



## WHAT IS DISEASE MANAGEMENT?



Whether your corporation is seeking solutions that improve healthcare costs, increase work productivity, or reduce disability claim incidences, disease management (DM) has proven to have positive results in all three areas. From information gathered by experts in the DM field, this series begins with an introduction that provides guidance for analyzing your needs, assessing your current program, or implementing a DM program. The series will demonstrate how a DM program is structured, how to determine the appropriate DM program, as well as the process and requirements necessary to implement and monitor effectiveness.

Escalating healthcare costs, an increased prevalence in chronic diseases, and insufficient quality of care for chronic diseases have heightened the need for strategic interventions. Disease management is a systematic approach that addresses some of the key challenges of improving the health of individuals while working to decrease medical care inflation. DM models are based on a system of interventions and measurements designed to optimize clinical and economic outcomes of a disease state.

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CCH Incorporated conducts surveys of corporations, analyzes workflows, examines industry trends, and monitors legislative developments. Among these surveys, CCH Inc. produces an annual Unscheduled Absence Survey. The 2003 survey revealed unscheduled absenteeism costs small companies an average of \$43,000 a year, while the larger employers ante up more than \$1 million. The average per employee costs of absenteeism climbed to an all time high of \$645 per year in 2003. The survey reported an average 4.4 percent of a company's budget is set aside to pay for unscheduled absenteeism and accounts for 2 percent of employer payroll expenditure.<sup>1</sup>

Individuals with chronic conditions have increased out-of-pocket expenses that can lead to insufficient income for other life necessities, a hindrance to accessing care, and an adverse effect on the quality of life. Traditional medical care has been isolated to the management of one single component where the provider and payer tend to address only what they are responsible for treating or reimbursing. This traditional approach, in part, has led to rising healthcare utilization and costs as well as an increase in disability claims. As a result, many health and disability insurance carriers have incorporated DM programs.

A DM program coordinates, assists, and supports the management of care, thereby potentially reducing out-of-pocket expenses in addition to increasing individual health. The fundamentals of a DM program begin with an approach to true health risk management utilizing evidence-based principles with proven results. The program supports the medical provider and patient relationship as well as plan of care. It also empowers the patient with prevention and strategies if complications arise.

Disease management interventions are intended to save healthcare dollars and develop critical point interventions to prevent the incidence of disease and, if possible, delay mortality as a result of a particular disease. Disease management models are developed for one prevailing diagnosis. Based on an employer group's claims experience or

absenteeism, it may be necessary to implement more than one model. For example, disability claims could reflect a high incidence of back injuries while health benefits claims reflect high utilization for diabetes. The objectives in all models are:

**IMPROVEMENT OF HEALTH** is intended to prevent co-morbidities, such as pneumonia or falls due to chronic health conditions or by implementing a wellness program, such as diet and exercise. Patients can complete surveys and results can be benchmarked to measure satisfaction and comprehension of the health improvement interventions and the effectiveness on his or her disease.

**IMPROVEMENT OF HEALTHCARE COSTS** by reducing the need for urgent, emergent, and inpatient care as well as unscheduled absences.

**LINKING THE MEDICAL CARE** by finding and providing services and resources, such as multi-disciplinary teams, specialized educational programs, Internet resources, and 24-hour access to health professionals.

**COLLABORATIVE EFFORT WITH PHYSICIANS** to offer educational programs which include pathways and guidelines for disease management best practices. This collaboration compliments the care administered by the physician. Physician completed surveys to benchmark physician satisfaction and comprehension of the DM program will provide valuable information on the effectiveness of this effort.

**DATA MANAGEMENT ANALYSIS** includes participant health questionnaires, surveys, medical claims, pharmacy utilization, and lab data. This information can translate into quantifiable and actionable results.

Success is contingent on a joint effort of behavioral changes by the patient and practice changes by the provider, both having a long-term commitment. The Disease Management Association of American (DMAA), a non-profit organization, has established scientific metrics of DM programs and continues with



research, training, and communication to support the DM community. According to the DMAA, participation in DM programs increased over 300 percent between 1998 and 1999 with studies that showed most DM programs take up to three years to achieve maximum results.<sup>2</sup>

According to the Partnership For Solutions Multiple Chronic Conditions: Complications in Care and Treatment 2000 Report, an estimated 125 million individuals had at least one chronic condition and 60 million had multiple chronic conditions. Additionally, the report stated that 79 percent of overall spending is from individuals with chronic conditions.<sup>3</sup>

**Partnerships for Solutions**, led by Johns Hopkins University and the Robert Wood Johnson Foundation, collected claims data from 1999 to 2001 reported by large, national employer-sponsored fee-for-service health plan. The data covered 3.6 million people using 5.9 million claims. The results demonstrated a higher incidence of co-morbid conditions exist with the typical working employee and the incidence of co-morbidities in younger populations.

**Sources:**

1. 2003 CCH Unscheduled Absence Survey, <http://hr.cch.com/press/releases>
2. The Disease Management Association of America, <http://dmaa.org>
3. Partnership for Solutions, <http://www.partnershipforsolutions.org/DMS/files/2002/multiplecoitions.pdf>
4. Partnership for Solutions, [http://www.partnershipforsolutions.org/DMS/files/Chronic\\_Condition\\_Trends\\_Fact\\_Sheet.doc](http://www.partnershipforsolutions.org/DMS/files/Chronic_Condition_Trends_Fact_Sheet.doc)

**CHRONIC CONDITION TRENDS<sup>4</sup>**

Most Prevalent Chronic Condition by Age	No Additional Chronic Condition		One or More Co-morbid Conditions	
	1999	2001	1999	2001
<b>AGE 0-17</b>				
Asthma	81%	78%	18%	21%
Pre-adult Disorders	65%	62%	35%	38%
Depression	45%	43%	56%	57%
Eye Disorders	74%	71%	27%	29%
Ear Conditions	76%	75%	24%	25%
<b>AGE 18-44</b>				
Lipid Metabolism Disorders	40%	37%	61%	62%
Hypertension	39%	34%	60%	65%
Depression	42%	39%	58%	60%
Thyroid Disorders	43%	39%	57%	62%
<b>AGE 45-64</b>				
Hypertension	12%	11%	87%	89%
Lipid Metabolism	21%	20%	79%	80%
Diseases of the Heart	13%	11%	86%	89%
Diabetes Mellitus	15%	12%	85%	87%
Thyroid Disorders	21%	1%	78%	82%
<b>AGE 65 and OLDER</b>				
Hypertension	12%	11%	87%	89%
Diseases of the Heart	9%	8%	91%	92%
Eye Disorders	14%	12%	86%	88%
Lipid Metabolism Disorders	8%	8%	92%	92%
Diabetes Mellitus	8%	7%	92%	93%

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