How to Evaluate Disease State Management Programs

What are disease state management programs? How do they work, and how are they evaluated? One method can enable MCOs to evaluate these programs so that the purchaser can identify what they actually are purchasing.

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There is confusion in finding a definition for disease state management (DSM). Each program that is offered seems to define the concept differently. However, there are commonalities that offer the potential to bring some unity to this issue.

Fundamentally, there is general agreement that DSM deals with a "systems approach" that includes a continuous quality improvement program for the entire process of managing disease. The second common understanding is that it is a "systemwide approach", meaning that it is not specific to the site (e.g., hospital, clinic, physician office, etc.). We are not dealing with specific stakeholder issues or what they can do to improve particular programs or costshift to another stakeholder. The third fundamental understanding is that there is some sort of a "comprehensive integrated approach" that allows care to be seamless, regardless

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of the site or condition of the patient.

The question that remains unanswered and unresolved is how we integrate or align the incentives between the provider, the insurer, and the disease management company, and how these incentives will be integrated into what is being offered. It also is necessary to address whether DSM is specifically disease based, outcomes based, education based, or patient-specific versus epidemiological based.

PARADIGM SHIFTS

The disease-based approach poses this problem: do we really manage disease or do we manage people? It seems clear to this author that we manage patients/people. With this assumption, is our emphasis in DSM entirely on disease or is it on a much broader perspective that includes the maintenance of health and wellness? DSM should be involved in the entire scope of care. However, when the focus is on managing the host, not just the disease, the illness model is much clearer. The "Managed Care Pyramid" typifies the levels of the problem (see Figure 1).

Moving from treating illness to managing hosts means moving from a known to an unknown entity, specifically an experience-based health care system to an inexperienced one. What is less clear is how to deal with the wellness part of the model. The management of health care includes the management of patient issues that are based heavily on individual discretion. This leads to the concern about how we align incentives in the DSM process. The example of car insurance illustrates this problem. If a person has a terrible driving record, he or she frequently pays more for insurance. The disincentive is financial. DSM programs are similarly directed to the financial incentive of saving health care dollars, but it is unclear if DSM programs directed to financial disincentives are creating a model for health care that actually is going to motivate change.

The Managed Care Pyramid directs

Figure 1. Managed Care Pyramid

attention to examining "financial issues" in relation to the "care issues." While out-of-pocket cost is the initial concern, the next step is the concern of laying off some personal risk by risk-sharing with health care insurance; and the final step is determined by how much health care the patient can afford.

DSM programs also exemplify the "component focus" as compared to the patient-centered focus. There is a long history of drug treatment or hospital-based systems with treating sickness, but how does health care approach a patient-centered focus that is not dependent on the site or method of care? Clearly, an information system is required as the patient moves through different sites of care and between different caregivers. This presumes that all sites and caregivers talk to each other. However, this is not necessarily true in today's health care system. Furthermore, there is not necessarily an alignment of incentives between the different sites and caregivers; thus, the continuum-of-care model for DSM is still not a reality. This causes confusion in that the purchaser of a DSM program is trying to understand what is being purchased. Is it a program for improving the efficiency of a component (e.g., asthma care in the ambulatory setting), or is it a program covering the entire spectrum of a patient-centered care system?

The component focus is exemplified by DSM programs that target specific medications or payor groups versus case management for the management of the patient. However, case management requires a database. The DSM program that deals with case management

Figure 2. Supply Side vs. Demand Side

SUPPLY SIDE	DEMAND SIDE
Providers	Patients
Managed Care Organizations (MCOs)	Employers
PBMs	Insurers
Drug Manufacturers	Government

must address the requirements for resources and capital to build the information systems to be able to take advantage of whatever is being offered.

Another aspect is the "enterprise focus" (i.e., hospital, clinic, ambulatory, etc.). Disease management programs that are delivered more from an integrated health network standpoint fit this particular approach significantly better than other kinds of definitions and models.

DSM programs marketed as "education based" are potentially redundant in that the provider already is supposed to be educating patients as part of their customary treatment. Patient education materials are directed to making a better-informed consumer who is prepared to make better buying choices. These programs are not disease management. They are actually directed toward differentiating one product from another so that people will understand the benefits of the product offering.

Those DSM programs that are focused on specific diseases are dependent on how the patients are identified (i.e., utilization review). If utilization review is based entirely on high cost programs using, for example, an asthma model, the program will select out COPD patients that are dealing with less expensive theophylline and corticosteroids, versus the more expensive people who are involved with all the bronchodilators.

STAKEHOLDERS

The intelligent purchasers must understand who the various stakehold-

ers are in health care and their different motivations (see Figure 2). There are those involved with the "supply side" (i.e., the providers and insurers), and those involved with the "demand side" (i.e., patients and payors).

On the supply side are people who assume risk all the time, such as physicians, pharmacists, or health plan providers. Insurance sharing targeted to a subset of the population needs to be focused on how to lay off some of that risk to reinsurance and stop loss protection, rather than how to lay it off to DSM or to the pharmacy benefit. The real question for supply siders, then, is what is their particular risk and how do they identify it?

The biggest problem here is that each stakeholder has different incentives. PBMs and pharmacists managing the pharmacy benefit for health plans are managing the local optimums exemplified by the drug budget. Likewise, physician providers are dealing only with those specific issues that impact their patient encounters. Managed care organizations who do not have many assets must lower their costs to make them more competitive and more attractive to capital investors. PBMs are trying to identify how they can differentiate themselves in the marketplace. DSM programs offered by drug manufacturers frequently are product based. These programs are targeted at improving market share, not disease management. Therefore, DSM programs offered by these stakeholders are designed to achieve competitive advantage or individual cost containment for the stakeholder and are not necessarily dealing with overall integrated, systemwide disease management.

On the demand side, patient and employer concerns are directed both to lowering the cost of care and ensuring that providers are committed to excellence. The expectation is that the DSM program is focused on quality. There may be a difference, and depending on how one defines quality and what is being offered, demand- and supply-siders may be mismatched.

Given the paradigms, the stakeholders, and the mismatches, the question is what do we look at when we have these service portfolios and we're trying to figure out just what it is that everybody's offering to us. There are several different issues here that are both product- and service-driven. If the concept is to improve on a drug or a therapy, then the focus is self-serving, giving impetus to a process that improves market share or does something to differentiate a given product.

Another issue to consider is where to emphasize the role of insurers as they move from a fee-for-service to a capitated environment? They have not done well in the past with regard to health care because they have not been able to deal with the utilization issue; and so their particular regard would be where utilization is being managed. From government's standpoint, the real issue is where the payoff is and how to deal with removing the inefficiencies in the system. Therefore, the answers are in the various offerings and the multiple stakeholders that have differing incentives here, what kind of paradigm shifts are involved, and how to use them to evaluate the particular offerings that are placed on the table. The bottom line for the purchaser, as each DSM company lays its particular offering on the table, is to determine what DSMs are and how they are differentiated, what they actually offer, and what ultimately is the payoff.

SERVICE PORTFOLIOS

In the marketplace, DSM programs generally are undifferentiated. This may benefit the purchaser by introducing competition to lower prices for these programs, but the winners in the DSM market will be decided by the market according to how much they buy a particular concept and whether one program and its particular value-added services are much better than the competition. The product-versus-disease focus should do a couple of things from the purchaser's standpoint:

▲ It should improve the efficiency of the system and decrease the overall unit cost of that system. This does not imply a cost-accounting emphasis on slicing and dicing every expense. It does imply that the bottom line costs should decrease. DSM programs targeted at deemphasizing high unit costs of drugs do nothing more than shift a high product cost into the disease expense where it cannot be isolated from other expenses to determine which factor is relevant in cost containment.

▲ The DSM service being offered should be unrelated to products. A clear definition of the service is required to determine whether the offering is something that is not already available internally or that it is a facilitation service to get the purchaser into something for which it does not have the resources or the knowledge base currently. The DSM service offerings that are unrelated to product frequently are characterized by an ill-defined concept and ask the purchaser to define what their service or product should be. These particular offerings should be short-lived in the marketplace as they offer little value.

▲ The service should have a very well-defined benefit. If a consultative service is being offered for developing information systems, there may be a significant benefit to those providers who have minimal expertise or capital to create their own systems. Also, DSM programs offering outsourcing of information system management, as is done currently in other industries (e.g., automobile manufacturers and financial institutions), offer provider groups required expertise without huge capital investments in equipment and programming. This may lead to new entrants into the DSM market. DSM/consulting type of offerings will be decided by need and potential for return on investment.

DSM education offerings should be based on behavior modification leading to healthier lifestyles and personal responsibility for health care decisions. Those DSM products that are entirely based on patient education seem to suggest that health care providers have

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done a poor job of educating patients and the public at large. High variability in the quality, costs, and delivery of care indicate that more information is needed by purchasers. Since risk is diversified with more knowledge and a more competitive marketplace is designed with more knowledge, those programs that offer a true-knowledge information database to providers may be offering them something that they can use.

Important questions to be asked are: What are the administrative costs involved? Is this a Total Quality Management (TQM) approach? Is the benefit sustainable and is it going to give us continuous benefit both in quality and cost? Is the benefit short or long range?

TOTAL QUALITY MANAGEMENT

The downside to Total Quality Management (TQM) is that the costs are front loaded. There is a significant cost in implementing TQM in terms of resources, people, information systems, and money. The initial high costs of TQM may not be offset immediately by the initial benefits. As the TQM program matures, benefits become incremental and improvements are derived from smaller improvements through a Continuous Quality Improvement (CQI) process. CQI works on the marginal expense side. As a result, there should be decreases in overall marginal expense. Therefore, the initial expense reductions from a TQM approach may not be sustainable. DSM programs based on TQM may provide significant benefits at the beginning while they improve inefficiencies and remove the "fat" from the system. However, is it sustainable and are we going to get an adequate return from regular payments to DSM programs, or should we have flexible payment structures based on the value received at each phase of the program?

One other caveat is important with regard to TQM offerings. A fundamental principle in business is to keep core competencies internal without outsourcing them. When DSM programs based on TQM offer to improve core services

by outsourcing them to the DSM vendor, the provider or purchaser is allowing their core competencies to be managed by someone else. These programs do not manage disease states, nor do they help any of the providers to manage risk. They are identifying that some providers should not accept risk. As a result, these types of DSM programs will not have a long life.

OUTCOMES ASSESSMENT

DSM programs that focus on outcomes assessment are delivering benefit metrics. CQI programs should be implicit in these offerings so that the outcome is actually being delivered. It is important for the purchaser to ask whether he or she is buying the outcome itself or the ability to measure the outcome. If a provider's performance is not very stellar and someone else can do it better, a CQI program will be necessary to improve the benefit metric, i.e., the purchaser's report card. Measurement and improvement cannot be separated.

Compliance Enhancement

Those DSM programs offering compliance enhancement are not offering disease management. Fundamentally, compliance enhancement is a CQI program to improve performance. Compliance issues do not deal with broad perspectives; they deal with the fact that a provider hasn't done a good job and offer a method for improving it. There is an obvious benefit in improving care; in fact, patients improve, drug manufacturers make more sales, providers can view the actual performance of given therapies, and insurers benefit from lower risks of complications compared to poor compliance. These benefits should ensure that providers pay attention to compliance issues as one of their basic functions. This is not DSM, but rather is one of the components of delivering efficient care.

Risk Issues

Risk from the standpoint of

providers is relatively clear. Providers have risk. DSM programs that offer to share risk are the concern. These offerings are hard to understand. Current DSM programs focus on specific diseases with groups that have small numbers of patients and high adverse selection and/or those that have usually been selected by high cost utilization screens. These utilization review screens have excluded a significant percentage of the population that allows some latitude to dilute risk and provide for reasonable financial controls through stop loss protection and re-insurance. So, why do DSM programs want it in the first place?

In DSM risk-based offerings, there has to be some alignment of incentives to meld core competencies between providers. The core competency of the provider is clear, but what core competency does the DSM company bring to the table and is that competency already available from specialists within the provider network? Is the DSM risk-based offering a CQI program or is it providing a competency that is not available within the network, such as information management, programming, or data mining? If a commercial population is involved, then the risk stratification has to deal with cost. If a MediCal/Medicaid program is involved, the provider is dealing with the risk of both cost and access. A Medicare population requires dealing with access (i.e., location of care, cost of care for expensive procedures and treatments, transportation) predominantly, because cost already is high. The focus is not on short-term gains but on limiting long-term risk from co-morbidities. Access issues are internal network problems or administrative management problems. DSM programs that offer advisory and facilitation assistance are consulting and not risk sharing. Consulting happens at the front end, not the back end.

OUTCOME INCENTIVES

Outcome incentives must match clinical, humanistic, and economic outcomes desired; and they need to be

Figure 3. DSM Cycle

1. Moving clockwise around the cycle starting at "Compliance and operational efficiency," the benefit is improvement in care.
2. Clearly, there needs to be an "information and knowledge base" in order to differentiate and diversify risk and to make sure that the consumer base is well informed. The payors must understand what they are buying and how they will get a continuing improvement in their overall system from just a one-time or short-term improvement in compliance.
3. Moving to the "corrective action" or the budget versus actual that gives us some sort of a modification; hopefully, not just educational but truly behavior modification. This moves us into the wellness where there may not be a good model. The DSM company should have a model that would give us a better system for dealing with behavior modification and aligning incentives between providers and patients.
4. Moving to the "practice guideline care management" kind of approach where we are not improving what we've done, go back to the outcome and start the process all over again.
5. If sustainability isn't involved in the disease management program, then fundamentally we don't have it.

defined by the purchasing organization. When different DSM companies present their competing portfolios, it is necessary to determine if the offering is consistent with the philosophy, programs, and incentives of the purchaser. This is not unlike managing any portfolio of risk.

When a DSM company identifies that it wishes to share in the capitation risk, the question is which piece of risk is the company going to provide and where is the benefit? In carve-out programs, (e.g., pharmacy carve outs), the benefit of a DSM company is limited to cost inefficiencies of the carve out, which are a one-time fix. Acute care programs are attractive in carve outs because they have a clear therapeutic endpoint with an immediate financial impact. On the other hand, in integrated systems DSM programs may have a greater impact on chronic therapies by dealing with long-term issues.

DSM Cycle

To evaluate TQM programs offered by DSM companies it is helpful to view the DSM process as a cycle (see Figure 3). The process is not unlike that used to establish a budget. The process allows evaluation of a program's sustainability.

Evaluation of Offerings

Since there is no well-established method in the literature for evaluating DSM programs, the evaluation tool in Figure 4 is suggested for purchasers, be they providers or payors. There must be a clear understanding of whether the program is directed to a specific enterprise or the entire delivery system.

BACK TO THE BEGINNING

Going back to the beginning, a major problem remains with the varied

Figure 4. Evaluation of Offerings

1. There should be an emphasis on health care, not therapeutics.
2. There must be provider network support.
3. Programs should include member education and motivation elements.
4. There should be an integration of the delivery system.
5. There should be a clearly defined system for organization and management.
6. There should be well-defined contractual criteria including performance criteria.
7. There should be a program for information management included.
8. There should be a well defined program for measuring outcomes.
9. The economic impact must be well defined.
10. There should be a risk assessment to base any risk sharing.
11. There should be a clear understanding of whether the program is a strategic partnership or a service offering.
12. There should be a clear evaluation of the TQM impact as an expectation or added value.
13. There must be performance audits and service guarantees, if applicable.

definitions of DSM. This problem raises several questions that reveal a parallel problem, since the concept is continually evolving: Is this a business looking for a customer? Or is it a customer looking for a business? Is this a scheme for a provider network or DSM firm trying to find a way to make more money from the customer or is there really customer demand? Why has it taken so long for most DSM companies to establish a market and is it an independent market? Fundamentally, who is the market? Is the consumer asking for this service? Does the customer know what it is? Would it seem that the customer hasn't yet identified a need?

Clearly, the concept of disease management has appeal. However, until we define what the appeal is and what we are going to get out of it, what we have is hype. And we have to separate hype from hope and define what it is we need and what we are getting. ■