CONNECTICUT CENTER FOR PRIMARY CARE

CareConcepts

Integrating Payor Sponsored Disease Management into Primary Care Practice

Executive Summary

Physicians' Foundation for Health Systems Excellence
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Introduction:
Primary care physicians and disease management entities are essential components to the disease management process. Each has substantial influence on the overall health of the patient, yet they work independently of each other to accomplish their goals. Improved communications between primary care physicians and disease management entities will only serve to improve the quality of chronic illness care.

In December 2005, the research team from The Connecticut Center for Primary Care (CCPC) received funding from Physician Foundation for Health Systems Excellence to implement a project called "CareConcepts: Integrating Payor Sponsored Disease Management into Primary Care Practice. The goals of the "CareConcepts" project are to improve the process of chronic illness care within primary care practices, and to improve clinical outcomes for chronic disease patients.

For Phase I of "CareConcepts", the specific objective was to identify barriers to the incorporation of disease management (payer sponsored) into routine primary care practice patient care. For Phase II, the specific objectives are: to educate providers about the capabilities of a disease management organization; to refine the 'CareConcepts' bi-directional communication tools for providers and disease management entities; and, to pilot the 'CareConcepts' communication tool, and develop appropriate workflows in "real world" conditions.

Methods:
In Phase I, the CCPC research team identified barriers to the integration of disease management in primary care practices. The research team sent surveys to 200 practitioners from ProHealth Physicians, a community-based physician network. In addition, the research team interviewed five medical directors of payer groups and disease management entities. The team qualitatively analyzed the data and diagrammed the data according to common themes. After compiling the data, the research team called together a panel discussion group representing physicians, disease management and payer entities, and an academic research team to help design methods to address the issues presented in the data.

With help from this panel discussion group, the CCPC research team utilized the barrier data to design a communication tool and work flow model between primary care practitioners, patients, and disease management entities. For Phase II of the CareConcepts study, the CCPC research team has created a pilot study designed to develop, refine and test a provider-based educational module on disease management capabilities, as well as the 'CareConcepts' communication tools. ProHealth providers and staff devoted to this project will also undergo extensive orientation regarding workflows and resources.

Data Analysis:
What is apparent from the literature review is that there is little research on the barriers of integrating disease management in primary care practice. Though quantitative analysis of the results is impractical due to the inclusion of anecdotal reports (Medical

Directors interviews, and open-ended physician survey questions), the study team is working to publish the results, including the process of developing a potential communication tool. The key results are listed below.

Survey of Primary Care Providers (MD, DO, APRN and PA)

Sixty-eight out of 200 providers responded to the survey. Of these respondents, 28% completed the survey online. The respondents have been in practice for an average of 18 years. They see an average of 23 patients per day; and, on average, 48% of their patients have a chronic illness.

Barriers to DM

- 33% believe that DM causes fragmented patient care
- 51% believe data accuracy is some or significant barrier
- 43% believe report timeliness is some or significant barrier
- 55% believe report relevance is some or significant barrier
- 42% believe lack of reimbursement is some or significant barrier
- 76% report the additional task in busy office as some or significant barrier
- 40% report the absence of electronic connectivity as some or significant barrier
- 92% of the respondents would feel more inclined to participate if they were reimbursed for their time

Interviews of Disease Management Medical Directors

The Medical Directors from five Disease Management entities agreed to be interviewed. For each entity, the Medical Directors expressed the main objectives of the Disease Management program as: to improve health outcomes, to achieve cost savings, and to follow NCQA standards. All of the entities use predictive modeling to determine risk levels for the patients, as well as evidence-based practices to formulate the DM guidelines. The health care teams (nurses or doctors as case managers) then coordinate disease management using telephonic monitoring.

Barriers to DM

- Lack of willingness to change behavior (Process and behavioral change); see chronic disease patients who are non-compliant more so than for acute illnesses like cancer;
- Contacting individuals who do not have phones; interaction with PCP to get contact information
- DM nurses have difficulties communication with PCPs – need calls to be doctor to doctor in order to open up respectful communication; PCP's only embrace DM when DM nurses are successful
- Lack of trust of PCP on true goals of health plans, so they don't help enforce patient compliance
- Not enough referrals from PCPs
- Communication difficult because of PCP time limitations (they are too busy to expect them to read reports)

- Receive negative reaction from PCPs who don't feel DM is appropriate/that it interferes with their care.
- Not viewed as a resource by most PCPs.

Development of Potential Resolutions: New system models

Utilizing the data, the research team called together a panel discussion group representing physicians, disease management and payer entities, and an academic research team. The group met bi-monthly to design an effective workflow model between primary care practitioners, patients, and disease management entities. Please see Appendix A for diagrams of the models described below.

Current Model:

For the current Disease Management system, disease management occurs without the involvement of the Primary Care Provider. Though the payers use predictive modeling to determine patient risk levels, and base the disease management program on the risk level, at no time do the DM entities contact the PCP for input on the care program. Most reports sent to the PCPs are irrelevant to the PCP's care plan for the patient, or inaccurate due to patient misperceptions or timing issues. Because of this gap in care, the disease management programs miss complicating factors due to co-morbidities, or other factors which are known by the PCPs.

New Model #1 Addendum to current system:

The aim of this model is to distill current information sent to the PCP's from the DM entities. This is a one-way communication model originating from the DM entities. In this model, the ProHealth Physicians central office would house a liaison (a nurse or trained medical professional) to communicate the disease management protocols between provider sites and MCO/DM entities. This person will receive the DM reports, weed out appropriate information, andreturn information to PCP using a standardized form.

Model #2 New (Business/Clinical) – Standardize Data Content:

The aim of this model is to reform the current process by giving the PCP's some control of DM for their patients. In this model, the PCP's will work with an MCO in Connecticut to develop a consensus driven health plan, a payer-physician model. Working together, the payer and PCPs will agree on at least 5 elements of a communication protocol for one disease state including its impact conditions. In addition, the reimbursement will be based on a system already in place (i.e. P4P). This model has three different scenarios: 1.) The PCP generates generic script for patient to call DM entity, chosen according to their insurance plan; 2.) The PCP generates a generic script for DM entity to call patient (chosen according to patient's insurance plan); or 3.) The PCP generates generic script for DM entity incorporating EHR methodology.

Model #3 New Model – PCP leads care management team:

The aim of this model is to fill in the defects of current system, and, like Model #2 will give the PCPs some control of the DM process. In this model, a form will be created for the PCP to list orders for DM entities. These orders will be based on: cognitive goals (patient understands disease), behavioral goals (patient loses weight, stops smoking,

etc), and skills (patient learns when to take meds, or how often to check blood glucose). In general, the PCP will generate an order to the DM entity as a supplement to treatment plan.

Theoretically, this model will eliminate the current barriers listed by PCPs in the survey, such as lack of reimbursement, lack of relevancy, and inaccuracy of reports. In addition, this model addresses the Medical Director concerns regarding the lack of referrals from PCPs.

Model #4 Disease Management in Primary Care:
The aim of this model is to give the PCP full control of the disease management process. For this model, ProHealth Physicians hires a Care Coordination team, housed in the central office. The PCP will create care orders. These 'orders' will be handed to a "care coordinator" who will make sure they are accomplished. This care coordinator will find available resources and get patient to the resources. Resources include: disease education (start with diabetes), smoking cessation programs, specialist appointments, and/or follow-up calls. Most care coordination will include telephonic monitoring, but will depend on patient risk, disease severity, and needs.

Development of Potential Resolutions: Communication Tools
After determining what appears to be the most effective workflow, the group created a communication tool to help expedite the transfer of patient-specific health information between the disease management entities and the primary care practitioner. The communication tool includes information specific to disease state and to disease management issues. Theoretically, the tool will allow the PCP to help guide the long-term care plan for the patient diagnosed with diabetes, COPD, CAD, CHF, and/or Depression.

Conclusions:
This study has successfully proven that communication is a key barrier toward integration of disease management into primary care. During Phase II of the CareConcepts study, the research team will pilot the communication tool and Model #3 in two to three ProHealth practice sites. The CCPC research team hopes to incorporate an improved communication process to improve chronic disease outcomes for patients of ProHealth Physicians providers. In addition, the team hopes to pave the way for direct transfer of patient-specific health information via electronic health records.

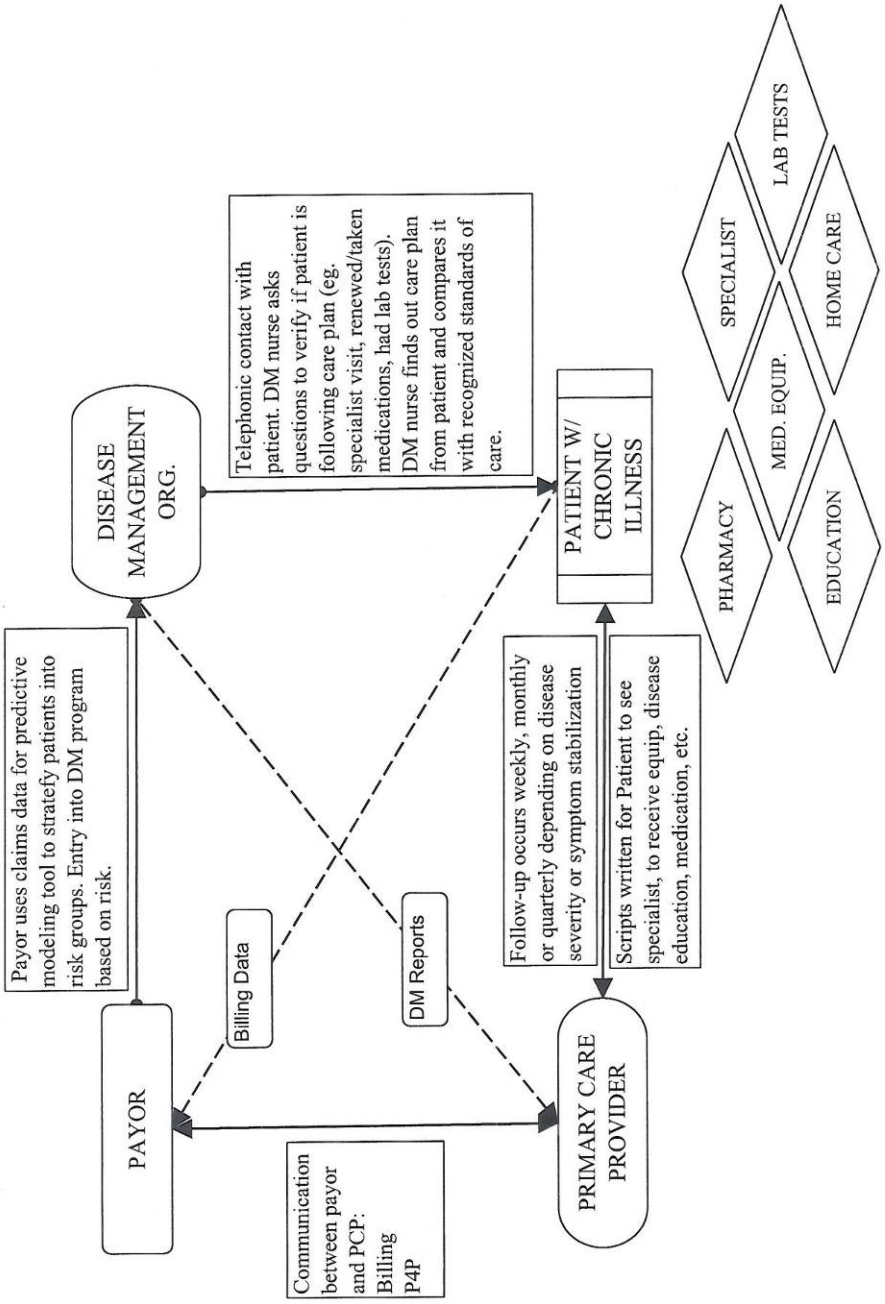
If successful, the CCPC research team hopes to continue to work with a disease management entity to secure additional funding. Future studies include the development and demonstration of a business model. For the development of a business model, the research team will develop a case study to test the revised model piloted in Phase II. The study design will take into consideration the cohort size and description necessary to establish clinically meaningful and statistically significant clinical outcome measures, as well as patient satisfaction measures. In addition, the purpose of this study is to determine the financial return on investment (ROI) in order to

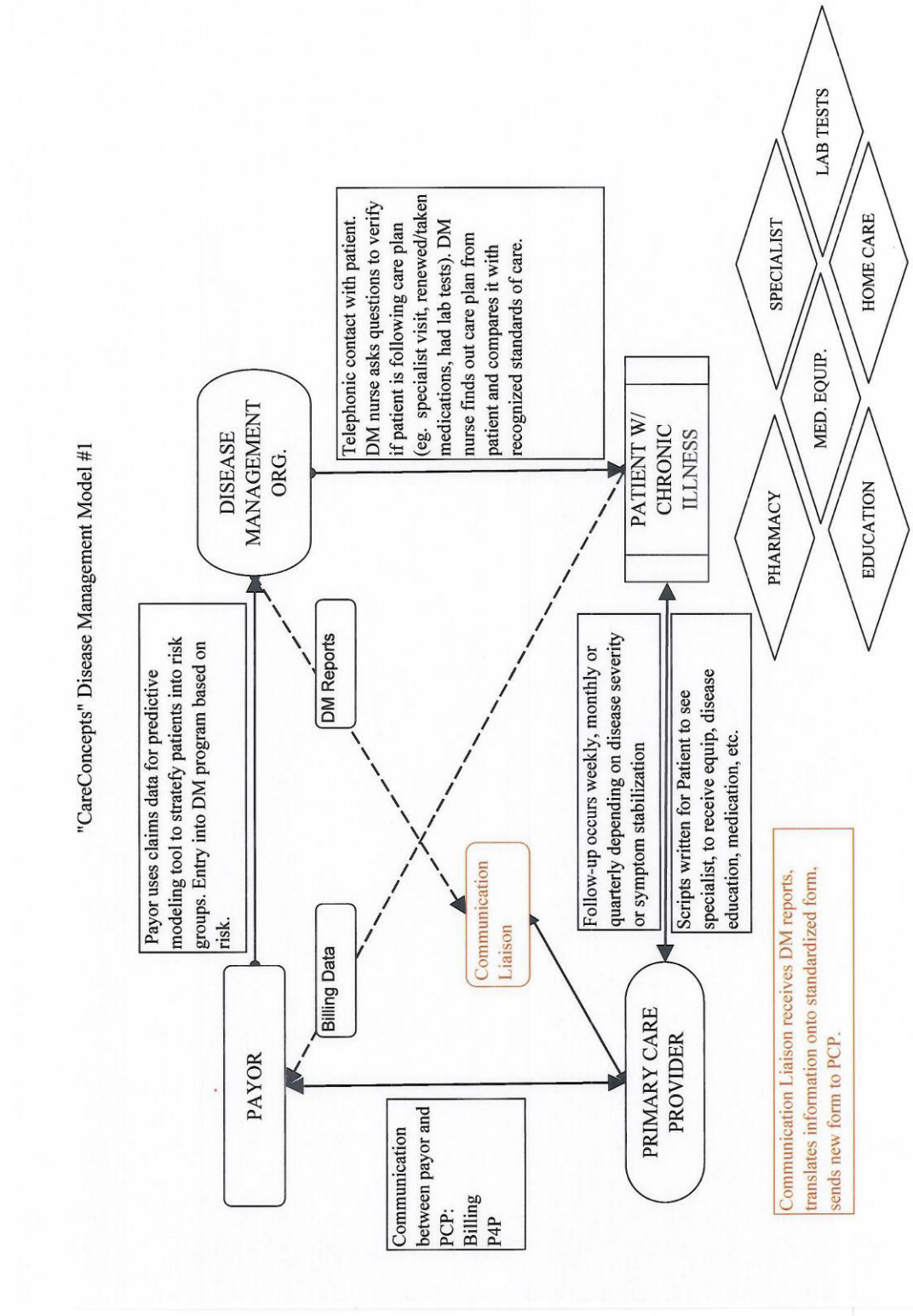
help develop a new value-based reimbursement structure for providers relative to disease management.

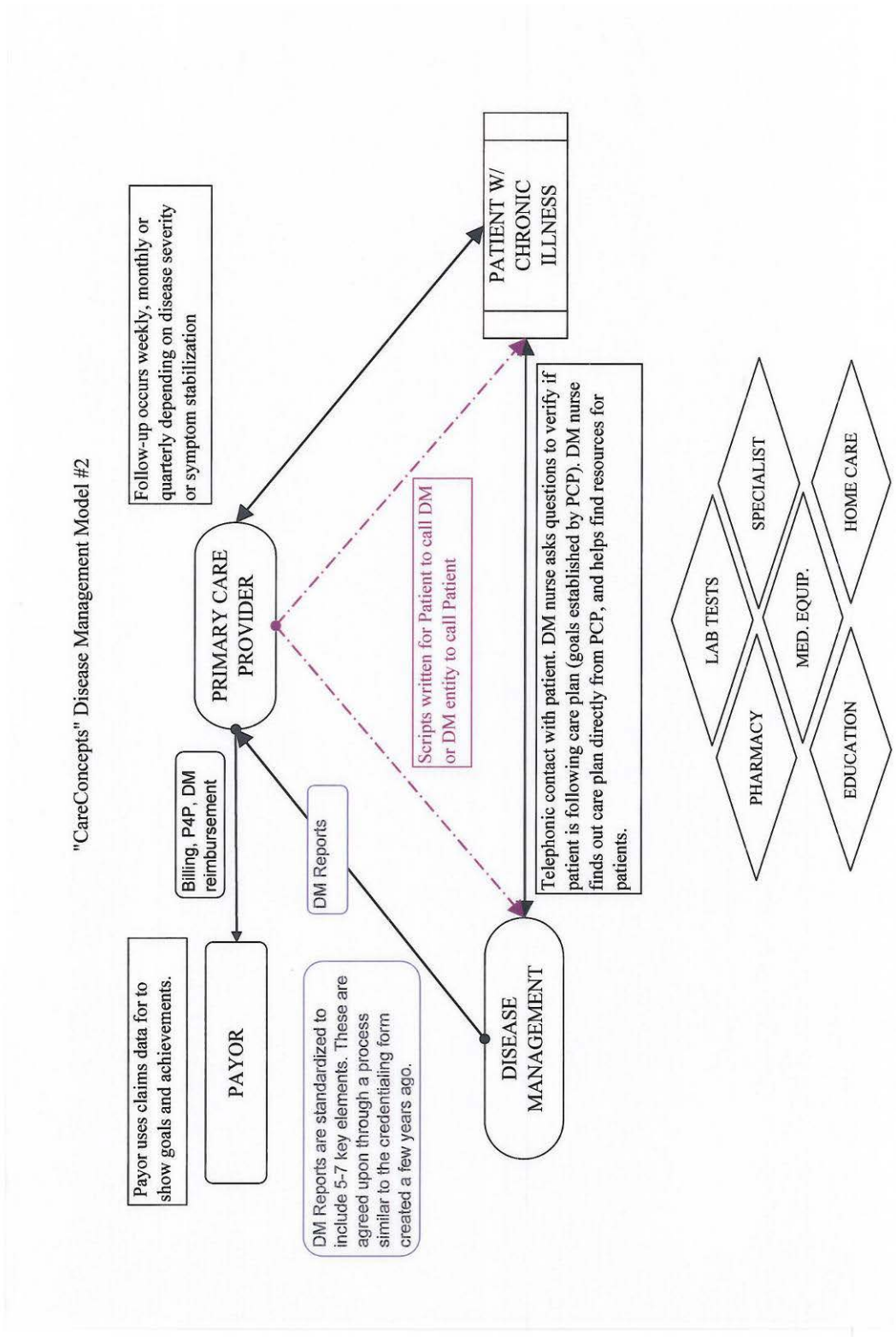
For the demonstration of the business model, the CCPC research team will present a Business Case to gain financial support for the implementation of a larger scale business model. This business model will include new, value-based reimbursement methods for practitioners who incorporate disease management and other innovative practice re-design concepts into practice.

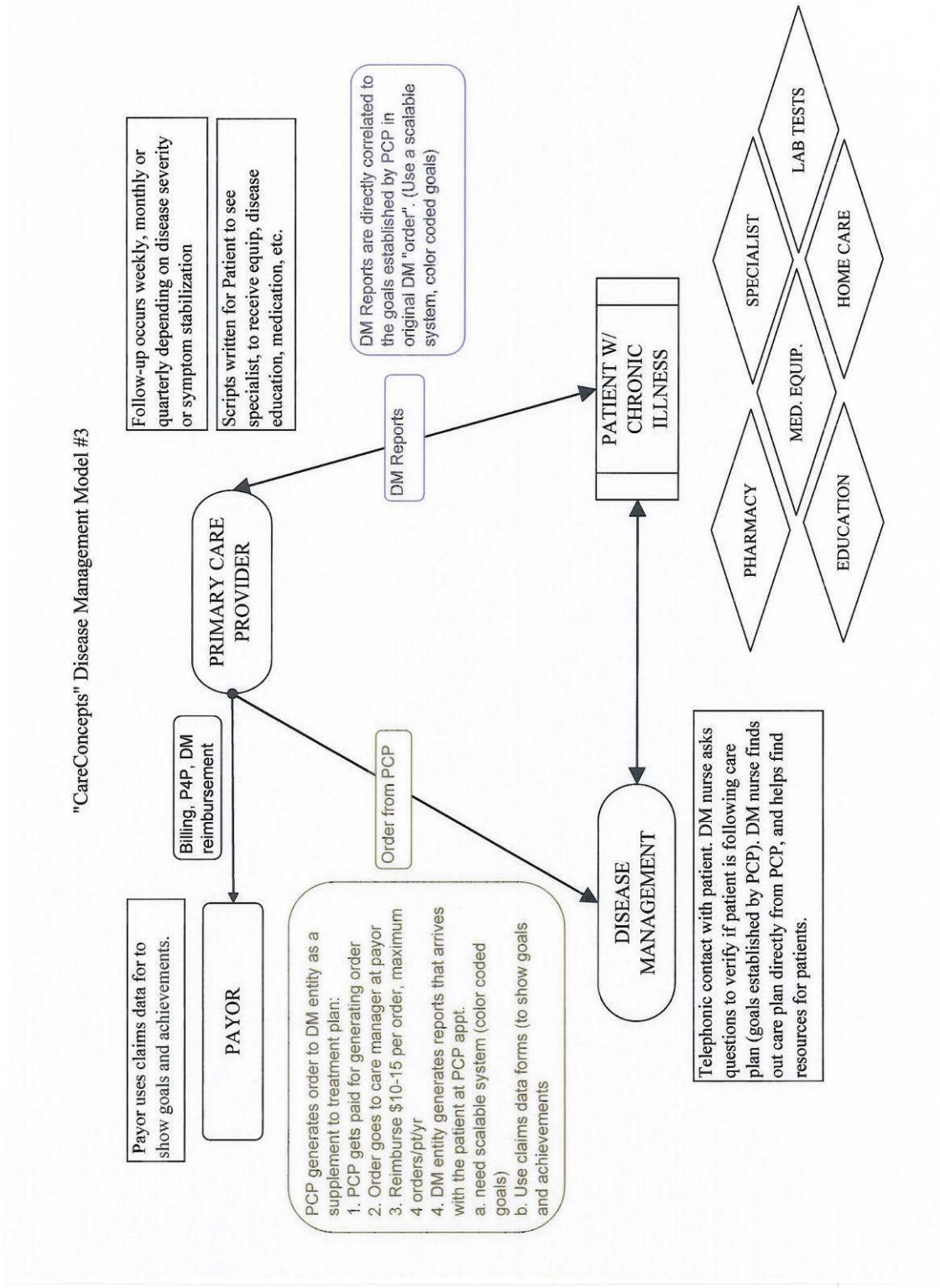
Appendix A: Communication Model Diagrams
Appendix B: Structured Communication Tool

CURRENT DISEASE MANAGEMENT MODEL

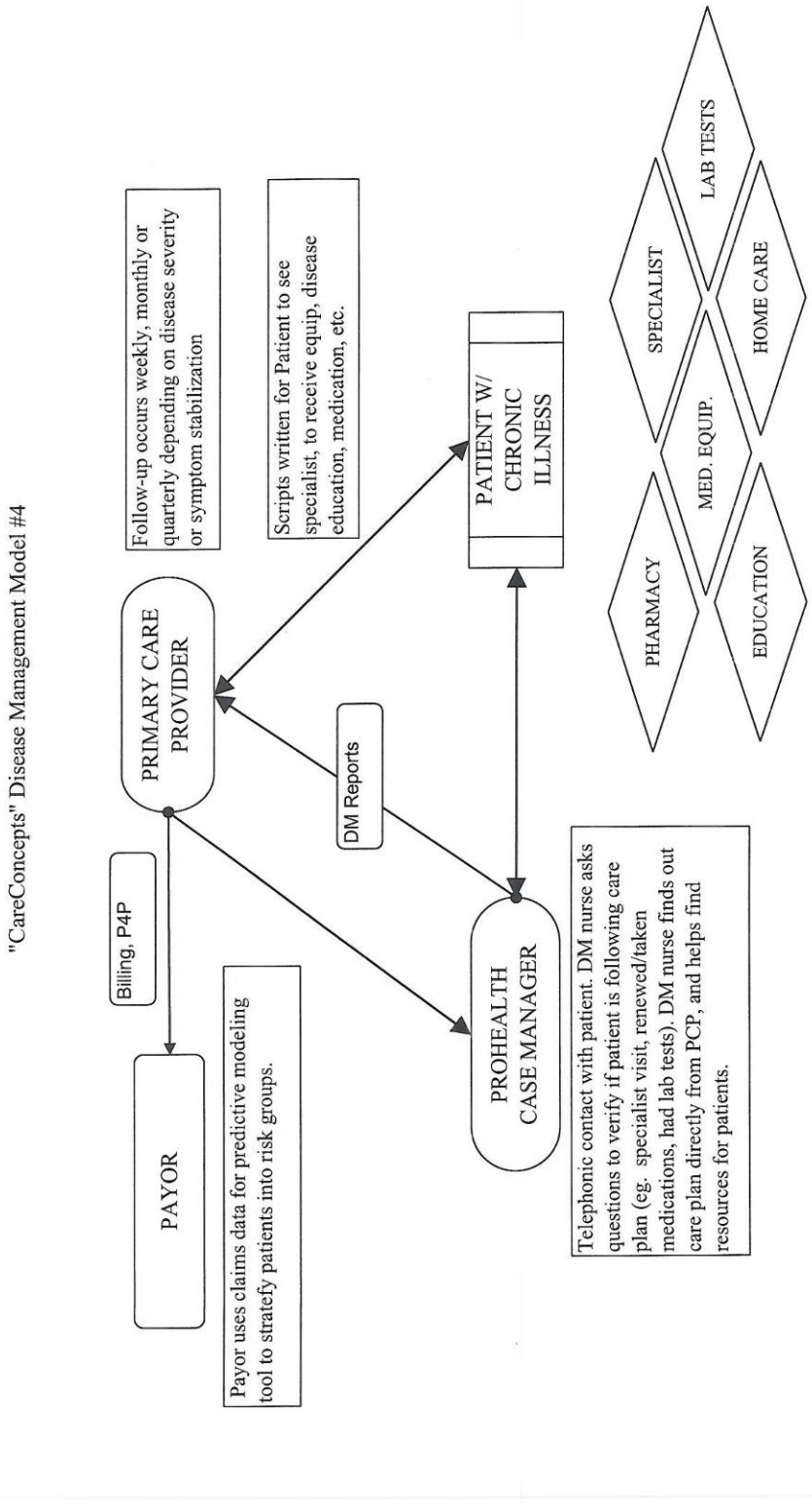



"CareConcepts" Disease Management Model #1
DISEASE MANAGEMENT ORG.
Telephonic contact with patient. DM nurse asks questions to verify if patient is following care plan (eg. specialist visit, renewed/taken medications, had lab tests). DM nurse finds out care plan from patient and compares it with recognized standards of care.
PATIENT W/ CHRONIC ILLNESS
PHARMACY
SPECIALIST
LAB TESTS
MED. EQUIP.
HOME CARE
EDUCATION
Payor uses claims data for predictive modeling tool to stratefy patients into risk groups. Entry into DM program based on risk.
DM Reports
Billing Data
Communication Liaison
Follow-up occurs weekly, monthly or quarterly depending on disease severity or symptom stabilization
Scripts written for Patient to see specialist, to receive equip, disease education, medication, etc.
PAYOR
PRIMARY CARE PROVIDER
Communication between payor and PCP: Billing P4P
Communication Liaison receives DM reports, translates information onto standardized form, sends new form to PCP.


"CareConcepts" Disease Management Model #2
Follow-up occurs weekly, monthly or quarterly depending on disease severity or symptom stabilization
PATIENT W/ CHRONIC ILLNESS
PRIMARY CARE PROVIDER
Billing, P4P, DM reimbursement
Payor uses claims data for to show goals and achievements.
PAYOR
DM Reports
Scripts written for Patient to call DM or DM entity to call Patient
Telephonic contact with patient. DM nurse asks questions to verify if patient is following care plan (goals established by PCP). DM nurse finds out care plan directly from PCP, and helps find resources for patients.
DM Reports are standardized to include 5-7 key elements. These are agreed upon through a process similar to the credentialing form created a few years ago.
DISEASE MANAGEMENT
LAB TESTS
SPECIALIST
PHARMACY
MED. EQUIP.
EDUCATION
HOME CARE


"CareConcepts" Disease Management Model #3
Payor uses claims data for to show goals and achievements.
PAYOR
Billing, P4P, DM reimbursement
PRIMARY CARE PROVIDER
Follow-up occurs weekly, monthly or quarterly depending on disease severity or symptom stabilization
Scripts written for Patient to see specialist, to receive equip, disease education, medication, etc.
DM Reports
DM Reports are directly correlated to the goals established by PCP in original DM "order". (Use a scalable system, color coded goals)
PATIENT W/ CHRONIC ILLNESS
Order from PCP
PCP generates order to DM entity as a supplement to treatment plan:
1. PCP gets paid for generating order
2. Order goes to care manager at payor
3. Reimburse $10-15 per order, maximum 4 orders/pt/yr
4. DM entity generates reports that arrives with the patient at PCP appt.
a. need scalable system (color coded goals)
b. Use claims data forms (to show goals and achievements
DISEASE MANAGEMENT
Telephonic contact with patient. DM nurse asks questions to verify if patient is following care plan (goals established by PCP). DM nurse finds out care plan directly from PCP, and helps find resources for patients.
PHARMACY
SPECIALIST
LAB TESTS
MED. EQUIP.
HOME CARE
EDUCATION

"CareConcepts" Disease Management Model #4



ProHealth Disease Management Program - Physician Order Form			
Todays Date:		DM Company:	
Patient ID#		DM Contact:	
Patient Name:		Next Appointment Date:	
Date of Birth:		Doctor ID#:	
Home Phone#:		Insurance Company:	
Email:		Insurance ID#:	
Preferred Contact Time:		HIPAA-authorized: Yes	
Diagnosis (Please Check):		Other Pertinent Diagnoses:	
□ Diabetes □ COPD □ CHF □ CAD			
New Medications:	Recent Lab Results:	Biometrics:	Other:
(See Attached Sheet)	(See Attached Sheet)	BP:_____ WT:_____	_____ _____
Please select the specific goals you wish your patient to attain			
Goal Achievement Schedule : (please circle)			
1 month	3 month	6 month	Other: _____
Case Management Concerns (Please check all that apply)			
□ Tobacco Use □ Weight/Diet Management _____ pounds per week □ Increase physical activity: _____ minutes per week □ Uncontrolled Diabetes □ Newly Diagnosed Diabetes □ Uncontrolled Hypertension □ Newly diagnosed heart failure □ Worsening heart failure □ Asthma Triggers □ Promote medication adherence □ Manage stress □ Reduce alcohol intake □ Other _____		<<Special Considerations>>	
Healthcare utilization - check and list all that apply:			
□ Hospitalization		Date_____	Reason_____
□ Emergency Room		Date_____	Reason_____
□ Specialist		Date_____	Reason_____
□ Primary Care visit		Date_____	Reason_____
Check and list all that apply:			
□ Last EF Measurement		EF%_____	Date_____
□ Last A1c		_____%	Date_____
□ Last Lipid Panel		Total ____ HDL_____ LDL _____ TRI _____	Date_____