CHRONIC CARE IN IOWA
Defining Chronic Care

A chronic condition is a disease that has one or more of the following characteristics:

- is permanent
- is progressive, if unmanaged
- is caused by non-reversible pathological alteration
- requires special training of the patient for rehabilitation, self-monitoring, and self-management
- may require a long period of supervision, observation, or care
Defining Chronic Care

A defining difference in providing chronic care versus acute care is that the Chronic Care Model is “patient-centric” versus “disease focused.”

Treatment outcomes are aimed at improving the quality of life for those with ongoing chronic conditions rather than curing disease.
Chronic Care Impact

Chronic Disease Burden

+

Aging Population

+

Budgetary Shortfalls

+

Low Reimbursement Rates

----------------------------------------

Escalating Healthcare Crisis
Chronic Care Impact - Asthma

About 200,000 Iowans have asthma, including 40,000 to 50,000 children (2001).

- Persons hospitalized
  - 2,498 - primary asthma diagnosis
  - 5,451 - either a primary or secondary diagnosis

- Outpatient visits
  - 10,584 - primary asthma diagnosis
  - 18,473 - either a primary or secondary diagnosis
Chronic Care Impact – Congestive Heart Failure (CHF)

53,057 (11%) of Iowa Medicare beneficiaries have CHF (CMS, 2003)

- Persons hospitalized
  - 10,148 - primary CHF diagnosis
  - 85% were older than 65 years

- Outpatient visits
  - 79% were older than 65 years
Chronic Care Impact - Diabetes

149,440 people with diagnosed diabetes in Iowa (BRFSS, 2001)

- The rate for diabetes has increased 25% over the past five years (BRFSS, 2003)
- Persons hospitalized
  - 3,629 - primary diabetes diagnosis
  - 12,062 - either a primary or secondary diagnosis
- Outpatient visits
  - 5,556 - primary diabetes diagnosis
  - 23,856 - either a primary or secondary diagnosis
## Iowa NGA Chronic Care Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>William Appelgate, PhD</td>
<td>Iowa Chronic Care Consortium</td>
</tr>
<tr>
<td>Senator Joe Bolkcom</td>
<td>Iowa Senate</td>
</tr>
<tr>
<td>Representative Ro Foege</td>
<td>Iowa House of Representatives</td>
</tr>
<tr>
<td>Gene Gessow</td>
<td>Iowa Medicaid, Department of Human Services</td>
</tr>
<tr>
<td>Mary Mincer Hansen, RN PhD</td>
<td>Iowa Department of Public Health</td>
</tr>
<tr>
<td>Representative David Heaton</td>
<td>Iowa House of Representatives</td>
</tr>
<tr>
<td>Josh Mandelbaum</td>
<td>Office of Governor &amp; Lt. Governor</td>
</tr>
<tr>
<td>Julie McMahon</td>
<td>Health Promotion &amp; Chronic Disease Prevention</td>
</tr>
<tr>
<td>Jill Myers Geadelmann</td>
<td>Chronic Disease Prevention &amp; Management</td>
</tr>
<tr>
<td>Sheila Riggs, DMSc</td>
<td>Wellmark Foundation</td>
</tr>
<tr>
<td>Fran Sadden</td>
<td>Siouxland District Health Department</td>
</tr>
</tbody>
</table>
The Vision of Iowa’s Disease Management Initiative is to be a state committed to health promotion, prevention and chronic disease management.
Priority

Promotion of chronic disease management models that will:

- increase the efficiency of Iowa’s health care service delivery,
- enhance the management of chronic diseases, and
- support the sustainability of healthy communities across the state.
Iowa NGA Chronic Care Team

Action Plan

- Promote chronic disease management in Iowa with models that include patients, providers and payers.

- Convene a Chronic Care Leadership Council
Iowa NGA Chronic Care Team

Action Plan

- Support implementation of the Chronic Care Model.
- Build data reporting elements and data outcome dissemination/utilization
Iowa NGA Chronic Care Team

Example of
Chronic Disease Management Model

- Chronic Care Model
- Dr. Edward Wagner
- www.chroniccaremodel.org
The Chronic Care Model

Six Essential Elements

1. Community
2. Health System
3. Self-Management Support
4. Delivery System Design
5. Decision Support
6. Clinical Information Systems

The Chronic Care Model as developed by Dr. Edward Wagner
Iowa NGA Chronic Care Team

- Development of White Paper
  - Research
  - Interviews

- Seeds of innovation in Iowa
## Iowa Chronic Care Initiatives

<table>
<thead>
<tr>
<th>Organization</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iowa Academy of Family Practice</td>
<td>Medical Home Model/Chronic Care Model</td>
</tr>
<tr>
<td>Iowa Health Clinics</td>
<td>Chronic Care Model</td>
</tr>
<tr>
<td>Mercy Hospital Clinics</td>
<td>Chronic Care Model</td>
</tr>
<tr>
<td>Iowa Medicaid Program</td>
<td>Disease Management &amp; Case Management</td>
</tr>
<tr>
<td>Iowa Chronic Care Consortium</td>
<td>Case Management &amp; Telemanagement</td>
</tr>
<tr>
<td>Avera-McKennen Health System</td>
<td>CMS Demonstration</td>
</tr>
<tr>
<td>Health Disparities Collaboratives</td>
<td>Chronic Care Model/Medical Home Model</td>
</tr>
</tbody>
</table>
Iowa Chronic Care Initiatives, cont’d

Iowa’s major health insurers

- Wellmark Blue Cross/Blue Shield
- John Deere Health
- Principal Financial Group

“Building” or “buying” disease management programs/services
Potential Barriers to Chronic Care Management in Iowa

National Level

- Policy regarding caring for the full spectrum of acute and chronic care must be more consistent.

- Administrative procedures between Medicare, Medicaid, and private insurance promote cost shifting, versus gaining cumulative benefits of more efficient services through integration.
Potential Barriers to Chronic Care Management in Iowa

Health System Level

- Lack of a reimbursement system that aligns financial payment with integrative care that supports patients through preventative, acute and long term care as needed.

- Provider networks must be integrated to provide comprehensive care.
Potential Barriers to Chronic Care Management in Iowa

Provider Level

- Providers must be supported to implement the Chronic Care Model in their individual office settings
  - Lack of reimbursement, resources and technical assistance
- Providers will need assistance to develop clinical information systems.
Potential Barriers to Chronic Care Management in Iowa

Patient Level

- Patients and care givers must be more informed about the costs, consequences and process of delivering chronic care.

- Patient education and support must be delivered at times when it is most likely to be accepted and understood.

- Patients must be empowered to make informed daily decisions about their health management.
Moving Ahead with Chronic Care

1. Forming an Iowa Leadership Council to guide the development of a statewide plan that addresses Iowa’s unique chronic care issues.

2. Utilizing support and resources of the NGA’s Chronic Care learning collaboratives to bring effective strategies into Iowa for rapid integration.
3. Partnering to explore ways that Iowa can build on its capacity to deliver population-based strategies for chronic care.

4. Facilitating the piloting of more aggressive population disease management programs to develop capacity and deliver chronic care.
Key Considerations for Next Steps

A sense of urgency and need for support systems including:

- development and promotion of common guidelines for use of chronic care models,
- availability and education on supportive technology
- provision of quality services (value-based issues)
- education at the state level on chronic care models and their integration and worth for providers and patients.
We can succeed!

The growing burden of chronic disease can be addressed by supporting efforts that improve the care of Iowa’s citizens with chronic disease.
Questions?

Iowa Department of Public Health

Promoting and Protecting the Health of Iowans