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Chronic Illness and Disease Management

House Joint Resolution 10 Task Force Key Findings and Recommendations June 2004

Respectfully Submitted to the Governor, President Pro Tempore of the Senate and Speaker of the House

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Executive Summary

Why is chronic illness in Delaware so important?

Amid concern about the increasing prevalence and cost of chronic disease in Delaware, the Delaware General Assembly in 2003 created the Chronic Illness and Disease Management Task Force. Its charge was to study disease management strategies and their potential to improve health status and health care quality and to contain health care costs.

Overall, about $4.4 billion was spent in Delaware on personal health care in 2002.[1] Much of this expenditure can be attributed to the diagnosis and treatment of chronic diseases and conditions such as cancer, diabetes, cardiovascular disease (primarily heart disease and stroke), asthma and depression. Care for chronic illness accounts for 78 percent of all health care spending.[2]

These diseases are among the most prevalent, costly, and preventable of all health problems. They account for 7 out of every 10 people who die in the United States each year. Nevertheless, very little is spent on their prevention.

As the number of people with chronic conditions continues to grow, expenditures for health care continue to rise. Most recent statistics for Delaware indicate that the total cost of health care is increasing at rate of about 10 percent annually.

In terms of human cost, the long, drawn-out course of illness and disability from chronic disease results in extended pain and suffering and in death.

What can be done?

Disease management is a logical tool to help diminish the cost and suffering associated with chronic illness. It is imperative that Delaware implement strategies to avert the onset of chronic diseases and help patients who develop chronic conditions, and their caregivers, control them and prevent unnecessary complications.

[1] The Total Cost of Health Care in Delaware, 2002, prepared for the Delaware Health Care Commission by Simon Condliffe and Edward C. Ratledge, Center for Applied Demography and Survey Research, University of Delaware

[2] State Official's Guide, Chronic Illness, The Council of State Governments.

The primary goals of disease management are to prevent chronic diseases, improve the quality of life for people who do develop them and reduce costs.

There are two types of disease management strategies. Primary prevention strategies aim to prevent the onset of chronic disease. Secondary prevention strategies seek to mitigate the impact of chronic disease once it has developed to avoid unnecessary complications.

Primary prevention strategies tend to focus on healthy behaviors. There is increasing evidence that the major chronic conditions in large part stem from or are worsened by individual lifestyles. These types of strategies are viewed as yielding long-term positive results. They also are more difficult to pin down in terms of savings in cost.

Secondary prevention strategies tend to focus on making sure patients get the necessary medical tests and treatments they need to control their disease. These strategies are viewed as yielding quicker and more easily measured results in terms of improvements in health and savings in cost.

Reducing the prevalence and impact of chronic disease will require multiple coordinated and complementary strategies. It will require the participation of private and public sector employers, insurance companies, health care providers, patients, their families and others.

Key factors impacting chronic disease management include:

Education – *employers and insurers, patients and their family care givers, health care professionals and state government must have accurate information about chronic disease and chronic disease management to establish effective policies and programs*

Data Collection and Analysis – *accurate and current data is required to determine the most effective means of targeting resources*

Incentives – *enticements to adopt lifestyles and recommended tests and treatments to prevent the onset of or better manage chronic diseases may be necessary*

Health Literacy – *patients must be able to understand their caregivers' orders and be able to process basic health information in order to most effectively manage their illness*

Identifying target populations – *some population groups are at greater risk for chronic disease than others*

Determining Resources – *financial and manpower resources are needed to administer chronic disease programs*

Identifying Responsible Parties – *administrative responsibility for overseeing chronic disease management programs must be assigned*

Recommendations of the Delaware Task Force

The task force identified five areas for initial focus.

1. Reduce unhealthy behaviors that are risk factors for many chronic conditions and the worsening of chronic conditions after they develop

2. Increase health care providers' use of chronic disease uniform treatment guidelines and other health management tools

3. Encourage employers, including the State of Delaware, to implement chronic disease management programs

4. Encourage the Delaware Medical Assistance Program, which has oversight for Medicaid and the Delaware Healthy Children Program, to implement chronic disease management programs

5. Establish an ongoing mechanism to enhance and monitor recommended strategies for mitigating the impact of chronic disease

It is recommended that the task force's efforts continue. The Delaware Division of Public Health and the Delaware Health Care Commission are charged with determining a means to ensure that implementation of the above listed strategies is supported and monitored.

Finally, the task force wishes to emphasize that its work was limited in time and scope and that this report is just a beginning of what will require a much larger and more comprehensive statewide effort. This work will occur in conjunction with other State of Delaware task forces and activities that share health concerns. These include, but are not limited to, Delaware Healthy People 2010, Delaware Diabetes Coalition, Delaware Advisory Council on Cancer Incidence and Mortality, the Lt. Governor's Challenge, Delaware Action for Healthy Kids, and the Governor's Council on Lifestyle and Fitness.

1. PROJECT BACKGROUND

Charge of Task Force

The purpose of the task force was to recommend strategies to reduce the incidence and improve the management of chronic disease to improve health and reduce costs.

Rather than focusing on disease-specific strategies, the task force chose to look at broad programs and strategies that would promote disease management across multiple settings and multiple diseases. These strategies will take short-term and long-term coordinated implementation and monitoring efforts.

Framework for the Report

The task force recognized that there are generally two methods of implementing recommended strategies -- mandate that they be adopted or encourage their implementation. The task force noted that there are several barriers to mandating behavior, and chose to focus on strategies that *encourage* change and the use of incentives.

Process Used by the Task Force to Complete its Work

The Task Force employed a three-part process to complete its work: (1) information gathering; (2) adoption of a definition for disease management; and (3) identification of recommended goals and strategies.

1. Information Gathering

This phase broadened task force members' understanding of chronic illness and disease management and their overall understanding of the existing disease management programs in the public and private sectors. While the information gathering process was intended to be as thorough as possible, most members recognized that, in actuality, it did not reflect the vast breadth and depth of activities taking place now or anticipated in the future.

Specific presentations included:

- Overview of chronic illness and disease management activities in other states, including lessons learned, by The Council of State Governments.

- Disease Management programs that are already occurring as well as those that are planned in Delaware's Medicaid program, by Delaware Medicaid

- Overview of the new Nemours Division of Health and Prevention Services that is aimed at health promotion and disease prevention strategies for the state's children, by the Nemours Foundation

- School-based programs aimed at curbing childhood obesity, by the Delaware Department of Education

- Specific disease management programs targeting asthma and heart failure at Christiana Care Health System, by Christiana Care Health System

- Increased issues concerning "special needs" populations, by the Nemours Foundation and Christiana Care Health System

2. Development of a Definition

Definition development included a process of reviewing existing national definitions of disease management. These sessions incorporated key themes and issues raised during the goals and strategies development processes.

3. Identification of Strategies and Recommendations

Successful disease management strategies are patient-centric and involve the commitment, understanding and perspectives of multiple stakeholders.

They involve family caregivers, employers and health plans, health care professionals and government.

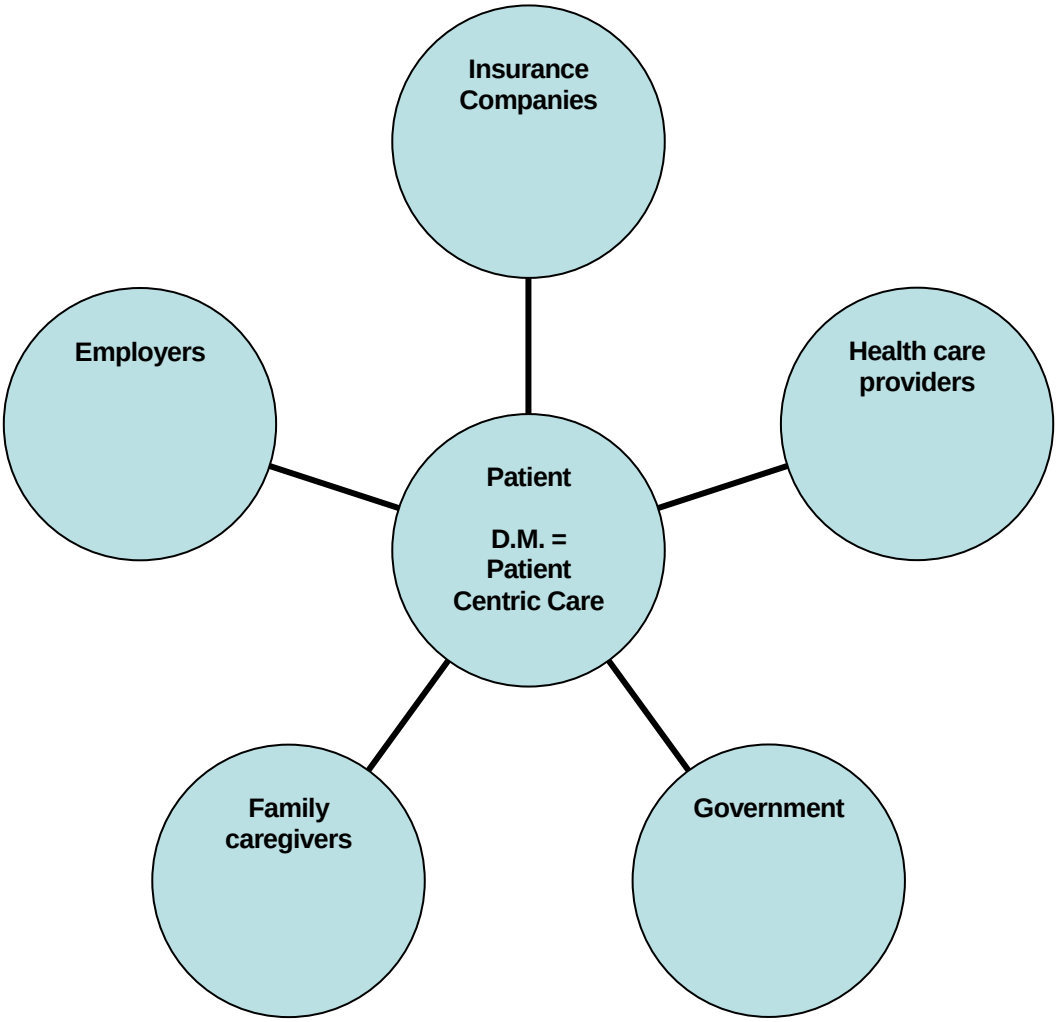
Family caregivers must understand the nature of the chronic condition, and be aware of the physical and emotional experiences of the person who has the chronic condition, in order to be equipped with the knowledge and compassion necessary to help.

Employers and health plans are equal partners in disease management in that understanding the condition will help assure that the workplace can support the physical needs of the patient, and that medically necessary treatments are obtained with minimal administrative obstruction.

Likewise, health professionals are an essential communication and treatment link, assuring that people with chronic illnesses can function at optimal level. They are involved in the initial screenings, intake, gate-keeping, treatment and referral points of service.

Government can create an environment that supports the roles of all the stakeholders. In many cases, government can improve access to services, promote standards of care and provide important research and program development.

Disease Management (D.M.) Is Patient Centric.



Key issues and broad goals are the foundation for the development of specific goals and strategies.

Recognizing that the development of recommended goals and strategies would vary by perspective, the task force split into four stakeholder specific workgroups to begin the process: (1) employers and insurance companies, (2) government, (3) patient and family caregivers, and (4) health care providers.

2. FAST FACTS ABOUT CHRONIC ILLNESS

The Delaware Healthcare Association defines chronic disease as a disease with one or more of the following characteristics: (1) is permanent, leaves residual disability; (2) is caused by nonreversible pathological alternation; (3) requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care.[3]

Some common examples of chronic illness are asthma, arthritis, Alzheimer's disease, cancer, depression, diabetes, heart disease and stroke. About half of all Americans are affected by one or more chronic illnesses. Chronic illness causes 7 out of 10 deaths each year and accounts for 78% of all health care spending.[4]

Chronic illness is becoming more prevalent for many reasons: the aging of the population, greater longevity, and advances in medical care that allow people to live longer with chronic disease.

For many, individual behaviors and lifestyles contribute to the development or increased severity of chronic conditions. Examples include poor diet, lack of physical activity and tobacco use. Obesity, for example, is a risk factor for a number of chronic diseases, including Type 2 diabetes, congestive heart failure, stroke and hypertension.[5]

Why is chronic illness in Delaware so important?

Delaware:

- Ranks 25th in the nation for deaths due to the five leading chronic disease killers - disease of the heart, cancers, stroke, chronic lower respiratory disease and diabetes[6]

- Ranks 34th in the nation for overall health status[7]

[3] DHA website, www.deha.org, July 2004
[4] Council of State Governments, State Official's Guide, Chronic Illness, 2003
[5] Prevention Makes Common "Cents", U.S. Department of Health and Human Services, September 2003
[6] The Burden of Chronic Diseases and Their Risk Factors, National and State Perspectives 2004, U.S. Department of Health and Human Services.
(This reporting is based on 2001 statistics, and the percentage of deaths in Delaware due to these five chronic diseases is 66.5%. The national average is 66.7%.)
[7] America's Health: State Health Rankings, United Health Foundation, 2003 Edition

- Ranks 31st in the nation for total cardio-vascular disease, 40th for coronary heart disease and 8th for stroke[8] [9]
- Ranks 4th highest overall in cancer mortality rates[10]
- Is in the top 25% of states for diabetes prevalence[11]
- Shows 11.8% of its population having lifetime asthma[12]
- Has estimated adult obesity-attributable medical expenditures of $207 million (in 2003)[13]

[8] Heart Disease and Stroke Statistics – 2004 Update, American Heart Association

[9] Total cardiovascular disease is defined as ICD/10 100-199; coronary heart disease: ICD/10 120-125; stroke: ICD/10 160-169.

[10] The Burden of Chronic Diseases and Their Risk Factors, National and State Perspectives 2002, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.
Notes: Deaths per 100,000, age –adjusted to 2000 total US population. In the 2004 update, rank is not longer a listed variable; however, a review of rates reveals DE still ranks 4th.

[11] The Burden of Diabetes in Delaware, Delaware Health and Social Services, 2002.

[12] Asthma Prevalence and Control Characteristics by Race/Ethnicity – United States, 2002, MMWR Weekly, February 27, 2004. Lifetime asthma means persons who responded "yes" to survey questions indicating that they have been told by a health professional at some point in time that they have asthma and self-report that they still have asthma

[13] OBESITY RESEARCH. Vol. 12, No. 1, January 2005 (Statistics for 2003)

3. TYPES AND ASPECTS OF DISEASE MANAGEMENT

Disease Management is a *Process*

Health promotion and disease management programs help people prevent and better manage chronic conditions so they may lead healthy and productive lives.

Both require long-term commitments.

It is generally recognized that there are two types of disease management: (1) primary prevention and (2) secondary prevention.

Primary prevention aims to prevent the onset of chronic illness. Healthy eating habits, smoking cessation and routine physical exercise are examples of primary prevention activities.

Secondary prevention occurs after a diagnosis of a chronic illness. Its aim is to prevent severe illness or disease progression. Testing blood sugar and changing the diet of a person who has been diagnosed with diabetes is an example of secondary prevention.

Employers striving to curb health care costs may view secondary disease management programs as the quickest and most measurable way of saving money and improving health. These programs have become particularly attractive to large employers striving to control health insurance costs and increase employee productivity. They also are attractive to state governments that are trying to control rising Medicaid costs.

However, the long term benefits of primary prevention are just as important. Primary prevention usually includes elements of personal behavior, such as adopting a healthy lifestyle. However, in the absence of "at the moment", clear-cut consequences of unhealthy behaviors, individuals may lack incentive to change the unhealthy components of their lifestyles. The cost benefits of primary prevention also are difficult to quantify, as they consist of cost avoidance rather than expense reduction. It is difficult to determine just what health care costs would be avoided for a person whose behavior has changed.

The task force embraces both primary and secondary prevention techniques. A narrow, short-term focus on secondary prevention will not

produce optimal long term results in terms of improved health status or reduced cost.

Definition of Disease Management

The task force embraced the principles that form the basis of the disease management definition adopted by the Disease Management Association of America.[14]

> *Disease management is an integrated system of healthcare interventions to patients, providers and payers, guided by patient management guidelines designed to optimize clinical outcomes, quality of life and total cost.*

The concept incorporates primary and secondary prevention, and, therefore, encompasses a wide range of disease management strategies.

The task force also firmly believes that disease management must be thought of as patient-centric.

While the above language speaks to guidelines and outcomes, just as important is the concept of empowering patients to control their condition or prevent it from occurring.

All key stakeholders have a role in assuring that this empowerment takes place, as demonstrated on the following page.

[14] The Disease Management Association of America DM definition: A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management: (1) supports the physician or practitioner/patient relationship and plan of care; (2) emphasizes prevention and exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies; and (3) evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Disease Management Components include: (1) population identification processes; (2) evidence-based practice guidelines; (3) collaborative practice models to include physician support-service providers; (4) patient self-management education (may include primary prevention, behavior modification programs and compliance/surveillance); (5) process and outcome measurement, evaluation and management; and (6) routine reporting/feedback loop. Full service Disease Management Programs must include all 6 components. Programs consisting of fewer components are Disease Management Support Services.

Stakeholder Roles in Chronic Disease Management

The following lists stakeholders and examples of their roles in disease management. These roles are neither mutually exclusive nor comprehensive.

Employers	Promoting disease management and healthy lifestyles in the workplace; enabling employees to manage their chronic illness while at work
Insurers	Incorporating disease management into their plans
Government	Promoting disease management for state employees and enrollees in public medical assistance programs, and providing leadership in calling attention to the key issues surrounding chronic illness and disease management
Providers	Adopting the use of treatment guidelines and communicating the importance of disease management and healthy lifestyles to their patients
Patients and Family Caregivers	Becoming informed and literate about chronic conditions and how to prevent and/or manage them, thereby becoming empowered to lead optimal lives

4. KEY FACTORS IMPACTING CHRONIC DISEASE MANAGEMENT

Education

People with chronic illness are helped by having accurate and current information about their illness, the latest science pertaining to their disease and guidance regarding specific steps that they can take to manage their disease.

Families and caregivers must be aware of the impact of the condition on the patient -- and on themselves -- if they are to provide the most effective and compassionate care.

Employers need to know the general facts about the most prevalent types of chronic conditions so they can help their employees function to their maximum ability and be productive in the workplace.

Insurers can provide participants in disease management programs information about their condition so that they can more effectively manage their disease and stay healthy. By educating patients about when and how to seek appropriate medical care and develop healthy habits, participants can avoid unnecessary emergency room visits and hospitalizations.

Health care practitioners need to know about recommended tests and treatments for chronic conditions and how to communicate with their patients so that they can render appropriate care using the best scientific evidence.

Government must provide disease management programs and encourage those for whom they are responsible to participate in them. This includes state employees and Medicaid beneficiaries. This is essential to having a productive workforce and to controlling costs. Government also is in a unique position of being able to promote disease management in the public and private sectors.

Data Collection and Analysis

There are multiple aspects of data collection and analysis within the realm of chronic illness and disease management. It is important to identify and

monitor the most prevalent chronic conditions in order to promote strategies to manage them.

Employers need to know which conditions are most likely to be present in the workplace.

Providers need to know which conditions they should be prepared to treat, as well as the best and most efficient treatment protocols to apply when treating patients with chronic illness.

Insurers can collect information on participants in disease management programs with regard to utilization of appropriate health services and clinical outcomes in order to improve case management.

The development of appropriate public health programs, as well as specific coverage programs – whether they are state health benefits or private insurer benefits – depend on good data about key chronic conditions.

Incentives

Encouraging healthy behaviors and the use of disease management tools may require incentives. Changing personal behavior is difficult. The person with a chronic condition may not immediately identify the ill effects of failing to manage his or her condition. Employers may not immediately see the cost benefit of promoting disease management strategies in the workplace. Providers may prefer to treat chronic conditions in a "tried and true" way as a result of habit rather than use newer and improved treatment protocols. Financial or other incentives can stimulate change.

Health Literacy

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[15] Patients must be able to understand the nature of their chronic illness, and the treatment advice and directions from their health care providers to improve health. One approach to solving problems regarding cost, access and the quality of health care is to encourage consumers to be more informed and actively involved in health care decisions. It is believed

[15] Definition used in Healthy People 2010, adopted from U.S. Department of Health and Human Services, National Institutes of Health, National Library of Medicine. In: Seiden, C.R.; Zorn, M.; et al.; eds Health Literacy, January 1990 through 1999, published in February 2000.

that more informed health care consumers would know more about how to access affordable health care, be more cost conscious, and know what questions to ask about tests and procedures. However, a major barrier to achieving a more informed and active health care consumer is a lack of basic health literacy in the United States.[16] It is estimated that nearly half of all Americans have difficulty understanding and using health information.[17]

Identifying Key Populations

There is no one set of disease management strategies that will fit the needs of all people. Different strategies are required for diseases and populations. It is critical to identify key target populations, identify their needs and offer strategies that will work for them. For example, adults with severe physical disabilities will have needs that are different from an otherwise healthy child who has asthma.

Determining Resources

Demand for financial and manpower resources to prevent and manage chronic disease can easily outstrip the available supply. Strategies that can be realistically implemented need to be identified.

Identifying Responsible Parties

Parties who are able and willing to lead and participate in the implementation of disease management strategies must be identified.

Good disease management programs require changes that will result in informed, activated patients and prepared interdisciplinary teams of providers working with family physicians, medical specialists and others. Elements of a health care system that encourage quality chronic disease management include the community, the health system, self-management support, delivery design, decision support and clinical information systems. State departments of health and other state agencies can provide information materials to help patients control chronic disease. National patient organizations (American Diabetes Association, for example) can promote self-help strategies. Health care delivery system design and individual health care organizations can create a culture and the mechanisms to promote safe, high quality care and assure that patient follow up care is standard procedure. Community based exercise

[16] Executive Summary, Excerpt from the Council of State Government's State Official's Guide to Health Literacy, Health Literacy Tool Kit.
[17] Institute of Medicine Report on Health Literacy

programs, disease education and self-management classes can enhance the ability of people with chronic disease to manage their disease.[18]

Key stakeholders that may be involved include employers, government agencies, health care providers, insurers, patients themselves and family caregivers.[19]

[18] Improving Chronic Illness Care, a National Program of the Robert Wood Johnson Foundation and The Chronic Care Model, www.improvingchroniccare.org

[19] Stakeholder groups identified by Delaware HJR10 Task Force

5. GOALS AND RECOMMENDED STRATEGIES

The task force identified five areas for initial focus.

1. Reduce unhealthy behaviors that are risk factors for many chronic conditions and the worsening of chronic conditions after they develop

2. Increase health providers' use of chronic disease uniform treatment guidelines and other health management tools

3. Encourage employers, including the State of Delaware, to implement chronic disease management programs

4. Encourage the Delaware Medical Assistance Program, which has oversight for Delaware Medicaid and the Delaware Healthy Children Program, to implement chronic disease management programs

5. Establish an ongoing mechanism to enhance and monitor recommended strategies for mitigating the impact of chronic disease

The task force began the process of identifying activities or strategies to help meet the above-listed goals. However, it clearly recognizes that the identified strategies need additional thought and detail, that additional strategies need to be developed, and that a means of ensuring the strategies are implemented needs to be put in place. These concerns formed the basis for recommendation number five (5).

The first phase strategies identified for meeting these goals and, in some cases, suggestions for who might be responsible for carrying them out and potential funding sources are provided.

GOAL 1

Reduce unhealthy behaviors that are risk factors for many chronic conditions and diseases, such as poor diet, lack of physical activity, tobacco use and alcohol and drug abuse.

Strategy A: Workplace initiatives that target all employees

Workplace strategies might be more successful if targeted to the entire employee population rather than singling out certain employees and encouraging them to change their behavior. This strategy would avoid any perceptions of inappropriate interference on the part of employers in the lives of their employees. At the same time, it would encourage healthy lifestyles and give employees basic information about the importance of healthy living.

Strategy B: Healthy lifestyle education programs with incentives to participate

Healthy lifestyle classes could provide the information needed to promote adoption of healthy eating habits and routine physical exercise and avoidance of tobacco use and of alcohol abuse. Incentives to take advantage of the class might be in the form of some type of financial reward, such as a discount on insurance premiums.

Strategy C: Support successful programs

Explore ways to increase awareness and promote the disease management programs that already are in place, such the Delaware Lt. Governor's Physical Fitness Challenge. The program challenges Delawareans to become more physically active and to make healthier food choices. Participants in the Lt. Governor's Challenge accumulate points by completing any of a wide variety of daily activities on a point list. After about three months, participants can earn a gold, silver or bronze medal, based on the number of points earned.

Strategy D: Promote primary prevention in schools

Increase activities to promote healthy lifestyles in public schools. Schools are a key setting in which to promote the health of children, teens, young adults and the wider community.

Strategy E: Increase the number of fitness trails, bike paths and sidewalks

Support public recreation and transportation systems that encourage walking and bicycling as a way to increase safe, affordable, opportunities for exercise.

Strategy F: Help health care providers promote healthy lifestyles

Develop a list of questions and appropriate responses that health care providers can use with their patients to promote healthy lifestyles.

Administrative Responsibility Possibilities

In schools, a team approach that involves teachers, non-teaching staff (i.e. school nurses), pupils, parents, government officials and the wider community could be used. In other venues, employers and government agencies should play a lead role.

Potential Funding Sources

Community organizations, community development block grants, public education and transportation funds, federal funding (Centers for Disease Control and Prevention, U.S. Department of Agriculture, Department of Education), and private foundations.

GOAL 2:

Increase the use of uniform treatment guidelines and other quality improvement tools for the prevention, early diagnosis and treatment of chronic disease..

The Uniform Treatment Guideline project of the Medical Society of Delaware in collaboration with the state's major insurance carriers is a very important first step. Strategies should now be implemented to increase the use of the guidelines already developed.

Strategy A: Link use of the guidelines to provider payments

Explore the feasibility of including in existing guidelines instructions on how to code billings to insurance carriers, since this will help assure that adhering to them will result in payment for the services provided.

Strategy B: Enable guidelines to be used for multiple chronic conditions

Develop a form that providers can use to screen for chronic disease that will cut across multiple types of conditions.

Strategy C: Promote use of the guidelines among patients

Publicize the existence of the guidelines among the general public in an effort to arm patients with the information that they need to be sure they are getting the recommended tests and treatments.

Strategy D: Provider recognition for use of the guidelines

Develop provider recognition programs, or promote the use of existing programs developed by national organizations, such as the American Diabetes Association, Quality Insights, and the Disease Management Association of America.

Strategy E: Research and distribute the findings on impact on medical outcomes of using the guidelines

Evaluate the extent to which the guidelines are being utilized by health care practitioners and the impact on patient health and/or caregivers' well being.

Strategy F: Highlight the value of the guidelines among providers

Publish articles about the guidelines in insurer newsletters to providers. Hold a "summit" for the purpose of getting insurers, the Insurance Commissioner, Medicaid and others to promote the use of the guidelines.

Strategy G: Make it easier for providers to use the guidelines

Develop a "tool kit" that would prompt providers on when and how to use the guidelines. This could be an encounter form or check list for providers to use during screening and assessments. It could apply to multiple chronic diseases.

Strategy H: Delaware Health Information Network

Disease management and uniform treatment guideline use will be enhanced with the implementation of the envisioned Delaware Health Information Network's Clinical Information Sharing Utility. The utility will enable clinicians to obtain patient information electronically (with patient consent and full privacy and security measures in place) from multiple sources of care. It is anticipated that the ability to review information such as treatments, prescriptions and lab results that have been conducted or ordered by other clinicians will reduce the chance of duplicate tests and adverse drug interactions, and increase the use of disease management and uniform treatment guidelines.

Administrative Responsibility Possibilities

The Medical Society of Delaware and other professional organizations could develop and administer activities to promote the use of the guidelines.

The Delaware Health Information Network in conjunction with the Delaware Health Care Commission will orchestrate the development of the clinical information sharing utility.

Potential Funding Sources

Public and private grants, private donations and possible user fees.

GOAL 3

Encourage employers, including the State of Delaware, to develop disease management programs for their employees and their families

Strategy A: Hold a summit on the impact of chronic disease in Delaware and the benefits of chronic disease management

The Delaware Insurance Commissioner should sponsor a disease management summit to highlight the prevalence and cost of chronic illness, both human and economic, and the importance of disease management.

Strategy B: Expand the existing chronic disease management pilot for state employees

The State Employee Health Benefits Plan has implemented a pilot disease management program at present. Subject to an evaluation demonstrating that the program is yielding improvements in terms of improving health and controlling costs, the pilot should be expanded.

Strategy C: Work with chambers of commerce and educational organizations

Collaboration between the chambers of commerce, community organizations and educational institutions, such as the University of Delaware, could produce strategies to promote disease management among Delaware employers.

Strategy D: Provide incentives to participate in disease management programs

Insurance premiums could be lower for employees who participate in disease management programs.

Administrative Responsibility Possibilities

Delaware Department of Insurance (Strategy A), State Employees Health Benefits Committee (Strategy B), Chambers of Commerce (Strategy C)

The Delaware Health Information Network, operating under the direction of the Delaware Health Care Commission, will orchestrate the development of the clinical information sharing utility.

Potential Funding Sources

For state employees and Medicaid recipients, the State of Delaware Employee Benefits Committee could negotiate disease management programs with insurance carriers. Private sector employers could negotiate with insurers to fund disease management programs.

Pursue funding opportunities with federal agencies, such as the Centers for Medicare and Medicaid Services and the Centers for Disease Control and Prevention.

GOAL 4

Encourage the Delaware Medical Assistance Program to develop disease management programs for enrollees.

The Delaware Medical Assistance Program provides oversight for Delaware Medicaid and the Delaware Healthy Children Program. Medicaid covers individual adults up to 100% of the federal poverty level, and a combination of Medicaid and the Delaware Healthy Children Program covers children up to 200% of the federal poverty level.[20] Currently, 96,000 people are enrolled in the Medicaid and the Delaware Healthy Children Program. This number excludes those covered by Medicaid for long-term care services.

Strategy A: Utilize a tracking system to monitor utilization

A tracking system known as the Atlantes system will be implemented in fiscal year 2005. It will provide profiles of patients in traditional Medicaid, and in Diamond State Partners, the managed care program administered by the Delaware Medical Assistance Program. It will track what services they are receiving and the service setting. A program-wide chronic disease management program[21] that leverages the capabilities of the Atlantes system should be implemented to help monitor utilization and ensure optimum patient care.

Strategy B: Complete feasibility analysis of implementing a Medicaid-Buy-In Program with a disease management component

The Delaware Medical Assistance Program is planning to present a Medicaid Buy-In Program implementation plan to the administration for inclusion in the State Fiscal Year 2006 budget. Under such a program, working individuals with disabilities who because of their earnings would otherwise not be eligible for Medicaid can gain Medicaid coverage. Such individuals would be able to "buy-in" to Medicaid by paying a premium (and perhaps a deductible). If such a program is developed, a chronic disease management component will be included.

[20] 100% of the 2004 FPL for a family of four is $18,850 gross annual income or $1,571 gross monthly income.

[21] Currently, Delaware Medical Assistance Program has limited disease management oversight of some service provided by managed care organizations for Medicaid recipients, i.e. asthma.

Strategy C: Hold a summit on the impact of chronic disease in Delaware and the benefits of chronic disease management

The Delaware Insurance Commissioner should sponsor a disease management summit for all insurers to highlight the prevalence and cost of chronic illness, both human and monetary, and the importance of disease management.

Administrative Responsibility Possibilities

Future activities would be undertaken by the Delaware Medical Assistance Program. The Delaware Insurance Commissioners' office, the Department of Health and Social Services, and others should assist as needed.

Potential Funding Sources

A disease management program would cost approximately $15.4 million. The program could be financed with 25 percent of the cost borne by the state and 75 percent of the cost covered by federal matching funds.

Funds must continue to be appropriated by the Delaware General Assembly.

Apply for federal demonstration grants.

GOAL 5

Establish a mechanism to monitor and support implementation of recommended strategies on an on-going basis.

Strategy 1: Determine the best method to strengthen the focus on chronic disease management in the private and public sectors.

The Delaware Division of Public Health and the Delaware Health Care Commission, along with other interested parties, should determine the means to ensure that the above-listed strategies and others that may be identified, are carried out, evaluated and modified based on the evaluation findings.

Administrative Responsibility Possibilities

Collaboration between the Delaware Division of Public Health and Delaware Healthcare Commission, with relevant non-profit and public organizations involved. The Commission will convene a workgroup to recommend the structure of an official advisory body to promote continuation of the task force's efforts.

Potential Funding Sources

Existing agency resources.

APPENDICES

House Joint Resolution 10

SPONSOR: Rep. Hall-Long & Sen. Blevins;

Reps. Atkins, Buckworth, Carey, Cathcart, DiPinto, B. Ennis, D. Ennis, George, Gilligan, Hocker, Houghton, Hudson, Keeley, Lofink, Maier, Mulrooney, Oberle, Plant, Reynolds, Schwartzkopf, Ulbrich, Van Sant, Viola, Williams; Sens. Amick, Connor, DeLuca, Henry, Peterson, Sokola, Sorenson, Vaughn

HOUSE OF REPRESENTATIVES

142nd GENERAL ASSEMBLY

HOUSE JOINT RESOLUTION NO. 10

CREATING A TASK FORCE ON CHRONIC ILLNESS AND DISEASE MANAGEMENT AND PREVENTION IN THE PRIVATE AND PUBLIC SECTOR IN THE STATE OF DELAWARE.

WHEREAS, chronic diseases such as congestive heart failure, cardiovascular disease, diabetes mellitus, and asthma are substantially increasing in great numbers among the general population in the State of Delaware; and

WHEREAS, these chronic diseases are statistically increasing in great numbers among Delaware's overall population and particularly among Delaware's Medicaid and Medicare eligible citizens; and

WHEREAS, the health of Delaware citizens would greatly benefit from a coordination of resources, data, information and treatment of chronic diseases between private and public health sectors; and

WHEREAS, the cost of treatment of chronic disease will continue to impact State financial resources and the private health care system;

NOW THEREFORE:

BE IT RESOLVED by the House of Representatives and the Senate of the 142nd General Assembly, with the approval of the Governor, that a Task Force be created within the Delaware Health Care Commission to examine issues surrounding disease management strategies, including their potential to improve individual health, promote quality health care and contain health care costs. Such examination can include review of existing programs in the public and private sectors in Delaware and other states, and identification of methods to promote and coordinate disease management activities.

The Task Force will be managed and staffed by the Delaware Health Care Commission and will consist of the following members:

1. Chairperson of the Delaware Health Care Commission or his/her designee;

2. State Insurance Commissioner or his/her designee;

3. Director of Public Health or his/her designee;

4. Director of Medicaid or his/her designee;

5. Three (3) members from Delaware authorized health insurers, HMO's or medical insurance corporations to be appointed jointly by the Speaker of the House and the President Pro Tempore of the Senate;

6. Chairperson of the Association of Delaware Hospitals or his/her designee;

7. Three (3) health care professionals who have the relevant knowledge and experience to be appointed by the Governor;

8. Two (2) members of the public who have the relevant knowledge and experience to be appointed by the Governor;

9. Two (2) representatives of the Delaware House of Representatives and two (2) representatives of the Delaware State Senate (one from each caucus);

10. One (1) employee from the Delaware State Personnel Office to be appointed by the Director; and

11. One (1) professor from a Delaware institution of higher learning to be appointed by the Governor.

BE IT FURTHER RESOLVED that the Task Force shall study the best approaches for coordinating chronic disease management between the private and public sector with specific suggestions for implementing said coordination.

BE IT FURTHER RESOLVED that the Chairperson of the Task Force shall be elected by a majority of members the Task Force.

BE IT FURTHER RESOLVED that the Task Force shall submit its findings to the Speaker of the House, the President Pro Tempore of the Senate and the Governor by March 31, 2004.

SYNOPSIS

This Resolution creates a Task Force to study the coordination of private and public health sectors for chronic disease management in the State of Delaware and sets a date to submit its findings by March 31, 2004.

Acknowledgements

Task force members, contributing guests and staff are to be commended for their contributions.

Task Force Membership

Task Force membership was designed to draw from multiple and diverse viewpoints to broaden each member's overall understanding of the multitude of issues surrounding chronic illness and disease management, and identify workable strategies and activities that would empower people with chronic illness to manage their conditions and lead their lives in optimal health. Established by House Joint Resolution 10, the task force was staffed and managed by the Delaware Health Care Commission.

Representative Bethany Hall-Long, Chairperson

Anthony D. Alfieri, D.O, *Healthcare professional appointed by the Governor*

Senator Patricia Blevins, *Delaware State Senate*

Lt. Governor John C. Carney, Jr., *Chairman, Delaware Health Care Commission Chairman*

Senator Dorinda "Dori" Connor, *Delaware State Senate"*

James Fierro, D.O., *Health care professional appointed by the Governor*

Joseph F. Fitzgerald, Jr., *Public member appointed by the Governor*

Jeffrey Fried, *Delaware Healthcare Association designee*

Evelyn Hayes, PhD, APRN, BC, *Professor from a Delaware institution of higher learning appointed by the Governor*

Judith Hendricks, *Public Member appointed by the Governor*

Paul A. Kaplan, MD, MBA, FAAFP, CPE, *Representing Delaware insurer, HMO or medical insurance corporation appointed jointly by the Speaker of the House and President Pro Tempore of the Senate*

Harvey Kaufman, MD, *Representing Delaware insurer, HMO or medical insurance corporation appointed jointly by the Speaker of the House and President Pro Tempore of the Senate*

Representative Pamela Maier, *Delaware House of Representatives*

Thomas Mannis, MD, *Representing Delaware insurer, HMO or medical insurance corporation appointed jointly by the Speaker of the House and President Pro Tempore of the Senate*

Debbie McCall, *Delaware State Personnel Office*

Jill Rogers, *Director of Delaware Division of Public Health designee*

Phil Soule, *Director of Delaware Medicaid*

Peter Stone, Deputy *Insurance Commission, State Insurance Commissioner designee*

Contributing Guests

Jill Floore, *State of Delaware, Budget Office*

Debbie Chang*, Nemours Health and Prevention Services*

Suzanne Raab-Long, *Delaware Healthcare Association*

Robert Frelick, MD

Trudi Matthews, *The Council of State Governments*

Kay Holmes*, Delaware Medicaid*

Linda Nemes, *Delaware Department of Insurance*

Al Rose, *Developmental Disabilities Council*

Jamie Wolfe, *State Council for Persons with Disabilities*

David Bowman, *Delaware Department of Education*

Mary J. Gant, *Chrisitana Care Health System*

Robert Simmons, Consultant, *Community Health Promotion & Chronic Disease Prevention*

Edward Woomer*, A.I. duPont Hospital for Children*

Brad Allen, *New Castle County Chamber of Commerce*

Gale Bucher, *Christina Care Visiting Nurses Association*

Les DelPizzo, *Quality Insights of Delaware*

Don Fulton, *Weiner & Associates*

Joann Hasse, *League of Women Voters*

Lisa Kaminsksi, *Graduate Student Nurse, University of Delaware*

Cindy Mannis*, Delaware Diabetes Coalition*

Staff

Paula K. Roy, *Delaware Health Care Commission*

Marlyn Marvel, *Delaware Health Care Commission*

Judith A. Chaconas, *Delaware Health Care Commission*

Resources

Centers for Disease Control and Prevention, 1600 Clifton Road, Atlanta, GA, 30333 404-639-3311 www.cdc.gov

The Council of State Governments (resources include State Official's Guide to Chronic Illness and a Health Literacy Tool Kit) 1-800-800-1910 www.csg.org

Delaware Health and Social Services, Delaware Division of Public Health, Disease Prevention and Control, P.O. Box 637, Federal and Water Streets, Dover, DE 19903 302-739-3033

Disease Management Association of America, 601 Pennsylvania Avenue, South Building, Suite 500, Washington, DC 20004 202-861-1490 www.dmaa.org

Improving Chronic Illness Care, a national program of the The Robert Wood Johnson Foundation at the MacColl Institute for Healthcare Innovation, Group Health Cooperative Center for Health Studies, 1730 Minor Avenue, Suite 1290, Seattle, WA 98101-1448 206-287-2704 www.improvingchroniccare.org

U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201 1-877-696-6774 www.hss.gov