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# Insights from the 2007 disease management colloquium.

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## Roundtable Discussion

### Insights from the 2007 Disease Management Colloquium

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*This roundtable discussion emanates from the presentations given and issues raised at the 2007 Disease Management Colloquium, which was held May 7–9, 2007 in Philadelphia, Pennsylvania.*

**David Nash, MD, MBA:** First of all, I want to thank all of you for joining me on this call. I'd like to turn first to Dr. Don Wilson. Don, you moderated the Health Information Technology (HIT) for the Consumer session. We're anxious to hear your review.

**Donald F. Wilson, MD:** I think we had a great session. It was well attended, and we had lots

of good participation, lots of questions from the audience, and dialogue back and forth. I'll go through each session and provide a synopsis of what happened.

The first session was entitled "Consumer Engagement: Personalized Information and Whole Person Health," and was presented by Dr. Dexter Shurney of Healthways. Basically that session dealt with using the fact that HIT

can help promote self-care; HIT can be used as a way of engaging and motivating consumers to reduce their risks and to modify their behaviors. This is, as we all know, a big piece of what really drives the whole disease management process. They're actually improving people's health and reducing health care costs.

Dr. Shurney talked about the fact that the benefits include decreased medical costs, decreased absenteeism, and increased productivity, so HIT does more than just improve overall medical care. There are many other positive benefits in addition to those.

He talked about the fact that you can use HIT not only to engage people to increase their own self-care, but also to actually teach patients the guidelines for their conditions. There really shouldn't be any inhibitions about providing patients with care guidelines so that they can use them to better direct their own care.

Dr. Shurney talked about the fact that HIT can be used to create the "veto rule," as I think he called it. This means helping to empower patients to be able to make decisions about health care that they may not need. An interactive guide is available to help a patient decide whether he or she should have surgery for back pain, for example. The guide helps patients to make their own decisions about how they feel about it.

And again, the whole concept is to encourage consumers to be proactive in their health care. I thought it was a great session.

The second session was on "Personal Health Records," and was presented by Dr. David Ahern of Brigham and Women's Hospital and Dr. Charles Eaton of Brown Medical School. They talked about a pilot project that they're working on at Memorial Hospital in Rhode Island. They have GE Centricity as their electronic medical record (EMR). They've been using the EMR for quite a while, and they've developed an initiative with ICW (InterComponentWare, Inc.), a German software company, that uses ICW's Personal Health Record (PHR) called *LifeSensor*. They're working on developing an interoperability platform between their EMR and ICW's PHR, and the GE Centricity system.

Right now I believe they have a pilot program with a thousand patients enrolled. It looks like they're going to get some very posi-

tive benefits and they're quite excited about it. Again, the goal is to be able to facilitate better communication and interaction with patients and to really engage patients.

One of the tools they offer that apparently is resonating well with patients is an interactive tool that patients can use to compute their heart age. A patient can enter various pieces of data into the tool and, based on that data and the patient's chronologic age, the tool will calculate the age of the patient's heart. They said that this really motivates patients because they can actually change the variables and see the effect. For example, a patient can calculate his or her heart age based on a cholesterol level of 250. Then he or she can lower the cholesterol level to 190 and see how the heart age is affected. By changing the data patients can see how, if they just make some minor modifications here and there, those changes could have a big effect. It really motivates their patients.

The next session was "Consumer Education on the Internet," presented by Michael O'Neil of GetWellNetwork and Charlyn Slade of TLContact, Inc. I thought Michael O'Neil was brilliant and an interesting guy. He had been a health care consumer himself. He had a significant personal illness and had spent a large amount of time as an inpatient in the hospital fighting a cancer diagnosis. He talked about how he felt totally unempowered during the whole process—like he wasn't an active participant at all. Once he got out of the hospital he decided to do something to change that. He formed a company that focuses on consumer education in the inpatient setting; Thomas Jefferson University Hospital is piloting the whole system that he has developed. The system works on the TV monitors in patients' rooms.

It's programmed to allow a certain amount of time between interactions and then will automatically key up, even if the patient is watching TV. The system interrupts and poses a question and asks the patient to respond. It encourages the patient to proceed with certain educational activities.

Or, for instance, it will ask the patient to rate his or her pain. It may just pop up in the middle of a TV program and ask the patient to rate his or her pain on a scale from 1–10. If the patient says that they're in a moderate or severe

amount of pain, the system automatically sends an alert back to the nurse's station.

I thought that was really a neat thing to see. Here again, you can see how that could help motivate patients, help improve communication, and streamline the process within the hospital setting.

Charlyn Slade talked about a program called "Care Pages," which is being piloted at the University of Pennsylvania. It's a system where patients with significant illnesses actually develop their own unique Web pages. This can be used to foster communication not only between care providers and that patient, but it also allows community and family members to communicate with that patient. It offers the ability to sign on and find out the status of the patient, if the patient has given consent.

It's a way to foster communication in the provider setting as well as with the family to help build the social support that's needed around fighting an illness. Ms. Slade talked about how certain family members sometimes can actually receive a lot of support from friends and family as they're trying to help their loved one through a prolonged illness.

The last session was "Online Peer Coaching" and this was conducted by Neal Sofian of The NewSof Group. I thought he was quite entertaining as a speaker and very enjoyable to listen to. His presentation was more about sociology than medicine, and he made a lot of great points.

He talked about the fact that learning is social; it's about identifying the "me" and then finding people who are like you who have had like experiences and learning from those people. One of the things he said is that you learn from the stories of the group. That's really how you learn.

He talked about a concept called "microcultures of meaning," which he termed "MOM." He started out his talk by saying, "By the end you'll understand—the crucial point is always listen to your MOM." And by the end, you understood what MOM was.

Basically MOM is a community of people with common needs and a common purpose. By developing those—using online tools to actually have discussion groups and blogs—people who are going through similar experiences

have a way to share their learning and build camaraderie.

Another memorable thing he said was, "Societies construct the lenses through which their members see the world." And basically you can do this by developing these microcultures online.

He also talked about the way these microcultures can be used by disease management companies to have members participate in online discussions that are monitored by a health care provider. It's another way of motivating people, but in an online group concept.

I think that's pretty much it for our group.

**Dr. Nash:** Thanks, Don, for that outstanding overview of the program. We appreciate your help in bringing it to the public.

Now, let's hear from Dr Leider.

**Harry Leider, MD, MBA:** My section was led off by a presentation by myself and Laurie Russell, our Senior Director of Health Solutions at XLHealth. It was entitled "Disease Management in Medicare—Early Lessons from Medicare Health Support and Chronic Care Special Needs Plans."

In this session, Laurie and I outlined the constructs or the conceptual models behind both Medicare Health Support and our program in Tennessee, as well as the models that are evolving around Chronic Care Special Needs Plans. We went over the legislation that enabled that to happen via the Medicare Modernization Act and the catalyzing event of Medicare moving to risk-adjusted payments that were fully implemented in 2007.

Laurie then went into some of the key disease management and complex case management competencies that are needed to manage a population that consists 100% of chronically ill seniors. We shared what we called the Six Competencies for launching and implementing a Chronic Care Special Needs Plan and some early lessons learned from Medicare Health Support.

The bottom line in both of these presentations is that rapidly engaging members or patients, getting them involved, and having an effective disease and case management program are the keys to success in both the Chronic Care

Special Needs Plans and Medicare Health Support.

It's too early to really know for sure how we're doing in the Medicare Health Support Program, and for that matter, it's probably the same for all the vendors for Medicare Health Support.

Our presentation was followed by Dr. Patricia Salber from PRS Strategic Healthcare Consulting. She reviewed her experience as a lead consultant for an insurance company that has launched a very innovative and rapidly growing private fee-for-service Medicare plan.

She educated the audience about how private fee-for-service Medicare plans work. In her view, they are a compromise between the fee-for-service Medicare model and the more traditional Medicare HMOs that are more restrictive. They cover some of the out-of-pocket charges that traditional Medicare burdens the beneficiary with. They are starting to put in place a case and disease management infrastructure to offer some care management on top of the fee-for-service network.

The plan that she was working with—I believe it was America Universal—has grown very, very rapidly—in just 4 or 5 months it grew from a handful of members to, I believe, 170,000 seniors in multiple states. The biggest challenge is developing the infrastructure and outsourcing relationships to do the health care risk assessments, coaching calls, and disease management interventions that they are trying to put in place for this membership. There are no financial or clinical results yet, but there is a lot of interesting information about how attractive this model is to seniors across the country.

That session was followed by two presentations about Pay-for-Performance (P4P) within disease management programs. The first talk was by James Hardy, the former Deputy Secretary from the Office of Medical Assistance Programs of the Commonwealth of Pennsylvania. He's the current president of the Sellers Feinberg organization.

He reviewed the experience in Pennsylvania with their Access Plus Medicaid program. In the State of Pennsylvania, there is a mandated managed Medicaid program that largely cen-

ters around Pittsburgh and Philadelphia. But in the more rural areas of the State, the so-called T-Zone (across the north and down the center of the state), there is a second network where there is no managed Medicaid—instead, it's an enhanced fee-for-service network.

In that region, Pennsylvania hired a disease management vendor to put in place a disease management program for certain diseases, as well as to put in place a provider pay-for-performance model. The model has 3 tiers of payments to doctors, largely focused on the primary care provider.

Essentially, the first tier is for engaging the doctor to help enroll Medicaid members into the disease management program. The second tier is for selected clinical process measures—for example, whether the patient is on a particular medication for asthma or for heart failure. The third tier is for actual clinical outcomes.

Mr. Hardy said it was a little early to know for sure the impact of the program, but the initial analysis is very positive and they have gone back to the Commonwealth for more funding for future P4P programs because they believe that the 600 primary care doctors who signed up for P4P (out of the 2,100 in their network) are achieving a higher quality of care than are the primary care doctors who did not sign up for P4P. So they saw this as a very positive initial outcome, and worthwhile to ask the State to invest more in this strategy.

Interestingly enough, the next presentation was by Dr. Gus Geraci, who is the Pennsylvania Medical Director for AccessPlus for McKesson, the vendor of the program outlined by Mr. Hardy. Dr. Geraci described his point of view of the program from the vendor's standpoint. He basically agreed with Jim Hardy that the program—although it had some implementation issues—was well received by the doctors and had some encouraging outcomes data for the 600 doctors who participated.

He was less able to quantify the impact of this P4P program in the Medicare Health Support Program in Mississippi, where it was implemented, because of hurricane Katrina. Due to this catastrophe, the impact of any programs implemented in Mississippi was limited as en-

rollees in the Medicare Health Support Program were dealing with a crisis rather than their disease-related issues. More recently, McKesson has dropped out of the Medicare Health Support Program. In summary, Dr. Geraci's program was a recapitulation and a validation of the prior P4P comments made by Jim Hardy.

It was a great afternoon session with a lot of good discussion and provocative topics. I think the general tone of the session validates my view that there is a lot of enthusiasm for disease management as a solution to many of the problems in the Medicare and Medicaid sectors, and there is a lot of government focus and a lot of interest in this very powerful tool.

**Dr. Nash:** Great, Harry. Thank you. And now, Tracey Moorhead, please tell us about the session you moderated.

**Tracey Moorhead:** I moderated a panel, rather than a track, and my panel comprised Chief Medical Officers from leading organizations within the disease management community. The panelists included Dr. Ron Loeppke from Matria; Dr. Richard Popiel from Horizon Blue Cross Blue Shield of New Jersey; Dr. Phil Benditt from United HealthCare; Dr. Charles Peck from Take Care Health Systems; Dr. Ray Fabius from CHD Meridian and I-trax, and Dr. Jan Berger from CVS Caremark.

We began the panel by inviting each of the panelists to give a quick overview of what they felt to be some of the most pressing issues confronting the industry today, and then engaged in a series of questions and answers and discussion among the panelists.

I will say that, in reviewing my notes on the panel, I was struck by 3 or 4 very clear themes into which we could break down the panel discussion.

First, there was a broad agreement that the current definition of disease management should be expanded to include prevention and wellness activities, given the expanse of programming within disease management organizations that reflects the full continuum of care and the services all along that continuum. Sec-

ond, we focused on engagement issues in the context of employees and other consumers and physicians. In discussing consumer engagement, both in the employer setting at the workplace and outside the employer setting at other touch points, panelists generally agreed that, as Dr. Loeppke stated, disease management is not quite on the verge of a direct-to-consumer, retail model. This will not be the case until consumers see clear financial incentives for participation in these types of care and wellness programs.

There was great interest in discussion of workplace clinic settings. In particular, Dr. Fabius, of CHD Meridian, mentioned that their studies have found employee engagement in companies with workplace clinics to be 3 to 5 times greater than engagement in other workplace settings. It was very interesting to hear the various opinions on consumer engagement touch points.

With regard to physician engagement, the general consensus was that disease management has not yet focused enough attention or resources on full-scale physician engagement. Although this is changing, it requires additional focus on the part of the health, disease, and care management communities. That was stated by Dr. Benditt, and the other panelists concurred.

In response to a question on this issue, the panelists seemed to concur that there is great opportunity for partnerships between physicians and the disease management model—both through integration of data and integration of multiple services. The panelists agreed, however, that there are major health policy challenges regarding reimbursement to physicians that need to be addressed and overcome before the medical home model, the disease management model, and direct-to-physician engagement can truly succeed.

There also was agreement that physicians should view disease management as supportive and collaborative, and that the industry needs to focus on promoting systems connectivity and automation to physicians. This is perhaps the best gift disease management has to offer physicians: to help them better understand how disease management can ease their

workload and streamline their workflow processes.

A third broad theme of discussion revolved around integration, both along the continuum—the various programs offered by disease management organizations—and among care providers—doctors, hospitals, and other care settings. There was general discussion about the integration of these programs as a business model to ensure that purchasers understand the need for interaction among these various programs.

A final area of general discussion was the value of investments and how to articulate to employers and other purchasers the very important value disease management services provide. Dr. Fabius likened employees to skilled athletes and suggested that employers, like sports team owners, can improve performance and achieve business goals by helping employees manage health and avoid illness.

Dr. Loeppke stated that the number one burden for employers is the burden of risk and illness. Communicating the value of investment and the emphasis on an integrated return on investment, rather than on siloed program return on investment, represents an enormous opportunity for the disease management community.

There also was discussion regarding the need to establish valid return on investment measures for health and wellness programs, as that is an area of great interest to employers. The industry needs to move forward to develop those valid measurement tools that will help employers understand the ultimate value of these types of programs.

There were discussions about other outcomes measures now under way, and a series of exchanges about other benefits to physicians in the medical home model.

Overall, I thought it was a great discussion with highly engaging conversation and contributions from the panelists.

**Dr. Nash:** Thank you, Tracey. Tine Hansen-Turton moderated and presented at the track entitled “Disease Management in the Community Setting.” Tine, please give us a brief summary of your track.

**Tine Hansen-Turton, MGA:** We had 3 different types of presentations in our panels. The first one was on “Convenient Care” clinics, presented by Dr. Chuck Peck from Take Care Health Systems. He did an outstanding job of laying out the landscape of convenient care clinics, the scope of practice within the clinics, and what potentially is the avenue for more disease management services within that sphere for the type of providers in the community.

I made a brief presentation on the “Nurse-Managed Health Centers.” I talked more about how to utilize them as safety net providers, what they’re doing in the disease management area, and obviously with the idea that they actually are open to research—it would be a great way to do additional work on such communities in the country.

The next speaker was Dr. Jeffrey Brenner from the Department of Family Medicine at the Robert Wood Johnson Medical School-Camden. He talked about an innovative approach of trying to bring health care providers together in an area like Camden to promote better uniformity, better communication among physicians and other providers, and to provide better customer and consumer care.

The next presentation, by Carole DeSpain Magoffin of National Minority Quality Forum, was on disease management zip-code mapping, which I thought was phenomenal in the sense that the more we can have data mapped, the better we’ll be able to do health care policy as well as look at streamlining programs in certain areas. It was very impressive from a big-policy perspective. The kind of data available from a mapping structure would be very beneficial to all of us as we plan—whether it’s for disease management or any other health care issue in this country.

Overall, I thought there was good discussion. Our panel dealt with many different topics, but the overarching theme was how to provide accessible disease management services in different settings. There was good feedback from everybody there.

**Dr. Nash:** Thank you, Tine. Well, the 4 of you have set a high bar. Now let me try to sum-

marize the final session, which I had the privilege of chairing. It was the CEO Panel called "Charting the Road Ahead."

As with Tracey's session, these were not multiple presentations, but rather a series of questions posed by me to the CEOs. There were 4 members on the panel: Dr. George Bennett from Health Dialog; Frank Martin from I-trax; Dr. Sandeep Wadhwa (sitting in for Emad Rizk) from McKesson, and Dr. Earl Steinberg from Resolution Health.

We covered a broad number of topics. I'll try to hit the highlights and where there was some controversy. One question concerned what the panel members see as the future of Pay for Performance (P4P). As you might expect, the CEOs were energized by P4P. They were wary of some of the measurement issues but, generally speaking, felt it would be a net gain for the disease management industry as the programs that they represent and promote would go a long way toward improving overall health status.

We had some discussion about the future of information technology challenges. Again, as expected, the CEOs were unanimous in saying that they all had comprehensive challenges within information technology, including such basic things as appropriate linking of lab results, to more comprehensive activities such as Resolution Health evaluating various prescribing habits of clinicians and being able to give the clinicians feedback about how well they were tracking these guidelines.

One area of some controversy was the question of whether or not we should create an accreditation or certification pathway within DMAA for nurses and others in the field of disease management. Surprisingly, all 4 CEOs were quite negative about the idea of an accreditation commission or certification examination.

Their critique focused on such things as timeliness, changes in the field happening at a rapid pace, the view of accreditation from outsiders, and introducing bias into the examination process and related activities. They were uniformly opposed to any kind of accreditation or certification within disease management.

Another area we discussed, like some of the

other panel members, was Medicare Health Support. The panelists were wary of what some of the current results coming from Medicare Health Support look like, but all expressed great hope that Medicare Health Support would be successful in the future, recognizing that Congress could be readily swayed by some of the early published results coming from the program.

We spent some time talking about a research agenda for disease management. While all 4 leaders are in favor of a research agenda, I would say they were tepid with regard to any kind of private sector funding for research. I-trax, in particular, was enthusiastic about their own research agenda, with multiple articles coming to *Disease Management* and others in the pipeline. The other CEOs felt it was important but, outside of I-trax, I certainly would not put research in their top 3 areas of priority.

We had some discussion about the future supply of primary care physicians and the possible impact of that on disease management. All 4 CEOs were very current in their knowledge regarding the potential future shortage of primary care doctors. They called for an expansion in nurse practitioner scope of practice. While they had no ready solution for improving the supply of primary care doctors, they did acknowledge the medical school challenges in helping students to pick careers in primary care, especially regarding the high debt incurred by the time students graduate from medical school and the long-term lower anticipated average income as compared to specialists.

Finally, I asked the panel members what advice they would give an incoming US President about the health care system.

I was very happy to hear that, across the board, the 4 leaders called for a greater emphasis on prevention, wellness, and screening, and an end to diverting so many resources to quaternary care. We bemoaned the fact that Medicare pays for bariatric surgery but doesn't pay for nutrition counseling, or the time a doctor spends helping a patient with diabetes better understand the pathophysiology of their disease. So, all 4 felt that a Presidential candidate would really need to sit and listen care-



fully about the need for greater emphasis on prevention and coordination of care. All were quick to point out that the current payment system is nothing short of toxic, and that if you pay doctors to do piecework, you can only expect more piecework.

In summary, I'd say it was a great panel. The CEOs were not provided with the questions

ahead of time. It made for aspects of live television and, despite their professed nervousness, all were very articulate and there were outstanding questions from the floor at the conclusion of the program.

Once again, I really appreciate all of you taking the time to join me in recapping the highlights of the colloquium.