Healthcare Dive

How providers and payers can bridge the disease management gap to cut costs

By Julie Henry | June 15, 2015

According to the Agency for Healthcare Research and Quality (AHRQ), chronic conditions have been rapidly replacing acute and infectious diseases as the major cause of death, disease and disability in the U.S. over the last 20 years. Disease management is designed to help patients and their families more effectively manage chronic conditions and to reduce costs from avoidable complications.

However, health plans and providers have different goals when it comes to disease management. Health plans offer disease management programs in order to reduce costs related to acute-care episodes that may result from improper management of chronic conditions. Although primary-care providers also want to help patients avoid unnecessarily hospitalizations, improving quality of life for those who have chronic conditions is equally important.

A good disease management program

According to the Academy of Managed Care Pharmacy (AMCP), a good disease management program should encompass all of the above. "Disease management programs should emphasize the prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, while evaluating clinical, economic and humanistic outcomes to improve overall health and quality of life for patients," AMCP says.

Since not all patients with chronic illnesses require services beyond basic care, the first step in developing a disease management program is to identify patients who may benefit from your services. This is also an area where insurers tend to take a different approach than providers. Health plans use claims data to assess patient risk. Providers rely more on instinct based on medical knowledge. It may be beneficial to work with insurers to come up with a combination of those methods.

Health plans and PCPs also tend to have different methods of managing chronic diseases. Health plan disease management programs generally rely on telephone management, most often by a nurse. PCPs tend to manage chronic diseases by providing ongoing care. They frequently use a combination of disease management methods including in-office follow-up appointments, telephone outreach, electronic communications and case management.

The Chronic Care Model

Although there is a great deal of variance among disease management programs, almost all promote one or more of the six core elements of the Chronic Care Model (CCM) developed by Ed Wagner and colleagues as a framework for guiding specific quality improvement strategies:

1. Healthcare organization and leadership
2. Linkage to community resources (e.g., nutrition counseling, peer-support groups, data for patient registries)
3. Support of patient self-management
4. Coordinated delivery system design
5. Clinical decision support
6. Clinical information systems

AHRQ says the CCM is the key to developing your program. According to AHRQ, "Research studies suggest that the more aspects of the Chronic Care Model you use, the likelier you are to achieve better process and patient outcomes."

AMCP says a comprehensive disease management program can:

Improve the safety and quality of care
Improve access to care
Improve patient self-management
Improve financial cost containment without sacrificing quality or patient satisfaction
Enhance efforts to provide health improvement programs on a population basis

If all this is true, a good disease management program should satisfy the needs of both payers and providers by reducing readmissions (and therefore, costs) and by improving quality of life for patients with chronic illnesses.

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