

Approaches to Managing Chronic Health Conditions

The chart below is a guide to alternative models for addressing needs of individuals contending with one or more chronic health conditions.

NAME OF MODEL	DISEASE MANAGEMENT	CHRONIC CARE MODEL (CCM)	CHRONIC RECOVERY MODEL	BEHAVIORAL HEALTH RECOVERY MANAGEMENT	CARE COORDINATION
Description	<p>Strategy for organizations and/or states to improve patient health outcomes and limit health care spending by identifying and monitoring high-risk populations; help patients and providers better adhere to proven interventions; engage patients in their own care management; and establish more coordinated care interventions and follow up systems to prevent unnecessary health spending.</p>	<p>Strategy to transform reactive health care system into one that keeps patients as <i>healthy as possible</i> through planning, proven strategies and management.</p> <p>CCM identifies essential elements of a health care system that encourages high-quality chronic disease care as: the community, the health system, self-management support, delivery system design, decision support and clinical information systems.</p> <p>Focuses on reform at the community, organization, practice and patient levels.</p>	<p>Focus on use of evaluation measures to assess addictions recovery process and make decisions about continuing care.</p> <p>Effective treatment will result in lasting reduction in SA and improve social and personal functioning.</p> <p>Promote collaboration between researchers, specialists, policy makers & practitioners to examine what works, why & disseminate to field.</p> <p>Multiphase: Detox / Rehabilitation / Continuing Recovery</p>	<p>Shifts focus of care from professional centered episodes to client directed management of long term recovery.</p> <p>Wraps traditional treatment with continuum of supports.</p> <p>Time sustained care to stabilize disorders and manage care till full remission or recovery is achieved or till disorders can be self-managed by individual and/ or family.</p> <p>Recognizes multiple pathways and styles of recovery.</p> <p>Incorporates DM.</p>	<p>Strategy to connect individuals with healthcare and/or social services to improve functioning, quality of life and /or independence; also reduce costs associated with inappropriate use of services.</p> <p>Focus on coordination of resources for specific consumers, levels of care, organizations, systems and / or communities.</p> <p>Can focus on “whole” person and continuum of care.</p>

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Target Population	Individuals diagnosed with specific disorder or set of disorders that typically respond positively to evidence based treatments.	CCM can be applied to a variety of chronic illnesses, health care settings and target populations (regions, communities, health systems, coalitions, practices).	Develop EBPs for interventions with substance abusing offenders & families of drug involved patients;	Focus on individuals with severe behavioral health problems.	Individuals at high risk for costly medical events and adverse outcomes.
Most Commonly Associated with	Used by organizations (JCAHO, NCQA & URAC) to accredit vendors. Typically used to address physical health conditions by large systems e.g. Medicaid, Medicare & HMOs, as well as practices. Recommended by National Governor's Association.	Edward Wagner, M.D., M.P.H., MacColl Institute for Healthcare Innovation/ GROUP HEALTH Breakthrough Series with IHI World Health Organization Development funded by RWJ	Thomas McLellan, M.D. U of Pennsylvania Treatment Research Institute (TRI)	William White, M.S. Illinois Dept. of Human Services' Office of Alcoholism & Substance Abuse funded BHRM Project. IRETA (addictions consensus report) Center for Study of Addictions & Recovery (C-STAR)	Initiatives focusing on managing care/costs of specific target groups
Focus on Addictions Disorders	Very limited.	Limited. Has focused on depression.	High.	High. Treatment, support & advocacy	Limited. Greater focus within mental health than addictions.

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<p>Reliance on Evidence based Treatment Guidelines</p>	<p>High.</p> <p>Focus on adherence to evidence based practice strategies.</p>	<p>High.</p> <p>Evidence-based change concepts underlie each CCM element; in combination, they foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise.</p> <p>Only use interventions proven in research and in practice.</p>	<p>High.</p> <p>Employ scientific methods and develop EBPs.</p>	<p>High.</p> <p>EBPs valued in addressing treatment needs, particularly for severe cases and for individuals with low social supports or co-morbidities.</p> <p>Pro use of approaches that have scientific support & services that remove barriers to recovery.</p> <p>BHRM tasked with developing DM guidelines for chronic MH & SA.& testing for validity, cost & utility.</p>	<p>Limited.</p> <p>Generally restricted to level of care or similar criteria.</p> <p>Not required.</p>

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Reliance on Protocols and Standardization	High.	High.	High. Use performance criteria/ milestones rather than time constraints to manage treatment. Uses care coordination protocols.	Provide for on going monitoring and support across the continuum of care, and over time.	Generally focused on utilization management or treatment planning.
Patient Role	Goal of self-management	Partner in self-management Stronger emphasis on patient education and support than DM.	Patient needs knowledge & skills to manage more effectively.	Patient choice. Patient full partner with providers.	Patient education individualized and may be limited.
Provider Role	Provide care consistent with practice protocols. Collaborate with other service providers.	Provide patient centered care. Providers should be supported with guidelines, specialty expertise and information systems. Teams partner with patients in self-management, shared problem solving and decision making.	Partner in research. Use tools & training, e.g. use of electronic databases.	Professional treatment is only one type of pathway to recovery. Less hierarchical model (consultant & ally) Early reintervention. Greater use nontraditional service providers including peer support services, home and community services.	Greater collaboration with others. Can include communities of recovery.

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Outcome	Management geared to specific desired outcomes, less emphasis on immediate cost reduction and more on longer term care management and quality improvement, as well as longer term savings.	The bottom line is healthier patients, more satisfied providers, and cost savings.	Drug dependence should be treated & evaluated similar to other chronic conditions e.g. long term medication management & continued monitoring.	<p>Goal of long term health and social function through stewardship of personal, family and community resources.</p> <p>Measures long term effects of multiple service interventions Balances science-based and consumer based evaluations of processes and recovery outcomes.</p> <p>Evaluate in collaboration with families and individuals in recovery; evaluate service events not on short term effect but over time.</p>	Limited, cost-based “outcome” measurement; key objective is to reduce adverse outcome, manage cost and generate savings.
Examples of Effectiveness	Community Care Plan, North Carolina Dept. of Health & Human Services’ Primary Care Case Management	Clinica Campesina Community health centers primarily funded by Bureau of Primary Health Care initiated CCM in Denver to address patient	Targeted Capacity Expansion Intervention Project (CSAT): City of Philadelphia Continuity of Care	Access to Recovery Grant to State of Connecticut Increased substance abuse treatment capacity while	NJ Intensive Case Management study for women substance abusers (302) receiving TANF funds. ICM

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	<p>Program. The Plan is a state and local partnership for managing the Medicaid population. Developed networks (12) of providers, health departments, and social services to deliver high quality cost-effective care while receiving training, best practices support and funding to support networks. Practices receive \$2.50 PMPM case management fee to manage high risk, high cost patients in DM programs. Physician driven model. Lowered asthma hospital admissions by 1/3 in children under 2; 8% lower ER use rate; reduced average drug costs in children by 25% per episode.</p>	<p>diabetes. Serve Latinos living below poverty line; many uninsured; higher than average rates of chronic illness. Self reported 1st year results include process and outcome improvements: reduce HbA (1c) from 10,5% to 8.6%; increase patients with at least 2 HbA(1c) tests from 11% to 71%; Patient self management goals from 3% to 65%; % having eye exams from 7% to 51%; % having foot exams from 15% to 76%.</p> <p>Wagner reports chronic care programs diabetes program savings range between \$800 and \$1500 within 15 months of implementation.</p>	<p>Initiative in Public Addiction Programs Targeted to patients in 5 addiction treatment centers needing multiple detox-only treatment each year with goal of expanding access to and continuation in treatment. Case managed 890 patients over 3 years and had 55% reduction in detox only admissions, 70% increase in use of rehab and 20 day increase in average LOS per episode. (This program evaluated a “practice”; not an experimental model & no control group).</p>	<p>ensuring informed choice by clients who select from compliment of clinical treatment and recovery support services. Unique focus on non clinical services. On discharge, 80% of participants abstinent from alcohol and drugs, 40% increase in employment and 98% report no arrests or jail time. Served over 18,000; 40% with no prior DMHAS contact.</p>	<p>clients had significantly higher levels of treatment system initiation, engagement and retention compared with control group. Almost twice as many ICM clients were abstinent at 15 month follow up as control group. Use CM, client incentives (food vouchers) and sanctions. NJ subsequently incorporated use of ICM model in multiple counties. NJ views participants as “welfare client” first, not SA.</p> <p>NYS OASAS Road to Recovery: Criminal justice diversion program nonviolent felons. 2005 DCJS evaluation found 16% RtR participant</p>

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	<p>Insufficient evidence to conclude that DM programs reduce overall health spending though may have other value (2004 CBO).</p>				<p>rearrested vs. 46% national rate. 86% of Steps/ RtR graduates employed and 8% in job training;. Completion rates: OP 91%; IRT 81%; CR 75%. Annually- 30 participants.</p> <p>Literature: Mixed findings on effectiveness of intensive case management among substance abusers.</p>