The 3rd National Disease Management Summit

"Strategies in Responding to the I.O.M. Report"

May 12, 2003

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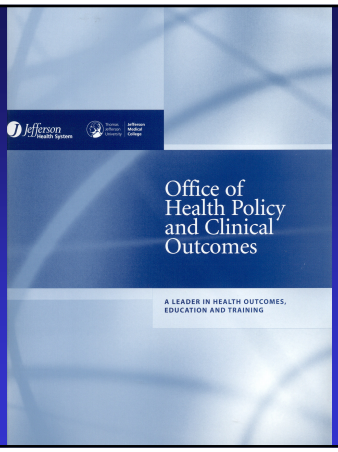

THE COMMONWEALTH FUND

Quality of Health Care in the United States: A Chartbook

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April 2002

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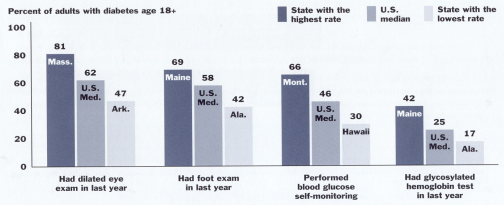
Chart 1–9

Diabetes Management

Up to three-quarters of adults with diabetes did not receive recommended care from their health care practitioner in the middle-range state during 1997–1999, and over one-half did not perform recommended self-care.



Source: Behavioral Risk Factor Surveillance System (CDC 2000c). U.S. data includes 39 states and the District of Columbia. Data were not available for the following states: Delaware, Illinois, Indiana, Maryland, Missouri, New York, Oklahoma, Oregon, South Carolina, South Dakota, Washington.

Reducing the Costs of Poor-Quality Health Care Through Responsible Purchasing Leadership

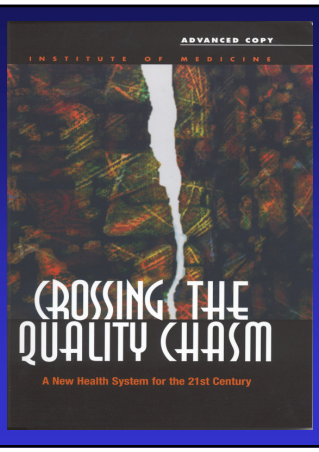
by
Midwest Business Group on Health
in collaboration with
Juran Institute, Inc.
The Severyn Group, Inc.

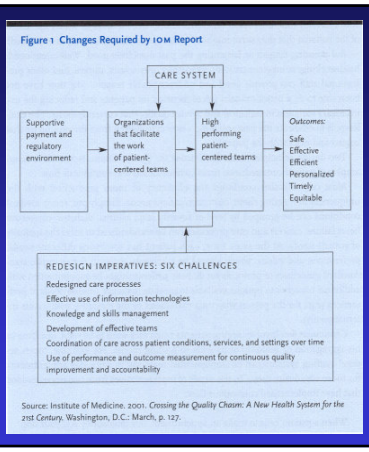
MBGH

Midwest Business Group on Health

Poor quality care costs the nation $500 to $600 billion annually

$1,350 Direct Health Care Expense and Waste
$ 350 Individual Cost
$1,700 Total Cost of Poor Quality per Employee, per year



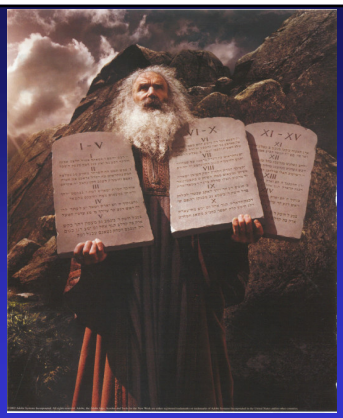


Restructure Health Care Around Priority Conditions

- AHRQ should identify 15-25 priority conditions (mostly chronic conditions)

Cancer	Arthritis
Diabetes	Asthma
Emphysema	Gall bladder disease
High cholesterol	Stomach ulcers
HIV/AIDS	Back problems
Hypertension	Alzheimer's disease/other dementias
Ischemic heart disease	Depression and anxiety disorders
Stroke	

- "Purchasers, health care organizations, and professional groups should develop strategies and implement action plans to substantially improve quality for priority conditions over the next 5 years."



Ten Commandments Crossing the Quality Chasm

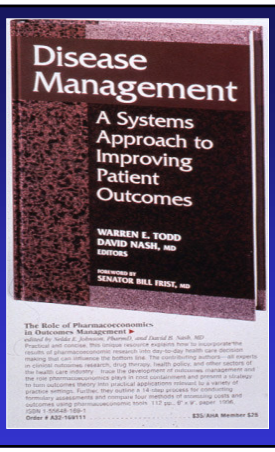
Current Rules	New Rules
1. Care is based primarily on visits	1. Care is based on continuous healing relationships
2. Professional autonomy drives variability	2. Care is customized according to patient needs and values
3. Professionals control care	3. The patient is the source of control
4. Information is a record	4. Knowledge is shared freely
5. Decision making is based on training and experience	5. Decision making is evidence-based

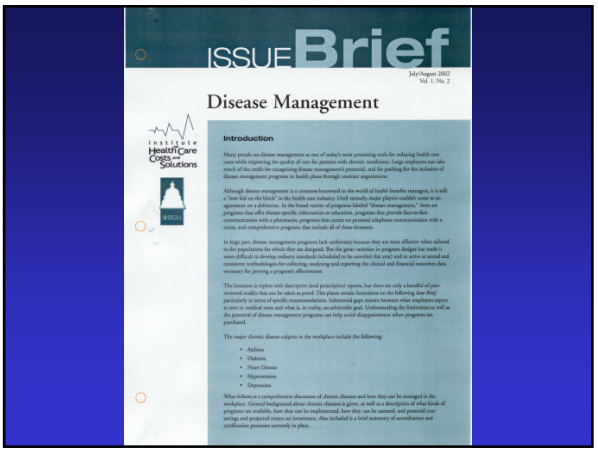
Don Berwick 2002

Ten Commandments (*cont.d*)

Current Rules	New Rules
6. "Do no harm" is an individual responsibility	6. Safety is a system property
7. Secrecy is necessary	7. Transparency is necessary
8. The system reacts to needs	8. Needs are anticipated
9. Cost reduction is sought	9. Waste is continuously decreased
10. Preference is given to professional roles over the system	10. Cooperation among clinicians is a priority

Don Berwick 2002





ISSUE Brief

July/August 2002
Vol. 1, No. 2

Disease Management

Institute Health Care Costs Solutions

Introduction

Many people see disease management as one of today's most promising tools for reducing health care costs while improving the quality of care for patients with chronic conditions. Large employers see take much of the credit for recognizing disease management's potential, and for pushing for the inclusion of disease management programs in health plans through contract negotiations.

Although disease management is a common buzzword in the world of health benefits managers, it is still a "new kid on the block" in the health care industry. Until recently, major players couldn't seem to set agreement on a definition. In the broad variety of programs labeled "disease management," there are programs that offer disease-specific information or education, programs that provide face-to-face communication with a pharmacist, programs that center on personal telephone communication with a nurse, and comprehensive programs that include all of these elements.

In large part, disease management programs lack uniformity because they are most effective when tailored to the populations for which they are designed. But the great variation in program designs has made it more difficult to develop industry standards (scheduled to be unveiled this year) and to arrive at sound and consistent methodologies for collecting, analyzing and reporting the clinical and financial outcomes data necessary for proving a program's effectiveness.

The literature is replete with descriptive (and prescriptive) reports, but there are only a handful of peer-reviewed studies that can be taken as proof. This places certain limitations on the following *Issue Brief*, particularly in terms of specific recommendations. Substantial gaps remain between what employers expect to save in medical costs and what is, in reality, an achievable goal. Understanding the limitations as well as the potential of disease management programs can help avoid disappointment when programs are purchased.

The major chronic disease culprits in the workplace include the following:

- Asthma
- Diabetes
- Heart Disease
- Hypertension
- Depression

What follows is a comprehensive discussion of chronic diseases and how they can be managed in the workplace. General background about chronic diseases is given, as well as a description of what kinds of programs are available, how they can be implemented, how they can be assessed, and potential cost savings and projected return on investment. Also included is a brief summary of accreditation and certification processes currently in place.

CURRENT STATE OF THE ART

FEATURES OF COMPREHENSIVE DM PROGRAMS:

- **Monitoring, reporting on and communicating with participants**
- **Primary care provider support**
- **Outcomes measurement and reporting**
- **Powerful information systems and technological support**

"In God we Trust – All others bring data"

WHAT OUTCOMES NEED MEASURING?

Clinical Outcomes

Process Outcomes

Behavioral Outcomes

Financial Outcomes

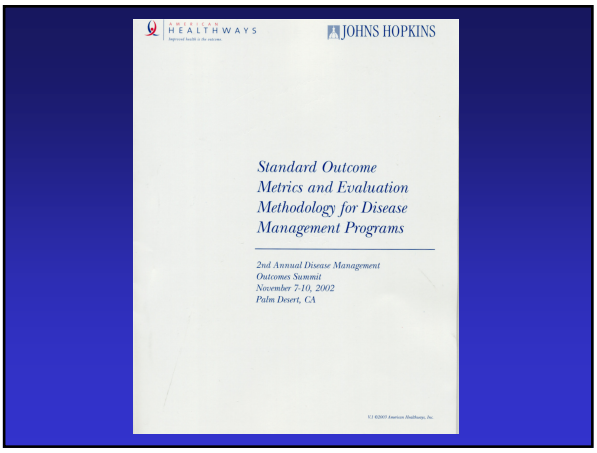
Satisfaction Outcomes

STANDARDIZATION OF OUTCOMES MEASUREMENT

- Standard health status and health screening tools
- HEDIS methodology
- DM Accreditation Standards (JCAHO, URAC, NCQA)

Convergence of IOM Principles and Accreditation Standards

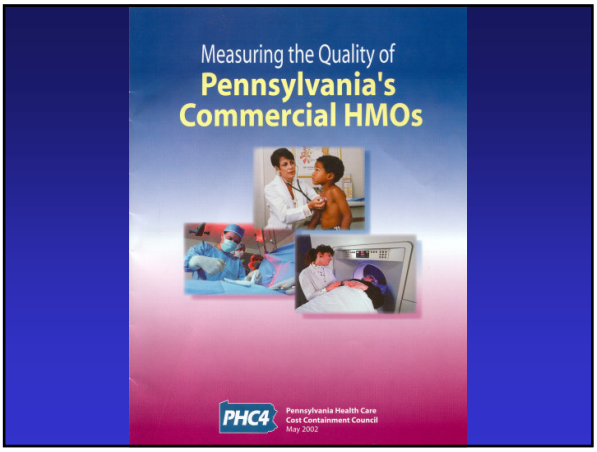
1. Safe	DM Programs must have systems for acting upon safety problems.
2. Effective	DM Programs must offer performance feedback to providers and be evidence based.
3. Patient Centered	DM Programs must address patient self management.
4. Timely	DM Programs must meet standards for timely administration of services.
5. Efficient	DM Programs must define scope of service, measure, and report.
6. Equitable	DM Programs must define the rights of all stakeholders.



SHOW ME THE "EVIDENCE"!!!

"Sometimes we learn just as much about how to improve care from carefully observing experiences as we do from randomized, controlled tests."

Jencks, Berwick and others



The Philadelphia Inquirer

Business

WEDNESDAY, MAY 22, 2002

A study on HMOs supports the 'ounce-of-prevention' theory.

Spending for care now may save money overall

By Josh Goldstein
INQUIRER STAFF WRITER

Health maintenance organizations that do a good job caring for people with chronic diseases have fewer members who require hospital care, a study due out today from the Pennsylvania Health Care Cost Containment Council has found.

HMOs and managed-care companies have long said an emphasis on prevention would result in improved health and lower costs. The council says its report is the first large-scale study to find a significant correlation between better disease management and lower hospitalization rates for some chronic conditions.

"We are the first and only state to do this kind of broad analysis," said Marc P. Volavka, executive director of the independent state agency.

"Our statistical analysis demonstrates that plans that do better on some of the preventative measures ... show a statistically lower hospitalization rate for their members," Volavka said.

The correlation was particularly strong in programs to control the conditions of HMO members with diabetes and high blood pressure.

The research also suggested that regular testing of the blood-sugar and cholesterol levels of diabetes patients might result in fewer hospital visits.

The report was based on 2000 data from various sources, including the council's own statewide database of hospital care.

"When you pay attention to the preventive measures, when you follow through, when you educate patients, it has a positive impact on the quality of care," said David B. Nash, a professor of medicine at Jefferson Medical College and technical adviser to the council.

For the HMOs, employers and consumers, the findings suggest that, in some areas, spending more money on prevention saves money by decreasing the number of preventable hospital visits.

Volavka said the findings gave insurers and purchasers of insurance a sense of where "to focus scarce health-care dollars."

This is the third year the council has issued a report that tries to measure the quality of the state's HMOs. But this is the first time the agency has been able to correlate disease-management efforts with hospitalization rates.

Thirteen HMOs were examined, including four plans operating in this area: Keystone Health Plan East, Aetna U.S. Healthcare, Cigna, and Health Net of Pennsylvania.

The council analyzed 16 disease-management areas, such as the percentage of members with diabetes who got eye exams, and the percentage of children who were given recommended immunizations by age 2.

See **HMO** on D4

For More Information

The full report by the Pennsylvania Health Care Cost Containment Council, an interactive database, and HMOs' comments on the report can be accessed on the council's Web site, www.phc4.org/reports/mcpr00/.

HMO from D1

Steven Udvarhelyi, chief medical officer of Independence Blue Cross, which operates Keystone Health Plan East, said that the insurer supported the council's efforts, but that the report had some limitations:

First, the data used to compare health plans may not be sufficient to show statistically accurate variations. Also, geographic differences in care within the state were not taken into account. And Udvarhelyi said the report did not show improvement of health plans over previous years, nor did it compare the HMOs with traditional fee-for-service insurers.

Aetna U.S. Healthcare echoed Blue Cross' praise for the council's effort, but it expressed similar concerns.

So did Cigna Healthcare of Pennsylvania president Vincent J. Sobocinski, who said: "We have done a tremendous amount of work in member satisfaction and quality" in the last two years.

The report also looks at members' satisfaction with their HMOs. And it analyzed the outcomes for patients of four procedures: hysterectomies, lumpectomies and mastectomies, neck and back operations, and prostate surgeries.

"The good news for Pennsylvania consumers is that ... our HMOs are doing better by and large than others in the rest of the country," the council's Volavka said.

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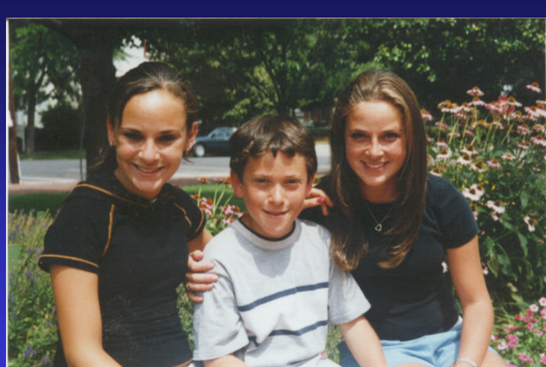
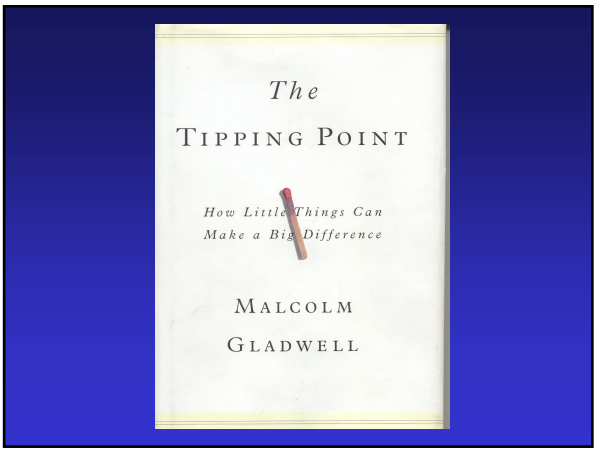
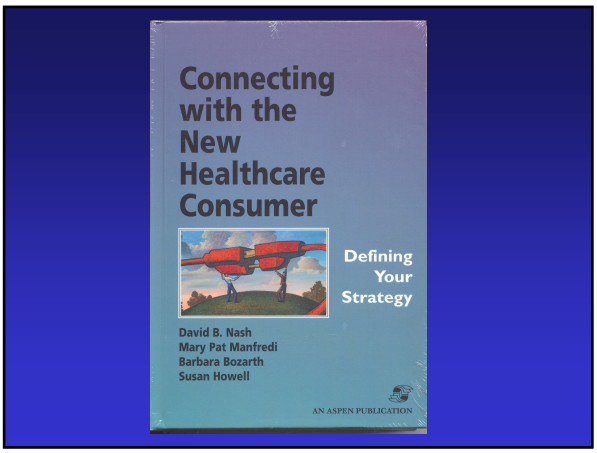
WHAT DOES THE BODY OF EVIDENCE TELL US?

- ❖ Credible reports show that DM does improve quality significantly
- ❖ Improved quality does not translate into immediate reduction in direct costs
- ❖ The most effective interventions for improving health and reducing use of health care resources are those focused on developing patient self-management skills







Disease Management NEWS

Independent, timely business intelligence on disease and demand management

Volume 8, Number 2 November 10, 2002

Firms Providing Drug Coverage, Assuming Financial Risk

QMed, CorSolutions, Diabetex Get Medicare DM Demos

The Centers for Medicare & Medicaid Services (CMS) has awarded its latest disease management (DM) demonstration projects to three prominent DM vendors. QMed Inc., CorSolutions Medical Inc. and Diabetex Corporation will spearhead three separate demonstration projects that will test whether models of DM can improve clinical outcomes and appropriate use of Medicare-covered services for targeted Medicare fee-for-service beneficiaries while managing Medicare expenditures and reducing overall Medicare expenditures.

The four-year demonstration projects, authorized by the Benefits Improvement and Protection Act of 2000 (BIPA), will target Medicare beneficiaries with three diseases: advanced-stage congestive heart failure, diabetes and coronary heart disease. Under the demonstration projects, the participating DM organizations will be paid a monthly premium for coordinating the care of patients in the studies and for the cost of all prescription drugs, even those drugs not related to the beneficiary's targeted condition.

This drug-coverage element sets the BIPA demonstration apart from the massive Medicare Coordinated Care Demonstration project that has been under way for nearly a year (*DMN*, 2/10/01, p. 1, 2/10/02. p. 1.) It prompted many DM organizations to take a pass on the BIPA demonstration, according to several DM industry sources.

The BIPA demonstration will require each organization to improve health outcomes and reduce Medicare program expenditures. In addition, each demonstration organization must accept risk or have another entity agree to accept risk if certain Medicare budget provisions are not met, specifically if the demonstration does not reduce aggregate Medicare program expenditures. In addition, the DM organizations must target severe and high-cost cases and must match their interventions to the patients' needs.

The firms participating in the demonstrations will use DM interventions to try to achieve three goals:

- Improve the quality of services furnished to specific beneficiaries;
- Introduce full prescription drug coverage to encourage patients to comply fully with medical instructions and requirements; and
- Manage expenditures under Medicare Parts A and B.

QMed will attempt to achieve these goals with the help of three other organizations that are partnering with the Laurence Harbor, N.J.-based DM firm in a demonstration project targeting 15,000 Medicare beneficiaries with CHF. QMed will work with PacifiCare Health Systems Inc., a Cypress, Calif.-based health plan, Prescription

FUTURE TRENDS IN DM

1. MORE CONSOLIDATION OF DM ORGANIZATIONS
   - ❖ Manage a variety of inter-related DM programs
   - ❖ Keep administrative costs down

FUTURE TRENDS IN DM

2. INCREASED STANDARDIZATION
   - ❖ DM Program components
   - ❖ Outcome measure methodologies
   - ❖ Financial predictive models

FUTURE TRENDS IN DM

3. RAPIDLY IMPROVING TECHNOLOGY
   - ❖ More facile data linkages
   - ❖ Improved call-center technology
   - ❖ Prompt systems for physicians, patients, ancillary health care personnel

FUTURE TRENDS IN DM

4. EXPANDED KNOWLEDGE BASE
   - Peer reviewed publications
   - "Best practices"