A Managed Care Stakeholder Assessment of Preventive Medicine: Practical Applications, Measurable Results, Evaluating Success

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Supplement
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4. Strive to report subjects of current interest to managed care pharmacists and other managed care professionals.

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Goal

The goal of this program is to educate the target audience of managed care pharmacists and other managed health care practitioners about opportunities to maximize the development and implementation of preventive programs. The goal will be reached through the appropriate selection of disease states, patient populations, and medications that will yield positive health care outcomes with program results that are more clearly evident and measurable.

Overview

The case for preventive medicine is rooted in the long-term positive impact on patient outcomes and total cost of care. However, the initial resources needed to develop and implement prevention programs perpetuate the debate over when, how, and to what extent preventive programs should be integrated into managed health care systems. The concept of preventing illness instead of curing disease is not new, but increasing pressure from health care stakeholders and renewed constraints on health care resources have led to discussion and review of care strategies.

Does the cost of implementation in the short term validate the long-term savings attained through preventive strategies? How should managed care decision makers identify disease states, patient populations, and medications appropriate for the practice of preventive medicine? In order to successfully implement a preventive program in managed care, health plans must select and evaluate programs that will maximize the human and financial resources of the plan and benefit patients and health care outcomes to the extent that the results are clearly evident and measurable. This monograph provides an assessment of preventive medicine programs from the perspective of a managed care stakeholder.

The Preventive Care Opportunity

Preventive health care—screening for early detection of common diseases, prescribing medications meant to delay or deny the onset of disease, and promotion of a healthier lifestyle—requires considerable investment. The stakeholders involved (the employers, health care plans, providers, and patients) must devote time, resources, and money to preventive efforts to ensure success of the programs. Because so many studies show clear benefits, both direct and indirect,
that are the result of preventive care, members of the health care community are taking the steps needed to make preventive care an integral part of patient care. Finding the best way to design, implement, and maintain a preventive care program challenges every stakeholder.

“Preventive care is a group of services designed to promote positive health outcomes through a healthy lifestyle and routine medical screening for early identification and intervention in common diseases.”
— Dr. Ross M. Miller, MD, MPH, FACPE

Questions from All Perspectives

Each participant in health care—the health care practitioner providing the service, health care plan providing the coverage, employer paying for the coverage, pharmacist providing medication, and patient—brings a unique perspective to the preventive care issue, and unique demands and pressures. Getting the most effective, cost-efficient solution for everyone involved is an ongoing challenge faced by the health care community.

Each group asks itself questions about the cost of investing in and the benefits gained from involvement in preventive care programs. Patients want access to programs that do more than treat injury and disease, and providers know they must address these patient needs. Employers want value for their health care plan dollar, and health care plans want to make sure their dollars provide the optimum benefit to their enrollees.

Health care providers treat thousands of patients over the course of a year. To provide excellent health care, providers need to excel at treating illness and injury as well as helping patients maintain or improve their current state of health. Health care providers ask:

• How can I most efficiently direct the right patients to the right preventive care programs and regimens?
• What can I do to help my patients comply with the requirements of such programs?

Health care plans have an obligation to provide service to members with different health needs. They are required to balance medical need and financial limitations. They ask:

• What programs will best serve the employers who purchase coverage?
• What options are best for the individuals covered by the plan?
• What measures will contribute to long-term contractual commitments from employers?

Employers know that attracting and retaining qualified, productive employees are key elements of business success. Benefit programs are one component of an employee compensation plan that can help achieve this fundamental business requirement. Payers ask:

• What is the plan that most closely matches the needs of my employees?
• Am I paying for options and coverage my employees won’t need or use?
• How can I get the most value for my health care coverage dollar?
• What is the cost of indifference?

Pharmacists, like other health care practitioners, have a close relationship with patients. Data collected at this level can help plans, providers, and patients answer these questions:

• What drugs are the most effective?
• What obstacles exist that prevent compliance and, therefore, place patients at risk for complications and need for increased treatment?
• How can we reduce socioeconomic barriers?

Pharmacy and Therapeutics (P&T) Committee members could consider a new model for evaluating medications designed for disease prevention for inclusion in plan formularies, such as the model in the sidebar chart. Such a model helps to answer the question:

• How do preventive therapies fit into the overall care picture?

Preventive Care and the State of Managed Care in 2001

In September 2001, the National Committee for Quality Assurance (NCQA) released its State of Managed Care Quality Report.1 The report, based on data contained in the Quality Compass®, contains plan-specific information on clinical performance, accreditation, and member satisfaction from 273 managed care organizations, which cover nearly 63 million lives, on issues relating to the health care provided and reimbursed by their plan. In examining preventive health care measures specifically, the survey found improvement over the previous year’s figures in many important areas. For example, the number of patients with high blood pressure under control rose from 39% to 52%. In addition, the percentage of patients prescribed beta-blockers after an initial heart attack rose to 89.4% from 85%. This 4.4% increase could result in the prevention of secondary heart attack—a benefit estimated to impact up to 500 cases.
Successful Prevention Programs Require Broad Collaboration

In a constantly changing environment, the managed care community must evaluate its role in preventive care: evaluating the cost, risk, and benefit to encouraging prevention and the opportunity for long-term benefits to plan members and the managed care community. What can managed care stakeholders afford to do? Over time, what can they afford not to do?

Over the last several years, the number of employers offering health insurance to their employees has increased, and despite escalating costs, employees have not seen their contributions rise at the same rate as costs. According to Jon Gabel, vice president of the Kaiser Family Foundation, reporting the results of its annual Survey on Employer-Sponsored Health Insurance, historical analysis indicates that a change is imminent and employees will be asked to contribute a greater portion of the overall costs. Thus planning successful preventive care programs will require attention to cost issues.

Collaboration of the top 3 contributors to any health care program—the plan, the providers, and the payer—is the minimum required for a prevention program to exist. For such a program to be successful, there must also be involvement of public health resources, employer-led business coalitions, and community health resources, and all participants must share common expectations and common goals. Employers, for example, must emphasize prevention of disease and injury as part of the corporate culture. Health care providers must routinely include referrals to prevention programs as part of basic exams. Plans must work to help physicians identify good candidates for enrollment in prevention programs.

SIDEBAR 1
The Impact of Pharmaceuticals on Health Outcomes: Into Which Category Does Preventive Care Fall?

Pharmaceutical products can be placed into six categories to help illustrate the relationship between drug costs and other medical expenses. This schema also considers the impact on health care payers based on when care will be provided and when it will positively benefit patient wellness and the financial resources of the health care stakeholders.

Fast Pay — Treatments that are expensive but that lower short-term medical costs
Such as: $1,095 annual cost for anti-coagulant therapy for a stroke versus $100,000 lifetime care costs for severe stroke

Slow Pay — Treatments that require several years to lower medical costs
Such as: antihypertensives and cholesterol-lowering medications that may reduce cardiovascular risk and, therefore, prevent costly MI, stroke, and angioplasty but must be taken for years in advance of the event

Narrow Pay — Treatments such as vaccines that lower costs for a specific population but do not decrease overall spending

Diffuse Pay — Treatments that lower nonmedical costs but increase medical costs
Such as: nonsedating medications for allergy that treat a low-cost medical condition and help patients remain productive

Later Pay — Treatments that improve health and decrease short-term medical costs yet lead to higher long-term aggregate costs
Such as: multiple sclerosis, cystic fibrosis, and other long-term medical condition treatments

No Pay — Treatments, such as acne medications, that improve the quality of life but that do not save money


SIDEBAR 2
Focus on Prevention: Cholesterol Management Data from the 2001 State of Managed Care Quality Report

- Patients receiving cholesterol screening after an initial heart attack: Up 5 points (from 69% to 74%)
- Patients with controlling cholesterol levels: Up 8 points (from 43% to 53%)
- Patients with diabetes receiving LDL cholesterol screening: Up 8 points (from 69% to 77%)

The managed care community finds itself needing not to determine if preventive care is a rational strategy but how to develop a rational preventive care strategy.

The Payer Perspective

The National Business Coalition on Health (NBCH), a Washington-based business organization of 85 member coalitions in 40 states, recently released the findings of its Quest for Quality 2000+ survey. According to NBCH President and CEO Dr. Gregg Lehman, a shift is occurring away from measuring outcomes (statistics such as death rates, recidivism rates, length of stay, and occurrence of complications) to examining the value of prevention and evaluating individual treatments based on cost, patient satisfaction, and on-the-job productivity.

Consumer needs, as identified by the survey, are factors in the shift to a consumer focus, in which the consumer is the primary decision maker concerning health care coverage issues. Consumers want to take on more responsibility for their health
care choices, and they need more information about health care practitioners, more information about the safety of the treatments they are prescribed, and more health promotion, preventive, and disease management information. They want their health care providers to act as health advocates and personal coaches.

Employers are taking these concerns into account as they make decisions about health care coverage investments. They must also consider factors such as an aging population; some employers in NBCH coalitions have more retirees than active employees enrolled in health insurance plans. Increasing health care costs, the economic outlook that has been negatively affected by the recent recession, and new, expensive technology are a catalyst for engaging employers to look for more cost-effective strategies to manage these challenges. Employers are looking for insurance plans and providers that

- thoughtfully manage costs,
- broadly define and clearly document quality initiatives,
- accurately report all Health Plan Employer Data and Information Set (HEDIS) data,
- routinely meet the highest accreditation standards,
- consistently employ superior practices and processes to ensure patient safety, and
- clearly focus on prevention and disease management.

### The Business Case for Prevention

Poor health is the source of negative trends that have a direct impact on an organization’s bottom line, as shown in the flow chart in Table 1. Employees who are in poor health but who come to work anyway may perform poorly. Their creativity and productivity are directly reduced as a result of their illnesses, or by comorbid conditions. Employees who are in poor health and too sick to come to work cause diminished organizational productivity through their absence. In each case, the organization experiences an increase in health care and administrative costs. All three factors—absenteeism, reduced productivity, and increased costs—contribute to poor organizational performance.

Employers everywhere are struggling to keep business productivity at high levels. They experience quarterly pressure to return profit to the bottom line of their business. As health care costs escalate, employers must decide what benefits they can afford to provide. Often the decision must be made between satisfying short-term health care objectives or selecting prevention-focused programs with greater long-term impact.

Based on survey work done by NBCH, employers agree that if a prevention program is put in place, measurements in important areas must show value. Although these are broad parameters, they provide a foundation for comparison and analysis and a vehicle to begin to assess prevention-program value.

<table>
<thead>
<tr>
<th>Program Evaluation Criteria</th>
<th>Measurement Tools</th>
</tr>
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<tbody>
<tr>
<td>Recovery time from illness</td>
<td>Few in-patient hospital days</td>
</tr>
<tr>
<td></td>
<td>Reduced medical costs</td>
</tr>
<tr>
<td>Quality of life</td>
<td>At work</td>
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<tr>
<td></td>
<td>At home</td>
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<tr>
<td>Functional status</td>
<td>Meeting workplace goals</td>
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<tr>
<td>Productivity gains</td>
<td>Absenteeism</td>
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<tr>
<td></td>
<td>Tardiness</td>
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<tr>
<td>Impairment at work</td>
<td>Resulting from primary condition</td>
</tr>
<tr>
<td></td>
<td>Resulting from comorbidities</td>
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</tbody>
</table>

**TABLE 1 The Business Case Flow Chart for Prevention & Organizational Success**

Employers are recognizing that data and information are the keys to understanding the true benefits of prevention programs. According to Lehman, “You can’t manage what you can’t measure.”

Employers can also use the formula published in the American Journal of Preventive Medicine to calculate the cost-effectiveness of a prevention program. Cost-effectiveness is the result of subtracting averted costs from the costs of prevention and dividing that number by the total quality-adjusted life-years saved. This calculation is another measurement tool that can be utilized to assess the potential impact of a preventive program.

Cost-effectiveness = prevention cost – averted costs

/ quality-adjusted life-years saved

### Employer Issues with Prevention Programs

An organization’s benefits management staff finds itself straddling the boundary between financial concerns and employee-relation concerns. The responsible financial manager must be concerned
about the return-on-investment of any prevention program. Yet, employers have a valid concern for their employees and want to be perceived as caring and concerned. Prevention programs help to foster this identity. This picture is complicated by legal guidelines that surround issues relating to privacy and confidentiality.

Assessment of prevention-program value is further complicated because it’s often the employees who need such programs least and for whom the cost benefit is the lowest, who participate. Most organizations employ a “silo” structure, segregating the costs related to worker’s compensation from disability from medical costs. This compartmentalization of accountability makes it difficult to see the true costs and returns of prevention programs.

Helping Employers Measure and Manage Prevention Programs

Several projects are underway to help employers better measure and manage prevention programs. The Employers Health Coalition, in Tampa, Florida, offers a program that helps employers analyze productivity increases, outcomes, and costs on a disease-by-disease basis to identify the effectiveness of specific interventions. A Clinical Performance Enhancement Center Pilot Study, the Cholesterol Community Cooperative Health Improvement Program, is another initiative by which NBCH can provide information to both providers and employers about prevention-program compliance.4

Another NBCH project, the Common Request for Information (RFI) Project,4 is intended to meet the needs of organizations seeking performance data from multiple health plans for comparison, evaluation, and selection. In addition to providing data that will help employers identify plans to offer to employees, negotiate rates competitively, and act as a positive force for quality improvements, a common information format helps consumers identify the type of plan they need and determine which plan to choose. From the plan perspective, a common RFI can reduce the number of individual requests, indicate directions in which employers would like health plans to move, and create opportunities for recognition and reward for quality achievements.

Contracting Issues from the Payer’s Perspective

As employers and health care plans alike respond to the shift in managed care toward a more patient-centric continuum-of-care model and consider the true cost and benefit of prevention programs, employers will begin to evaluate prevention programs as they do any other business strategy. They will look for accountability from plans and providers in terms of quality, use of standard guidelines, and active case management of members at risk for diseases for which prevention programs have shown a clear benefit. In return, there’s an understanding in the business coalitions who are members of NBCH, for example, that when employers find plans that satisfy the demands of this new model, they will avoid switching plans every year. These mutual expectations should result in more multiyear contractual commitments.

Changes go beyond contracting issues. According to Lehman from NCBH, employers need to consider rewarding providers and plans with prevention programs, perhaps by paying an incentive for these services. On the corporate side, prevention must become part of the culture, and human resource principles must be supported at all levels within the organization and incorporated into an organization’s long-term business strategy.

Prevention Programs — Coalition Initiatives4

These are examples of programs administered by business coalitions promoting preventive health care initiatives:

- **Dallas-Fort Worth Business Group on Health**
  Web-based program: cardiovascular health Web site

- **Heartland Health Care Coalition**
  “Refuse to Misuse” antibiotic awareness program

- **Colorado Business Group on Health**
  Cervical cancer screening

- **Buyers Health Care Action Group**
  Educational sessions at employer locations to promote prevention programs

The Health Plan Perspective

Health plans in the managed care community are concentrating on determining if preventive programs yield a payoff. For example, Dr. Michael Victoroff explores the “myth” that health plans have no interest in prevention since the return-on-investment takes years, and the tenure of members is too short for the plan to realize any benefit.6 In his analysis, he demonstrates that regardless of the length of time needed to realize a return-on-investment and regardless of the brevity of the employee’s tenure in the plan, preventive care is still the appropriate course to pursue.

Historical Perspective on Prevention

Knowledge of the history of preventive care programs is helpful for health plans to understand the role of prevention programs in today’s managed care environment. In 1922, the American Medical Association developed standard annual physical examination guidelines. Since that time, other organizations have contributed other standards, including the United States Preventive Service Task Force’s (USPSTF) Guide to Clinical Preventive
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Services,7 considered the most comprehensive guide to both primary and secondary prevention measures. The guide is organized by age, gender, disease, and other important criteria. The current edition of the Guide to Clinical Preventive Services identifies the role of preventive measures in improving the outcome of disease and includes these other important findings:

- Health care providers and patients should share the responsibility for decision making.
- Health care providers should take every opportunity to deliver preventive services.
- Health care providers must be selective about the tests and screenings they order for their patients.
- Health care providers need to understand the critical importance of interventions that address patients’ personal health practices.
- Health care providers must realize that, at times, interventions from other sources might be more effective than clinical interventions.

**Choosing a Preventive Care Program**

Understanding the need for preventive care programs is only one part of the picture for the health care plan. Choosing which programs to offer is another often very difficult task the health plan must complete. An initial evaluation of member demographics often eliminates certain programs, while making it clear that others are good choices for implementation.

Health plans must determine if a given program meets quality-of-care requirements. For example, NCQA standards (1) require separate guidelines for each age group, (2) require specific prevention or early detection guidelines that include recommended frequency, (3) require health care provider’s input in the development of those guidelines; and (4) must be in place at least two years and be subject to review at least once every 2 years.

There are some obstacles to consider. Like employers, health care plans track costs associated with coverage in “silo” structures. Like employers, therefore, health care plans may find it difficult to track the true cost and benefit of prevention programs. Turnover of employees from health plan to health plan is a complicating factor in determining if a prevention program is successful. If a member leaves the plan before the benefit of participation in a prevention program is realized, was the cost of the program justified?

**National Initiatives for Preventive Programs**

Throughout the medical community, many guidelines and publications emphasize the importance of disease and injury prevention measures. The U.S. Department of Health and Human Services published Healthy People 2000,4 followed by the 2000 release of Healthy People 2010.9 The American Academy of Family Practice adopted the “Put Prevention into Practice” program in an effort to meet the goals published in the Healthy People series.10 The National Committee for Quality Assurance standards for accreditation include specific guidelines for preventive health programs.11

It must be possible for health plans to clearly measure the results of the program; that is, the program must be outcome-based. Analysis must also be possible for both the long term and short term to take into account the sharing of members among health care plans.

In choosing preventive-care programs, health care plans must also take into account the interest level and attention span of the people using the programs: the health care providers and the public. If stories in the public media emphasize the importance of a particular preventive intervention, interest in the program is like-
ly to increase. Cholesterol management, for example, is an issue generating interest in the press and, as a result, is interesting to patients. A prevention program could focus on a specific population identified by HEDIS, such as people who have been discharged after an acute myocardial infarction, coronary artery bypass surgery, or a coronary angioplasty and use survey instruments to determine whether they have been screened for LDL cholesterol levels and, if they have, what the levels were.

■ Careful Selection Yields Success

As discussed, prevention programs must be focused on the needs of all parties in the health care transaction. Pharmacists are in a pivotal spot to help plans make choices about which programs to sponsor. By identifying the diseases, populations, and medications that are the best candidates for prevention programs, pharmacists can help ensure the success of the programs, maximize the return on plan investment in the program, and increase patient satisfaction.

Positive outcomes are more likely in disease conditions in which the health care practitioner quickly and correctly diagnoses patient problems and prescribes an appropriate treatment. Pharmacists can, first, identify diseases in which there is a clear diagnosis-treatment relationship and, second, identify the likely level of patient compliance with treatment. Even when there is a clear path from diagnosis to treatment, if the patient does not comply with therapy recommendations, the outcome of the case may be negative. By understanding this three-part relationship—diagnosis-treatment-compliance—the pharmacist can determine if a specific disease is a good candidate for positive results from a prevention program.

■ Population Selection

An effective prevention program focuses interventions on a population that can best benefit from them. For example, patients who have already had one cardiac event or who are diabetic are at the greatest risk for cardiac problems. This population would be a good one for a prevention program, as the benefit would be apparent in a short time frame.

■ Medication Selection

In general, patients consider medications in similar ways—for treating an active disease or symptom. However, there are some important differences between active therapy (that is, therapy to treat an illness and preventive therapy). Pharmacists understand these distinctions (and the fact that patients use these therapies differently, even if they are not aware of their actions), and this knowledge can help identify medications that are good candidates for prevention programs, based on the medications used in the prevention effort. For example, a patient may be more compliant with pain medication since it administers relief that is tangible; patients feel symptoms decrease. Alternately, patients at risk for osteoporosis may not be as diligent with therapy if they do not have active symptoms and do not experience some type of physical change with therapy.

When considering efficacy, for example, patients taking medications in active therapy can usually see a direct, short-term improvement. Patients taking medication as part of a preventive program, on the other hand, may not see any apparent benefit and may stop taking the medication long before it has the chance to do any good, especially if the disease is asymptomatic and the medication has noticeable side effects.

All factors that impact the ease with which patients integrate prevention-program requirements into their lives contribute to the success or failure of the program. If a medication requires dosing and titration adjustments, there are concerns about the medication’s safety record, the treatment duration is lengthy or the procedures complicated, the medication is unable to achieve treatment objectives, or the medication is expensive, patients will be less likely to continue using the medication. Pharmacists can help identify medications with profiles best suited for preventive therapies.

■ Preventive-Care Program Interventions

Once a health care plan has decided to develop a prevention program, decisions about the interventions to be included follow. Some common elements include the development of guideline-based material for distribution to providers and patients, patient notification materials, direct-mail campaigns, incentives for both providers and patients, and analyses of success and barriers to success.

All ongoing prevention efforts should be as individually focused as possible. Providers prefer seeing a list of specific patients who can benefit best from the program. Patients prefer to receive information that is customized to their personal health care needs. All efforts should foster a good relationship between the health care provider and the patient.

Plans should include support for health care practitioners such as data analyses and referral information for local resources that might enhance patient compliance. Training of health care provider office staff is another value-added feature that health plans can offer to providers, and, by extension, to plan subscribers.

■ The Pharmacy Perspective

In an informal survey of attendees at a recent managed care symposium sponsored by AstraZeneca concerning the role of the pharmacy in prevention programs, Dr. Diane Giaquinta reported that approximately 60% of the survey group’s employers were engaged in providing some form of preventive health programming. Of that group, representatives of only a few organizations reported that their pharmacy department was involved in the planning and implementation of prevention programs.

Pharmacists can play a vital part in disease management and
prevention programs because of their knowledge of drugs and drug therapy management. Based on their expertise, experience, and access to important data and analysis information, pharmacists should be consulted in the planning and development of prevention programs. This firsthand knowledge is comprehensively supported by the wealth of data available in most pharmacy information systems.

### Pharmacy Contributions to Prevention Programs

The pharmacy department can be a driving force behind the creation of prevention programs or it can participate in programs already in operation. Education programs, a clinical review of treatment alternatives, data collection and analyses, and compliance measuring are all ways in which the pharmacy can participate in prevention programs.

The pharmacy department, using the clinical background and expertise of its pharmacists, is well positioned to do comprehensive reviews of various treatment alternatives. These reviews can help provide information as to which therapies have the greatest likelihood of delivering desired outcomes in specific populations and may be used to support guideline development and physician and patient education.

Education efforts can be directed to health care providers, to explain the benefits of a prevention program, and to help providers understand factors that contribute to the success or failure of a program. For example, a health care provider can counsel patients and prescribe preventive medications; the pharmacist can tell the provider if the patient is, in fact, using the medication. On the other side of the equation, the pharmacist can support provider efforts by educating the patient. Hearing the same message about the effectiveness of the prevention measures from both the pharmacist and the physician is likely to increase patient compliance with the program.

Prevention-program success is measured by outcomes, first and foremost. Pharmacists can help provide a complete outcome profile by contributing data about prescription medication use, patient compliance, and clinical outcomes. In addition, pharmacists can help in communicating the benefits of prevention programs and the results of prevention interventions.

### Sample Prevention Program: Cardiovascular Disease

Annual mortality rates for cardiovascular disease show that it remains one of the leading causes of death in America. The American Heart Association data show that, for example, in 1999, there were more than 950,000 deaths from cardiovascular disease and that more women die from cardiovascular disease than any other disease. The incidence of coronary heart disease, as shown in Table 2, increases dramatically as risk factors accumulate. Those patients who have high lipid levels, a history of hypertension, and diabetes are at the greatest risk.

With the benefits from reducing risk factors established, the goal of a prevention program described by David Clark, vice president of The Regence Group, Portland, Oregon, was to increase the number of patients who reached healthy lipid levels. The program was designed to determine if interventions could reduce the number of cardiovascular events in the study population. National surveys showed that approximately 65% of high-risk patients were not receiving any treatment at all and that fewer than 10% were treated to goal. Health care providers involved in the program were provided an analysis of their patient population.

Program components included

- identification and targeting of high-risk patients and
- education of physicians and office staff in both the identification and treatment of high-risk patients.

By the end of the program, the number of patients still not receiving therapy had dropped to about 10% from more than 60%. The number of patients being treated to goal had risen to 20%. These results provided evidence of the value of the program.
population, remains another potential barrier to success.

Clearly, the pharmacy can play an important role in any prevention program. The roles that pharmacists can play in capturing and providing data for health care plan and provider analysis, about educating their consumers, and in being an active participant are critical in the success of prevention measures.

An Aligned Approach to Prevention

Once prevention programs are examined from multiple perspectives—the employer, the health care plan, the pharmacy—it becomes clear that an aligned approach, in which costs are clearly understood and benefits clearly identified, is the best way to achieve successful programs. Dr. Schumarry Chao, chief medical officer and senior vice president for strategic development, MedImpact Health Care Systems, and clinical professor, School of Medicine, University of Southern California, works toward reconciling the interests of the stakeholders in the preventive care transaction into such an aligned approach.

Chao says that employers need to move away from segregated financial accountability so that the true costs of health care can be calculated and analyzed, making the business case for prevention even clearer. They may need to consider rewarding employees for participation in prevention programs and providing financial incentives in the form of long-term contracts to health care plans that can provide such programs.

Health care plans must also work toward integrating financial data about costs in all areas to more fully realize the relationship between the cost of providing prevention programs and the cost (direct and indirect) of hospital and medical claims. Providing information about these relationships, not simply data, to decision makers at employers and providers will help in identifying the best candidates for prevention interventions and increase the chances for program success.

Pharmacies can play an active role in prevention programs, occupying, as they do, a key position between the patient and the physician. Pharmacy data, when properly analyzed, can help plans and physicians better understand patient compliance and the long-term effects of prevention programs on the cost and quality of managed care services.

According to Dr. Chao, providers are not currently rewarded for making preventive care part of their overall patient care activities, whether they operate under a fee-for-service model or a capitation model. In the fee-for-service model, where profit is based on increased utilization, providers have a disincentive for involving patients in preventive care interventions since those interventions are aimed at reducing visits and treatments. In the capitation model, because revenue is capped, profitability can be greater if the provider does less. Preventive interventions that typically have a long-term payoff can be easy targets for elimination. One possible solution may be to pay for preventive care as a carve-out from capitation, under a fee-for-service arrangement. This method
could provide physicians with an incentive to increase the volume of preventive care while preserving a disincentive to increase utilization due to illness (See Tables 3 and 4).

If employers can move toward integrated financial accountability, perhaps through being rewarded for such a structural change, and health care plans similarly alter their profitability structures, if providers are no longer penalized for providing preventive care and pharmacies help to provide valuable data to all stakeholders, then, according to Chao, the following goals can be achieved:

- lower total health-related costs,
- higher consumer satisfaction,
- healthy population, and
- productive workforce.

REFERENCES
Continuing Education
A Managed Care Stakeholder Assessment of Preventive Medicine

Date: __________________________
Program expiration date: June 1, 2004

In order to receive CE credit for this program, you must complete this form and the Program Evaluation form in addition to completing the post-test with a score of at least 70% (forms may be photocopied). Please mail all materials to the University of Texas, College of Pharmacy, Office of Pharmacy Continuing Education, Room 5.102, Austin, TX 78712. To receive credit, these forms must reach the University of Texas College of Pharmacy by May 15, 2004. CE certificates will be mailed to your address (below) as soon as possible after receipt of the Record of Attendance and Program Evaluation forms and the post-test is graded and successful completion is determined.

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Please print your name as you would like it to appear on the CE certificate:

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Please circle the correct answer.

1. Preventive health care encompasses the following components:
   a. early detection of common diseases
   b. prescribing medications meant to delay or prevent onset of disease
   c. promotion of a healthier lifestyle
   d. all of the above

2. According to J.D. Kleinke, “slow pay” refers to treatments that require several years to lower medical costs.
   True or False

3. According to the 2001 State of Managed Care Quality Report, patient-controlling cholesterol levels remained unchanged from the previous year.
   True or False

4. Employers are looking to insurance plans and providers that
   a. do not attempt to manage costs
   b. focus on prevention and disease management
   c. create their own measurement standards
   d. none of the above

5. Absenteeism, reduced productivity, and increased costs contribute to poor organizational performance.
   True or False

6. According to survey work done by the NBCH, employers agree that measurements in the following areas must show value:
   a. recovery time from illness
   b. productivity gains
   c. a & b
   d. none of the above

   True or False

8. The U.S. Preventive Task Force recommends all except which of the following for preventive screening programs?
   a. cardiovascular
   b. vision and hearing
   c. mental health and substance abuse
   d. allergy

9. The true cost and benefit of prevention programs are easy to track.
   True or False

10. Based on the burden of the disease and cost-effectiveness of prevention, the following would be considered appropriate choices for prevention programs:
    a. smoking cessation in adults and adolescents
    b. colorectal screening in adults
    c. alcohol-use counseling in adults
    d. all of the above

11. Prevention programs may include all except which of the following?
    a. patient notification materials
    b. disincentives for providers and patients
    c. direct mail campaigns
    d. analysis of success and barriers to success

12. By identifying the right diseases, populations, and medications for prevention programs, pharmacists can work to ensure the success of the program.
    True or False

13. Positive preventive-program outcomes are more likely in disease conditions where the diagnosis is unknown.
    True or False

14. Patient compliance with preventive medication, especially if the disease is asymptomatic and the medication has noticeable side effects, can be a challenge to achieving a desired treatment outcome.
    True or False

15. There is no difference between the use of medication for treatment and use for prevention.
    True or False

16. The incidence of coronary heart disease is associated with each of the following except
    a. alcohol consumption
    b. history of hypertension
    c. high lipid levels
    d. diabetes

17. The goal of a prevention program implemented by The Regence Group was to increase the number of patients who reached healthy lipid levels.
    True or False

18. Program results of the Regence preventive initiative concluded that the number of patients not receiving therapy dropped from 60% to 10%.
    True or False

19. Providers are currently rewarded for making preventive care part of their overall patient activities.
    True or False

20. The goals of an aligned approach to prevention for all stakeholders ultimately include
    a. lower total health-related costs
    b. higher consumer satisfaction
    c. healthy population
    d. productive workforce
    e. all of the above
A Managed Care Stakeholder Assessment of Preventive Medicine

Using the scale above for Questions 1–5, please rate how well you will be able to accomplish the following objectives based upon successful completion of the program.

Objectives:

1. Predict the outlook for preventive medicine through a comprehensive examination of the impact of such initiatives on employers, health care plans, providers, and patients. __

2. Differentiate between medications used for prevention and those used for treatment and contrast the short-term and long-term approaches to appraising outcomes and resource utilization. __

3. Formulate criteria for evaluating and selecting preventive care programs that maximize human and financial resources and where initiative success can be measured. __

4. Identify strategies to drive preventive program success, including the implementation of complementary components such as program customization, patient and provider education, and reminder materials for plan members. __

5. State the important role of the pharmacy department and the managed care pharmacist in developing preventive programs, specifically their role in disease-targeting, patient and medication selection, and outcome evaluation. __

Using the scale above for Questions 6–8, please indicate the number that best expresses your opinion.

6. What is your overall rating of this program? __

7. How would you rate the pertinence of the program materials to your practice? __

8. Please rate each of the following program aspects:
   a. Content __
   b. Clarity __
   c. Knowledge gained __

9. To what degree do you anticipate changes in patient care as a result of the material presented? (circle one)
   1            2              3             4                5
   No Change                                        Significant change

10. Please indicate the length of time it took to complete this program: (Circle selection)
    Hours: 1    2    3
    Minutes: 0   15   30   45

11. Please rate the difficulty factor for completing this CE program: (Circle selection)     Easy     Moderate     Difficult

12. Please rate your willingness to recommend this program to colleagues: (Circle selection)
    Very Willing    Willing    Not Willing

13. Please indicate which venue you prefer for obtaining continuing education: (Circle selection)
    Written monograph    Slides    Videos    Internet-based
    Live sessions    Other: __________________________