EXECUTIVE SUMMARY
As the human and financial costs of chronic disease continue to escalate, health care payers and retailers are developing innovative new models of chronic disease management. This white paper examines how health care payers are expanding and improving their well-established disease management programs, while partnering with providers in new ways. It also looks at how retail pharmacies and convenient care clinics are positioning themselves as accessible, neighborhood health centers that complement traditional primary care and offer excellent patient monitoring, engagement and education.
The Alarming Costs of Chronic Disease in the United States

The numbers are stark. About half of all adults in the United States have a chronic health condition, such as heart disease, diabetes or respiratory disease. One in four adults has two or more chronic conditions. The proportion of adults with multiple chronic conditions rises to two out of three among Medicare beneficiaries in the fee-for-service program. In 2010, seven of every ten deaths were caused by chronic diseases.\textsuperscript{1,2} These numbers are expected to continue to grow, in part because the population is aging and chronic disease prevalence increases with age. Between 2012 and 2022, the number of people age 65 or older is projected to increase by about one-third.\textsuperscript{3}

The human cost of chronic disease in pain, suffering and diminished quality of life can be severe. People with diabetes, for example, can face life-altering complications such as kidney failure, lower limb amputations and blindness. More than one in four people with a chronic condition lives with an activity limitation, such as difficulty walking or needing help to dress or bathe. Such limitations may also restrict the ability to work.\textsuperscript{4} More than 40 percent of adults with diagnosed arthritis, the leading cause of disability, say that arthritis interferes with their daily activities.\textsuperscript{5} Patients with chronic conditions and their families also shoulder the financial burden of the high out-of-pocket costs that come with high utilization of medical care.

The growth of health care spending has outpaced the growth of the economy for decades.\textsuperscript{6} Chronic disease is a major driver of rising health care costs: 75 cents of every health care dollar spent in the United States pays for the medical care of people with chronic diseases.\textsuperscript{7} To give a sense of the scale of this spending, the United States spent $2.9 trillion on health care in 2013.\textsuperscript{8} Recent estimates place direct medical costs at $193.4 billion for heart disease and stroke and at $176 billion for diagnosed diabetes, to name just two examples.\textsuperscript{9}

In the coming years, the treatment of chronic conditions will be the chief focus of our health care system. It’s imperative for the health of the population and the health of the economy that we provide effective and efficient solutions to the management of chronic disease.
Chronic Disease Management and the Changing Health Care Landscape

Our current system of financing and delivering health care evolved in the 20th century with a primary focus on treating acute illnesses, such as infections and heart attacks. This model of care has been very successful in helping patients survive acute events. Indeed, improvements in survival rates for acute illnesses have contributed to the growing prevalence of chronic disease.10

But the acute, episodic model of care does not adequately address the needs of people with chronic conditions. People with chronic conditions typically see multiple providers, and the health care system has offered few incentives and little support to coordinate care across providers and service settings. The result is that patients experience gaps in care. They may undergo duplicative testing. They may receive conflicting advice and treatment from different providers, including prescriptions that interact to cause adverse reactions. They may seek care in emergency rooms rather than outpatient clinics. Patients whose conditions are not well-managed often experience costly and dangerous complications as well as hospitalizations that could have been avoided.

The acute model of health care delivery also does not adequately support chronic disease patients in the self-care necessary to manage their conditions. Most people need both education and encouragement to adhere to complex treatment plans, such as taking all prescribed medications as directed, following a nutritional plan, and monitoring vital signs. Patients may need to set goals for lifestyle changes, learn to assess progress, and address problems that emerge over time. Improving patient self-management may be one of the most promising strategies for producing better health outcomes and reducing the cost of care.11

Research shows that 20 to 30 percent of drug prescriptions are never filled and that about 50 percent of medications for chronic disease are not taken by patients as prescribed. This nonadherence is estimated to be responsible for approximately 125,000 deaths and at least 10 percent of hospitalizations in the United States each year.

THE EXAMPLE OF MEDICATION NONADHERENCE. One can look to the example of medication nonadherence to see how gaps in the current health care system can lead to poor outcomes and exorbitant costs. Research shows that 20 to 30 percent of drug prescriptions are never filled and that about 50 percent of medications for chronic disease are not taken by patients as prescribed. This nonadherence is estimated to be responsible for approximately 125,000 deaths and at least 10 percent of hospitalizations in the United States each year. The health care system in this country is burdened by costs of between $100 billion and $289 billion annually to pay for the consequences of medication nonadherence.12,13

NEW MODELS OF CHRONIC DISEASE MANAGEMENT. The dual pressure of unsustainable health care spending and unacceptable patient outcomes is leading to the development of new models of care that can more effectively manage chronic disease. These models, such as the Patient-Centered Medical Home, look to close the gaps in care that are produced by the acute, episodic model of health care delivery, emphasizing instead the creation of a continuum of services. The aim is to help patients slow the progression of disease in a sustained way over time, rather than wait for an acute exacerbation to receive care. These new models are built around the importance of coordinating care among all of a patient’s providers and across all health care settings.
Communication and coordination may be facilitated by shared electronic health records. These new models also make it a priority to support patient self-management with educational and coaching interventions by physicians, nurses, pharmacists or other health care staff, often with the aid of technological tools that deliver actionable, evidence-based information.

New models of chronic disease management are gaining traction in part because of reforms in the way providers are compensated. Health care payers have been developing delivery models that reimburse providers based on the quality and efficiency of patient care, aligning payments with patient outcomes. Quality-based reimbursement provides incentives for providers to focus on care coordination and patient education, incentives that are lacking in traditional fee-for-service arrangements.

THE IMPACT OF THE AFFORDABLE CARE ACT (ACA). The ACA is also a force that is changing the landscape of chronic disease management. New rules on medical loss ratio (MLR), or the proportion of premium dollars that payers must spend on medical care and quality improvement, are prompting plans to hone and enhance their disease management programs. The ACA includes provisions to implement and evaluate new ways of paying Medicare providers. For example, the Medicare Shared Savings Program creates accountable care organizations (ACOs) in which providers coordinate their services for patients and share in any cost savings that result.

The ACA has been phasing in reductions in federal payments to Medicare Advantage plans to align average payment per enrollee more closely with those for Original Medicare. But the act also has instituted a system of bonus payments that reward Medicare Advantage plans that perform well on Medicare’s measures of plan quality—the star rating system. In 2015, only plans that receive a four or five star rating will receive these bonus payments, which can play a significant role in a plan’s financial outlook. Medicare’s quality metrics include indicators of how well plans manage chronic disease. The star rating system thus creates an imperative for Medicare Advantage plans to work closely with providers to monitor and improve chronic care and to give patients the tools and support they need to stay healthy.

Expanded insurance coverage under the ACA means that there are more patients seeking care from an already overburdened system. This, along with population growth and the aging of the population, is creating shortages of primary care physicians. A recent projection indicates that there will be shortage of 45,000 primary care physicians by 2020 unless we make changes in the way we deliver care.14 There is a dire need for alternative health care providers. Health care payers, retail pharmacies and clinics are stepping up to provide solutions.
Health Care Payers Are Leaders in Chronic Disease Management

Health care payers have been innovators in chronic disease management since health plans began developing programs to manage diabetes in the 1980s. Health plans have traditionally had a greater incentive than providers to decrease the costs of care and a greater capacity to perform analyses of patient populations. In the Medicare program, Medicare Advantage plans, which are required to make chronic disease management a core plan function, produce better outcomes on a number of quality measures than are seen within the fee-for-service program.

In the current environment, where providers are experiencing increased pressure and enhanced incentives to reduce costs, health plans will continue to provide leadership because of their depth of expertise in population health management. As providers reorganize their practices according to models of patient-centered and value-based care, health plans will act as partners to catalyze, augment and strengthen their efforts.

Essential components of a chronic disease management program. Health care payers are expanding and refocusing their chronic disease management programs. These revamped programs emphasize holistic approaches that address all of a member’s care needs, not just their primary condition. Essential components of a chronic disease management program include:

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<th><strong>Identification of patients and risk stratification</strong></th>
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<td>Plans should use predictive analytic techniques to predict which members are at increased risk for high-cost care. These techniques use claims data as the primary input and produce a risk score for every plan member. Patients may also be identified by referrals, health risk assessments or a recent diagnosis of a chronic condition.</td>
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<th><strong>Engaging patients in self-care management</strong></th>
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<td>A case manager, often a nurse, works one-on-one with patients to help them better understand and manage their condition. These interactions can happen in person or over the phone. Case managers typically use a patient-centered coaching approach, helping patients to set achievable goals and gain confidence in managing their own health. Case managers may work with patients to improve behaviors such as symptom monitoring, medication adherence, diet or exercise. Case managers can also check to see that patients are scheduling necessary screenings and appointments.</td>
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<th><strong>Patient education</strong></th>
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<td>The work of case managers can be extended by engaging patients with dynamic educational content, often delivered through the health plan’s member portal and customized to meet member needs.</td>
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<th><strong>Engaging providers</strong></th>
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<td>Chronic disease management programs work best when they coordinate as closely as possible with providers and support the provider’s care plan for the patient. Payers can alert providers about their patient’s risk score and engage them to encourage the patient to participate in the payer’s chronic disease management program. Payers can alert providers when their patients are experiencing gaps in care, and providers can access payer-sponsored portals to monitor the patient’s progress with the case manager, as well as get updates on clinical indicators such as prescription refills and lab results.</td>
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<th><strong>Program evaluation</strong></th>
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<td>Payers regularly evaluate their chronic disease management programs using outcome measures appropriate to the program. Program evaluation can also help payers to understand the factors that improve patient and provider engagement with the program. Payers may also conduct a financial analysis to establish return on investment.</td>
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There is strong evidence supporting the effectiveness of patient self-management support in improving outcomes for people with chronic diseases. This aspect of chronic disease management is labor-intensive since it relies on one-on-one counseling by a case manager, but technological innovations and shared responsibility for patient care are improving the efficiency and scalability of self-management interventions.
Retail Pharmacies and Clinics Are Emerging as Key Players in Chronic Disease Management

In recent years, the retail pharmacy industry has been redefining its role in health care. Pharmacies have taken on an expanded role in offering consumer-centric health services, and the retail convenient care clinic is gaining acceptance as a needed addition to the primary care infrastructure. Retailers are becoming convenient one-stop shops for health products and services.

The role of the retail pharmacist is expanding. Pharmacists now interact with patients as a health advisor, spending time with patients to educate them about their condition as well as about the effects and possible side effects of their medications. Studies have documented that pharmacists can intervene to increase medication adherence among patients and reduce health care costs.21,22 A recent J.D. Power study also found that customer satisfaction and front-end sales increase when pharmacists spend time to help patients understand and manage their medications.23

THE PHARMACY AS A HUB OF CHRONIC DISEASE MANAGEMENT. Major retail pharmacies are also adding value by offering chronic disease management services within the pharmacy setting. Rite Aid pioneered this model with its Health Alliance initiative. Rite Aid Health Alliance uses a team approach where a specially trained in-store health coach coordinates with the pharmacist and the patient’s physician to create a personalized action plan for the patient and to help the patient meet health goals that will improve outcomes.

Across the retail space, pharmacies are developing targeted programs for people with specific chronic conditions, such as high blood pressure or diabetes. These programs engage with patients at the pharmacy or by phone and communicate with the patient’s physician as needed. Pharmacists provide customized educational materials and referrals to existing disease management programs, such as programs operated by the patient’s insurance plan.

THE RISE OF THE RETAIL CLINIC. Retail walk-in clinics first entered the marketplace in the early 2000s as a convenient way to get care for common acute illnesses. In the last few years, retail clinics have been expanding their services to offer chronic disease management as well. It’s estimated that there are more than 2,800 retail clinics operating in the United States in 2015.24 Retail clinics are stepping up to serve a critical need in the primary health care system. With a shortage of primary care physicians and a growing population of patients, it will become increasingly difficult for patients to get timely appointments to see a primary care physician. Retail clinics aim to be a convenient and affordable complement
to traditional primary care. Clinics can help to coordinate a patient’s care and manage their conditions between doctor appointments. They offer transparent pricing, ease of scheduling online appointments, and walk-in services.

Retail clinics are run by nurse practitioners or physician assistants. Most clinics collaborate with medical doctors who review charts and who are available for consult. Clinics are positioning themselves as part of the patient’s care team rather than as a replacement for the patient’s physician. For example, the clinic can coordinate a patient’s lab work and testing and make sure that results are sent to the patient’s doctor. If a patient doesn’t have a primary care doctor, the clinic can help diagnose an illness, start treatment and refer the patient to a primary care physician.

A strength that retail clinics bring to chronic disease management is the expertise that nurses and physician assistants have in providing education about chronic diseases. The effectiveness of nurses in this area is well-supported by the evidence. A recent study found that health education for patients with chronic diseases needs improvement, with patients receiving education about how to manage their conditions at fewer than 50 percent of outpatient visits. Nurses and physician assistants, however, provided education to patients with chronic conditions at a higher rate than physicians. The rise of alternative venues for health care delivery, such as convenient care clinics, staffed by clinicians who may be more accustomed to engaging and educating patients, may facilitate more and better education for patients with chronic diseases.

The increase in the number of patients participating in the health care system as a result of the ACA, as well as the growth and aging of the population, puts time pressure on all health care professionals. But technology is making the job of educating patients easier than ever before, as providers can now turn to reliable information and resources to create customized education for their patients. And patients can easily access and engage with these multimedia educational materials through patient web portals and mobile applications.
Conclusion

Chronic disease is the major challenge facing the health care system today, taking a tremendous toll on public health and driving unsustainable levels of health care spending. As the health care landscape changes to meet this challenge, clinicians need access to high-quality information and educational resources in order to deliver effective and efficient chronic disease care, whether they practice in a traditional setting or in an alternative setting, such as a health plan or retail health center.

Clinical resources and patient education materials must be current, accurate and entirely relevant to the patient’s condition. Clinicians will save time and money, while vastly reducing the chance of errors and misinformation, by using a trusted content provider that constantly updates information based on the latest research and best practices. It is also important to have flexibility in format and the ability to customize content as needed.

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References