

Chronic Disease Management Program
A Case Study in Policy Development
Mid-America Regional Public Health Leadership Institute Year 12 Fellows
‘WhoosiersWhoServe’

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Background

In 2000, more than 55,000 citizens died in the State of Preventa and 75% of those deaths were caused by some form of chronic disease.¹ In the nation, 125 million people suffered from chronic illness in 2000 and this number is expected to reach 157 million by 2010.² In many states, the Medicaid program provides the primary source of medical care for thousands of citizens with chronic disease. The State of Preventa is no exception. The Preventa Medicaid program covers approximately 765,000 recipients at a cost of \$4.3 billion to date.³ As enrollment and demand continue to increase, the need to address rising expenditures is critical. By 2010, it is estimated that 78% of all healthcare costs will result from chronic disease care, which represents approximately 80% of total Medicaid expenditures.⁴ Recognizing the consequences of this anticipated increase in the prevalence of chronic disease, leaders from the Preventa Public Health Department (PPHD) and the Social Services Administration (SSA) developed a model for case management that will not only attack the primary drivers of rising Medicaid expenditures, but also begin to change the overall system for providing health care to all citizens.

According to research, several factors have made this program development critical to the future sustainability of the Medicaid program in Preventa. The major drivers of rising Medicaid expenditures are over-utilization and poor quality of services.⁵ This can be illustrated by the average experience of chronic disease patients. Historically, these patients have received uncoordinated, fragmented care that results in little preventive treatment and minimal support for self-management. Furthermore, less than 50% of chronic disease patients receive care that follows accepted guidelines for treatment.⁶ These facts show the need for a program to address the issues of both patient and physician support, along with education. Unfortunately, these trends are not limited to patients receiving chronic disease care, which demonstrates the necessity to also address the primary care system on a broader scale. There are several options available to states developing case management programs, however, the benefits of each must be carefully weighed against the costs in order to develop a system that best meets the needs of both patients and practitioners.

Introduction

The Institute of Medicine (IOM) defines public health as “what a society does collectively to assure the conditions for people to be healthy.” The recent national crisis has illustrated the weaknesses of the public health system and clearly identified deficiencies that affect a vast array of agencies, from governmental public health to the private physician. These vulnerabilities include outdated technology, fragmented communications, inadequate workforce

education, and poor access to essential public health services.⁷ The elevated risk of bioterrorism and emerging diseases has only now forced national recognition of these underlying concerns which have long impeded everyday public health practices and programs ranging from immunizations to chronic disease management.

The IOM defines the core functions of public health practice as assessment, policy development, and assurance. There are ten essential services that public health must provide in order to adequately perform these functions. Public health practitioners must monitor health status, investigate health hazards, educate and empower communities, mobilize community partnerships, and assure access to personal health services for all citizens.⁸ It is clear from this list that management of chronic disease care is becoming an increasingly important component of public health practice. Thus, when the state of Preventa began to address this issue of rising Medicaid costs, it was a natural, but not necessarily a traditional, collaboration for SSA and PPHD.

Case History

The Social Services Administration (SSA) and the Preventa Public Health Department (PPHD) provide related services to an overlapping population. The Office of Medicaid Policy and Planning (OMPP) is part of the SSA, which manages the Medicaid program and provides health insurance coverage to low-income residents of Preventa. Carole Allen is the Assistant Secretary of the OMPP and represents the interests of the Medicaid program. The mission of PPHD is to “promote, protect, and provide for the public health of people in Preventa.” The State Health Commissioner, Dr. Jim Tucker, has great interest in maintaining a strong, effective Medicaid program because of this broad goal to protect the health of all Preventa citizens. The State Health Commissioner in Preventa is required by law to be a licensed physician, which has limited the degree of collaboration between the agencies. Although the Secretary of SSA and the State Health Commissioner are required by statute to collaborate on programs such as Medicaid, legislators have been hesitant to rely upon PPHD for Medicaid policy decisions. Some believe that, as a physician, the commissioner would face a strong conflict of interest when establishing payment rates for healthcare providers.⁹ This viewpoint created a challenge for our leaders when they began to question the plan proposed by the legislature to address the issue of chronic disease management.

The Preventa General Assembly first began to address this issue during the 2001 legislative session. The OMPP was mandated to contract with a commercial vendor capable of providing disease management services to patients with a wide variety of chronic diseases. It was further requested that patients with expenditures in the top 10% be provided more comprehensive case management services.¹⁰ The OMPP received four bids and began negotiations with one vendor. However, during the negotiation period, the leaders were offered a unique opportunity to work with national chronic disease experts. Information presented during this event led Preventa policymakers to carefully examine the call for contracting with a commercial vendor and fostered the development of a comprehensive chronic care model.

During this time, Preventa was one of eight states chosen to attend the National Governors Association Policy Academy on Chronic Disease Prevention and Management. The team of policymakers included representatives from the legislature, SSA, PPHD, the American Heart Association, and Preventa University.¹¹ During this academy, the group developed a strategic action plan for chronic disease management. The primary objectives included patient

self management, integration of primary care with case management, utilization of the existing public health infrastructure, and cost effectiveness.¹² The leaders also envisioned this model as capable of generating long term change to the overall primary care delivery system across the state, not just for the Medicaid population. The challenge then became choosing the appropriate mechanism for delivery of services and deciding on the entity that should undertake the management responsibility.

As policymakers learned about developing a plan, they weighed the costs and benefits of the three available approaches to creating a novel chronic disease management model: to make, buy, or assemble the program. The “make” approach would require the state to develop all components from scratch, and thus assume all of the risk involved with devoting large amounts of time, resources, and financing into the project. The “buy” approach would shift full accountability and financial risk to the commercial vendors. However, there would be less flexibility in project design and the state would be limited to the services or products provided by a particular vendor.¹³ The final choice, the “assemble” approach, would allow the state to both “make” and “buy” different components of the program. The leaders could utilize elements of the existing infrastructure and available resources, while contracting out services that cannot be provided through state agencies. The leaders gathered information that led them to more carefully examine the options available to the State of Preventa.

During this conference, Carole Allen and Dr. Tucker met with national experts in the field of chronic disease and they began to question whether the services provided through a private vendor could meet the needs of citizens of the state of Preventa. The agency representatives questioned the “guarantees” offered by the commercial vendors and became less certain of the benefits to this approach. This presented a challenge for policymakers because the vendors could offer the promise of a “solution” within a specific timeframe, while public officials understood that these projections were not realistic. The challenge was to convince legislators that these projections were unattainable. Before attempting to persuade members of the General Assembly, the leaders first enlisted the support of national experts to develop an alternative model that would utilize available Preventa resources and more effectively meets the needs of Medicaid patients.

The leaders enlisted the support and expertise of two nationally recognized forces in not only chronic disease care, but health care in general. Dr. Tom Weaver and his staff from the Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative helped develop a program founded upon principles of the Chronic Care Model. The Improving Chronic Illness Care (ICIC) program developed the Chronic Care Model through support from the John Bob Woodson Foundation. The central premise of this model is to improve the delivery of care and promote overall change to the health care system by incorporating use of evidence-based guidelines, patient self-management, and extensive involvement of practitioners.¹⁴ Once this model was developed, Carole Allen and Dr. Tucker realized they would need strong data and a team of influential leaders to convince the legislators to change the requirements for commercial management of the program.

The agencies gathered data to persuade members of the General Assembly that there were alternative approaches available for developing a chronic disease management program. There were unique costs and benefits related to the three available approaches: use of a commercial vendor, chronic illness software, or the chronic care model. The advantages to the commercial vendor approach included comprehensive services from one source, limited financial risk for the state, and large supplies of resources. The disadvantages included limited input from local

stakeholders, loss of jobs and revenue to another state, and no sustainable investment in the state infrastructure. Another “buy” approach involved the purchase of Chronic Illness Software, which had the advantage of being ready to use and previously tested. However, the disadvantages of this approach included a lack of input from local stakeholders and limited flexibility in program format, which created problems when interacting with existing claims programs. The final approach, the Chronic Care Model, while it allowed for greater benefit to the Preventa citizens, also required the state to assume full financial risk.

The Chronic Care Model was carefully developed to maximize benefits through utilization of existing public health resources and minimize costs by creating a comprehensive local infrastructure for case management. The advantages of this approach included use of evidence based methodology with proven results and creation of a new source of sustainable employment for the state. The program also built upon the experience of local practitioners and stakeholders to promote the patient self-management component. The implementation of the model, however, meant significant financial risk for the state and expenditure of considerable amounts of Preventa resources. In addition, the cost-savings from prevention based programs are generally not immediate and are realized only after years of implementation. If successful though, this model is capable of building a locally based infrastructure to provide effective case management for not only the Medicaid population, but also primary care patients in general.

After gathering this evidence, Carole Allen and Dr. Tucker assembled a group of respected and influential leaders in the field to present this information to the General Assembly. This group included experts in the field of chronic disease from state and national institutions, representatives from the legislature who had attended the Policy Academy on Chronic Disease Prevention and Management, experts in the field of health care insurance and finance, groups representing local practitioners, along with advocates for the needs of patients suffering from chronic illness. This team met with legislators to discuss the Chronic Disease Model with the goal of convincing the group to lift the mandate for a commercial contract. The team presented the cost/benefit analysis, which directly challenged the estimates and timelines developed by the commercial vendor. In addition, personal stories from individuals suffering from chronic illness illustrated the present state of the system and showed how the Chronic Care Model could best meet the need of these patients. After weeks of discussion and debate, the General Assembly removed the requirement for SSA to contract with a commercial vendor. The team then began to work on developing a comprehensive program from the model.

Once the mandate was lifted the group began to more thoroughly develop the Preventa Chronic Disease Management Program (PCDMP). There were several resources available to help the leaders develop the program. The main objectives were to develop a network to provide support for primary care providers and then implement a model for chronic disease management into primary care practice.¹⁵ The Chronic Disease Advisory Council was utilized at PPHD to develop evidence-based guidelines for practitioners and gain support from critical stakeholders. This group included representatives from private health plans, academia, non-profit organizations, minority groups, consumers, employers, health care practitioners, and now also Medicaid.¹⁶ The group decided to initially target patients with diabetes and congestive heart failure, with future expansion to include asthma, stroke, hypertension and HIV/AIDS patients.¹⁷ The team developed a model for the PCDMP that is operating today and there are several components of the program that utilize the existing expertise and resources available through Preventa state agencies.

There are five major components of the PCDMP. These include: program management, primary care, care management, patient data registry, and program evaluation. The SSA and PPHD share responsibility for the management of the chronic disease program, which includes policy development, managing contracts, and evaluating performance.¹⁸ The main focus of this program is to develop a network for primary care physicians enabling them to utilize evidence-based strategies for patient care and support them in the case management process. The “care management” component includes a nurse care manager network that provides high risk patients a system of more rigorous follow-up and support. This component also includes a Call Center that tracks patient status and uses standardized protocols to assess follow-up needs. A similar component is the Patient Data Registry, which is an electronic data registry available to all physicians and used for every patient. This component involves an internet based registry that tracks chronic disease patients when admitted to the hospital. This system is funded through public health preparedness funds and will also be useful to epidemiology staff in the event of a public health emergency.¹⁹ The final program piece is evaluation, which includes a randomized controlled clinical trial to be completed through Preventa University. This study will determine overall program effectiveness by evaluating the total cost of the initiative and individual program components. Overall, the PCDMP creates a system of support for both patients and physicians that will increase the quality of care and life for those who suffer from chronic illness, while also saving valuable state resources.

Conclusion

The PCDMP is a model currently utilized for the treatment of the chronically ill in Preventa. The success of the program has led other states to consider implementing this model with the potential for expansion to care for the general population as well. The concept of building a locally based infrastructure and providing education to physicians is not novel; however few have attempted implementing a program considering the complex challenges faced by policymakers. Although PPHD and SSA share a common goal for protecting the public health, the collaboration needed to develop such a program was non-traditional and few had attempted such an effort in Preventa. In addition, prevention-based programs are difficult to promote to state legislators because the cost savings are not generally realized for some time after program implementation. The final result, however, was that our leaders addressed every obstacle and gathered critical stakeholders, experts, and policymakers to develop an evidence-based model that could not be ignored by the General Assembly. These statements illustrate the true accomplishment for the leaders of the PPHD and SSA in building a complete program from initial idea to implementation, which will potentially create a foundation for change to the overall health care system in the state. Their shared vision and combined efforts to challenge the process demonstrated their leadership abilities in policy development.

Case Study Discussion Questions

1. Identify the public health issues or problems that led the leaders in this case to challenge the current process and develop their own chronic disease management program.
2. What were the main advantages of this collaborative partnership between the two agencies initially involved in the process?
3. What were the advantages of forming additional public-private partnerships and enlisting other constituencies in this initiative?
4. Provide specific examples in the case study that exemplify one of the following leadership skills from Kouzes and Posner's *Leadership Challenge*:
 1. Model the Way
 2. Inspire a Shared Vision
 3. Challenge the Process
 4. Enable Others to Act
 5. Encourage the Heart
5. In what ways were the two key people in this case study visionary leaders? In what ways were they facilitators of change?
6. Which practices associated with policy development were used by the two leaders in this case?
7. Indicate how the policy development practices of the two leaders relate to the essential services of:
 - a. Informing
 - b. Educating
 - c. Empowering
 - d. Mobilizing Community Partnerships

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- ¹ State Health Commissioner and Assistant Secretary of FSSA, interview by Carole Kacius. Family and Social Services Agency. Nov 3 2003.
 - ² Testimony of Assistant FSSA Secretary, before the House Energy and Commerce Committee Subcommittee on Health. U.S. House of Representatives. Washington, D.C. Oct 15 2003: 3.
 - ³ Assistant FSSA Secretary, 2.
 - ⁴ Assistant FSSA Secretary, 2.
 - ⁵ Assistant FSSA Secretary, 2.
 - ⁶ Ed Wagner. "Improving the Care of Low Income Chronically Ill Patients" Chronic Disease Management Program Collaborative Learning Session 1. June 27 2003.
 - ⁷ Committee on Assuring the Health of the Public in the 21st Century. "The Future of the Public's Health in the 21st Century." Institute of Medicine. Nov 2002: 3.
 - ⁸ Bernard Turnock. Public Health: What It Is and How it Works. Gaithersburg, Maryland: Aspen Publishers, 2001.
 - ⁹ Eleanor Kinney. "Medicaid and State Budgets: A Case Study." The Kaiser Commission of Medicaid and the Uninsured. March 2002: 1-4.
 - ¹⁰ Assistant FSSA Secretary, 5.
 - ¹¹ State Department of Health. "'Preventa', Eight Other States, Chosen to Receive Assistance on Plan to Address Chronic Disease." SDH Express. May 17 2002.
 - ¹² Presentation of Assistant FSSA Secretary before the Select Joint Commission on Medicaid Oversight. Legislative Services Agency. Sept. 22 2003.
 - ¹³ Testimony of Assistant FSSA Secretary, before the House Energy and Commerce Committee Subcommittee on Health. U.S. House of Representatives. Washington, D.C. Oct 15 2003:5.
 - ¹⁴ Presentation of Assistant FSSA Secretary before the Select Joint Commission on Medicaid Oversight. Legislative Services Agency. Sept. 22 2003.
 - ¹⁵ Testimony of Assistant FSSA Secretary, before the House Energy and Commerce Committee Subcommittee on Health. U.S. House of Representatives. Washington, D.C. Oct 15 2003: 4.
 - ¹⁶ State Department of Health. "'Preventa', Eight Other States, Chosen to Receive Assistance on Plan to Address Chronic Disease." SDH Express. May 17 2002.
 - ¹⁷ Assistant FSSA Secretary, 4.
 - ¹⁸ Assistant FSSA Secretary, 8.
 - ¹⁹ Presentation of State Health Commissioner and Assistant Secretary of FSSA. Health Insurance for 'Preventa' Families Committee Minutes. Government Center. Sept. 3, 2003.