SANIT

Report: Disease Management Programs and Their Impact on the Health Sector

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1) Introduction and Purpose

Over the past decade, many health plans and organizations have begun to offer a new model of care mainly for chronically ill patients: Disease Management Programs. These programs are an attempt both to improve the quality of care that enrollees receive as well as to slow down the growth of healthcare costs. Through a combination of enhanced screening, monitoring, and education; the coordination of care among providers and settings and the use of best medical practices, Disease Management seeks to identify chronic conditions more quickly, treat them more effectively, and thereby slow the progression of those diseases. The presumption is that better care today will mean better health and, perhaps, less expensive care tomorrow.

But improving health outcomes and mitigating healthcare costs do not necessarily go hand in hand, and Disease Management Programs may be a worthwhile investment even if they do not reduce overall healthcare spending. However, the debate about the value of Disease Management has encompassed both arguments. Proponents often claim that Disease Management Programs not only improve quality but also pay for themselves by decreasing the use of acute care services enough to offset the costs of the additional screening, monitoring, and educational services.

The purpose of this paper is to give an overview of general Disease Management Programs (DMP). We will start by describing the nature and objective of DMPs and where they are usually applied. Then, we will go through a sample process of sample DMP for diabetics and we will introduce methods to measure the outcomes of DMPs.

In the second main part of the report, we will investigate and analyze the impact DMPs have or can have on the most important stakeholders: the patients, the providers, the payers and the health system as a total. The last category will also include a quick perspective from the pharmaceutical and governmental side of the health system.

Finally, we will give a conclusion on Disease Management Programs and an outline of the most recent developments.
2) Disease Management Programs

2.1) Introduction to DMPs

It might not be difficult to envisage a group of primary care physicians, surgeons, nurses and pharmacists as members of a classic music orchestra, ready to perform. But when the show starts, does the sound flow harmoniously? It certainly does not if the orchestra is following medicine's traditional pattern. The reality is that most healthcare agents are used to doing "solos." The self-sufficiency for which they are trained makes them defiant to orchestration. This is particularly true in caring for chronic illness, where uninformed and passive patients usually interact with unprepared practice teams.

Over the years, healthcare systems have gotten better at acute care, and as a consequence people are living longer and suffering more chronic diseases (i.e. prolonged conditions that are rarely completely cured). Furthermore, although chronic care patients consume huge amount of resources (in the U.S. studies state the chronic patients account for 88% of all prescriptions filled, 72% of all physician visits, and 76% of all inpatient stays; in Germany studies show a similar result, where 20% of the publicly insured are chronic patients and account for 80% of the insurer’s total costs), they remain largely undertreated.

At the same time, healthcare insurance premiums are still increasing even though insurers and providers conscientiously search for effective strategies to control costs. Shorter hospital stays, patient safety issues and the rise of interest in consumers directing their own care have created an environment where a new approach to medical management has appeared: Disease Management.

The first Disease Management Programs have been developed in the U.S.A. as a technique of Managed Care. The official definition by the Disease Management Association of America (DMAA) \(^1\) states that “Disease Management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.”

The term “Disease Management” covers a range of activities that attempt to address several perceived shortcomings of current medical practice. First, chronic conditions often go

\(^1\) The Disease Management Association of America is a non-profit, voluntary membership organization, founded in March of 1999, which represents all aspects of the disease management community in the U.S.A.
untreated or are poorly controlled until more serious and acute complications arise. Second, as reported by the Institute of Medicine, a large gap often exists between evidence-based treatment guidelines (what medical research has shown to be the most effective protocols for treating specific diseases) and current practice. Third, patients often receive care for a disease from many different physicians or providers and frequently are called upon to monitor, coordinate, or carry out their own treatment plan – but with limited ability to do so.

Disease Management Programs vary widely in the specific techniques and tools that they use, but they share several components that are designed to address those above mentioned shortcomings. One component is to educate patients about their disease and how they can better manage it. The goal is to encourage patients to use medication properly, to understand and monitor their symptoms more effectively and possibly to change their behavior to achieve a better compliance and increased self-management. A second component is to actively monitor patients' clinical symptoms and treatment plans, following evidence-based guidelines. Processes and outcomes need to be measured, evaluated and managed. A third component is to coordinate care for the disease among all providers, including physicians, hospitals, laboratories, and pharmacies. A Disease Management Program can provide feedback on individual patients and support to physicians about patients' status between office visits as well as up-to-date information on best practices for particular patients. Routine feedback loops are an important keyword here. Furthermore, DMPs need a system that allows for the implementation of necessary changes based on the findings from the feedback and outcome measures. Communication and collaboration among providers and the relationships between providers and patients are also crucial in this context.

In short, all these components should help to achieve the following objectives:

- Improving patient self-care through patient education, monitoring, and communication
- Improving physician performance through feedback and/or reports on patient progress in compliance with protocols
- Improving communication and coordination of services among patient, physician, Disease Management Organizations, and other providers
- Improving access to services, including prevention services and prescription drugs as needed.
Although Disease Management is sometimes used as a catchall that addresses any and all limitations of fee-for-service care, it does not encompass general coordination of care or basic preventive services, such as flu shots.

When talking about Disease Management Programs, it is also worth to differentiate it from case management approaches: Whereas DMPs target individuals diagnosed with specific conditions, such as diabetes or congestive heart failure, Case Management focuses on high-risk patients with complex combinations of medical conditions and which was often triggered by an acute event such as hospital admission. The former often involved applying standardized techniques in a systematic way, while the latter requires a treatment plan tailored to each patient’s unique circumstances. However, the distinction between the two approaches has blurred as Disease Management has adopted broader and more-comprehensive approaches. Today, DMPs are rapidly expanding services and now typically assume responsibility for coordinating care for the range of chronic conditions that a patient may have.

### 2.2) Areas of Application

Because of the high costs of DMPs, they are mainly used for high volume diseases, e.g. diabetes, where alone in the U.S. 18 million people are affected and an improvement on quality and/or a reduction in cost would have a major effect.

This also explains why Disease Management Programs are widely used for many chronic diseases. However, there are also other severe diseases for which DMPs have been developed or are under development. The most common diseases for DMPs include:

- Congestive heart failure
- Coronary artery disease
- Diabetes mellitus
- Asthma
- HIV/AIDS
- Hemophilia
- Hypertension
- Cancer
- End-stage renal disease
- Sickle cell anemia
Considerations in selecting a disease for Disease Management are often the following:

- availability of treatment guidelines with consensus about what constitutes appropriate and effective care
- presence of generally recognized problems in therapy that are well documented in the medical literature
- large practice variation and a range of drug treatment modalities
- large number of patients with the disease whose therapy could be improved
- preventable acute events that often are associated with the chronic disease (e.g. emergency department or urgent care visits)
- outcomes that can be defined and measured in standardized and objective ways and that can be modified by application of appropriate therapy (e.g. decreased number of emergency department visits or hospitalizations)
- the potential for costs savings within a short period (e.g. less than 3 years)

As regards the countries that apply DMPs, it can be observed that more developed countries like e.g. the U.S.A. or Germany are very active in progressing in this area. This can be explained by several factors such as the availability of resources in terms of money, equipment and skill sets as well as the level of development of the health sector. Disease Management Programs are an already very advanced tool of managed care that can usually only be successfully applied if the region already disposes of a sound health infrastructure, i.e. enough and experienced doctors, relatively educated patients and access to data. IT and telecommunication often play an important role in the successful implementation of DMPs.

2.3) Process and Evaluation of DMPs
To illustrate how a typical Disease Management Program might work, consider a program for treating diabetes, a disease characterized by a lack of control of blood sugar. Diabetes patients need to monitor their blood sugar frequently and often support sugar level control by taking synthetic insulin or other medications. Thus, patients take a large role in providing their own care, but many have difficulty doing so properly. The consequences of poor control can be serious and can result in long-term complications, including damage to blood vessels and peripheral nerves, which then can result in blindness, loss of kidney function, stroke or amputation.
In the beginning, a DMP would aim to improve “process outcomes”, e.g. to increase the number of enrollees who received a set of exams recommended by accepted standards (e.g. in the U.S.A. by the American Diabetes Association): regular blood pressure screening; annual foot and eye exams; annual lab tests for kidney function; annual tests for cholesterol levels; and at least biannual lab tests for hemoglobin A1c, or HbA1c\(^2\). In addition, since diabetes is associated with an increased risk of heart disease and stroke, taking steps to help diabetics control their blood pressure and cholesterol and counseling them to quit smoking are also critical process outcomes.

If those process outcomes succeeded and complications could be prevented or reduced, the DMP’s impact would be reflected in measures of health outcomes, e.g. in the rates of amputations, heart attacks, and death. Here, a difficulty occurs, since those health outcomes typically only occur many years later after the onset of diabetes, so they are not commonly measured in typical short-term studies of Disease Management. Instead, studies of the effectiveness of DMPs often use measures of process outcomes (such as the monitoring of blood pressure and the regular screening of HbA1c levels) and measures of intermediate outcomes (such as improvement in blood pressure and HbA1c levels) as indicators of improvement in health.

Health outcomes affect both the quality of life and the utilization of healthcare. The quality of life is difficult to measure but seeks to encompass both physical and emotional well-being and has particular importance in cost-effectiveness analyses - often reported as costs per “quality-adjusted life year” which captures changes in quality as well as in years of life. Healthcare utilization, such as hospital admissions and emergency department visits, reflects the number of acute episodes experienced by patients. A complete economic analysis would take into account the costs of those acute services and expenditures for other types of care that might substitute for hospital-based care. (Please also see Appendix 1.)

\(^2\) A measure of the control of blood sugar levels over the previous two to four months.
3) **Impact on Stakeholders in the Health System**

3.1) **Patient Perspective**

Disease Management provides strict and expert support for individuals with chronic and/or severe illnesses in order to help them become more aware of their condition and of their treatment choices, modifying their behavior, reducing their risk and building solid relationships with their physicians. Therefore, patients become more engaged in handling their own healthcare, which usually increases their compliance. Hence, patient education and self-management are key in managing chronic diseases. These factors together with the fact that throughout the program an individual patient happens to get in contact with other patients in the same condition also boosts his intrinsic motivation (even transcendental motivation, if a patient takes pleasure and helping co-patients with their situation). Furthermore, it is possible that some institutions put into practice a system of financial incentives to also extrinsically motivate the patient to actively participate in DMPs (reduced out-of-pocket payments could be an option).

Some voices claim that DMPs necessarily entail a risk regarding data confidentiality since in some of these programs patients are able to enter and record monitoring data and transmit them to a web server owned by a private third party that permits providers to log in and access the data of their patients. The question of patients’ rights to access parts or all of their record, the physical storage and access rights as well as the issue of data ownership become essential when monitoring data are stored physically at a different location controlled by a private company. The most direct implications of this reality are possible threats to data privacy and this situation leads to ethical debates about restructuring this key aspect of the delivery process. The DMAA, however, proclaims boldly that without IT support “…patients will lose the benefits of Disease Management Programs if patient data confidentiality proposals curtail the ability of health plans and Disease Management Organizations to access patient data. Society as a whole will face higher healthcare costs resulting from a sicker population”.

While there is no consensus among different players of the healthcare industry concerning the results of DMPs in the U.S., most of the major 150 private and semi-private companies currently offering DMPs in the U.S. show encouraging statistics, for instance, 90 percent of
patients in Humana’s Congestive Heart Failure program\(^3\) showed stabilized or improved disease status, with 62 percent showing a reduction in hospitalization and also a significant number of Humana members in the End Stage Renal Disease program met their dialysis adequacy targets at a higher percentage when compared to the national average listed through the U.S. Renal Data System (USRDS). Hospital bed days were 45 percent lower than the USRDS average, and Emergency Room visits decreased by 75.

In conclusion, the most important benefit for the patient lies in the increased quality of care which results in an improved total well-being of the patient, hence a higher quality of life.

3.2) Provider Perspective

It is a reality that many physicians do not even want to hear the “D” word. For them, Disease Management Programs are a sneaky opportunity for managed care plans to increase profits by limiting services, thus reducing their costs, hence reducing the remuneration of the providers. This raises the question on how providers should be paid in a Disease Management Program. The classical fee for service reimbursement environment still increases the incentive to actively fill hospital beds. However, the current healthcare arena has evolved to a capitation reimbursement model, and the incentives are now related to achieving economies in the way healthcare is provided. Likewise, Disease Management is used as a tool to achieve cost savings and better patient outcomes, since its whole concept stems in moving from the acute perspective of healthcare delivery to a proactive and preventive one. The objective of a DMP is to prevent patients from getting into the acute healthcare system. Once they are in an Emergency Room, it is a lot more difficult if possible at all to achieve extra cost reductions in the acute healthcare system. Again, incentive alignment in the remuneration system is an important factor to ensure the support and cooperation from the provider side.

On the other hand, DMPs also offer new opportunities to providers: they can gain in depth insight into a specific chronic disease and become a specialist in that area. The introduction of electronic medical records has the potential for decreasing errors and making periodic health maintenance easier to track, hence increasing the timeliness and effectiveness of service provision. Providers can position themselves early in the game and take part in the

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\(^3\) Humana Inc., headquartered in Louisville, Kentucky, is one of the U.S.’s largest publicly traded health benefits companies, with approximately 5.8 million medical members located primarily in 15 states and Puerto Rico. Humana offers coordinated health insurance coverage and related services through traditional and Internet-based plans to employer groups, government-sponsored plans and individuals.
development and standardization if DMPs to build an image and enhance their reputation in this area. On top of it, access to data from large populations suffering from the same disease leaves a lot of room for research and studying on the provider side – again an opportunity to benefit from.

Another impact on providers will be the change in required skill sets towards more psychological competencies, since patient education plays a vital role in DMPs. The provider effectively gives away power, since he is supposed to increase patient self-management and responsibility in order to make the DMP successful. This also changes the patient-provider-relationship towards rather a partnership instead of the classical superior role of the provider in comparison to the patient. Providing medical care will become a real service and not only a science. This means physicians working with DMPs will have to improve their skills on the communication and feedback side.

In addition, the possibility of developing clinical practice guidelines for treating chronic diseases using evidence-based medicine and the free flow of clinical information can not only promote cooperation between the provider and the patient, but also between different types of providers from primary care physicians and specialty care physicians to nurses and home care entities.

### 3.3) Payer Perspective

Payers in this context are to be understood as those parties bearing the majority of costs of healthcare which goes together with bearing the risk of increasing healthcare costs. These parties are primarily the health insurance providers, depending on the countries and the health systems; these can be primary health insurers, HMOs, employers, governmental organizations or others. Their primary interest is to reduce costs and minimize financial risk of their portfolio.

Effective Disease Management strategies can provide the payers with the opportunity to collect and analyze data on medical service processes and their outcomes, which enables them to steer quality and efficiency of medical services based on evidence-based guidelines. Ideally, this results in avoidance of unnecessary treatments and redundant services and therapies, hence reduces costs on this side. As with many current trends in healthcare management, the payers will gain in power in comparison to the provider. The access to data is a critical
element in this context, which is why, if the payers want to improve their control options, they will need to invest in a sound IT infrastructure and a good data warehousing system to be able to effectively and efficiently manage patient and provider data.

For employers, the better quality of services and better outcomes in health should lead to better productivity of employees due to e.g. reduced sickness days.

Another benefit for the payers is the positive image and reputation that goes together with the offering of a DMP to their portfolio or employees. An early adoption of these programs still can provide them with a first-mover advantage, so that they can a) take part in the formation and standardization of this business area and b) position themselves as innovative and technologically advanced. Especially for employers this might give them a recruitment advantage, but there is also a big risk attached with it: anti-selection. This means that mainly the chronically sick or high-risk people seek employment or insurance coverage with these payers.

3.4) Total Health System Perspective
From the total health system perspective DMPs are a tool to target specific problem diseases of a defined group of people. As an example, a DMP for coronary heart diseases in Germany would be targeted to one of the most important problem diseases specific to that country. The desired outcome is to achieve both a reduction in healthcare costs and an increase in quality of care at the same time.

Crucial from the total healthcare perspective is the selection of the targeted population. This is important in terms of reaching a critical mass to benefit from economies of scale and justify the introduction of high effort DMPs from a macroeconomic side. Selection of the targeted population is also important in a way that criteria for eligibility and accessibility for patients need to be defined. These criteria also have to ensure that only those patient groups have access to DMPs that are likely to benefit from quality improvements and cost reductions. Otherwise increased costs for DMPs will offset the expected savings.

As regards the expected savings, various studies exist, but as mentioned before they are still short-term only and often also biased by the respective perspective of the study’s sponsors. Furthermore, especially quality outcomes are difficult to measure. Even the quantitative findings vary greatly depending on the size of sample group, the region, the program
implemented and the situation measured against. Even specialists like ArztPartner almeda\textsuperscript{4} are not able to commit on one number of expected savings, reduced hospitalization days or re-hospitalization days. In appendix 2 an overview of different study outcomes posted on their webpage can be found.

But in any case, in order to achieve cost reductions in the total healthcare system, it is necessary that the reductions in hospitalization days, re-hospitalizations and ambulatory care lead to reductions in healthcare budgets and will not totally be compensated by shifts to e.g. pharmaceutical costs (studies show that pharmaceutical costs for DMP patients are higher than for those outside of the program), medical inflation and/or price increases. Experience with other healthcare initiative has shown that this is a long way to go.

In terms of quality improvements, successful DMPs would increase the quality of life in a country by integrated provision of health services due to efficient coordination of care and cooperation between patients, providers and payers. This could be measured by e.g. an improvement in the quality-adjusted life year figure of a country or an upward movement in the WHO ranking of healthcare systems.

\textsuperscript{4} ArztPartner almeda is a subsidiary of DKV (the largest private health insurer in Germany) and offers healthcare programs and services to public and private health insurers in Germany since 1997. In 2000 they started their first DMP. Since then they continuously develop new DMPs and also do a lot of research on the costs and benefits of DMPs. \texttt{www.arztpartner.com}
4) Conclusion and Recent Developments

Disease Management Programs gain more and more importance in managed care settings and a variety of stakeholders are affected by these initiatives starting with the patients themselves, the service providers, the payers, and other stakeholders like e.g. the governments and pharmaceutical companies. Like many current trends in managed care also DMPs shift power away from the provider in this case to the patients and also partly to the payers. This is also why Disease Management requires a higher integration of different healthcare functions like e.g. operational aspects (process of delivery), qualitative aspects (quality of service), financial factors (ways of payments and remuneration systems) and informational factors (data management). This is not only changing the perspective on chronic diseases, but also the way the different players interact and coordinate care. A remarkable feature of DMPs is that they are almost entirely driven by patients’ and providers’ behavior changes, not by utilization controls. This again turns soft factors like education, motivation, incentive alignment, continuous feedback and communication into critical success factors.

As regards the cost-benefit ratio of DMPs, until today, there is still insufficient evidence to conclude that DMPs can generally reduce overall health spending. But it is important to note that such programs could be worthwhile even if they did not reduce costs, due to the described benefits described in chapter 3: improved quality results due to better data and coordinated care processes, higher compliance and better motivation on the patient’s side and usage of evidence-based guidelines. Unfortunately, until today there are no long-term studies that would provide evidence on the long-term success of such programs. The few studies that report cost savings do so for controlled settings and generally fail to account for all healthcare costs, including the cost of the intervention itself. In addition, most of the studies and opinions are biased by individual perspective of the researching entity and its interests. But this is something many health organizations are working on and the more developed and widespread DMPs will become, the more experience and evidence will be available to give a final judgment on the cost-benefit relation of DMPs.

The most recent development in Disease Management is in the U.S.A. where a Chronic Care Improvement Program (CCIP) is about to start its pilot phase these days. The CCIP is the Disease Management component of the Medicare Prescription Drug Improvement and Modernization Act of 2003. Administered through the Centers for Medicare and Medicaid
(CMS)\(^5\), CCIP is a voluntary program that seeks to enhance the quality of care and improve outcomes for older Americans with chronic illnesses, specifically congestive heart failure and/or complex diabetes, and chronic obstructive pulmonary disease. Starting in December 2004, 10 pilot programs will be offered in geographic areas in which at least 10 percent of all fee-for-service Medicare beneficiaries live (please also see Appendix 3). Applications for the first phase are still running and were announced to be reviewed by December 8\(^{th}\), 2004. However, at the point of finalizing this report, no final results could be found in the web.

Finally, it is worth mentioning that the applicability of DMPs in rural and/or poor geographical areas is still a blank field. No evidence or field studies could be found on the implementation of DMPs in these areas and also after discussions with insurers it became quite clear that DMPs today are a healthcare tool for rather developed and well-advanced countries. This in not only due to the high efforts and infrastructural requirements associated with DMPs, but also with the needs of different regions. Poorer countries usually still struggle with basic healthcare needs and provisions, so that chronic diseases are not part of their immediate healthcare problems. Nevertheless, once successfully running in industrial countries, it leaves a huge question on how to make these programs accessible to poorer regions in the world.

\(^5\) CMS runs e.g. Medicare, the nation's largest health insurance program, covering nearly 40 million Americans at a cost of just under $200 billion.
- Appendix -

Appendix 1:

The path by which a DMP can lead to better health outcomes and lower healthcare costs at the example of diabetes:

- Selection of patients
- Education
- Communication
- Monitoring
- Feedback
- Coordination of Care

Adherence to evidence-based guidelines, such as:
- Annual foot and eye exam
- Annual tests for kidney function and cholesterol
- Biannual test for hemoglobin A1c, or control of blood sugar

Changes in intermediate measures, including:
- Hemoglobin A1c
- Blood pressure
- Cholesterol

Changes in the incidence of outcomes, including:
- Blindness
- Leg amputation
- Heart attack
- End-stage renal disease
- Death

Changes in the utilization of services, including:
- Hospitalization
- Doctor visits
- Emergency dept. Visits
- Dialysis

- Cost of the intervention minus any savings from health improvements
Appendix 2:

Sample study results on DMPs published on the website of ArztPartner almeda AG

Studies on DMPs for Diabetes

Study 1:
- Reduction in costs per patient per month ($395 vs. $502)
- Reduction in hospital days (0.56 vs. 0.98)
- Reduction in hospital admissions per patient per year (0.12 vs. 0.16)
- Reduction in emergency room visits per patient per year (0.49 vs. 0.56)

Study 2:
- 4-times higher savings than investment costs for the DMP
- 23% fewer hospital admissions

Study 3:
- Savings of $50 per patient per month
- Reduction in hospital admissions: 18%
- Reduction in total hospital days: 21%

Studies on DMPs for congestive heart failure

Study 1:
- Reduction in hospital admissions from 1.5 patients per year before the program, 0 patients afterwards (we assume that this refers to already affected patients only)
- Savings of $8571 per patient

Study 2:
- Reduction in re-hospitalizations by 59%
- Reduction in hospital admissions by 87.2%

Study 3:
- Reduction in re-hospitalizations by 85%
- Savings of $9.800 per patient

Study 4:
- Reduction in re-hospitalizations (68 vs. 118)
- Reduction in hospitalization days (460 vs. 1173)
- Total savings of $490.300

Study 5:
- Reduction in re-hospitalizations (141 vs. 106)
- Reduction in hospitalization days per patient per year (4,2 vs. 8,2)
- Savings of $1300 per patient

Study on influence of living habits on hypertension
- People with light hypertension could reduce their blood pressure by diet, physical workout and less consumption of salt only
- The change in lifestyle could reduce the risk to develop hypertension from formerly 38% to 12%
- The risk for cardiovascular diseases could also be reduced
- Already small reductions in blood pressure led to 34% fewer strokes

Source: www.arztpartner.com
Appendix 3:

**An Overview of CCIP:**

The Chronic Care Improvement Program (CCIP) is an important component of the Medicare Modernization Act and demonstrates a commitment to improving and strengthening the traditional fee-for-service Medicare program. This program is the first large-scale chronic care improvement initiative under the Medicare FFS program. CMS will select organizations that will offer self-care guidance and support to chronically ill beneficiaries. These organizations will help beneficiaries manage their health, adhere to their physicians’ plans of care, and assure that they seek or obtain medical care that they need to reduce their health risks. The Chronic Care Improvement Program is referenced in Section 721 P. L. 108-173 and was created by the Medicare Modernization Act of 2003 (MMA).

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<th><strong>Highlights of the Program</strong></th>
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<td>✔️ In Phase I, the pilot phase, there will be approximately 10 regional CCI programs, collectively serving approximately 150,000 - 300,000 chronically ill beneficiaries, in regions where at least 10% of Medicare beneficiaries reside. The Phase I programs will operate for 3 years and be evaluated through randomized controlled trials.</td>
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<tr>
<td>✔️ The program will offer self-care guidance and support to chronically ill beneficiaries to help them manage their health, adhere to their physicians’ plans of care, and assure that they seek (or obtain) medical care that they need to reduce their health risks.</td>
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<td>✔️ The programs will include collaboration with participants’ providers to enhance communication of relevant clinical information. The programs are intended help to increase adherence to evidence-based care, reduce unnecessary hospital stays and emergency room visits, and help participants avoid costly and debilitating co-morbidities and complications.</td>
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<td>✔️ Initially, the programs will be focused on beneficiaries who have Congestive Heart Failure (CHF), Complex Diabetes, or Chronic Obstructive Pulmonary Disease (COPD) because these beneficiaries have heavy self-care burdens and high risks of experiencing poor clinical and financial outcomes.</td>
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<td>✔️ The new programs are NOT single-disease focused. They will be designed to help participants manage all their health problems.</td>
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<td>✔️ Participation will be entirely voluntary. Eligible beneficiaries do not have to change plans or providers or pay extra to participate. They will be able to stop participating at any time. They will not restrict access to care.</td>
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<td>✔️ Selected organizations will be required to refund some or all of their fees to the federal government if they do not meet agreed-upon standards for quality improvement, savings to Medicare, and increased satisfaction levels in their assigned beneficiary populations.</td>
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<td>✔️ This is a flexible business model. Health insurers, disease management organizations, physician group practices, integrated delivery systems, and consortia of these entities or other legal entities the Secretary determines appropriate are all eligible to apply to become CCI organizations.</td>
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