Disease Management and Multiple Chronic Conditions

Introduction

Disease management (DM) is becoming the next wave in health care service and delivery as consumers respond negatively to tightly managed networks and payers grapple with rising health care costs. It is an intervention intended to save health care dollars and improve health outcomes through better management of one or more chronic conditions. DM programs focus on patient education, patient self-management, and, often, physician feedback. DM strategies vary considerably—from those with an exclusive focus on patient education to those that work with health care providers. While DM appears promising, a critical question is: How far can DM strategies go to address the needs of people with multiple chronic conditions who are the heaviest users of health care services and often have poor outcomes?

What is Disease Management?

The Disease Management Association of America (DMAA) defines disease management as "…a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant." DM programs typically incorporate prevention, patient self-management education, clinical practice guidelines, and population identification processes. The National Committee on Quality Assurance has recently begun accrediting DM programs. Despite the abundance of anecdotal reports, clinical trial evaluations of DM programs are rare.

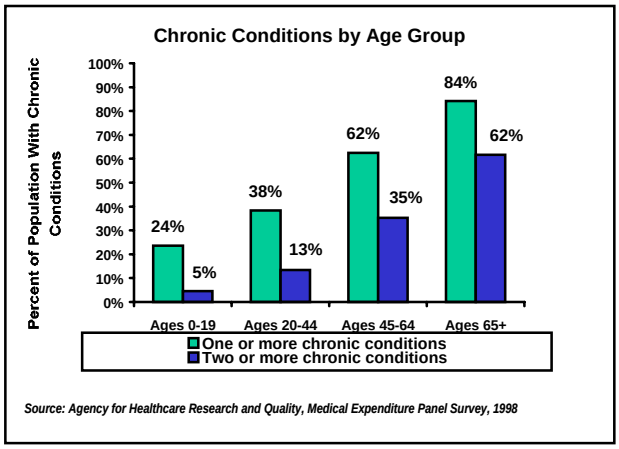
Who Uses DM?

DM programs have become increasingly popular in the US—particularly in health plans and programs that serve the employed, insured population. The DMAA reports that participation in DM programs grew by over 300 percent on average in the U.S. between 1998 and 1999.[i] Almost all health plans have at least one DM program—97 percent have a diabetes program and 86 percent have a DM program for asthma—and about half of all plans have between four and six DM programs while another 40 percent have seven or more. [ii] Health plans either use vendors or operate programs in-house.

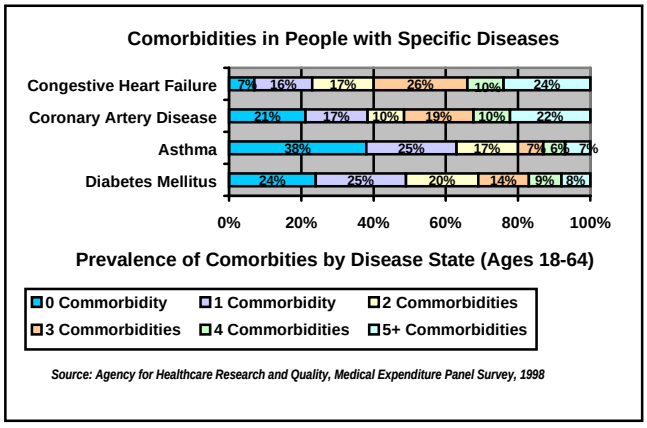
DM focuses primarily on the care of chronic conditions. Forty-three percent of the American population has at least one chronic condition, and spending on their behalf consumes almost 80 percent of health care dollars.[iii] Almost half of all people with chronic conditions have more than one condition.

Who Are People with Chronic Conditions?

People with chronic conditions are found in all age cohorts, economic levels, and racial/ethnic groups. Age is a particularly important factor in the prevalence of multiple chronic conditions; younger, working-age people are less likely to have multiple chronic conditions than are older people. The prevalence of multiple chronic conditions increases with age. See graph below.



Mental health problems, such as depression, are some of the common comorbidities in people with chronic conditions such as cancer, cardiovascular diseases, and diabetes.



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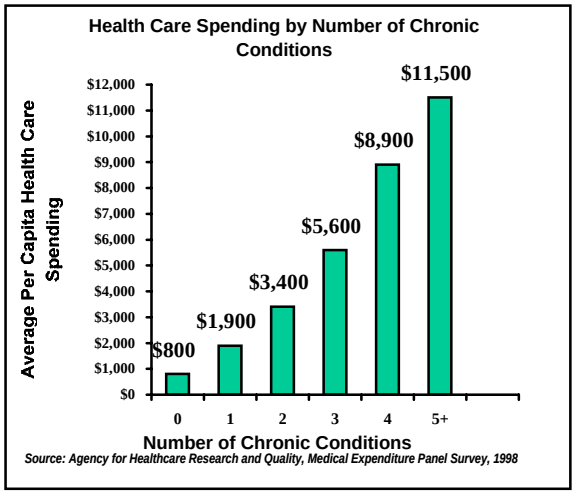
Health care costs increase dramatically with the presence of each new disease, indicating that better management of chronic conditions could result in real savings and improved quality of life for many people with multiple chronic conditions.



What are the Implications of DM?

As policymakers, health plan administrators, and payors think about expanding the role of DM in health care programs, there are several key issues that should be considered.

- How does the DM program address people with multiple chronic conditions, not just chronic conditions that are highly associated with each other, such as hypertension and diabetes?[iv]
- How does the DM program address comorbidities with multiple evidence-based treatment guidelines?
- How do treatment guidelines comport with the health plan's formulary or general prescription drug plan? Are recommended medications available on a first-tier basis?
- How does the DM program address mental/behavioral health issues that are prevalent comorbidities?
- What type of physician support does the DM program have, and is there a feedback loop or other relationship with clinical providers?

Where Can DM Programs Take the Health Care System?

Not all DM programs are the same. They run the gambit from patient reminder systems to those that coordinate all health care received by a patient. Some programs identify potential enrollees through prior use of hospital inpatient or emergency room services, while others employ more sophisticated, proactive, multiple disease profiles. Some vendor programs use centralized nurse counselors to contact patients by phone and have no particular relationship to treating physicians, while others provide direct support to physicians. In a recent survey, 86 percent of health plans indicated that their DM programs used a collaborative practice model that included clinical and other service providers, although it is likely that the level of collaboration varies among these programs.[v]

Newer DM programs may hold considerable promise for people with multiple chronic conditions because they acknowledge the existence of multiple conditions in their enrollees rather than screening for the presence of one condition for which there is an evidence-based guideline. These programs work closely with physicians or are run directly through a physician's office, and they leverage non-medical support services (that may or may not be covered under the insurance plan) to improve a patient's quality of life, treatment compliance, and the effectiveness of the medical treatment itself, all of which reduce the incidence of acute and costly exacerbations of illness.

About Partnership for Solutions

The Partnership for Solutions, led by Johns Hopkins University and The Robert Wood Johnson Foundation, is an initiative to improve the care and quality of life for the more than 125 million Americans with chronic health conditions. The Partnership is engaged in three major activities: conducting original research and identifying existing research that clarifies the nature of the problem; communicating these research findings to policymakers, business leaders, health professionals, advocates, and others; and working to identify promising solutions to the problems faced by people with chronic health conditions. Our partner organizations include: Alzheimer's Association, American Academy of Pediatrics, American Diabetes Association, American Geriatrics Society, Family Voices, National Alliance for the Mentally Ill, and National Chronic Care Consortium.

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[i] Disease Management Association of America, press release, March 1, 1999.

[ii] Unpublished results from the American Association of Health Plans' 2001 Annual Industry Survey.

[iii] "Multiple Chronic Conditons: Complications in Care and Treatment," May 2002, available at www.partnershipforsolutions.org.

[iv] Sower, J.R. et al. "Diabetes, Hypertension, and Cardiovascular Disease,"*Hypertension* 37 (2001):1053-1059.

[v] Welch, W.P. et al., "Disease Management Practices in Health Plans," *The American Journal of Managed Care*, 8 (Apr. 2002): 353-361.

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