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DM Profile

The Field of Disease Management at the Crossroads: An Interview with David B. Nash, M.D., M.B.A.

As David B. Nash, M.D., M.B.A., takes the helm of Disease Management *as Editor-in-Chief, the practice of disease management—now a decade old—depends on its practitioners to continue to provide "economic proof of concept." This effort to accrue the credibility needed to design and fund programs will provide further evidence that new technologies can be integrated into care programs across large populations to reduce costs while improving healthcare and access to it.*

Q: Why is this a particularly opportune time for you to become Editor-in-Chief of *Disease Management*?

A: First, we're thrilled to have this new responsibility and recognition of our work in the field. So we're very grateful to Mary Ann Liebert, Inc., for thinking of us in this role. And, secondarily, we believe disease management is at a critical crossroads at the beginning of this new century. This idea has been around for almost a decade, and one of the many challenges that disease management still faces is "economic proof of concept." In other words, have we really been able to demonstrate that all of the great tools that we've created over the last decade—interactive voice recognition technology and related tools—have we been able to demonstrate that these tools really are going to improve clinical outcomes and reduce costs at the same time?

I think at the moment there is modest proof of the concept. We thought by taking over the only peer-reviewed journal in the field that we would accrue the research evidence to support the idea that disease management indeed works.

So I think it is a great opportunity for us to jump right into the fray at a crucial time, really the crossroads, for disease management.

Q: The term itself, "disease management," as you noted, for the past decade has been making inroads from mainly managed care entities. Do you sense in the past two or three years that it is making inroads beyond the original set of "true believers" who implement programs?

A: Yes. I think that disease management has evolved, especially over the past four to five years. Here's how. Originally, disease man-

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agement seemed to be exclusively a patient education program fostered and promoted by the pharmaceutical industry. The industry worked very hard, of course, to promote their own products. Providers, both doctors and managed care organizations, recognized over time, as did the pharmaceutical industry, that this sole method was not going to work.

In addition, the growth of the Internet and other technologies—the confluence of these events: the pharmaceutical companies realizing that individual drug programs [were not going to be successful] and the growth of the Internet—together dramatically altered the face of disease management just within the last three to four years. Specifically, I think the pharmaceutical industry recognized that sophisticated brochures that were product-specific were not going to have an impact on patients' behavior. The pharma industry realized that the day-to-day work of getting patients to comply with any kind of clinical program is messy, and it is complicated. I have written on this subject about the pharmaceutical industry not really appreciating the power of "the white coat" and the complexity of the doctor-patient relationship. It is not their area of concern, historically speaking. When they began to appreciate just how complicated compliance programs were, they began to retreat from disease management, *per se*.

At around that same time, we had the growth of consumerism and the Internet, interactive voice recognition, e-mail, and it became clear that these new technologies could completely transform the disease management field. And I think, again, it goes back to our first question, that is, why I believe we're at the crossroads. The pharmaceutical industry has taken a back seat, new technologies have come, and we have an opportunity to prove the concept in everyday practice.

Q: Let's pick up for a moment on your mention of the Internet and the Age of Consumerism, using the example of the Winona Health Online Group. The outcomes of that study show, perhaps for the first time, that consumers are comfortable with the Internet being involved in a most personal aspect of their lives—their health data gathered from their living rooms. What does this step mean in terms of helping provide proof of outcomes?

A: As you know, the Cerner Corporation in Kansas City—along with an outside advisory board and people from the University of Minnesota Medical School and School of Public Health and Cap Gemini–Ernst and Young—support what I would call a large social experiment in a small town of 26,000 outside Minneapolis called Winona. The idea here is to take the town and essentially create a randomized trial, or at least an observational trial, based on giving half of the town access to these new technologies, while the other half will lack access to them. The goal at the end of two years is to measure the impact of the technologies on health outcomes, on access to care, on patient satisfaction, and on utilization of resources.

I think it is premature to say we have had an impact. We have just started the program. Winona has one hospital and about 100 doctors. So it is a town where this kind of experiment is possible. It is relatively isolated from other towns, so it is a kind of natural experimental place. But I give a lot of credit to the leadership of Cerner. I give a lot of credit to Cap Gemini–Ernst & Young for their support early on, and a lot of credit to the faculty at the University of Minnesota who have been very supportive in creating the advisory board for this social experiment.

I think the results are going to be very important. I do not want to say that they will make or break the situation, but clearly the results of the Winona experiment will give us some sense of impact of these programs and perhaps even a guidepost for the future. Winona will give us a sense of what works and what doesn't. Because the field is so young and there are no experiments comparable to Winona, results will be critically important.

Q: Let's talk about the concept of outcomes that are needed. Do you feel through your work in the field that the outcomes proof is needed more for the providers or the payers, or is it pretty much an even split?

A: My own belief is that the need for good outcomes information is shared by all stakeholders. Providers will not practice disease

management unless they see it has a patient-specific outcome. Payers will not pay for disease management unless they see a population-based outcome. I don't think patients will participate in disease management unless they see an improvement in their own condition. Our own research, specifically on diabetes disease-management programs, which has been published in *Diabetes Care*, points out that patients have very definite feelings—positive and negative—that one can measure in a reproducible, valid way, about the quality of the disease management program itself. And we found evidence of that in our work with a diabetes disease-management evaluation tool which we call the DMET. Others have done work in this field as well. We are trying to evaluate the impact on the patient. So to get back to your question, every stakeholder in the system is interested in the outcomes, and that's one of the main reasons we wanted to get involved with *Disease Management*, to serve as the principal vehicle to promote an agenda about outcomes measurement. For the past twelve years, our Office of Health Policy and Outcomes here at Jefferson Medical College has been devoted to these issues.

Q: In terms of patients seeking care, not limiting the discussion to demographics or a particular generation of patients, compared to say twenty years ago, is there a difference in acceptance of preventive care?

A: Research evidence supports the fact that the tail end of the Baby Boom generation—those born between 1955 and 1965, those entering AARP [American Association of Retired Persons] age—are very concerned with preventive measures. They want to prevent aging. They want to prevent cancer. They want to prevent osteoporosis. I think younger generations—Generation X, Generation Y—still believe in their immortality to some extent. But I think in general terms, the entire population is much more in tune with issues like lipid-lowering therapy, erectile dysfunction, staying in good physical condition, due in no small part to direct-to-consumer advertising and the power of consumerism in general. But, specifically that Baby Boomers are one of our key audiences for disease management. They also have aging parents who suffer all of the chronic illnesses for which many disease management programs have been designed. So there are key sectors within the population who are interested in these programs.

Q: You have assembled quite an outstanding Editorial Board. Will you comment on your expectations of the members?

A: We're very proud of the sixty or so persons from around the country who have agreed to serve. Let me tell you a little about the Board. We went to every sector in healthcare to reach out to national thought leaders, practitioners, public and private sector individuals, academics, provider groups—virtually every sector is represented by members of the Editorial Board. We asked Editorial Board members to pledge to us that they would help us recruit articles, reviews, and write on topics themselves. We have nationally prominent persons from each possible division within the healthcare sector. I'm also excited because we have persons from the pharmaceutical industry, people from the disease management industry itself. These are people who have been in the trenches, who are practitioners of disease management and have the scars to prove it. We have academicians who are experts in outcomes measurement. We have people from managed care who support and pay for disease management programs. We have people from consumer groups who are the beneficiaries (or the victims) of disease management programs. We strove for the broadest possible representation, and we assigned them real work to do. We hope they are as proud of their service as we are to have them.

Q: Is there more original research being designed and carried out to prove healthcare outcomes, or is there still resistance from funding sources to attempt to prove that preventive care provides benefits over the long term?

A: Regrettably, I think there is resistance from funding sources at this moment in time. We hope that through the Journal and good research that we will erode some of that resistance. That is a very important question about

the marketplace. I'm also hoping that the journal will be a lightning rod to spur other people on to doing research. Our motto is, "In God we trust; all others bring data." We want to promulgate that way of thinking. We want to disseminate good projects in the hopes of stimulating others to question and evaluate their own programs. How do we know where we're going if we don't measure where we are currently? I think disease management has really suffered, especially in the last three years, from a lack of measurement and a lack of self-evaluation, and we see the Journal as a lightning rod for both of those areas.

Q: If we could ask you to put on your futurist's cap for a moment, reflecting on the work that has been done in the past ten years, as well as ongoing work, would you tell us what you think is in store for the healthcare profession and patient care within disease management programs in the next ten or twenty years?

A: As Will Rogers said, "There is no future in predicting the future." But here goes. I think the widespread application of the Internet, e-mail, and related tools will eventually lead us to what Wall Street calls "the mass customization of clinical information," which means our ability to share, through e-mail and other technologies, specific patient-related lab tests, educational material, and feedback from providers. I envision a wireless, Web-based world of people receiving on a continuous, longitudinal basis, information about their healthcare through disease management companies and technologies in concert with their providers. People will be in constant communication, whenever they feel like it, with their providers—getting new educational material, reporting their blood sugar levels if they have diabetes, their weight if they have heart failure, their forced expiratory volume if they have asthma. Whatever it is, I think we will be able to customize our approach to disease management, harnessing the power of the Internet. There are, as you know, many companies attempting to do this now. We are involved in some of them. Many of them are represented on the Editorial Board, like Doctor Quality, Medscape, and others. I'm very excited about the whole industry that I see coming in the next decade of wireless, Web-based, completely transportable, clinical feedback of information. It is a very exciting prospect for the future.

—*Interview conducted by Tim Basting*
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