As stakeholders are now beginning to collaborate to meet the goals of health care reform and modernize their businesses, it has become imperative for physicians and payers to exchange information and share in the creation of new services and resources.

To facilitate this exchange, OptumInsight has formed a Physician Advisory Board composed of a diversified group of practicing physician-leaders. It’s clear that physician leadership will be critical to the future shape of health care. Our Physician Advisory Board has a number of functions: It provides independent review of our data privacy and security approach and practices; but more importantly, it provides a vehicle for OptumInsight to understand the significant needs and burdens of practicing physicians as our health care system transforms around them.

Ignite offers us another way to examine some of the issues that affect physicians/providers and consider opportunities to work together to improve care delivery. In this issue, we examine the critical role of physicians in rural health care and physician use of actuarial services to bridge the gap between payer and provider. We also take a closer look at the value and opinions of a member of OptumInsight’s Physician Advisory Board through an interview with Susan Strate, MD.

Rounding out this issue, you will find a feature on medication adherence as well as coordinated care opportunities for individuals who qualify for both Medicaid and Medicare.

You can find additional information on all of these and other topics by visiting our website at ignite.optuminsight.com. Look for a recent video on physician alignment with gain-sharing models as well as a podcast about self-pay patients.

There is a great array of resources here for you. I hope you enjoy this latest issue of Ignite, and as always, I look forward to the conversations that ensue.

Sincerely,
Andy Slavitt
CEO, OptumInsight

Learn more about the Physician Advisory Board at optuminsight.com/physicianadvisoryboard
Stakeholders are looking for new ways to manage patients enrolled in both Medicare and Medicaid.

New models give a boost to pharmaceutical companies’ focus on patient adherence and education.

The UnitedHealth Center for Health Reform & Modernization explores the challenges of rural health care.

Joel Hoffman explains the need for data analysis to calculate cost-cutting opportunities.

Susan Strate, MD, describes the role of the physician in the creation of new health care delivery models and resources.

“We need to look at ways to put the patient back in the driver’s seat in their own health care.”
Physicians and Gain/Risk Sharing
New health care models create gains and risks for physicians. Miles Snowden, MD, of OptumHealth, discusses the importance of physician alignment in making the models work.

Adapting to Self-Pay Patients
The number of self-pay patients is on the rise. Scott Armstrong, of OptumInsight, explains how hospitals can accommodate them—and collect payment.

HIGHLIGHTS

Blog: Technologies to Fuel Collaborative Care
New technologies are critical to accountable care models. Todd Cozzens, of OptumInsight, describes three important technological solutions.

Podcast: The Physician Voice in Health Care Reform
As IT and other solutions change around physicians, Susan Strate, MD, of OptumInsight’s Physician Advisory Board, says physicians can voice their concerns and help curb costs.

Podcast: Integrated Care Management for Dual Eligibles
Holly Michaels Fisher, of OptumInsight, explains the potential for programs for patients enrolled in Medicare and Medicaid and how plans can help integrate care management for this population.

SOCIAL SPACES

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For the 50 million Americans living in rural areas, it can be a challenge to find quality health care close to home. To identify and suggest ways to meet the unique needs of such communities, the UnitedHealth Center for Health Reform & Modernization produced a report, using data from their own analysis of primary care and a national UnitedHealth Group/Harris Interactive survey on the modernization of rural health care.

The report demonstrates that health care reform could bring an additional set of challenges and opportunities—changes that could both stress the rural health care system and generate innovative solutions. Resources and services such as mobile health clinics, electronic health records and telemedicine could be the key to closing care gaps and increasing quality.

The survey of current rural residents found that...

- 19.5% say they’re in fair or poor health.
- 31% have Medicare or Medicaid as their primary source of coverage.
- 15% are over age 65.
- 24% consider local care only “fair” or “poor.”
- 5.2 million live in areas with a shortage of primary care physicians.

1 UnitedHealth Center for Health Reform & Modernization released the report, “Modernizing Rural Health Care: Coverage, quality and innovation.” To read the full report, visit unitedhealthgroup.com.
Number of People Who Live in Rural Counties with < 33 Primary Care Physicians per 100,000 Residents
This ratio marks a shortage of primary care physicians, by federal government standards.

Distance Traveled for Specialty Services: Urban vs. Rural
Rural primary care physicians report that 51% of patients referred for specialty services are referred to locations more than 20 miles away from the primary care facility.

The future of U.S. rural health care:
By 2019, an additional 8.1 million rural residents could join Medicaid and state insurance exchange plans.

- 59% of rural primary care physicians plan to accept newly eligible Medicaid patients in 2014.
- 1 in 5 rural residents live in counties where they expect an increase in insured patients and a strain on available primary care.
Time for Physicians to Calculate Opportunity

By Joel Hoffman, ASA, MAAA, FCA
Senior Vice President, OptumInsight Payer Solutions

Today’s providers (hospitals and physicians, that is) are leery about what happened in the mid-1990s, when they readily accepted risk without really knowing what it meant to be accountable for a population—in other words, what it meant to assume and manage population risk. Although they didn’t need to assume all payer functions (e.g., product development, rating, underwriting, claims adjudication, member services), they needed to be knowledgeable and actively participate with the payer in some of these functions (e.g., underwriting) for their own protection and proactively assume other functions (e.g., care, case, disease and transitional care management and the foundational actuarial analyses, clinical informatics, and financial analytics) to even have a chance at success.

Fast-forward 15 years: We’ve learned from our mistakes and grown in our understanding of the problem. We are much better situated to make risk-sharing work between plan sponsors/payers and providers. There’s better technology, better information, better connectivity—and with 15 years of inflation, there’s an even bigger burning platform: The cost of health care is far too onerous. We have to do something now.

In an accountable care environment, providers need to work with their plan sponsor/payer partners to acquire exposure-based administrative claims data. This data will help them begin the analyses to understand the population for which they are accountable—who they are, where they live, their morbidity profiles, how and where they consume medical
resources, who needs intervention now, etc. This is a first step to delivering high-quality, efficient health care to their constituent populations, while curbing health care cost trends and ultimately (we hope) reducing the price of health insurance.

But in most cases, providers do not have the information or the ability to perform such analyses—not to mention that the compensation models haven’t been historically aligned for it to make sense for them to do so. Although payers possess both the information and the ability, they are far removed from the point of care and thus the maximum effectiveness of such information; the two parties are still not contractually aligned. And in the 1990s version of downstream risk models there was just no incentive for them to provide such services to providers who in most cases were left holding all the risk.

Actuaries are one source to bridge this gap between the plan sponsor/payer and providers. Actuaries can identify and capture the necessary information and turn it into actionable opportunities for providers through analytics.

Calculating Opportunity
Actuaries evaluate opportunity for health care delivery systems across the country to help providers begin to understand both their risks and opportunities. Specifically, actuaries work to:
1. Identify, collect and manipulate data
2. Use these data to identify how patients and providers consume medical resources (e.g., they may identify patients who access the health care system in the wrong way or providers who overuse diagnostic services)
3. Synthesize data into actionable information that affords broad care management, population health and financial performance management

These steps set the stage for the plan sponsor/payer and provider partnership to achieve the triple aim: 1) better care for individuals, 2) better health for populations and 3) lower growth in health care expenditures. These parties must work together effectively, stop being adversaries and successfully engage the consumer/patient for there to be any hope of achieving a much-needed transformation.

Putting the Data into Action
Once they “know” the population for which they are accountable and where performance opportunities lie, “connected” providers must execute around the fundamentals of care delivery, utilize actionable information at the point of care and put clinical programs in place to begin to realize this potential. Putting a definitive road map in place to get from point A to B, along with placing necessary tools in the provider’s quiver and wrapping them with the necessary clinical and operational infrastructure, will be vital to facilitating the necessary change. Plan sponsors/payers must help in the latter regards and in providing data. In some cases, this may require provider behavioral changes.

Providers will have to look at ways to bend the cost curve—shifting in-office check-ups to nurse practitioners or physicians’ assistants, focusing on frequent outreach to chronic patients, reducing excesses in procedures and diagnostics, making use of other clinically equivalent or better and more efficient modalities of care, and so on. At the same time, providers will also have to consider ways to replace lost revenue (e.g., the elimination of lower-intensity admissions driven by better access to appropriate ambulatory care). A clinically integrated delivery system with aligned incentives and plan sponsor/payer-driven enabling product designs can not only repatriate any current “leaked” utilization, but also increase volume through membership growth driven by reported quality outcomes and lower market price points.

By quantifying opportunity over a number of years and explaining how achievement of optimal performance will have to happen over time, actuaries can help providers “get their heads around” the journey—how it will not only improve care, but also yield financial benefit. Overlaying any contractual terms providers may enter into with plan sponsors/payers, such as gain share or two-sided total cost of care contracts, must be done for full appreciation of the opportunity. With this knowledge in tow, providers can begin the trip to deliver high-quality, cost-effective care and quarterback their partners through the creation of connected, intelligent and aligned health care communities.
PLANS FOR PATIENTS ENROLLED IN BOTH MEDICARE AND MEDICAID COULD DRAIN—OR SAVE—THE HEALTH CARE SYSTEM.

BY LYNN ZIMMER
A provision of the Patient Protection and Affordable Care Act (PPACA) aims to better coordinate Medicare and Medicaid benefits in order to improve the care of low-income seniors and people with disabilities who qualify for both programs.

After years of little coordination, PPACA established the Federal Coordinated Health Care Office (“Medicare-Medicaid Coordination Office”) to develop ways for these two programs to work together more effectively. The goal is to improve access to care for “dual eligibles”—those enrolled in both Medicare and Medicaid—and to eliminate conflicting regulations and financing, as well as the cost-shifting that has historically taken place between state and federal governments.

In April 2011, in a move to change the way benefits for this population are managed, the Center for Medicare and Medicaid Innovation (CMMI) awarded 15 states federal contracts of up to $1 million each to design coordinated care demonstrations for dual eligibles.

This represents an opportunity for states, as well as health plans and health care providers, to find new ways of integrating benefits for dual eligibles in an effort to improve care for this high-cost, high-need population.

The Cost of Dual Eligibles

More than 9 million Americans qualify for both Medicare and Medicaid benefits. That represents just 16 percent of all Medicare enrollees and 15 percent of Medicaid enrollees. In spite of its relatively small size, however, the dual population accounts for 27 percent of Medicare spending and 39 percent of Medicaid’s spending. This year, the government will spend approximately $330 billion caring for beneficiaries of both Medicaid and Medicare (see sidebar).

“It’s the most costly population,” says Holly Michaels Fisher, vice president of OptumInsight. Dual eligibles, she says, “utilize many more health services than other Medicare and Medicaid cohorts. They are admitted to the hospital disproportionately and use nursing home services and home care services disproportionately.”

More than half of this population is being treated for five or more chronic conditions, and 43 percent has one or more mental or cognitive impairment conditions.

A recent report by Emory University found that the federal government stands to save $125 billion over a 10-year period by enrolling dual eligibles in an integrated program that better coordinates their care.

Payment Model Road Test

With only a few exceptions (Medicare Advantage plans with
Special Needs Plans, Managed Long-Term Care and PACE programs, among others), the financing and care delivery for dual eligibles has not been integrated. Two new proposed models aim to change that.

In July 2011, the Centers for Medicare & Medicaid Services (CMS) released a “State Medicaid Director” letter offering preliminary guidance on financing alternatives. Proposals included capitated and fee-for-service integration models that CMS wants to have tested.

Capitated models will involve a three-way contract between CMS, states and participating health plans. Health plans, in turn, will be responsible for managing primary and acute care, behavioral health and long-term care services. The managed fee-for-service model would be set up with an agreement between CMS and the state, with the state responsible for delivering integrated Medicare and Medicaid benefits and for coordinating care.

The fundamental idea, according to Stephen Wood, vice president with OptumInsight, is to consolidate the revenue streams between Medicare and Medicaid, “to eliminate duplication, eliminate conflicting regulatory environments and coordinate care so that you don’t have unnecessary procedures and events that could be avoided if you didn’t have these different funding streams.”

States are expected to develop new designs aimed at better managing care for dual eligibles over a period of 12 months, at which point CMS will choose which proposals will be implemented. States can choose either model, or some combination thereof, and are in the beginning stages of working through the details of how they’ll integrate Medicare and Medicaid benefits.

“What CMS asked for was, give us your best shot on a proposal for how you would handle this in your state,” Wood says. Some states indicated in their grant applications that they intend to maintain separate fee-for-service payments and de-

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**BY THE NUMBERS**

9 MILLION
Number of individuals eligible for both Medicare and Medicaid in 2010

NEARLY 90%
Percentage of dual eligible treatment that occurs on a fragmented fee-for-service basis

ESTIMATED 8%
Fee-for-service savings potential with full integration of Medicare and Medicaid benefits

$330 BILLION
Amount the federal government was projected to spend on dual eligibles in 2011

$206 BILLION
Amount the federal government is projected to save over 10 years with full integration of Medicare and Medicaid (assumes savings would phase in over three years)

<10%
Percentage of Medicaid dual eligibles who are enrolled in long-term care programs

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velop ways for providers to coordinate services that are offered under the separate Medicare and Medicaid programs, says Laura Dummit, vice president in the federal health practice of The Lewin Group, an OptumInsight company that provides policy research and consulting services. Under the fee-for-service model, it may be more difficult to coordinate care because individual providers will continue to have incentives to deliver more services, she says.

The challenge, according to Dummit, will be to ensure that the incentives play out in the way they are intended to and that beneficiaries receive the most appropriate services regardless of whether they are paid for under Medicaid or Medicare. Currently, Medicare beneficiaries are not required to enroll in managed care plans. However, a number of recent studies suggest that, as compared with fragmented care under a fee-for-service system, managed care plans can reduce unnecessary hospital readmissions by as much as 40 percent.

Under the capitation model, beneficiaries could be automatically enrolled with a monthly opt-out option.

Many experts see a move to managed care as a way to best achieve the goal of true integration, creating a big opportunity for health plans around the country. “I am optimistic about it,” says Jane Ogle, deputy director of health care delivery systems with the California Department of Health Care Services. “It is not unreasonable to think that some of the people that we take care of should be in managed care too, because it seems to work pretty well for a lot of other people.”

According to Dummit, “Under the rubric of a managed care organization, it’s easier to see how the money could be pooled to provide the Medicare and Medicaid benefits in such a way that the plan has incentives to provide the best care, but also lowers the total cost of services provided.”

In addition, Wood says, when the financial risk is transferred to a health plan, it’s easier than in a fee-for-service arrangement to require plans to deliver quality-of-care protocols, keep track of all grievances and appeals, and provide health care effectiveness data and information set (HEDIS) information, among other measures, that enables close tracking of the quality of care being delivered. “You can benchmark against each other, you can do comparisons, you can hold them to a very high standard, you can require all sorts of mechanisms for reviewing provision of care and quality and HEDIS measures,” Wood says.

Making the Move to New Financial Models
Of course, all of this has major implications for health plans and providers looking to contract with states to manage the care of dual eligibles. Health plans in particular need to understand the nature of their market to determine how they can impact and improve the management of care for a dual eligible population, Michaels Fisher says. “Early focus for plans is to understand their market and understand what exists today,” she says. “How large is the population? How are they getting care today? What is the state looking at doing?”

Also critical for plans, according to Michaels Fisher, is to examine how its current membership base would be affected by taking on this population, in addition to how the state medical and long-term care delivery service systems currently work.

Having a full understanding of the type of providers operating in the area and anticipating issues around access to care must also be taken into consideration early in the process. It’s likely that for many plans, provider networks and clinical management systems are not yet well aligned with the needs of this population.

“If you are a commercial carrier, you’re going to have a large provider network that is not in the target geographical or market segment, where these populations are either going to live or need services,” Wood says. “There is a fair amount of provider contracting that will need to be done.”
Along with expanded provider networks, there is a need to retool claims payment systems to accommodate payments for an entirely new set of services.

In addition, Dummit says, managed care plans and provider groups will have to make decisions about which sub-populations they will be good at taking care of. “I think there are going to be some real niches of providers and plans that take care of specialized population groups,” she says.

**Redesigning Existing Care Management Models**

Care management is another area that most health plans will have to rethink entirely, Michaels Fisher says. Historically, it is treated as more of a short-term need with the goal of graduating patients. But dual eligibles are a high-need, complex population that generally requires a model that addresses psychosocial issues, access to entitlement programs, housing, and a host of other issues that reach well beyond initial medical care.

“If you’re going to focus in some significant way on this population, all of a sudden you’re talking about investing in nurse care managers, needing a robust care management system and/or working with community organizations to provide it, and having relationships with physicians and medical groups to change how care is delivered,” Michaels Fisher says.

Given the significant mental health needs of this population, integrating behavioral health services will be a major issue that needs to be addressed. “The plans that are in existence today are not well integrated, by and large, with mental health services,” says Peter Harbage, an independent consultant working with the state of California to develop dual eligible pilot projects.

The same goes for long-term care services. “These services are completely apart and separate from medical care, and this coordination effort is going to ask the plans and the providers to help bring them together,” he says.

Among the care management models being considered by many states is that of medical homes, a model included in the health reform law. This care delivery model is likely to play a major role in improving clinical outcomes and assuring appropriate use for this population.

According to Ogle of the California Department of Health Care Services, there is an expectation that the use of medical homes and strong care coordination will be employed by health plans and provider organizations interested in working with the state of California. “We don’t want business as usual,” Ogle says. “We want to see across the whole spectrum that somebody’s care is integrated and planned and managed.”

The effort at coordinating care will also depend, in large part, on good data—both that flowing from CMS to the states as well as between health plans and providers.

The ability to share meaningful information in a way that can be easily understood and interpreted varies and can have a significant impact for health plans and/or providers financially responsible for dual eligible care coordination.

**On the Road to Change**

Although the integration of Medicare and Medicaid benefits for the dual eligible population will require substantial changes, most experts say aligning these two programs is needed and long overdue.

Right now, Michaels Fisher says, “States are loath to invest in the kinds of programs that would actually make a difference for this population because they feel that the majority of savings then go to Medicare. So, they are spending Medicaid dollars, and then the feds benefit from their investment.”

By coordinating Medicare and Medicaid benefits and aligning financial incentives, dollars will be saved at both the state and federal levels, but most importantly, beneficiaries will come out ahead in the form of care that is better coordinated and more appropriately delivered services.

“It’s always the right thing for the state to try to do more to keep people healthy and keep people out of the hospital,” Harbage says. But the way things currently stand, according to Harbage, “you just have the incentives and the dollars in the wrong place.”
With a focus on patient education, pharmaceutical companies can leverage new health care delivery models to move the needle on persistence and compliance.

By Kim Ribbink
n a clear signal to the health care community that it needs to confront patient compliance, a report from the New England Healthcare Institute estimates that additional care for non-adherent patients places a $290 billion cost burden on the industry. With health reform initiatives focused on three clear goals—better health, better care and improved costs—there is strong incentive for education around medication adherence and persistence.

The scale of the problem is vast. Following an electronic prescription from a physician, up to 22 percent of patients do not obtain the medication prescribed (or an appropriate alternative) within an acceptable period of time. Reasons for primary non-adherence vary based on patients’ individual barriers, such as poor understanding of an illness or the importance of a medication, low motivation, or affordability. This is a particular concern with chronic diseases, which, if not managed effectively, can take a heavy toll on the patient both physically and financially.

Certainly, in the case of accountable care organizations (ACOs), adherence seems to be a priority. The Centers for Medicare & Medicaid Services (CMS) has adopted rules for objective assessment of ACOs, including a list of 33 quality measures. One measure requires Medicare patients to self-report medication adherence
after an inpatient facility discharge. Though working to ensure accuracy and patient safety is a positive step, relying on patients to compare medications at home against their discharge orders may not be enough to improve overall medication adherence rates, says Craig Schilling, PharmD, vice president, patient insights for OptumInsight’s life sciences business.

The Connected Patient
ACOs and other private-sector models, such as the patient-centered medical home, have established multiple touchpoints for patients, which include not only doctors but also nurses, pharmacists, case managers, health coaches and other allied health care professionals, Schilling says. It stands to reason, then, that the greater the teamwork and health care support, the better the opportunity for improved health outcomes.

These multi-participant health care models are better positioned to provide unbiased educational material to help patients change their behavior around medication use, says Lou Brooks, vice president of marketing analytics for the life sciences division of OptumInsight.

“The current health care organization is fairly disjointed, with various parties pushing and pulling in slightly different directions,” he says. “The concept of the ACO is to mitigate the counter strategies that each of these different entities have and get them working collaboratively to improve not only the outcome for the patient but the overall balance that exists in the health care system.”

Moreover, because patients today often turn to the Web when seeking health information, ACOs and similar organizations already have an eager audience.

Jerry Hester, national account manager at Forest Pharmaceuticals, a prescription product manufacturer and distributor based in St. Louis, agrees that it will take a group effort to make new health care models work long term. “Health care providers, pharma companies included, can all do a better job in communicating the value of adherence by disease state, along with the consequences of non-adherence,” he says.

The Role of Pharma
There is a growing awareness among many health care participants that adherence requires a multifaceted response and that the one-size-fits-all approach is less effective. Furthermore, there are practical and perceptual barriers to compliance, and these differ among patients as well as from one disease to the next. As the health care industry deals with these challenges, there is a role for pharmaceutical companies in all of this, regardless of their lack of direct access to patients. Where pharmaceutical companies can have impact, Schilling says, is in helping payers and providers understand the value of their

PODCAST
Find out how physicians are adapting to secure payment from self-pay patients at ignite.optuminsight.com
medication by conducting comparative effectiveness research trials with specific products within therapeutic categories.

"Specifically, evidence-based evaluation of health outcomes and overall health care costs associated with varying degrees of adherence will provide further support as to the value of those medications," he says.

Here are a few other strategies pharma should consider:

A Segmented Approach: Aunia Grogon, global head of adherence at Novartis, a multinational pharmaceutical company headquartered in Basel, Switzerland, says her team recognizes the need to take a segmented approach and the importance of taking behavior modification into account. There is evidence, she explains, to demonstrate that many factors contribute to non-adherence and that these are highly variable at the patient level.

"With our programs, we have increasingly looked to try and provide different combinations of benefits, so what we put together works for different patients, even within the same disease state," Grogon says.

To determine how best to segment patients, Novartis began with qualitative and quantitative research around adherence, says Cynthia Hogan, vice president of patient services and mature brands at Novartis Pharmaceuticals Corporation. After extensive testing, her group developed seven questions for patients that provide insight on how to segment them and what program to enroll them in. Now that the program has been developed, Novartis is reaching out to managed care organizations, cities and government entities to work collaboratively on improving compliance. "We're targeting leading health care providers who are known to be innovative, and we've had a significant amount of interest," she says.

Disease-specific Programs: One of the limiting factors of many pharmaceutical adherence programs is their tendency to be product-specific. "A lot of the programs today are driven by pharma manufacturers and are designed to keep people on a particular drug longer," says OptumInsight’s Brooks. "But that drug may or may not be appropriate for that individual patient."

In response, some drug companies are becoming interested in disease-specific programs; however, as with most promotional activities, Brooks says, it’s a slow transition. "They will need to test and evaluate it to determine that it's working for them before they shift their marketing dollars significantly in that direction," he says.

Novartis is one such company that has begun taking this approach. The programs Hogan and her team have developed are non-branded and aimed at helping drive compliance, regardless of which drug a patient is prescribed. So far, they have launched a hypertension program and have performed extensive testing on other cardiovascular conditions, oncology, multiple sclerosis and chronic obstructive pulmonary disease (COPD).

"Continuing to provide non-branded educational programs and tools that enhance the patient-provider interaction are all great opportunities for the pharmaceutical industry that has less direct access to the patient," Schilling says.

New Partnerships: Hogan and others in the industry recognize that new health care models can also help further their adherence efforts.

"Today when a pharmaceutical company wants to communicate about a program, they must approach many individual providers," Brooks says. "The ACO, however, spans a network of providers, making it easier to get a message out and heard since companies won't be trying to partner with thousands of individual physicians."

However, these partnerships may take time to develop. "With the complexities of launching a new program, many ACOs may be reluctant to partner with pharma in the beginning," Hester warns. "I believe many pharma companies and ACOs will wait for the program to work out the kinks before jumping into large-scale partnerships."

Measuring Outcomes
It is important, in determining the success of adherence programs, to understand how medication compliance is measured. "When assessing adherence interventions in the literature, if one truly wants to compare apples to apples, he or she should be confident that the programs have used the same methodology to calculate adherence rates," Schilling says.

In particular, Brooks says pharma companies have not been consistent at evaluating and understanding the drivers of adherence, the types of components that work and how to optimally integrate those components for long-term impact. While
MANAGING DIABETES

By 2020, 52 percent of the U.S. population is expected to have diabetes or prediabetes, according to the Centers for Disease Control and Prevention. This large subpopulation added $195 billion to U.S. health spending in 2010. And with the increase in diagnoses, the spending is projected to rise to $500 billion by 2020.

Evidence shows that efforts to control diabetes and manage the complications of the disease can reduce costs and improve health outcomes. Programs include:

- Diabetes awareness and education, which state and federal governments have already started
- Intensive lifestyle interventions, such as weight loss, fitness promotion and cardiovascular risk factor reduction
- Diabetes-oriented disease management programs, which promote behavioral change through patient empowerment and education
- Coordination and management of chronic conditions among primary care medical homes, primary care physicians and their teams
- Treatment plan adherence assistance, provided to patients by community-based care providers

The potential savings from intervention programs:

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved medication adherence for people with diabetes</td>
<td>$34 billion</td>
</tr>
<tr>
<td>Lifestyle intervention for weight loss for people at risk of prediabetes and diabetes</td>
<td>$45 billion</td>
</tr>
<tr>
<td>Lifestyle intervention for people with prediabetes using a diabetes prevention program</td>
<td>$105 billion</td>
</tr>
<tr>
<td>Intensive diabetes lifestyle intervention</td>
<td>$88 billion</td>
</tr>
<tr>
<td>Total illustrative savings opportunity from all initiatives, if fully implemented</td>
<td>$250 billion</td>
</tr>
</tbody>
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Source: “The United States of Diabetes: Challenges and opportunities in the decade ahead,” UnitedHealth Group, 2010

These types of analyses have been embraced in clinical trials and other outcome-related studies, they tend to be overlooked in marketing-oriented activities.

“We need to shift the focus on adherence programs away from a marketing viewpoint and toward a clinical-oriented viewpoint, and push the ownership of adherence programs more toward the medical directors,” Brooks says. “When that happens, it will be easier to put in place better procedures to test and measure these programs.”

One group that is proactive in developing standard quality measures is the Pharmacy Quality Alliance (PQA), a consensus-based nonprofit organization committed to improving the quality of medication use. A number of pharmaceutical companies are represented on the PQA adherence work group and have supported demonstration projects to evaluate and compare various adherence interventions.

In addition, several tools that have become available over the past few years can better connect providers and measure adherence. These include electronic health records (EHRs), e-prescribing, and mobile and digital communication channels, among others. In fact, according to recent University of Colorado research on medication adherence, primary non-adherence is the failure to pick up a prescription within 30 days, and researchers recommend linking pharmacy systems to EHRs so providers can view primary non-adherence.

Hester says innovative approaches to driving patient adherence are important, including the use of smartphone applications to send compliance reminders to tech-savvy patients or to the patient’s physician for follow-up.

Most experts in the health care industry say there is still a long way to go with these technologies; however, as new care delivery models bring together different stakeholders to collaborate on outcomes, technology will play a significant role.

Collaborating for Change

Although patients must take a lead role in their health care, Brooks says that having a support system to help educate patients and guide them through the process should remove some of the apathy that may exist.

Because ACOs, patient-centered medical homes and other initiatives are focused on the health of the community, the incentive is there for pharma to be more proactive in providing education, rather than waiting for patients to seek it out. “That’s the big component from an adherence perspective,” Brooks says. “It’s getting the adherence message out before it’s too late.”
through final decisions about health care reform may occur at the government level, it is not without the input of multiple stakeholders from all levels. Physician input is particularly important, as physicians are often the face of health care delivery—and their offices could be the first place patients encounter change.

To ensure the physician’s voice is heard in the creation of new delivery models and mechanisms, Susan M. Strate, MD, serves as a delegate to the American Medical Association (AMA) House of Delegates (HOD) and as a member of OptumInsight’s Physician Advisory Board (learn more on p. 1). Strate is an anatomic and clinical pathologist and president of Texoma Independent Physicians, an independent practice association in Wichita Falls, Texas. Ignite recently spoke with her about her take on the physician’s role in the changing health care landscape.

IGNITE: WHAT ARE PHYSICIANS’ BIGGEST CONCERNS REGARD TO HEALTH CARE REFORM, AND HOW CAN THEY VOICE THESE CONCERNS?

Strate: The biggest challenge currently facing physicians is the declining payment system in conjunction with increasing practice expenses. This threatens the viability of physician practices. The other major concern is the impact of health system reform on patients and practices.

A group of physicians together is the best possible body to vet these issues and make decisions about health care delivery. Physicians who are seeing patients every day know best how to cut costs without cutting quality. It is best if physicians are a part of groups locally, whether that be their health care system, independent practice association or county medical society. Physicians can have an impact at the state and national level through their state medical and specialty societies, the AMA, and national specialty societies. It is easy to communicate online now, so it’s easier for physicians to be involved at multiple levels.

IGNITE: HOW ARE YOU ABLE TO MAKE AN IMPACT THROUGH YOUR ROLES AS A DELEGATE TO THE AMA HOUSE OF DELEGATES AND THE PHYSICIAN ADVISORY BOARD?

Strate: It’s a two-way street as a physician delegate in a House of Delegates:

1) You have a responsibility to represent your constituents. It’s important that physicians who are
actively involved in patient care are developing the policy that will affect health care.

2) Delegates are responsible for communicating HOD activities back to their constituents.

But it’s not just a communication highway—policies that are made at the HOD, in many cases, result in changes in laws or regulations in the United States.

As for the advisory board, in 28 years of practice, I have never seen a time when so many regulations on medical practice are coming down the pike. That, coupled with waiting rooms full of very sick patients and a complex health care system, means we need to look for ways to make the health care system more efficient and more effective and most of all, we need to simplify. Physicians who are in practice every day are in the best position to advise on different information technology (IT) systems and other innovations by OptumInsight.

IGNITE: HOW CAN PHYSICIANS HAVE A SAY IN HOW QUALITY IS MEASURED?

Strate: Physicians need to be actively involved in development and implementation of performance measures. Physicians must review their performance measure results and look at them objectively to determine if they’re accurate. If they’re not accurate, then physicians have to stand up and say, “This measure is not effective and we shouldn’t be using this measure.” If it is a good measure, then it’s important for physicians to look at ways to improve patient care.

IGNITE: WHAT CHANGES ARE NEEDED TO COORDINATE CARE WHILE CUTTING COSTS?

Strate: First, the health care delivery system needs to be simplified. To continue to make it more complex and expect it to become less expensive is not realistic. From a physician’s standpoint, that means developing ways, whether it be IT or other innovations, to cut the cost of doing business and to deal with the regulations in a cost-effective way.

Second, physicians need to be able to share patient information. HIPAA and other laws make it difficult for physicians to share relevant patient data. Changes to HIPAA would help in that regard, and physicians need tools that will help them to comply with the law.

Third, we badly need tort reform at the national level and some relief from the antitrust laws. We still have some antiquated antitrust laws on the books that prohibit physician practices from coming together to share information and data.

Another issue is patient involvement and patient compliance. We need to look at how we can put the patient back in the driver’s seat in their own health care—better ways to educate patients and incentivize patients toward healthy behavior.
About OptumInsight
OptumInsight provides health information, technology and consulting services. Commercial health plans, physicians, hospitals, life sciences companies, government agencies and other organizations that comprise the health care system depend on OptumInsight solutions and insights to improve their performance. OptumInsight is part of Optum, a leading information and technology-enabled health services company dedicated to making the health system work better for everyone. Visit www.optum.com or www.optuminsight.com for more information.

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