

# DM DISEASE MANAGEMENT ADVISOR™

## Looking into the DM crystal ball Greater integration expected in 2008

*Editor's note: Disease Management Advisor asked DM leaders to predict what will happen in the field this year. In this issue, we have compiled articles highlighting their predictions.*

A coalescing of DM, prevention, and wellness under a larger umbrella of chronic care management is a trend many in the DM field are predicting for 2008.

**Ariel Linden, DrPH, MS**, of Linden Consulting Group in Hillsboro, OR, points to wellness as the “hottest topic” in DM and estimates that it has grown tremendously in the past couple of years.

“It’s now the new frontier,” says Linden. “It’s funny because it’s not a new topic. Health promotion has been around since the ‘40s . . . But suddenly, everyone has recognized that wellness is important and there are long-term savings to be had. So everyone is looking seriously

at preventative measures, along with applying more evidence-based behavioral change strategies.”

Linden expects that most health plans will offer wellness programs, and **David B. Nash, MD, MBA**, chair of the department of health policy at Jefferson Medical College of Thomas Jefferson University in Philadelphia, predicts those services will become the norm within the next year to 18 months.

**Vince Kuraitis, JD, MBA**, principal of Better Health Technologies in Boise, ID, is surprised wellness has become such a popular concept, namely because gauging

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### The new DMA

Welcome to the new, expanded version of **Disease Management Advisor**. This month's issue may look the same from the cover, but inside, there's an added bonus.

Starting with this issue, **DMA** is including **Medicare Disease Management** as a monthly supplement to each issue of **DMA**. We are merging **MDM** and **DMA** to bring even more information to the loyal subscribers of these two publications.

Subscribers of **MDM** will continue to receive the same valuable information about Medicare DM programs, but with the added benefit of receiving **DMA**.

For those new to **DMA**, this publication provides real-world examples and practical strategies to help make your DM programs a success.

In other words, with the new **DMA**, readers are getting the best of both worlds.

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This is an exciting time for us, and we hope the improved publication will benefit you and your business. Thank you for your continued support.

## Greater integration

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ROI is more difficult and payback takes much longer for wellness programs. He says companies with long-term employees, such as automobile companies, understand the economic incentives in offering wellness programs. "I'm a little surprised but also pleased to see that wellness seems to be persisting in the marketplace," says Kuraitis.

Nash expects "very aggressive corporate health activities" that will penalize employees who don't comply with health improvements, such as smoking cessation and weight loss. He says some companies will offer free counseling or provide access to appropriate resources to help employees tackle specific health issues. If the

lifestyle changes are not implemented after a given time, Nash foresees employers terminating noncompliant employees.

"Corporate America is fed up and recognizes that they have a real role," says Nash, adding that if workplaces have to offer health insurance, then those companies should lead how insurance is organized and deployed.

**"Corporate America is fed up and recognizes that they have a real role."**

—David B. Nash, MD, MBA

**Jim Giuffre, MPH**, president and chief operating officer of Healthwise in Boise, ID, says wellness is a trend toward investing in the whole population, not just those who are chronically ill.

There is a huge opportunity to save hospital costs by finding those who are in at-risk categories and engaging them in work-site wellness, DM, and online self-management programs. "I see both employers demanding it in their [request for proposals], and I see health plans and DM companies expanding their programs," says Giuffre.

Finding those at-risk folks will require "smart predictive modeling," says **Julie Meek, DNS**, chief science officer at CareGuide in Coral Springs, FL, and founder of The Haelan Group in Indianapolis. She predicts employers will switch to health assessment surveys that provide individual results to employees and allow confidential outreach and expert coaching assistance to those at risk for being high spenders.

## State of DM

DM is an industry in flux; Meek says one needs to look only at Disease Management Association of America's recent name change to DMAA: The Care Continuum Alliance to see the evolving nature of the industry.

Meek says DM is entering the "dawn of a new era," and integration is a movement that has been in the

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## ROI dispute continues

How to properly and accurately evaluate ROI has long been debated in DM. DMAA: The Care Continuum Alliance has tried to resolve the issue with the second volume of the *Outcomes Guideline Report*, released in September 2007, by adding new clinical measurement statements. The report came in response to requests from providers and other stakeholders concerned that DM needed to create consistent and proper outcomes guidelines.

Several DM experts point to DMAA's *Outcomes Guideline Report* as proof that the industry is serious about creating more rigorous ROI guideline measurements, especially given Medicare demonstration projects.

"I think the industry has learned that this is an extremely complex process," says **Vince Kuraitis, JD, MBA**, principal of Better Health Technologies in Boise, ID. "I commend what DMAA has done the last two years to get its arms around ROI and the common methodological issues across companies. I think those have been constructive efforts and begin to provide some consistency, though [they] don't fully address the problem."

**Julie Meek, DNS**, chief science officer at CareGuide in Coral Springs, FL, and founder of The Haelan Group in Indianapolis, serves on DMAA's Outcomes Steering Committee, which worked on the *Outcomes Guideline Report*. She says the industry has made "enormous strides in publishing evaluation guidelines."

The heart of the struggle, she says, is that the DM industry is faced with several types of entities that are not conducting proper ROI analysis or using correct methodologies.

Clients don't know how to recognize bad outcomes data, so they hire actuarial, benefit, or brokerage houses, which often use incorrect methodologies or simply don't know the nuances of conducting complicated outcomes analyses, Meek says. "They tend to promulgate a methodology that is not necessarily as robust as it can be," she says.

Meek says DM has to raise awareness of the ROI issue among employers so they understand that many of their financial consultants are not working with proper methodology.

"Clients are laypeople who don't have PhDs in research like we do. Translating outcomes to clients, I think, is really something that needs a lot of the industry's attention and certainly will be something I advocate for within DMAA," says Meek. "It's headed in the right direction. It's not there yet."

Though a number of DM experts applaud DMAA's *Outcomes Guideline Report*, not everyone is satisfied. **Ariel Linden, DrPH, MS**, president of Linden Consulting Group in Hillsboro, OR, encourages the industry to move beyond the status quo of measuring financial outcomes using a pre-post method and applying an actuarial trend line.

"Given that the standard industry method always shows large program savings that cannot be replicated when strict research designs are used, we must push the industry to follow more rigorous, and defensible evaluation methods," he says.

**David B. Nash, MD, MBA**, chair of the department of health policy at Jefferson Medical College of Thomas Jefferson University in Philadelphia, says the industry needs to include other measures to calculate ROI.

The industry should measure programs' successes by evaluating presenteeism, absenteeism, and overall productivity in relation to DM program participation. "I believe that the ROI calculation is going to evolve, and so we need to move away from disease-based calculations to a productivity basis," Nash says.

**Warren Todd, MBA**, founder and executive director of International Disease Management Alliance in Flemington, NJ, says not having that kind of data to weigh the success or failure of programs has hampered DM's growth.

He hopes that the second and third generations of DM programs provide literature that properly measures programs.

Though most agree the industry is moving in the right direction when it comes to ROI, financial experts say there is still room for improvement.

"I expect we will be debating ROI in DM for quite a while," says Kuraitis.

## Greater integration < continued from p. 2

making for three to four years. "I think what smart companies are doing is taking the essence of DM, which is that people have knowledge and skill gaps related to the management of their chronic care conditions, but understand now that people also have decisional, behavioral, and care coordination needs as well that need to be fully integrated."

### Insourcing

Another change in the market is that several health plans have started to insource DM programs. Notwithstanding a potential shift from outsourcing to insourcing, **Warren Todd, MBA**, founder and executive director of International Disease Management Alliance in Flemington, NJ, says health plans have generally been slow to develop their own DM services because of four reasons: inertia, relationships built between the plans and DM companies, the ease of outsourcing the programs, and the fact that DM companies are doing a "very good job" managing client relations. Any change in insourcing versus outsourcing will likely depend on how successful DM companies are in reengineering existing programs in such a way that health plans are not able to duplicate them.

"I think health plans and DM companies will find themselves in a competitive situation. They are both

doing 'medical management,' " says Todd, adding that smaller health plans will still need to rely on DM companies because they don't have the capacity to offer full-blown DM programs. One way for DM companies to prevent the shift to insourcing of DM by health plans, according to Todd, is to create programs that are so sophisticated that a health plan could not replicate those services. Todd expects DM's second- and third-generation programs to rely heavily on new technology, and he points to several recent instances in which technology and DM companies have joined forces.

Kuraitis says he is optimistic about growth in the DM market. DMAA: The Care Continuum Alliance conducted a market analysis that estimated the market potential at \$30 billion in 2005. However, today the market is still under \$2 billion, which Kuraitis says suggests there is room for growth.

"There's a tremendous amount of upside," he says. "If we see glitches or bumps in the marketplace, there is still a lot of chronic care that needs to be delivered."

Nash says the DM industry will need to make changes, particularly after the difficulties faced by CMS' Medicare Health Support project. "We are going to have to regroup and expand into work-site wellness, retail clinics, [and] corporate-based individual employee incentive programs. DM is going to have to evolve," says Nash. ■

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## Going mobile

### Technology will play bigger role in 2008

Technology has changed the way Americans bank and shop, so it makes sense that healthcare would develop technology that targets chronic care. Technological advances in DM are making it possible for patients to telecommunicate with their doctors and for physicians to collect health information and change care if warranted. **David Whitlinger**, president and chair of the board of Continua Health Alliance in Beaverton, OR, says technological improvements are a needed change in the healthcare system.

"The belief is that the healthcare system has to change. That individuals and families will have to become much more a part of the caregiver aspect of delivery of healthcare and, from that, these personal telehealth tools will be key," says Whitlinger, who is also the director of healthcare device standards and interoperability for Intel Corp. in Beaverton, OR.

**David B. Nash, MD, MBA**, chair of the department of health policy at Jefferson Medical College of Thomas

Jefferson University in Philadelphia, says big players such as Google and General Electric are driving technological advancements in healthcare, and he expects wireless Internet-enabled technology that utilizes cell phones to become a larger part of the market.

“Technology is going to evolve so that the cell phone or its equivalent will be a medical, social, networking tool,” says Nash.

**Ariel Linden, DrPH, MS**, president of Linden Consulting Group in Hillsboro, OR, says DM companies are now realizing the need to collect daily health data from patients at high risk of hospitalization. Emerging telehealth technology is more effective than the old DM model, he says.

“We need to move beyond the model of making outbound calls to patients every three months, talking to them for 15 minutes, and expecting that to keep them out of the hospital. We need to take advantage of advanced technology, plus incorporate interventions that are based on the best behavior change science,” says Linden.

Whitlinger expects to see a large number of remote monitoring DM trials focusing on people with diabetes this year.

Whitlinger says he won't be surprised if those trials are successful, the programs double in size, and telehealth becomes the norm for patients and providers to monitor diabetes daily.

Although he expects growth in the diabetes market, Whitlinger predicts modest movement in technology for

chronic disease patients who are homebound or nearly homebound. In addition to helping patients, the telehealth and online improvements will help caregivers, says **Jim Giuffre, MPH**, president and chief operating officer at Healthwise in Boise, ID. Many baby boomers don't live in the same region as their parents, but technology is allowing them to keep track of their loved ones.

“New Web-based technologies allow older people to enroll in online programs, including interactive conversations that give them helpful information for managing their conditions. Parents can share this information with their baby boomer sons and daughters, so they can really assist and reinforce their older parents in managing their health,” says Giuffre.

Giuffre expects online social networking to play a larger role in people's search for health information. With that added networking, health companies will need to confirm the information is medically accurate. “The challenge there is knowing what is evidence-based and what's not,” says Giuffre.

He also expects more federal demonstration projects involving technology and pay-for-performance—though probably not in 2008.

**Gordon Norman, MD, MBA**, executive vice president and chief science officer at Alere Medical, Inc., in Reno, NV, expects to see broader adoption and interoperability of technology, particularly in personal health records.

“Without interoperability and standard formats, there's not going to be much progress.” ■

### Continua leads technology charge

**David Whitlinger** has crisscrossed the country since the Continua Health Alliance effort was launched in June 2006, building bridges that have laid a foundation that Continua members hope will bring an interoperable telehealth system this year.

Whitlinger is president and chair of the board of Continua Health Alliance in Beaverton, OR, a collaboration of an ever-growing group of 135 companies working to establish

a system that allows interoperable personal telehealth products that empower people and organizations to better manage health and wellness.

Whitlinger says creating interoperable telehealth systems is critical as the nation faces a doctor shortage coupled with an aging boomer population. “To a large degree, many in the health policy world believe that the healthcare system

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## Continua leads technology charge (continued)

simply has to change because of scalability," says Whitlinger. "Because of the demand for healthcare and the insufficient number of beds, hospitals, and doctors . . . the scalability is going to hit us square in the face in a decade and a half."

Whitlinger says the idea of greater interoperability germinated in Intel Corporation's offices in Beaverton, where he is director of healthcare device standards and interoperability. Intel officials sought to take what they learned from other marketplaces and create a team of companies that would develop an interoperable system that would become the telehealth norm.

Whitlinger began reaching out via phone to gauge interest and forged ahead with face-to-face and summit meetings before Continua launched in June 2006.

Continua includes many of the big names in technology, including Dell, IBM, and Panasonic, and health insurers and DM companies, such as Aetna and Kaiser Permanente.

Whitlinger says Continua officials have spoken to CMS about telehealth reimbursements.

"[CMS is] running some of their own trials to see the effectiveness of remote monitoring . . . That's all building up in some sort of CMS policy in this regard," says Whitlinger.

Continua plans to have completed interoperability guidelines at the beginning of this year, which will allow companies to go through Continua's certification process and guarantee out-of-box interoperability. "It will probably be early [2008], but we have already had some plug fests where companies had brought together prototype devices

and tested those. Each quarter, we will include those events. By the time the guidelines are published, I expect several parallel products will be certified. The first half [of 2008] will be pretty exciting," says Whitlinger.

Continua has also signed up ADT Associates to collect remote patient monitoring studies published in the United States and Europe.

With that information, which may be released at the beginning of this year, Whitlinger says Continua will assess common barriers to adoption and then begin talks with payers in the middle of the year.

He expects remote monitoring services and electronic health records that share data across networks to be in Version 1 of the software interface. Whitlinger predicts a handful of those interfaces will be shipped in 2008, possibly in the third quarter.

Continua is a necessary step to address the lack of remote monitoring device interoperability, says **Vince Kuraitis, JD, MBA**, principal of Better Health Technologies in Boise, ID.

Kuraitis is bullish about the technology and says making devices plug and play will help, but he says there are at least two more fundamental issues: reimbursement and licensing. Interoperability will raise the "ugly head" of licensing across state lines and other legal regulatory issues.

"I think they will be more problematic once we get some of these other things out of the way," says Kuraitis, referring to the licensing issues.

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# MEDICARE

## DISEASE MANAGEMENT

### Blue Cross/Blue Shield promotes medical home demonstrations

The concept of a medical home is taking shape in several demonstration projects that include elderly patients with multiple chronic conditions, as well as fewer sick patients who stand to gain from wellness and DM interventions that are led by the patient's physician. Some of the largest insurers in the country are leading the way in this effort. Blue Cross and Blue Shield Association (BCBS), Chicago, and 27 participating BCBS companies have joined with four major U.S. physician groups, national employers, and consumer groups to examine the medical home model of care in primary care demonstration projects around the country.

Many of these demonstrations are an outgrowth of existing efforts to focus on patients and give the lead to doctors. They were the main subject of discussion at a stakeholders' meeting in Washington, DC, in early November 2007 about the patient-centered medical home. (See the story about the Patient-Centered Call to Action Summit on p. 2 of **MDM**.)

"Our providers came to us back in 2004 and said, 'Disease management belongs to doctors,'" says **Jon Rice, MD**, senior vice president and chief medical officer for BCBS of North Dakota in Fargo, who is organizing a demonstration in his state. "Our doctors said, 'Give us the seed money, and we will manage patients and demonstrate cost savings.'"

Rice says the demonstration is an extension of the initial program that his company started in response to the request from doctors.

"Our program began with a series of stakeholder meetings to help us understand how to better add value to services provided by our physicians," says **Barbara Ann Muller, MD**, medical director for Wellmark BCBS of Iowa. "We wanted to find a better way to support the doctor-patient relationship than the current broken and fragmented system."

#### The North Dakota model

BCBS of North Dakota covers more than 450,000 members in North Dakota and Minnesota. MeritCare, an integrated clinic and hospital system and the state's largest group practice provider, with more than 400 physicians, is the leader of this demonstration project. The doctors in this practice conducted an Advanced Medical Home Project beginning in 2005

**"Our providers came to us back in 2004 and said, 'Disease management belongs to doctors.'"**

—Jon Rice, MD

that enrolled more than 3,000 members with only \$20,000 in start-up money, says Rice.

Results for the enhanced diabetes DM services, including nurse education and an electronic medical record to monitor and manage patient needs, were measured using a control group.

The 2005 program resulted in savings of \$500 PMPY, with the savings split equally between BCBS and the physician group.

Rice says the new demonstration program began September 2006 and has already enrolled 246 patients. He anticipates that approximately 2,000 members will be enrolled over the two-year course of the

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## Home demonstrations

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demonstration. Based on projected savings similar to the earlier demonstration program, BCBS is paying physicians \$175 per enrollee up-front, says Rice.

“Because we already have an electronic health record, we can now focus on putting more people in place to help improve clinical outcomes,” he says.

## National summit addresses benefits of patient-centered medical home

At a national summit held in Washington, DC, in early November 2007, several commercial providers—as well as CMS—expressed support for what is now called the “patient-centered medical home.”

The hallmarks of this concept stand in contrast to Medicare’s premier DM program in the fee-for-service population, Medicare Health Support (MHS). The patient-centered medical home is led by the patient’s physician, who coordinates care for all chronic conditions that a beneficiary may have, and is driven by the goals of achieving improved clinical outcomes and reduced healthcare costs.

CMS is finding that the MHS model lacks integration with physicians, involves more than one physician overseeing multiple chronic conditions, and is facing resistance from hospitals and other providers who do not want to see a decrease in reimbursements for care, according to **Linda Magno**, director of demonstration projects for CMS.

Magno spoke at the Patient-Centered Call to Action Summit, a meeting sponsored by the Patient Centered Primary Care Collaborative (PCPCC), a coalition representing business leaders, policymakers, and more than 300,000 PCPs. Political leaders, such as former Speaker of the U.S. House of Representatives Newt Gingrich (R-GA) and Congressman Patrick Kennedy (D-RI), also were on hand to promote the medical home model.

**Paul Grundy, MD**, chair of the PCPCC, explains the new model this way: “The patient-centered medical home concept provides primary and preventive care that is personalized for each patient. It emphasizes the use of health information technology, including electronic health records, to help prevent and manage chronic disease and features consumer conveniences such as same-day scheduling and secure e-mail communications

between the provider and patient.” Participants in the collaborative include four professional groups representing physicians (American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, and the American Osteopathic Association) as well as business leaders, including Blue Cross Blue Shield Association (BCBS), WellPoint, CIGNA, Humana, Aetna, and UnitedHealthCare.

There are 27 BCBS companies across the United States that will participate in the patient-centered medical home demonstration projects. Some have already enrolled patients in the pilots, which are scheduled to last for a minimum of two years. These companies include Wellmark BCBS of Iowa in Des Moines and BCBS of North Dakota in Fargo.

## Two task forces implemented

According to **Joe Grundy**, a PCPCC staff member, the Collaborative has implemented two working task forces to address future needs. Participation in the biweekly telephone meetings is open to healthcare providers working to implement a medical home, he says. (For more information about how to participate in the Tuesday calls, e-mail [jgrundy@eric.org](mailto:jgrundy@eric.org).)

The first task force is working on the development of a series of all patient-centered medical homes. These pilot programs would include commercial and government payers, such as Medicare, as well as large employers, says Grundy.

The second task force is providing technical assistance to state Medicaid programs that want to incorporate the principles of a patient-centered medical home into their health system. The task force is helping states to define the medical home and write service contracts that include a medical home.

This includes a nurse educator and chronic care case management nurses. “We felt that we would achieve more improvements by giving the practice money at the start of the program rather than at the end,” says Rice.

When the American College of Physicians first approached BCBS of North Dakota about participating in the patient-centered medical home demonstration project, the insurer wasn’t sold on how it might achieve additional improvements, says Rice. “We were already vertically integrated with our hospital affiliation, and the electronic health record had made our operations much more centralized and patient-centered,” he says. “We decided to focus this next improvement step on

improving the relationship between doctors and patients by hiring a nurse who serves as a combination educator and patient facilitator.”

BCBS of North Dakota may expand the program during the course of the demonstration if the outcomes are positive, he says, but the company would likely wait to make this determination until December, when it has at least one year of claims data to review.

### Registry helps decrease fragmentation

Two years ago, Wellmark BCBS of Iowa in Des

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### Effect of a medical home

Attendees at the Patient Centered Primary Care Collaborative Summit received an “evidence document” outlining the effect of a patient-centered medical home on quality and costs. Research results included the following:

- ▶ The Center for the Evaluative Clinical Sciences at Dartmouth College studied the effect of a medical home on patients with severe chronic diseases and found the following:
  - Lower Medicare spending (inpatient, reimbursements, and Part B payments)
  - Lower resource inputs (hospital beds, ICU beds, total physician labor, primary care labor, and medical specialist labor)
  - Lower utilization rates (physician visits, days in the ICU, days in the hospital, and patients seeing 10 or more physicians)
  - Better quality of care (fewer ICU deaths and a higher composite quality score)<sup>1</sup>
- ▶ Barbara Starfield, MD, MPH, of Johns Hopkins University in Baltimore, conducted an analysis of studies comparing healthcare in the United States with healthcare in other countries.<sup>2</sup> She concluded:
  - Adults with a PCP had 33% lower costs of care and were 19% less likely to die from the conditions than those who received care from a specialist (adjusting for health and geographic characteristics)

- PCPs are associated with improved health outcomes for patients with cancer, heart disease, stroke, life expectancy, and self-rated care
- In England and the United States, the availability of primary care is associated with a 3%–10% decrease in mortality
- ▶ Researchers from RAND and the University of California Berkeley evaluated 4,000 patients who were managed clinically in a medical home model for diabetes, congestive heart failure, asthma, and depression. The researchers found that:
  - Patients with diabetes had significant reductions in cardiovascular risk
  - Congestive heart failure patients had 35% fewer hospital days
  - Asthma and diabetes patients were more likely to receive appropriate therapy<sup>3</sup>

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3. A Robert Wood Johnson–funded evaluation of the effectiveness of the chronic care model and the Institute for Healthcare Improvement Breakthrough Series Collaborative in improving clinical outcomes and patient satisfaction with care, accessed June 19, 2007, at [www.rand.org/health/projects/icice/index.html](http://www.rand.org/health/projects/icice/index.html).

## Home demonstrations

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Moines brought together stakeholders for what Muller describes as “frank discussions about the future.”

One of the key concerns raised at these meetings was that PCPs didn’t know what was happening with their patients when they were seen by other doctors, she says.

“Coordination of services was lacking,” says Muller.

**“A true medical home has all of the patient’s information, and that’s the system that we want to achieve.”**

—Barbara Ann Muller, MD

Physicians also realized that they were providing little to patients in the way of wellness and prevention.

This wasn’t a priority during brief office visits.

“From the patient’s perspective, we heard about fears of harm when interacting with the healthcare system and their own doctors based on media reports and government reports,” says Muller.

“There were any number of support services, but they were not being aligned for the sake of the patients, and physicians were not coordinating care for their patients because they lacked information,” Muller adds.

Something had to be done. “After all, who knows the patient better than their own doctor?” she says.

“A true medical home has all of the patient’s information, and that’s the system that we want to achieve,” says Muller. “What we started to do then and will continue in this demonstration is to go back to the drawing board and find ways to improve and prevent illness and disease complications,” she says.

A major key is now in place—a patient registry that is tracking information from 1,200 clinicians. Office nurses now review each patient’s overall care plan and any corresponding services that have or have not been provided when the patient comes for a visit.

“The nurses are highly trained to use decision support tools and assess the implementation of the care plan,” says Muller.

For example, a DM nurse may see that a diabetes patient hasn’t had a foot or eye exam or that a patient with congestive heart failure hasn’t refilled a prescription drug. It also alerts the nurse and doctor to any potential medication interactions.

During the demonstration period, Wellmark is encouraging its participating physician groups to devise their own strategies for quality improvement and the implementation of a patient-centered medical home in their own practice setting, says Muller. “We don’t want to be prescriptive,” she adds. Each practice will choose an area to focus on. For example, one practice is implementing a diabetes DM program, while another is focusing on immunizations.

Wellmark will use the new standards for medical homes developed by the National Committee for Quality Assurance to measure the success of individual efforts.

As part of the demonstration, DM nurses will be on call for patients around the clock. Other new components available to practices are medication management and wellness prevention. “We want to give our physicians something tangible that can improve their practice,” says Muller.

This particular demonstration will not have a practice management fee.

“As demonstrations gain momentum, we will be able to see what works best and make financial commitments in those areas,” Muller says. The issue of pay-for-performance incentives for doctors is a growing dilemma. Should they be based on best practices, HEDIS measures, or actual patient outcomes? Do financial incentives actually affect physician practice behavior?

“Nobody really knows how to structure practice management payments or how to best reward physician practices,” says Muller. “Our doctors haven’t asked us for money. They want to improve their own practices and their patients’ care.” ■

## What's next for Medicare?

Even those who closely follow the latest Medicare developments are unsure what to expect this year. CMS' Medicare Health Support (MHS) projects, which take a more traditional DM approach, have not been successful, and a handful of companies involved have dropped out.

**Vince Kuraitis, JD, MBA**, principal of Better Health Technologies in Boise, ID, is one of the leading experts on CMS, and even he acknowledges he doesn't know what its next move will be.

"The legislation had very specific mandates to CMS if the projects were successful, but there's nothing in there that says if it's not successful, then do something else," says Kuraitis. "I think answers are going to be within the Medicare bureaucracy, and that's a very difficult animal to try to understand . . . I don't see high leadership level really a champion for continuing some kind of experimentation with Medicare in DM, and so it's very difficult to see what's going to happen."

Though some have viewed the early results as disappointing, **Jim Giuffre, MPH**, president and chief operating officer at Healthwise in Boise, says it's still too early to decide on MHS' results. He suggests the industry may see better results as MHS progresses, and it can then adequately gauge the successes or failures.

**Gordon Norman, MD, MBA**, executive vice president and chief science officer at Alere Medical, Inc., in Reno, NV, says CMS learned from MHS Phase I in the areas of program design, risk level, and targeted cost savings, and he hopes CMS returns with a better program in MHS Phase II.

**Ariel Linden, DrPH, MS**, of Linden Consulting Group in Hillsboro, OR, on the other hand, is not as hopeful. Linden predicts CMS won't forge ahead with a Phase II, but will fund projects that focus on physicians rather than DM companies, such as the medical home model. "There is little hope that CMS is going to expand [MHS] to DM vendors, given that several of them have already pulled out of the demos, and the remaining programs do not appear to be meeting targets. What I do see happening is that they will use this money to expand

other Medicare demonstration projects that are provider-centric, since those are showing positive early results," says Linden.

**Warren Todd, MBA**, founder and executive director of International Disease Management Alliance in Flemington, NJ, says that CMS really wants DM to succeed within the Medicare community, but how CMS will deal with mixed results is less clear, because some of the original supporters of DM within CMS are no longer there, and the degree of support from new CMS staffers is uncertain. Todd says the biggest concern he has with the MHS pilots is that the initial preliminary report did not address what seems to be working and what is not working. "In my opinion," says Todd, "the most important outcome from the collective analysis of all the MHS pilots is what works and what does not work. We need to better understand how the original commercial DM model needs to be modified to be successful in the senior market."

Todd speculates that some of the projects have not been successful because of lack of experience in the Medicare sector, combined with the fact that the companies involved in the pilots did not have a great deal of time to tweak their commercial programs.

Elderly patients may need "more high touch" than younger people, perhaps including some face-to-face contact. In addition, the DM companies also may not have had adequate development time to build in more technology tools, he adds.

In addition to focusing on older Medicare patients for the CMS projects, Giuffre says Medicare should invest in programs that target younger seniors who are in the early stages of their chronic conditions. "They need to make the investment earlier if they are really going to slow down the expenditures for Medicare," he says.

Kuraitis says Medicare is involved in dozens of demonstration projects in several areas, including the Physician Group Practice project, which places the care

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## What's next? < continued from p. 7

coordination in the physician's practice rather than with a DM vendor. If Medicare ultimately finds another demonstration project that is not a DM project and provides a better way to care for its beneficiaries, Kuraitis hopes Medicare explores that route.

"Medicare can and ought to draw conclusions about how to care for chronic care patients across a wide range of demonstration projects, whether or not they are labeled DM. How they are going to do that is very unclear, and whether they are going to do that is very unclear," he says.

### Legislation

The DM experts that **Disease Management Advisor** interviewed don't expect much federal healthcare legislation this year, given the ongoing presidential race and President George W. Bush's final full year in office.

Healthcare is at the top of most voters' domestic issues, says **Julie Meek, DNS**, chief science officer at CareGuide in Coral Springs, FL, and founder of The Haelan Group in Indianapolis. Meek predicts a lot of healthcare debate and brainstorming in 2008 but doesn't expect healthcare legislation that brings about change until 2009 or 2010.

Linden says that any CMS legislation and demonstration projects will focus on the physician, such as the

medical home model. Although not much is expected out of Washington this year, there could be DM-related legislation at the state level. Meek hopes other states follow the model of the legislation she authored in Indiana a decade ago, which was finally passed in summer 2007. The measure provides state corporate tax credits for employers with between two and 500 employees that implement wellness programs.

Meek says Indiana Governor Mitch Daniels' support of the bill was the reason the long-delayed legislation finally made it through the legislature in 2007.

Meek adds that her legislation was actually written a decade too soon.

Most employers did not have wellness programs when the bill was first written. Now, "there is a federal grassroots effort under way, and I would love to see that kind of thinking expanded across other states and federally as well," Meek says.

Although federal legislation is not expected this year, **David B. Nash, MD, MBA**, chair of the department of health policy at Jefferson Medical College of Thomas Jefferson University in Philadelphia, says that doesn't mean the DM industry should not evolve on its own. "I don't think we should be waiting for legislation. That's the last resort," says Nash. ■

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## Pharmacy program with DM component targets CKD

### Navigator catches patients before dialysis

The money spent to care for patients on dialysis and those with chronic kidney disease (CKD) is staggering—yet health plans are slow to tackle the issue without knowing whether DM programs are cost-effective.

A recent study published in the *Journal of the American Medical Association (JAMA)* highlighted the prevalence of CKD among adults in the United States. According to the authors, who were led by Josef Coresh, MD, PhD, of Johns Hopkins University in Baltimore, 13% of Americans have

CKD in part because of the prevalence of diabetes and hypertension. CKD also elevates the risk of cardiovascular disease and kidney failure and leads to more expensive healthcare costs. Studies have shown the average dialysis patient incurs costs of about \$70,000 per year.

"Estimation of the prevalence of earlier stages of CKD in the U.S. population and ascertainment of trends over time is central to disease management and prevention planning, particularly given the increase in the prevalence

of obesity, diabetes, and hypertension, the leading risk factors for CKD," the study states.

The researchers found that the prevalence of CKD stages 1–4 increased from 10% in 1988–1994 to 13.1% in 1999–2004. Most of those with CKD are in the early stages of the disease, meaning there is still an opportunity to stop the slide into dialysis.

Authors of the *JAMA* report said that greater awareness is needed.

"The high prevalence of CKD overall, and particularly among older individuals and persons with hypertension and diabetes, suggests that CKD needs to be a central part of future public health planning," they wrote.

Given the increasing number of Americans afflicted with CKD and the costs associated with dialysis care, Diplomat Specialty Pharmacy of Swartz Creek, MI, developed a program called CKD Navigator, which combined DM with a medical management approach. McLaren Health Plan (an HMO covering about 52,000 Michigan residents) of Flint, National Kidney Foundation of Michigan in Ann Arbor, and corporate sponsor Genzyme of Cambridge, MA, joined the pilot program.

The CKD Navigator pilot showed:

- The managed care group enjoyed a \$300 per patient per

month savings in combined medication and medical costs compared to the control group

- The managed care group enjoyed a \$150 per patient per day savings in combined medication and medical costs because of delaying the onset of dialysis
- An ROI of about 5:1

Though the pilot program shows savings, its effect on health and quality of life is unknown. Organizers say the program's short length of time (six months) and small patient sampling (less than 100) does not allow them to accurately gauge the program's health effects.

"It is solid enough to get some good financial metrics, but not big enough yet to pull in some lifestyle information," says **Ron Alexander**, Diplomat's vice president of clinical services.

### Slippery slope

**Phil Hagerman**, president and CEO of Diplomat Specialty Pharmacy, says the company is interested in targeting those with CKD because of the costs associated with kidney disease and dialysis care. Similar to hypertension, CKD is a silent condition that people often don't realize is ravaging their bodies until it's too late. The goal is to help patients in early stages of CKD before they descend down the slippery slope of dialysis, says Hagerman.

CKD Navigator reached out to patients in Stages 3 and 4. Those in Stage 3 often feel healthy and don't realize how close they are to dialysis. By stabilizing those in Stage 3, health plans could save patients from dialysis, which could mean the difference between a patient living a long, productive life and spending six months in a hospital, says Hagerman. "We believe that with Stage 3, you have the best opportunity to get the most bang for your buck," he adds. Hagerman says dialysis is a tremendous trigger event, both in terms of quality of life and finances. Once a patient goes on dialysis, baseline costs skyrocket. "We realized that if we can stop the movement to dialysis, we believe that the return on investment is one of the greatest in any of the disease states."

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### Breakdown of the savings

Diplomat Specialty Pharmacy's CKD Navigator pilot showed combined medication and medical costs savings of \$300 per patient per month for the managed care group in a chronic kidney disease study. Here is how the savings were achieved:

- Average combined prescription and medical costs for the control group were \$999 per month
- Average combined prescription and medical costs for the managed care group were \$639 per month
- That equaled an average savings of \$360 per month per patient
- The total average savings was \$300 per month per patient when the pilot services' costs of \$60 per patient per month were added to the equation

## CKD < continued from p. 9

When selecting McLaren members to take part, and without knowing members' glomerular filtration rate (GRF), which measures fluid filtered by the kidneys, pilot organizers searched for patients with comorbidities who were taking certain medications that would suggest they were suffering from CKD. Almost 100 members were chosen for the project—50 in the managed group and about 40 in the control group. All were Michigan residents, and the majority was in the Medicaid population.

Three Diplomat nurses, trained in motivational interviewing and medication therapy management techniques, took part in the program. They made at least one call per month to those in the managed group.

Nurses coached patients and conducted a full medication review during 20-minute calls, during which they

were able to form a bond with patients, according to Alexander. After nurses contacted the patients, they created plans of action and faxed them to the individual physician offices. The doctors reviewed and changed care if needed.

Alexander says the three keys to the Diplomat program were communication with the patient, medical therapy management, and physician intervention. Gaining physician trust is often the difference in creating a successful DM program. Alexander says after the PCPs knew Diplomat wasn't trying to take away their patients or move them to nephrologists, they were receptive to CKD Navigator.

Alexander says PCPs are important to a successful CKD program. "The primary care physician is still the pilot. We're just trying to be the navigator out there trying to help them." ■

### Kidney function test largely unknown

Growing numbers of Americans know their BP numbers and cholesterol figures, but most don't recognize the letters GFR. Through education programs, some groups are trying to change that. **Maurie Ferriter**, National Kidney Foundation of Michigan's director of programs and services, says most people with chronic kidney disease (CKD) don't realize they have the disorder. Instead, many people go to their doctor or an ER complaining of dehydration and thinking they have the flu—only to find themselves on dialysis. "It doesn't reach out to bite you in the butt, so to speak, until you're just about ready for dialysis," says Ferriter.

The GFR, which stands for glomerular filtration rate, measures fluid filtered by the kidneys. The relatively new test is a gauge similar to cholesterol tests and is considered the best way to measure kidney function. Patients are given a GFR number, which places them into a CKD stage. "GFR is not only a marker of kidney disease, but it's the easiest, simplest one," says **Phil Hagerman**, president and CEO of Diplomat Specialty Pharmacy in Swartz Creek, MI.

With more people diagnosed with the disease, why do so few Americans understand CKD or know their GFR? There are various reasons, including the newness of the

GFR test, overworked doctors, and a skeptical DM industry. "When the doctors out there practicing in the world were trained, we didn't know what we know now about CKD," says Ferriter. The managed care industry's resistance was evident in the reaction to Diplomat's Navigator program. Though Ferriter calls the program "one of the greatest breaths of fresh air" in the dialysis industry, larger health plans were not ready to commit to take part in the pilot without knowing the monetary benefit. However, there is good news on the CKD front. Education is reaching physicians, legislators, and managed care companies. Hagerman says managed care companies now better understand the costs associated with CKD. After the ROI success of its CKD Navigator program, Diplomat is reaching out to sign up other health plans in the Michigan/Ohio area. Officials hope to have 1,000 patients in the CKD Navigator program by the middle of this year. Hagerman says as Diplomat continues highlighting savings in larger populations, he expects larger health plans will show interest.

"We have shown the savings. Now we want to go back and see what this means to the patients as well," says **Ron Alexander**, Diplomat's vice president of clinical services.

## Program brings hypertensive patients within BP ranges

Automated telephone systems can serve as a barrier for senior citizen patients. However, a recent study focusing on hypertensive elderly patients showed that telephony backed by nurses didn't affect health results and saved money.

Healthways of Nashville and Varolii Corporation of Seattle teamed up for "Use of Automated Telephony to Optimize Blood Pressure and Medication Management of Hypertensive Elderly Patients," which they presented at DMAA: The Care Continuum Alliance's Disease Management Leadership Forum in September 2007. The study explored whether elderly hypertensive patients were willing to self-report BP and medication adherence during weekly automated calls. The study authors sought to see if the system could improve medication management, quality of care, and live agent utilization.

An automated BP cuff and telephony system, backed by Healthways nurses, produced the following results:

- ▶ 54% of participating patients received a change to or an additional prescription for BP medication by nurses longitudinally tracking BP readings
- ▶ 87.5% of those in the program now have systolic BP readings within target
- ▶ 96.79% are in compliance with diastolic BP target ranges

When calculating costs spread across 50,000 or more beneficiaries, the study found a savings of 4% (taking into account the cost of BP reading using the traditional system of a Healthways nurse making the calls vs. Varolii automated calls). The actual savings will depend on the volume and specific contracts.

There were no differences between Varolii and nurse-treated cohorts in terms of the clinical endpoints (systolic and diastolic BPs).

Healthways and Varolii tackled hypertension because of the costs associated with the ailment and its prevalence in older Americans. Hypertension is evident in more than 70% of Americans older than 80, and high

BP is the single most important risk factor for stroke.

**Michael F. Montijo, MD, MPH, FACP**, Healthways' senior vice president of government operations, provides this sobering number: The healthcare system spends about \$50,000 in the first year alone on the average Medicare patient after a stroke. Costs associated with hypertension, which can lead to heart attacks and CHF, caused Healthways and Varolii to create a program that could

**"One of the Varolii secret sauces here is that every single communication is uniquely constructed to the patient and can be understood and accepted by the elderly patient."**

—S. Michael Ross, MD, MHA

control costs while not adversely affecting patient health.

Engaging the elderly population can be difficult, and Montijo says he was not overwhelmingly optimistic at the start.

"This is a tough environment, and I did not have high expectations going in that we would have marked improvement in blood pressure," says Montijo.

The study included Healthways members from the Maryland/Washington, DC, area who had primary diagnosis of either CHF or diabetes and recently reported BP readings higher than the established target ranges for those diagnoses, which are as follows:

- ▶ CHF patients: 140/90
- ▶ Diabetic patients: 130/80

When the study began, 58% of the CHF patients and 30% of the diabetic patients were within the target ranges. Six hundred and twenty-two patients from the Medicare Health Support pilot population were asked whether they wanted to take part.

The patients were told the study was an outreach program that would measure their BP longitudinally, which would allow their doctors to better manage BP toward the goal of reducing the likelihood of heart attack or

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## BP ranges

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stroke. They were not initially told about the automated phone system. The treated and untreated cohorts broke down as follows:

- 318 patients consented to participate in the trial (291 were given automated BP cuffs; the rest already possessed BP recording devices)
- 304 patients who declined to take part received Healthways nursing program's usual services

The program lasted from March 19 to May 24, 2007. Those in the treated cohort were called once a week by the automated system, which asked the patients to self-report their BP readings and medication adherence.

The automated system was fortified by a rules-based transfer that was predicated on their responses. For example, if patients reported BP numbers that were greater than the target range or that they were having trouble taking their BP or not managing medication properly, the phone system transferred the person to a Healthways nurse. The nurse, in turn, communicated with the patient's doctor, who changed the medication regimen if needed.

At the beginning of the study, 40%–50% of patients in the treated cohort were transferred to a nurse. That number dropped to less than 20% by the end of the two months after BP was normalized, according to **S. Michael Ross, MD, MHA**, Varolii vice president of healthcare.

The study found that the automated system cost per BP reading was "significantly lower than using a live agent to retrieve the reading." Ross says gaining trust is particularly important when dealing with the elderly. However, on the plus side, they are easier to contact because they are usually home and welcome phone calls.

Though the larger population views a telephone system as simple technology, elderly patients may still feel apprehensive taking part in such a program. Montijo says the up-front education informing the patients what to expect and the benefits of the program engaged the

population. "They say, 'It is pretty easy, pretty simple, they aren't selling me anything, and it's helping me. What's in it for me? It's helping me, I can see my blood pressure coming down, I can see my doc and bring these numbers with me,'" says Montijo.

Ross says the elderly are open to Varolii's automated communications backed by high-tech protocols that forward callers with problems to live professionals. The findings reported no statistical difference between the phone system and nurses' ability to get the information from patients.

"One of the Varolii secret sauces here is that every single communication is uniquely constructed to the patient and can be understood and accepted by the elderly patient," says Ross.

Montijo says Healthways is exploring which other patient populations could benefit from a similar automated communications system. Ross says a comparable program could work with certain patient populations, such as those with diabetes.

Ross is optimistic about telephony as a way to reach patients, especially given many Americans' preference to use automated systems. He cites the example of an ATM. During bank hours, customers could just as easily go to tellers, but prefer banking via ATM.

"I'm not sure how the elderly feel in this regard. A lot of people want to just get it over with, and a computer just works fine. 'Give me the information. Give me those automated numbers, and I'll just plug it in and be done,'" says Ross about the changing way Americans are dealing with companies. ■

### Questions? Comments? Ideas?

**Contact Editor  
Les Masterson**

**Telephone 781/639-1872, Ext. 3157**

**E-mail [lmasterson@hcpro.com](mailto:lmasterson@hcpro.com)**

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