The Evolution of the Management of Chronic Illness

The number of insured individuals with chronic conditions is alarmingly high and growing, a challenge that is not going to get easier as health care costs increase and population health worsens. This article discusses the seriousness of chronic illness in the United States currently, the shortcomings of existing programs aimed at managing chronic illness and emerging alternatives for increased success in addressing chronic disease. Employers clearly understand that to be successful, long-term medical cost management requires a reduction in health risk factors. The author explains how and why reducing health risk factors requires employers wage war on two fronts, seeking both to increase participant engagement in health and to address flaws in the current delivery system payment approach.

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Over the past decade, the health care market has placed significant focus on the frequency and severity of chronic illness events. As such, great strides have been made in the development and implementation of innovative disease prevention and health improvement plans. The goal of these programs is to decrease the development of chronic diseases such as diabetes, heart disease, cancer and others.

As health care costs continue to climb, we have seen an increasing number of employers implementing these programs in the workplace, and they have deployed multiple strategies over the years to get these programs to succeed. Among them are social marketing initiatives, workplace competitions, program branding and increased attention to the food employers offer in their vending machines and cafeterias. Employers have also tried to encourage participation in chronic disease management programs by enlisting champions within the organization—leaders or other employees who are dedicated to health improvement and can lead others by example—or offering incentives for participation. We have also seen a rise in engagement in these programs through online, telephonic and face-to-face coaching, which in some cases has resulted in meaningful reduction in risk factors for chronic illness.
In this article, the author discusses the seriousness of chronic illness in the United States currently, the shortcomings of existing programs aimed at managing chronic illness and emerging alternatives for increased success in addressing chronic disease.

**The Current State of Chronic Illness in the U.S.**

The number of insured individuals with chronic conditions is high and growing, and the numbers are alarming. According to the Robert Wood Johnson Foundation:

- In 2000, 125 million Americans had one or more chronic conditions, and by 2030 this number is projected to increase by about 46 million people.\(^1\)
- For people between the ages of 18 and 64, the most common chronic conditions are hypertension (30%), cholesterol disorders (20%), respiratory disease (19%) and diabetes (12%).\(^2\)
- In 2006, 28% of all Americans had multiple chronic conditions.\(^3\)

Individuals with chronic disease today typically receive fragmented, low-quality care from multiple physicians who have difficulty coordinating on any level, and health care reform means more individuals with chronic conditions will be accessing a system that offers inconsistent quality and inadequate coordination. Consider these facts:

- More than 50% of the individuals with chronic disease receive care from three or more physicians.\(^4\)
- 14% of individuals with chronic conditions received different diagnoses from their providers.\(^5\)
- 17% of individuals with chronic conditions receive conflicting information from providers.\(^6\)
- 18% of individuals with chronic conditions had duplicate tests and procedures.\(^7\)

The situation does not improve from the physician perspective:

- More than 50% of physicians believe that the receipt of contradictory information produces bad outcomes.\(^8\)
- More than 40% of physicians felt that poor care coordination resulted in adverse drug interactions and unattended emotional problems.\(^9\)
- 36% of physicians felt that poor care coordination resulted in unnecessary hospitalizations.\(^10\)

**History of Chronic Condition Management Programs**

The growing prevalence of chronic illness is one of the largest drivers of health care costs, lost productivity and increasing absenteeism in the workplace. In fact, the 15 most costly chronic medical conditions drive 80% of the cost for all chronic disease worldwide (health and absence cost).\(^11\) If employers are able to meaningfully affect as few as three of the behaviors, they can see a savings of as much as $700 per employee per year (Figure 1).

Historically, most employer-sponsored chronic condition management programs have yielded less-than-impressive results, though they demonstrated decent fundamentals. The industry essentially approached the process in five steps:

1. **Data acquisition**, including medical claims, pharmacy claims and, to the extent they are available, health assessment data, biometric data and absence data.

2. **Identification and stratification.** Each vendor used some type of predictive modeling tool to organize the data around a person, assign a risk score and allow for the vendor to have some idea of which pa-

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**FIGURE 1**

**Causes of Chronic Illnesses Worldwide**

patients could potentially benefit from a form of coaching intervention.

3. **Enrollment.** This almost always involved a telephonic process with rehearsed scripting to entice a member to enter into a relationship with a coach that could result in clinical and financial improvement. Overall, the results of this process were suboptimal, with less than 25% of members actually agreeing to enroll. These phone calls were typically made at the dinner hour or on Saturday morning, and with the advent of caller ID, most were not answered as they identified an insurance company name or a name unfamiliar to the member.

4. **Engagement.** This is the step in which the patient not only says yes to a coaching relationship but actually participates in multiple calls that include history taking, medication review, the development of a care plan and achievement of certain goals.

5. **Reporting and analytics.** This would be the production of a return on investment (ROI) for the intervention and the observation of a change in important clinical metrics. Unfortunately, only about 25% of patients who enrolled actually engaged, so the financial and clinical results of these programs never met expectations.

It is worth noting that a missing element in many of the current chronic condition management programs is an interface with the treating physician. As explored below, that missed connection point has made it difficult for patients to navigate messages from the condition management program relative to the guidance from their personal physician.

**The New Frontier of Condition Management Programs**

As popular and prevalent as disease management programs were over the last ten years, employers are continuously questioning the impact of these programs. In Aon Hewitt’s most recent employer survey, 76% of employers identified increasing participation in wellness and chronic condition programs as a key priority. However, 69% identified motivating participants to change health behavior as a key obstacle to their success.

Employers are now realizing that they cannot afford to do the same thing over and over again and expect a different outcome. Two new employer strategies have emerged as effective solutions for the enhanced management of the chronically ill. In both models, the patient is reconnected with a treating physician or similar clinician, addressing a key flaw in today’s condition management models.

**The Company Clinic**

Over the last decade, a growing number of employers have opened company clinics and have evolved them into multifunctional facilities. Aon Hewitt’s research shows that 21% of employers currently offer an on-site clinic, and another 22% are considering adding one in the next three to five years. Most of the impetus of the growing employer interest in these clinics was the lack of primary care access and the lost time involved with having a doctor’s appointment off site. Now, we see these clinics providing basic primary, preventive and urgent care (either by a primary care physician or nurse practitioner/physician assistant), educational sessions (nutrition, exercise, etc.) and often an on-site pharmacy.

On-site clinics also have added a face-to-face component to condition management programs. Chronically ill patients who are in greatest need can get face-to-face coaching as often as they need in addition to receiving preventive maintenance and prompt and accurate medication refill and review. Compliance with medication and appropriate specialty visits is enhanced with a concomitant decrease in emergency room visits and hospital admissions. This is accomplished with the employee missing minimal time at work. Once the relationship is built with the clinic professional, supplemental telephonic coaching—which typically is ineffective on its own—becomes very appropriate and effective.

**Patient-Centered Medical Homes**

Patient-centered primary care is a model of primary care where the relationship between a physician or other licensed health care practitioner and a
patient ensures that appropriate care is structured, delivered and coordinated around the specific needs of each patient and offers significant promise for improving health care value. When a consumer or a patient has this type of relationship and coordination with their health care practitioner and practice, they are considered to have a patient-centered medical home.

It is very apparent why patient-centered medical homes would be ideal for a patient with chronic illness, and employers are increasingly interested in adopting these models. Aon Hewitt’s research shows that while just 14% of companies say integrated delivery models like patient-centered medical homes are part of their health care strategy today, another 61% said they are considering these approaches in the next three to five years.

The concept of a medical home is not new. It was initially introduced by the American Academy of Pediatrics (AAP) in 1967 and referred to a central location for a child’s medical records, particularly important for children with special health care needs. This concept evolved over time from a centralized medical record to a method of providing comprehensive primary care for children at the community level. In 2007, the major medical associations endorsed this concept for adult care.

To deliver patient-centered primary care, primary care practitioners have to restructure their practices so that they are more accessible and promote prevention and wellness more effectively. These practices must also proactively support patients with chronic illness, rather than treat the symptoms of those illnesses, and proactively support patients in self-management and decision making. These changes result in better care and potentially lower costs.

There are seven characteristics of a patient-centered medical home:

1. Each person has an ongoing relationship with a personal physician of any specialty or other licensed health care practitioner trained to provide first contact and continuous and comprehensive care.
2. The personal physician or other licensed health care practitioner leads a team at the practice level that collectively takes responsibility for the ongoing care of patients, including disease and/or case management.
3. The personal physician or other licensed health care practitioner is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care, chronic care, preventive services and end-of-life care.
4. Care is coordinated and integrated across all domains of the health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes, as well as the patient’s community) facilitated by registries, information technology, health information exchange and other means to ensure that patients get the indicated care when and where they want it.
5. Quality and safety are hallmarks of the medical home. This includes using electronic medical records and technology to provide decision support for evidence-based treatments and patient, family, physician and practice involvement in continuous quality

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employee benefits and chronic conditions

improvement. Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes.

6. Enhanced access to care through systems such as open scheduling, expanded hours and new options for communication among patients, their personal physician and practice staff

7. Payment for physician practices that appropriately recognizes the added value provided to patients who have a patient-centered medical home.

Conclusion

Chronically ill patients are truly a challenge to manage. And this challenge is not going to get easier as health care costs increase and population health worsens. Employers clearly understand that to be successful, long-term medical cost management requires a reduction in health risk factors, which, in turn, will improve overall health and drive improved performance. New and innovative approaches to managing chronic illnesses are emerging that are proving to be much more successful in engaging chronically ill patients and improving their outcomes over time.

But these approaches require a fundamental shift in how care is delivered, and this requires the support and commitment of all stakeholders. As purchasers, employers have an important role to play in this transformation. Employment-based coverage is the most prominent form of health insurance in the United States. The manner in which employer purchasers buy health insurance coverage for their employees and dependents directly influences how health care is delivered and how patients fare. For approaches like patient-centered medical homes to be the ultimate solution for the chronically ill, employers must create health insurance product design and health insurance performance requirements that align incentives with goals of improved quality and efficiency. Equally important, they must engage providers in joint efforts that will transform health care delivery. In essence, employers must wage a war on two fronts, seeking both to increase participant engagement in health and to address flaws in the current delivery system payment approach. (See Figure 2.)

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Endnotes

3. Ibid.
5. Chronic Illness and Caregiving, a survey conducted by Harris Interactive, Inc. 2000, National Chronic Care Consortium, Washington, D.C.
6. Ibid.
7. Ibid.
9. Ibid.