

Purchaser Demands for Care (Disease) Management

Employer group purchasers are requesting increasingly specific information from health plans about "disease management" because they understand that better management of chronic diseases—which account for a disproportionately large use of health care resources—reduces health care costs and increases employee productivity. Responding adequately to some employer group purchasers was difficult initially, but Kaiser Permanente (KP) is preparing to show its commitment and effectiveness in Population Health Care Management by responding to employer groups from our strength and experience as an integrated delivery system and as a health maintenance organization (HMO) designed on the group-practice model.

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- From 1997 UC Request for Proposal to Kaiser Permanente

California employer groups (purchasers) are holding health plans accountable for their clinical and administrative performance by issuing performance standards and (financial) guarantees.^{1,2} In 1997, the Kaiser Permanente California Division (KP-California) returned several hundred thousand dollars to California employers for not meeting negotiated 1996 clinical performance improvement targets based on the Health Plan Employer Data Information Set (HEDIS) measures and returned several more hundred thousand dollars for not meeting administrative and membership services guarantees. At first, in 1997, Atlantic Richfield Company (ARCO) chose Foundation Health Systems (HealthNet) and did not pick KP as its 1998 benchmark health plan for their employees and dependents, in part because KP scored low in demonstrating use of population-based "disease management" for our members. However, that choice occurred at the same time that KP-California was selected as the Blue Ribbon HMO by the Pacific Business Group on Health (PBGH)² and was shown to have among the lowest risk-adjusted perinatal mortality and acute myocardial infarction mortality in California.

Heavily influenced by their health benefits consultants (William M. Mercer, Towers Perrin, Deloitte & Touche, Watson Wyatt), the larger, sophisticated purchasers (Southern California Edison, Hughes Electron-

ics, Disney, Digital) have understood the 80-20 rule, ie, that 20% of their employees—mostly those with chronic conditions—account for most of the companies' insurance costs as purchasers of health care.³ The population of current and future insured employees, dependents, and retirees is aging, and the prevalence and incidence of chronic disease in that population is increasing. These demographic and epidemiologic changes predict an even greater economic burden for purchasers of health care. Employer groups are requiring evidence that health plans are effectively managing these populations, which they hope will help lower health care costs and increase employee productivity (function) as well as time on the job.

Employer Group Purchasers' Expectations

As part of their "value purchasing" strategy to assess and compare competing health plans, employer groups are requesting more clinical data, performance results, and information from health plans in their Requests for Proposals (RFPs)—much more information than is provided by HEDIS measures. Over the last couple of years, these requests have become increasingly specific in asking for information and outcomes of "disease management."

A representative sampling of RFP questions from purchasers is shown (Fig. 1). Purchasers have specific expectations about how health plans should engage in disease management. For example, the RFP from the University of California (UC) framed questions as if disease management were a study with hypothesis and testing criteria. Carrying this focus even further, several purchasers (including UC and Hughes) are now requesting employer-specific outcomes and results. Responding to these kinds of detailed questions presents a formidable task.

Employer groups are evaluating, grading, and comparing health plans based on RFP responses, sometimes supplementing these processes with on-site interviews and audits. Some employers have created their own report cards. Hughes and UC (advised by Deloitte & Touche), for example, use their Value Equation[®] to grade a health plan's performance. Based on these evaluations, employer groups are selecting health plans to offer their employees and are promoting specific health plans as preferred or benchmark plans, sometimes providing attractive underwriting or subsidizing the cost to encourage enrollment.

Reaction to KP Responses

Overall KP clinical quality in the California marketplace has been judged to be good based on HEDIS results; however, overall clinical performance was

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Figure 1. Representative examples of Request for Proposal (RFP) questions from employer group purchasers about KP's "disease management" practices.

From University of California (UC), 1997

UC (and Hughes)-specific disease management programs will be conducted during 1998 for asthma, diabetes, and heart disease. In addition, the following information will be provided to UC for each program:

- hypothesis of the study
- proposed measurement criteria
- workplan and timeline for each study
- baseline data
- objective measures that will determine the success of the program

From University of California (UC), 1998

- Describe any care management programs you have in effect and provide outcome reporting.
- Summarize the results of your programs; include health improvement and financial impact.
- At a minimum, UC would like an annual analysis of prescription drug data identifying UC employees and retirees by chronic disease. Please confirm you will provide this information for diabetes, asthma, hypercholesterolemia, hypertension, depression, AIDS, cardiovascular disease, coronary heart disease, and other.

From Los Angeles Unified School District, 1997

Has your plan sponsored, become a partner in, or outsourced any specific disease management programs (for example, asthma and diabetes management)? If so, provide a detailed explanation of the program(s) including: type of program and parties involved, start date, organization, funding/risk sharing, operational details, data collection, and provider and member satisfaction.

From General Motors, 1998

Identify the key elements below for the following disease management programs the HMO currently has in place: asthma care, chronic obstructive pulmonary disease, depression, low back pain, diabetes, gastroesophageal reflux disease/PUD/H. pylori, HIV/AIDS, pregnancy/childbirth, low-birthweight infants, heart disease, hypertension, coronary artery disease/hyperlipidemia, post-heart attack/ASA therapy, other coronary artery disease programs, congestive heart failure, atrial fibrillation/stroke prevention/anticoagulation, elder care, prevention of falls, management of hip fractures, cancer care, breast cancer, prostate cancer, or other disease states.

- Indicate the number of members who have this disease or condition and the number who are enrolled in your disease management program.
- Do you have Clinical Practice Guidelines that guide each disease management program?
- Are Clinical Practice Guidelines updated at least annually?
- Do you have physician performance measures tied to the Clinical Practice Guidelines?
- Are physicians routinely provided with lists of their eligible/at-risk patients?
- Do you have targeted member outreach designed to draw at-risk members into the disease management program?
- Do you track the results of process and outcome measures associated with this disease management program?
- Do you routinely re-evaluate and modify the disease management program-based results of the tracking of process/outcome measures?

From Southern California Edison, 1998

For your HMO's top five disease management efforts, please attach a copy of the Clinical Practice Guidelines currently used (with the most recent date reviewed) and complete the following questions:

- How are members targeted? Please define criteria used to identify the at-risk population (age, gender, familial history, health risk assessment questions, pharmaceutical use, etc.).
- What is the number of current enrollees eligible for and currently in the program?
- How does the HMO identify potential enrollees to physicians? How often does this occur?
- How does the HMO factor physician participation in its disease management programs into physician performance measures and incentives?
- Please list the objectives or performance measures the HMO has used or will use to evaluate the success of this program?
- Please provide the date of the most recent program evaluation and the recommendations that evolved from this process? If feedback was collected from participating physicians and patients, please attach a copy of the tool(s) used to gather this information.

From Pacific Business Group on Health (PBGH), 1999

How does your plan oversee the management of chronic conditions for the over-65 population? On which chronic conditions, if any, are current programs focused? Do you conduct outreach/early intervention programs? If yes, how do you measure the progress of these programs? Is it available to all locations and members?

From Interim Services, 1997; TWA and Toys R Us, 1998

- There is (ie, health plan shall have) a disease management program with member enrollment for the following clinical conditions: allergy, asthma, cancer, diabetes, drug and alcohol abuse, hypertension, mental health, migraine headaches, osteoporosis, smoking cessation.
- Is disease management subcontracted to an outside entity?

“After receiving this feedback, we committed ourselves to three goals: 1) learn more from purchasers and their consultants, 2) develop better ways to effectively show KP’s strengths in managing the care of members who have chronic conditions, and 3) encourage KP in Southern California (KPSC) to focus on improved approaches to managing the care of members who have chronic diseases.”

“Beginning in 1998, KPSC is targeting clinical populations for greater alignment with our Clinical Strategic Goals and purchasers’ expectations (eg, for treating congestive heart failure, diabetes, and asthma).”

seen as lower in 1997, partly because of our failure to convincingly respond to the wave of RFP questions about specific Disease Management Programs. Specifically, both Hughes and UC gave KP in Southern California a “C” rating for disease management after applying their Value Equation®. ARCO initially found our responses about disease management inadequate and therefore selected HealthNet instead as its preferred, benchmark health plan. According to the purchasers, KP responses in 1997 indicated to them that KP did not specifically conduct disease management and that KP differed from other health plans because primary care physicians at KP had responsibility for managing disease. KP was characterized by these purchasers as being unresponsive and inflexible, failing to understand the purchasers’ interests and expectations for disease management.

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First, our purchasers mentioned that several other health plans have established relationships with many of the more than 40 leading disease management vendors, eg, HealthNet with Schering-Plough Corporation, Lovelace Health Systems (CIGNA) with Greenstone Solutions (Upjohn). Other health plans, such as PruCare, have implemented their own centralized, claims-based tracking systems; targeted mailings to providers and members; telephone outreach; and health risk assessments. Using health plan claims, membership files, and data from pharmacy benefit management services, disease management vendors have analyzed health plan populations to develop data bases from which the vendors create member mailings, initiate telephone interventions with care managers, and give limited notification to the providers. Although the effectiveness of these methods has not yet been shown, employer groups have seemed satisfied that these health plans were actively conducting disease management.

Second, interviews were conducted with consultants from Deloitte & Touche, Watson Wyatt, and other firms who were willing to advise us on how to better respond. In large part, employers and KP seemed to be speaking in different dialects. But once we began to speak in terms of clinical populations and of managing health or care for defined populations of members or patients, our approach to care management could be understood as comparable to the “disease management” models. Employers could find persuasive the description of KP as always having been focused on improving the health of our members—a focus which is part of our core values as stated in the KP Aspiration Statement (Fig. 2). The specific, population-based KPSC Clinical Strategic Goals for improving outcomes in cardiovascular disease, cancer, communicable diseases, pregnancy and newborn care, and asthma—along with evidence of objective clinical measures and results—would

further illustrate the KP approach to “disease management,” which we now call Population Health Care Management.

Third, KPSC committed to increasing its focus on population-based care management. Care management is not new to KP. For example, KPSC has a long history of specific regionwide

Care Management Programs like that for Elder Care (1986) as well as others for perinatal services/high-risk pregnancy (1983), HIV/AIDS (1988), and end-stage renal disease (1992). In addition, local programs for treating diabetes, asthma, coagulation dysfunction, and congestive heart failure are flourishing. We had an opportunity to build on this base of experience by greater coordination, facilitation, and transfer of successful practices.

Beginning in 1998, KPSC is targeting clinical populations for greater alignment with our Clinical Strategic Goals and purchasers’ expectations (eg, for treating congestive heart failure, diabetes, and asthma). To do this, KPSC is identifying Permanente leaders in care management across the Region; providing increased support for the information systems, data, and analysis; and providing project management and consultative services for care management in all service area operations. With availability of patient lists

Figure 2. Kaiser Permanente Medical Care Program Aspiration Statement.

“We aspire to be the world leader in improving health through high-quality, affordable, integrated health care. We will be distinguished by our strong social purpose, physician responsibility for clinical decision-making, and an enduring partnership between our Health Plan and our Medical Groups.”

—Kaiser Permanente Partnership Group, 1997



and with patient registry capabilities, our physicians already have a growing appreciation of the power of coordinated, integrated systems for effectively managing the care of our large clinical populations.

Demonstrating the Value of KP Population Health Care Management to Purchasers in 1998

KP-Southern California has begun to respond to purchasers requests for information about "disease management" by noting that KP is an integrated, group-model HMO with extensive experience in Population Health Care Management and with the following strengths:

1. Outcome- and performance-driven model (eg, our Clinical Strategic Goals for populations) with objective and measurable targets for improvement;
2. Provider-driven medical delivery system with central support instead of central or vendor add-on programs;
3. Clinical information systems and registries that support clinical practice in the care delivery setting, support production of measurable clinical results, and give feedback and assistance to providers;
4. Organizational structure, priorities, and accountabilities for clinical performance that foster learning in the organization; innovation and local initiatives to identify, actively transfer, and replicate successful practices;
5. Objectively measured process and outcome results (beyond HEDIS), eg, raw and risk-adjusted perinatal mortality, risk-adjusted mortality after acute myocardial infarction, and improvement in diabetes testing and blood sugar control.

Our recent experiences with employer groups in 1998 have been positive. Since late 1997, we have

totally rewritten our responses to RFPs so that we describe our Population Health Care Management. We have presented our descriptions and results of Population Health Care Management to many employer groups and consultants. Subsequently, ARCO was very impressed with our Population Care Management Initiatives, and PepsiCo announced that KPSC will be their benchmark health plan for 1999. We were told that our ability to show the population focus of our integrated delivery system along with objective clinical results and outcomes was very persuasive. Hughes has given KP "A" grades this year on the Value Equation® for disease management. This rating will be taken into consideration in these employers' open-enrollment communications with employees about health plans.

We continue to develop and improve our approaches to Population Health Care Management and show the value of Permanente Practice for measurably improving health outcomes. With purchasers and accreditors (ie, the National Committee for Quality Assurance, NCQA) setting expectations for care management and with the changing demographics and diseases seen in our health plan member population, KP's future success will depend greatly on its effectiveness in managing the care and services provided to specific populations of members. Indeed, the most successful HMOs will be those that produce the best population outcomes most efficiently and with the highest patient satisfaction. ♦

References

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