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What is TNA's Approach to this New Concept?

TNA will strive to identify nurses in Texas who are involved in disease management. These nurses will provide TNA front-line information, which will be disseminated through our publications and our website.

TNA will monitor and testify before the Senate Committee on Health Services as it "evaluates the ability of Medicaid managed care organizations and the state to manage chronic illnesses and develop specific strategies for disease management for certain populations."¹¹ TNA will also monitor the House Committees where it is rumored interim studies will be conducted.

TNA will continue to be part of an informational group of other health associations that are meeting on regular basis to explore disease-based management and its effects on patient care.

FOOTNOTES

¹ Ellrodt, et al., "Evidence-Based Disease Management, JAMA, Nov. 26, 1997, Vol 278, No. 20.

² Meyer, L.C., Rohl, B., "An Innovative Approach to Treating Chronic Disabling Asthma," Case Management 1993; 54-69.

³ Reeder, Linda, RN, "Anatomy of a Disease Management Program," Nursing Management, April 1999, p. 41.

⁴ Ibid

⁵ Joshi, Maulik & Bernard, David, "Classic CQI Integrated with Comprehensive Disease Management: A Model for Performance Improvement." Journal of Quality Improvement, Vol 25, No. 8, p.385.

⁶ Ibid

⁷ Ibid

⁸ Ibid

⁹ Ibid

¹⁰ EzM Health Services, 14275 Midway Road, Suite 220, Dallas, Texas 75244.

¹¹ Interim Charges to the Senate Committee on Health Services, 9/9/99, Special Report



Nursing that Works

A Publication of the Center for American Nurses

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Disease Management

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As health care continues to change in dramatic ways, new concepts of care emerge that provide both new opportunities and the potential of risk to both patients and providers. The latest concept to move into the spotlight is *disease management*.

Disease management is typically defined as an approach to patient care that coordinates health care resources for patients across the entire health care delivery system. A major distinction between disease management and other approaches to traditional medical care is a shift from treating patients during episodes of care to highly coordinated care across a continuum.¹

Why Disease Management?

One of the driving forces behind this new health delivery model is the fact that such a large percentage of health care dollars goes to such a low percentage of the population. In group health plans, as few as 10 percent of the participants may consume up to 70 percent of the health care cost.² Therefore, one critical need for the development of disease management is to optimize the health outcomes of this population while controlling costs. Ninety million Americans suffer from at least one chronic condition, including one in four children under age 18, and 39 million suffer from more than one chronic disease.³

Currently such identified populations experience huge variations in treatment and outcomes. Obviously, the optimal care is to decrease that variation, improve quality, and lower costs.

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What is Nursing that Works?

"Nursing That Works" is an educational resource for the Center for American Nurses Constituent member association (CMA) to be shared with individual nurses to support and guide them personally and professionally. Each quarter a new chapter will be sent to each state to add to the book.

The structure of the material will be similar each quarter and is designed for ease of use. The programs will take the reader no more than 30 minutes to complete. The executive summary may be used in the CMA's news publication to market the program to members or in any other way seen appropriate. The primary content is available for use as hand-outs at meetings or sent electronically to individual members. The materials may be used in full or in parts as the CMA finds most useful.

The Center for American Nurses delights in offering this educational resource to the CMA's and the individual members. The purpose of the ongoing series is to support, guide and educate nurses who are providing services to those entrusted to the care.

The Center for American Nurses is a professional association whose mission is to create a community of nursing organizations that supports individual nurses by providing programs, services, and policies that address the concerns of nurses and promote their personal and professional growth.

Nursing that Works

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Diseases that are Selected for Disease Management

In managing chronic disease, key stakeholders that can include patients and their families; integrated delivery networks; health plan; HMO providers; employers; pharmaceutical companies; and communities; need to define the key characteristics of the condition being considered for disease management against the following:

- Existence of high-cost acute events associated with the disease
- High variations in cost or practice
- Heavy loss impact on work or school days
- An understanding of the disease and a realistic way to alter the course of the disease
- Different treatments and interventions, and ways to identify costs of each
- Ways to monitor compliance and collect objective data
- Ways to determine standardized, measurable and objective outcomes.⁴

The most common diseases being studied or implemented for disease management are:

- Asthma
- Congestive heart failure
- Depression
- Peptic ulcer disease
- Diabetes
- Hypertension
- Osteoporosis
- HIV/AIDS⁵

Components of a Disease Management Program

Basically, there are four components involved in disease management. They are:

Method to Design Best Practices for Diseases: Identifying evidence-based best practices on the basis of literature is a crucial first step, but it must be combined with clinical expertise and pathophysiology knowledge. Primary care physician, specialty physicians, nurses, pharmacists and other professional staff must work jointly to develop the "best practice".⁶

Clear Plan to Influence Clinical Decision-Making: Health care has traditionally invested extraordinary resources in developing best practice approaches, including guidelines, but little time and effort has been targeted to implementation and use -- the stage where most efforts fall. Literature suggests the best method for changing clinician behavior includes education, clinical decision support, performance profiling, and feedback. Clinical decision support might involve prompts and reminder systems for the individual practitioner.⁷

Delivery of Best Practices: A companion activity to changing clinician behavior is the delivery of best practices across multiple providers and sites of care. The strongest strategies have included the use of information systems,

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care managers, and office-based coordinators. Few information systems exist today that are tailored to an electronic medical record system, but they will be in the future. Today, some disease management companies use an Internet strategy as a distribution mechanism for disease management protocols. Care managers - usually advanced practice nurses -- work directly with the primary care and specialist physicians, home care and other providers to coordinate care for the patient. They may also conduct patient education for moderate and high-risk patients and maintain contact with the patient and family. The office coordinator - often a nurse - identifies patients for disease management programs, places relevant best practice algorithms into the record, makes reminder phone calls, assists with referrals, and supports patient education.⁸

Improved Outcomes: To accurately evaluate current practice of disease management, important clinical and economic outcomes should be measured. Quality Indicators are collected from multiple sources, including patient satisfaction and health risk assessment, medical record review, and managed care risk data. Over time, data is compiled that outlines the clinician performance. Such data is usually fed back to providers twice a year with strengths and opportunities for improvements.⁹

Possible Outcomes of Disease Management

Potential outcomes in disease management may be varied and numerous. By way of example, here are reported studies on two documented disease management outcomes:

- In a trial of 282 elderly patients hospitalized with congestive heart failure, a nurse-led management team, including a dietician, a geriatric cardiologist, and home care providers, showed improved quality-of-life scores and significantly reduced health care costs over 90 days. The nurses and staff interacted with the patients every day, seven days a week, through personal contact, automated telephone technology, and by computer.
- EzM Health Services, a Dallas, Texas-based corporation specializing in chronic disease management, developed a two-year study for Spohn Memorial Hospital in Corpus Christi. In the study, a group of 107 patients were treated using EzM's model of care for one full year by a multi-disciplinary team consisting of diabetic nurse educators, community pharmacists and hospital staff physicians. Study results revealed average health care costs were reduced by \$4,258 per patient over a 12-month period.¹⁰

Are There Down-sides of Disease Management?

To definitively answer this question, more well-designed trials are needed to evaluate this new concept of care. Some concerns voiced are deterioration in clinician's decision-making skills, suboptimal patient-provider communication, and disruption of continuity of care. But such concerns must be either validated or invalidated by trials and studies.

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