciplinary team on a longer-term basis.

At all three levels of care, there is a core emphasis on developing self-management skills. Beginning in November, Kaiser will be adding a new Internet-based program developed by HealthMedia that is designed to stress this aspect, according to Ed Baas, HealthMedia’s director of product marketing, who also took part in the Webinar. “We have developed the technology to be able to deliver programs over the Web,” said Baas. “And we surround all those programs with engagement tools so that we can reach out to the members to get them [engaged]. And we have content libraries.”

Just unveiled in July, HealthMedia’s Care for Pain program follows the model established by many of the company’s other DM and wellness offerings in that it

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begins with an assessment that the patient can complete online and then automatically uses the information collected to produce and deliver a series of tailored messages and tools to the patient. For example, the program includes sections and resources related to the doctor-patient relationship, medication compliance, stress, and relaxation techniques.

Baas noted that the program draws from behavior-change science and evidence-based guidelines and that it is designed to carry out many of the same sorts of functions that a live counselor might do when working with a patient. However, the intervention is computer-generated, so there is no person-to-person communications.

**Preliminary results are positive**

Kaiser plans to use the HealthMedia program as an adjunct to the other components in its approach to managing pain. The idea is to reinforce the concept of self-management of chronic pain and to serve as an added resource to providers. “We have very busy PCPs seeing our members, and they tend to focus on the medication aspects of pain management,” said Bertagnolli. “We have tried to get our providers to emphasize nonpharmacological approaches, but this has been troublesome because they don’t often have the training in these areas, and it takes up time.”

Consequently, whereas PCPs might refer their level one patients to the Care for Pain program as one of their first steps, the program may be used as more of a refresher tool to level two and level three patients who have already undergone more extensive interventions.

One of the chief goals of Kaiser’s approach is to stop or slow the escalation of acuity in chronic pain patients, noted Bertagnolli. “We are hoping to not only address the needs of our level two and level three patients but also to do things to prevent folks from moving from level one to level two,” he said. “We know [that] if people adopt a lot of the strategies that we teach them in the more intensive programs earlier on in their pain experience, they are less likely to move up [to a higher acuity level].”

Because the Care for Pain program is just being introduced to the market, no long-term outcomes data are yet available. However, Baas noted that preliminary data from early studies conducted by HealthMedia indicate that the approach has a positive effect on self-reported pain symptoms as well as productivity at 30 days.

Whether these results will hold up over the long term remains to be seen, but Kaiser is one of four organizations planning to roll out the program to members in the next few months, and HealthMedia routinely provides follow-up reports about outcomes at 30, 90, and 180 days, so longer-term clinical and financial data should be available soon.