A New Model for Chronic Care Management
A Community-based “Utility”

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President
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DIABETES
Two Models of Disease Management

Chronic Care Model

- Community Resources and Policies
- Health System
- Delivery System
- Decision Support
- Clinical Information Systems

- Supportive, Integrated Community
- Self-Management Support
- Delivery System Design
- Informed, Activated Patient
- Functional and Clinical Outcomes
- Productive Interactions
- Prepared, Proactive Practice Team

OR

Disease Management

- Payer-sponsored Diabetes Disease Management Program
- Total # of Participants > 40K

Practice Centered “MEDICAL HOME”

Payer Sponsored “DISEASE MANAGEMENT”
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Chronic Care Model</th>
<th>Disease Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Entity Name</strong></td>
<td>Medical Home</td>
<td>Disease Management Organization (DMO)</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td>Clinic</td>
<td>Remote</td>
</tr>
<tr>
<td><strong>Sponsorship</strong></td>
<td>Demonstrations</td>
<td>Payers/purchasers</td>
</tr>
<tr>
<td><strong>Pt. Identification</strong></td>
<td>Registries</td>
<td>Claims</td>
</tr>
<tr>
<td><strong>Care Managers</strong></td>
<td>On-site</td>
<td>Remote</td>
</tr>
<tr>
<td><strong>QI Data Source</strong></td>
<td>Chart (including EHR)</td>
<td>Administrative + direct patients</td>
</tr>
<tr>
<td><strong>Cost Data Source</strong></td>
<td>Local-Partial</td>
<td>Payer-Global</td>
</tr>
<tr>
<td><strong>Contents Core</strong></td>
<td>EBM/Guidelines</td>
<td>EBM/Guidelines</td>
</tr>
<tr>
<td><strong>Agency (represents...)</strong></td>
<td>Treating provider</td>
<td>Payer</td>
</tr>
<tr>
<td><strong>Payment Source</strong></td>
<td>Demos</td>
<td>Employers, MCOs, Government</td>
</tr>
<tr>
<td><strong>Coordination Capability</strong></td>
<td>Limited, Intra-clinic</td>
<td>Limited-Patient driven</td>
</tr>
<tr>
<td><strong>Coordination Technology</strong></td>
<td>EHR (Limited)</td>
<td>PHR (Limited)/Payer portal</td>
</tr>
<tr>
<td><strong>Practice transformation</strong></td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td><strong>Care Teams</strong></td>
<td>Local (intra-clinic)</td>
<td>Remote (patient-DMO)</td>
</tr>
<tr>
<td><strong>Medical Cost Savings</strong></td>
<td>Under-emphasized</td>
<td>Unproven</td>
</tr>
<tr>
<td><strong>Patient Acceptance</strong></td>
<td>High</td>
<td>Variable</td>
</tr>
<tr>
<td><strong>Development Costs</strong></td>
<td>High/duplicative</td>
<td>Low (already in place)</td>
</tr>
<tr>
<td><strong>Physician Revenue</strong></td>
<td>High potential</td>
<td>Low (P4P)</td>
</tr>
<tr>
<td><strong>Linkage with Hospitals</strong></td>
<td>Undetermined</td>
<td>No</td>
</tr>
</tbody>
</table>
The Complex Role of Primary Care Physicians

- Delivery of Basic Primary Care
  - ✔

- Between Visits Supportive Care (DM)
  - ✗

- Coordination of Care
  - ✗
    - a) No time
    - b) No data
    - c) No information systems
    - d) No mass communication infrastructure
    - e) Limited or no decision support
    - f) Limited staffing
    - g) No reimbursement
Payer 4
DIABETES
The Actual Patient Experience

Health Care Providers

Dr. # 1
Dr. # 2
Dr. # 3
Hospital
Pharmacy #1
Pharmacy #2
Acupuncturist
Health Store
Diet Center
Grocery
Neighbor

time

Source: Dr. J.K. Jones, The Degge Group, Ltd.
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Practice Centered “MEDICAL HOME”

Payer Sponsored “DISEASE MANAGEMENT”
Combined Model of Care Management

Chronic Care Model

- Community Resources and Policies
- Health System
  - Health Care Organization
- Self-Management Support
- Delivery System Design
- Decision Support
- Clinical Information Systems
- Informed, Activated Patient
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- Productive Interactions
- Prepared, Proactive Practice Team
- Functional and Clinical Outcomes

AND

Disease Management

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Practice Centered

“MEDICAL HOME”

Payer Sponsored

“DISEASE MANAGEMENT”
A Community-based “UTILITY”
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Secure Standarized Data

CM

DM

Medial Home

Data

Between Visits Support Services

Data

Between Visits Support Services

Payer 1

Payer 5

Payer 2

Payer 3

Payer 4
A Community-based "UTILITY" Funding for The Newly Insured
The Complex Role of Primary Care Physicians

• Delivery of Basic Primary Care

• Between Visits Supportive Care (DM)

• Coordination of Care

  a) No time
  b) No data
  c) No information systems
  d) No mass communication infrastructure
  e) Limited or no decision support
  f) Limited staffing
  g) No reimbursement
A Community-based “UTILITY”

- Infrastructure
- Funding

Open Issues

PATIENTS
- Role
- Rights
- Responsibilities

PROVIDERS

PAYERS
A Community-based "UTILITY"

Questions?
Comments?