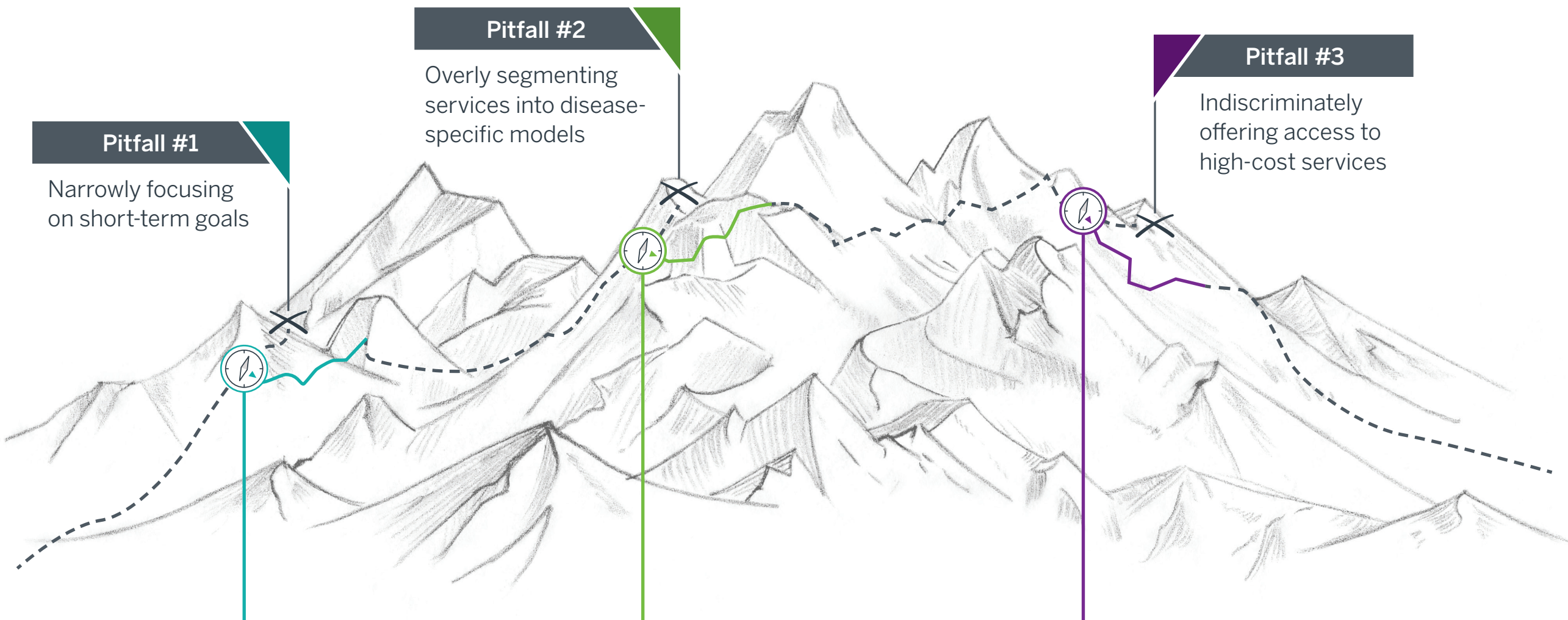# The right route to avoid pitfalls of chronic disease management

Because of the complexity of chronic diseases, providers often struggle to find scalable management approaches that improve outcomes and reduce avoidable utilization. Our survey of chronic disease management programs identified common design flaws that result in ineffective patient care. Learn how to avoid these common pitfalls that lead to poor patient outcomes and elevated costs.

Pitfall #1
Narrowly focusing on short-term goals

Pitfall #2
Overly segmenting services into disease-specific models

Pitfall #3
Indiscriminately offering access to high-cost services

SOLUTION #1

Anchor consistent, long-term services in ambulatory care

Ongoing support in low-cost settings improves self-management skills and reduces acute utilization in the long term.

Transition strategy to prioritize ongoing care

● **BEST PRACTICE:** Long-term ambulatory management

- Care team identifies any needed changes in care plan or medication regimen with multiple follow-up PCP visits.
- Community health worker or health coach builds a trusting relationship, assists with complex social needs, finds patient-centered solutions to change behavior.

✓ **Positive outcomes**

- Months of self-management support and psychosocial navigation stabilize patients in the long term.
- Providers measure long-term reductions in acute utilization, leading to avoided costs and stronger finances under value-based care models.

● **STANDARD PRACTICE:** 30 days post-discharge

- Discharge planner schedules follow-up PCP appointment.
- Community health worker/social worker performs home visit to identify and address immediate needs.

✗ **Consequences**

- If the care team is successful, provider organizations avoid the 30-day readmission penalty under the Hospital Readmissions Reduction Program.
- Band-Aid fixes to psychosocial needs don't address root cause challenges, threatening care plan adherence.
- Sustained behavior change less likely for most acute patients, leading to later escalation.

SOLUTION #2

Find ubiquitous, modifiable patient risk factors

Instead of disease-specific services, tier support by patient acuity and offer increasingly hands-on services as risk levels increase.

Design a program based on patient risk factors

ALL (including LOW-RISK) patient services

- Institute universal screening.
- Use geo-targeting to find hot spots of community need.
- Strengthen community outreach techniques.
- Screen for activation levels and psychosocial needs.
- Connect acute care patients with transition support.
- Offer disease education.
- Fill gaps by engaging specialists for follow-up care.

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RISING-RISK patient services

- Equip patients to self-manage.
- Support PCPs with virtual medication counseling.
- Enable patients to access social support as needed.
- Prolong engagement with low-investment technology.

HIGH-RISK patient services

- Equip patients to self-manage.
- Enroll patients in face-to-face medication therapy.
- Offer in-depth navigation of social services.
- Devote high-investment technology to monitor stabilization.
- Connect patients with home, palliative, or hospice care.

SOLUTION #3

Set clear triggers and pathways to specialists

High-cost services, like specialty care or telehealth, don't offer the same ROI for all patients. Reserve use for those who benefit most to ensure the program remains scalable.

Inform care planning with disease-specific considerations

	Treatment considerations	Specialist trigger
CHF	Remote monitoring reduces travel for patients with limited mobility and has a strong ROI.	Set clinical indicators to trigger automatic referrals to cardiology.
COPD	Engagement practices* reduce elevated rates of stigma or self-blame and improve appointment attendance.	Flag for specialty outreach if PCP appointment is missed. No-shows may increase readmissions.
Diabetes	Peer support/group visits can support behavior change while respecting cultural/family traditions.	Train peer coaches and caregivers on warning signs that may require specialist attention.
Asthma	Home visits can identify unhealthy environmental risk factors that exacerbate symptoms.	Negligible improvement may necessitate referral to pulmonology.
Behavioral health	Primary care integration addresses provider access challenges and normalizes behavioral health treatment.	Escalate to psychiatry if patients show little improvement or have highly complex conditions.

Learn more about creating a scalable chronic disease management strategy at **advisory.com/ManageChronicDisease**

* Motivational interviewing, shared decision-making, etc.