DMAA

Disease Management Association of America

Physician Involvement in Disease Management

Roundtable Discussion

7th Annual Disease Management Leadership Forum

San Diego, California

October 16, 2005

The Disease Management Association of America (DMAA), at the 7th Annual Disease Management Leadership Forum (DMLF), hosted a roundtable discussion titled, "DM Engagement Strategies—How All Stakeholders Can Support Each Other to Achieve Positive Outcomes." DMAA hosted the discussion to catalog the views of a distinguished panel of industry thought leaders, practicing physicians, care managers and patient advocates to suggest best practices by which multiple stakeholders can support and are supporting each other to achieve positive outcomes. Victor Villagra, MD, Health and Technology Vector Inc., moderated the discussion and developed the attached report. The roundtable discussion was made possible by an education grant from Pfizer Health Solutions Inc.

Disease Management is a relatively young discipline that is continuously evolving. Interventions are moving away from simple care management toward adoption of tested behavior change strategies. Programs are progressing from a focus on discrete conditions toward population health improvement. Models are adapting to better engage physicians and other providers. These shifts highlight the importance of understanding and incorporating a variety of view points as the disease management community works together to shape future strategies and ideals.

Executive Summary

- Roundtable participants favored the notion that a more direct connection between disease management programs and practicing physicians was desirable. However, not everyone agreed this is indispensable for success.

- Competing views between a practice-centric (medical home) and a patient-centric (patient home) perspectives of disease management were presented.
    A. It was not a given that physicians closely associated to clinical practices favored a practice-centric approach.
    B. Nurses directly engaged in disease management at the practice site favored a practice-based, integrated approach.

- The causes for failure to engage physicians include:
    A. lack of financial incentives;
    B. lack of technology that facilitates disease management-physician communications; and
    C. the need for a practice-based champion with data at hand that physicians trust.

- Lack of understanding of the full benefit of DM to physicians' practice is also a barrier. A concerted effort should be made to develop physician leadership in disease management. This could be accomplished through the DMAA, starting with a comprehensive curriculum development effort, recruitment of highly qualified faculty and high standards for acceptance and graduation.

- In settings where DM had a close relationship with practicing physicians, but that relationship has faded, there was a clear sense that something worthwhile had been lost.

Introduction

The DMAA definition of disease management (DM) affirms that DM programs should seek collaborative relationships with physicians and their office staff (1). Many disease management programs have reached out to practicing physicians, but to a large extent, close, collaborative relationships have not developed outside of integrated delivery systems (2).

In the absence of a closer DM-physician collaboration, most DM programs have concentrated their efforts on interactions with patients, with good results. The difficulty in establishing operational links with physicians' offices, coupled with good initial results, has generated questions about what role, if any, practicing physicians have in disease management programs. But early successes, even without physician involvement, have not diminished the DM community's interest in establishing a closer working relationship with practicing physicians. More recently, the mandate in the Medicare Health Support pilot that DM organizations coordinate their activities with physicians and community organizations has provided even greater impetus to explore the best ways to establish DM-physician collaboration.

In a paper titled, "Integrating disease management into the outpatient delivery system during and after managed care," (3) the author suggested that DM organizations and physicians must find common ground across several relational dimensions before a meaningful collaborative arrangement between DM and physicians can be realized. These dimensions include financial; communication protocols; roles and responsibilities; medico-legal issues; technological interfaces; and a longer-term process of mutual cultural approximation.

Traditional physician training and clinical practice focuses on meeting the needs of individual patients, whereas DM programs focus on populations. Understandably, the two perspectives define different priorities and approaches to care. It is fortunate that the roles of physicians and disease management programs are complementary, rather than duplicative. To put it simply: Time constraints and the organization of a typical outpatient practice dictate that physicians devote most of their time to diagnosing diseases, determining treatment plans and, later, modulating treatment plans based on patients' responses. Disease management programs, on the other hand, do not initiate or change treatment plans without the authorization of physicians. Disease management provides patient education, motivation and support adherence to physician-initiated, evidence-based treatment plans, including lifestyle changes. These different but interrelated roles, the different organizational infrastructure, staffing and competencies create ideal conditions for collaboration.

The DMAA Roundtable sought the opinion of experienced disease management thought leaders regarding the challenges and opportunities of DM-physician collaboration. Pfizer Health Solutions, the disease management arm of Pfizer, sponsored the Roundtable through an education grant. DMAA convened the Roundtable from its roster of recognized physician and non-physician DM leaders. Participants represented a variety of organizations, all of which had either implemented disease management or related programs; or had in-depth, research-based knowledge

about population health and/or how to integrate physicians, patients and nurse care managers into DM programs. The session was moderated by Victor G. Villagra, MD, President of Health & Technology Vector Inc., a disease management consulting firm.

Roundtable Participants

Participant	Title	Affiliation
Donald Fetterolf, MD	Corporate Vice President, Health Intelligence	Matria
Margaret Gunter, PhD	President/ Executive Director	Lovelace Clinic Foundation
Pshyra Jones, MHP, CHES	Manager	Molina Healthcare
Soeren Mattke, MD, MPH, D.Sc.	Scientist / Cardiologist	RAND Corp
Melissa Mikelson, RN	Manager	Marshfield Clinic
Julie Schilz, RN	Vice President of Operations	Physicians Health Partners
Jaan Sidorov, MD	Medical Director, Care Coordination	Geisinger Health Plan
Paul C. Tang, MD	Vice President, Chief Medical Officer Chair, AMIA 2006-2007	Palo Alto Medical Foundation
Victor Villagra, MD	Moderator	Health & Technology Vector
Paul Wallace, MD	Executive Director, Care Management Institute	Kaiser Permanente
Janet Wright, MD	Chair, DM Oversight Task Force	American College of Cardiology
Observers	**Title**	**Affiliation**
Tracey Moorhead	Executive Director	DMAA
Shailja Dixit	Clinical Developer	PHS
Maryam Navaie-Waliser	Senior Manager	PHS

The Roundtable session lasted about two hours. The method consisted of a semi-structured discussion using a combination of Socratic discussion and open dialogue. The attached Appendix is an edited version of the original transcript. A special effort was made to preserve the contents and nuance of the original discussion and of the verbatim transcript. The principal ideas explored at the Roundtable are summarized below.

Roundtable Discussion Summary

I. What should be the role of physicians in disease management?

Opinions regarding the role of physicians were somewhat divided. While all agreed with the notion that physicians must play a role, some participants favored a central role for physicians.

"…the management of the diseases has to start with a medical home."
Julie Schilz, RN

Other participants placed more emphasis on the needs and the role of patients. For example, in response to the above question, opinion leaders made the following statements:

"Physicians are a component of it."
"They're necessary, but they're not sufficient"
"The whole point of disease management is not the physicians."
Jaan Sidorov, MD

"I agree there needs to be a home, but I don't think it's a medical home. I really think it's the patient's home. The patient is the one who has the most at stake."
""We need to provide more support to the patients than to the docs, who already have more of the information at hand."
"So if I looked at the phrase engaging physicians, I'd say engage them to support patients taking a more active role."
Paul Tang, MD

"*My own belief is, despite where I work, that physicians will have an increasingly limited role, a decreasing role in being the medical home for chronic condition care, but they'll still be looked to as a critically important connector in chronic condition care and reactive care intercept."*
Paul Wallace, MD

"It's important to give patients the tools they need to manage their disease, because many of them are not going in to see our physician and they're not going to the medical homes, so we're trying to reach them where they are and we use our physicians as support."
Pshyra Jones, R.N.

Some participants expressed concerns with the disease management model itself, in part because it is often tied to insurance carriers. This association hampers DM programs' ability to provide continuous care as patients change insurance carriers. In contrast, physicians can provide continuity and comprehensive care.*

"Patients migrate out of these models quite frequently with change of insurance, change of jobs, so it's more likely that they keep their doctors than they keep their respective care management group. Unless this changes dramatically, I think there has to be a very central role for physicians to provide continuity, which cannot be provided by disease management."
Soeren Mattke, MD, MPH, D.Sc.

"I guess I come from a place with the idea of a 'medical home' and—for both chronic disease—essentially it's not just one chronic disease but it's a multitude of diseases."
Julie Schilz, RN

II. Why have DM programs failed to engage physicians' interest?

Some barriers to a good DM-physician relationship have been described. They include the absence of financial incentives for physicians and the wide cultural divide between physicians devoted to the care of individual patients and disease management, which focuses on populations of similar patients. There has been a concern that DM organizations could negatively affect physician income and/or interfere with the patient-physician relationship, but formal research has not borne that out (4). There are concerns that DM activities could take too much time on the part of physicians and/or their staff, and may cause disruptions in the office workflow. The absence of sophisticated technology, such as electronic medical records, or more reliable online connectivity with physician offices to allow exchange of patient-related information between visits, also has been identified as a barrier.

An important barrier identified during the roundtable was that physicians have treated DM programs as extensions of payers rather than extensions of their own practice. The association with payers is historically important because of the high tension between providers and payers prevalent at the height of the anti-managed care backlash. However, even as tensions have eased, much remains to be learned about how to promote collaborative relationships

"I think they saw it [DM] as an insurance company, who is generally an annoyance, and they see [utilization management] and 1-800-mother-may-I. It is the same company trying to harass them."
"Managed care/DM said 'Here's the entire infrastructure that you need to manage diabetes. Would you like us to help you?' I think the difference in the way it was presented, from being a manager showing doctors how to practice medicine versus someone offering a gift was a huge error on the part of the whole health care delivery system."
Donald Fettrolf, MD

* This perspective is valid, but it must be viewed with some caution because barriers to continuity of care go beyond insurance affiliation, including a high degree of consumer mobility (common change in residence and work place) and changes in physician network configuration, and a preponderance of specialized care.

III. What successful strategies exist to engage physicians in DM activities?

Not all disease management programs have fallen short in engaging physicians. In an integrated delivery system, the disease management program is an extension of the physician practice, so the separation would be somewhat artificial. In these settings, the nurses charged with care coordination and disease management activities are co-located in the clinic providing onsite support, as well as remote patient care between visits.

In some practices, such as the Physicians Health Partners, the physicians are very committed to the care/case management model, so they actually pay for case management for their patients.

A number of examples of successful relationships were described at the Roundtable. In a group practice setting, the following three elements were considered critical.

"You start with data."
"…and then if you could get one physician and you use that physician. You start small and you have to go from place to place, to physician to physician, and use a peer. It has to be a peer who has lived it, who said I [didn't] believe this stuff either, and now I do."
"It will hit them at the heart, and that's when you bring in patients and stories"
Julie Schilz, RN

"You need a physician [inaudible] champion. Our medical director has just really gone out there and helped; in other words, sell the program for our physicians. With the CMS demonstration project, we have developed champions throughout our sites"
Melissa Mikelson, RN

When asked "What would physicians in a busy practice like to adopt from a disease management model to improve quality?" the following description was offered:

"How can I care for that individual patient better? It is to have a mechanism to collect the data in a form I can use and at a time that I can use it. That data must be accurate and [in a format to] share with those who should see it and protect it from those who shouldn't."
"I must have adequate time and resources to have a meaningful encounter with that patient."
"I need a way to interact with my patients when we are not face-to-face, because I truly agree that we have not shifted to accommodate the population of patients we care for."
"I also think that I underserve a huge number of people [in] that I'm not able to help them prevent (their illness)"
Janet Wright, MD

The experience at the Lovelace Clinic is particularly telling because for many years the clinic was considered a national leader in physician involvement in disease management. One of the success factors in getting physicians involved in DM was to free them from activities that are time consuming, but important, components of comprehensive care. Finding the right balance of engagement and delegation of functions is the key.

"…we engage physicians in just the right level of involvement?"
"They [physicians] need to know what's going on with their patients, and we've got to find the best way to do that. But we need to, I think, free them from some of the burdens of certain things I think they'd love to have help with—whether it's reminders, whether it's some things that they would totally agree that somebody else could take care of"
Margaret Gunther, Phd

A similar experience continues to be at play in the successful DM program at the Geisinger clinic.

"Now, I think what they [nurse care managers] accomplish for docs—and this is based on my own personal experience—is that they give the docs more time. They off-load stuff that physicians don't want to do, or aren't trained to do."
Jaan Sidorov, MD

Success stories from staff model practices or integrated systems do not translate well to networks of independently operated small practices. Solutions applicable to networks are still lacking.

IV. What other strategies can DM programs use to engage physicians?

Roundtable participants identified the electronic health record (EHR) as a major catalyst to engage physicians. Several organizations have experienced the positive effects of the HER, to the point they almost took it for granted. The ultimate advantage is that the information reaches the physicians in real time, making the nurse remote encounter with patients synchronous with the physician input. Physicians feel they are truly involved in decisions and that the logistics of participation in the care of patients is simple, not onerous, as it can be using a paper-based system.

Electronic connectivity also is helpful to nurse care managers:

"We have our [EHR], which for me, and our nurses, represents a complete advantage at connecting with physicians."
"We're coaching patients, develop patients' plans, educating them [on] just how to communicate with their physicians."
"I look at this as kind of a stepping stone in between their visits and when we're tracking our patients. If it's something that's pertinent, we put that in the [EHR]. That's a huge advantage [to] connection between care management team and physician practice."
Melissa Mikelson, RN

While the EHR was considered a great help in communicating and engaging physicians, it should not be construed as a "magic bullet" that will solve all problems. In fact, the results of disease management programs among physicians with access to EHR are not necessarily better than among those without it. The role of the nurses was deemed more important in driving results than the EHR.

"I think people tend to think that [EHR] applications solve many problems of the health care sector, and [that] they may overestimate how powerful that change may be, because I don't think that we can change just the technology."
Soeren Mattke, MD, MPH, Dsci

***"**About half of Geisinger health plan's business is outside the Geisinger Clinic [without access to the Geisinger EHR] and we can't discern any difference between the success of our disease management programs inside or outside the Geisinger Clinic"*
Jaan Sidorov, MD

V. Can assisting physicians in reaching pay-for-performance targets help bridge the gap?

Physicians continue to be concerned about financial issues, particularly in primary care. Contributing to that concern were scheduled cuts in Medicare physician fees in 2006 and beyond, and the strain Hurricane Katrina recovery costs placed on the federal budget. At the same time, physicians are not convinced, or have not fully considered the possibility, that DM programs can help preserve higher payment levels by contributing to attainment of pay-for-performance goals.

A different issue raised at the Roundtable is the potential role of patient adherence to self-care recommendations as an important determinant of better quality indicators and improved outcomes. However, there is relatively little experience with patient incentives.

"You know, maybe what we should do, in addition to what we do for physicians is [that] we need to do something on the patient side. We've got to do something where we have informed patients that are incentivized, for example through co-pays."
Margaret Gunter, PhD

VI. What are the best ways for a Disease Management program to communicate with practicing physicians?

Communication protocols with physicians must be, whenever possible, standardized to avoid the multiplicity of formats from multiple sources, which invariably annoys physicians and discourages the use of DM patient reports.

"One of the things that drives physicians crazy is to get different profiles from different health plans."
"So I get a profile on...three of my diabetes patients from health plan A, and another five from health plan B."
"All these different health plans' profiles do not provide a sense overall of how I am doing."
Margaret Gunter, PhD

Ideally, physicians receiving the information must be involved in the design of the contents of what they are to receive to make it relevant and to enhance buy-in. The need for customization for each physician practice is suggested by the fact that focus groups developed to understand how best to transmit information resulted in as many opinions as there were members of the groups. The information must be accurate and, preferably, brief.

Multiple physician communication ideas have been tried. One center distributed well-constructed patient registries in electronic format (CDs), but physicians did not have ready access to computers in the clinic. The problem was not the quality of the report, but the lack of an appropriate communications interface.

Another practice opted to include a physician profile in the same electronic environment used by physicians to track claims.

Much more needs to be learned about how to communicate with physicians effectively. Innovative approaches, such as greater reliance on patients themselves as couriers of information, was mentioned as one possibility. Care must be taken, however, not to make the patient "work-flow" unduly burdensome.

VII. What type of health policy reform would encourage DM-physician collaboration?

The most significant example is the Medicare Health Support pilot. Most ideas expressed by Roundtable participants revolved around payment system reform. Pay-for-production (encounter-based payment) was identified as unsatisfactory, but difficult to change. The implication is that paying for outcomes is inherently better and advantageous to disease management because it aligns well with the industry's historical business model (risk-based, outcomes-oriented compensation).

One suggestion was to stop payment for preventable complications of diseases because they create "incredibly perverse incentives." Sweeping changes such as that would be difficult in a private, market-oriented system, such as ours. Furthermore, the costs of benefits of disease management and other chronic care initiatives cannot be easily internalized in a private system, where patients frequently enter and exit health plans. In a centralized, more stable health care system, the cost of long-term benefits could be more readily internalized and justified. Building incentives for better care remains a good concept, as Medicare is the eventual last payer and ultimately we, the consumers, are the true "universal payers."

Initiatives such as MHS and MMA will force Medicare to become more and more a care management organization. Another potential repository of innovative ideas is Medicaid, because of the severe fiscal strains on that system.

In response to the objection that disease management programs do not offer continuity to patients, the following idea is offered for future discussion: A legislative initiative that would guarantee portability disease management benefits to chronically ill patients after they participate in a DM program for more than one or two years. Establishing a trusting DM-patient (which sometimes extends to DM-caregiver) relationship entails a significant investment of time, effort and emotional commitment by patients. Beginning anew with a different DM team is an onerous imposition on patients already burdened by their chronic conditions. By making disease management a portable benefit, the considerable investment of building a trusting relationship will be protected.

VIII. How can DMAA assume a leadership position in the formation of future DM physician leaders (who are receptive to collaboration)?

An expanded disease management leadership pool among practicing physicians, academics, payers and allied health care professionals is critical for the future of the industry. DMAA should assume a strong leadership role in physician and allied health professional education about the philosophy of disease management and its practical expressions.

A first step would consist of the development of a comprehensive disease management curriculum with well defined learning objectives. The curriculum should take advantage of the vast experience among DMAA member organization and individuals, which might offer exposure to the day-to-day practice of disease management.

The program should seek a group of highly qualified and motivated faculty. Stringent evaluation procedures should be in place to reflect the DM community's commitment to scientific rigor and public accountability. A stable financial base though tuition, grants, donations and other funding mechanisms will be required.

The DMAA disease management curriculum should be rigorous enough to attract highly qualified applicants. The program need not be limited to clinicians. Because of the team approach to health care delivery, the DM curriculum should cover key topics in health economics, health care informatics and management. An appropriate certificate would indicate proficiency in selected areas of DM.

A lively Roundtable discussion ensued around this topic. The following comments exemplify the sweeping endorsement of this idea.

"You addressed an incredibly intriguing suggestion. In my mind, I liken it to the Robert Wood Johnson [ph] fellowship program. And I think it would address many of the ideas that have been discussed here today, such as champions".
Tracey Moorhead

"I think that so much of American medicine, whenever they're confronted by change, says, "No, because." "And the leadership issue is to convert people to say, "Yes, if." "I think that there are very few who do."
Paul Wallace, MD

"You know, Victor, I've seen the magic of physician leaders in my own organization. I think it's a very exciting future. There's a lot of potential there!"
Jaan Sidorov, MD

The Roundtable promoted a rich exchange of ideas, including several that will be the subject of follow-up work by the DMAA leadership and Pfizer Health Solutions.

Reference List

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(4) Fernandez A, Grumbach K, Vranizan K, Osmond DH, Bindman AB. Primary care physicians' experience with disease management programs. J Gen Intern Med. 2001;16:163-67.