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Disease Management National Policy Issues


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The Disease Management Colloquium
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DMAA Vision and Mission

- Our vision is that every person has access to coordinated, comprehensive, evidence-based care.
- Our mission is to be a catalyst to change the system to that end.
- Our activities to achieve that mission are advocacy, education, research, and policy development.

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Our healthcare "system" is facing great challenges

Cost concerns

- Managed care backlash
- Premium increase cycle
- Advances in tech & pharma
- Worker productivity

Societal changes

- Epidemic of risk factors
- Addiction to quick fixes
- Aging parents
- Lack of extended family

Demographic factors

- Baby boomer generation
- Consumerism
- Aging population
- Longer life expectancy

Delivery system

- Physician supply
- Lack of IT infrastructure
- Rapidity of medical advances
- Lack of time

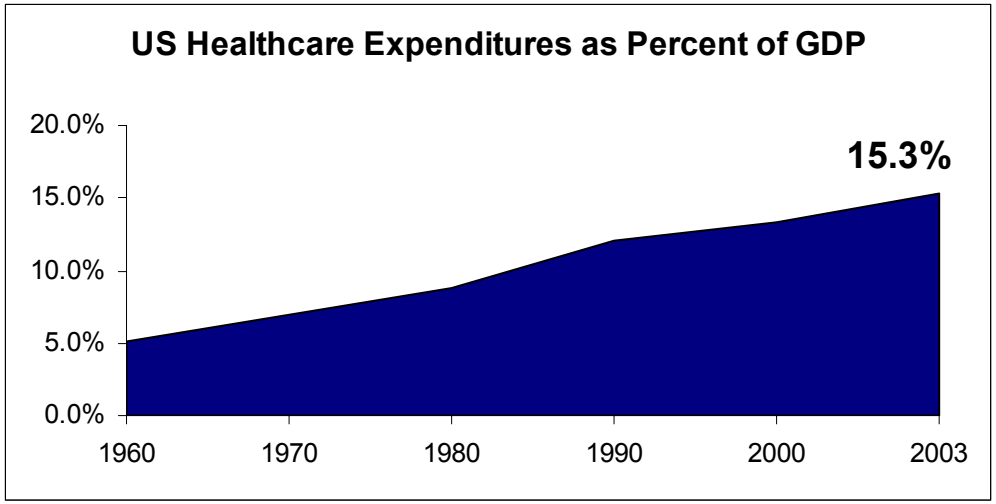
These Issues Lead to Gaps (Underuse of EBM)

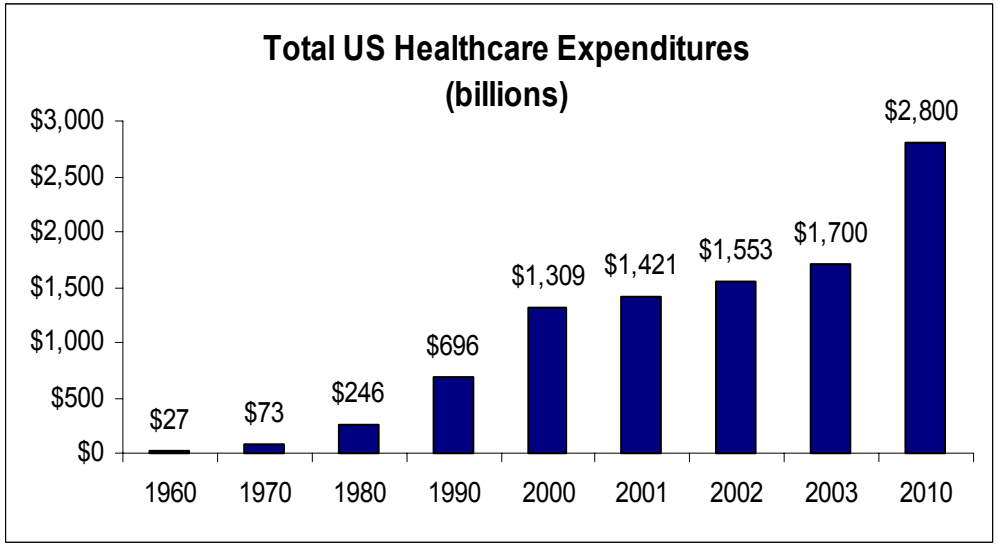
People with Chronic Conditions only Receive 56.1% of Recommended Care*

- Only 24% of people with diabetes received three or more HbA1c tests in a two year period
- Only 45% of people presenting with an MI received beta-blockers

Condition	% Not receiving Recommended Care
Diabetes	54.6%
Hyperlipidemia	51.4%
Asthma	46.5%
COPD	42%
CHF	36.1%
Hypertension	35.3%
CAD	32%

And Increasing Healthcare Cost





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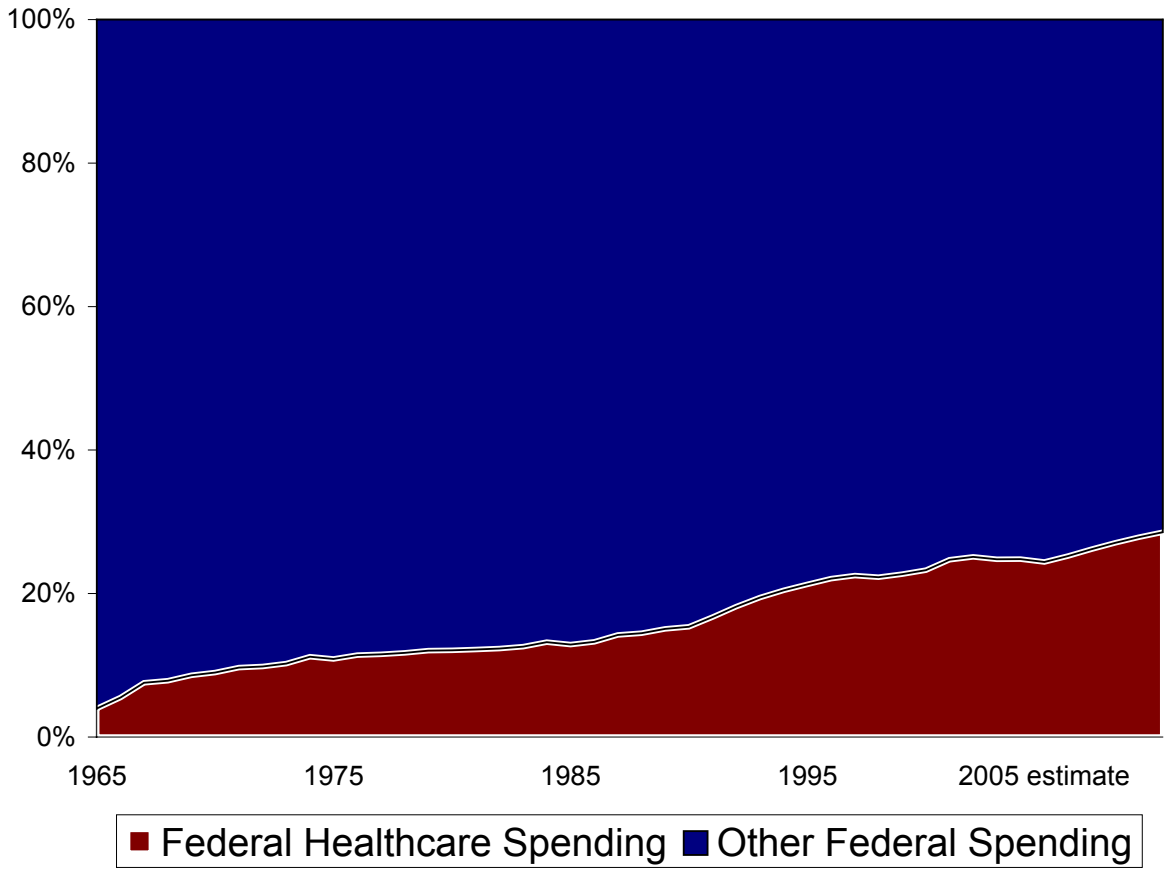
Government Cost Trends



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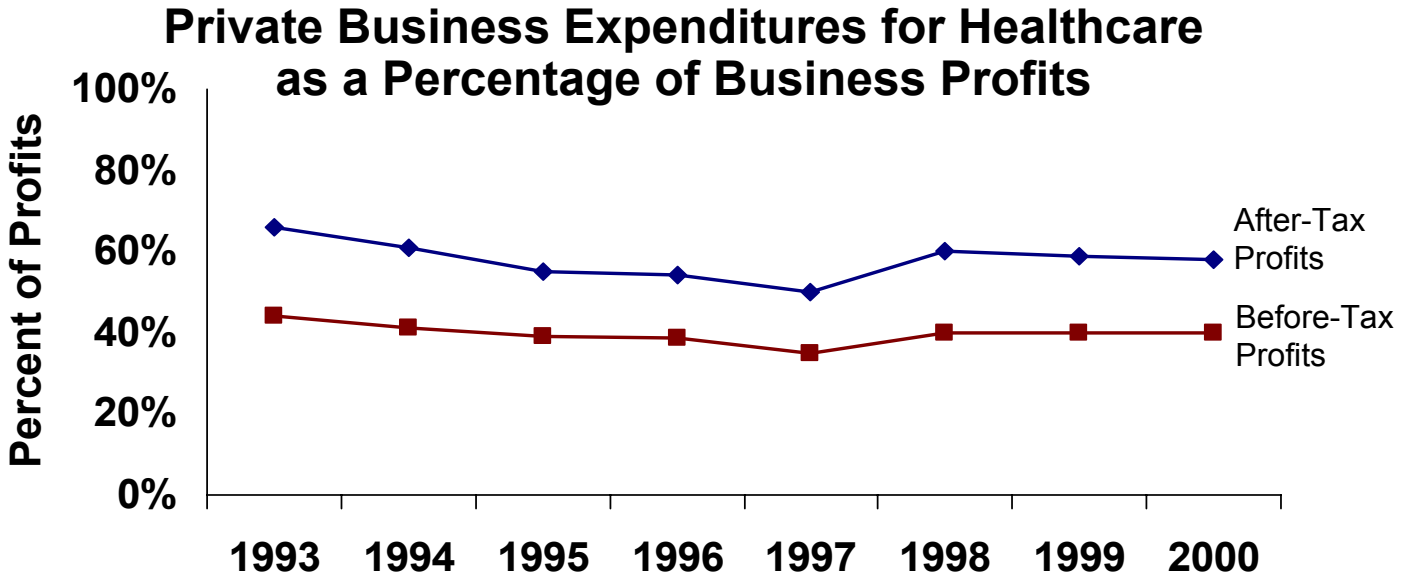
Employer Cost Trends



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Employer Cost Trends

By the Numbers

1.1 million Number of people General Motors covers for health insurance.

$5.2 billion Amount GM spent to cover these people last year.

$400 million Amount GM expects its overall health care costs to rise this year.

$1,500 Amount added to the price of each GM vehicle to cover health care costs.

THE WASHINGTON POST

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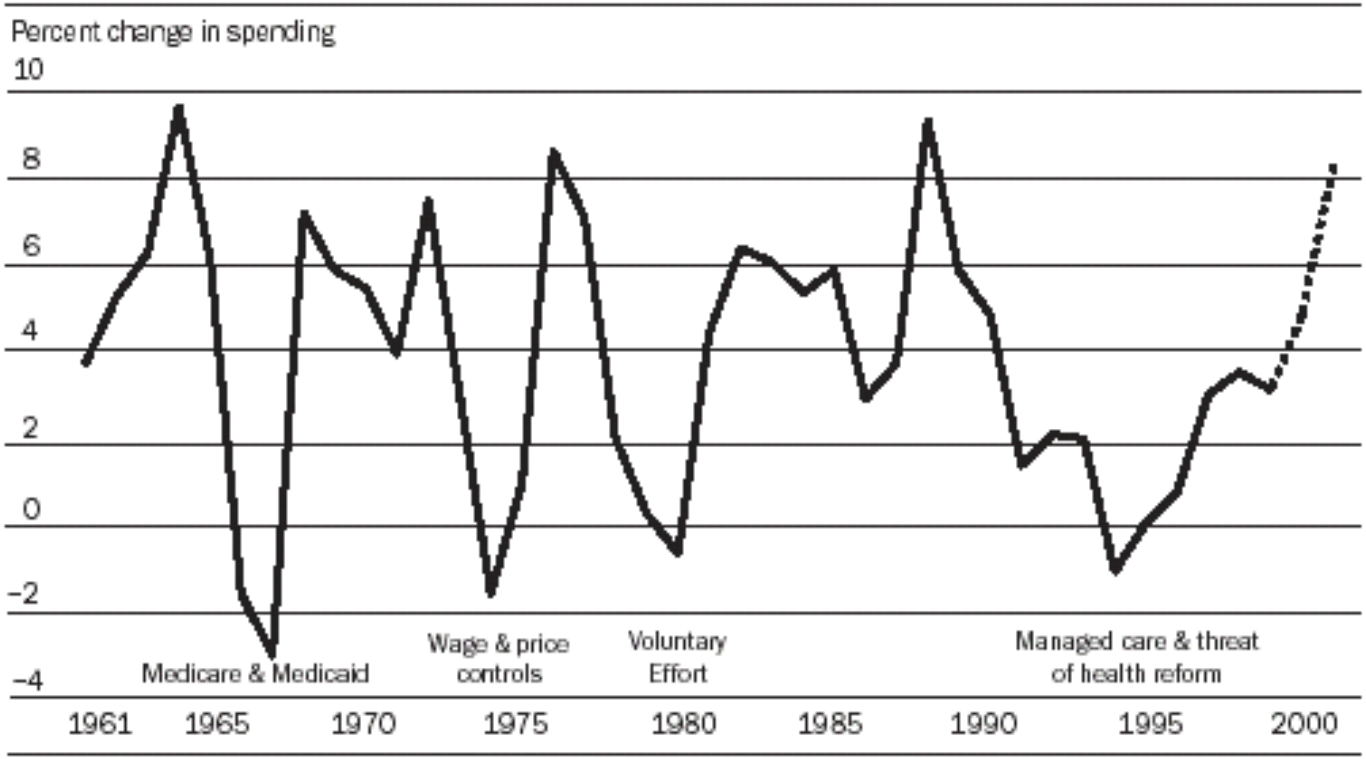
Healthcare Premiums in the U.S. Constantly Cycle Up and Down

EXHIBIT 1

Annual Change In Private Health Spending Per Capita (Adjusted For Inflation), 1961–2001



SOURCES: Henry J. Kaiser Family Foundation analysis. Private health expenditures per capita, 1960–1999, are from the Centers for Medicare and Medicaid Services (CMS). Change in private spending per capita, 2000–2001, is estimated based on average premium increases for employer-sponsored coverage from the Kaiser/HRET Survey of Employer-Sponsored Health Benefits.
NOTES: Real change in spending is calculated using the Consumer Price Index (CPI-U) all items, average annual change for 1961–2000 and July-to-July change for 2001. This analysis was inspired by an analysis done by Jeff Merrill and Richard Wassermann more than fifteen years ago. See J.C. Merrill and R.J. Wassermann, "Growth in National Expenditures: Additional Analyses," *Health Affairs* (Winter 1985): 91–98.

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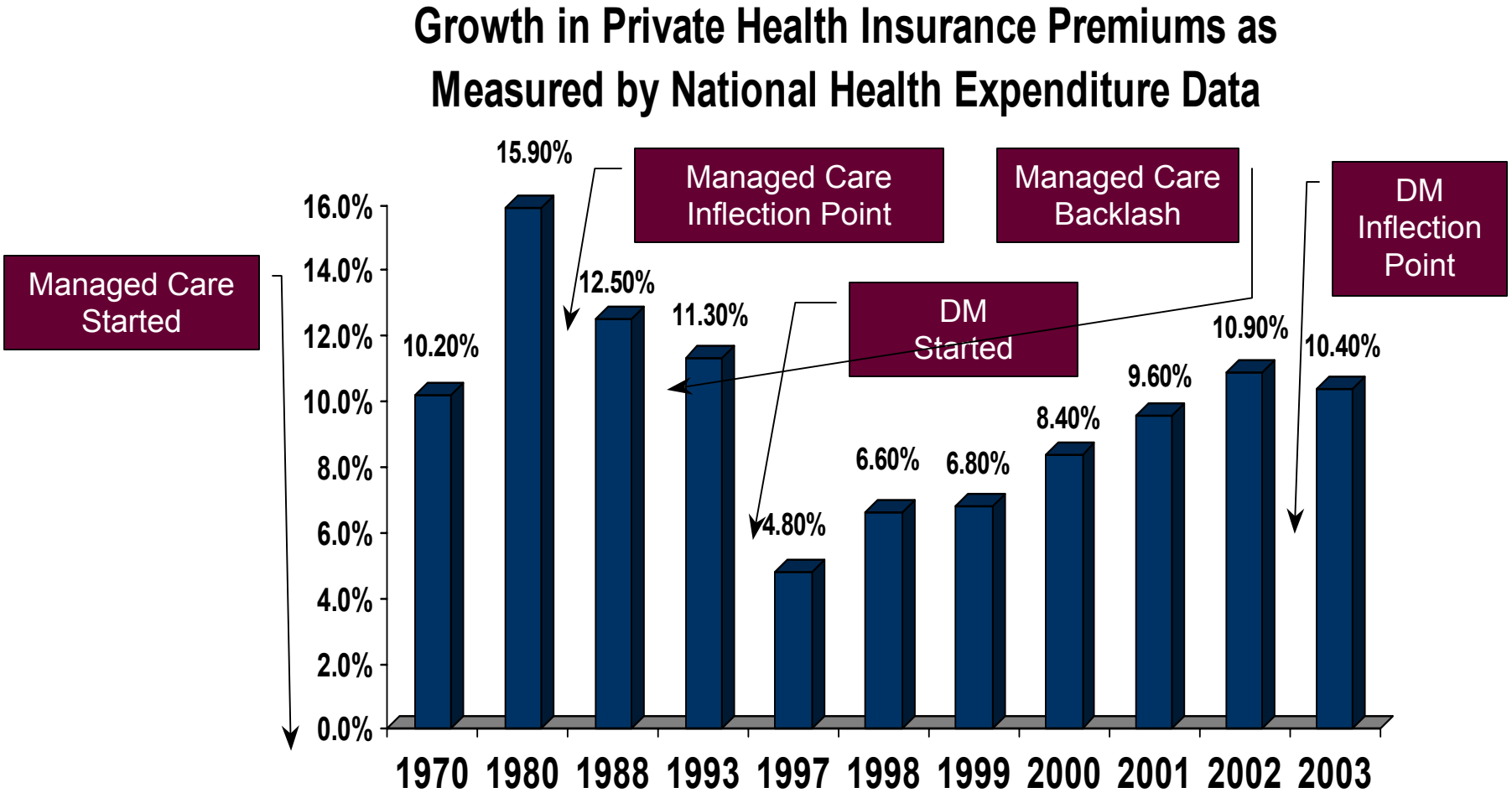
Something has Changed: Longest "Up" Cycle in 40 Years



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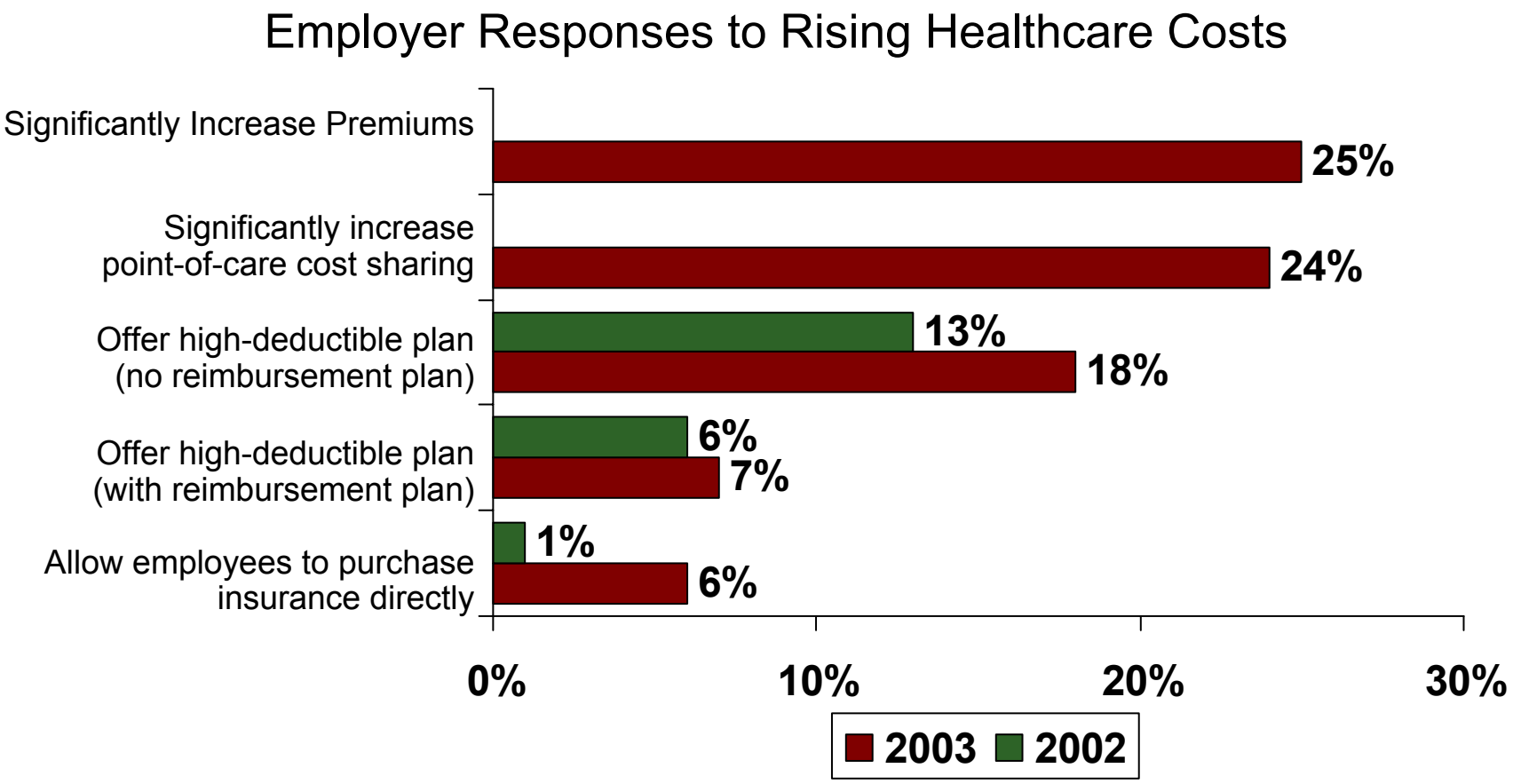
Employer Strategies Vary



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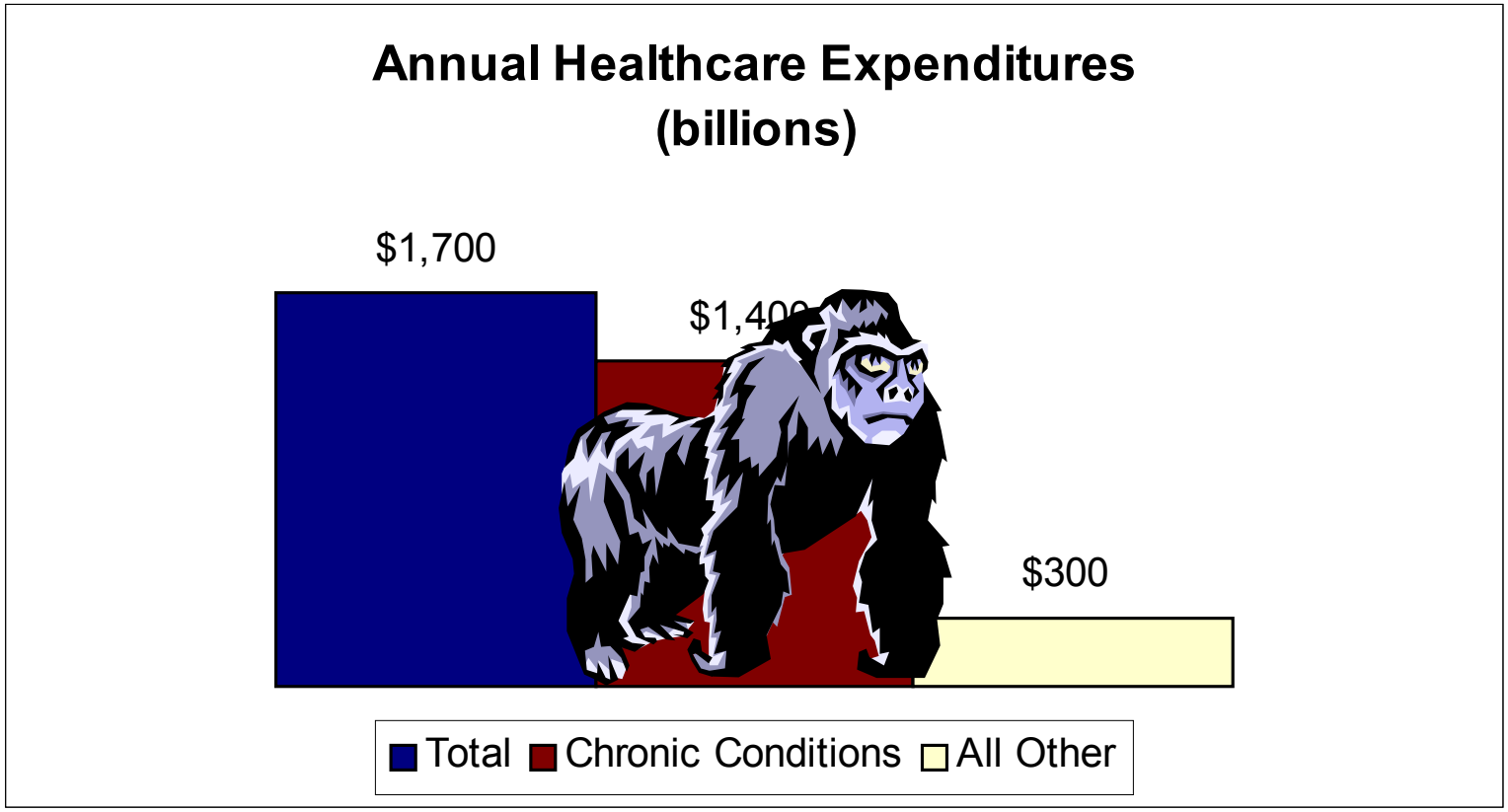
Cost Shifting will no Longer Work



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Major Goals of Disease Management

- To close the significant gaps in evidence-based care for individuals with chronic conditions
- To support the control of escalating costs associated with the increasing prevalence of chronic disease

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DMAA Definition of DM

- A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant, supporting the physician/patient relationship and their plan of care
- Emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies
- Evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health

Disease Management Components (DMAA definition)

- Population identification processes
- Evidence-based practice guidelines
- Collaborative practice models to include physician and support-service providers
- Patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance)
- Process and outcomes measurement, evaluation, and management
- Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling)

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Objective of Disease Management

To help each individual achieve optimal health by:

- Closing the gaps between recommended and actual care (promoting evidence-based medicine)
- Encouraging patients to adopt a healthy lifestyle (promoting self efficacy)

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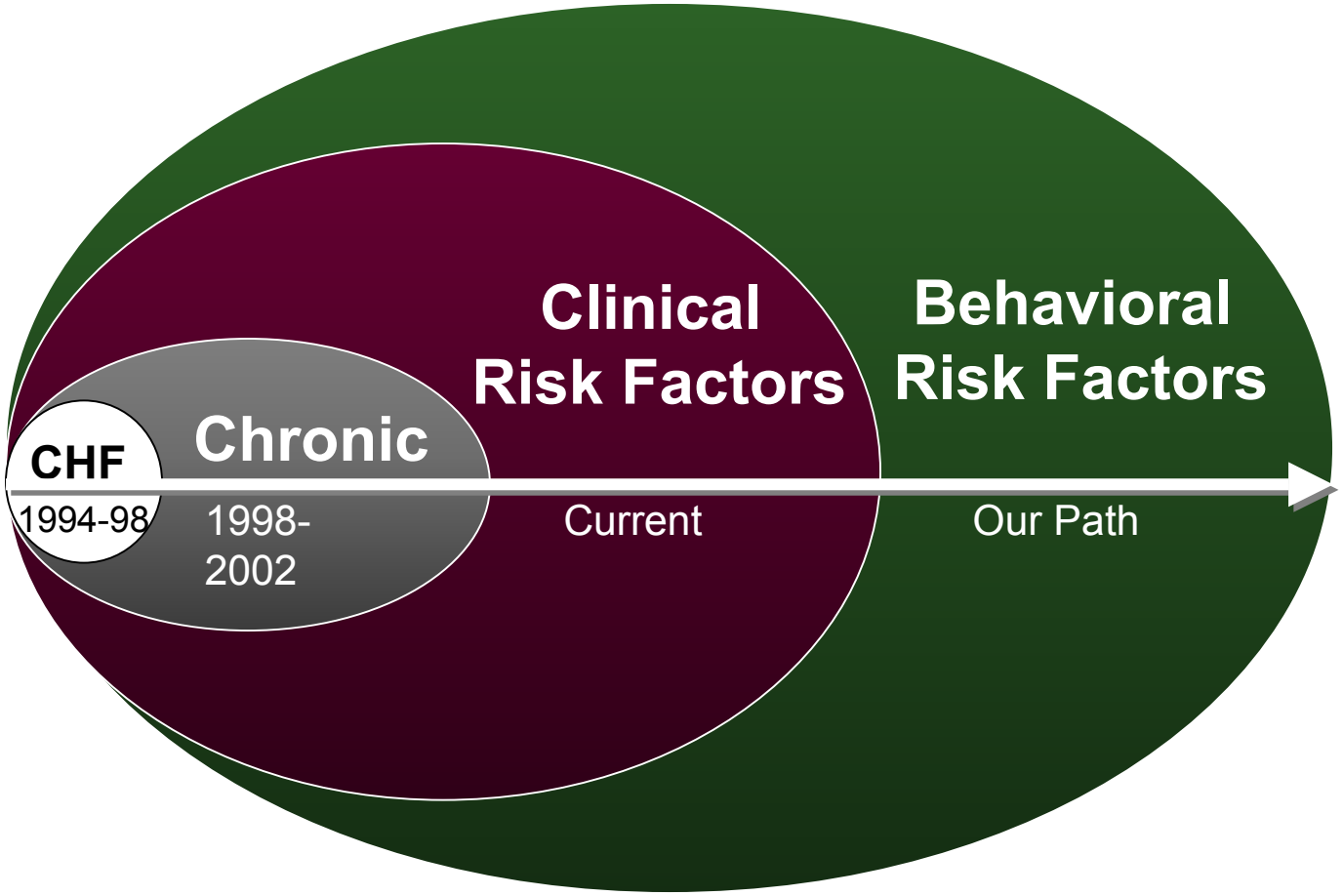
DM is Evolving Toward Multiple Conditions and Prevention



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DM Also Expanding its Scope – Integrating with Health Mgt.

Disease Management Programs

Health Benefits Administration

Population Health Improvement

Wellness Lifestyle Mgmt. HRA/DM "Light"

Medical Management Services

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Maturity of DM Model Varies by Market Segment

Health Plans

Employers

Government

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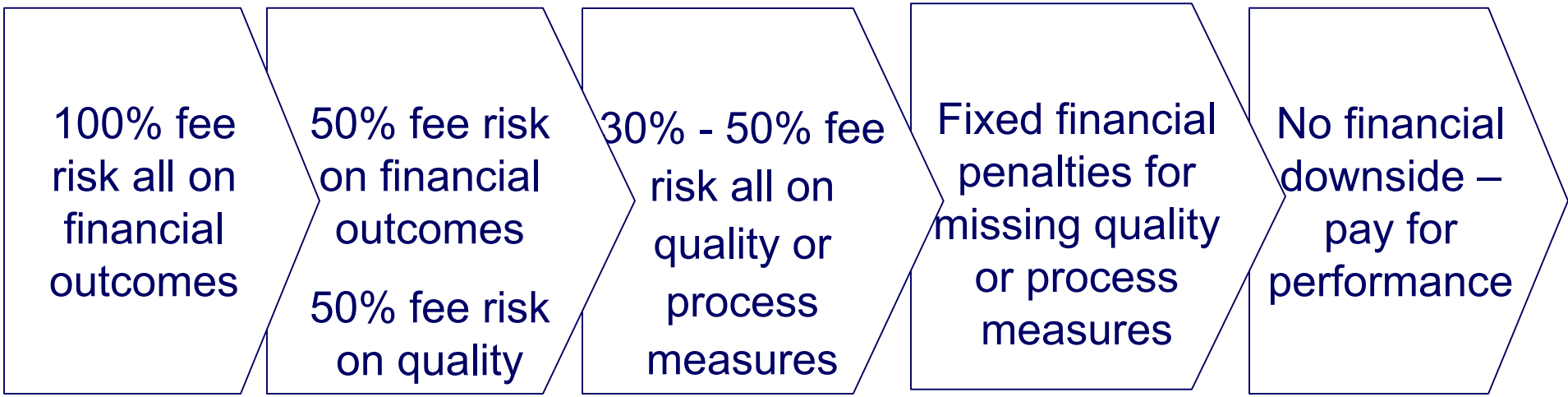
The Standard of Proof is Evolving as DM Matures



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National Policy Issues

- Ensuring parity in availability of DM
  - Medicare
  - Dual Eligibles
  - Medicaid
  - Retirees/pre-retirees
- Addressing racial and ethnic disparities
- Developing equitable payment methodologies
- Ensuring broad stakeholder support
- Moving upstream toward prevention (reinvesting savings)
- Integrating DM with public health efforts
- Measuring results
- Scaling up while ensuring quality
- Realizing the “promise” of DM

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Challenges/Opportunities on the Horizon

- Pay for Performance
- Chronic Care Improvement Programs
- Health Savings Accounts
- Benefit Design
- Integration

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The $1.7 Trillion Question(s)

- Can DM serve as a platform to reduce underuse and misuse?
- Can DM avoid suffering the fate of prior medical management efforts?
- Can DM generate enough savings in the long run to fund more comprehensive coverage and preventive efforts?
- Have we reached enough of a crisis to try?

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