NAMI POLICY RESEARCH INSTITUTE

DISEASE MANAGEMENT PROGRAMS: A NEW APPROACH IN STATE MEDICAID COST CONTAINMENT POLICY

December 2003

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Background

Disease management (DM) is becoming the new trend in health care service and delivery as public and private sector health care purchasers grapple and respond to rising health care costs and health insurance premiums. It is an intervention intended to reduce health care spending and improve health outcomes through better management of one or more chronic conditions. DM programs focus on patient education, patient self management and physician feedback.

What is DM?

DM is a collaborative multidisciplinary effort to patient care that relies on a standardized assessment of symptoms and outcomes.

DM (also called illness management) is a broad set of strategies designed to help individuals with chronic diseases such as severe mental illness, collaborate with health care caregivers, reduce their susceptibility to the illness (including co-occurring disorders and other related health conditions), and cope effectively with their symptoms.

DM coordinates medical resources for patients across the entire spectrum of care. A critical distinction between DM and other approaches to traditional care is a shift in focus from treating patients during discrete episodes of care to the provision of high-quality care across the continuum. A core philosophy of DM is continuous quality improvement.

DM strategies are designed to correct the structural deficiencies in the current care system, improve quality and health outcomes, and to reduce costs by:

- Identifying high-cost and high-risk patients;
- Educating those patients and empowering them to become better engaged in their own care;
- Improving provider awareness and adherence to evidence-based care strategies; and
- Establishing more coordinated care interventions and follow-up systems to prevent unnecessary medical complications (1).

What Has Been the State Experience?

State DM programs target the most costly chronic diseases in their Medicaid population and those that offer the greatest potential for cost savings from improved provider practices and patient self-management. DM programs most often focus on asthma, diabetes, hypertension and mental disorders. Medicaid managed care companies have used DM programs and their associated tools for several years in the Medicaid program.

Many states are now beginning to attempt to institute DM programs on the fee-for-service side of the Medicaid program, which primarily serves the more chronically ill, aged, blind, and disabled recipients (2).

State DM programs vary in design but often include:

- Educating providers and supporting their efforts to adhere to evidence-based practice protocols;
- Assisting doctors in monitoring patients;
- Enhancing patient self-management and adherence to treatment care plans;
- Providing feedback to the medical provider and patient; establishing communication and collaboration among health care providers and between the patient and providers; and measuring outcomes (3).

More specifically, state programs use chronic disease registries to track and monitor patients, engage doctors in training on evidence-based best practices; provide decision support systems to help health care providers adhere to practice guidelines; employ nurses, pharmacists, dieticians, respiratory therapists, psychologists, and other care providers to supply patient case management and education; and support patients through counseling, home visits, call centers with 24-hour patient supports, and appointment systems.

More than 20 states are engaged in developing and implementing Medicaid DM programs (4). To date, limited quantitative research has been conducted to evaluate the impact of state programs. Early reports from programs that have conducted assessments indicate that DM programs have contributed to quality improvements in Medicaid and to some cost savings. The following section summarizes the experiences of those states that have outcome data for their initiatives.

Florida

Florida was one of the earliest adopters of Medicaid disease management. Since 1999, Florida has been contracting with vendors for DM programs and now has contracts in place for HIV/AIDS, hemophilia, diabetes, asthma, cancer, congestive heart failure, chronic kidney disease, and hypertension. In general, Florida officials believe the programs have been successful in generating improvements in care quality and modest expenditure reductions (5).

Community Health Centers and the Chronic-Care Model

States are already benefiting from a broad-based effort to reform chronic-care services in community health centers. The Bureau of Primary Health Care (BPHC) is engaged in the Health Disparities Initiative (HDI), a major program to improve the quality of chronic illness for their 10 million clients. One model being used, the Chronic Care model, developed by the MacColl Institute for Health Care Innovation in Seattle, Washington, guides the transformation of chronic care systems from being episodic and reactive to

being comprehensive and proactive. The Chronic Care model focuses on reforming medical care at the community, organization, practice, and patient levels (6).

Thus far, over 350 health centers have participated in training collaboratives to improve diabetes, asthma, congestive heart failure, hypertension, and depression. North Carolina has been actively engaged in adopting the Chronic Care model throughout its community health center system.

Texas and the Disease Management Initiative

The state of Texas is strongly committed to a disease management approach for treating people with severe mental illnesses. In May 2003, the legislature passed a measure requiring that local mental health authorities in the state ensure the provision of assessment services, crisis services, and intensive and comprehensive services using DM practices for adults with bipolar disorder, schizophrenia, or clinically severe depression and for children with serious emotional disorders (7).

The legislation (HB 2292) instructs the local mental health authorities to ensure that individuals are engaged with treatment services that are:

- Ongoing and matched to the needs of the individual in type, duration and intensity;
- Focused on a process of recovery designed to allow the individual to progress through levels of service;
- Guided by evidence-based protocols and a strength-based paradigm of service, and
- Monitored by a system that holds the local authority accountable for specific outcomes.

The Texas Department of Mental Health and Mental Retardation (TDMHMR) is mandated to study the implementation of disease management strategies and submit a report to the Governor and the state legislature on the progress of implementing such programs.

DM will be initially implemented at four sites that have elected to be the first to participate in the new model: Hill Country MHMR, Lubbock Regional MHMR, Authority of Tarrant County, and Texas Panhandle MHMR. In collaboration with TDMHMR, they will operationalize the new approach so that processes can be tested and further refined for a limited time before the model is implemented system-wide (8).

Partnering with Pharmaceutical Firms – The Colorado DM Initiative

Colorado recently launched a DM and care-coordination project for its Medicaid beneficiaries, financed entirely by $1.75 million in contributions from drug companies. Colorado is targeting schizophrenia, asthma, diabetes, breast cancer, and high-risk infants through vendor-based contracts.

In addition, Colorado has contracted for an overarching care-management organization to coordinate all DM programs and to establish a system for identifying beneficiaries for the effort. In total, the state has used funding from seven drug firms to obtain nine DM contracts within an eight-month time frame.

The Medicaid agency will retain all savings generated through the program. The initiative is expected to end in August 2004. By using funds from the private sector, the state has been able to avoid federal Medicaid requirements and changes to the state plans.

DM – Other 2003 Laws

Delaware created a Task Force within the state Health Care Commission to examine disease management strategies including their potential to improve individual health, promote quality care and contain health costs.

Indiana amended the state's existing DM program by striking HIV/AIDS as a covered condition and instead including hypertension, along with asthma, diabetes , and congestive heart failure. A statewide pilot addressing two of those diseases must be completed before full implementation of the program begins.

Iowa law directs the Department of Human Services to pursue chronic disease management aggressively, in order to improve care and reduce costs in the Medicaid program.

New Mexico requires managed care organizations to provide or strengthen DM programs for Medicaid recipients through closer coordination with and assistance to primary care/safety net providers and seeks to adopt uniform key health status indicators. The law also directs the Human Services Department to design a pilot DM program for the fee-for-service population, charging it with ensuring that the program will be based on key health status indicators, accountability for clinical benefits and demonstrated cost savings.

Research on DM for People with Severe Mental Illness

Provider Psychoeducation

Research on DM for persons with severe mental illness (in the area of enhancing patient self-management and adherence to treatment care plans) including 40 randomized controlled studies, indicates that psychoeducation improves people's knowledge of mental illness; that behavioral tailoring helps people take medication as prescribed; that relapse prevention programs reduce symptom relapses and rehospitalizations; and that coping skills training using cognitive-behavioral techniques reduces the severity and distress of persistent symptoms. DM and education-based approaches are especially common in the treatment of other chronic illnesses such diabetes, heart disease, and cancer (9).

DM should be distinguished from peer-based services where peers are able to convey the lessons they have learned from personal experience. DM programs for purposes here are professional/provider-based.

Assertive Community Treatment (ACT) Programs

ACT programs are effective, evidence-based, outreach-oriented service-delivery models for people with serious mental illnesses. Using a 24-hours-a-day, seven-days-a-week , team approach, ACT programs deliver comprehensive community treatment, rehabilitation, and support services to consumers in their homes, at work, and in community settings.

ACT consists of a multidisciplinary group of mental health professionals who work as a team to provide intensive services to patients with severe mental illnesses. Fully staffed ACT teams include psychiatrists, nurses, social workers and vocational rehabilitation specialists, substance abuse counselors and peer specialists. Consumers in the ACT programs receive all services from the ACT team, not from loosely linked mental health, substance abuse, housing, and rehabilitation agencies. The majority of services are delivered where consumers live, work, and spend their leisure time, not in the program office.

Through its multidisciplinary structure, ACT provides an integrated approach offering:

- Direct provision or coordination of all medical care, both psychiatric and general health care
- Help in managing symptoms of the illness
- Immediate crisis response
- Up-to-date, careful use of medications
- Supportive therapy
- Practical on-site support in coping with life's day-to-day demands including: Help in obtaining housing, help with learning how to socialize, job placement, and support, education, and skill-teaching for family members.

Research conclusively demonstrates that comprehensive and aggressive services and supports, such as ACT programs, lead to positive outcomes for people with serious mental illnesses, in terms of higher consumer and family satisfaction, reduced hospital admissions and reduced involvement with criminal justice systems (10). Unfortunately these vital services are frequently lacking in many parts of the country.

What are the Implications of DM?

As policymakers, health plan administrators, and health care purchasers think about expanding the role of DM in health care programs, and specifically in the mental health services, there are several key issues that should be considered:

- How does the DM program address people with multiple chronic conditions?
- How does the DM program address mental/behavioral health issues that are prevalent comorbidities with multiple evidence-based treatment guidelines?

- How do treatment guidelines comport with the Medicaid or a health plan's formulary? Are recommended medications available on a first-tier basis?
- What type of physician support does the DM program have, and is there a feedback loop or other relationship with clinical providers?

Issues for Consideration for Advocates

As DM programs are implemented it will be critically important to identify how savings in DM initiatives translate into additional funds for mental health programs. This issue was at the forefront of discussions in Texas. Cost savings should be earmarked so that they are translated into increased funding for mental health programs. It is likely that as state economies continue to lag, the disease management strategy will receive more attention in state capitals and Medicaid agencies across the country.

DM may present state advocates with a subtle, but new, opportunity to engage state policymakers and officials. It is difficult to obtain increased funding for any program in this budget-deficit environment. However, if evidence-based DM programs become more commonplace, it enables NAMI advocates to engage officials on other programs and efforts that deserve increased funding – ACT, supported employment and housing, and family education and support. Advocates can make the case that several services and programs fall under the heading of DM. Moreover, DM should offer an opportunity to discuss with policymakers the importance of retaining open access to newer medications within the DM construct.

It should be noted that the DM approach has some potential downfalls. By its very nature the DM approach can fragment coalitions, for example, by drawing a line between major depression and mild to moderate. Further, in Texas, there are concerns about providers overstating a diagnosis in order to gain access to care. The bill design in Texas also places persons with an emerging illness in a difficult position as far as accessing services, as the bulk of state funds will only apply to those individuals who meet the priority population.

DM approaches could help open the door for changing the perceptions of legislators to better fund programs and treatments. In this financing environment, advocates need to help legislators recognize programs that are worth funding.

The jury is still out the effectiveness of DM and is new territory for the many states as they introduce the DM to mental illness delivery. However, DM presents unique funding and advocacy opportunities for NAMI. The more evidence-based information that NAMI advocates can get in front of legislators, the increased likelihood that mental illness services and programs will receive more attention and funding. DM may be a critically important device to communicate and illustrate to policymakers the importance of other evidence-based efforts.

November 2003

Notes

1. *Disease Mangement: The New Tool for Cost Containment and Quality Care,* National Governors Association, February 2003.
2. *Disease Mangement: Findings from Leading State Programs*, AcademyHealth, December, 2002.
3. *Disease Management and Multiple Chronic Conditions,* Partnership for Solutions, September 2002.
4. *Disease Mangement: Findings from Leading State Programs.*
5. *Disease Mangement: The New Tool for Cost Containment and Quality Care.*
6. *Curing the System: Stories of Change in Chronic Illness Care,* National Coalition on Health Care, May 2002.
7. HB 2292; Section, 533.0354.
8. HB 2292; Section, 533.0354.
9. Dixon, L., et al, "Evidence-Based Practices for Services to Families of People with Psychiatric Disabilities," *Psychiatric Services*, (52):7: July 2001, pp. 903-910; and Drake, R., et al, "Implementing Evidence-based Practices in Routine Mental Health Services Settings," *Psychiatric Services*, February 2001, (52):2, , pp. 179-182.
10. Phillips, S., et al, "Moving Assertive Community Treatment into Standard Practice," *Psychiatric Services*, (52): 6, June 2001, pp. 771-791.