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EDITORIAL

Authors Explain the Language of IT

Health care is woefully behind other industries in embracing information technology. Even so, health care organizations of all sizes have achieved success with computer systems, which is what William Bria, MD, and Richard Rydell point out in their book, *The Physician-Computer Conundrum: Get Over It!* In this new book, published by the Healthcare Information and Management Systems Society, the authors explain how physicians can use a structured and phased approach to implement information systems.

Bria, a leader in applied medical informatics, is a clinical associate professor of internal medicine and medical director of clinical information systems at the University of Michigan School of Medicine in Ann Arbor. He is also the medical co-director of the university's medical ICU and asthma airways program. Richard L. Rydell, MBA, is a founder and executive director of the Association of Medical Directors of Information Systems, and senior vice president and chief information officer at Memorial Health Services, in Long Beach, Calif.

Bria and Rydell offer case studies to press their point, and address such topics as which term in industry parlance is more appropriate: "electronic medical record" or "electronic health record." EHR is replacing EMR as the term of choice because it implies health maintenance, prevention, and self-management and conveys a notion of patient engagement, they say. The authors also discuss nagging abbreviation problems, such as whether CPOE means "computerized pharmaceutical order entry" or "computerized provider order entry." They argue that computerized provider order entry is more comprehensive and encompasses all providers (including physicians, nurses, technicians, clerks, and hospitals).

In their book, Bria and Rydell discuss how clinician information systems offer physicians many advantages. Such systems allow physicians to view a wide variety of patient data during a patient visit, to spend more time with patients, to retrieve charts instantly, and to eliminate dictation. They enable physicians to be productive in all aspects of their practices, so that they can see more patients and thus increase income. They also help improve cash flow by speeding claims processing and help physicians get compensated at the highest appropriate code level. By improving computer documentation, they also afford some protection against malpractice suits, the authors say. What's more, clinical information systems allow staff to schedule appointments on the day patients call, reduce waiting times, facilitate scheduling of appointments and refilling of prescriptions, make it easy to get and send laboratory or x-ray reports, and provide timely educational material. In this 90-page book, Bria and Rydell state their message in clear and compelling language: clinical information systems afford a healthy return on investment.

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CHF-Specific Programs Boost Results

Many cardiologists are finding that, among their patients with congestive heart failure, the outcomes of those who participate in disease management programs are better than the outcomes of those who don't participate in such programs. The goal of these programs is to identify enrollees with CHF, educate them about their condition, ensure that they understand the treatment plan outlined by their physicians, and prompt them to contact their physicians when an intervention is necessary. These programs can have significant benefits for cardiologists as well as patients.

"DM programs serve as the eyes and ears of the practicing physician between patient visits," says Al Lewis, executive director of the Disease Management Purchasing Consortium International in Wellesley, Mass. "The most significant benefit to physicians is that they receive immediate notice if something is going wrong with one of their patients. In this way, DM programs enable physicians to achieve better outcomes for their patients at no additional cost."

Acute vs. Chronic Care

In general, the health care system tends to react more effectively when a patient has an acute episode and is not well suited to providing care for patients with chronic conditions, experts say. "CHF patients have recurring interactions with the health care system, which is geared toward acute rather than chronic care," says James Pope, MD. "Disease management plays a role in ensuring that the condition is treated appropriately and that gaps in care are filled." Pope, a cardiologist, is executive vice president and chief medical officer of American Healthways, a DM company in Nashville.

Michael Reardon, MD, national medical director for Aetna Inc., in Hartford, Conn., agrees, saying that DM programs are particularly important given the fragmentation of the U.S. health care system. "These programs help patients monitor their condition and prompt them to connect with their physicians before their health deteriorates significantly," he says. Aetna works with LifeMasters Supported SelfCare, a DM program in Irvine, Calif., to offer disease management to about 30,000 Aetna members who have CHF. The program was started in 1998.

Quality of Life

Disease management is particularly applicable for patients with heart failure because those who have this chronic disease require close monitoring. "CHF lends itself to disease management because the patient's knowledge, understanding, and ability to self-monitor his or her condition correlates so directly and so proximately with exacerbations in the condition," Lewis explains. "By enhancing that knowledge and understanding, a DM program can directly and demonstrably reduce the likelihood and severity of those events in the short term. That effect does not occur nearly as quickly when DM is applied to other conditions."

Since heart failure hinders a patient's ability to breathe and thus the ability to function, it can have a significant effect on a patient's quality of life, Reardon explains. "But specific actions can be taken to help these patients stay healthy," he adds. "Most of these actions are very straightforward, such as taking medications properly and monitoring body weight. DM can help prompt patients to take these actions and follow their prescribed treatment plan, thus improving outcomes."

One factor important to cardiologists is that DM programs do not attempt to replace physician care, says Pope. "Rather, these programs amplify physician care by reinforcing messages and notifying physicians of problems with their patients," he adds.

Improving Outcomes

The primary benefit to physicians of participating in a CHF disease management program is that the outcomes for patients in these programs are better than the outcomes for patients who do not participate, says Lewis. "The best programs track a wide range of indicators quite closely in order to confirm that the patient population is achieving improvements in health," he explains.

Patients with CHF often find it difficult to adhere to complicated regimens regarding diet, sodium restriction, fluid intake, medication, and daily weight monitoring, Pope explains. "DM programs monitor patients' health, reinforce physician messages, and field simpler procedural questions while redirecting more critical questions back to the cardiologists," he notes. "Also, DM nurses prepare patients for the possibility of

(Continued on page 4)

DM is particularly applicable for patients with heart failure because those who have this chronic disease require close monitoring.

(Continued from page 3)

changes to their medication regimens, so they are more agreeable and adaptive when the physician suggests these changes."

Research has shown that patients participating in DM programs more closely follow their prescribed treatment plans and achieve better outcomes than nonparticipants, although individual patient outcomes may vary, Reardon says.

Harold Picken, MD, medical director of clinical coordination with Blue Cross Blue Shield of Massachusetts, echoes those research findings. "Through educational efforts and other interventions, CHF disease management programs teach patients self-management skills and encourage compliance with their doctor's treatment plan," he points out. Since 2001, BCBSMA has used Cardiac Healthways, a CHF disease management program developed by American Healthways. Currently, 5,500 enrollees participate in the plan. "By enhancing clinical outcomes and functional status, the program helps participants lead comfortable and productive lives," he adds.

Data on the effectiveness of the Cardiac Healthways program demonstrate improvements in functional status and patients' understanding of their condition, required treatments, and self-monitoring activities. "For example, our most recent results show that prior to enrollment, 43% of commercial program participants weighed themselves daily; after 12 to 24 months of program participation, this measure increased to 63%," Picken says. In addition, the proportion of participants who understand their nutritional plan increased from 1.3% to 34.6% after dietary education, and hospital admissions decreased by 13%.

Aetna's program, which won the "best disease management program" award from the Disease Management Association of America in 2003, has shown that over six months, program participants achieved better adherence to medication regimens, fewer hospital admissions, decreased length of stay, and fewer emergency room visits than CHF patients who did not participate in the program.

Increased Efficiency

Given data showing improved outcomes, physicians typically do not need any other incentives to participate, says Lewis. However, DM programs do provide other benefits to physicians. "Physicians who participate in these programs say that the volume of patient calls and visits does not necessarily change, but the content of those calls and visits does," he observes. "They are much more likely to be contacted for appropriate reasons. Physicians participating in DM programs also receive detailed and ongoing data about their patients, thus facilitating their care."

Participating in such programs also can enhance a physician's standing with a health plan. "There is no doubt that payers who sponsor DM programs track the level of cooperation by participating physicians," Lewis says, adding that there is a return on investment for the payer: CHF disease management programs have been shown to offer $2 in savings for every $1 spent.

Reardon observes that physicians support the Aetna program in part because of the measured improvement in patient outcomes. "Cardiologists say that they like the fact that we prompt patients to schedule office visits when necessary," he says. "Since they are so busy, cardiologists appreciate that sort of support." As a result of such prompting, DM programs confer efficiency benefits on physician practices. "Physicians can rely on our resources to enhance their efficiency," Reardon states.

Cardiologists affiliated with BCBSMA have found that the program complements their work with little interference, Picken adds. "Clearly, a cardiology practice benefits when outcomes improve," he points out. "Also, cardiologists and their staff can spend only so much time providing basic patient education. As a result of the program, patients come to the office informed and primed to comply with physician suggestions. Furthermore, it can be distracting to cardiologists when their patients are hospitalized because they must divide their time and attention between office visits and inpatients. By reducing hospital admissions, the program enhances physician efficiency along with care quality and patient satisfaction."

Indeed, cardiologists have been pleased with the program, reports Picken. "At first, they were unsure as to the implications of the program for their own practices," he says. "But over time, their patients have told them that the program has made a significant difference in their lives."

Patients' satisfaction with their physicians may also be higher when those physicians participate in a DM program. "When a DM program nurse encourages a patient who is not feeling well to schedule an office visit, the physician has the opportunity to help that patient, which then reflects well on that physician," Reardon says. "People who are prompted to become more engaged in their health care will feel better about their health and their doctor.

"The best programs connect with physician practices to inform them when something is amiss with one of their patients," Reardon continues.

Patients' satisfaction with their physicians may also be higher when those physicians participate in a DM program.

For More Information

Readers who are interested in determining the quality of a DM program may purchase the *Disease Management Vendor Directory*, a publication produced by the Disease Management Purchasing Consortium International (at www.dismgmt.com), in Newton Highlands, Mass. The directory includes contact information for disease managers, client lists, revenue estimates, users' comments, and ratings for quality.

Another source of information is the National Committee for Quality Assurance, a health plan accrediting agency in Washington, D.C. NCQA lists its accredited disease management programs on the Web (at www.ncqa.org). —DJN

"We send physicians a list of their patients who are involved in the program. When a patient is having a problem, we inform the doctor quickly. We also send physicians a quarterly report that shows variations in problems that occurred over a given time period to help them assess their care patterns."

Reardon is hopeful that, over time, physicians will be more active in referring patients to participate in such programs. "Ideally, physicians should refer patients to a DM program as early as possible, rather than waiting until we contact them when the claims come through," he says. "We could begin educating patients earlier so that they are informed when they come in for a visit and they know when to seek an intervention."

Program Components

Typically, program enrollees are identified through claims data or through caregiver referral. Once Aetna identifies patients with CHF, the DM program staff sends a welcome letter that includes a telephone number offering 24-hour, 7-day accessibility to nurses who can answer questions and address health concerns. "We also send participants a blank treatment plan form that prompts them to capture all the relevant information the doctor provides during their office visit," Reardon explains.

American Healthways applies a stratification model to determine patients' level of risk and the corresponding program needs, explains David Brumley, MD, associate medical director of DM programs at BCBSMA. "American Healthways cardiac nurses perform a more detailed assessment of each patient over the telephone to determine what level of intervention is necessary," he says.

Next, participants in these programs receive educational mailings and nurses call them to introduce themselves, review their health history, screen them for depression, and ensure they are following their doctor's treatment plan.

"If the nurses find patients who do not understand their treatment plan, they encourage these patients to re-engage with their doctors so that they know how to maintain their health," says Reardon. "Depending on how sick they are, we reach out to them weekly, monthly, quarterly, or bi-annually so that their condition is continually monitored."

At Aetna, the nurses who call patients encourage them to do self-monitoring, Reardon explains. "For example, patients with heart failure must monitor their weight on an ongoing basis," he says. "Therefore, we make certain that these patients have a scale at home, that they weigh themselves often, and that they understand that a significant shift in weight is a problem that needs to be addressed with their doctor immediately."

At American Healthways, high-risk patients also receive home monitoring so that weight, blood pressure, heart rate, and other data are transmitted daily to American Healthways, Brumley adds.

"Most physicians are so pressed for time that they offer general comments, such as, 'Drink less fluid,' and 'Don't eat so much salt,' " Pope comments. "They don't have the opportunity to talk to patients at length regarding specific dietary or cultural factors that drive dietary, fluid, or sodium intake. DM programs include registered dietitians who have deeper and more personal conversations regarding a patient's obstacles to change."

Physicians affiliated with BCBSMA first receive information about the program when their patients are offered the opportunity to participate, Picken explains. "Then, they receive a list of their participating patients along with periodic updates and progress reports," he says.

American Healthways sends provider service managers to visit physician practices to determine which patients may need extra intervention. The service managers also offer information about medications and get feedback about the program.

"As part of our regular communication with doctors, we remind them about commonly accepted guidelines, including those endorsed by the American College of Cardiology," Picken says. "But our program does not intrude on the cardiologists' practices. It does not direct the physicians to select a certain treatment plan. Instead, the cardiac nurses emphasize that patients adhere to the physician's treatment plan, suggest opportunities for behavior change, and improve patients' knowledge about their condition, all of which are activities that cardiologists support."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

Data-Matching Programs Compared

A new report by the California HealthCare Foundation, in Oakland, Calif., reviews four commercially available software products that match data to specific patient records. Data matching is a process that electronic medical records are designed to do, but data matching programs can do it for less than it would cost to have an EMR do it.

The data-matching programs reviewed in the CHCF report are aimed at small to medium-size provider organizations of 30 and fewer physicians. But the comprehensive list of criteria used to evaluate these products will be useful to buyers of all sizes, says Walter Sujansky, MD, PhD, one of the authors of the report. "For the price, these tools provide excellent ease of use, configurability of matching weights, the ability to edit, expert results, and user documentation," he notes.

Data matching involves coordinating information about individual patients and collecting those data in a single patient record. It is an important function in the delivery of quality care, and doing it well can help a group practice improve the efficiency of administrative processes, say experts.

"Gathering data, such as hospital encounters and lab reports, and matching those data to specific patient records improves the quality of care," says A. Mark Fendrick, MD. "The technology is available to allow physicians to do that, but some of it is more expensive than others." Fendrick is a professor at the University of Michigan Medical School in Ann Arbor who has studied the use of data to improve outcomes.

The patient data-matching task is an important and challenging step in the disease management and quality improvement processes. And, while many health care and provider organizations have developed software that use simple algorithms to match patient data from disparate sources (hospital and ambulatory encounter data, pharmacy claims, laboratory reports, and so on), the effectiveness of such systems is often less than desired, say experts.

The Right Tools

"Using the right tools to match the right data with the right patient is a critically important step to improving care delivery," says Sam Karp, who leads CHCF's Health Information Technology projects. "With increasing national emphasis on the use of 'real time' clinical information systems, deploying effective patient matching tools is a key component to improving care at the point of patient contact." Sujansky & Associates, consultants in health care informatics and software development in San Carlos, Calif., prepared the report, *Patient Data-Matching Software: A Buyer's Guide for the Budget Conscious*, for the CHCF.

In a survey of about 1,200 group practices of fewer than 20 physicians, researchers found that although only 13% had even rudimentary EMRs in place, more than a third of respondents expressed a strong interest in developing a data-based recordkeeping system such as an EMR. The survey results were published in the March/April issue of *Health Affairs*, in the article, "Physicians' Use of Electronic Medical Records: Barriers and Solutions."

Overcoming Hurdles

"Clearly, data collection and EMRs are of growing importance to many physicians," says Robert Miller, lead researcher for the *Health Affairs* survey. "A significant barrier is cost." Miller is an associate professor of health economics in residence at the Institute for Health and Aging, University of California, San Francisco.

The initial financial costs of implementing an EMR are a primary barrier to adoption, Miller's report says. Such costs range from $16,000 to $36,000 per physician, and some practices see revenue decline at least initially because they may see fewer patients while addressing the administrative complexity of converting an office to an EMR-based system.

An alternative to that expense is what the CHCF report calls moderately priced, commercially available software products that can assist organizations in the patient-matching process. "These tools all apply advanced techniques and are easy to use," says Sujansky. "They can serve as useful starting points or even alternatives to EMRs."

Matching data with patient records without having software designed specifically to do such work can be challenging and error-prone, according to the report: "Because no standard patient identifier exists with the private health care system, clinical data must be matched based on multiple, imprecise data elements, such as name, date of birth, health plan identification numbers, and medical record numbers. "These identifying attributes may be shared by multiple patients, represented inconsistently across data sources, and subject to

Matching data with patient records without having a software program designed specifically to do such work can be challenging.

change over time."

In commissioning the guide, CHCF sought to identify products that met the following criteria: availability on a desktop platform; application of advanced matching techniques; the ability to integrate into existing patient-matching workflows; and a total cost of ownership not exceeding $50,000. Of the four products that met these criteria, the report provides a qualitative description of the capability of each product, describes 20 features, offers a comparative quantitative score for each product, and provides an inventory of each product's capabilities with respect to provider organization needs.

Compatibility

An additional important feature the authors looked for in making their recommendations was that all four products had to have the ability to be installed and run on a Windows-based PC. "We found that the task of actually performing the matching functions usually worked independently, using the tools already at their disposal that they are familiar with, and most use Microsoft Windows," Sujansky says.

The authors consider four products to be comparatively low cost (meaning generally less than $50,000 for an unlimited number of records) and suggest that budget-conscious health care organizations should consider using these programs for patient data-matching:

1. Dataset V Suite, manufactured by Intercon Systems in Blue Bell, Pa. (at www.ds-dataset.com)
2. Dedupe4Excel, manufactured by DQ Global, Ltd. in Fareham, Hampshire, United Kingdom (U.S. distributor is DQMax in Tucson, Ariz.) (at www.dqglobal.com), and described by the authors as appropriate only for very small groups of two or three physicians
3. Linkage Wiz, manufactured by LinkageWiz Software in Payneham South, Australia (at www.linkagewiz.com)
4. SureMatch, also manufactured by DQ Global

Although the report says the best products overall are DataSet V and LinkageWiz, all of the programs are similar in terms of cost and the data they process. Wide variation was found in manufacturer support. The four products all follow the same sequence of steps:

- Import the data.
- Massage the data to facilitate a field-by-field comparison of records.
- Specify match weights for the relevant demographic and other fields.
- Run a number of matching algorithms against the data and compute matching scores that indicate the likelihood of a record-pair match.
- Display the actual and possible matches for a manual (clerical) review and editing.
- Export the set of matching records for further processing and data integration.

Prerequisites for Success

The authors found the tools they recommend to be "flexible and easy to use," but they say there are several prerequisites to adopting these programs successfully in physician groups. First, staff using the software must have a "basic understanding of probabilistic and fuzz-matching techniques." That's because most of the tools require "some configuration of matching weights and desired data transformations, which requires familiarity with terms such as 'exclude lists' and 'blocking variables.'"

Second, the data must be available in tabular format. Third, the practice must have a master patient file with unique identifiers. Fourth, the users of the tools must be familiar with the specific values to be matched, meaning "users must know which fields are more and less accurate, which have common synonyms, which are sometimes omitted, and which are more specific to individuals." Fifth, the practice must have the ability to convert the collected data into a clinical data repository, meaning a database that allows for comparisons, such as an Excel spreadsheet. "All the tools accommodate data in a Microsoft Access database or a Microsoft Excel database," the authors say.

The amount of documentation and service support varies widely among the three manufacturers of the four products. LinkageWiz provides a 113-page user manual and online support and 10 hours of e-mail support. SureMatch has online manuals only, explanation is minimal, many product features are not described, and e-mail and phone support are not provided, the report says. Dedupe4Excel offers online support only and explanation is minimal, but e-mail and phone support are provided. DataSet V Suite has a large (168-page) comprehensive user manual, and e-mail and phone support are included.

"There's no doubt that matching claims, lab, and pharmacy data to patient records produces the kinds of data that are invaluable to physicians who want to see how well they are following guidelines and how productive they are being," says Fendrick. "Software that can do that need not be expensive."

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More information on practice strategies is available on our Web site (see page 16).

The authors found the tools easy to use, but say there are some prerequisites for successful implementation.

Four Top Medical Centers Have Much in Common, Author Says

***Daniel Beckham** is president of The Beckham Co., a health care consulting firm in Bluffton, S.C. Most of his engagements involve strategic planning for hospitals, health systems, and multispecialty group practices. His clients include the Mayo Clinic and the Cleveland Clinic. Beckham is writing a book about four major health systems: the Mayo Clinic, the Cleveland Clinic, Johns Hopkins, and Duke University Medical Center. He discussed the book with editor in chief Richard L. Reece, MD.*

Q: *Let's begin by discussing why you decided to write this book.*

A: These four organizations—the Mayo Clinic, the Cleveland Clinic, Johns Hopkins, and Duke University Medical Center—regularly rank in the top five of the annual rankings of hospitals and medical centers by *U.S. News and World Report*. I was interested in looking into the characteristics they share that have allowed them to climb to the top of the list and what differentiates them from other institutions.

Q: *How did you go about writing the book?*

A: To begin, I went through the *U.S. News and World Report* rankings and did a simple adjustment for heart care and cancer, the two big killers. The magazine's methodology is based on how many specialties from these organizations are ranked in the top. *U.S. News* doesn't give any comparative weighting to the various specialties, so I gave special weighting to heart disease and cancer. Both of those specialties create a strong aura and reputation. When I did my weighting adjustment, those four institutions popped right to the top of the list.

Q: *Two of these institutions (Mayo and Cleveland) are major multispecialty clinics and two (Duke and Hopkins) are major academic medical centers. What do these four organizations have in common?*

A: One characteristic is that they are all led by physicians. You have to go pretty far down the *U.S. News* article to find a top hospital that is not physician led. All of the big four have long traditions of being physician-led, dating back 70 to 100 years.

I also suggest they have all benefited from remarkably strong leadership and management. All four are alike in that they operate as employed models, in which all physicians are on salary. Each is committed to the medical triangle model of teaching, research, and patient care. What makes each of them unique is the emphasis given to the various legs of the triangle. For example, Mayo has described itself as a tricycle. The big wheel for Mayo is a focus on patient care. The research and teaching wheels are smaller but still fundamental. What's more, all four emphasize pragmatic application. Hopkins can claim two Nobel prizes but it preserves an orientation toward putting scientific discovery to work in an entrepreneurial culture. Each has cultivated a powerful brand identity and very strong consumer preference.

Q: *While writing your book, you visited each of these institutions. What struck you most during your visits?*

A: What struck me most is that each institution has a strong sense of what's important. The people at the Cleveland Clinic, Mayo, Hopkins, and Duke care deeply about what their institutions stand for. They adhere to fundamental principles. They have a clear sense of mission, purpose, and values. They are all good at articulating what they stand for. All of them at every level—from those on the frontlines of care to those in the laboratory doing bench research—know why they are there and what they want to do. They all want to be part of a world-class institution. They are willing to trade off higher incomes and more independence for that goal.

> **"Inevitably, medicine is going to go in the direction of large physician-led organizations."**

Q: *What can you say about the culture at these organizations?*

A: As one physician told me, at Mayo you know that if you fall, people will catch you before you hit bottom and help you back up. That is not the case in a lot of other organizations or in struggling independent practices.

Hopkins, which shares a reputation as a hard-driving, competitive organization, insists on this fabric of support. When Hopkins recently hit a rough patch financially, Ed Miller, MD, the dean and CEO, announced a freeze on salaries. After that announcement, he received only three e-mail messages of protest. But when Hopkins lost a physician husband and wife team in an accident, he received thousands of inter-

nal e-mails of condolence and sorrow. Miller thought that was symbolic about what the Hopkins family is all about.

Q: *Often one hears that because academic centers serve the poor and disenfranchised, they are in economic trouble. Do you find that to be true?*

A: Not really. For multiple reasons, these institutions are not as overburdened when it comes to caring for the poor. One characteristic they share is that they are all private institutions, so they may have less pressure from a public standpoint. In Baltimore, a lot of the indigent care is provided at the University of Maryland. Mayo's home base, Rochester, Minn., bears no resemblance to the inner city, so Mayo's exposure to an indigent population is limited. Duke, because of its location, doesn't have a particularly heavy load of poor patients. Cleveland Clinic gets some criticism for not sufficiently serving the poor, but I don't think the criticism is justified. The clinic has done a remarkable job of revitalizing downtown Cleveland, and it has seven affiliated hospitals, some of which are in the most impoverished areas in Cleveland and in the nation.

Q: *Is it true that these institutions are committed to strategic innovation and to improving care?*

A: Yes, and that may be because they are not as consumed by local issues. They aren't distracted from the bigger picture. Each of these organizations has been blessed with great leadership. Look at Fred Loop, MD, the CEO of the Cleveland Clinic. When he took over 15 years ago, the clinic had revenue of $675 million. Today, it's a $3.6 billion organization. That growth reflects Loop's drive, his strategic vision, and, as a world-renowned heart surgeon, his intimate knowledge of the organization and its work.

Q: *How do these organizations treat the outside medical world? Surely they have strategies to cultivate outside collaborators.*

A: All of them will tell you that, as they move into the future, becoming more open is one thing they will spend more time on. They know there is a danger in insular monastic cultures. To remain robust, they'll bring new ideas and new people into their inner circle, while at the same time preserving their founding principles.

Q: *Do independent physicians, many of whom are struggling, have to simulate what these big institutions are doing?*

A: I think so. I have always felt that way. It seems as though the rest of medicine takes a couple of steps in that direction, and then a couple of steps back. We saw that with the proprietary group practice model that PhyCor and MedPartners introduced. That model fell apart. And we saw hospitals acquire practices. That hasn't always worked out well. But, inevitably, medicine is going to go in the direction of large physician-led organizations.

In Cleveland, we see a dramatic example of that. The malpractice situation is so bad there that many physicians feel they're witnessing the accelerated death of private practice. Physicians who three or four years ago wouldn't even think of joining the Cleveland Clinic are now putting on Cleveland Clinic Foundation lab coats because the malpractice situation is so unbearable.

Q: *So with the decline of private practice, we will have the rise of larger physician-led organizations. Does that logically follow?*

A: Not necessarily. You need leadership. What struck me most when I visited these places is leadership. That's a characteristic that is easy to look past, but leaders are the key to why these organizations have been successful. The physician CEOs provide a powerful role model for organizations inside and outside of health care. These are organizations and leaders that should be emulated. What you see are people who are not only good managers and strategic thinkers, they are also people who are intimately familiar with the value-adding work of their organization.

Loop, for example, is a cardiothoracic surgeon and he knows how the Cleveland Clinic produces value. He knows what it means to be a patient and what it means to be a doctor. He has been to the rodeo. The same is true at Mayo, Duke, and Hopkins. You can't always say that about leaders of many of America's corporations. And you can't always say that about leaders of other hospitals and health systems in America.

It's important that these leaders are all doctors, who have actually put hands on patients and have made scientific and technological contributions as well. Loop's successor, Delos Cosgrove, is a heart surgeon too. Cosgrove has, as I recall, 18 patents

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"The malpractice situation is so bad there that many physicians feel they're witnessing the accelerated death of private practice… Physicians are now putting on Cleveland Clinic Foundation lab coats because the malpractice situation is so unbearable."

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stemming from his heart surgery work and has performed more than 22,000 procedures. Mike Wood and Denny Cortese at Mayo are physicians. Ralph Synderman at Duke is a physician. Ed Miller at Hopkins is a physician. All of them know the real work of their institutions.

Q: *Do these institutions train their leaders from within and are therefore trusted by their physician followers?*

A: I think so. These institutions do not necessarily have formal leadership development programs, but they have a process that works very well in developing leaders. For example, they rely on physician leadership councils and committees at Cleveland and at Mayo. These forums have a way of showcasing the abilities of rising physician leaders. They provide a "hot house" in which physicians with innate leadership abilities can develop. They focus on real issues and deal with real challenges. You usually don't find these hothouses in other organizations.

Q: *Also these organizations seem to have made the necessary accommodations and trade-offs between clinicians and administrators.*

A: That's an excellent point. Mayo is probably the institution most associated with the notion of being physician-led but at the same time is professionally managed. But all four of them share this dual characteristic, which is significant. They are led by a physician who is technically trained and who understands medicine, but they also have a strong administrative person in a high role. In these organizations, the physician and administrative leaders have a lot of respect for each other. But it's also clear who's in charge: It's a physician.

Q: *Will the lack of infrastructure among independent physicians lead to the downfall of independent physicians and to the necessity to regroup?*

A: I think so. We're just on the front-edge of a requirement to have standards for quality, safety, and compliance. The organizations that have the infrastructure and are already working on those kinds of things are going to have a huge lead.

Q: *Is it true that another characteristic of these models is that they have set aside resources and capital to improve infrastructure whereas independent physicians have been lax in that regard.*

A: Even for sizable group practices, not setting aside enough retained earnings is a huge issue. They often simply do not have the money or the will to set aside resources to fund their growth.

Q: *In other words, large institutions have an advantage in developing information technology infrastructure?*

A: Yes. Just look at Mayo's history and one of its founders, Dr. Henry Plummer. Nearly 100 years ago he set up a conveyer belt system to transport records and charts from one end of the Mayo campus to the other, from the clinics to the hospitals. Mayo understood early the importance of IT. There were no computers then, but it was still information technology.

Q: *Is it true that these four organizations are involved in growth through consolidation?*

A: Mayo bought some competitors in southern Minnesota and Wisconsin. Duke has regional outposts and affiliated hospitals. The Cleveland Clinic has seven affiliated hospitals in Cleveland. Among all four, consolidation is a shared characteristic. In the cases of Mayo and Cleveland Clinic, there's also a distant outreach strategy in Florida. They tend to emulate each other, although they won't always admit it. They've also pursued the closer-to-home 100-mile circle expansion. In both of those situations, you get a sense of the value of their brands. Cleveland built its regional system, which consists of seven hospitals, for relatively little. It's not unusual to buy hospitals at about eight times earnings before interest, taxes, and amortization (or EBITA).

Using that formula, seven hospitals would have cost the Cleveland Clinic billions. The reason it was able to buy them for less is that it is the Cleveland Clinic. The other hospitals said, "We need to be part of something that's world class, so we'll forgo eight times EBITA just to be part of the Cleveland Clinic. Mayo did the same thing. It was able to pursue a similar strategy with doctors. It doesn't buy practices; it just says, "Here's the employment agreement."

Q: *That strategy certainly simplifies matters, doesn't it?*

A: Well, it makes things a lot cheaper. It doesn't have the huge cost of acquisition that a lot of health systems have to shoulder.

—Edited by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

"In these organizations, the physician and administrative leaders have a lot of respect for each other. But it's also clear who's in charge: It's a physician."

COMMENTARY

Should the Federal Government Pay for Treating Obesity as a Disease?

By Richard L. Reece, MD, editor in chief

Physicians who treat overweight patients may be bolstered in their efforts by Medicare officials' decision to modify the government's stance on obesity. In July, Tommy G. Thompson, secretary of the U.S. Department of Health and Human Services, said Medicare will remove barriers to covering anti-obesity interventions if scientific and medical evidence demonstrates their effectiveness in improving health outcomes.

This step is encouraging to Medicare beneficiaries who would seek treatment for obesity, but the decision does not mean treatments for patients who want to lose weight will be covered—at least not yet. However, it opens the door for individuals and physicians to submit applications to Medicare for coverage of such obesity therapies as stomach surgery, diet programs, and behavioral and psychological counseling.

Scientific Review

"Obesity is a critical public health problem in our country that causes millions of Americans to suffer unnecessary health problems and to die prematurely," Thompson says. "Treating obesity-related illnesses and complications adds billions of dollars to the nation's health care costs. With this new policy, Medicare will be able to review scientific evidence in order to determine which interventions improve health outcomes for seniors and disabled Americans who are obese and its many associated medical conditions."

Medicare covers specific medically necessary services for patients who are ill or injured. The previous wording stated that obesity was not an illness, which could thus prevent Medicare from covering treatments for diseases related to obesity, Medicare officials said. The move is one of several by the federal government to fight the nation's rising obesity problem. Many public health experts, anti-obesity advocates, and doctors welcomed the decision. But not everyone agrees that it is correct.

Medicare's decision doesn't yet promise government subsidies or tax deductions for those who attend weight control programs or buy diet books. Most of the government's attention will be focused on gathering evidence to justify payment for surgical procedures to relieve morbid obesity. Federal officials also will seek to determine whether diet programs and behavior therapies are effective in controlling weight. As *The Washington Post* stated in an editorial, "It is a useful regulatory change, because this is precisely the sort of evidence gathering that Medicare, with its financial clout, ought to be doing, and that the diet industry, long a haven for quacks and cranks, desperately needs."

Some critics believe it's absurd for government officials to decide whether obesity is a disease. Clearly, obesity is a health problem, they argue, since it leads to diabetes, high blood pressure, heart disease, and other health problems. In fact, recent surveys suggest that obesity is more directly associated with illness than are alcohol and cigarettes. Obesity is also a problem that can be addressed early, before it debilitates and kills.

In the past, health plans and Medicare have paid for the consequences of obesity, rather than prevention efforts to slow the disease. But now, some health plans are beginning to experiment with various forms of preventive medicine. Meanwhile, Medicare officials are looking at the success rates of some weight-loss programs, and the Medicare Prescription Drug Improvement and Modernization Act of 2003 calls for Medicare to pay for an initial physical for those entering the program. So, perhaps it is appropriate to begin to pay doctors for counseling patients about obesity.

Many surgeons who perform procedures to reduce the size of the stomach or to bypass the stomach do so on patients who are morbidly obese. People who are considered morbidly obese are more than 100 pounds over their ideal weight as calculated by body mass index, a standard, if flawed measure of weight. These patients have actual health problems that are often life threatening, surgeons say, adding that they consider morbid obesity to be a chronic disease untreatable by diet or exercise alone.

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The government will gather evidence to justify payment for surgical procedures to relieve morbid obesity.

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Personal Responsibility

On the other hand, some experts believe obesity is completely under the control of the individual. These skeptics argue that if people didn't eat so much or sit so long, they wouldn't be fat. Many in the food industry and in conservative organizations contend that obesity is a problem stemming from personal or parental irresponsibility, rather than a problem that requires intervention by the government or advocacy groups.

"This is truly a dumbing-down of the term 'disease,' " says Rick Berman. "This is the only disease that I'm familiar with that you can solve by regularly taking long walks and keeping your mouth shut. It's terrible to start using taxpayer money like this when there are other legitimate diseases that need to be addressed." Berman is executive director of the Center for Consumer Freedom, an advocacy group in Washington, D.C. that is funded by the food industry (at www.consumerfreedom.com).

At least one critic believes the government's decision is based on flawed science. Paul F. Campos, JD, a law professor at the University of Colorado, who wrote the book, *The Obesity Myth,* says that "the decision is irrational, given that being underweight is more of a health problem for the elderly than being overweight. It's not just a bad idea (he says of the change in Medicare policy), it's completely unscientific. We're in the grip of a kind of out-of-control cultural hysteria on this issue that leads to really irrational social decisions, such as making obesity a disease among the elderly."

Perhaps so, but many experts who support the change in Medicare policy say that it may help to eliminate the social stigma associated with being overweight and may encourage more physicians to treat patients who are overweight as they would treat patients with other medical conditions. The change might also prompt overweight individuals to seek help.

"The lack of recognition of obesity as a disease has cast a pall over the field," says Louis J. Aronne, MD. "Now Medicare is saying obesity deserves treatment like any other disease." Aronne is a clinical associate professor of medicine at Cornell University and president-elect of the North American Association for the Study of Obesity, in Silver Spring, Md. (at www.naaso.org).

Being overweight and obese clearly raises health risks and the risk of death, according to Walter Willett, MD, a professor of epidemiology and nutrition at the Harvard School of Public Health. In a study in 1995 of 115,195 nurses, researchers found the risk of death rose 60% in even slightly overweight women. Other studies show that being overweight causes a five- to tenfold increase in diabetes risk compared with the risk of someone who is very lean, Willett says. "Being obese triples the risk of coronary heart disease and endometrial cancer; it doubles the risk of hypertension and stroke," he adds. Losing even a little weight leads to significant improvements in blood fats, blood pressure, and blood sugar control, he comments.

"Every 10 years someone comes along who thinks he or she has discovered fatal problems in the relationship between body mass index and mortality," Willett says. "But it's always someone who doesn't understand medicine and human disease processes and epidemiology."

Areas of Agreement

The controversy notwithstanding, there is one fundamental issue on which most experts agree: Diets work poorly. Most people can lose only about 10% of their body weight by dieting, and most tend to gain back that weight.

The experts also agree that exercise improves health, regardless of weight. In fact, it's better to be fat and fit than be lean and unfit, says Steven Blair, president and CEO of the Cooper Institute, a nonprofit research and education foundation in Dallas. He says exercise is by far the most important factor in long-term health. The institute has monitored the fitness levels of thousands of men and women for many decades and has shown that a person's performance on a treadmill test at the study's start was a better predictor of later health than was body weight.

Perhaps Mark McClellan, MD, PhD, administrator of the federal Centers for Medicare & Medicaid, summed up the issue best when he said, "From the standpoint of Medicare coverage and the health of our beneficiaries, the question isn't whether obesity is a disease or a risk factor. What matters is whether there's scientific evidence that an obesity-related medical treatment improves health. This change in Medicare's coverage policy puts the focus on public health. The medical science will now determine whether we provide coverage for the treatments that reduce complications and improve quality of life for the millions of Medicare beneficiaries who are obese."

—More information on physician practice strategies is available on our Web site (see page 16).

There is one fundamental issue on which most experts agree: Diets work poorly.

Aggressive Strategies Are Back

Several aggressive managed care utilization management strategies that were largely abandoned in the 1990s are now making a comeback in response to a continued rise in health care costs, according to a report published in the Aug. 11 issue of the health policy journal, *Health Affairs*.

To some degree, health plans had been backing away from strategies such as requirements for prior authorization, specialist referrals, concurrent and retrospective review, and provider profiling that were unpopular with both physicians and patients. By 2000, consumer dissatisfaction with managed care prompted employers to favor less restrictive insurance products. Double-digit increases in health care premiums and a general economic downtown, however, have prompted some health plans and employers to revisit these strategies in an attempt to manage health care usage more closely.

Shifting Costs

The fact that health plans are revisiting abandoned utilization management strategies is not surprising, says lead author Glen Mays, PhD, MPH, an associate professor at the University of Arkansas for Medical Sciences in Little Rock. "Cost pressures have accelerated," he says. "In response, health plans and employers have moved to benefit designs that shift more costs to consumers. But these strategies can only go so far before undermining the value of health insurance. At some point, health plans have to consider other mechanisms for constraining costs. Utilization management mechanisms had proven effective in the past, so it is natural to revisit some of these tools."

But these mechanisms are being adapted to make them more palatable to doctors and consumers. "Health plans are being more selective in how they are using these cost controls, in particular by targeting them to services and procedures that are likely to be overutilized or that provide minimal clinical benefit," observes Mays.

Mays and his colleagues also note that while controls may be less stringent than they were during the 1990s, health plans seem to be implementing them in a broader range of insurance products than they did initially.

What's more, health plans are carefully monitoring the effect of these tools on their relationships with providers. "Plans are reluctant to place more administrative burdens on providers, given the provider backlash during the late 1990s and the resulting contracting disputes," he states. "In the interim, plans have taken concrete steps to improve their relationships with physicians and hospitals and they don't want to jeopardize any progress they've made."

Community Tracking

The report is based on an analysis of data collected as part of the Community Tracking Study (CTS), a longitudinal study sponsored by the Center for Studying Health System Change in Washington, D.C. The mission of the CTS is to track changes in health systems and the effect of those changes on different health care constituencies. For the study, researchers gather data through national surveys of households, physicians, and employers as well as site visits made every two years to 12 metropolitan communities in which local health care leaders are interviewed.

Communities in the CTS were randomly selected to represent health care markets with more than 200,000 residents; they are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; Northern New Jersey; Orange County, Cal.; Phoenix; Seattle; and Syracuse.

As part of the CTS, four rounds of site visits occurred in 1996-97, 1998-99, 2000-01, and 2002-03. Interviews were conducted with providers, hospital executives, health plan executives, employers, insurance brokers, and legislative and regulatory agencies. The analysis of the 2002-03 site visits included data from 56 health plans in 12 communities.

Prior Authorization

The authors found that a considerable number of health plans reimplemented managed care cost containment and utilization management strategies in 2002 and 2003 after eliminating or relaxing them in 2000 and 2001 in response to employer and enrollee dissatisfaction.

For example, in 2002 and 2003, health plans in six of the 12 communities re-implemented requirements for preauthorization of certain services after having eliminated these requirements. Five plans in four communities increased use of preauthorization of

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Some health plans and employers are revisiting old strategies in an attempt to manage health care usage more closely.

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hospitalization. Five plans in four communities increased use of preauthorization of outpatient services or procedures. Four plans in three communities increased use of preauthorization for specialists. Seven plans in four communities increased use of preauthorization for prescription drugs.

Health plan executives interviewed assert that services subject to preauthorization requirements are rarely denied. Still, they believe that the existence of the requirements dissuades requests for services that are not medically necessary, thereby reducing costs.

Furthermore, many plans have reintroduced preauthorization requirements that are less restrictive than those used previously, the authors add. For example, Regence BlueShield in Seattle now requires preauthorization only after certain utilization thresholds (such as three MRIs or 10 chiropractic visits) have been exceeded.

In addition, seven plans in five communities increased their use of concurrent review of inpatient services in an effort to reduce length of stay and in-hospital diagnostic tests and procedures. Strategies to monitor inpatient care include implementing telephone-based review procedures and even placing utilization review nurses in hospitals that are used most frequently.

The authors found that while most plans historically have adopted concurrent review processes only in HMOs, in 2002 and 2003 several plans began employing these strategies in their PPO products as well. Furthermore, some plans have expanded concurrent review processes beyond hospitals to other inpatient facilities, such as skilled nursing and rehabilitation facilities.

Provider Profiling

The analysis also revealed a significant use of retrospective review and provider profiling. Fifteen plans in nine communities increased their use of retrospective review and provider profiling based on indicators of provider health care utilization and quality of care.

Utilization and quality measures varied widely across plans, the authors note. One health plan developed a claims review system to track inappropriate care and then followed up with providers. Another plan is collecting comparative data on utilization and costs and will use these data during contract negotiations with physicians. Yet another plan is using Health Plan Employer Data and Information Set (HEDIS) measures of quality to profile physicians and will provide feedback to foster quality improvement.

The analysis also revealed that health plans are not only revisiting previously discontinued utilization management activities, but that trends in the development or promotion of numerous cost-containment activities among health plans are continuing.

To manage the costs associated with the care of patients with chronic conditions, for example, 15 health plans in six communities have expanded their investment in disease management programs. Some plans have developed new DM programs. Other health plans have established programs for additional conditions to complement ongoing DM initiatives. Still other plans have expanded participation in existing DM programs, such as by extending offerings for HMO enrollees to PPO enrollees as well, the authors note.

In general, providers may be more amenable to cost-containment activities such as DM programs, Mays says. "These programs can potentially be quite helpful to physicians who are trying to improve patient compliance," he explains. "While evidence is limited regarding the cost effectiveness of these programs, plans feel they hold promise and so are continuing to expand their program offerings."

A large number of health plans are targeting high-risk, complex patients whose conditions are likely to generate high costs. Since 2001, 18 health plans in nine communities have increased their use of case management programs. These programs offer customized, intensive interventions to help improve outcomes and lower costs. Participants are typically identified through predictive modeling techniques based on data from health care claims and health risk assessments.

The authors state that some plans have developed these case management programs to complement existing DM services. However, other plans envision case management as an alternative to DM, believing that a case management strategy will be more successful in serving patients with complex needs whose health outcomes may not be optimized by standardized DM initiatives and who are often the highest cost users of the health care system.

Provider Networks

In response to consumer backlash against restrictive provider panels, in the late 1990s many plans eased restrictions and developed panels that were more inclusive. But, some plans are again developing restrictive provider networks in an attempt to contain rising health care costs.

Four plans in three communities developed limited network products called exclusive provider organizations. EPOs maintain panels that are smaller than PPO panels, offering this

The analysis also revealed a significant use of retrospective review and provider profiling.

curtailed choice of physicians and hospitals at a lower cost to enrollees. For example, one plan in Orange County, Cal., is developing an EPO that is about half the size of its PPO panel, and is expecting to offer this new product for 10% to 15% less than the PPO.

In addition, nine plans in six communities developed tiered-network products. Tiered-network products group providers into tiers based on their costs to deliver care. Enrollees are given financial incentives (usually reduced cost sharing) to choose providers in the lower-cost tiers. Some plans are including only hospitals in their tiered network products, while other plans are including both hospitals and physicians. However, the authors note that to date, these networks have not been embraced due to objections from providers, challenges in differentiating providers based on cost, and concerns regarding the absence of quality considerations in the tier formation.

Another cost-containment approach gaining popularity involves offering financial incentives to providers. Some plans have created new provider incentive programs designed to encourage efficient, cost-effective, high-quality clinical practice. While such programs were initially implemented in HMOs, the authors note that plans are now adopting these incentives in both HMO and PPO networks.

Fifteen plans in seven communities introduced a financial incentive program, according to CTS data. Several plans are offering financial incentives to physicians who achieve or exceed thresholds of quality performance based on HEDIS standards. One plan is offering higher reimbursements to hospitals that achieve certain patient safety standards, such as reduced medication errors.

Cost-Sharing

Almost all health plans have continued to change benefit designs or increase enrollee cost-sharing in an attempt to manage rising health care costs, the authors found. Cost-containment approaches that employers and health plans have adopted include

- Increasing enrollee copayments and deductibles
- Adding deductibles to HMO plans that previously had offered first-dollar coverage
- Introducing coinsurance to products that previously offered fixed-dollar copayments
- Adding consumer-directed products that incorporate member-directed spending accounts and require out-of-pocket expenditures before a given threshold is reached
- Offering lower cost plans to enrollees who sign up for a limited provider panel or select high-deductible catastrophic coverage.

Since 2001, 35 health plans in 12 communities increased deductible and copayment levels; 30 plans in 11 communities introduced consumer directed health plans; five plans in three communities introduced coinsurance options; and two plans in two communities introduced a deductible with an HMO.

Gatekeeping, Capitation

Interestingly, the authors found that among health plans there was no increase in primary care gatekeeping strategies, a utilization management activity that was popular in the early years of managed care. Rather, the growth in open-access HMO and PPO options reported in 2000-01 continued in 2002-03. However, many plans maintained their existing gatekeeper HMO products as a way to offer a lower cost option.

Similarly, health plans did not attempt to reintroduce capitated payment arrangements in the communities studied. While some plans, particularly those in Orange County, Cal., continued existing capitated provider payment systems in Medicare and Medicaid HMOs, most plans that had abandoned such systems in 2000 and 2001 did not reintroduce capitation as a method of cost management, likely due to provider resistance, the researchers say.

Many health plan executives and employers interviewed for the study questioned the ability of these cost-containment strategies to reduce health care costs significantly, the authors say. Certainly, short-term effects on costs will be limited as these strategies are only beginning to affect enrollees, the researchers explain.

Furthermore, the success of utilization and cost-containment strategies will depend to a large extent on the cooperation of physicians and other providers, the authors add. Following the managed care backlash, many plans are still reluctant to impose stringent requirements on physicians and hospitals, and in fact lack the leverage to do so in many markets in which providers have consolidated.

Finally, advancements in medical technology represent a potent driver of escalating health care costs, undermining the ability of utilization and cost-containment strategies to have a significant effect on health care costs overall. "These strategies may be helpful, but ultimately costs will grow due to advancements in medical technology," Mays says.

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

Some plans are offering physicians financial incentives achieving or exceeding thresholds of quality performance based on HEDIS measures.

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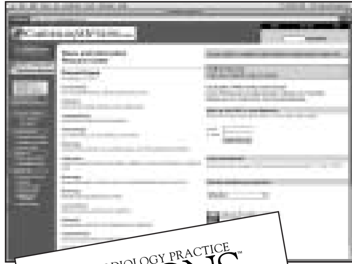

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