

New Health Care Models for Managing Chronic Illness: Lessons for Addiction Treatment

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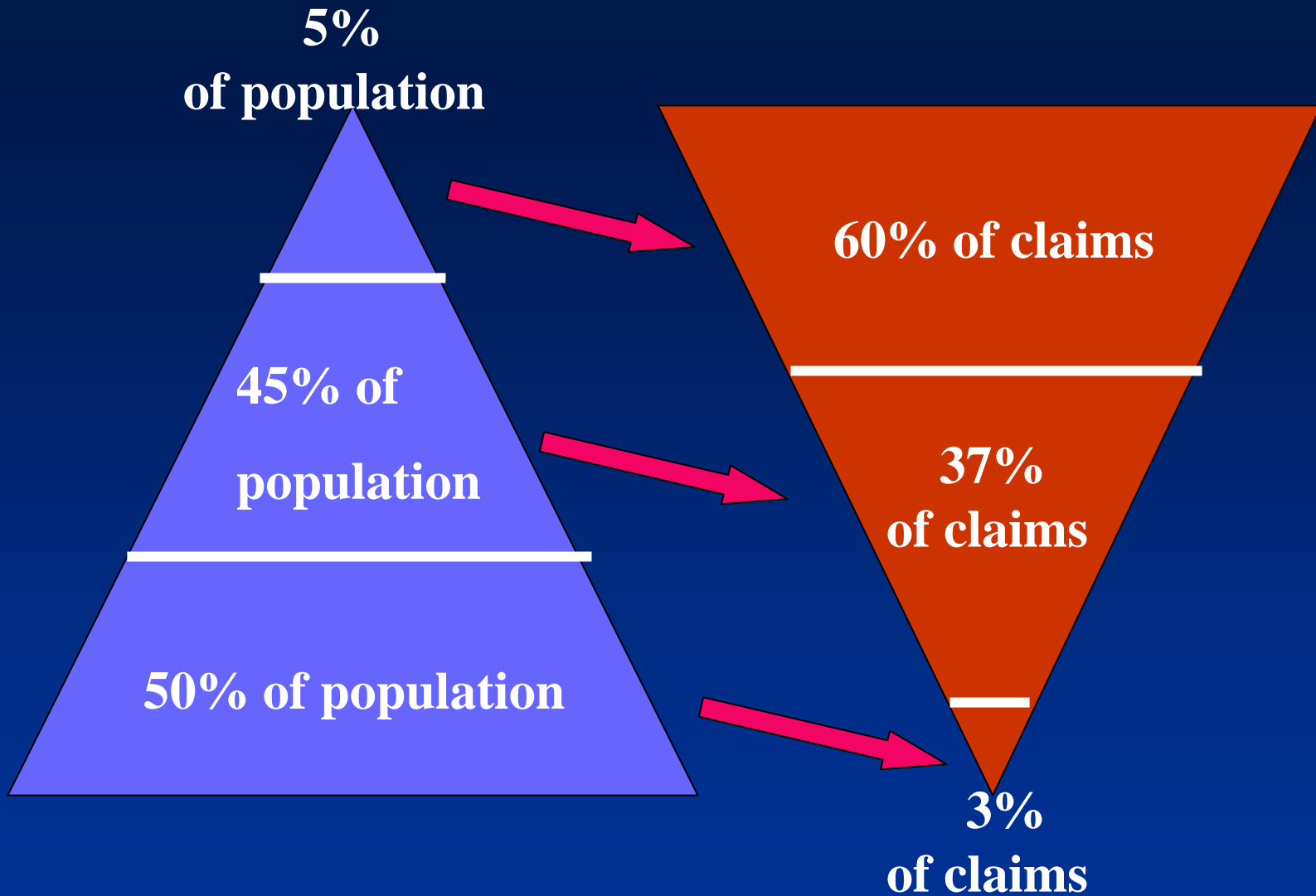
Outline

- The prevalence and cost of chronic illnesses
- The next generation of managed care
- Components of Disease Management Programs
- Reimbursement Models & Pay for Performance
- Example from Depression Disease Management
- Relevance to addiction treatment services

Step # 1:

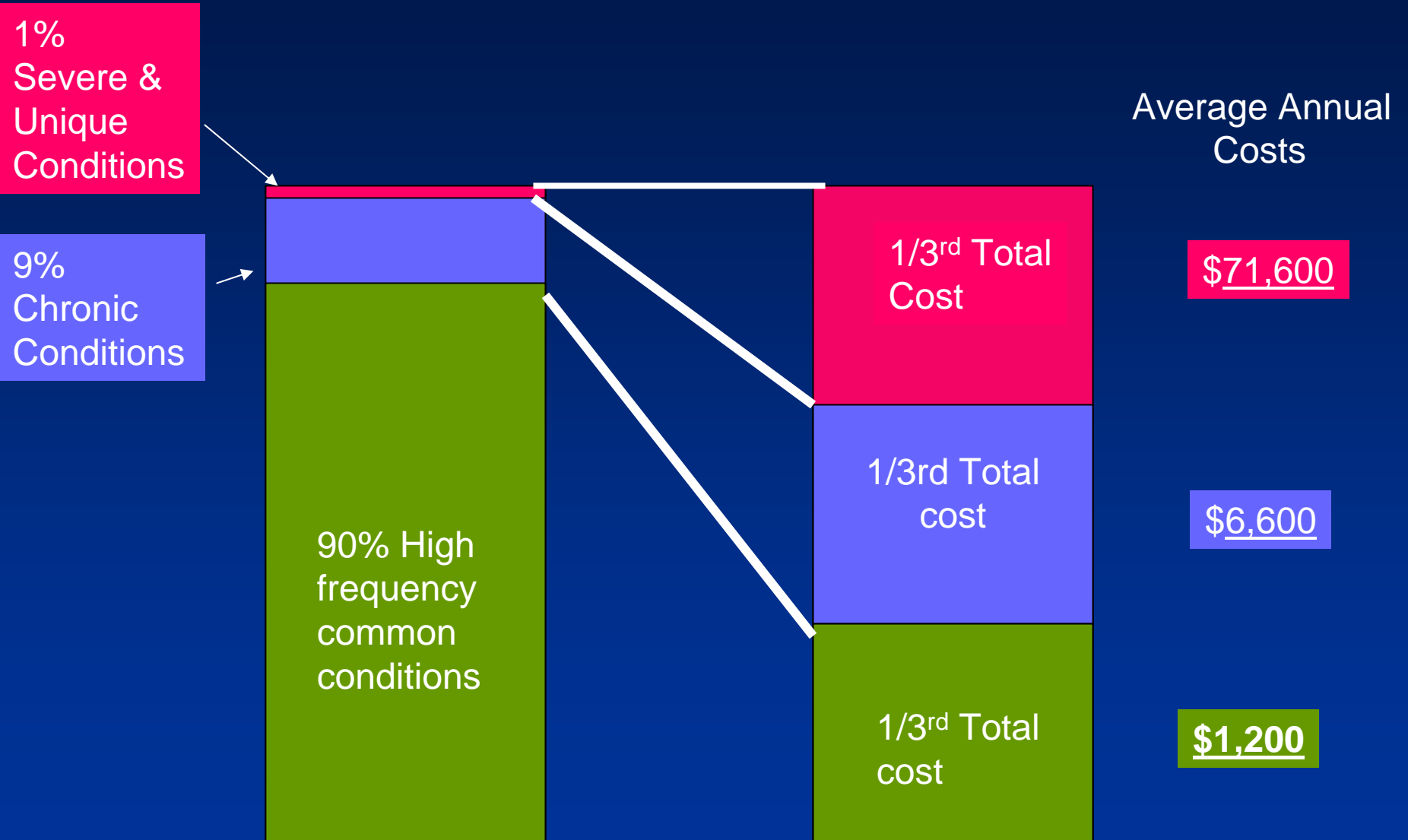
Sick people cost more.....





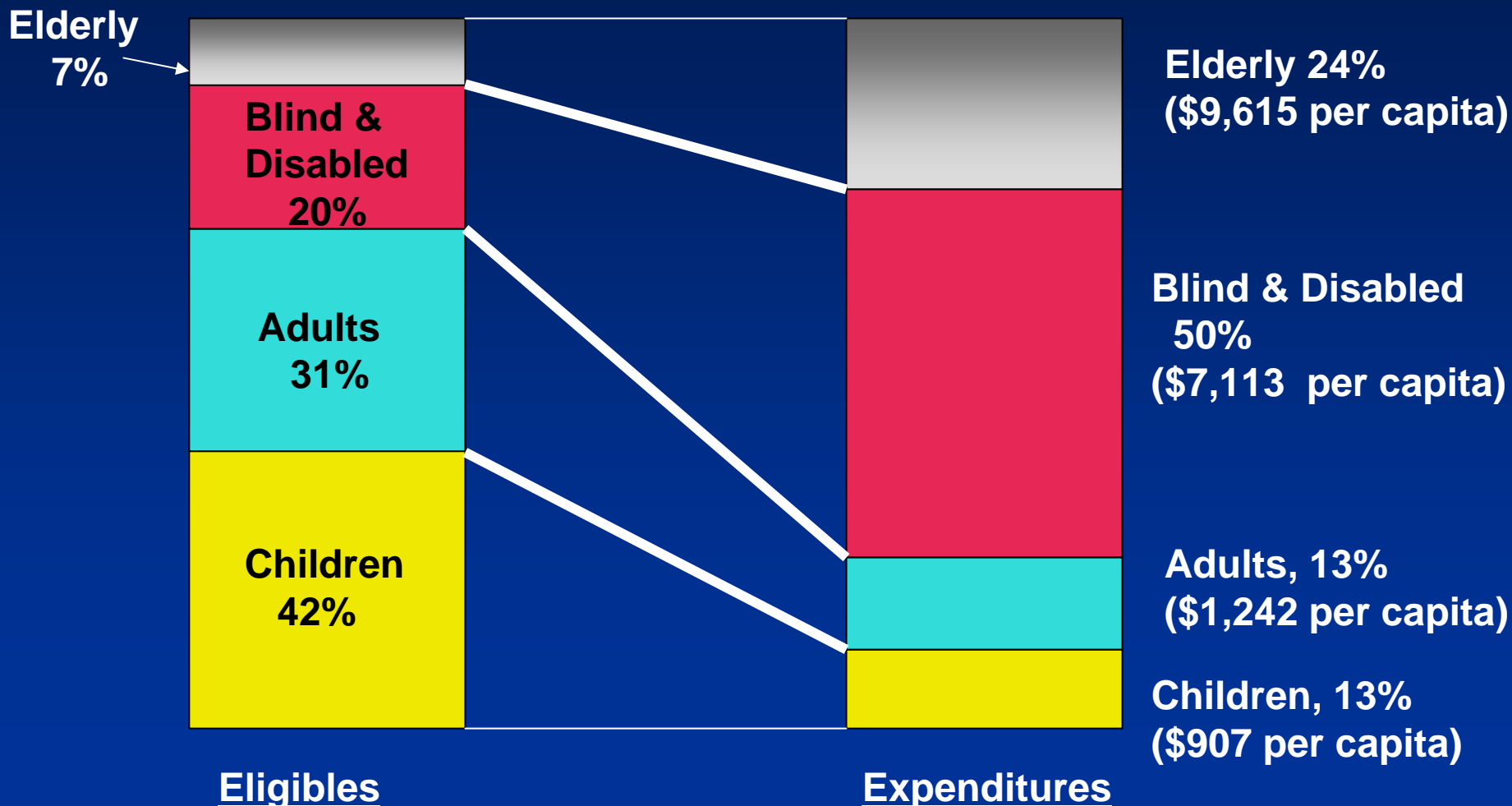
Todd, W., Nash, D., Disease Management: A Systems Approach to Improving Patient Outcomes, 1997

Driving One-Third of Health Care Costs: The 80% / 20% Rule

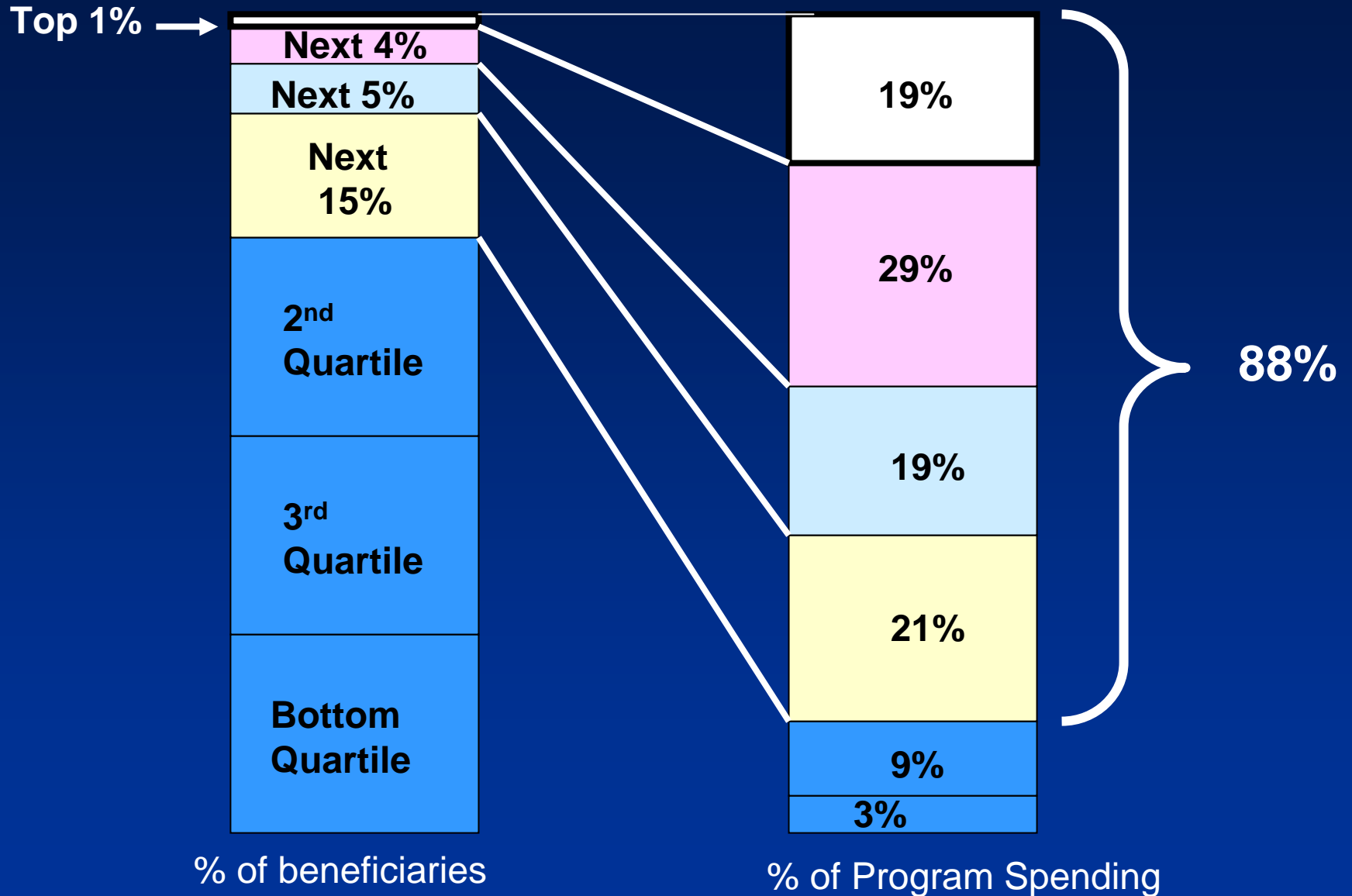


From: Franklin Health, Chase H&O

FY 2002 Dept. of Community Health: Michigan Medicaid per Capita Expenditures



Medicare FFS 2002 costs concentrated in small group beneficiaries



from: "Report to Congress: New Approaches in Medicare", MEDPAC, June 2004

Step #2: Big problems require big solutions

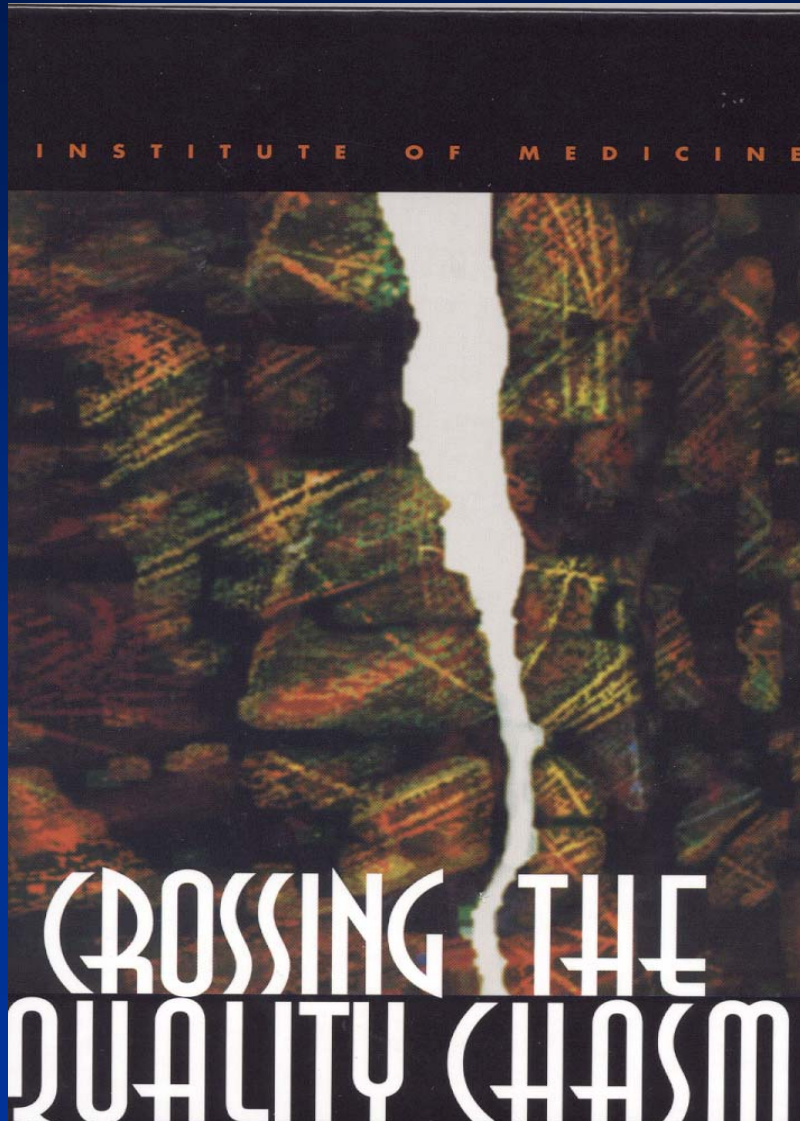
“We should get used to the idea of double-digit health insurance increases for the next 10 years. I see no relief coming”

Uwe Reinhardt, 2002

“As a society, we expected managed care to fix, in a few short years, the disaster in slow motion that is the U.S. health care system. We asked large, organizationally complex insurance companies to reform a century’s worth of self-serving professional habits, rein in ever-expanding consumer and patient demands, and fix dysfunctional economic behaviors – all while answering to the taskmasters on Wall Street every quarter.”

Kleinke, Oxymorons: The Myth of a U.S. Health Care System, 2001

Step #3: *It's not what you know, its what you do.*



“The American health care delivery system is in need of fundamental change.”

“Between the health care we have and the care we could have lies not just a gap, but a chasm.”

Step # 4:

***Big solutions require
fundamental redesign of
the ways we deliver
care.....***

Organizations will need to negotiate successfully six major challenges:

- 1. Redesign care processes to serve more effectively the needs of the chronically ill for coordinated, seamless care across settings and clinicians and over time.**
- 2. Making effective use of information technology**
- 3. Manage the growing knowledge base**
- 4. Coordination of care across patient conditions, services, and settings over time**
- 5. Continually advance the effectiveness of teams**
- 6. Incorporate performance and outcome measurements for improvement & accountability**

Step #5: Common Chronic Conditions should serve as a starting point for the restructuring of healthcare delivery

“...the health care system must focus greater attention on the development of care process for the common conditions that afflict many people... nearly all these conditions are chronic.”

“Health care for chronic conditions is very different from care for acute episodic illnesses. Care for the chronically ill needs to be a collaborative, multidisciplinary process.”

Definitions of “Chronic Illness”:

“Chronic illness may be defined as a condition that lasts for a substantial period of time or has sequelae that are debilitating for a long period of time. It is also commonly defined as a condition that interferes with daily functioning for more than three months in a year, causes hospitalization for thirty days or more per year, or (at the time of diagnosis) is likely to do either of these.”

Jennings, Callahan and Caplan (1988)

The (Re)Invention of Care Management

- Care Coordination Program starts by targeting 2 broad categories of chronically ill people:
 - 1. Those at “high risk” for suffering adverse, expensive health outcomes (case management programs or **complex care management** programs).
 - 2. Those whose main health problems are certain specific diagnosis (**disease management programs**)

Step #6: Not everything fits neatly in single disease programs – “Complex Care Management”

- **Clinical role responsible for assessing patient status, environment, and self-management capacity and planning, organizing, implementing, and coordinating assistance and health care services to respond to the needs of patients with complex medical & psychosocial needs. This role involves extensive education/coaching of patients and family members to empower them in health management as well as intensive follow-up to monitor completion of care management interventions and patient status and progress.**

Step #7: Think (& practice) Disease Management

DM is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease Management:

- supports the physician or clinician/patient relationship and plan of care
- emphasizes prevention of exacerbations and complications utilizing evidence based 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 include:

- Population identification processes
- Evidence-based practice guidelines
- Collaborative practice models to include physician & support-service providers
- Patient self-management education
- Process & outcomes measurement, evaluation, and management
- Routine reporting/feedback loop

JCAHO Disease Specific Certification

- Utilize standardized method of delivering or facilitating integrated & coordinated clinical care based on evidence-based clinical practice guidelines
- Support a participant's self management activities
- Tailor treatment and intervention to individual needs

JCAHO Disease Specific Certification

- Promote the flow of participant information across settings and providers, while protecting rights, security & privacy
- Analyze and use data to continually improve treatment plans
- Evaluate ways to improve performance and clinical practice, thereby improving participant care

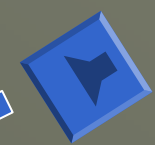
- Health Risk Appraisals
- Screening instruments
- High Cost Lists
- Predictive Modeling
- Disease Registries
- Data Dashboards
- Data Warehouse(s)
- Pharmacy claims
- ER utilization summaries

DATA



Complex Care Managers
(Health Navigators)

ER referrals



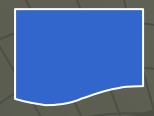
Inpatient Admissions (daily)



Disease Management Programs

- Heart Failure
- Diabetes
- Asthma
- CAD
- Depression

Health Plans



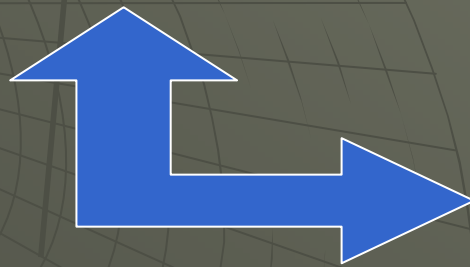
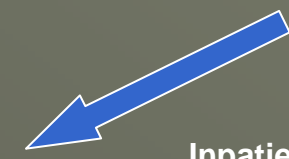
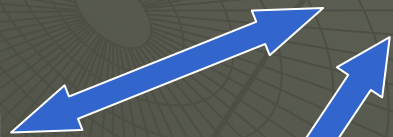
Public System Partners



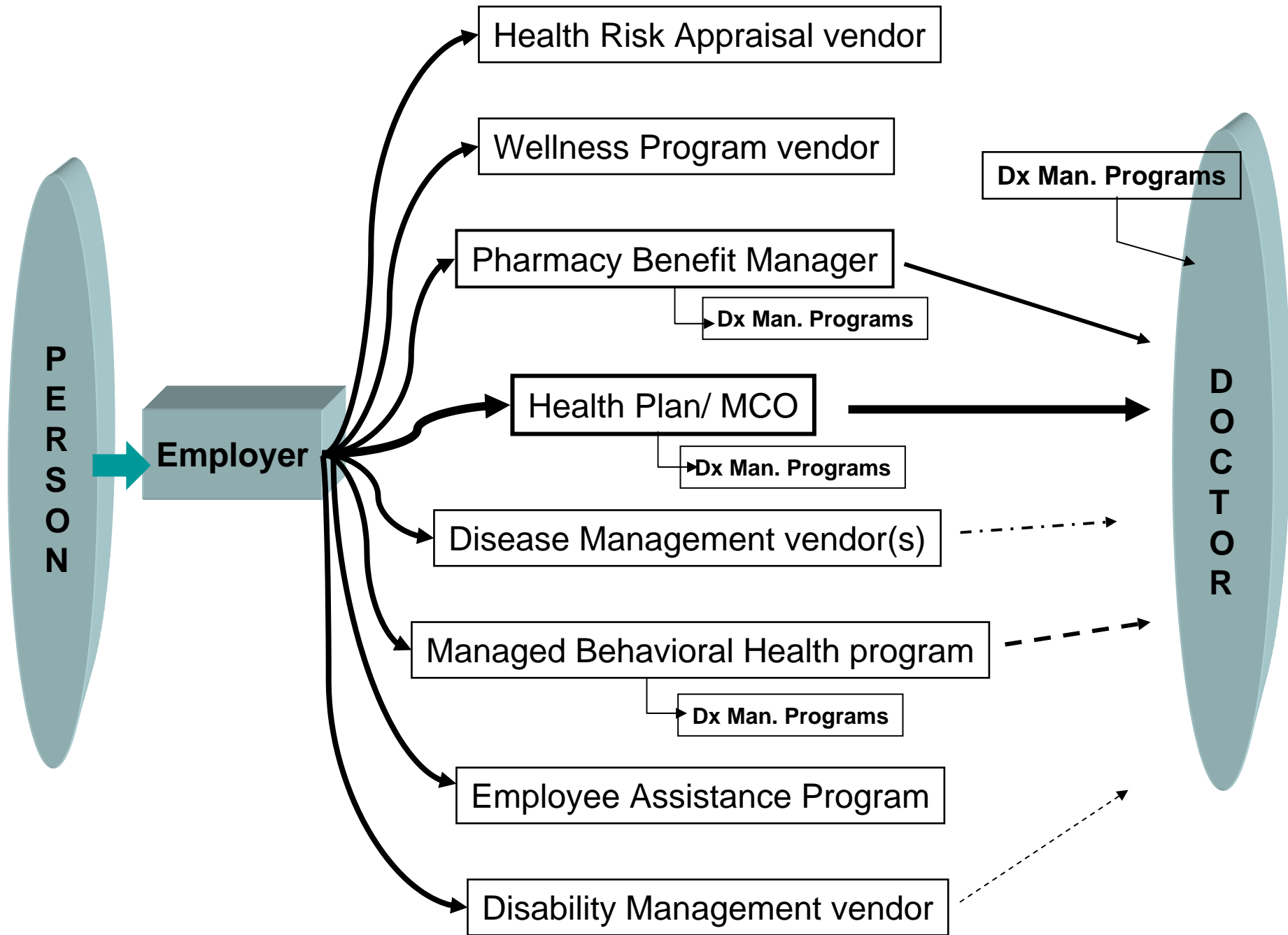
PCPs



Patients & Families



Step #8: Intermediaries move into
Market spaces



Step # 9: It's an ROI world

- Define the population to be measured
- Must move beyond pre-post
- Comparison group(s)
- Risk Adjustment methodologies
- Standardize cost/fee schedules
- Minimum time frames

Step # 10 : Paying for doing “right”

“Well, then, says I, what’s the use you learning to do right when it’s troublesome to do right and ain’t no trouble to do wrong, and the wages is just the same?”

Huckleberry Finn, Mark Twain (1884)

Newer Models of Reimbursement

- Administrative fees for Disease Management
- Tiered/stratified enrollment fees for disease management programs
- Pay for Performance/Pay for Quality
- Shared risk – Shared Savings

Step #11: Follow the path of Depression Disease Management & First create the environment

- Publicity & anti-stigma campaign
- Cost/outcome research
- Get the standard setters to make you a “metric”
- Employers pressure health plans
- Provider groups respond

Depression Disease Management: Program creation

- Find a buyer
- Link to physical health side
- Build or buy IT and data analytic
- Dedicated MSWs and RNs
- Call Center System
- Electronic charting
- Registries

Depression Disease Management: Program creation (cont)

- Stratification (Risk Assessment)
- Guideline driven protocols
- Treatment plans based on Goals
- Patient & Family education and self-management tools
- Prompts, reminders, dashboards
- Measure outcomes (including cost)
- Criteria for decreasing intensity of services

Step #12: Challenges for Substance Abuse and Addiction Treatment Services

1. “PR” problem
2. Cost/productivity argument yet to be made
3. Silo problem
4. Funding problem(s)
5. Anti-Evidence based medicine problem