

Disease Management NEWS

Independent, timely business intelligence on disease and demand management

Volume 11, Number 12

June 25, 2006

Firms Predict Deeper Penetration of DM Programs, 'More Realistic' ROIs

Health Dialog, American Re Form Strategic Alliance

Health Dialog Services Corporation and reinsurance giant American Re HealthCare have formed a strategic alliance under which the two organizations will develop and market a suite of risk-based care management products to health plans, self-insured employers and Medicare and Medicaid plans.

Among the products that Boston-based Health Dialog and American Re envision: chronic disease specific carve-out coverage, specific or aggregate loss protection and growth capital support through reinsurance, says George Bennett, president and chief executive officer of Health Dialog.

At the same time, American Re plans to insure or reinsure Health Dialog's disease management (DM) contracts to back Health Dialog's efforts to successfully meet medical cost and quality outcomes established for its DM programs. "This will provide additional assurance to Health Dialog's clients that targeted performance savings will be real-

ized," Bennett tells *DM News*.

A pair of drivers brought the two organizations together in this novel alliance, according to Bennett. The first was Health Dialog's successful bid to get one of the eight Medicare Health Support (MHS) DM pilots launched last year by the Centers for Medicare and Medicaid Services (CMS). "When we got the MHS contract, one of the conditions of CMS was that all MHS contractors guarantee at least a 5 percent net savings," Bennett explains. "Under current accounting laws you can't recognize the revenue [earned in DM programs] until the results of the program are finally computed. The final results for the MHS pilots won't be computed for two to three years out, although within a year there will be interim results. Therefore, we thought it would be useful to have some reinsurance so that we could recognize the revenue [earlier]."

Health Dialog approached American Re to reinsure the DM

firm's MHS pilot, and the reinsurer agreed to back the firm. "It ends up that our performance, historically, and our record keeping are such that they were able to make an actuarial commitment to provide us with insurance for our MHS contract, so they now share the exposure with us," Bennett says.

The second driver for the formation of the strategic alliance was American Re's decision to help recapitalize Health Dialog last year. While going through the due-diligence process for that as well as to assess Health Dialog's merits as a reinsurance candidate for its MHS DM pilot, American Re "got a very close look at Health Dialog," Bennett says. "They became fascinated with us and with the DM industry, and they then decided to participate in a recapitalization of the company that we did. They invested a substantial sum of money and assumed a noticeable shareholder position within Health Dialog, in excess of 10 percent."

continued on page 4

APS to Combine DM with EHR in Novel Medicaid DM Program

The Missouri Division of Medical Services has awarded APS Healthcare a five-year contract to establish and manage a chronic care improvement program (CCIP) for the state's nearly 900,000 Medicaid beneficiaries.

The disease management (DM) program will be similar to Medicaid DM programs launched in other states over the last three years in that it will attempt to cut administrative and medical costs and eliminate

waste in caring for Missouri Medicaid beneficiaries with chronic illnesses. However, it will differ markedly in two noteworthy ways. First, APS will employ its favored community-based model, rather than the traditional nurse call center-based approach to DM, to manage the care of Missouri Medicaid beneficiaries enrolled in the program. Second, APS will establish an electronic health record (EHR) for all partici-

continued on page 4

IN THIS ISSUE

Medical Home Concept May Put DM, Docs on Collision Course...2

DMAA Launches Obesity Management Initiative, Defines "Obesity".....3

JCAHO'S 2007 Patient Safety Goals for DM Programs Unchanged.....6

Study: Patient/Physician Disconnect Impeding Effective Diabetes DM.....7

Medical Home Concept May Put DM, Docs on Collision Course

The medical home concept being advanced by many primary care physician (PCP) organizations and their members could put disease management (DM) companies on a collision course with PCPs, predicts a well-respected thought-leader in the DM industry.

"There is a lot at stake here," says Vince Kuraitis, a principal with Boise, Idaho-based Better Health Technologies. "No matter what the doctors intend, the effect of the medical home model could be competitive to DM companies and others. The medical home could affect the flow of hundreds of billions of dollars, money that over time might flow either to physicians or to private companies. Ironically, this occurs at a time when most DM companies are picking up the pace of improving relationships and communications with doctors."

While the medical home model isn't new, Kuraitis points out that it has recently received formal endorsements from prominent primary care physician groups. For example, the American Academy of Family Physicians (AAFP) adopted a policy endorsing the medical home concept in May 2006, and the American College of Physicians (ACP) approved a position paper supporting the use of the medical home in January 2006. The AAFP represents 94,000 family medicine physicians, and the ACP represents 119,000 internists.

This movement among PCPs

puts DM companies in an awkward position, Kuraitis believes. On the one hand, DM companies have been working hard to improve their relationships and workflow integration with physicians, he explains. "While the need for better relations has been evident for years, the recent Medicare Health Support pilot projects underscore the urgency felt by DM companies to coordinate with doctors," he says. "These projects focus on frail, elderly patients who are particularly dependent on their relationship with their primary care physicians"

On the other hand, the medical home model could put physicians into direct competition with DM companies, Kuraitis says. But do physicians have the ability to compete with DM firms? Kuraitis says "yes and no." There are strong arguments on both sides.

On the "no" side, according to Kuraitis:

- Physicians cannot be cost effective. The use of expensive physician time is not economical to provide care coordination; a mix of nurses, other professionals, lay persons, and technology will be much more cost effective.

- Physicians lack training and experience at care coordination. DM companies and health plans have spent the past decade developing their care coordination capabilities.

- The medical home model does not provide financial guarantees for purchasers. Many DM pur-

chasers require guaranteed financial savings; these guarantees are typically backed by reinsurance and/or a very strong balance sheet. For example, the current MHS projects require contractors to guarantee 5 percent savings. Guaranteed savings for purchasers is not an integral part of the medical home model.

- Physicians lack capital and management expertise. Most physicians work in small groups or solo.

On the "yes" side, according to Kuraitis:

- The medical home is a better clinical model. The medical home approach integrates the Chronic Care Model. It provides for better integration of local care providers and strengthens the physician/patient relationship. Meanwhile, DM companies and health plans have been viewed as operating parallel to the physician/patient relationship or as getting in between physicians and their patients. Initiatives to develop and validate the Chronic Care Model have been supported by the Robert Wood Johnson Foundation, the Institute for Healthcare Improvement, RAND Corporation, and the World Health Organization.

- Technology levels the playing field. Physicians can provide DM services efficiently. They can subcontract with DM companies or other specialized vendors to gain access to appropriate call center services, health coaching and other

continued on page 3

About the Medical Home Concept

The American College of Physicians (ACP), which represents 119,000 internal medicine specialists, approved a position paper supporting the use of the medical home concept in providing primary care to people with chronic diseases and illnesses in January 2006. Here's how the ACP defines and describes the medical home:

"The advanced medical home is a physician practice that provides comprehensive, preventive and coordinated care centered on their patients' needs, using health information technology and other process innovations to assure high quality, accessible and efficient

care. Practices would be certified as advanced medical homes, and certified practices would be eligible for new models of reimbursement to provide financing commensurate with the value they offer. These practices would also be accountable for results based on quality, efficiency and patient satisfaction measures. The advanced medical home would be particularly beneficial to patients with multiple chronic diseases -- a population of patients that is growing rapidly and that consumes a disproportionate share of health care resources."

Source: American College of Physicians

Medical Home *continued from page 2*
technologically supported interventions.

- Physicians can leverage their grass roots connections. Primary care physicians live everywhere in America. Physicians are often influential citizens in their local communities and will have broad access to all members of Congress. Working with their national organizations, they will be able to influence passage of legislation favorable to the medical home model.

- Physicians have trusting relationships with patients. "How do you think the doctor and the patient will respond at the moment of truth in the privacy of the exam room when the patient asks, 'Doctor, should I sign up for this DM program being offered by my health plan, or should I sign up for your medical home pro-

gram?'" Kuraitis asks.

While competition between physicians and DM firms may be looming because of recent advancements of the medical home concept among PCPs, a range of collaborative scenarios could also result, Kuraitis notes. "Companies holding DM contracts could subcontract with physicians for their services, and physician groups who have signed up medical home patients could subcontract with DM companies," he says.

These views are all highly speculative, Kuraitis stresses. "Many things are still unclear," he tells *DM News*. "Do the national physician organizations speak for individual member physicians in advocating the medical home? Can physicians gain political support for their medical home proposal? Can

physicians get payers, especially Medicare, interested in the medical home model? Can physicians develop evidence to support clinical and cost effectiveness of the medical home model?"

Ultimately, Kuraitis believes physicians will learn to expand their vocabularies to include words like "compete." "Physicians also read the analyst reports predicting that DM will grow to become a \$10 billion to \$30 billion a year market," he explains. "They are understandably asking, 'Is some of that coming out of our pockets? How do we get our share and hang onto the bread and butter activities that define the physician of the future?'"

Contact: Vince Kuraitis, *Better Health Technologies*, (208) 395-1197, vincek@bhtinfo.com. □

DMAA Launches Obesity Management Initiative

The Disease Management Association of American has launched a new initiative it hopes will lead to effective ways for disease management (DM) organizations to help health plans, employers and other stakeholders in population health management stem the rising incidence of obesity and the co-morbid conditions associated with it.

DMAA's Obesity with Co-Morbidities Initiative, which the association launched last year under a grant from a major pharmaceutical firm, seeks to define and expand the understanding of co-morbid obesity, lead development and encourage adoption of best practices for managing the condition and promote health outcomes research related to obesity, according to Carl Graziano, a spokesperson for DMAA, the Washington, D.C.-based professional association representing the nation's DM providers. Other planned work products of the initiative include a collection of article submissions to *Disease Management*, DMAA's peer-reviewed journal, creation of an online resource center and an Obesity Management Summit that will be held this December during DMAA's 2006 Disease Management

Leadership Forum in Denver, Graziano says.

DMAA has shined a spotlight on obesity because the condition and the many diseases associated with it present a "looming national health crisis," says Donald Fetterolf, M.D., chair of DMAA's Obesity with Co-Morbidities Steering Committee, which is overseeing the association's initiative. New thinking suggests that obesity be viewed as a disease and, as such, that DM be focused on those who are at highest risk, are already obese and have a cluster of risk factors or co-morbid conditions, Fetterolf notes. "As an organization that represents all aspects of disease management, we recognize the need to be at the forefront of the management of obesity as a chronic illness," he says.

As a first step in the obesity management initiative, DMAA has developed a new definition of "obesity with co-morbid conditions." DMAA expects the definition to serve as the foundation for the association's larger obesity with co-morbidities project, according to Graziano.

DMAA's definition of obesity with co-morbid conditions is embedded within a larger document that

contains background information on the causes of and health problems associated with obesity along with statistical information on the prevalence of obesity in the United States. The definition notes that 64 percent of Americans 20 and older are overweight, and 30 percent are obese. Moreover, 15 percent of school-age children are overweight, with even higher rates within some ethnic groups. In all, 97 million U.S. adults are overweight or obese, and many exhibit pre-diabetes and other co-morbid conditions, the DMAA definition states.

DMAA's document also includes numerous literature citations that lead DM professionals interested in learning more about obesity and its health impact to other resources. The definition will be included in the second edition of DMAA's *Dictionary of Disease Management Terminology*, which the association expects to publish this summer, Graziano says.

According to DMAA's definition of obesity, the concept of obesity and obesity with associated co-morbidities as manageable, chronic conditions is an emerging phenomenon

continued on page 6

Health Dialog *continued from page 1*

As part of that deal, American Re gained a seat on Health Dialog's board of directors. That arrangement put the executive leadership of the two firms in "close proximity," according to Bennett, and they began to discuss opportunities for the two organizations to work together in other ways for their mutual benefit. The strategic alliance that Health Dialog and American Re formed is an outgrowth of those discussions.

"The boundaries of the alliance are still evolving," Bennett explains. "But their interest is in taking on fairly significant risk. They are willing to take big risks in order to make money. But we don't think they are big risks because we are confident about the impacts that we are able to have with our programs."

Bennett says American Re has so much confidence in what Health Dialog can do in terms of meeting the financial and clinical goals established for its DM programs that it intends to go beyond backing fee risk to assume risk for total medical costs. "They are an owner in Health Dialog and have a special relationship with us," Bennett says. "The fact that they have invested in us and have gone through the due diligence in order to underwrite some of our work says that they have confidence in what we can do."

Bennett believes that Health Dialog's alliance with American Re will raise the bar on what DM firms will have to do to prove their value to purchasers of DM programs. Ironically, the bar will be raised by Health Dialog's efforts to drop average returns on investment (ROIs) in its DM programs to lower, "more realistic" levels, he adds. "It is our view that health plans and the self-insured employers have not been

anywhere near bold enough [in investing in DM programs]. It is my personal contention that the expenditures commitment to this arena is off by at least a factor of four and maybe a factor of six, meaning that the per member per month (PMPM) rates that have evolved in the industry are yielding very high ROIs now, in the 4 to 6 times range, which says we are not investing enough in it."

The smaller the investment that purchasers make in DM programs, the shallower that DM providers go in addressing the needs of an eligible population, Bennett says. "The more they pay us, the deeper we can go on the list," he explains. "In my view, for the last person you coach, if you put in \$1 you ought to get out \$1.20, meaning that you ought to work way down the list so that the last person you coach is at the margin at your cost of capital. That would mean the overall average ROI should be significant lower than those we are seeing."

By being affiliated with American Re, Health Dialog can embolden purchasers of its DM programs through somewhat passive means by assuming more risk itself thanks to the backing of American Re, Bennett says. "We can change who it is that gets bold in order to see how far we can go with our programs," he says. "If what you want to do is to bring a 10 percent growth in medical costs down to 2 percent, you're not going to do it at the PMPM levels that have characterized [our] shy industry. We just haven't been aggressive enough. By having American Re beside us we can say to the health plan we don't want to negotiate how many dollars PMPM you pay us. What we want to do is say if you will let us be more aggressive we will spend five times what you spend. We're going to bend

those curves a boatload more because we have a group with the actuarial sophistication of American Re standing behind us."

Bennett paints this scenario for how the strategic alliance with American Re will lower the bar on ROIs through more aggressive penetration of DM programs: "If you have \$1 billion in medical costs and we say we will guarantee that it will not inflate to more than 4 percent, we will decide how much to spend on care management because we have lots to gain if the curve comes in bending at 2 percent and we submitted to you that the bend is no more than 4 percent. So the real reason for this alliance is not that [our customers] are requesting it. It is to put a tool in our tool kit that permits us to talk health plans into being much less shy and tentative than they are now and to be very aggressive. We are prepared to say that we haven't even approximated the impact our care management programs can have because the expenditure levels are so low."

Bennett says expenditure levels are set so low because DM industry price levels were set at a time when DM purchasers -- and DM providers themselves -- didn't know whether DM had any impact. "Despite the debates that still rages [over DM outcomes], we have private data that argues convincingly that it is saving and saving dramatically," Bennett explains. "And we have found a partner who's willing to stand behind us and take on these significant risks. It's a big deal. This could be a significant development in the industry."

Contact: Kiran Ganda, Health Dialog, (617) 406-5239, kganda@healthdialog.com; Claudia Scott, American Re HealthCare, cscott@amre.com, (609) 419-8578. □

APS *continued from page 1*

pants in the statewide DM program and use it as a core management tool to coordinate care for all program participants.

"This is the first foray for a CCIP and an associated EHR that is dealing with patient-specific contacts and the associated coordination

with primary care physicians," says David Hunsaker, president of public programs for Silver Spring, Md.-based APS Healthcare. "It is brand new and has some very exciting features to it that are first in the nation. We are extremely pleased to be partnering with the state of Missouri on this."

Hunsaker says the Missouri Medicaid DM program will mark the first time that a comprehensive EHR will be combined with a CCIP that is "comprehensive and holistic" in its approach to managing the various diseases in a population. Potential contractors had the option

continued on page 5

APS *continued from page 4*

on bidding on the care management component, the system component or both. APS opted for the latter. "We bid on two separate requests for proposal, and we won them both against the most substantial competition in the country in both DM and the electronic health record arena," Hunsaker says.

APS' CCIP will be an enhanced primary care case management program that incorporates the principles of disease management, care coordination and case management to serve patients identified through a risk assessment and disease stratification model, according to Hunsaker. Under the DM initiative, APS will rely on its community-based care management model, which places health coaches and nurse care managers in community health centers and provider locations throughout the state. This decentralized, collaborative care model improves Medicaid beneficiary and provider engagement in care management programs, increases compliance with recommended care plans and improves coordination of care, Hunsaker tells *DM News*.

But the most striking aspect of the Missouri Medicaid DM program will be the use of an EHR to coordinate and manage care for Medicaid beneficiaries, adds Hunsaker, whose division operates 35 government programs in 21 states and reaches about 30 percent of the nation's Medicaid population with its DM and other care management programs. As part of the overall Missouri CCIP, APS will deploy an Internet-based plan of care using its proprietary online health and care management tool, which it calls APS CareConnection, in tandem with the CCIP.

"Missouri is the first state in the nation to use the care management tool in conjunction with an Internet-based plan of care health information technology to help coordinate care for Medicaid beneficiaries," Hunsaker says. "The Internet-based plan of care enables all participants -- patients, providers and health coaches -- to work more effectively together using a collabora-

tive medical record. We are very excited to partner with the state of Missouri to assist chronically ill Medicaid beneficiaries and, with their providers and natural supports, to facilitate their achievement of better outcomes."

Under the five-year annually renewable contract, APS will attempt to reach about 520,000 Medicaid beneficiaries who will be eligible for the CCIP. The total Medicaid population in Missouri is about 887,000, but the CCIP will exclude about 367,000 Medicaid beneficiaries enrolled in a Medicaid HMO now operating in the state. "It is intended to be a statewide program, but we will be rolling it out in some of the more populated areas of the state first," Hunsaker explains. "This should be one of the largest disease management programs in the country."

The CCIP contract includes no risk components in the initial stages of the contract and does not specify any financial targets that APS is obligated to hit, according to Hunsaker. "But we have a fiduciary obligation as a contractor to make sure our programs run efficiently and that they are outcomes-focused," he says. "So I anticipate that we will demonstrate a significant value in the program to the state. "We do a good job in administering both ROI and non-risk based disease management programs, and we've been successful universally in both arenas. Many of the programs we do for state governments don't have specified risk parameters, yet we have time and time again saved a considerable amount of money for our clients."

How will Missouri Medicaid measure whether the program is a success? "There are a variety of pretty extensive reports that we will be producing that are based on clinical outcomes, and I'm certain that we will be producing associated cost indicators," he says.

Hunsaker says the CCIP is being rolled out not so much as a DM program as it is a "population-focused health management program as opposed to targeting specific diagnoses. The main target diag-

noses that you find in chronic illnesses are important, and we will be reporting on those. But the program is really being rolled out as more of an enhanced care management approach for chronic illness than traditional disease management."

As such, the CCIP will particular focus on community and provider involvement in the program. "The program has a champion provider concept that we're quite excited about," Hunsaker explains. "We will be using various performance metrics and outcomes to identify providers who are doing an above-average job."

All constituents involved in the CCIP -- providers, consumers, state agencies, allied health agencies and APS itself -- will also be heavily involved in the EHR, Hunsaker adds. "We've designed the electronic health record so that it truly becomes a community document so that anyone with a right and need to know and is a participant in the program can view their information."

For security reasons, the information is arranged for different roles, according to Hunsaker. For example, Missouri Medicaid beneficiaries enrolled in the CCIP will see only their own information. But key representatives from Missouri Medicaid will be able to see everything as will APS as the program administrator. A provider, however, will see only its particular patient panel. "But they will be able to see all of the activity for their panel," Hunsaker says. "So they will be able to see every specialist, every pharmacy order and every claim that has been incurred for their entire patient panel."

A plethora of peer support data will be made available to the CCIP's various community constituents. And it will be available for all constituents involved in the care management process to make sure that duplication is reduced or eliminated and that no safety issues occur. "It gives a great deal of what was previously viewed as research project-oriented critical decision support," Hunsaker says.

For example, the EHR portion

continued on page 6

APS *continued from page 5*

of the data contains full demographics for each program participant and two years of health claims. It also includes a comprehensive plan of care that will be maintained by health coaches and community providers, a set disease-specific assessment instruments and a comprehensive quality management center.

The quality management center has information on general health education topics and specific health education materials that will help a particular patient deal with his or her particular chronic illness, according to Hunsaker. It also will have the performance metrics that APS will use to select "champion" providers, a patient satisfaction sur-

vey component and a "profiling center" where providers will be able to view their performance. All of these data will be stored on a server residing at APS' Missouri service center and will meet all security requirements specified under HIPAA. "It is an extraordinarily comprehensive health record," Hunsaker says.

Missouri Medicaid is optimistic that the APS-managed DM initiative will produce benefits for the state. "We are looking forward to our partnership with APS and utilizing its innovative community-based care management program," says Q. Michael Ditmore, M.D., director of the Missouri Division of Medical Services. "APS will be

instrumental in helping our Medicaid beneficiaries better manage their chronic diseases and improve their overall health."

Hunsaker agrees. "We believe that this is a great leap forward [in Medicaid DM] and that no one in the industry has a system that is at all comparable. It takes many of the things that have been traditionally used -- both in terms of the health record itself and decision tools -- and removes them from a 'black box' structure and makes them available to the broadest variety of people who are able to impact the care conditions."

Contact: Sarah Clark-Lynn, APS Healthcare, (800) 305-3720, sclynn@apshealthcare.com. □

Obesity *continued from page 3*

non. It states that "robust epidemiological and scientific evidence clearly demonstrates that obesity should be considered in the context of chronic disease." And because DM "proactively interfaces" with other chronic diseases common in obese individuals, better care can result by DM organizations recognizing the central role that obesity plays in development of these illnesses, the definition states.

The definition points out that being overweight or obese substantially increases the risk of chronic conditions and illnesses such as hypertension, type 2 diabetes, coronary artery disease and stroke, as well as breast, prostate and colon cancer. It incorporates the commonly

accepted clinical definition of obesity -- a body-mass index of greater than 30 and waist circumference of 40 inches or more for men and 35 inches or more for women.

DMAA's definition of obesity with co-morbid conditions also points out that the DM industry has its work cut out for it with regard to identifying candidates for obesity management programs. For example, it points out that claims data collection systems were not designed to collect information with which to assess obesity levels. This deficiency in claims data collection has hindered DM program development in the obesity management arena, the definition states.

In the future, other methods of identifying the risk associated with

obesity may be needed. These could include assessing for signs of insulin resistance, glucose intolerance or a proinflammatory or prothrombotic state, the definition states.

DMAA expects to release additional information about its initiative at its Obesity Management Summit in December, according to Graziano. The summit will focus on programs that have successfully helped participants to manage obesity through a variety of methods. The complete DMAA Obesity with Co-Morbidities definition document is posted on DMAA's web site at www.dmaa.org/pdfs/obesity_definition.pdf.

Contact: Carl Graziano, DMAA, (202) 737-5781, cgraziano@dmaa.org. □

JCAHO'S 2007 Patient Safety Goals for DM Unchanged

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will make no major changes to its 2007 national patient safety goals and related requirements that will apply specifically to its certified disease-specific care (DSC) programs, say officials with the Oakbrook, Ill.-based organization.

The patient safety goals target critical areas where patient safety can be improved through specific actions in healthcare organizations,

says Charlene Hill, a spokesperson for JCAHO. A panel composed of patient safety experts, nurses, physicians, pharmacists, risk managers and other professionals who have hands-on experience in addressing patient safety issues in a wide variety of healthcare settings updates the goals each year based on a solicitation of input from practitioners, provider organizations, purchasers, consumer groups and other stakeholders in patient safety.

With no major changes made to

the 2007 DSC national patient safety goals, the major goals remain to:

- Improve the accuracy of patient identification.
- Use at least two patient identifiers when providing care, treatment or services.
- Improve the effectiveness of communication among caregivers.
- For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having

continued on page 7

JCAHO *continued from page 6*

the person receiving the information record and “read-back” the complete order or test result.

- Standardize a list of abbreviations, acronyms, symbols and dose designations that are not to be used throughout the organization.

- Measure and assess, and, if appropriate, take action to improve the timeliness of reporting and the timeliness of receipt by the respon-

sible licensed caregiver of critical test results and values.

- Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions.

- Improve the safety of using medications.

- Accurately and completely reconcile medications across the continuum of care.

- Encourage patients’ active

involvement in their own care as a patient safety strategy.

- Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.

JCAHO has posted the full text of its 2007 goals and requirements on its web site, jointcommission.org.

Contact; Charlene Hill, JCAHO, (630) 792-5175, chill@jcaho.org. □

Patient/Physician Disconnect Impeding Effective Diabetes DM

A limited understanding of how diabetes progresses and physician frustration with disease management as a method to manage cost and quality issues associated with diabetes care management are impeding progress in managing type 2 diabetes.

That’s the stance of members of the Diabetes Roundtable, a multidisciplinary group of diabetes experts convened by the American Association of Diabetes Educators (AADE) and the American Association of Clinical Endocrinologists (AACE). The group was formed to advocate for improvements in the current diabetes care system, including the use of available resources to help patients best manage the disease. It is calling for the medical community to take a more collaborative approach to caring for people with type 2 diabetes as a way to improve both DM management and cost and quality outcomes associated with disease DM.

A recent survey commissioned by AADE suggests that a “disconnect” exists between what patients with type 2 diabetes, and primary care physicians who treat the disease, believe to be the current state of diabetes management. For example, about two-thirds of patients surveyed said they feel very knowledgeable or knowledgeable about managing their conditions. At the same time, 81 percent of physicians surveyed said they are frustrated with the number of their type 2 diabetes patients who do not follow their treatment regimens exactly as

prescribed. The survey also shows gaps in understanding of the disease itself. Half of patients surveyed said they have little or no understanding of their HbA1C levels or in the past six months have not had it checked or are unsure if they have had it checked.

“We are dealing with some critical information gaps,” says S. Sethu Reddy, M.D., chairman and program director of the Department of Endocrinology, Diabetes and Metabolism at The Cleveland Clinic and a member of the Diabetes Roundtable. “Type 2 diabetes is a chronic and complex disease, and for patients to self-manage their condition it is useful for them to fully understand the basics of the disease and its progression.”

Reddy says the AADE surveyed revealed the following evidence of the disconnect that appears to exist between physicians and their patients with type 2 diabetes:

- 83 percent of patients who said they are on a healthy, balanced diet think they follow their healthcare providers’ instructions well or very well. However, in comparison, only 29 percent of physicians believed this to be the case.

- 77 percent of patients who engage in regular physical activity said they comply well or very well with healthcare providers’ instructions for getting regular physical activity, while only 18 percent of physicians said that is the case.

In another striking finding, the AADE survey also showed that only 59 percent of patients sur-

veyed have worked with a diabetes educator. Meanwhile, almost four in five patients surveyed (78 percent) who have not worked with a diabetes educator said they would like to learn something from one, including how to reduce the risk of diabetes complications (39 percent), strategies for healthy eating (38 percent) and information on new type 2 diabetes medications (33 percent). The survey also showed that diabetes educators have had a positive impact on how knowledgeable patients feel about managing their diabetes.

The survey revealed that physician understanding of the pathophysiology of type 2 diabetes seems to be inconsistent, Reddy says. For example, the prevailing thinking in diabetes care today is that the incretin system plays an important part in regulating blood sugar levels, yet only 51 percent of physicians surveyed said the incretin system is somewhat important or not at all important in regulating blood sugar levels. Moreover, while the prevailing thinking is that beta cell dysfunction plays a large role in the progression of type 2 diabetes, 78 percent of the physicians surveyed said insulin resistance is the most important contributor to type 2 diabetes progression in most of their patients. Only 20 percent mentioned beta cell dysfunction.

These responses indicate the U.S. healthcare system needs to do a better job of managing type 2 diabetes, says Donna Rice, wellness

continued on page 8

Diabetes *continued from page 7*
 program manager at Botsford General Hospital in Novi, Mich., and president-elect of AADE. “We are not making the best use of our resources for managing type 2 diabetes,” she explains. “All too often patients feel they have ‘failed’ and feel guilty, physicians feel frustrated, [so] no one wins. Increasingly we recognize that a team-centered approach involving the patient, primary care physician, diabetes edu-

cator, behavioral scientist and endocrinologist provides the support and resources best needed to help patients manage the disease.”

Rice says members of the Diabetes Roundtable believe care for people with type 2 diabetes could be enhanced by regular treatment from a team that aligns the latest in science, treatment options and education around lifestyle behavior change. In an effort to begin developing a roadmap to improve collabo-

ration between the many areas of care directly involved in type 2 diabetes treatments, the group plans to work with other professional and patient groups to begin identifying potential solutions.

Further information on the Diabetes Roundtable survey is posted on the group’s web site at diabetesteamsite.com.

Contact: *Julia Gendler, American Association of Diabetes Educators, (212) 601-8188.* □

DM NEWS BRIEFS

Matria, UnumProvident form DM partnership. Matria Healthcare and UnumProvident, a Chattanooga, Tenn.-based provider of group and individual disability income protection insurance, have formed a new disability and DM partnership aimed at helping employers combat rising healthcare costs and improve workforce productivity. UnumProvident will link its disability claims management expertise with Matria’s DM programs to supplement and manage the care of employees with chronic or high-cost health conditions. Executives with the two firms expect the partnership to generate significant saving in direct healthcare costs attributed to employees with chronic conditions and indirect costs to employers associated with absenteeism and decreased productivity. The UnumProvident-Matria offering is being made available initially to new or existing UnumProvident customers with at least 5,000 employees enrolled in group short-term disability benefit programs.

Contact: *Suzanne Ross, Matria Healthcare, (800) 343-6311, suzanne_ross@matria.com.*

QMed submits plan bids for Special Needs Plans. Eatontown, N.J.-based QMed Inc. has submitted four plan design bids, all including a non-coverage-gap Part D pharmacy benefit, for an existing Special Needs Plan (SNP) in South Dakota and for three others it expects to launch next year. These bid submissions are required for its Medicare Advantage projects. In South Dakota, where QMed has an operating SNP, the submissions relate to both chronic and dual eligible products. For New Jersey and Florida, where QMed plans to launch new SNPs in 2007, the submissions relate to a chronic eligible design. Executives with QMed say they expect to gain

approvals for the plans later this summer.

Contact: *Robert Mosby, QMed Inc., (732) 544-5544, Robert.Mosby@qmedinc.com.*

PHS goes international with DM program in U.K. Pfizer Health Solutions has launched a new DM program in Birmingham, England. Called Birmingham OwnHealth, the new DM program is being delivered in partnership with primary care physicians, the National Health Service and PHS in the U.K. The program is expected to serve up to 2,000 people in Birmingham diagnosed with cardiovascular disease (CVD), heart failure and/or diabetes. PHS executives say the DM program will begin to transform the National Health Service from a “sick” care service into a modern day healthcare system, which values innovation, early intervention and disease prevention.

Contact: *Jennifer Hillyer, Pfizer Health Solutions, (212) 573-2395, jennifer.hillyer@pfizer.com.*

Healthways expands contract with CareFirst BlueCross BlueShield.

Healthways Inc. has expanded its partnership with CareFirst BlueCross BlueShield to provide its DM programs to an additional 500,000 CareFirst members participating in the Federal Employee Program (FEP), which CareFirst administers for the federal government. The expanded agreement, which begins July 1, brings the combined reach of the CareFirst/Healthways collaboration to 1.25 million members throughout Maryland, Northern Virginia, the District of Columbia and Delaware. Under the agreement, CareFirst’s FEP members will receive Healthways’ DM programs for diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease and asthma.

Contact: *Kriste Goad, American Healthways, (615) 263-7524, kriste.goad@amhealthways.com.* □

Disease Management NEWS

©Copyright 2006 National Health Information, LLC, P.O. Box 15429, Atlanta, GA 30333-0429; phone (404) 607-9500; fax (404) 607-0095. Publisher: David Schwartz. Editor: **Tony Sullivan**, phone (630) 665-7510; fax (630) 665-7580. Contributing Editor: Russell Jackson. Subscriptions cost \$397 a year for 24 issues via first-class mail; add \$10 for Canadian and \$25 for international.

FEDERAL COPYRIGHT RESTRICTIONS

Disease Management News is a trademark of National Health Information, LLC. Reproduction or redistribution of this newsletter in whole or part by photocopying, entry into a data retrieval system, or any other means is a violation of federal copyright law and is strictly forbidden without express prior permission of the publisher. All rights reserved. (ISSN 1084-7146) □

VISIT OUR WEB SITE AT www.nhionline.net