PHC4 fyi

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Disease Management Programs

Prevailing wisdom holds that an ounce of prevention is worth a pound of cure. That principle is an important component of many managed care plans, reflected in the implementation of disease management (DM) programs. But do disease management programs work, and are they worth the additional investment they often require?

Simply put, DM programs are designed to prevent existing chronic conditions like asthma, diabetes or heart disease from worsening. For example, a person with diabetes under proper medical management can lead a normal and productive life. If left unmanaged, however, diabetes can result in blindness, amputation, and repeated hospitalizations - even death. That's where disease management can make a difference.

DM typically involves a system of coordinated interventions by nurses or other medical practitioners, along with outreach and education, targeted to clinical areas where patient self-care efforts or behavioral changes can make a difference. A successful DM program must be a partnership between patient and health care provider, must reflect an employer or purchaser's commitment of resources, and involve effective implementation by the health plan. Some purchasers hire vendors or contract with specialized commercial DM firms to assist them. DM programs are generally implemented through HMOs, pharmacy benefit management (PBM) firms or Medicaid agencies.

The Disease Management Purchasing Consortium & Advisory Council reports that DM is a $340 million dollar industry in the U.S. and one of the fastest growing investments in health care. DM activities frequently occur in the workplace; approximately 44% of employers in the U.S. offer DM programs to help improve the health of their workforce, according to the Pharmacy Benefit Management Institute.

Do DM programs work?

While no reasonable person would dispute the logic of preventive health care, there is a shortage of scientific evidence that DM programs result in improved health and restrained costs. However, because of its unique database, PHC4 has the ability to analyze the HEDIS (The National Committee for Quality Assurance's Health Plan Employer Data and Information Set) prevention measures against HMO-specific inpatient clinical data. The combination of these analyses is beginning to demonstrate statistically significant relationships between prevention measures and hospitalization rates.

For example, a recent PHC4 report, *Measuring the Quality of Pennsylvania's Commercial HMOs,* (http://phc4.org/reports/mcpr00/default.htm) suggests that HMOs that focus heavily on preventive care may be helping to keep their members out of the hospital for related conditions. PHC4's study showed lower hospitalization rates for diabetes and hypertension for those HMOs who helped high percentages of their members control their blood sugar and blood pressure levels. Unfortunately the reverse is true as well; HMOs with low levels of preventive care measures have higher hospitalization rates for those same conditions.

These differences can help purchasers ask more informed questions of their health insurance plans regarding their focus on DM and prevention. Purchasers might also ask themselves: Does an increased emphasis on DM make sense for my organization and its members, employees or participants?

Over please

Disease management and diabetes

Controlling diabetes is a common DM program (others include asthma, heart disease and depression), and for good reason. According to the American Diabetes Association, approximately 17 million people in the U. S. have diabetes; 5.9 million of those people are undiagnosed. Direct medical costs related to diabetes have reached $44 billion and indirect costs (e.g., disability, work loss, premature mortality) $54 billion - a staggering $98 billion total.

According to the Pennsylvania Department of Health, 7% of Pennsylvania adults reported being diabetic in 2000, and the diabetes prevalence rate has shown a steady increase since 1997. One large Pennsylvania employer has reported that 21% of their outpatient pharmacy costs are due to diabetes. *PHC4 data shows that patients with diabetes in Pennsylvania accounted for 16.5% of all inpatient hospital discharges in 2001.*

Many employers have found that comprehensive DM programs can help reduce complications from diabetes, thereby reducing insurance premiums, short-term disability payouts and other costs, increasing productivity, decreasing absenteeism, and reducing 'presenteeism' (employees who are at work but not functioning at full capacity).

In Western Pennsylvania, the Pittsburgh Regional Healthcare Initiative (PRHI) is working with providers and employers to improve the process of care for patients with diabetes. PRHI plans to work as a facilitator among insurers, providers, and employers to ensure better access to information and more coordinated medical management. They also hope to help create incentives for physicians to do more education with their patients who have diabetes as well as to overcome perceived barriers in the health care system. Notably, Pennsylvania law requires that insurance companies cover the cost of diabetes education and certain medical supplies.

Should purchasers implement disease management programs?

When evaluating whether to implement a DM program, it is important to know the willingness of employees or members to modify their own individual behaviors. Pre- and post-testing of participants is important to demonstrate whether the program is effective. But getting people to use DM programs can be a challenge. *Protection of privacy must be emphasized so employees know that employers will not have a direct role in identifying or tracking participants*. Participation should not be burdensome and the program should contain tangible benefits or incentives for participants. Consequently, a strong DM program can become part of an organizational culture that values health and productivity.

One major barrier to DM implementation is cost. Many employers want health plans to encourage providers to offer DM and embed the DM costs into their health insurance premiums. Often though, DM programs are add-ons with extra costs to the purchaser, although these costs can vary widely from one plan to the next.

For example, one large Pennsylvania employer reports that they invest about $800 per employee each year. However, they expect a larger return on that investment with decreases in pharmacy claims and hospitalizations, and gains in productivity. A Geisinger Health Plan study of 6,799 patients with diabetes (*Diabetes Care, April 2002)* revealed that those who enrolled in a DM program averaged $394.62 per month in health care costs, while those not enrolled cost $502.48 monthly – a difference of $1,200 per member annually. Notably, Geisinger's HMO is one of several health plans in Pennsylvania with significantly lower than expected diabetes hospitalization rates in PHC4's latest report about the quality of HMO services.

Other purchaser concerns can include liability issues, patient privacy concerns, vendor reliability, limited resources, employee turnover, inadequate information systems, and the difficulty in changing entrenched health care behavior. Finally, each DM program might involve a different scope, intensity, and outreach plan.

Given these factors, focusing on a specific strategy can be challenging. Yet, precise contracting with health plans to achieve DM goals, initiatives, and expectations can be accomplished. Purchasers might evaluate their current health plans and assess whether DM is part of the plan, and if so, ask what exactly the DM plan offers? Purchasers can join with coalitions, purchasing groups, and quality initiatives to compare programs, goals, and results. PHC4 reports can also be useful in determining which HMOs deliver the best prevention-related results.

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