HIV Disease Management

ANALYSING THE STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

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Defining Disease Management

Source: Disease Management Association of America (DMAA)

Disease management is a system of coordinated healthcare interventions and communications, for populations with conditions in which patient self-care efforts are significant, and which aims to:

- Support the practitioner/patient relationship with a plan of care.
- Emphasize prevention of exacerbations and complications utilising evidence based practice guidelines and patient empowerment strategies.
- Evaluate clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Defining Disease Management

Source: Cameron Institute, "The Effectiveness of Disease Management Programs in the Medicaid Population," 2011.

To improve health outcomes and reduce costs, successful chronic disease management programmes should utilise:

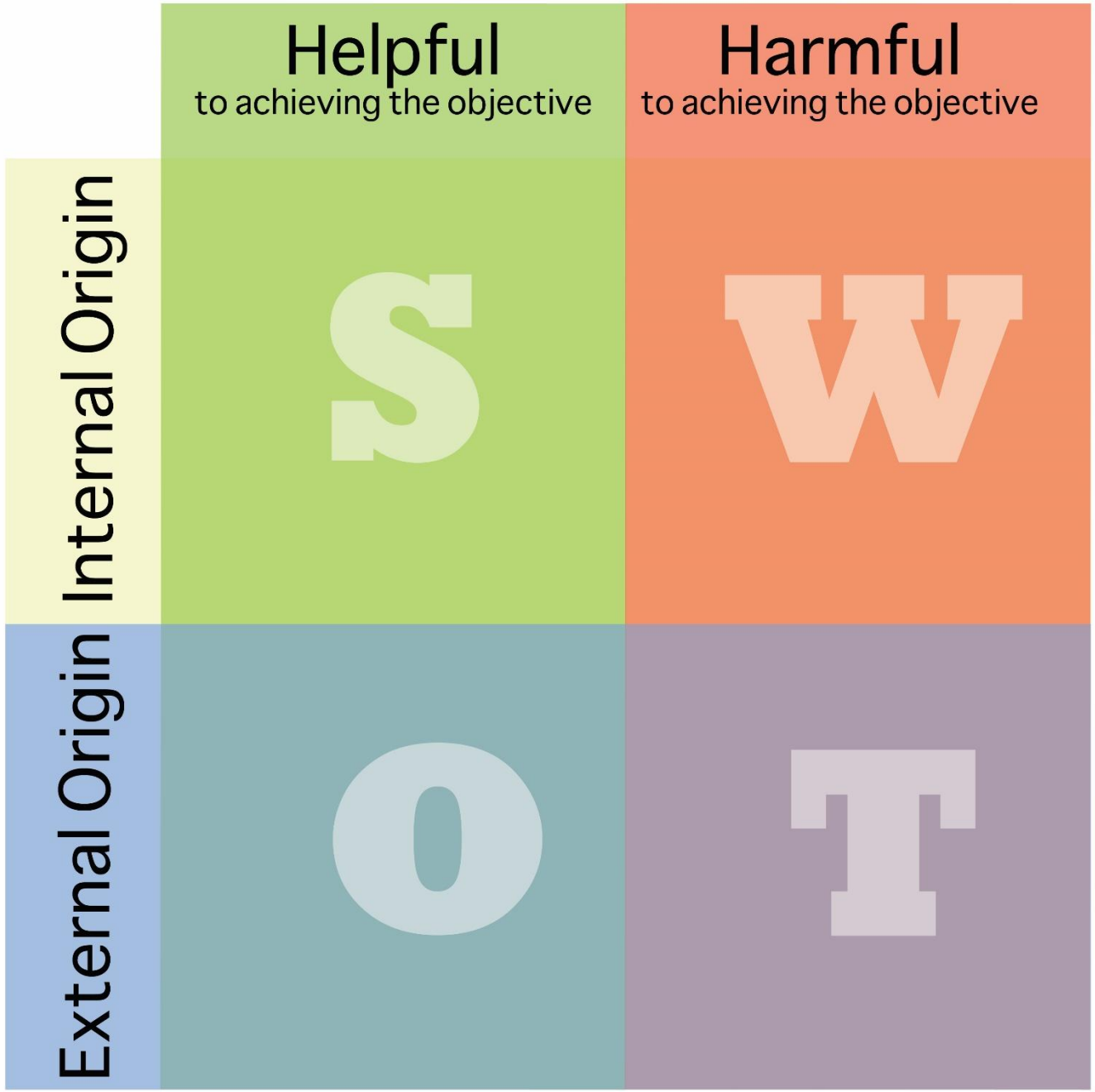
- Nurse care management
- Telephonic care management
- Physician-directed population management

Disease Management: Perceptions vs Aims

DOCTORS	DISEASE MANAGEMENT
Interfere	Collaborate
Some good, some bad	Variability in treater experience
Change my scripts/question my decisions	Variability in prescribing practices
Interested only in cutting costs, profits	Maximise patient benefits/prevent denials
Don't ever speak with a doctor	Ensure patient retention/trace LTFUs
Don't know what they're doing	High rate of late scripts, serologies
Don't do anything	Impact of hospitalizations

Challenges Facing the Industry

- High variability in the practices of disease management programmes (DMPs)
- Which practices effect significant positive changes for the patients?
- Which practices support the treating physician effectively?
- Which practices provided returns to the medical aid, both short- and long-term (i.e., patient retention, disease avoidance)?
- Which practices undermine these goals?
- And how should we be measuring DMP efficacy? VL, ROI, QALY?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Strengths

- DMPs are most effective when dealing with high-cost, high-risk populations whose risk of serious comorbidity is associated with treatment adherence.[1]
- Evidence supporting the effectiveness of DMPs based on evaluation of diabetes, depression, coronary heart disease and chronic heart failure.[2]
  - Reduction in hospitalizations and enhanced rate of ACE inhibitors among patients with CHD and CHF.
  - Greater likelihood of control of glycated haemoglobin and higher rates of screening for retinal, neurological, foot and renal complications in diabetic patients.
- Those DMPs able to decrease hospitalization admissions by as little as 10% typically cover their programme costs.[3]

Sources:
1 Krause, D. "Economic Effectiveness of Disease Management Programs: A Meta Analysis." *Disease Management*. 2005, 8(2):114-134.
2. WHO Europe. "Are disease management programmes (DMPs) effective inimproving quality of care for people with chronic conditions?" August 2003.
3. Billings, J. and Mijanovich, T. "Improving the Management of Care For High Cost Medicaid Patients."*Health Affairs*. 2007, 26(5):1643-1654

Strengths

Cohort of 2,235 patients enrolled continuously in Medi-Cal ART management programme from 2005-2007:

- had greater overall adherence (69.4% vs. 47.3%)
- were more likely to remain on a single ART regimen (71.7% vs. 49.1%)
- were less likely to use contraindicated regimens (8.9% vs. 12.2%)
- had significantly lower annual expenditures for inpatient services ($3,083 vs. $5,186)

Sources: Hirsch, J. et al. "Antiretroviral therapy adherence, medication use, and health care costs during 3 years of a community pharmacy medication therapy management program for Medi-Cal beneficiaries with HIV/AIDS." *J Man Care Pharm.* 2011 April 2011;17(3):213-23.

Weaknesses

- Largely unregulated sector
- Tremendous variability among DMP models
  - Intensity of interventions (directly related to patient health outcomes)
  - Role of the Medical Advisor
  - Approvals systems
- Lack of consensus/inconsistency regarding reporting, programme measures, and even the transfer of EMR
- As a result, DMPs often rises and falls on individuals

Opportunities

- The most effective DMPs are those that manage multiple diseases simply by the fact that one disease informs another, affording greater proactive intervention.
- Investment in a coordinated, industry-wide reporting/EMR technologies (or at the very least, broader, implementable reporting standards).
- Greater investment in technology, to allow for dynamic—and ideally, cost-effective—physician-led care.
- Allowing for disease avoidance/QALY/cost efficacy research.
- Reducing health care costs will require focusing on patients with multiple comorbid diseases.

Sources: Charlson M, Charlson RE. Briggs W.Hollenberg J. "Can disease management target patients most likely to generate high costs? The impact of comorbidity."*J Gen Intern Med.* 2007 Apr ;22(4):464-9.

Threats

- Should SAHIVCS guidelines be consolidated, or should they provide clinicians the means to access appropriate, evidence-based treatment based on available resources within the private sector? (Regulation 15)
- How do we avoid potential conflicts of interest in companies that serve as both DMP and pharmaceutical dispenser, particularly in pharmaceutical product selection?
- With an aging HIV population prone to the premature non-HIV-related comorbidities, can we continue to be effective if we are unable—either structurally or for confidentiality reasons—to access patient primary care records?
- Can we afford to ignore high rates of expired scripts?
- Should HIV be notifiable to the contracted DMP? Do confidentiality rights exclude the right to appropriate outreach if ART or CD4 count is requested?
- How much should the lack of clinicians in the Industry Technical Advisory Panel's (ITAP) *Initiative on Managed Care Treatment Guidelines of HIV* concern us?

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