

DM DISEASE MANAGEMENT ADVISOR™

Data collection important step in fight against racial, ethnic disparities

Racial and ethnic disparities in health are costing lives and money as minorities face barriers to wellness that result in higher levels of chronic care and mortality rates and lower quality of care than white Americans.

The reasons for the barriers are often debated and can be language-related, structural, financial, or discriminatory. Overcoming these challenges in healthcare will only become more critical: The census bureau predicts that half of Americans will be a member of a racial or ethnic minority group by 2050.

Experts in the field believe that in order to provide proper healthcare to those in minority groups and keep costs under control, the healthcare industry will need to adopt programs to help better understand racial and ethnic populations. Several groups have developed suggestions that could help bridge the disparity gap. One of

the nation's leaders in promoting the need to deal with the healthcare of minorities is the Center for Health Care Strategies, Inc. In August, the nonprofit released *From Policy to Action: Addressing Racial and Ethnic Disparities at the Ground Level* by **January Angeles** and Stephen A. Somers, PhD. The report provides the following recommendations

regarding opportunities to address disparities:

- ▶ Strengthen and standardize efforts to collect information about enrollees' race and ethnicity
- ▶ Incorporate disparities reduction goals and objectives into health plan and provider contracts
- ▶ Link monetary incentives to initiatives to reduce disparities
- ▶ Analyze utilization and performance data by race and ethnicity to identify disparities and target patient and provider interventions
- ▶ Increase access to culturally and linguistically appropriate care
- ▶ Develop community-based strategies to reach out to minority members

"The ability to understand and respond to patients' varied perspectives and beliefs about health and healthcare can significantly impact care and outcomes of minority groups."

—January Angeles



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The authors wrote that "it is now time to move beyond documenting disparities and to focus our efforts on actionable steps to eliminate them." They added a "comprehensive, multistakeholder strategy" is needed in order to battle the problem. Managed care organizations have the opportunity to lead because they can "create systems that better coordinate care, reach out to

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members in need of preventative care services, provide health education, and support physicians in their networks.”

The first step in bridging the racial and ethnic disparities gap in healthcare is collecting data. “If you don’t have this information, then you can’t see where the disparities are or if they exist. You can’t target interventions effectively,” says Angeles. Having data about beneficiaries’ ethnic and racial backgrounds allows health plans to better understand their members’ healthcare needs and status, plan programs to address identified care needs, and set priorities.

The authors note that establishing standards in collecting racial and ethnicity data would be a step forward. Currently, those who are collecting data use different race and ethnicity categories, which can make it difficult to combine information from multiple sources.

Rather than create a separate coding program, the authors suggest following existing guidelines for data collection, such as the uniform framework developed by the Health Research and Educational Trust (HRET), for collecting and reporting this information in hospitals.

One barrier to racial and ethnicity data collection is the misconception that it is illegal.

Thomas LaVeist, PhD, director of the Hopkins Center for Health Disparities Solutions at Johns Hopkins Bloomberg School of Public Health in Baltimore, says the myth probably came about because some states forbid home insurance companies from collecting data about race because of concerns about them being used to discriminate. This was mainly for homeowner’s insurance.

“It’s used as a reason to not collect data on race—inappropriately so,” says LaVeist about the misconception that data about race and ethnicity are not allowed in healthcare. Managed care companies that do not collect such data can’t determine whether there is a problem, says LaVeist. “You don’t actually know if they have disparities in the health system because they are not collecting the data.”

A handful of health plans collect racial and ethnicity information from members who provide it voluntarily. The first health plan to collect the data was Aetna, which has this information for more than 5.2 million members (about one-quarter of its members). Staff members collect the data through enrollment forms and Aetna’s Web site, Aetna Navigator.

Wayne Rawlins, MD, of Aetna’s racial and ethnic equality program, says racial and ethnicity data are used only to improve member healthcare. In fact, Aetna created stringent guidelines for any Aetna employee who seeks to use the race and ethnicity information. A committee,

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which includes Rawlins, reviews internal applications to ensure that the data are used strictly to benefit health programs. In addition to telling members the information will only improve healthcare, Aetna officials show the benefits of data collection by implementing programs that tackle the issue. “You reassure people by putting the comments into action,” says Rawlins.

As a member of the National Health Plan Collaborative, Aetna is working with nine other health plans, totaling 87 million members, to establish standards for collecting and using race and ethnicity data.

For those who are not ready to ask members about their race and ethnic background, there are indirect methods, such as geocoding (a way to assign geographic identifiers) and surname analysis, that provide a rough marker of a member’s racial and ethnic background.

Although commercial insurers would need to create new mechanisms to collect data about race and ethnicity for their members, Medicaid health plans have data about beneficiaries’ racial and ethnic backgrounds from their state agencies. The authors believe Medicaid is “an ideal venue for addressing disparities”—given that it serves about 52 million beneficiaries and is the “largest provider of health insurance for minority populations, covering at least one in five nonelderly Hispanics and African-Americans compared to one in 10 whites.”

Given those numbers, the authors believe the federal government has a “vested interest in reducing racial disparities in healthcare delivery” and called Medicaid “an important catalyst for efforts to eliminate racial and ethnic disparities.”

Cultural competence

Health plans communicate better if they know their members’ languages and backgrounds. Not communicating properly can lead to medical error. Some minority communities have difficulties with medical terms and health numeracy. By knowing the audience, health plans can create programs that reach out to those populations. “It is really important that cultural competency is a large part of how to address disparities,” says Angeles. “A lot

of difficulties in quality, I think, can be attributed in the ways that [people of different] racial and ethnic backgrounds communicate.”

Cultural competence means health plans must understand the background but doesn’t necessarily need to have employees from the same background.

“It’s important to learn that you need to treat everyone the same and acknowledge the value of their contributions,” says **Joyce Page, MSPH, MPH**, director of Project DIRECT, a North Carolina-based program that targets diabetes in the African-American community of southeast Raleigh, NC. “The person you select to come into the community should be sensitive to the community and respect their contribution.”

“You need people who are literate in the culture you are trying to reach who will understand the nuances and interpret people’s behavior a little better because they understand the unique cultural aspects,” says LaVeist.

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Upcoming audioconference

November 13—Cultural Diversity and Disease Management: Improving care in ethnic populations. **Brenda Schmidt, MS, MBA**, managing director of diversity wellness, and **Winston F. Wong, MD, MS**, medical director of community benefit and director of disparities improvement and quality initiatives for Kaiser Permanente, will use evidence-based examples to illustrate how your program can target groups with traditionally high nonparticipation rates. Concepts such as the use of incentives, the importance of person-to-person contact and community healthcare, and other creative ideas will be among the strategies presented.

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LaVeist says there is an issue of health literacy, which he describes as being literate about the management and maintenance of health. Patients have better outcomes when they are better educated about how to maintain good health and manage conditions, he says.

“We sometimes think that for Americans, if we give them a brochure about the condition they have, they will read the brochure and understand it,” says LaVeist, but minority populations might not understand the language or may have culturally different conceptions of the disease process. As a way to teach healthcare providers and their clinical employees about racial and ethnic communities, Aetna offers them free access to online courses called “Quality Interactions: A Patient-Based Approach to Cross-Cultural Care.” One of the tools is a physician-focused video called *Crossing the Health Care Gap*. The video explores three cases: that of an African-American woman, an Asian man, and a Hispanic woman.

By seeing healthcare through their eyes, professionals are able to better relate to their patients. Another critical way is through one-on-one communication. For

instance, if a physician is not able to communicate effectively with a patient and her caregiver about her diabetes, care will suffer. “We believe that doctors and nurses are better able to care for our members than if they had not taken the course,” says Rawlins.

Getting community involved

Experts in healthcare disparities say insurers must tailor interventions to the community’s needs and understand the cultural values when creating programs.

“When implemented well, managed care organizations partnering with community-based organizations and health workers gain the ability to effectively reach populations that would otherwise be underserved,” according to the Center for Health Care Strategies report. One program that has been successful in making connections with a minority community is Project DIRECT.

In response to the disparities issue, the Centers for Disease Control and Prevention (CDC) in the 1990s sought proposals for programs that would tackle the problem. Project DIRECT, a partnership between southeast Raleigh, North Carolina’s Department of Health and Human Services’ Division of Public Health, Wake County Human Services, and the CDC, began community interventions (diabetes prevention and control activities) in 1996. Project DIRECT involved the community in planning and monitoring the program from the start, including a 13-member executive committee. By getting that buy-in, says Page, the project was able to make inroads into the community. “I can say with great confidence that if not for the community, the program would not have survived. It was the glue that held it together,” says Page.

The community participated in reviewing and evaluating the plan. The feedback included tweaking the literature to make it more culturally appropriate, such as changing phrasing and removing technical terms.

Project DIRECT uses the church, a common thread within the southeast Raleigh community, to reach out to residents. “When we did a preliminary study with focus

Comparing Raleigh with Greensboro

Researchers compared Raleigh, NC, with the nearby community of Greensboro to review the effectiveness of Project DIRECT.

They reported the following findings:

| | Raleigh | Greensboro |
|-------------------------------|----------------|-------------------|
| Diabetes prevalence | | |
| 1996–1997 | 10.5% | 9.3% |
| 2003–2004 | 16.7% | 18.6% |
| Self-reported diabetes | | |
| 1996–1997 | 10.5% | 9.3% |
| 2003–2004 | 15.1% | 16.7% |
| Sedentary behavior | | |
| 1996–1997 | 39.4% | 35.3% |
| 2003–2004 | 29% | 32.7% |

Source: Project DIRECT.

groups, people told us that they would listen to messages from their ministers on health issues. Therefore, church outreach efforts were very important," says Page.

In addition to getting the support of ministers, Project DIRECT conducts nutrition workshops with church kitchen committees about nutrition and established walking groups in churches and other community organizations.

Page estimates more than 6,000 community members (about one-quarter of the target population) have taken part in Project DIRECT programs, including screenings, workshops, and walking events. She adds the number of people actually reached by Project DIRECT is unknown because many of those who took part in activities returned to their families and friends and passed on the word about diabetes and health. "We reached more people than walked through our doors," says Page.

Bottom line

As the nation becomes more diverse, addressing health disparities will only become a larger economic concern.

Angeles believes improving the quality of care to reduce disparities has the potential to save health plans money by reducing inappropriate utilization. Once savings are found, health plans will be more apt to tackle the issue of healthcare disparities.

"If plans can demonstrate that they're getting a positive return from these interventions, then it gives them leverage to expand new interventions," says Angeles.

The healthcare system is being called upon to develop ways to bridge the gap while improving care and keeping costs under control.

"The country is becoming very diverse quickly," says LaVeist. "All of the social problems in society ultimately end up in the treatment room. We're just not set up for all these cultural issues, but the implications for the ability to maintain a high level of quality in healthcare dispensing is immense . . . It's important to keep an eye on that and stay ahead of the curve and make the appropriate adjustments to control costs and also keep quality high." ■

CMS news

Physician-focused option shows savings

CMS' first pay-for-performance initiative for physicians within the Medicare program is turning the classic DM model of call center-based care on its head.

The results of the first year of CMS' Physician Group Practice (PGP) project, which ran from April 2005 to March 2006, shows two groups earned performance payments for quality and cost efficiency of \$7.3 million as part of their share of the \$9.5 million savings in the Medicare program. The payments work this way: Practices whose Medicare spending growth rate for assigned beneficiaries is more than 2 percentage points lower than their comparison population earn performance payments of up to 80% of the savings they generate with the remaining 20% going to The Medicare Trust Funds.

Two groups, Forsyth Medical Group in Winston-Salem, NC, and St. John's Health System in Springfield,

MO, met all 10 diabetes clinical quality measures in the PGP project. All 10 of the physician groups (which represent 5,000 physicians and 224,000 Medicare beneficiaries) achieved benchmark or target performance levels on at least seven of the measures. Reviewing the first-year findings, **John Pilotte**, senior research analyst at CMS, said the areas of concern are foot exams, blood pressure, and flu vaccinations. "I think it's important to not only look

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Questions? Comments? Ideas?

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at the cost side, but also the quality side, especially in the ambulatory care environment,” said Pilotte, who spoke at DMAA: The Care Continuum Alliance’s (formerly the Disease Management Association of America) Disease Management Leadership Forum in September. The idea behind the three-year project is to reward physicians for “improving the quality and cost efficiency of healthcare services delivered to a Medicare fee-for-service population,” according to CMS. CMS hopes the demonstration “encourages physician groups to proactively coordinate beneficiaries’ total healthcare needs, provides incentives to physicians to provide services efficiently and effectively, rewards improvements and delivery of high quality care, and creates a framework to collaborate with providers to the advantage of Medicare beneficiaries.”

Marshfield (WI) Clinic and the University of Michigan Faculty Group in Ann Arbor, MI, earned performance savings of \$7.3 million. Other groups achieved lower Medicare spending growth rates than their local markets during the first year, but the growth rates were not low enough to share in the savings.

Marshfield Clinic

Marshfield Clinic, a 41-location system that provides patient care, research, and education in northern, central, and western Wisconsin, has 42,000 people assigned by

CMS. Although the physician group had already planned the programs that they expanded in the PGP project, **Theodore A. Praxel, MD, MMM, FACP**, Marshfield Clinic’s medical director of quality improvement and care management, says it is too early to have specific ROI for the interventions used. Participation in the demonstration accelerated the process, according to Praxel. “Part of the reason Marshfield Clinic was interested in participating was that the tenets of the project were consistent with the tenets of the clinic’s mission to provide accessible, high-quality healthcare to our patients, and we felt we could learn from participating in this project,” says Praxel. The following are goals of Marshfield’s care management program:

- Enhance the electronic health record (EHR) to implement care management and coordination processes
- Expand the anticoagulation care management program across the entire system and develop a heart failure care management program
- Promote use of a nurse triage line

Marshfield has used EHRs in some form for 20 years, and Praxel says it hopes to be completely chartless by the end of this year. The electronic records are more than just a collection of notes. They allow a provider to call up multiple applications showing patient diagnosis, recent

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Tale of two projects

The release of the CMS Physician Group Practice (PGP) demonstration project’s first-year findings this summer shows a possibly successful new avenue for DM programs.

Rather than the call center-based model on which DM was founded, the PGP project places doctors squarely in the middle of DM care.

“There certainly is a difference when the providers are engaged in disease management in their own organizations,” says **Randall Williams, MD, FACC**, CEO of Northfield,

IL-based Pharos Innovations, LLC, which took part in the demonstration project. “When a provider endorses a program to patients, they are more likely to participate in the program.”

The release of PGP’s year one performance results comes on the heels of the findings from the first six months of CMS’ Medicare Health Support (MHS) program, which was based on a more traditional DM model. Although the PGP project is being lauded as the model of chronic care management in

the Medicare population, the results from the MHS projects have been disappointing.

The congressionally mandated report *Evaluation of Phase 1 of Medicare Health Support Pilot Program Under Traditional Fee-for-Service Medicare* found that fees spent in the first six months of the MHS program far exceeded the savings produced. Faced with needing to guarantee savings of 5% in their intervention groups when compared to control groups, two vendors have already quit the MHS program.

Thomas Wilson, PhD, DrPH, and **Vince Kuraitis, JD, MBA**, principal and founder of Better Health Technologies in Boise, ID, wrote a commentary on the latter's Better Health Technologies blog in which they ran the numbers from the report. They found MHS organizations "will need to produce an average savings of 19.9% of costs of the participants in the intervention group to achieve financial 'success' for the project." Summing up, they wrote, "The bottom line: We believe MHS is in big trouble."

"The conclusion to draw is not that disease management is a failure. The conclusion is we need to try something different," says Kuraitis.

If the MHS announcement was tempered, PGP's first-year findings could have been preceded with the sound of trumpets. Two of the 10 physician groups will share in millions in Medicare program savings.

The physician-focused PGP program is a change in focus for DM, and the medical home concept is one that physicians support. "When you talk medical home, that's something doctors have cooked up and there is ownership. It's theirs, and they believe in it," says Kuraitis.

Kuraitis says older, sicker patients in the Medicare demonstration projects trust their PCPs and rely on them as the stewards of their healthcare. When a DM company is added to the mix, the elderly patients often become confused. Plus, the issues involving an 80-year-old patient are more medical than motivational.

The question is who is going to lead the DM process, the companies or the physicians? "The disease management model and the medical home model may seem very black

and white, but there's also room for lots of shades of gray in there too," says Kuraitis. "I would anticipate that we are going to see hybrid models perhaps where disease management companies will start to pay physicians part of their fees as an inducement to get the doctors to participate, and we also may see doctors with medical home projects recognizing a need for a health coach, a call center, and remote monitoring, and they will need to buy that from private companies."

Speaking at DMAA: The Care Continuum Alliance's 2007 Disease Management Leadership Forum in September, **David Wennberg, MD, MPH**, president and chief operating officer of Health Dialog Analytic Solutions in Boston, said providers and organizations have their own strengths and weaknesses and are usually complementary.

"There is a debate right now . . . which is, 'Is this a doctor thing or a care management thing?' I think that's the wrong question," said Wennberg. "It isn't one or the other, but a combination of both."

Kuraitis says there is a reimbursement question involving care management led by physicians. "In my mind, if we want doctors to do disease and care management, I think paying them for it is a necessary piece of that—and that they will in turn respond and provide services that we will pay them to do," he says.

Whether DM's future will mean greater physician focus is not a question. It's only a matter of how that's going to happen, says Kuraitis.

"This is really, in my mind, the central issue in disease management today," says Kuraitis. "Are we going to continue to see a more carved-out model driven by the disease management companies and health plans, or do healthcare providers get reintegrated back into disease management?"

With MHS and PGP on either side of the spectrum, healthcare leaders await CMS' next step in the process. "At this point, what Medicare is going to do is unclear. It's very cloudy. I'm someone who has followed this since day one, and I have no clue what Medicare is going to do in relationship to disease and care management," says Kuraitis.

CMS news

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appointments, allergies, medications, alerts, and prevention services, such as making sure the patient is up to date on tests and immunizations. Praxel says the electronic record is necessary for Marshfield's success because it helps to ensure the patients are getting the services they need.

Regarding the anticoagulation care management program, Praxel says Marshfield decided to enroll patients in the service even though it's not being reimbursed by Medicare. Praxel says Marshfield believes the program brings better care through coordinating care, such as educating patients about their medications and drug interactions. The care management nurses act as an extension of the physician practices and relay patient information to the physician. The nurse advice line is successful because of the electronic records and guidelines that allow the nurses to take an active role in a patient's health, according to Praxel. "All the documentation between the

various programs are part of the electronic records . . . so we're really an extension of that provider's practice rather than separate entities in the system," says **Marilyn Follen, RN, MSN**, Marshfield Clinic's administrator of quality improvement and care management.

If the care managers connect with the patients before doctor office visits, they are able to collaboratively handle comorbid conditions and allow the physician to spend more productive time with the patient.

Praxel gives the example of one diabetic patient who stopped taking medication after reading online that cinnamon helped her condition. During one of the calls, the patient told the care manager, who was able to contact the patient's physician and help to get the patient back on the medication.

The physician group has received \$3.42 million as part of its savings to the Medicare program. Marshfield

Slow turnaround criticized

If the 10 groups involved in the CMS Physician Group Practice (PGP) demonstration project don't know what areas to address until a year later, then how are they going to improve their programs?

That is a refrain being echoed throughout the managed care world.

CMS didn't release the findings from the first year of the project until this summer, which was a year after the end of the demonstration's first year.

If the 10 groups received the information sooner, **David Wennberg, MD, MPH**, president and chief operating officer of Health Dialog Analytic Solutions in Boston, said they may have been able to learn from their mistakes and improve services.

Speaking at the September 2007 DMAA: The Care Continuum Alliance's Disease Management Leadership Forum (DMLF) in Las Vegas, Wennberg said, "There are lots of opportunities to substantially increase the delivery of data. We don't need it perfect."

Marilyn Follen, RN, MSN, Marshfield (WI) Clinic's administrator of quality improvement and care management, one of the two physician groups that received financial bonuses, says receiving the data sooner would allow Marshfield to examine its programs and correct areas of concern. "One of the challenges that we had with this demonstration and continue to have is, as we talk about performance year one, we are in the middle of performance year three," says Follen. "Such delays in data make course corrections difficult."

The lag in time will remain a factor for year two of the demonstration project. **John Pilotte**, senior research analyst at CMS, said at the 2007 DMLF that the second-year results will be ready in the summer of 2008. That kind of news does not please those in the managed care field.

"The lack of data and the lack of quick data is far from optimal for these companies," says **Vince Kuraitis, JD, MBA**, principal and founder of Better Health Technologies in Boise, ID.

was one of the two physician groups that received financial bonuses.

If Marshfield remains cost-effective in the project's remaining two years, CMS will award Marshfield another \$1.14 million in 2009. Praxel says the money is going into clinical infrastructure to improve quality of care in the areas of CHF, CAD, hypertension, preventive services, and adult immunizations.

Pharos Innovations

Pharos Innovations, LLC, in Northfield, IL, was involved with two physician groups in the PGP project totaling about 40,000 Medicare patients. **Randall E. Williams, MD, FACC**, CEO of Pharos, says Park Nicollet Health Services in St. Louis Park, MN, and Billings (MT) Clinic utilized Pharos' Tel-Assurance system with heart failure patients.

Williams says the choice to focus on heart failure patients was because heart failure is an area in which medical groups could avoid costs and unnecessary hospitalizations.

Heart failure patients are enrolled in daily telephony and Web-based interaction, which requires the patient to log in or call each day to report or track their test results, behavior, and medication compliance.

"Part of the challenge is building a technology that patients will use," says Williams. "We use whatever communications the patient prefers. Therefore, the system itself is architected by the phone, computer, PDA, whatever the patient is comfortable using."

Tel-Assurance captures the data, and algorithms identify which patients need interaction with care management nurses, who are based in the patients' physicians' practices. The early identification process allows for averted potential trips to ERs and the hospital, according to Williams.

The telephone system, which is utilized by most of the patients in the program, features a human voice with a slower speech pattern geared to the demographic. Williams says even patients with mild dementia are able to use the Tel-Assurance system.

The system also allows for communication between the case management nurse and physician, and an opportunity for troubleshooting. For instance, if the algorithms report a problem, the care management nurse can contact the physician and adjust medication or schedule an appointment.

Williams says PCPs have been receptive because the case manager is in the practice. "The physicians can see these patients as high maintenance and challenging," says Williams. "Physicians favor this approach because of the fact that they are not getting phone calls in the middle of the night because the troubleshooting caught the problem in the middle of the day."

Hospitalizations averted

Williams says Park Nicollet Health Services and Billings Clinic have averted one heart failure admission per year per enrollee. He estimates about 70% of the cost for care for heart failure patients is because of hospital charges. "The overwhelming cost is through hospitalization, so if we are able to avoid one admission per patient per year, there is a robust cost savings," says Williams.

Williams estimates there are 250 patients for one full-time case manager nurse. The technology costs are about \$50 per enrolled patient per month. When analyzing the technology and salary costs to the savings on hospitalizations, Williams estimates the Tel-Assurance program enjoys a three-to-one ROI.

Because Tel-Assurance avoids hospitalization, the next question is reimbursement. Providers are not reimbursed for using programs like Tel-Assurance because the services are not rendered at a physician's office or hospital. Williams says the healthcare system needs to review this reimbursement issue and revise what services should receive reimbursement.

"The biggest challenge to the approach in general is that CMS and other payers have not yet reimbursed the incremental time and effort a program like this requires," says Williams.

The second year of the demonstration project, which ended earlier this year, dealt with CHF and CAD. Hypertension and cancer are the focus of the third year. ■

Physician support critical for DM

A supportive physician backing a DM program can often be the difference between success and a lost opportunity.

In order to improve member lifestyles via DM, most experts believe all stakeholders must get on the same page to help those faced with diabetes, asthma, and chronic obstructive pulmonary disease (COPD).

However, in many cases, an unsatisfied physician, who may remember managed care slights, can become an unmovable barrier to a healthier lifestyle. It's not that the physician wants to block a patient from positive outcomes, but the doctor has negative experiences with managed care organizations and believes they serve as a barrier.

"I think they feel neglected, threatened by the disease management companies who really work for the plans, not for the doctors," says **Michael Eliastam, MD**, associate dean of SABA University's School of Medicine, a Caribbean school that is headquartered in Gardner, MA. "By and large [the health plans] basically tell patients, 'We're here to help you deal with your diabetes,' and the doctor at best is ignored, at worst feels threatened and angry about it."

The patient is more trusting of his or her PCP than a faceless health plan or DM organization, and gaining the physician's trust is a critical stamp of approval for the program.

Whether that river of doubt and suspicion can be crossed is the question.

"I would be naive if I said to you that it's easy because so much water has gone under the bridge. There's so much bad feeling," says Eliastam, who has worked for Boston City Hospital as chief medical officer and clinical leader of Accenture, a global healthcare practice.

Three experts who have experienced success bringing physicians into the fold (**James Ehlen, MD**, chair of Hallelund Health Consulting in Minneapolis, **Sandeep Wadhwa, MD**, vice president of care management ser-

vices at McKesson Health Solutions in San Francisco, and **David Kelley, MD**, chief medical officer for the Pennsylvania Department of Public Welfare's Office of Medical Assistance Programs in Harrisburg) spoke at an August 28 HCPro, Inc., audioconference, "New Directions in Disease Management: Strategies to overcoming physician resistance."

When it's time to create a program, the experts suggest the following:

- ▶ Keep the program simple
- ▶ Link payment to clearly defined activity
- ▶ Reward physicians quickly
- ▶ Don't penalize for patient noncompliance
- ▶ Communicate effectively with physicians (i.e., make sure the information is correct, timely, and useful)
- ▶ Provide timely feedback to physicians
- ▶ Keep patients engaged
- ▶ Develop understandable processes and logical outcomes
- ▶ Establish excellent outcome measurements
- ▶ Improve communications between physicians and patients via technology
- ▶ Follow the AMA's pay-for-performance (P4P) guidelines (see "AMA's P4P principles" on p. 131)

"The overarching theme here is to pay attention to detail that is important to physicians and caregivers," said Ehlen. "It's important that before the program is installed that the key stakeholders are engaged . . . We found that communication back to the physicians in days and not in weeks was deemed to be more effective. We also learned from our system that talking to the proper physician was important."

Ehlen said Hallelund needed to show the physicians that the managed care organization was committed to the particular DM program.

Constantly switching focus to the so-called new-and-improved programs only leads to cynical physicians, he added.

To demonstrate sustainable outcomes was helpful in winning physician support, said Ehlen.

Mississippi case

McKesson Health Solutions is involved in a Medicare Health Support program in Mississippi. McKesson identified approximately 21,000 beneficiaries for the intervention group in the rural, poor population, and nearly 14,000 participated.

The managed care company also signed up about 40% of the PCPs in the state.

Getting the physicians on board and being part of a Medicare program were positive steps for patients. The organization needed to repair hurt feelings and misunderstandings from past negative managed care experiences. DM programs should bring each aspect of a person's healthcare together—not divide them with managed care on one side and the physician on the other, said Wadhwa.

"We needed to regain our trust with providers in the community," Wadhwa said.

McKesson was able to accomplish this by clearly explaining the program to physicians. Not all physicians were keen on taking part. Wadhwa reported nursing home doctors were slower in showing support and were not responsive to mailings. Instead, McKesson found face-to-face group meetings worked.

Having both Medicare and the individual physicians behind the DM project made patients more apt to take part. "We thought that was a strong message to say this program is sponsored by Medicare and endorsed by your doctor," said Wadhwa.

Pennsylvania case

Kelley said the ACCESS Plus Program, which covers 290,000 people living in rural Pennsylvania, found success through collaboration.

Approximately 34,000 ACCESS Plus Program members have chronic diseases (e.g., asthma, diabetes, COPD, CAD, and CHF) covered by a DM program operated by McKesson Health Solutions.

During the planning stage of the program's pay for performance, officials brought many different health-care stakeholders to the table. The Pennsylvania Medical Assistance Program formed a P4P workgroup that included several state medical organizations and consumer groups to help them create a program that both physicians and consumers would support.

"We have a lot of consumer advisory activity in the state of Pennsylvania. We thought it was important to get their input on the program," said Kelley.

Communication is key when working with physicians. "Incorrect communications could be worse" than no communication, said Ehlen. "Making sure that we are communicating in the right direction can be a way to avoid the skepticism."

Phase one of the P4P program included early rewards, such as \$200 for signing up for the program, \$30 per patient to encourage consumer participation, and \$40 per patient for identifying DM candidates.

Phase two focused on payment for collaboration via care plans, such as \$60 per care plan with a cap of two care plans per year.

Phase three of the incentive plan involves quality of care process improvements and a \$17 payment per process accomplished for each patient. Kelley said the next wave of payments will be linked to quality of care processes.

> *continued on p. 132*

AMA's P4P principles

American Medical Association lists five principles for pay-for-performance (P4P) programs:

1. Ensure quality of care
2. Foster the relationship between patient and physician
3. Offer voluntary physician participation
4. Use accurate data and fair reporting
5. Provide fair and equitable program incentives

Source: AMA's Web site: www.ama-assn.org.

Physician support

< continued from p. 131

Almost two years into the P4P program, Kelley said, there are more than 800 participating providers, whose offices care for more than 15,000 DM patients (more than 7,000 high-risk patients). The P4P program has meant more than \$600,000 to the physicians who have taken part.

Higher payments needed

In general, Eliastam says P4P payments must increase in order to have physicians interested in DM programs. Paying a physician a small amount does not affect his or her practice in a grand scale, he adds.

"I'm underwhelmed at the size of the pools being put out there," says Eliastam. "I think you have to put some serious money into this stuff, like 10%–20%, to get a change in behavior . . . They're not going to do that for nothing. You have to share the wealth."

In order to get physicians on board with DM programs, Eliastam suggests increasing payments, providing money for electronic medical records so physicians can communicate effectively, and involving doctors to refine call centers.

Eliastam says managed care must also spark interest among patients to see the benefit of DM programs.

"You can see the patients don't see that much value yet. You look at the enrollment rate and the compliance

rate. You don't see people beating down the doors to be in disease management programs," he says.

Eliastam shares the view of many physicians who simply are not sold on DM. He wonders why managed care programs back DM and suggests there is political appeal and public relations value for insurers to buy DM programs.

"I think the theory is correct. I think population health and interventions and stratification of populations and customized interventions helping patients in collaboration with their providers is excellent, but that's not what we got," says Eliastam. ■

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