Providers and Chronic Condition Management: Concerns and Opportunities

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Doctors and Disease Management

- Concerns
  - Risk selection, discontinuity
  - Differential services based on payer
  - Financial issues
- Opportunities
  - 2 Approaches: centralized vs. office-based
  - Relative strengths & weaknesses
- Future

Risk Selection

- The problem
  - What happens to physician practices if some patients are “engaged” by DM programs while others are not?
- Does it happen?
  - Data is sparse
  - Partners experience

Partners DM programs GERD and CAD

- Opt-in design (similar to Section 721 of MMA)
- Identified patients at risk who agreed to be “engaged” in program:
  - Less likely to be depressed (RR=0.5)
  - Less likely to smoke (RR=0.4)
  - More likely to be symptomatic (RR=1.3)

Opportunities with Physician Involvement

- Physicians screen/select patients
  - Improved accuracy for opportunities (?) (Tim – what means)
  - 50% of identified patients screened out by MDs
- Enroll and engage rate = 65%
  - Typical DM program less than 20%
- Communication to patient via PCP
  - Trusted source

The Challenge

- **If** we can identify patients who will be high cost
- **And** we can engage them in care improvement
- **And** we can anticipate their needs
- **And** we can effectively address the identified needs
- **Then** we should be able to improve care and reduce costs

The Disease Management Process

- Step 1. Identification
- Step 4. Reach and Engage
- Step 2. Collect additional information
- Step 3. Risk stratification or gap identification
- Step 5. Intervention

Identifying Patients Using Predictive Models: Ideal and Real

- Medical Claims Data
- Pharmacy Claims Data
- Demographics
- Patient Reported Information (HRA)
- Laboratory Data

Goodson Guidelines (1)

- The goals of DM and ICM should include the best application of medical knowledge, the education of the providers of care, and the empowerment and education of the patient and their families. (Tim: what is ICM)

Goodson Guidelines (2)

- DM and ICM should
  - support and encourage the professional relationship between the patient and physician
  - not disrupt continuity of care
- Need for standards for communication among MD and DM/ICM teams.

Goodson Guidelines (3)

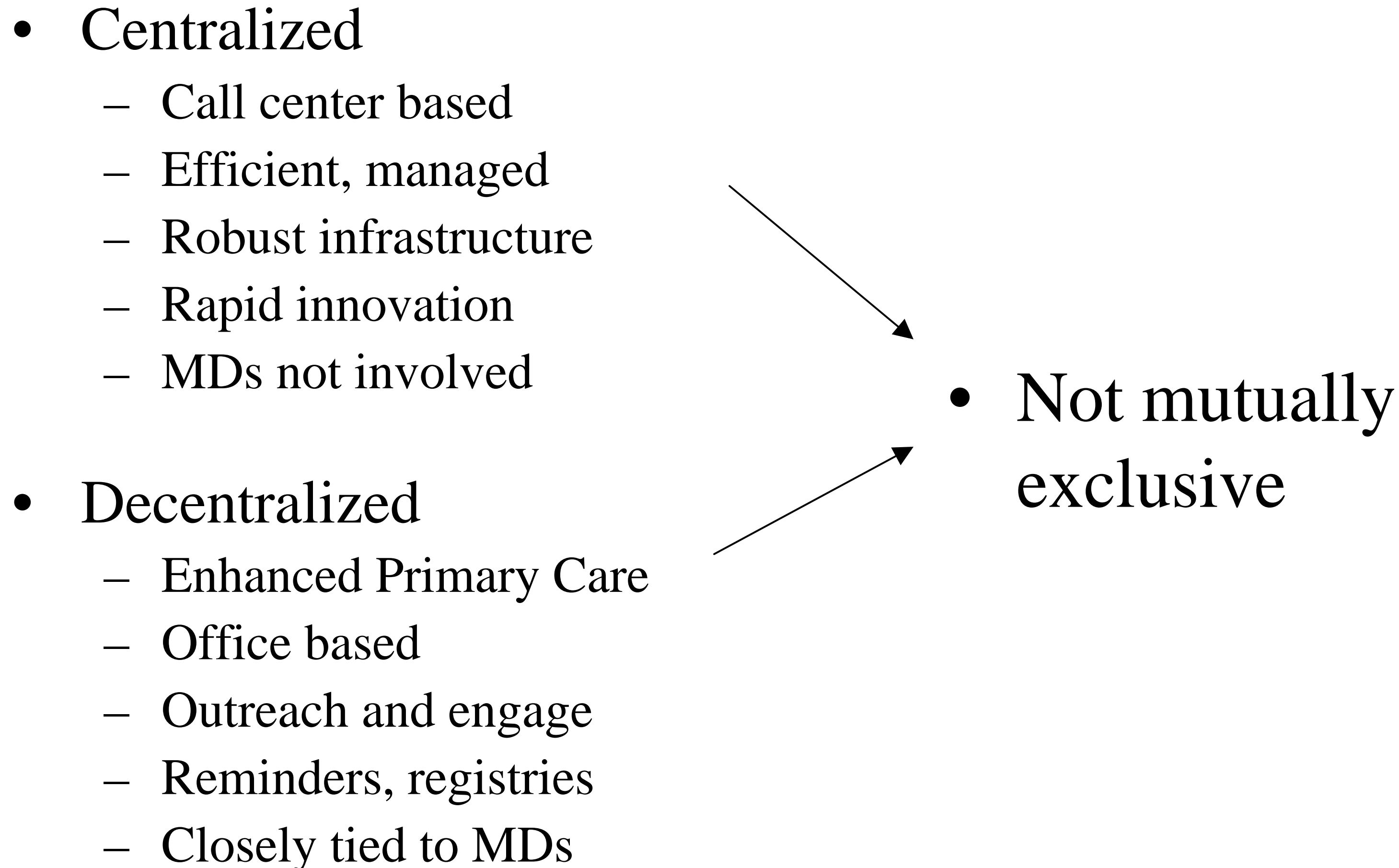
- Physician reimbursement should include payment for longitudinal care of patients (care planning)

- MDs may choose to delegate the management of specific segments of care for patients to DM or ICM teams

or

- work with patients to achieve the clinical goals of DM or ICM within a traditional doctor-patient relationship.

Two Approaches



Identification

Centralized

- Relatively poor predictive capacity
- Relatively poor identification of opportunities

Decentralized

- Better predictive capacity
- Improved identification of opportunities

Reach and Engage

Centralized

- Equal ability to reach patient (?)
- Relatively poor ability to engage patient
  - Lack of trust

Decentralized

- Equal ability to reach patient (?)
- Improved ability to engage patients
  - Personal relationship

Collect Additional Information

Centralized

- Improved ability to collect and process information (?)
  - Though more limited pool of patients and no access to medical records

Decentralized

- Less ability to collect and process information (?)
  - Though lower need if medical records are complete and accessible

Intervention

Centralized

- Improved capacity for quality control
- Less rapid response to changing management plans
- More steps for new prescriptions

Decentralized

- Less capacity for quality control
- More rapid response to changing clinical needs
- Fewer steps for new prescriptions

Summary of Provider Perspective

- Managing chronic illness is the job of primary care
  - longitudinal, first contact, coordinated
- Primary care is under-funded
- To improve chronic illness care we could:
  - A) Increase payments to primary care
  - B) Pay an innovative for-profit industry who has identified a market niche, creating greater discontinuities in patient care and further reducing incentives to provide primary care.

The Future?

- Ongoing antagonistic relationship may make both approaches better than they currently are.
  - Competition from DMOs may spur investment and/or attention to chronic condition care in primary care
  - Limited ability of DMOs to reach/engage patients may spur greater integration with providers
  - As telephonic DM becomes more common, increased potential for overlap and waste
  - Potential for hybrid approaches
- Where practice based approaches can demonstrate competence, this is likely to be both more effective (and more expensive?) option.