ASSESSING THE MARKET FOR CONDITION MANAGEMENT SOLUTIONS

CHILMARK RESEARCH

MARKET SCAN REPORT

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Executive Summary

Increasing pressure to control rising healthcare costs related to chronic conditions has led the industry to begin exploring the use of mobile apps, devices, and other digital interventions that help patients manage the symptoms of these conditions (referred to in this report as condition management solutions). In certain cases, these solutions may slow or even reverse their progression. Interest is higher among the stakeholders responsible for paying for care (payers, self-insured employers, and patients) than it is among those who deliver care (healthcare organizations), though the wider adoption of value-based care (VBC) models that place increased financial risk on HCOs is expected to drive adoption among provider organizations.

Selling to these stakeholders, as opposed to providing direct-to-consumer (DTC) products common in digital health markets such as fitness and nutrition, forces vendors to prove both clinical efficacy and return on investment (ROI) for their solutions. It also forces vendors to demonstrate ease of use and improved efficiency. While this has presented hurdles, it has also forced the condition management market to mature quickly, as pitches from vendors with good usability but no outcomes or ROI have fallen on deaf ears. This will also drive vendors to do a better job of making their case to HCOs that hope to improve condition management under emerging VBC models but remain wary of unproven solutions.

MARKET DYNAMICS

Solutions are currently available to address many chronic conditions, but activity is greatest in seven key areas:

- Type 1 diabetes management.
- Type 2 diabetes management and prevention.
- Weight management.
- Hypertension.
- Respiratory conditions (asthma and COPD).
- Mental and behavioral health.
- Prenatal and early childhood care.

Given this breadth of conditions, as well as the need and desire among participants as well as customers (chiefly payers and employers but also HCOs) to create more personalized programs, there is little consistency regarding how solutions provide functionality for a variety of processes, though there are some commonalities. (See Table 1.)

Solution Differentiation	Solution Alignment
Program Enrollment	Digital Workflow
Care Management	Bidirectional Communication
Patient Engagement	Automated Intervention
Follow-up and Assessment	Expanded Care Team Involvement

Table 1: Alignment and Differentiation Among Condition Management Solutions

The primary challenge for vendors is providing extensible solutions as opposed to single-condition or even single-symptom applications (which, again, are much more common in the DTC market). Overcoming this obstacle will demonstrate that vendors can do two things – scale beyond a pilot program (from a small population of prediabetics in a single risk-based contract to a larger population of prediabetics, for example) and address cohorts

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with similar needs or comorbidities (such as hypertension or weight management). Doing this will also help vendors shift the conversation with potential HCO customers from working with a single department within the organization to working with a greater portion of the organization and its partners.

LOOKING AHEAD

At present, condition management capabilities outpace the healthcare delivery system at large. Many vendors are ready to scale but are waiting for HCOs to pull the trigger. Just as Chilmark Research expects 24 to 48 months to pass before the typical HCO is ready to embrace more longitudinal care coordination, it is likely to be 24 to 48 months – or more – before the typical HCO is ready to deploy condition management beyond high-cost and high-risk patient populations (the targets of early pilot programs) to address rising-risk and at-risk patients. Absent financial incentives tied directly to improving outcomes for rising-risk patients, HCOs will continue to emphasize episodic care management (largely if not entirely tied to hospital readmission penalties) for high-risk patients. Even accountable care organizations (ACOs), which by definition take on additional financial risk with the hope of improving outcomes and reducing spending, are not yet ready for condition management. [1]

On the other hand, payers and employers – who are on the hook for paying for care and seek solutions for cutting costs – have more direct motivation to utilize condition management solutions. Through both health risk assessments and the analysis of claims data, they identify members/employees who could benefit from a condition management program, facilitate enrollment, subsidize costs, and monitor short- and long-term progress.

That said, the nascent trend of payer-provider convergence, spurred by the growth of VBC, could motivate HCOs to adopt condition management solutions as part of shared-risk contracts with payers or even large employers. In these models, entities would partner to purchase, administer, and support one or more condition management programs for a select pool of participants, track outcomes as well as shared savings, and modify or expand the program as needed. This convergence – namely, the support of the entities that pay for care delivery – could be the catalyst that HCOs need to move forward.

KEY TAKEAWAYS

- **Interest in condition management programs is on the rise.** Healthcare increasingly sees a need for more personalized and long-term solutions to help patients manage common chronic conditions.
- **Type 2 diabetes prevention has provided momentum.** Government endorsement of the Diabetes Prevention Program (DPP) in March 2016 catalyzed interest in a more holistic approach to condition management.
- **Payers and employers lead the way.** Because HCOs remain focused on episodic condition management, vendors have had much more traction selling to self-insured employers and payers that are taking on more risk.
- **Vendors should focus on platforms, not just apps.** HCOs in particular, but all potential customers in general, are wary of one-off solutions. They are more interested in an extensible platform that can add value to an entire organization.
- **Lifestyle management is the next step.** Chronic conditions rarely travel alone, especially in older patients. Vendors must prepare to shift from addressing single conditions to the larger health, wellness, and lifestyle issues associated with living with comorbidities.
- **Behavior change is the end goal.** To prevent the onset or worsening of symptoms, vendors are emphasizing subtle nudges and incremental progress that can help providers achieve sustained behavior change that help patients make better, healthier decisions.

[1] Source: MobiHeathNews. Twine Health CEO John Moore said risk-based contracts "are just not risky enough" and don't provide incentives to scale projects "at all."

About the Author

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Brian Eastwood joined Chilmark Research in June 2015. His research focuses on the role that provider, payer and personal technology can play in advancing consumer-driven health and empowering consumers to make healthy decisions.

Prior to joining Chilmark after 12 years as a journalist, with more than five years of experience covering the healthcare industry at Fierce Markets, CIO.com and TechTarget. He has covered topics such as meaningful use, HIE, fitness tech, interoperability, analytics, innovation and the health insurance industry.

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