



Rx: Health Care FYI #26

Subject: *Taking Control of Chronic Conditions:
Patient Care Management Lowers Health
Care Costs*

From: *Rep. Tim Murphy (PA-18)*

The problem: Almost 80% of the nation's total medical care costs (including Medicaid expenditures) is spent on the treatment of chronic conditions.⁵ Chronic disease often involves multiple diagnoses, complications, hospitalizations, tests and treatments.

What is Patient Care Management?

- Individualized health plans for chronic condition patients that coordinates treatments among healthcare providers, uses nurses or caseworkers to monitor patient compliance and involves patients in their own care to improve patient outcomes and lower health care costs.

The annual direct medical costs of the following chronic conditions:

- Diabetes: \$44 billion.
- Arthritis: \$22 billion.
- Cardiovascular disease (Heart Disease and Stroke): \$300 billion.
- Depression: \$12.4 billion.
- Asthma: \$5.1 billion.¹

Patient care management lowers health care costs:

- A study of 363 Medicare patients who received follow-up protocol for seniors with coronary artery disease reduced hospital readmissions by 16% for a savings of \$1 million in Medicare costs.²
- A comprehensive diabetes patient care management program of 20,539 Medicare patients improved health status in the short-term and reduced the severity of complications in long term care with average savings of \$1.5 million per 1,000 patients with diabetes.³
- A patient care management program that provided an individual care plan and case management from nurses for 11,000 Medicaid patients with diabetes, asthma and congestive heart failure in Oregon saves \$6 million annually in reduced health care costs and improved outcomes. For example, the program improved the management of blood sugars and lowered lipid counts among diabetes patients with high cholesterol.⁴
- A study of 300,000 children (under age 21) on Medicaid enrolled in a pediatric asthma management program had a 34% lower hospital admission rate and an 8% lower emergency room rate, compared to children not in the program.⁵

¹ American Medical Association. Management of Chronic Disease. Report 11 of the Council on Scientific Affairs (A-04) Full Text. June 2004.

² Naylor, Mary. Comprehensive Discharge Planning and Home Follow-up of Hospitalized Elders. *JAMA*. 1999;281:613-620

³ American Healthways. American Healthways' Comprehensive Diabetes Disease Management Program Improves Health Status for Medicare Recipients and Reduces Health Care Costs by 17.1 Percent. July 2000.

⁴ Moody Robin. Disease Management Saves State Health Plan Money. *Portland Business Journal*. April 2005.

⁵ NGA Center for Best Practices (2003). "Disease Management: The New Tool for Cost Containment and Quality Care." *Issue Brief* (Washington, DC: NGA).

An example of success:

- A program at the Washington Hospital of Southwestern Pennsylvania taught patients to self-manage their disease through diet, lifestyle changes, medication monitoring and depression screening resulting in an over 50% decrease in hospital readmission rates.

The Federal Government's Role:

- The Centers for Medicare and Medicaid Services (CMS) in a February 2004 letter announced it would *match* state costs of running disease management (patient care management) programs aimed at improving health outcomes while lowering the medical costs associated with chronic diseases. States can develop these programs under either a Medicaid waiver or state plan amendment. Almost half of states have implemented or are in the process of implementing Medicaid disease management (patient care management) programs. Research on the impact of state Medicaid disease management programs is currently being collected.
- The new Medicare Prescription Drug, Improvement and Modernization Act (MMA) establishes two new programs, the Voluntary Chronic Care Improvement Program and the Care Management Performance pilot program to further explore the potential of disease management techniques.
 - The Voluntary Chronic Care Improvement program will provide guidance to beneficiaries with chronic diseases that could be responsive to disease management (patient care management) interventions.
 - The Care Management Performance Demonstration is a three-year Medicare pay-for-performance demonstration with physicians to promote the adoption and use of health information technology to improve the quality of patient care for chronically ill patients. Doctors who meet or exceed performance standards established by CMS in patient outcomes will receive bonus payments. It will be implemented in four states: Arkansas, California, Massachusetts, and Utah with the support of local Quality Improvement Organizations. It was announced on October 14, 2005 and is accepting applications until December 13, 2005.

Recommendations:

- Continue pay-for-performance incentives that improve the quality of care and improve outcomes.
- Use Electronic Medical Records to coordinate care across disciplines, improve communication and patient monitoring to manage and prevent disease.
- Reduce costs in federal Medicare and Medicaid spending by implementing patient care management programs.