Successful Implementation of Universal Health Care in CT: The Critical Role of Chronic Disease Management

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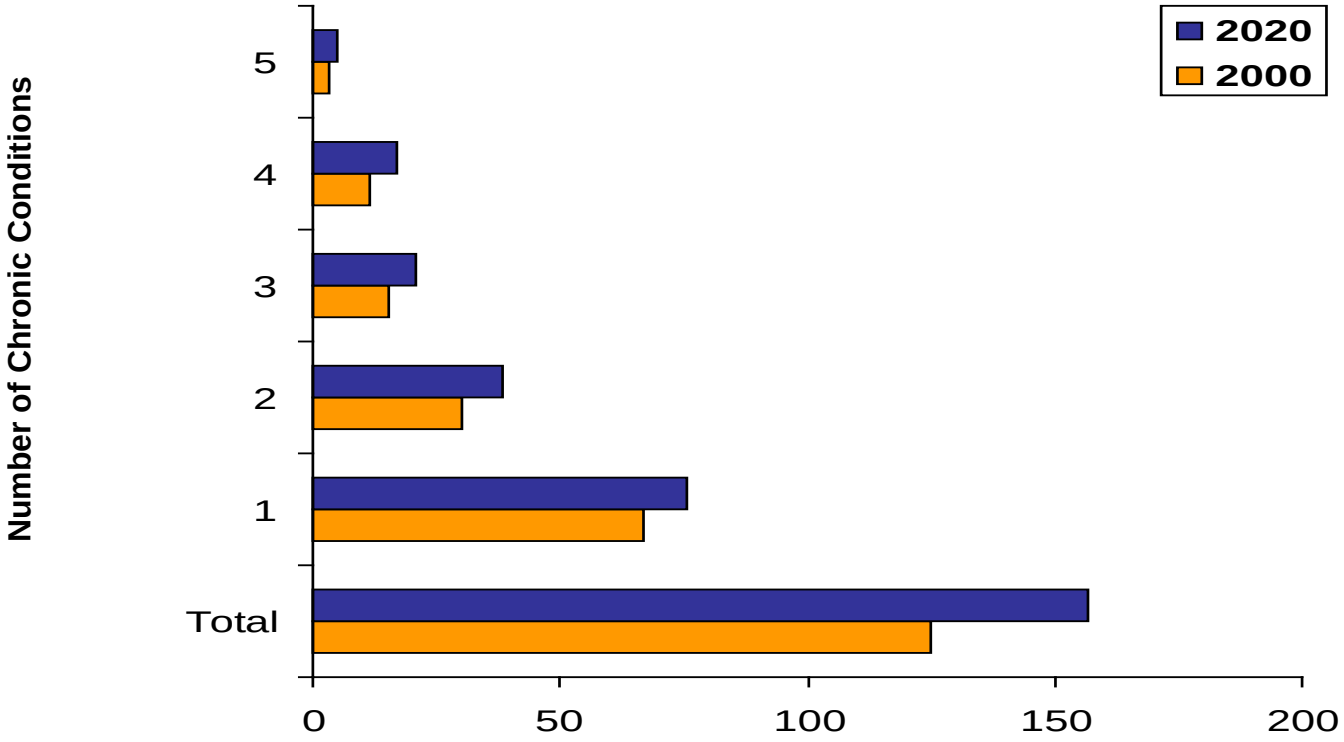
Chronic Disease: A Growing National Concern

Nearly half of the population (125 million Americans) lives with some type of chronic condition, defined as a condition which lasts a year or longer, limits what one can do and may require ongoing care. Sixty million Americans live with multiple chronic conditions.

-John Hopkins University and The Robert Woods Johnson Foundation

Americans Affected with Chronic Conditions, 2000-2020



What is Disease Management?

•Disease management is an organized, proactive, multi-component approach to healthcare delivery, involving all members of a population with a specific disease such as diabetes.

•Care is focused on and integrated across the spectrum of the disease and its complications, the prevention of comorbid conditions, and the relevant aspects of the delivery system.

•Disease management's essential components are: 1) identification of the population, 2) care guidelines or performance standards, 3) management of identified people, and 4) tracking and monitoring systems.

•Disease management's goal is to improve short-term and long-term health and/or economic outcomes among people with the disease

Centers for Disease Control Task Force for Community Preventive Services.

Source: http://www.cdc.gov/mmwr/pdf/rr/rr5016.pdf

What is Disease Management?

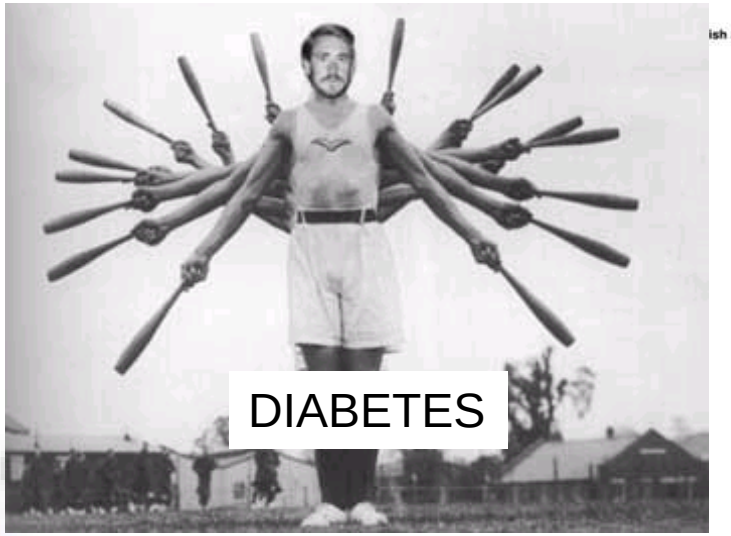
"Disease Management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant"

Disease Management Association of America

Source: www.dmaa.org/definition


Consumer Retail and Professional Distributor
Foot Care Products


The Balance of Good Health
Fruit and vegetables
Bread, other cereals and potatoes
Milk and dairy foods
Foods containing fat
Foods and drinks containing sugar
There are five main groups of valuable foods


DIABETES


M
S
T
W
T
F
S

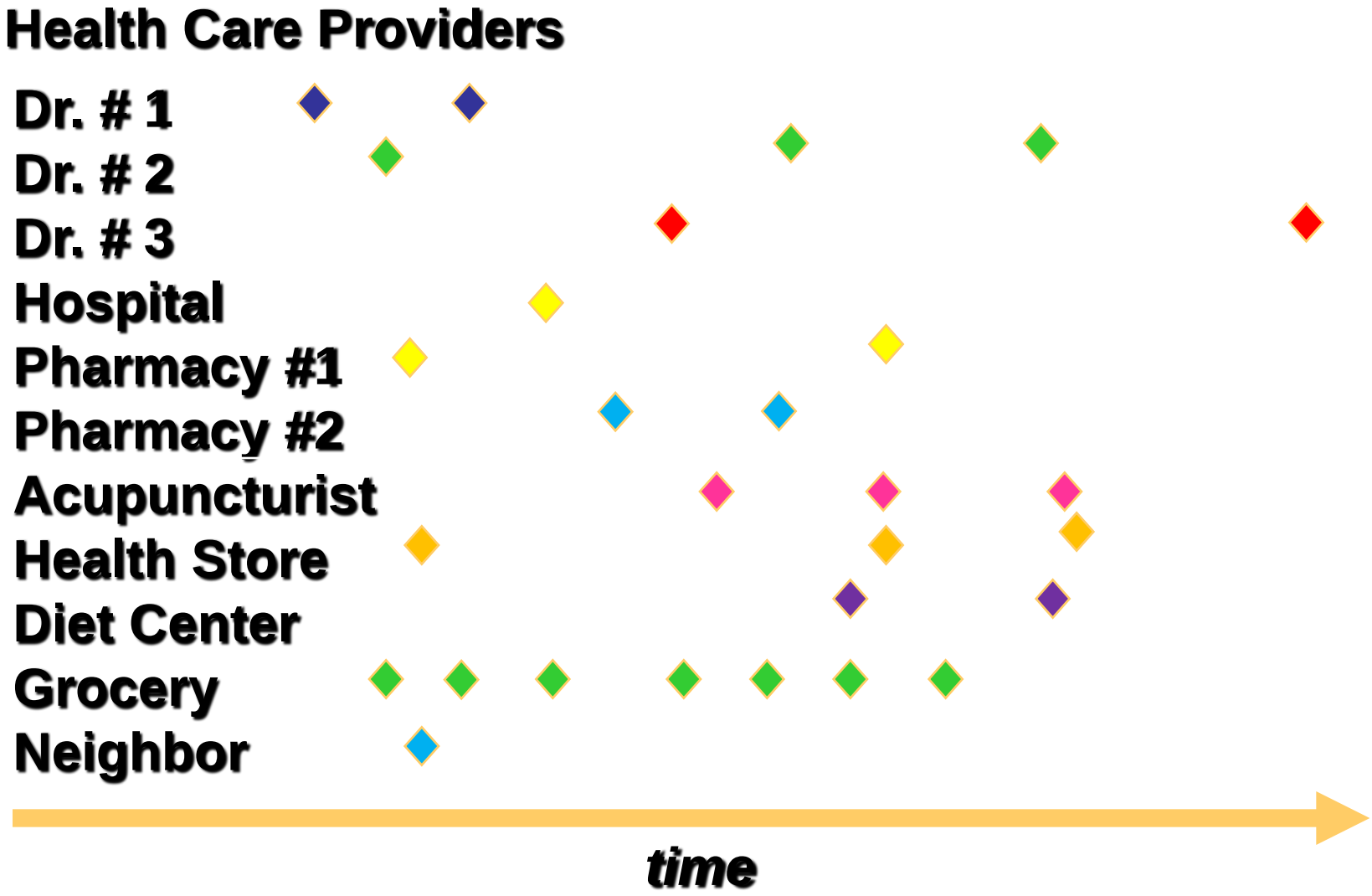
“.conditions in which patient self-care efforts are significant”

In keeping with the guidelines, a patient with diabetes, COPD, osteoporosis, and hypertension will be asked

- To take **twelve** medications
- **Nineteen** doses per day
- At **five** different times,
- And to adhere to **fourteen** non-pharmacologic behavioral recommendations.

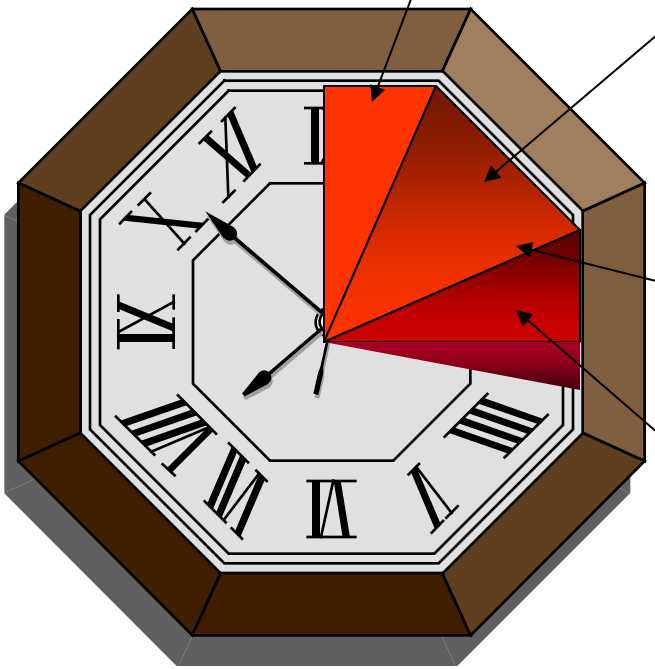
Boyd CM, Darer J, Boult C, Fried LP, Boult L, Wu AW. Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: implications for pay for performance. JAMA. 2005;294:716-24.

The Actual Patient Experience

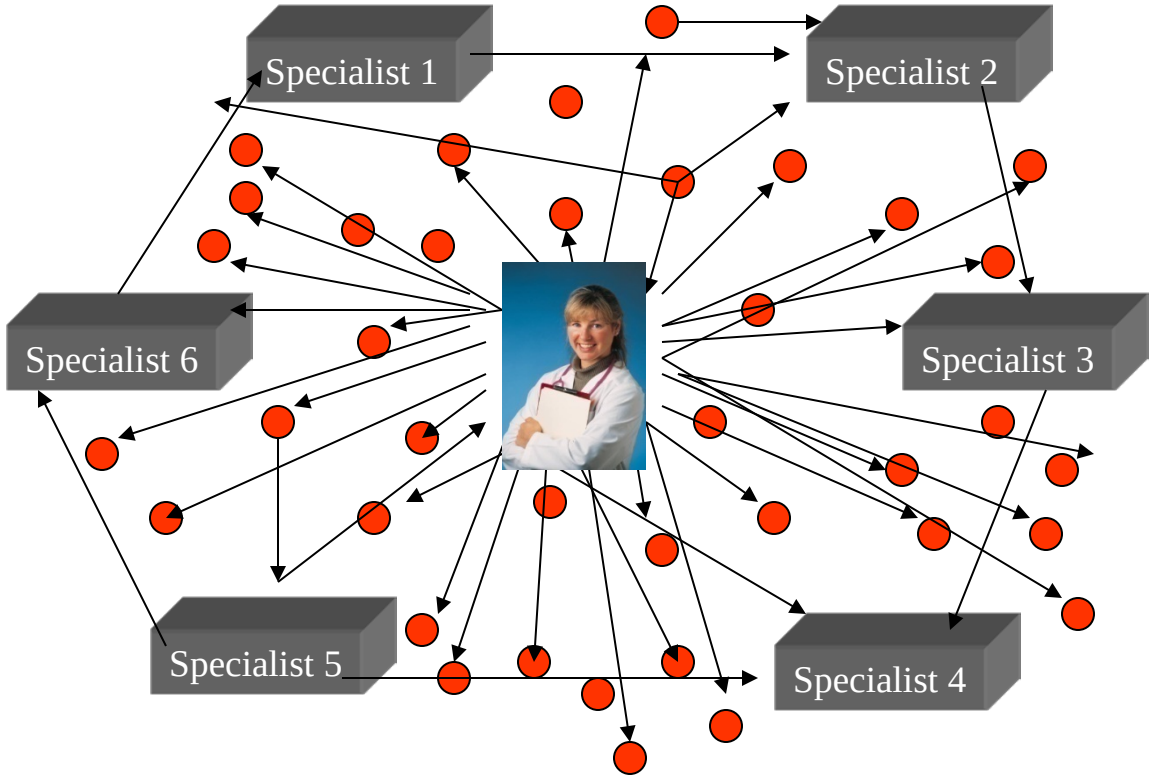


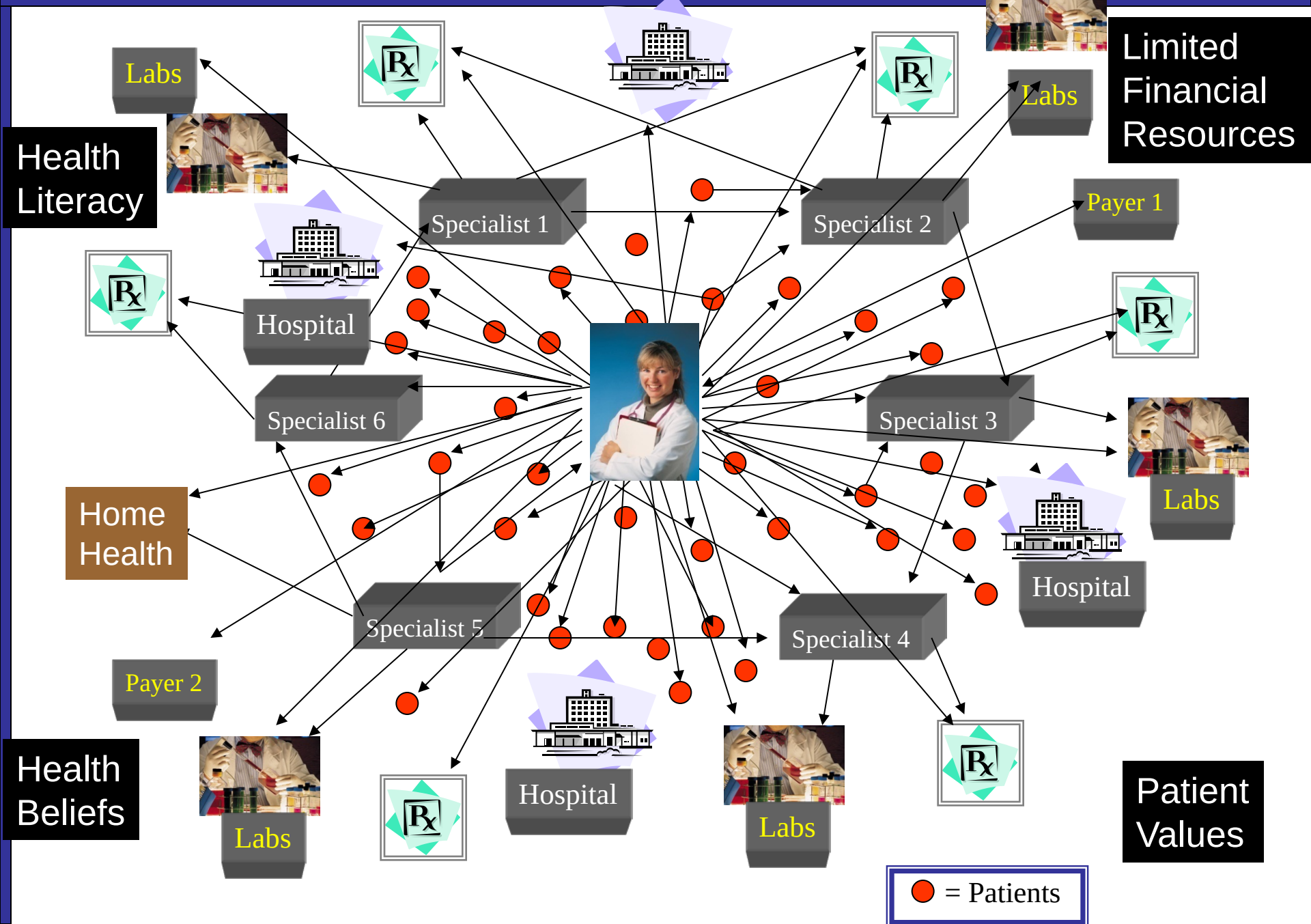
Source: Dr. J.K. Jones, The Degge Group, Ltd.

DM
CHF
COPD
Depression

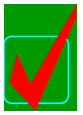
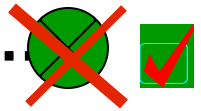


- Clinical History
  - Brief update on issues discussed at last appiontment
  - New symptoms
  - Limited review of systems
  - Lab results and biomedical measures
- Focused physical exam:
  - Skin
  - CV
  - Retinal
  - Neurologic
  - Peripheral vascular
- Rx refills or adjustments dose/frequency
- Patient education
  - Smoking cessation
  - Nutrition
  - Exercise

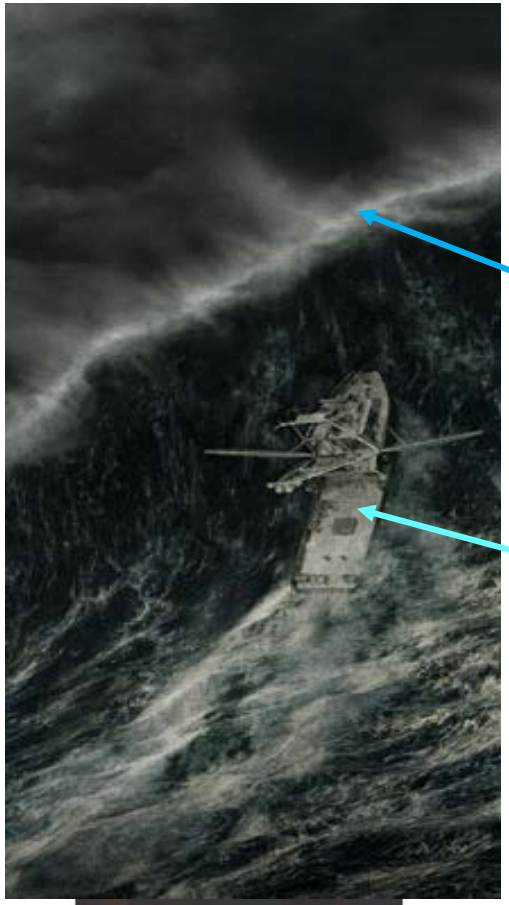

Specialist 1
Specialist 2
Specialist 3
Specialist 4
Specialist 5
Specialist 6
= Patients


Limited Financial Resources
Health Literacy
Labs
Specialist 1
Specialist 2
Payer 1
Hospital
Specialist 6
Specialist 3
Home Health
Labs
Hospital
Specialist 5
Specialist 4
Payer 2
Health Beliefs
Labs
Hospital
Labs
Patient Values
= Patients

The Complex Role of Primary Care Physicians

- **Delivery of Basic Primary Care……** 
- **Between Visits Supportive Care (DM)……** 
- **Coordination of Care……** 

  a) **No time**
  b) **No data**
  c) **No information systems**
  d) **No mass communication infrastructure**
  e) **Limited or no decision support**
  f) **Limited staffing**
  g) **No reimbursement**



Demand vs. Supply Of Services

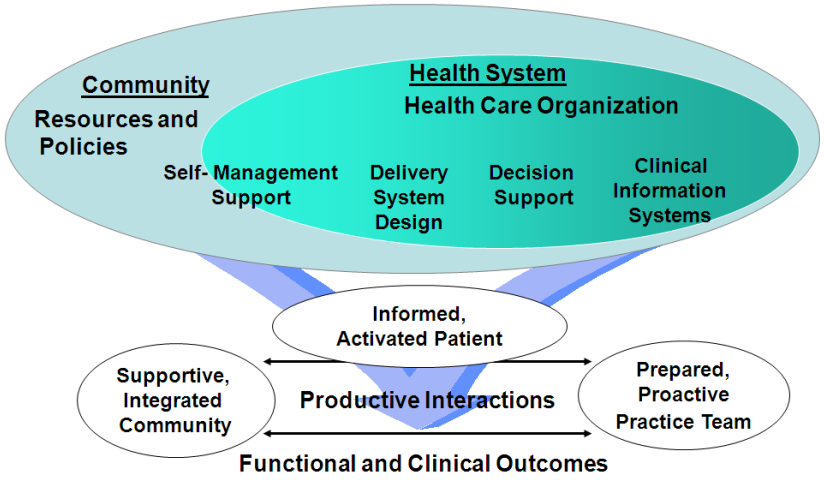
- Coming of age of baby-boomers
- Universal health care for CT residents

- Overwhelmed PC delivery system
  - ✓ Insufficient # of PCPs
  - ✓ NOT organized to deliver chronic care
  - ✓ Poorly reimbursed

- Dissatisfied patients
- Poor outcomes

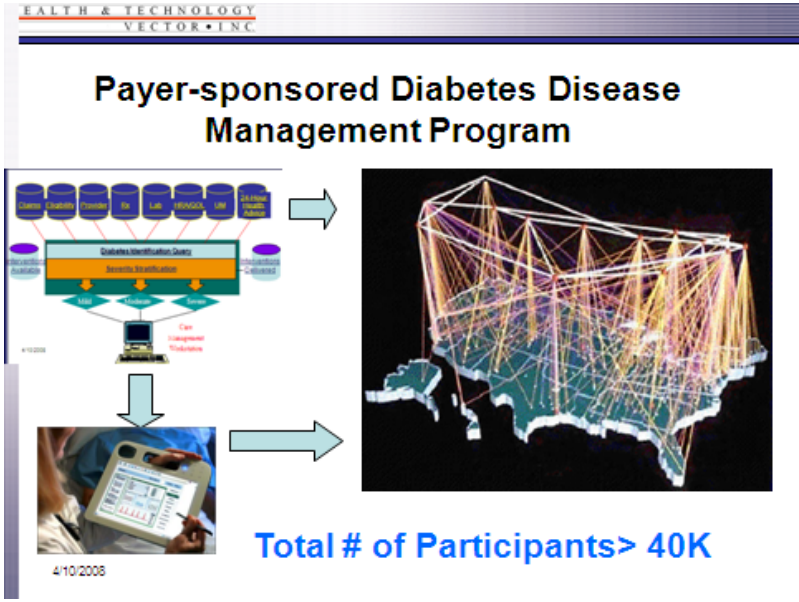
Two Models of Disease Management

Chronic Care Model



OR

Disease Management



Practice Centered

Payer Sponsored

Characteristic	Chronic Care Model	Disease Management
Entity Name	Medical Home	Disease Management Organization (DMO)
Location	Clinic	Remote
Sponsorship	Demonstrations	Payers/purchasers
Pt. Identification	Registries	Claims
Care Managers	On-site	Remote
QI Data Source	Chart (including EHR)	Administrative + direct patients
Cost Data Source	Local-Partial	Payer-Global
Contents Core	EBM/Guidelines	EBM/Guidelines
Agency (represents…)	Treating provider	Payer
Payment Source	Demos	Employers, MCOs, Government
Coordination Capability	Limited, Intra-clinic	Limited- Patient driven
Coordination Technology	EHR (Limited)	PHR (Limited)/Payer portal
Practice transformation	High	Low
Care Teams	Local (intra-clinic)	Remote (patient-DMO)
Medical Cost Savings	Under-emphasized	Unproven
Patient Acceptance	High	Variable
Development Costs	High/duplicative	Low (already in place)
Physician Revenue	High potential	Low (P4P)
Linkage with Hospitals	Undetermined	No

Payer Sponsored DM Model

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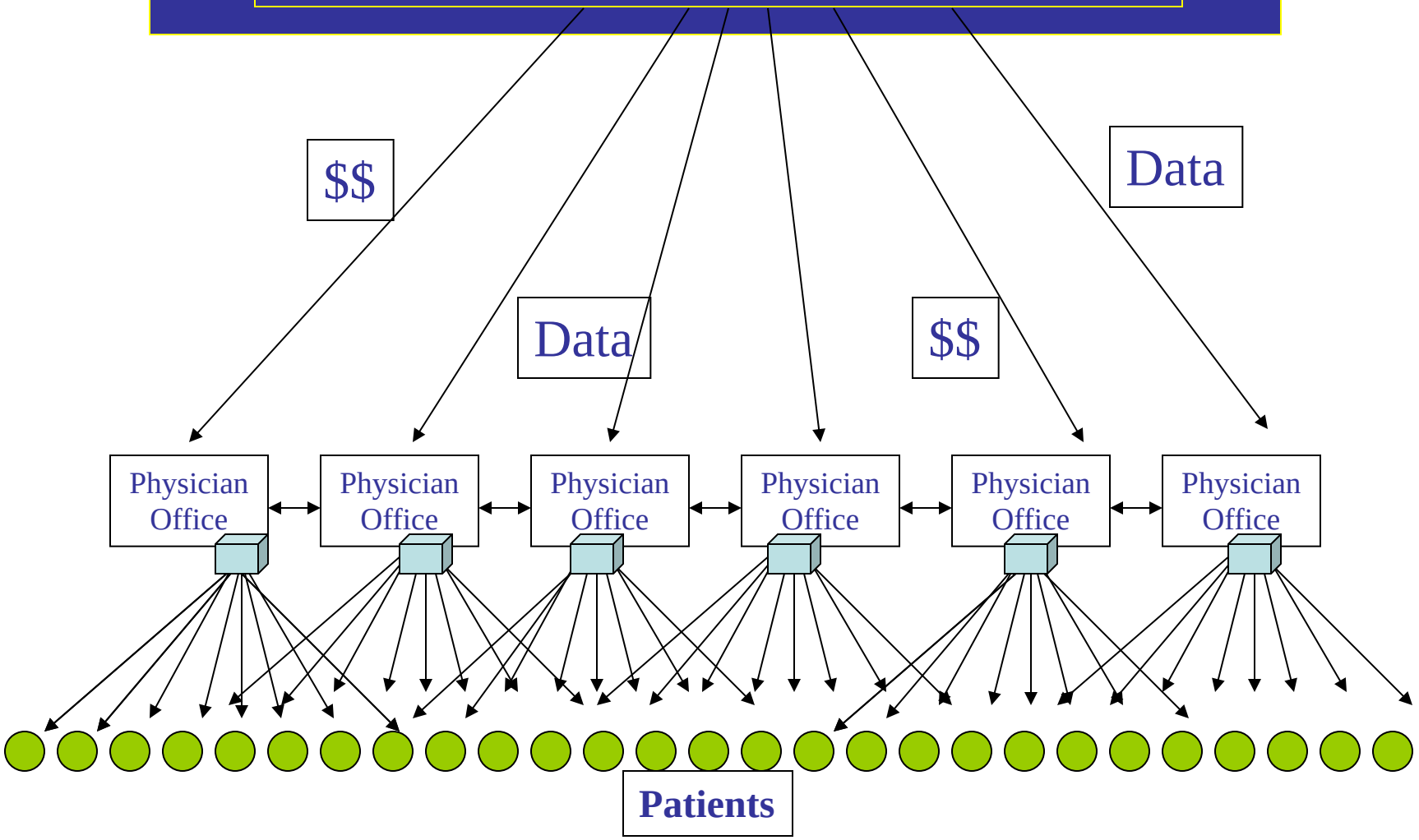
Data

Physician Office | Physician Office | Physician Office | Physician Office | Physician Office | Physician Office

Patients

Quality **Satisfaction** **Cost-Effectiveness**

Chronic Care/Medical Home Model



Quality **Satisfaction** **Cost Effectiveness**

Multi-payer Supported Care Coordination Model

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Data

Community-Based Care Coordination Center

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Data

Data

Physician Office

Physician Office

Physician Office

Physician Office

Physician Office

Physician Office

Patients

Quality **Satisfaction** **Cost Effectiveness**

Characteristic	Hybrid Community-Based Care Coordination Model
Entity Name	Care Coordination Center (CCC)
Location	Community "Utility"
Sponsorship	Mixed
Pt. Identification	Registries and Claims
Care Managers	Local community
QI Data Source	Combined
Cost Data Source	Payer-Global
Contents Core	EBM/Guidelines
Agency	Treating provider
Payment Source	Employers, MCOs, Government
Coordination Capability	Inter-clinic, Care Coordination Center (CCC)driven
Coordination Technology	Community-wide, multi-payer "Hub"
Practice transformation	Moderate
Care Teams	Local community of providers +DMO
Medical Cost Savings	Undetermined
Patient Acceptance	Likely High (local community operation)
Development Costs	Moderate (shared)
Physician Revenue	Yes-Moderate (shared CCC/Physicians)
Linkage with Local Hospitals	Yes

The Perfect Storm

Healthcare Spending and Uneven Quality in the US