Hidden Hazards: Closing the Care Gap Between Physicians and Patients with Multiple Chronic Conditions

A Survey of Primary Care Physicians and Medicare Patients

Quest Diagnostics™

Introduction

The Toll of Chronic Health Conditions in the United States

Efforts to improve healthcare in the United States frequently focus on strengthening the nexus between care quality, outcomes and cost. The ability to identify risk and intervene to prevent disease (or its progression or complications) in individuals and populations can better all three. In few areas of healthcare is this more evident than in the management of chronic health conditions.

Chronic health conditions are those that require ongoing medical attention or limit activities of daily living.[1] These conditions, which include hypertension (heart disease), cancer, arthritis, and diabetes, can cause substantial long-term physical and even cognitive impairment.

Chronic health conditions are also costly to treat. About 71 percent of all healthcare costs are due to chronic conditions.[2]

The risk of developing one or more chronic conditions increases with age. Three in four Americans over the age of 65 have two or more chronic health conditions.[3] These patients are generally sicker, more likely to use hospitals and emergency rooms, have greater limitations in their daily living, and experience accelerated decline in their quality of life.[4]

New Care Models

In recent years, different care models have emerged to provide support to patients with complex care needs. One of these is chronic care management (CCM), which involves facilitating care in-between physician office visits for patients with multiple chronic conditions. Care coordination between traditional physician office visits can help individuals follow their care plan, adhere to their medication regimen, and keep scheduled doctor appointments. Yet, despite government reimbursement for providers (and modest copays for patients), CCM adoption by clinicians and patients is low.

A Survey of Primary Care Physicians and Medicare Patients

What challenges do physicians face when caring for older patients with multiple chronic conditions? What changes to healthcare do they believe could improve care quality and value, and can CCM be enhanced to create greater value? And finally, what are the perspectives of patients about the care they receive?

This report, commissioned by Quest Diagnostics, illuminates answers to these and related questions. Based on an independently conducted survey of primary care physicians (PCPs) and Medicare patients with multiple chronic conditions, it aims to empower clinicians, healthcare executives, and patients and their caregivers to take actions to close gaps in care for vulnerable individuals.

Key Findings

Chronic Care Management (CCM)

Recognizing CCM "as a critical component of primary care that contributes to better health and care for individuals," the Centers for Medicare & Medicaid Services (CMS) reimburses for care for Medicare Part B beneficiaries meeting certain criteria, such as multiple chronic conditions. These services involve clinical staff time directed by a physician or other qualified health care professional, such as electronic and phone consultation, medication management, and 24-hour access to care providers.

Physicians are too time-constrained to probe for complex care needs.

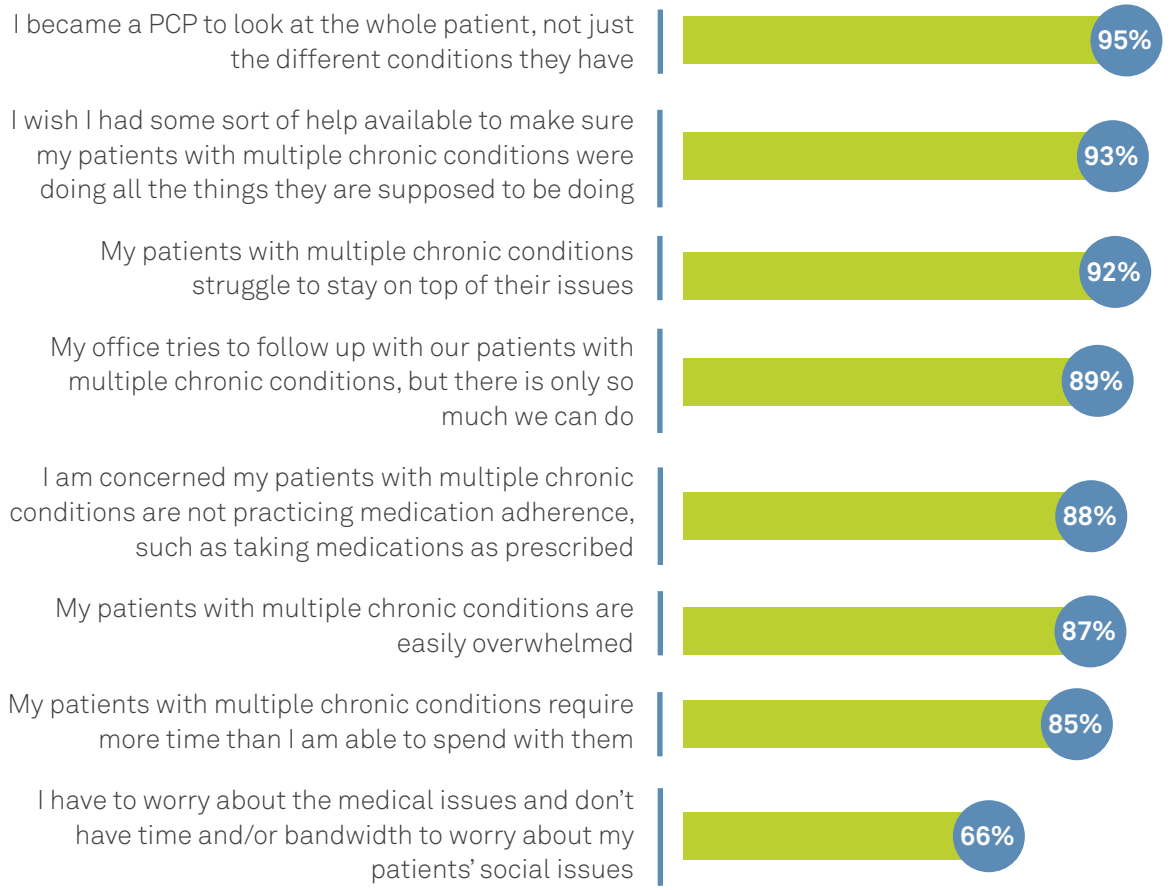
PCPs feel overwhelmed and overworked – and they worry lack of time impedes care quality for their patients with multiple chronic conditions. Almost nine in ten PCPs (86%) say they have felt unable to address the needs of their chronic care patients adequately, with almost three in ten (28%) saying this happens a lot.

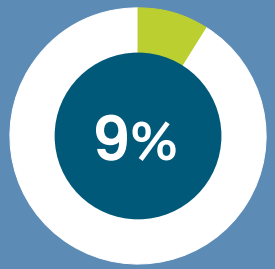
For most physicians—85 percent—lack of time is the key culprit.

Time constraints also appear to limit the ability of physicians to evaluate patients holistically. Nearly all physicians (95%) surveyed said they entered primary care to care for the "whole patient," yet 66 percent say they don't have time to address social and behavioral issues, such as loneliness or financial concerns, that could affect the health of their patients.

Many physicians also fear their patients with multiple chronic conditions are easily overwhelmed and struggle to stay on top of their health issues.

HIDDEN HAZARDS:
Physician worries about how time constraints impede comprehensive care





Only 9 percent of physicians are **very satisfied that their patients are getting all the attention they need** to care for all medical issues.

Patients may not recognize or share all health-related concerns.

While physicians worry that their ability to care for patients with multiple chronic conditions is inadequate, their patients largely disagree. More than nine in ten patients (92%) surveyed are satisfied they are getting all the attention they need to deal with their multiple medical issues from their PCP. And 87 percent believe their physician has all or most of the information needed to manage their care.

Yet, patients may not always connect the quality of care they receive from their primary doctor—and social and behavioral factors that occur outside the physician setting—to their overall health.

Two in five patients with multiple chronic conditions (44%) tell their doctor about their medical conditions, but not other issues they are facing that could affect their health, such as loneliness, financial issues and/or transportation issues. Some patients feel overwhelmed by their medical needs, feel like a "burden" on loved ones, and feel no one understands their concerns.

The findings are significant in light of other research that finds 80 percent of health outcomes are related to factors outside the traditional realm of healthcare delivery, including social, economic, and behavioral.[6] The present analysis suggests many patients with multiple chronic conditions may not recognize their own risks or feel comfortable sharing them with their primary physician.

For some older and sicker Americans, healthcare feels like a solitary journey.

HIDDEN HAZARDS:
What patients aren't sharing with their physicians

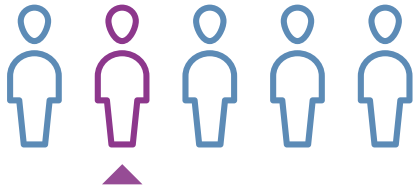
43% of patients with multiple chronic conditions **worry about getting new medical conditions.**

27% **fear falling outside.**

22% **fear falling at home.**

15% **worry they "have no one to talk to."**

12% are concerned about either **forgetting to take medications or mixing them up.**



Nearly one in five patients (19%) say they **struggle to stay on top of their medical issues and need more help**.

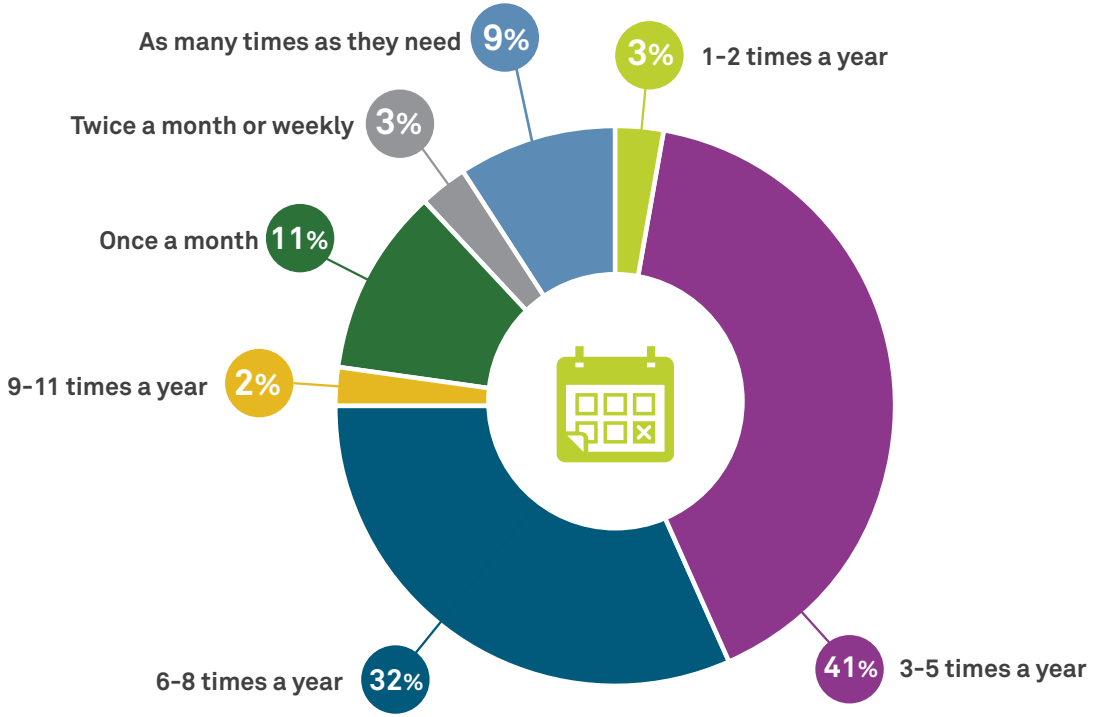
The same percentage admit that "**much of the time I feel like a burden** because of my different conditions and **am hesitant to ask anyone for help**."

Physicians feel more office visits are needed to manage care.

Under Medicare, patients are eligible for an introductory preventive visit within 12 months of qualifying for Medicare and an Annual Wellness Exam every year thereafter. But many patients with multiple chronic conditions have more complex and substantial health needs. Most PCPs surveyed believe that they should visit with their patients with multiple chronic conditions as often as six to eight times a year, and one in four say it should be monthly, weekly, or as often as needed.

While patients overwhelmingly say they feel their PCP gives them enough attention, when probed further, many wish they could spend more time with their doctor. More than four in ten patients (42%) believe that seeing their physician only 1-2 times a year to manage their multiple conditions "is just not enough."

HIDDEN HAZARDS:
PCPs report that in order to properly manage patients with multiple chronic conditions, they should see them:



Seven in ten patients say their doctors are limited to only **10-20 minutes** in an office visit.

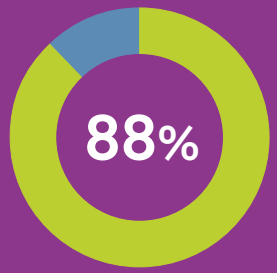
Medication nonadherence is a top concern of PCPs.

Medication nonadherence—unfilled prescriptions and prescriptions that are taken incorrectly—is associated with higher rates of hospital admissions, suboptimal health outcomes, and increased morbidity and mortality.[7] Nonadherence is also associated with increased healthcare costs of approximately $100 to $300 billion of U.S. healthcare dollars spent annually.[8,9]

Patients with chronic conditions account for 83.1 percent of all prescriptions in the United States.[10]

Given these statistics, it is perhaps not surprising that nearly nine in ten PCPs (88%) said they are concerned their Medicare patients with multiple chronic conditions are not taking their medications as prescribed.

And these concerns appear to be valid. Many patients surveyed confess to behaviors demonstrating lack of medication adherence, yet only 8 percent seem to be worried about these behaviors.



of PCPs **worry that their patients are not adhering to medication** as prescribed.

HIDDEN HAZARDS:
Patients confess that at one time or another they have …

- **22%** Forgotten to take their medication
- **5%** Taken the wrong medication at the wrong time or not at all
- **4%** Been unable to pay for prescriptions
- **2%** Been unable to get to the pharmacy to pick up prescriptions

… BUT FEWER THAN ONE IN TEN PATIENTS SURVEYED SAID THEY WERE WORRIED ABOUT:

- **8%** Forgetting to take their medications
- **4%** Mixing up their medications

Physicians and patients value chronic care management, but barriers exist to its adoption.

The survey suggests that both PCPs and Medicare patients with multiple chronic conditions see the value of chronic care management, but concerns about ease of implementation and costs may limit adoption.

Only half of the physicians (51%) surveyed know that CMS pays separately under the Physicians Fee Schedule for CCM for qualified patients with multiple chronic conditions, and that physicians who qualify can receive payments for these services. But only one in four (23%) have implemented CCM. Complexity of coding and paperwork were named as key impediments.

Patients also appear to be interested in CCM. When informed of CCM services, nearly half of patients (45%) say they would be likely to access them; that number jumps to 58% when informed CCM is a covered service through Medicare.

When explaining how they might benefit, almost half of patients (48%) say by discussing new conditions they are experiencing, one-third (34%) say by having someone to talk to about their medical conditions that isn't a family member, and over one-fourth (27%) say by having someone who can answer questions they couldn't ask their doctor.

87% Almost nine in ten PCPs say they would **use a service to monitor their patients** with chronic conditions by setting up a monthly call with a nurse or nurse coordinator.

84% say **CCM could be an extension of their practice** in meeting quality care for patients.

86% **believe CCM would help them** achieve quality metrics for value-based care.

90% say medication monitoring through a CCM program would provide them with "**peace of mind**."

YET, MANY HAVE YET TO IMPLEMENT IT DUE TO:

- **43%** Complexity of coding
- **37%** Paperwork
- **25%** Reimbursement too low

In 2017, CMS implemented changes to the CCM program to simplify service element requirements and ease administration through new CPT codes and a new add-on billing code. Depending on the service, average reimbursement can range from **$42.84 to around $62.**

Conclusions

As the Baby Boomer population ages and age expectancy is extended, the number of individuals with chronic and complex health conditions will also grow.

Our survey suggests that there are gaps in care between PCPs and their Medicare patients with multiple chronic conditions. Time constraints and a feeling of helplessness to address patients' comprehensive needs concern physicians, while patients' professed satisfaction with their care may mask social and behavioral risks and needs.

This gap is not insurmountable. While CCM may hold potential to bridge these divides, CCM adoption is hobbled by several factors. Perception of complexity by PCPs is a clear deterrent, so solutions that simplify the process (by providing coding expertise, for example) stand a better chance of adoption.

Our analysis also suggests points of discussion PCPs can raise with patients to encourage their use of CCM. First, PCPs may wish to explain to patients that social and behavioral factors, including medication adherence, play critical roles in health, and extra monitoring may help identify potential problems. Second, they can reassure patients that CCM has only modest copays under Medicare, as they may otherwise assume a steep financial burden for participating.

And perhaps most importantly, PCPs may wish to explain that CCM may help them identify issues before they become a major medical concern. Notably, the number one worry of patients surveyed was "getting another medical condition" (43%), while the second worry was "being a burden on my loved ones" (32%). CCM may help illuminate potential health risks before they occur, so individuals can retain their health and independence longer while reducing caregiver needs. With improved monitoring, individuals with multiple chronic conditions may expect a better quality of life.

This report was released in May, 2018.

Quest Diagnostics is committed to empowering better health through diagnostic insights.

For more information on our Extended Care services, including CCM, please visit **www.QuestDiagnostics.com/CCM**.

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*Research was conducted by Regina Corso Consulting on behalf of Quest Diagnostics, February 2-18, 2018. A total of 801 study respondents, comprised of primary care physicians who care for Medicare patients with MCC, and adults 65 and older with MCCs were surveyed. Forty-seven percent of the PCPs claim to participate in an accountable care organization. Respondents completed online surveys regarding perceptions and experiences with chronic care and chronic care management services. Strengths of the research include the specificity of respondents' medical state and nationally representative data, while limitations include self-reported data and a lack of direct comparability between study populations. For more information, please visit ccm.questdiagnostics.com/qccms