On Telephone-Based Disease Management: Wrong Diagnosis, Right Prescription

TO THE EDITORS:

Although I largely agree with the conclusions Dr Motheral reaches in her recent article "Telephone-Based Disease Management: Why It Does Not Save Money," the article's title and overall negative tone obscures its most valuable point—that disease management (DM) must evolve to remain relevant. It should not be news to anyone that DM has done just that, building on lessons of the past 2 decades to move well beyond the limited model examined here.

The article might have been more aptly titled, "Why Evidence-Based Guidelines Don't Save Money," a point it seems to make—albeit, unintentionally—in its criticism of DM as a vehicle for promoting and reinforcing evidence-based care. Dr Motheral ably supports her assertion that the most common guidelines for the primary chronic conditions have a poor record of cost savings, with congestive heart failure the lone exception. This, more than anything else, should concern those who care about improving quality, given that the Healthcare Effectiveness Data and Information Set (HEDIS) and other quality measures assume evidence-based care reduces preventable utilization and, ultimately, costs. Dr Motheral instead shoots the messenger, DM, rather than taking on the broader issue of whether the guidelines themselves can generate savings or only improve quality.

The article offers no real insight to support the author's contention that "telephone-based" DM doesn't work, other than to hold it up against the most desirable attributes of transitional care, such as multidisciplinary teams and in-person contact. In fact, most DM programs today incorporate these features for more costly and impactable patients. It also fails to acknowledge the evolving nature of DM when discussing a cost-saving chronic care program that incorporates shared decision-making and enhanced care support. The article notes the program's incorporation of "some elements of DM," then summarily discounts DM as a factor in the program's strongly positive outcomes.

The larger point missed is that even absent savings, DM improves care quality and, in turn, value. Progress does not require that we achieve better health at no cost or negative cost (ie, savings), only that we do better than the status quo, which is the whole purpose of assessing and comparing cost-effectiveness. Indeed, therapeutic interventions almost never save costs—some are not even cost-effective—yet is anyone suggesting we stop allowing physicians to treat patients because it doesn't save money?

Chronic condition care ultimately requires a wide variety of strategies and communications channels to engage patients and change behavior, and DM has evolved along those lines. It would be far more helpful to focus research on understanding

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how, and for which population segments, the telephone, social media, face-to-face visits, and other modes of outreach contribute to successful health management programs that result in accountable care and achieve the triple aim.

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Author Disclosure: Ms Selecky reports having served on the Board of Directors of the estate of LifeMasters Supported SelfCare, and having attended the September 2010 Care Continuum Alliance Conference. She also reports serving as a paid consultant for American Specialty Health.

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IN REPLY:

In response to Ms Selecky's comments, I agree that the article also explains why greater adoption of evidence-based guidelines for diabetes, asthma, and hyperlipidemia, whether through DM or HEDIS initiatives, will not lead to short-term medical savings. I also subscribe to the belief that a move toward cost-effectiveness as the primary measure of success for DM services would represent a more equitable and realistic expectation. However, numerous interviews that I conducted with employers on this very issue suggested that their demand for shorter-term cost savings for DM will continue. In the interviews, employers struggled with the concept of quality-adjusted life-years and, after years of selling DM to their executives as a cost saving program, consistently said they were quite reluctant to lower expectations for near-term cost savings. A 2010 market survey from the Care Continuum Alliance found that when asked how they measure program value, purchasers most often cite improved program participation and reduced annual care expenses.[1] A majority of purchasers said they expect to see a financial return on investment in 1 to 2 years.

Although transitional care is sometimes cited as a component of DM services in requests for proposals (RFPs) as Ms Selecky suggests, there is a lack of published, peer-reviewed evidence demonstrating that DM companies have implemented cost-saving transitional care programs (outside the original health system models from the 1990s), the recent exception perhaps being Health Dialog. A late 2010 evaluation of Health Dialog's unique care management model has been a welcome development for the industry, but the mechanisms for savings, as the study authors note, are not entirely clear.[2] As I commented elsewhere, savings were clearly generated from 2 areas: 1) shared decision-making for preference-sensitive conditions; and 2) care management for heart failure patients.[3] It also appears that Health Dialog implemented a modified transitional care model that likely contributed to their savings, particularly for heart failure. As to traditional DM, the study found no improvement in pharmaceutical use or laboratory values, the 2 key levers in evidence-based guidelines, leading to the logical inference that savings were generated outside the traditional DM model that emphasizes adherence to evidence-based guidelines.

As to the suggestion that DM has largely moved to more innovative models and that the telephone-based model is no longer relevant, I disagree. Published data are lacking on this point, but a review of vendor Web sites and recent RFPs suggest that there are still millions of DM patients who are served by the telephone-based, opt-out, guideline-focused model. That said, the key point of the paper is for plan sponsors to learn why the DM model did not save money in order to be more prudent purchasers of future versions of DM. Second, although I hold hope that the current market experimentation and retooling will lead to more effective programs, it is important that the rhetoric not get ahead of the evidence. The recent move by Health Dialog to a shared savings model based on randomized comparison trials has set a new standard for the industry, which, as Ms Selecky notes, will require other DM vendors to evolve to remain relevant.

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