

comprehensive disease prevention and health promotion program called Partners for Better Health, hopes to improve care in a variety of settings, including medical clinics, a telephone hotline, work sites and the community.

Both a member's risk level and willingness to improve health affect the level of intervention prescribed by HealthPartners' systematic approach to population management (see Checklist, this page). By assessing members' readiness to change, Pronk says it is possible to select appropriate disease management and health promotion interventions, messages and tactics based on motivation; empower members to take control; and avoid force-feeding them care.

"Partners for Better Health integrates lifestyle management efforts of the Population Health Cycle with members' encounters at the clinical level, creating synergy between multiple efforts and settings," Pronk adds. The cycle incorporates a clinical quality improvement component.

Addressing different conditions, levels of risk and degrees of readiness to change, HealthPartners sponsored a six-month pilot program, "A Call to Change: Balancing Life With Diabetes," for 120 members. Offering diabetes management via telephone, the program indicated a drop in HbA1C from 7.5 to 6.8; an increase in those reporting an understanding of diabetes from 35% to 94%; a heightened confidence in dealing with the program, 30% to 81%; and comfort in discussing the disease, 96%, up from 80%. Based on the positive outcomes, the program has been expanded to all members with diabetes.

TOUCHING MANY MEMBERS

BCBS of Minnesota's disease management started several years ago with a "vanilla" program for diabetes, coronary artery disease (CAD) and high-risk pregnancies. These three conditions were later joined by congestive heart failure (CHF), end-stage renal disease, chronic obstructive pulmonary disease (COPD) and asthma, and eventually

CHECKLIST



HealthPartners' Population Health Cycle

1 SET GOALS Goals are applied to five-year periods, currently running from 2000 to 2005, addressing a major area of health needs and establishing specific and measurable objectives.

2 ASSESS WILLINGNESS TO PARTICIPATE

3 HEALTH STATUS/RISK HealthPartners assesses the risk status of its population through claims data, chart audits and Internet-based risk assessments, and stratifies them along a risk continuum. Interventions move those at high risk to a lower-risk category and prevent those at lower risk from becoming more ill.

4 ASSURE READINESS TO CHANGE The model identifies the stages as precontemplation, contemplation, preparation, action, and maintenance, then matches messages to each level.

5 PROVIDE INTERVENTIONS

These run the gamut from patient and provider education materials, health education courses, phone-based counseling, work site health promotion programs, and community health promotions.

6 EVALUATION HealthPartners reviews its progress toward its goals, such as identifying the rate at which members are receiving preventive screenings for specific diseases or achieving optimal lipid levels and blood pressure readings.

7 MODIFY GOALS Every five years the plan revisits its goals. While HealthPartners is focusing on fewer disease states, it is looking more comprehensively at goals related to lifestyle risk factors.

MHE Source: HealthPartners

supplemented by 11 more this past June, including low-back pain, osteoarthritis and irritable bowel syndrome.

The plan's choice of many conditions embodies its goals of touching as many members as possible, recognizing symptoms early, coordinating care, treating comorbidities, educating members and providing emotional support.

"The human connection is a critical element, applying interventions to more people to achieve higher satisfaction and better outcomes," says Dr. William Gold, medical director for the health plan. "Disease management is not a commodity."

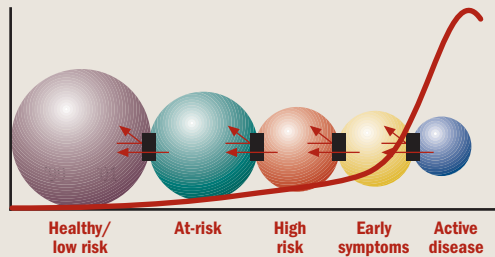
To accomplish its objectives, BCBS of Minnesota has partnered with American Healthways in a 10-year commitment rid-

ing on a variety of components: predictive modeling to identify members who need care and to determine the costs they are likely to incur in the future; health risk assessments supported by evidence-based medicine; letters to engage members in disease management and wellness programs; packets of appropriate educational materials; and a call center managed by nurses.

Members and their physicians receive feedback on health status, making members more responsive to interventions and physicians a more integral part of the program, according to Bob Stone, executive vice president of Nashville, Tenn.-based American Healthways.

"American Healthways' technology platform is intuitive, records what has tran-

HealthPartners' population health model risk distribution



20% of members generate **80%** of costs.

Population health aims to move members down the continuum toward healthy/low risk.

MHEGRAPHIC

MHE Source: HealthPartners

spired, recalls information and gives prompts to members and physicians,” Gold says. “We are touching 97% of those with the conditions we target, and the more people with whom we interact, the easier it is to engage physicians.”

SHARING DECISIONS

In an effort to create an integrated disease management program, Highmark partnered with two companies: CorSolutions in Buffalo Grove, Ill., a disease management company, and Health Dialog, a Boston-based company that emphasizes shared decision-making between patient and provider based on current, unbiased information. Highmark’s comprehensive portfolio of services considers the specific needs of members and prioritizes interventions to meet those requirements.

“To be successful in managing members, health plans need to provide a whole suite of tools to gather information and suit different personalities, as well as a combination of preventive, lifestyle, disease management and change management tools,” says Richard Vance, president/CEO of CorSolutions. “Programs have to acknowledge that members do not fit into

one category; they may not have the same risk for different diseases. You can’t put everyone into the same box.”

Accenture, a consulting firm, also worked closely with Highmark in developing its integrated condition management model for diabetes, asthma, CHF, COPD and CAD.

Tom Heatherington, a senior manager in the Pittsburgh office, says the approach combines proactive identification, management and monitoring; personalization; decision-support tools; health information provided through a variety of channels, including a health coach, Internet, video and audio tapes and print materials; tools, information and services to promote self-care; and outcomes analysis to track the effectiveness of interventions.

Heatherington says the new strategy matches the right interventions to the right people at the right time, as opposed to the traditional model of limited care coordination and process and data integration, overlapping interventions, physician and member frustration and high administrative costs.

One of the plan’s major challenges, says Dr. Don Fischer, a medical director

for Highmark, is finding care gaps—lack of an annual HbA1c test for low-risk members with diabetes, for example. Through Health Dialog’s SMART Registry, primary care physicians receive a list of patients with diabetes, CHF and CAD, (and comorbidity of hypertension) and a list of patients who need routine testing, exams or treatment as indicated by claims data. “The registry and nurse health coaches help ensure that members don’t fall through the cracks,” Fischer says.

A HEALTHY STRATEGY

Likewise, Dr. Richard Popiel, vice president and chief medical officer for Horizon Blue Cross Blue Shield of New Jersey, says targeting the entire population, not just those enrolled in a disease management program, will garner better outcomes—something that he keeps a keen eye on to ensure there is a return on investment, both financially and clinically.

The plan’s integrated approach hinges on six goals that form the acronym “HEALTH”: 1) Have the right providers; 2) Early identification of risks; 3) Advocate prevention; 4) Limit unnecessary care; 5) Teach evidence-based medicine; and 6) Help members negotiate the healthcare maze. Dr. Popiel says he is confident that the program will identify members with co-morbidities and that its predictive modeling component will improve quality through appropriate interventions.

“It’s important to find out who is at risk early on, develop the right interventions to wrap around physician treatment plans, and track progress to determine how well we are doing based on guidelines,” Dr. Popiel says.

As for the future of TPM, Plocher at Cap Gemini has his predictions: improving predictive modeling; ensuring that more physicians are using evidence-based medicine; aligning financial incentives so patients are motivated to comply to interventions and physicians are rewarded for adhering to guidelines; and developing ways to measure outcomes. **MHE**