WHAT ARE THE COMPONENTS OF DISEASE MANAGEMENT?

POPULATION IDENTIFICATION PROCESSES

As a first step, disease management programs need to identify a population, as well as how to enroll patients. Demographic characteristics and health care use and expenditures are generally reviewed to identify individuals who will benefit from a disease management program.

Programs are designed to target individuals with a specific disease. Costly chronic conditions, including asthma, diabetes, congestive heart failure, coronary heart disease, end-stage renal disease, depression, high-risk pregnancy, hypertension, and arthritis, have been the focus of these programs. Individuals with multiple conditions may also benefit from a disease management program. Enrollment in a program that targets the most severe disease necessitates attention to and coordination of care for other conditions.

EVIDENCE-BASED PRACTICE GUIDELINES

Physicians and providers within these programs are critical to educating patients on an ongoing basis about how to better manage their conditions. Many programs provide physicians with practice guidelines, based on clinical evidence, to ensure consistency in treatment across the targeted population.

COLLABORATIVE PRACTICE MODELS

Disease management generally entails using a multidisciplinary team of providers, including physicians, nurses, pharmacists, dieticians, respiratory therapists, and psychologists, to educate and help individuals manage their conditions. Health care providers may also work with support-service providers to fill in any gaps in the care team, such as the need for nutrition screening or remote-patient monitoring.

PATIENT SELF-MANAGEMENT EDUCATION

Disease management programs are based on the concept that individuals who are better educated about how to manage and control their condition receive better care. This could ultimately result in cost-savings. Program enrollees may need additional support to stick to their medical regimen. Counseling, home visits, 24-hour call centers, and appointment reminder systems have been used to support individuals who are managing their chronic conditions.[4]

PROCESS AND OUTCOMES MEASUREMENT

A method for the measurement of outcomes, including health care service use, expenditures, and patient satisfaction, must be determined prior to the start of the program. These measures are commonly compared to a baseline or a control group in order to measure the impact of the program.

ROUTINE REPORTING AND FEEDBACK BETWEEN PATIENTS, PROVIDERS, AND HEALTH PLANS

Routine reporting and feedback between patients, physicians, and other providers on the care team is often necessary to assure that patients are effectively managing their conditions and receiving the care they need. Additionally, health plans need feedback from patients and providers in order to evaluate their programs.

SOURCE: Disease Management Association of America.