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Consumer Attitudes Toward Disease Management

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Questions ???

- What do we know about attitudes toward Disease Management?
- How useful are satisfaction surveys? And what have they told us?
- What can we gather from the literature as to consumer attitudes and needs?
- How might we better meet the articulated needs?
- How might we structure such a program?
- When can we use common sense?

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Who Cares??

- Consumers (**PATIENTS and FAMILIES**) don't know that DM exists, let alone have an attitude about it.

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DM Attitudes Towards Consumers

- DSM programs developed by companies to accomplish two purposes (but one real purpose):
  - Improve care in patients with chronic illness
    - Save money
  - Decrease hospitalization and other expensive resources
    - Save money
  - Most Programs are Disease Focused targeting those patients who spend the money.
- Only need to 'satisfy' patient to keep them in the program (**The real customer is the payer**)
- Programs almost never designed around what the patient needs or wants but are prescriptive

Health Care 101- *Follow the $$$$$*

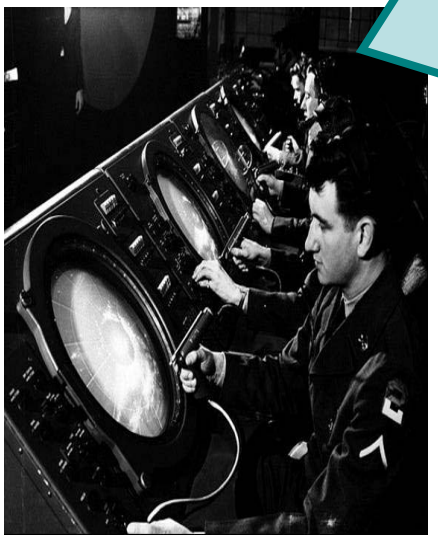
The Health Buck Starts Here

Step 1
Employers
Government
$$$$$$$$$

Step 2
MCOs
$$$$$$

They get the money to pay for your health

Step 3
DM
$
The Cost Containment Strategy



Step 4
The Patient
The Cost Center

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Consumers View of DM

What we learned:

- Unable to find specific research or data on consumer attitudes toward DM. Some limited data on focused case and care management for specific conditions
- Limited research on consumers' wants in health care, particularly senior population. May be a proxy
- Satisfaction surveys traditionally a proxy-don't tell us what the consumer wants or needs
- Surveys only recently included consumer perspective

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Satisfaction Surveys – Maybe the Next Best Tool, But….

- No standard tool used by all DSM companies
- Some administer themselves, others outsource
- Timing of surveys varies
- Usually only survey those in the program, not the dis-enrolled or non-participating
- Participation rates generally low
- Often considered ‘happiness’ survey

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DMAA Member Satisfaction Project

- Striving for methodological validity including:
  - Objective survey sampling and data collection methodologies
  - Relevant and validated survey questions
  - Appropriate survey frequency
  - Adequate survey response rate

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Questions to Consider

- What do we want from a satisfaction survey?
- Are we asking the ‘right‘ questions?
- Is the survey inquiring about what the patient really needs?
- Does satisfaction with a DSM program measure the effectiveness of interventions?

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Survey of DSM Companies

- Six companies contacted, asked the following questions:
  - Who does your patient survey?
  - What is your return rate? [#returned/# sent]
  - % of responses in top 2 categories?
  - When is first survey sent? Frequency thereafter?

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Short Survey of DSM Satisfaction Surveys

	A	B	C	D
Outsource	yes	yes	yes	yes
Return rate	5-25% = 200 - 1000	55% [Tele]	50% [Tele]	35% = 6722
% Top 2 categories	85-90%	96-97%	90 –95%	90.5%
Frequency	annually	4 wks post hosp	Annually [p 12 mos active]	Q 6 mos starting after 6 mos

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What Do Surveys Tell Us?

- Little about the patient attitudes
- Return rates low even with telephonic surveying
- All measure ‘happiness’ with program
- All show similar results
- 2 programs ‘touch’ the patient
  - 1 has relatively short term involvement
- 2 are telephonic only

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What Does Other Research Tell Us

- Certain issues and gaps cry out
  - Coordination of care
  - Access to care
  - Information, communication, and education
  - Respect for patient's values, preferences and expressed needs
  - Emotional support-alleviation of fear and anxiety
- Care needs escalate with multiple chronic conditions
- Needs intensify further as frailty increases an ADL's impacted

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What We Know

- **Relationships** are the fundamental building block essential for change
  - Patient/doctor relationship
    - Most DM companies try to have the same nurse work with a patient
  - Patient behavior change is much enhanced by working with a trusted person
  - Chronically ill patients with multiple co-morbidities require more hands on to influence behavior
  - The frail and elderly often suffer from isolation and a lack of relationships

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The Gap

- Dr. visits are brief
- Patients only retain 20 % of visit
- Messaging is complex
- Patient compliance complicated by isolation and depression
- Complicated by decrease cognitive function
- DM programs have limited impact on this population

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What About Current DM Programs?

- These patients often sicker, not able to meet criteria, regular telephone contact
- Seem to slip thru the cracks
- Recognized by MCOs as being high risk and costly
- Need a different model of care focusing on care, keeping them well enough to stay at home
- Model still needs to be cost effective

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The Solution

Patient Centered Model of Care for the Medically Complex

- Hands on Community Programs
- Scalable
- Defined Content
- Able to integrate into the existing health care system
- Able to integrate with the medical infrastructure of MCO's

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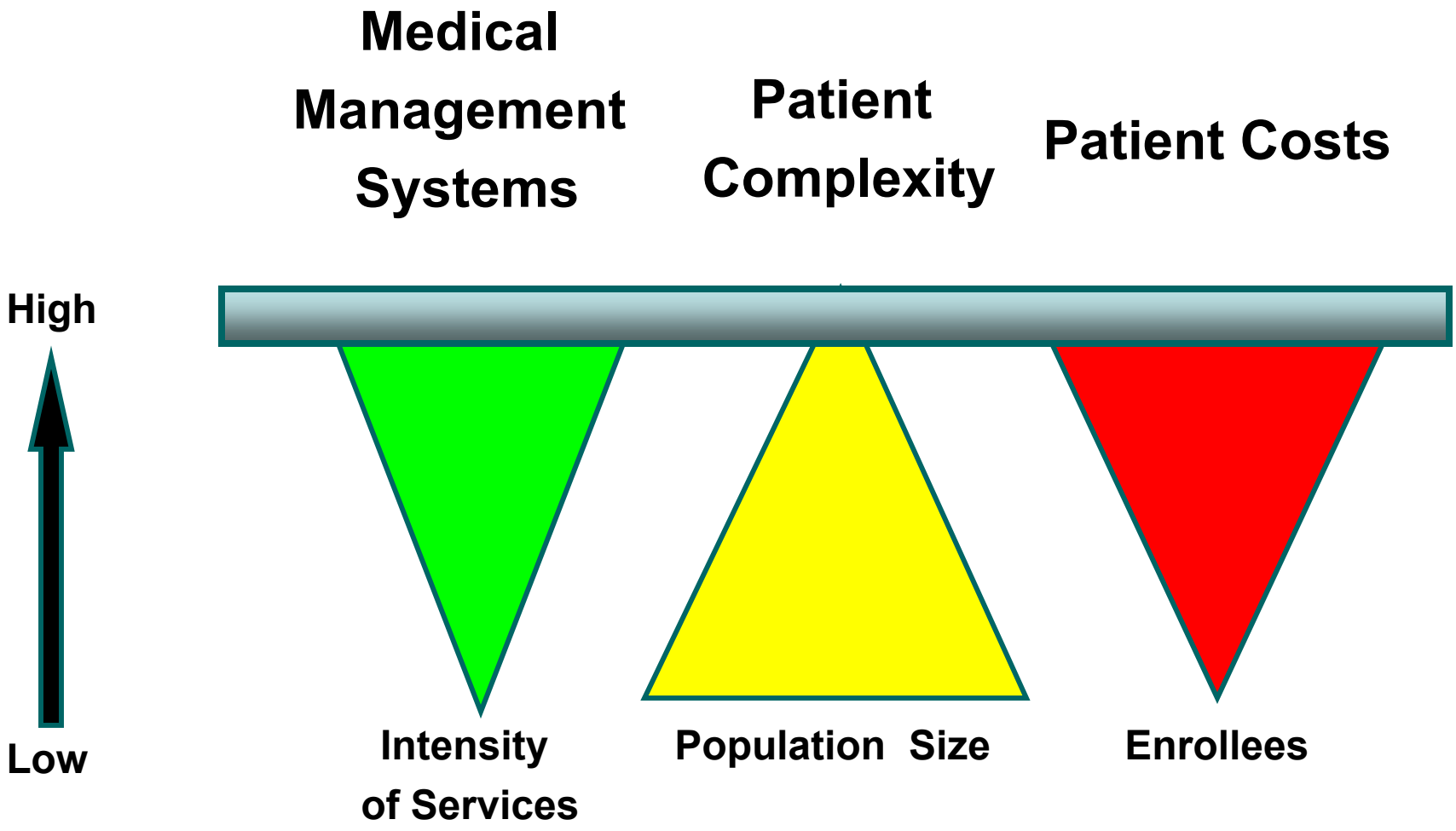
The Pyramids



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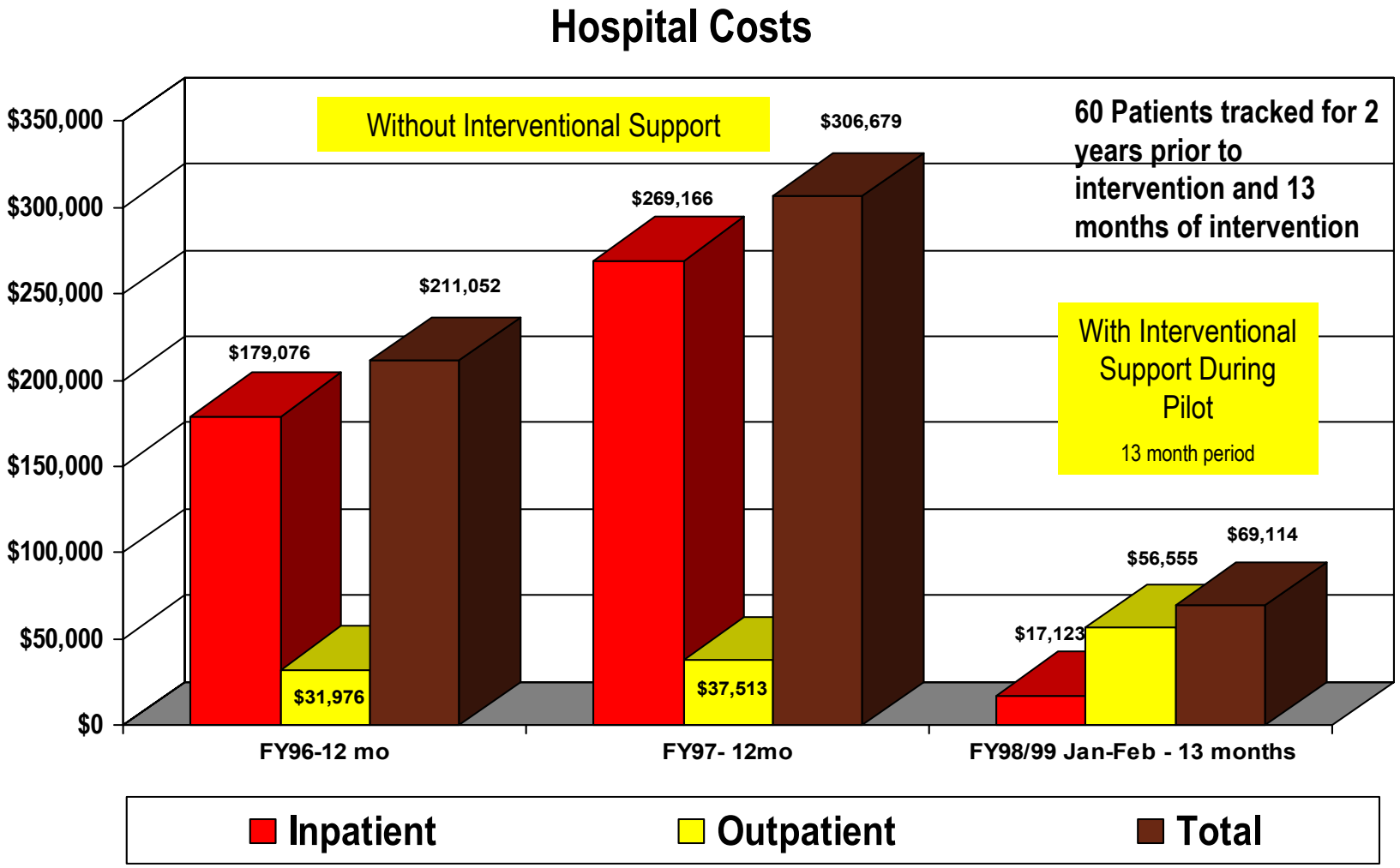
Dramatic Decrease in Hospital Expenditures

Analysis of Hospital Costs and Related Activity



* Source: Bridgeport, CT Hospital Pilot Data, January 2000

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Patient Centered Care –
Care In The Home –Health Management

"Patients can undo a months worth of expensive and intensive care by just going home and going about their normal routine"

- **Community-based ECI Nurse or Nurse Practitioner conducts patient visits**
- **Comprehensive Health Status Evaluation**
  - **Gap-filling education - family, caregiver and patient**
  - **Proper use of medication**
  - **Address depression and Isolation**
  - **Implement disease-specific exercise program**
  - **Home safety improvements**
  - **Coordinating and integrating care**
  - **Reviewing/upgrading nutrition**
  - **Initiating health monitoring systems**
  - **Defining advance medical directive**

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Patient Centered Care –
In the Community for the Most Impaired

"The community is one of the most strategically important ingredients to improved health and outcomes"

- **Weekly group meetings**
- **Catalyzed socialization** – Overcome Isolation
  - Coffee and Cookies
  - Introductions to new people
  - Recreation and Entertainment
- **Exercise programs** – New Level of Fitness
- **Geriatric pharmacist reviews medication**
- **Nurse monitoring** for adherence / warning signs
  - Meds
  - Vitals Signs
  - Communicates issues with MD
  - Motivation
  - Nutrition
  - Exercise

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The Physician Message

- "We exist to fill in a known and growing information gap between your patients evolving condition and your treatment strategy."
- "We are an MD-directed, comprehensive, community-based nursing intervention program ***built to enhance your care and fill in the gaps between what you prescribe and what your patient does***."
- "We work to reconnect the individual within their community, to improve socialization and decrease depression and isolation."
- "We coordinate care "

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Caregiver Solution –
Supporting, Stabilizing the Home

- **Caregiver Support Program offers:**
  - **Information and Referral Sources**
  - **Emotional Counseling Hotline 24 / 7**
  - **Legal Guidance Hotline**
  - **Financial Guidance Hotline**
  - **Veterinarian Hotline**

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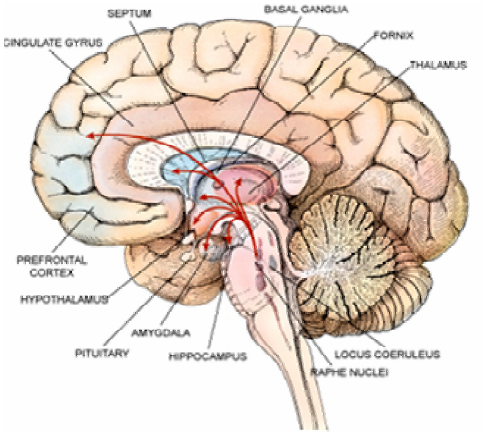
The Electronic Health Record – *The Brains*

- **Software is the engine driving care**
  - **Patient Selection – HRA, MDS, administrative data**
  - ***Efficient data entry***
    - ***All tools are point click and hand writing recognition.***
  - **Integrated Patient Specific Care Plans**
  - ***Integrated Care Guidelines***
  - **Integrated Reports – For the patient, family, physician**
  - ***Integrated Communications – Web based with Fax and email capability***
  - **Integrated Bio-Metric tools**
  - ***Integrated Dashboards – to drive Outcome metrics***
  - **Integrated Outcome Reporting – On over 150 outcome measures**
  - ***Integrated Nurse activity tracker***



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The *Magic Sauce*

- Hands on Intervention,
- EMR – driving efficiency and outcomes
- Addresses Depression and Isolation
- Caregiver Support
- Disease Specific Exercises
- Full suite of BioMetric monitoring devices
- True Integration with Physician
- Delivering Care in the home- Nurse Practitioners oversee treatment with the patient's physician
- Integrating evidence based care guidelines.
- Case management – coordinating and integrating care
- Measurable Outcomes

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Consumer Attitudes

We don't know much

- What we do know is that most consumers don't know what DM is.
- We know that DM is a cost savings strategy
- Improved health outcomes is the Tactic used to control costs
- That the people most impaired need the most contact and *Relationship is the most important driver of behavior change*
- Easy Care – Community Care Management Program is a vehicle to create Relationship, Health Outcomes and Cost Savings