Creating Provider Buy-in for Disease Management

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Overview

- How did our industry get here?
- Payer model vs. Provider efforts
  - DM programs vs. Chronic care models
- What do the payer/ vendor and provider models have in common; not in common?
- What are the current forces driving Provider adoption of chronic care programs?
- What can be learned from adoption of the chronic care model?
- Care Management - Current state; transition state; future state
- Role of Health plans, DM Vendors, Hospitals, Professional Societies

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Current State

- Care remains fragmented
- Inadequate capture and exchange of data
  - Clinical
  - Quality measures
- Perverse incentives predominate
  - Acute care over prevention
  - Procedures over education
  - Volumes over efficiencies
- Under penetration of "best practices" and DM enrollments

Net Result - >$100B in avoidable cost for chronic disease

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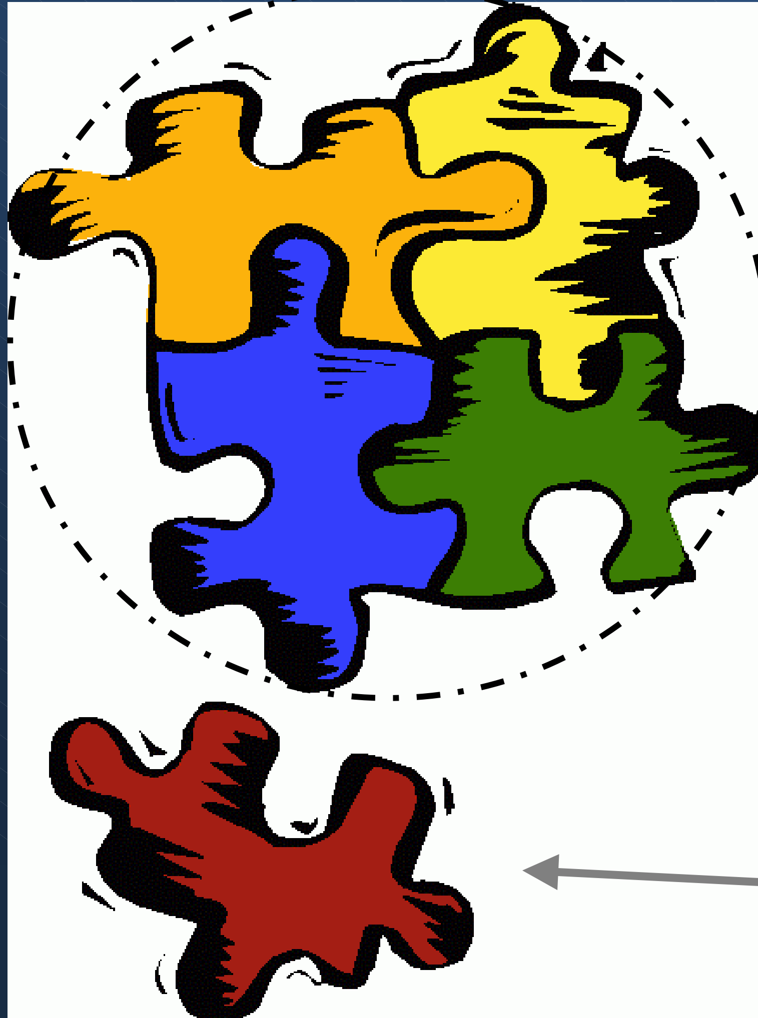
Current State



Plan sponsored resources

- PBM/ Formulary
- DM programs
- Ask a nurse line
- Etc.

Providers

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How is the DM model limited?

	Without Providers	With Providers
Patient Identification	80%	95%
Patient Enrollment	50%	90%
Clinical Care Improvement	20%	60%
Total Effect	8%	51%

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The Provider View of Disease Management

- The provider perspective on DM
  - ***"I*** do disease management"
  - Vendor programs black boxed
  - Programs haven't been put through "usual" clinical trial validations
- Why has DM not traditionally been done by providers?
  - Access to capital
  - Financial / performance incentives
  - Organizational structures
  - Fragmentation of care delivery
- Providers have begun asking: "Is there a better, more effective model?"

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Chronic Care Management

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Core Functions in Chronic Care Management

- **Self-Management Support:** Emphasizing patient role, assessment, problem-solving, and interventions to enhance self-management
- **Delivery System Design:** Defining care team, planning visits, follow-up reminders, continuity of care, and referral system
- **Decision Support:** Use of clinical guidelines, provider education, and specialty support
- **Clinical Information Systems:** Establishment and maintenance of patient registry, use of registry for patient follow-up, and quality improvement

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Disease Management vs. Chronic Care Management

Similarities

- Both address cost/quality targets
- Both strive for standardized best practices
- Both organize around empowered patients
- Both leverage technology and process improvement

Differences

- DM is a "new" care system; CCM is a reengineered "old" system
- DM is struggling with provider incentives and participation
- CCM organizes around providers; but may lack payer buy-in

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Why is Provider Adoption Increasing?

External forces impacting provider organizations:

- Reimbursement
  - CMS demonstrations, CCIP and MMA
  - Commercial push for quality measures
  - Pay for Performance movement
- Demographics
  - Aging of population
    - Requirements for clinical resource reallocation
    - Anticipated growth in chronic disease

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External Forces Impacting Provider Organizations

- Competition
  - Market differentiation
- Technology advances
  - Availability of public reportin data
  - EMR, e-prescribing, e-consultation, and remote monitoring
  - Issue of access to capital
  - Adopters vs. observers

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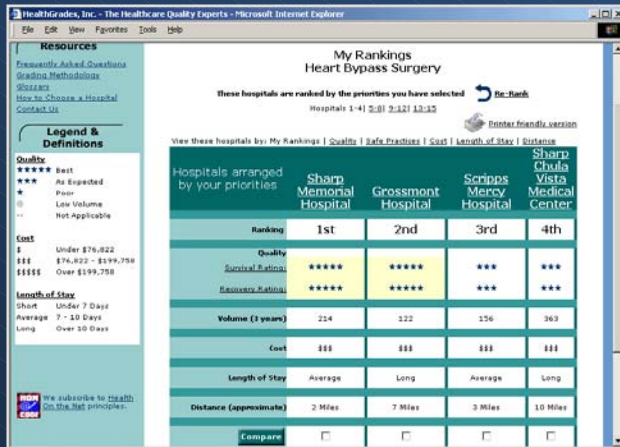
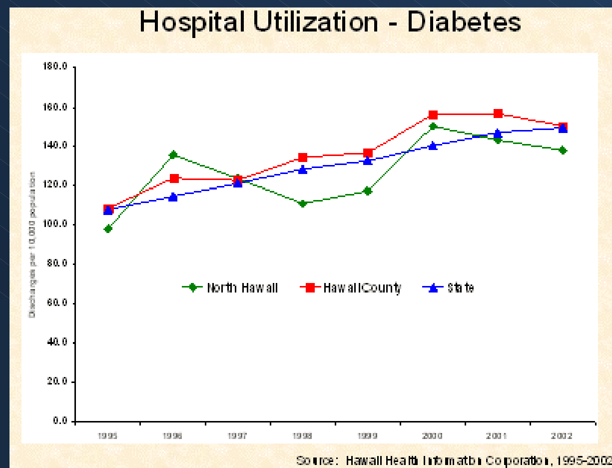
Internal Forces Impacting Provider Organizations





- Clinical
  - Quality being measured/ reported
  - Safety concerns
- Operational
  - Bed capacity challenges
  - Staffing limitations
  - Higher margin care being squeezed out by acute exacerbations of chronic disease (low margin)

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Internal Forces Impacting Provider Organizations

- Financial constraints
  - Access to capital
  - Thin operating margins
  - Internal competition for limited financial resources
- Demands from consumers and physicians for technology upgrades
  - Clinical
  - Operational

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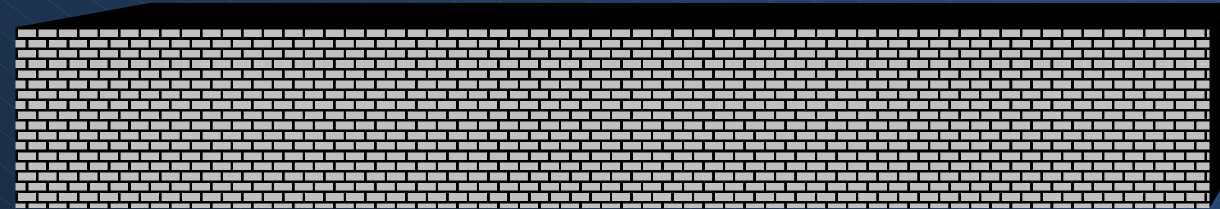
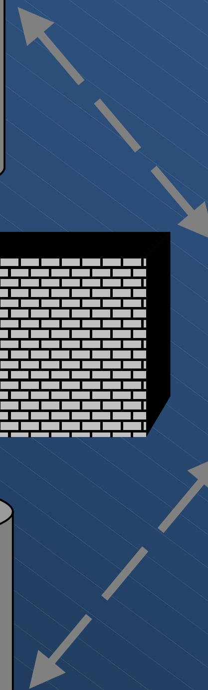
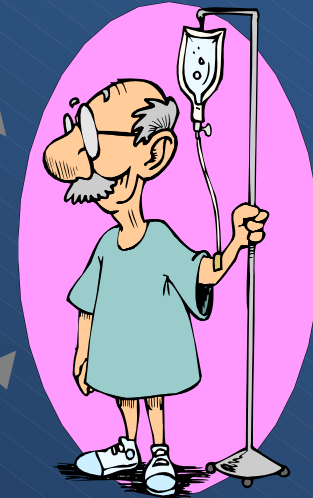
Transition State

Disease Management Programs







Chronic Care Management Programs

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An Alternate View of the Transition State?!

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Transition State Opportunities

- Identify variability in care patterns
- Restructure financial incentives
- Build-out of provider care team models
- Rigorous measurement of cost and quality impact
- Create data exchange between ALL stakeholders
- Tie infrastructure investment needs to payment models

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What Can We Learn from the Transition State?

- Tools/ technologies are becoming rapidly disseminated at the provider level
- Incentives exist today, and are rapidly increasing, yet not formally aligned
- Size, scale and critical mass are becoming less an issue
  - Large systems
  - Regional cooperatives

Bottom Line – "..teach them to fish and you feed them for life; give them a boat, and a market opportunity and you could feed the world"

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Toward the Future State: Creating Provider Buy-In

- What payers tell us
  - Compelling need to work at the provider level
  - Limitation in the traditional DM model
    - Nurse call center and claims monitoring = triage
    - Care Management requires CLINICAL intervention
  - Moving from an administrative function to a clinical function within payer mindset
- What patients tell us
- What providers tell us

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Addressing Provider Perceptions

- Clinical
  - Quality of care
  - Scientifically validated approach
  - Safety
- Financial
  - Chronic disease as a loosing proposition
  - Medico-legal liability
  - Increased cost of overhead/ technology
  - Role of P4P

Bottom Line – Loss of Control

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Addressing Provider Perceptions

- Operational
  - Higher margin opportunities
  - Staffing and workflow
- Competitive advantage
  - Differentiation
  - Patient and Payer loyalty

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Future State Vision

- Providers 'baked in' to Care Management programs
- DM vendors integrate with providers through tools and technology
- Scale and critical mass achieved through multiple entities:
  - Provider systems
  - RHIO's
  - DMO's
- Payer incentive alignment

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Future State

- Efficient
- Quality defined, measured and reported
- Outlier providers and patients identified
- Data captured *within* existing workflows
- Payment tied to new/ desired activities
- Bonus incentives for improvement

Bottom Line – Integration around the patient and for common purpose: improve quality/ reduce costs

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The Role of Payers

- Unique population data
- Ability to align financial incentives
- Ability to motivate and reward organizational change
- Promotion of public performance data
- Supporting technology adoption

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The Potential Role for DM Vendors

- Clinical care network infrastructure
- Backstopping of financial risk
- Care management process expertise
- Care management personnel
- Care management technologies

Bottom Line- They can provide Scale, but must provide tools and technologies

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The Potential Role for Hospitals

- Aggregate physicians
- Technology hubs
- Incubators and think tanks for care management and quality improvements
- Physician education centers

Bottom Line- They, too could provide Scale; but must acquire tools and technologies

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Professional Societies as Influencers

- Independent and respected arbiter of Quality definitions and measures
- Define and disseminate "Best Practices" standards
- Development of care guidelines
- Access to physician champions
- Database and technology infrastructure support

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Where is this working today?

- CMS demonstrations
  - HQI
  - PGP
  - Doc IT (?)
- P4P and Delegated Services in California
- EMR roll-outs; e-prescribing initiatives; remote monitoring programs; disease registries
- Regional hospital systems
- Integrated delivery systems

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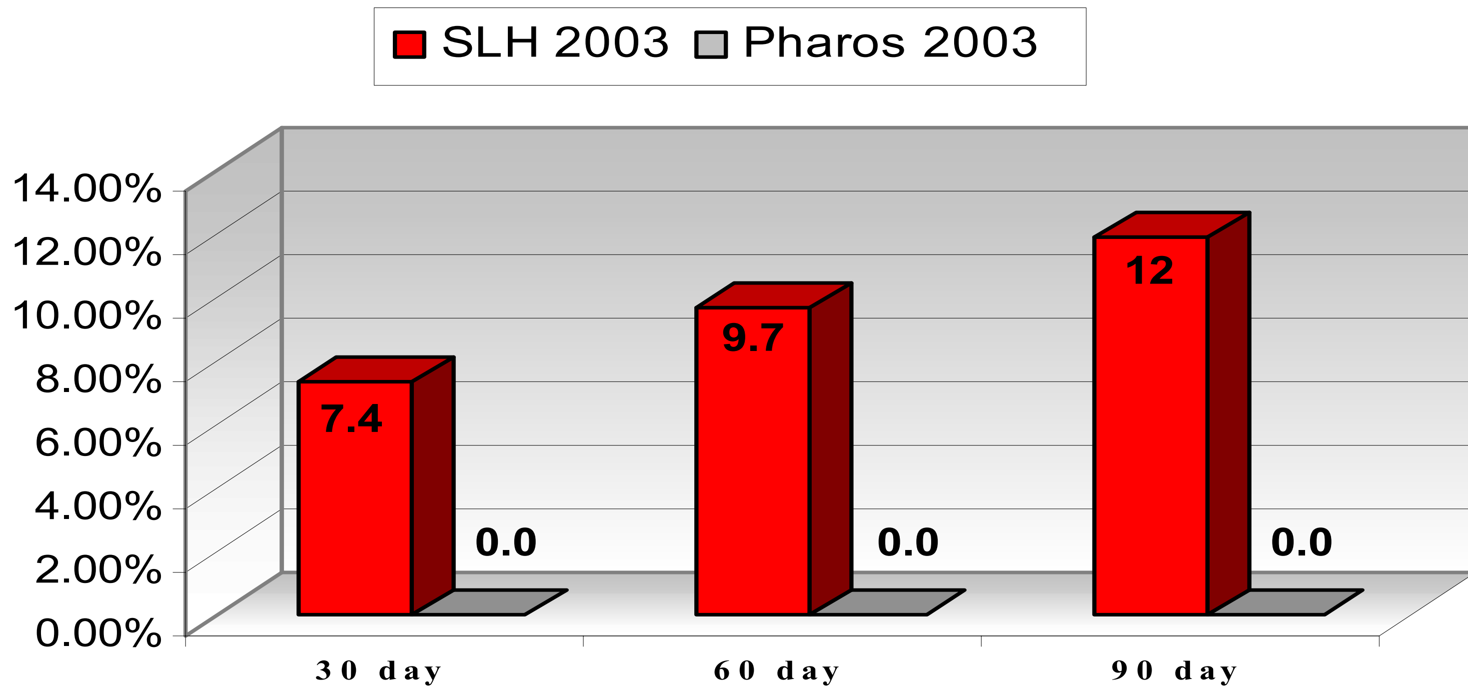
The Impact of Provider Based Technology



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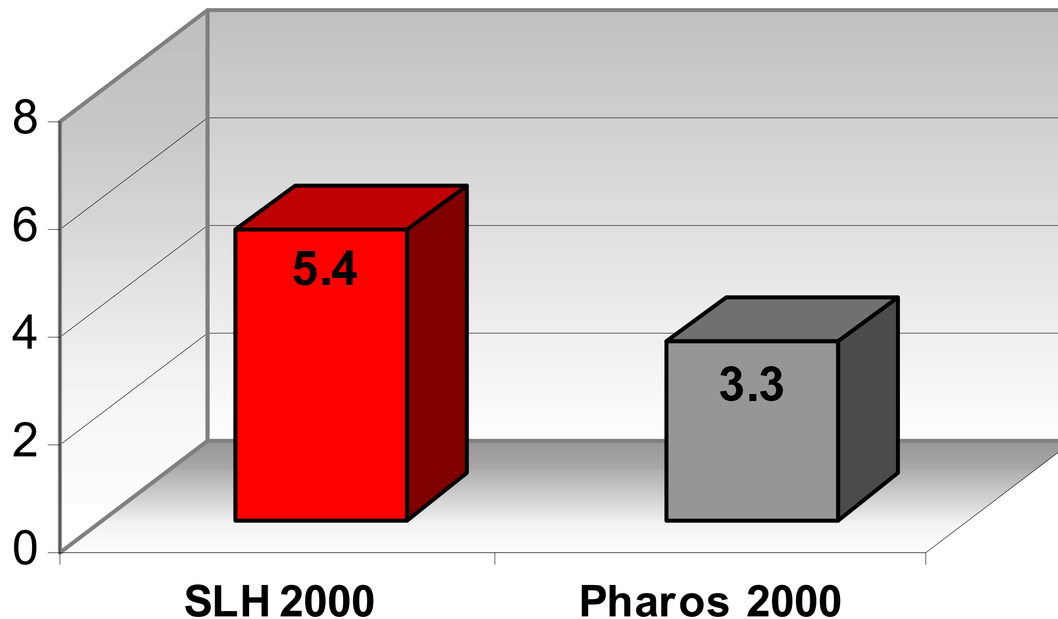
Impact on Hospital Efficiencies



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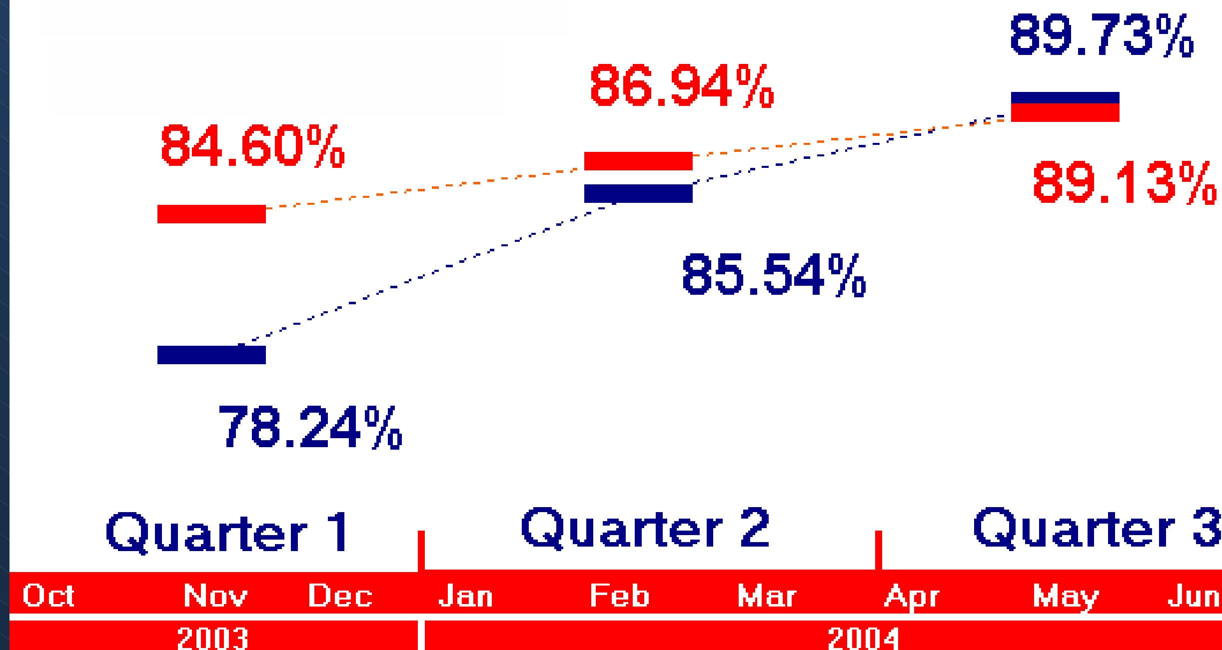
Impact on Quality Performance



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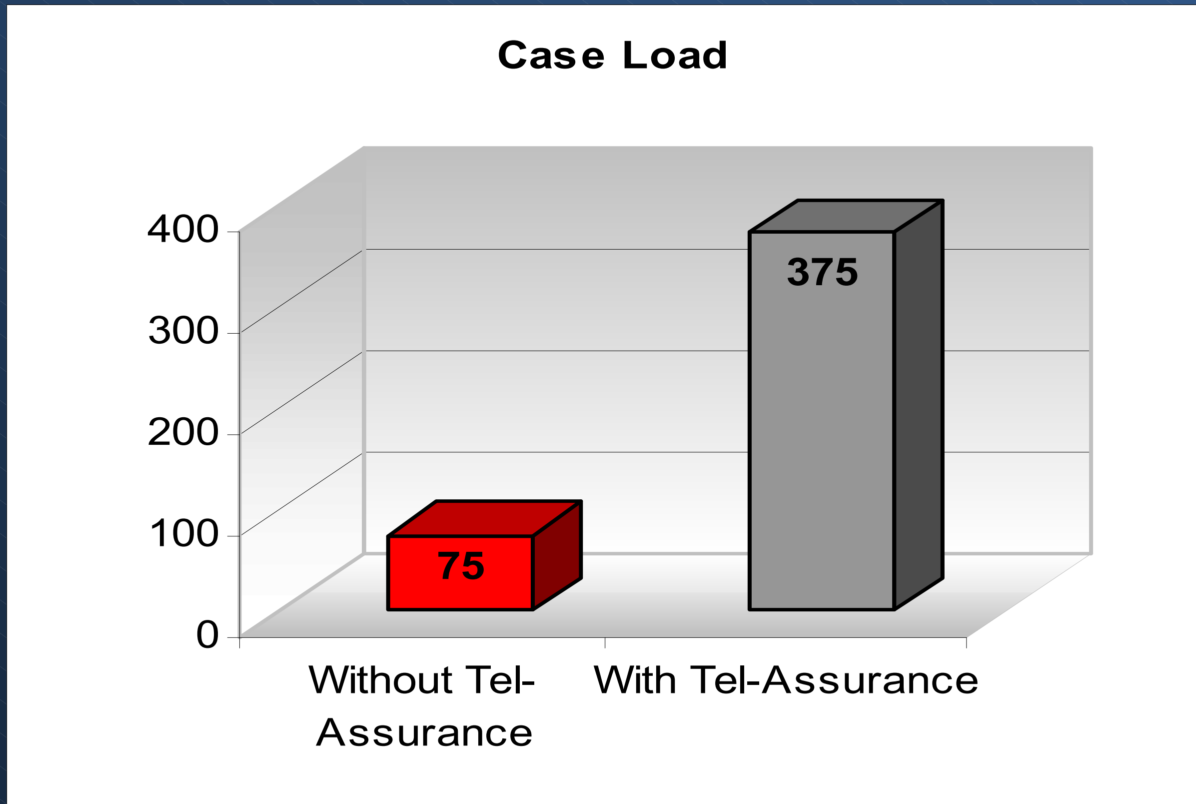
Impact on Provider Productivity

Increase case loads 5x without additional FTE's



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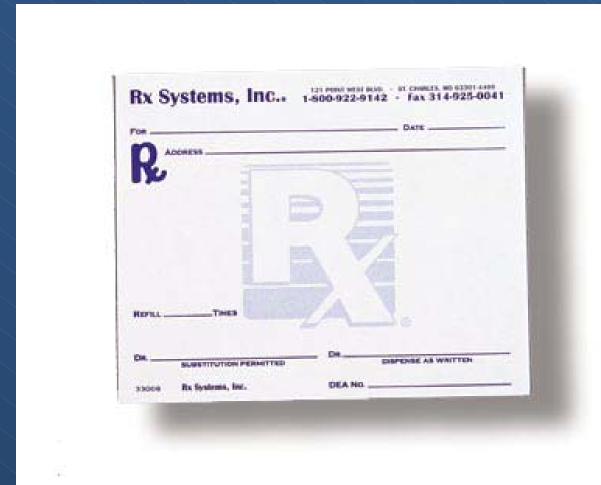
Summary

- Traditional DM has been an important, yet "reactive" agent of change
- Emergence of advanced models leveraging technology, outcomes analysis and clinical trials
- Provider involvement has been (and will remain) key to future state improvements
- Current Transition State marked by competing models and agenda
- Future success will maintain a crucial roll for care management tools and technologies, incentive alignment, and critical mass/ scale



Focus must be on Providers "Baked In" rather than Provider "Buy-in"

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