Boehringer Ingelheim

## *COMMENTS SUBMITTED TO THE PUBLIC HEALTH COMMITTEE*
## *March 5, 2014*

## *HB 5386* An Act Concerning Care Coordination for Chronic Disease

Senator Gerratana, Representative Johnson, Senator Welch, Representative Srinivasan and members of the Public Health committee, Boehringer Ingelheim is pleased to submit these comments in support of **Raised House Bill 5386, An Act Concerning Care Coordination for Chronic Disease.**

Boehringer Ingelheim is a family owned company committed to the discovery; development, manufacture and marketing of innovative health care products that help bring more health to patients and address unmet therapeutic needs. We recognize that chronic conditions are a significant issue facing states, and we are committed to continuing to make advances in chronic disease areas that are of critical importance to patients and their families.

There is considerable evidence about how to prevent, postpone and treat chronic conditions. Implementing evidenced-based prevention strategies can reduce health care costs borne by states for its employees, state retirees and it's low-income and disabled populations enrolled in Medicaid. One estimate is that 83 cents of every Medicaid dollar is spent on preventable and highly manageable chronic diseases, including diabetes, asthma and hypertension.[1]

According to the Center for Disease Control, seven in ten deaths in the United States are caused by chronic diseases, a total of 1.7 million deaths each year.[2] These conditions include heart disease, cancer, stroke, respiratory diseases and diabetes, and mental health disorders which are estimated to contribute more than $1 trillion in spending across the U.S. each year.[3]

In Connecticut, nearly two million cases of seven common chronic diseases — cancers, diabetes, heart disease, hypertension, stroke, mental disorders, and pulmonary conditions — were reported. The cost of treating these conditions resulted in $3.3 billion, plus the impact of lost workdays and lower employee productivity resulted in an annual economic loss of $12.9 billion in the state.[4]

House Bill 5386 establishes a working group to develop a plan to reduce incidences of chronic disease and improve chronic care coordination. The bill further requires this work group to report to the Committee and the Governor on: the impact of chronic diseases that are most likely to

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[1] Partnership To Fight Chronic Disease. (2011) "Medicaid in a New Era: Proven Solutions to Enhance Quality and Reduce Costs." http://www.fightchronicdisease.org/events/medicaid-new-era-proven-solutions-enhance-quality-and-reduce-costs

[2] Centers for Disease Control and Prevention. http://www.cdc.gov/chronicdisease/index.htm, accessed March 3, 2014.

[3] DeVol, Ross, et al. "An Unhealthy America: The economic burden of chronic disease." The Milken Institute. October 2007.

[4] Ibid.

cause death or disability, the approximate number of people in the state affected by these chronic diseases, and an inventory of programs in the state that have been implemented to improve chronic care coordination. The goal of this bill is to reduce the incidence of chronic disease in Connecticut and to coordinate care for patients with multiple chronic conditions.

While BI recognizes and applauds the work that the State Department of Public Health has conducted in the past by identifying and establishing plans for a number of individual chronic conditions, we believe it is important to address the needs of patients with multiple chronic conditions, including recommendations on how best to treat this vulnerable population in a more coordinated fashion. Additionally, much of what is contemplated in this bill was originally included in Public Act 09-148. However, that Act was subsequently repealed and many of the recommendations relating to effectively managing chronic conditions were never implemented.

The passage of this bill will help provide a comprehensive and consolidated strategy to identifying best practices for addressing chronic care coordination in an effort to reduce the burden of multiple chronic conditions for vulnerable patients in the State of Connecticut.

BI offers the following recommendations to House 5386:

- We recommend the Commissioner's plan to develop a coordinated care plan should not be limited to hospitals and health care facilities only, but should include other stakeholders that provide primary care in Connecticut

- The plan should also include input from those newly forming entities designed specifically to provide a coordinated approach to care in Connecticut (i.e., Accountable Care Organizations, Patient-Centered Medical Homes, etc.)

- The plan should also include a focus on Comprehensive Medication Management (CMM), since most patients suffering from chronic disease take multiple medications prescribed by different physicians. Studies have shown that coordinating medication both improves clinical outcomes and reduces health care costs. **One study found that CMM saved $614 per patient.**[5]

Finally, we have attached a recent report from the Office of Legislative Research which outlines key efforts other states have undertaken to address the Medicaid "super-utilizers" population.

Thank you for your time and consideration of our comments. If you have any questions please contact Joseph Oros, Regional Director, National Government Affairs, Boehringer Ingelheim at 860-781-2126.

[5] "Quality Assessment of a Collaborative Approach for Decreasing Drug-Related Morbidity and Achieving Therapeutic Goals" Isetts, B.; et al- *Ach Intern Med* 2003; 163; 1813-20.

Office of Legislative Research

Research Report

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# CHRONIC CARE IN MEDICAID AND PUBLIC HEALTH

By: Mary Fitzpatrick, Legislative Analyst I
James Orlando, Associate Attorney
Alexander Reger, Legislative Analyst II

## QUESTION

This report addresses several questions on programs targeting frequent use of the emergency department (ED) by Medicaid beneficiaries, as well as questions on chronic disease programs and related legislation. The specific questions and answers follow.

## 1. WHAT IS THE CENTERS FOR MEDICAID AND MEDICARE SERVICES' (CMS) GUIDANCE ON CONTROLLING AND TARGETING MEDICAID "SUPER-UTILIZERS" IN ORDER TO DECREASE COSTS AND IMPROVE QUALITY?

The Center for Medicaid and CHIP Services (CMCS), a part of CMS released guidance for states interested in establishing programs targeting Medicaid "super-utilizers" in the CMCS Informational Bulletin from July 24, 2013. The term "super-utilizers" generally refers to those patients who accumulate large numbers of ED visits and hospital admissions which might have been prevented by relatively inexpensive early interventions and primary care. The bulletin describes several policy decisions state policymakers should consider when establishing such a program, emphasizes data analysis, and outlines several ways in which Medicaid can support these programs.

### *Policy Questions to Consider*

***Should the state create a super-utilizer program?*** CMCS advises states to first identify their super-utilizer populations by analyzing claims data for evidence of higher use of acute care (i.e., ED visits and hospital admissions) than expected

among any subpopulations of Medicaid recipients. Speaking with providers, payers, and community organizations may also help state policymakers identify patterns that indicate high use.

Once state policymakers have quantified the super-utilizer population, CMCS advises considering whether or to what extent this high use of acute care is "impactable" or preventable through state intervention, in contrast to those Medicaid recipients living with conditions that require ongoing, expensive care. If some amount of costs appears preventable, CMCS advises state policymakers to begin to identify interventions and estimate costs and savings.

***What payers are involved?*** Programs targeting Medicaid super-utilizers may opt to serve Medicaid recipients only or they may partner with other payers such as Medicare or commercial insurers. CMCS notes that a Medicaid-only program can use existing data systems and analytic tools, while a program partnering with multiple payers may have advantages such as greater provider incentives and more opportunities for funding, but may also create data challenges.

***Who provides services and what is their relationship to primary care providers?*** Programs may closely partner with primary care providers or they may transfer super-utilizers to a specialized care setting. Approaches for programs partnering with primary care providers include (1) a centralized approach that embeds state-employed case workers or care managers in primary care practices; (2) building supportive networks of care managers employed by community-based organizations who can travel between primary care practices; and (3) community-based care teams of social workers, care managers, and behavioral health workers who visit patients in their homes and community settings. Approaches for programs using specialized care settings include (1) short-term interventions in a super-utilizer clinic that provides medical, mental health, addiction treatment, and social services for a limited time and (2) a permanent ambulatory intensive care unit (ICU) that takes over care of patients when they have complex needs beyond the capacity of the primary care provider.

***What is the targeting strategy?*** CMCS identified targeting (i.e., identifying potential patients) as a critical element of super-utilizer programs. Potential patients are both likely to experience high levels of costly but preventable care and likely to respond favorably to a super-utilizer program. They identify seven specific targeting approaches: (1) targeting based on high observed-to-expected costs; (2) targeting based on specific patterns of care; (3) targeting very high levels of utilization; (4) targeting based on referrals and follow-up investigation; (5) excluding candidate clients with medical conditions associated with high but non-

preventable costs; (6) targeting by presence of risk factors associated with high, preventable costs; and (7) targeting by community. Programs may use multiple approaches, and CMCS noted that targeting high levels of spending alone may not adequately identify unnecessary use of medical resources.

***What services are provided?*** CMCS recommends matching program services to patient needs, engaging patients while they are still in the hospital or ED, and following-up with existing enrolled patients when they visit an ED. Program services may include care coordination, in-person medical care, in-person behavioral health care, assistance with social needs, and health coaching. Segmenting individuals into subpopulations may help a program match services to needs. The capacity and infrastructure of existing primary care providers and behavioral health services may dictate the scope of services available in a super-utilizer program.

CMCS suggests considering the physical location where people will receive services, as well as the type of staff providing services. Providing services in the same physical facility may reduce the need for referrals and resulting missed appointments, while deploying outreach workers to patient homes may allow the program to reach patients who are otherwise difficult to reach. While programs may use various combinations of professions within their staffs, CMCS recommends recruiting staff with many years of experience in the field with very vulnerable and complex patients.

***How is the Program Funded?*** CMCS advises state policymakers to carefully consider payment mechanisms, as they may create unanticipated incentives and have implications for the sustainability of the program. CMSC also emphasizes avoiding duplication of funding streams.

CMCS describes five payment mechanisms in use by existing programs.

1. Medicaid case management payment: Members of the program pay a fixed fee per month that supports care managers and primary care practices.
2. Multi-payer case management payment: The program receives fixed monthly fees from members from Medicaid and Medicare programs, as well as commercial insurers.
3. Per-episode of care payment for program services: The program receives a single payment for each episode for each insured individual from Medicaid as well as managed care organizations (MCOs).
4. Per-member per-month payment to MCOs: The state Medicaid agency provides a payment for each Medicaid client enrolled.
5. Shared savings for total cost of care: The state Medicaid agency enters into a risk-sharing arrangement with the care team and shares savings generated by the program.

## *Data Analysis*

Throughout its informational bulletin, CMCS notes the importance of data use in supporting elements of any super-utilizer program. CMCS states that programs need to invest significant resources up-front to build necessary analytic infrastructure to support program functions, including targeting super-utilizers and coordinating their care.

CMCS identifies several necessary analytic tools:

1. web-based provider portals with patient data that allow providers and programs to sort their patients by the number of recent hospitalizations and ED visits, allowing programs to consider their utilization patterns when targeting potential super-utilizers;
2. state health insurance exchanges (HIEs) configured to send utilization and clinical data to programs to create daily reports of current hospital inpatients categorized as super-utilizers, which program staff can then use to identify and engage potential clients; and
3. decision support tools that identify potential super-utilizers based on patterns such as frequent hospitalizations or gaps in care.

CMCS also recommends using quantitative data, displayed as a dashboard, to present updated information on a variety of metrics to determine whether the needs of program clients are being better met in the program than they would be otherwise.

## *Medicaid Support for Super-Utilizer Programs*

CMCS outlines several options for states to get support (either through funding or data access) for their super-utilizer programs from Medicaid authorities, subject to various restrictions. Many of these funding options may be combined.

***Federal payment to improve state Medicaid information systems.*** States can pursue a 90% matching payment to improve their Medicaid Management Information System to support data infrastructure and analytic tools.

***Federal payment to improve state Health Information Exchanges (HIE).*** States can pursue a 90% matching payment to enhance Medicaid functionality within statewide HIE, the networks that allow doctors, nurses, and other providers to access and securely share medical information electronically. CMCS identifies this support as ideal for multi-payer super-utilizer programs because these exchanges are not limited to Medicaid users alone, but can also identify super-utilizers in the commercially insured and Medicare populations.

***Administrative Contracts.*** State Medicaid agencies may claim a 50% federal matching payment to hire a vendor through administrative contracts to collect and analyze data.

***Medicaid Health Homes.*** The federal Affordable Care Act contains a provision that allows states to establish "health homes" to coordinate care for people with Medicaid who have chronic conditions. States can receive a 90% federal matching payment for the first eight quarters of operations of the Medicaid Health Home. A state could use its Health Home to serve individuals fitting its definition of super-utilizers.

***Integrated Care Model (ICMs).*** ICMs are care delivery and payment models that may include patient-centered medical homes; accountable care organizations; or other models that emphasize person-centered, continuous, coordinated care. These models may allow states to improve quality and lower care cost.

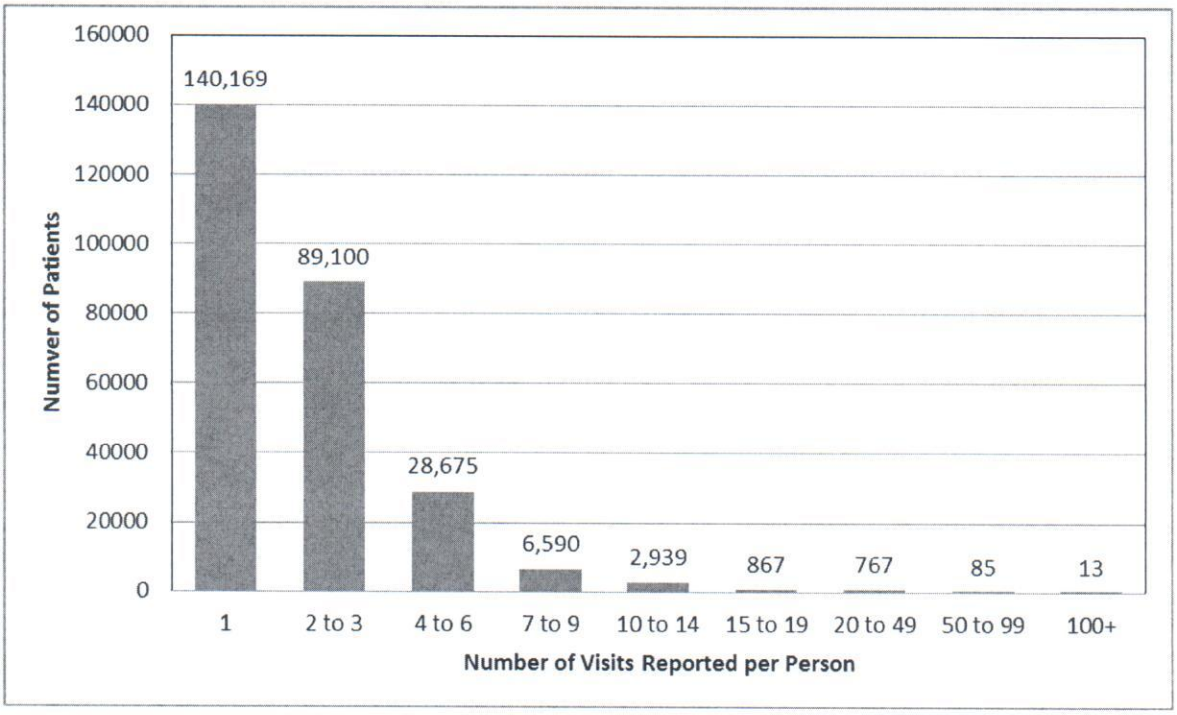
***Targeted Case Management.*** This service may be added to a state's Medicaid plan to support care managers who address the needs of super-utilizers. These services are reimbursed at a state-specific rate, less generous than the 90% match.

***Medicare Data Access and Assistance.*** The Medicare Medicaid Coordination Office can provide access to and free assistance with Medicare data for states interested in using that data to coordinate their care activities.

## 2. WHAT IS THE SUPER-UTILIZER POPULATION IN CONNECTICUT AND WHAT PORTION OF MEDICAID SERVICES ARE CONSUMED BY THIS POPULATION?

We were not able to obtain a number of super-utilizers for Connecticut, but the Office of Program Review and Investigations (PRI) provided us with data on ED visits during 2012 by Connecticut Medicaid patients (see Figure 1). While the figure shows the number of patients with multiple ED visits, it does not indicate how many patients had visits that could be prevented and might be considered "super-utilizers." In January 2014, PRI will release findings related to hospital emergency use and its impact on the state Medicaid budget. This report may have more information.

Figure 1: Emergency Department Use by Connecticut Medicaid Clients in 2012




While we do not have data on the cost to Medicaid of super-utilizers, the administrative services organization contracted with the Department of Social Services to provide services for the state Medicaid program estimated that the average cost of each ED visit to the state Medicaid program was $385 in March 2013.

## 3. DESCRIBE THE VERMONT CHRONIC CARE INITIATIVE (VCCI), INCLUDING PROGRAM DESCRIPTION, STAFFING LEVELS, AND COST SAVINGS ACHIEVED.

VCCI is a program established in the state of Vermont to target Medicaid super-utilizers. Programs such as VCCI attempt to improve care for these patients while also reducing their hospitalization and ED visit rates and reducing state Medicaid spending.

VCCI serves Medicaid beneficiaries who are (1) not also eligible for Medicare, (2) experiencing one or more chronic conditions, and (3) in the top 5% of highest Medicaid users or demonstrate high utilization patterns such as multiple ED visits and inpatient admissions.

## *Staffing*

The program is operated by the Department of Vermont Health Access (DHVA). The agency works with a vendor that provides data support and additional staffing for the program. Table 1 provides a count of both state and vendor staffing levels.

**Table 1: VCCI Staffing Levels**

| *State Staff* | | *Vendor Staff* | |
|---|---|---|---|
| *Title* | *Number* | *Title* | *Number* |
| Field Director | 1 | Program Director | 1 |
| Managers | 2 | Medical Director | 1 |
| Administrative Assistant | 1 | Manager | 1 |
| Nurses | 19 | Liaison | 1 |
| Medical Social Workers | 3 | Nurses | 5 |
| Licensed Alcohol and Drug Counselor | 1 | Pharmacist | 1 |
| Licensed Independent Clinical Social Worker | 1 | Social Worker | 2 |
| | | Client Service Coordinator | 1 |
| | | Informatics Specialist | 1 |
| | | Reporting Specialist | 1 |
| **Totals** | **28** | | **15** |

Once program staff identifies potential clients based on the use of services, the program targets those clients where it can impact cost or quality of care. This requires data analysis that considers a variety of data points including a diagnostic score used by Medicaid programs, the actual cost of the patient's care to the Medicaid program, the number of the patient's chronic conditions, the number of the patient's ED and impatient encounters, and evidence of fragmented care.

Program staff are embedded in private primary care practices, federally qualified health centers, and hospitals. They assess clients for social needs and behavioral risk. The program then provides several types of ongoing support to clients including health literacy coaching, developing a care plan, assessing non-clinical barriers to health, reviewing medication lists, and providing intensive transitional supports following inpatient admissions or ED visits.

### *Cost Savings and Hospital Readmissions*

The VCCI achieved financial savings of approximately $11.5 million (after program expenses) over anticipated costs in FY 2012. In that same time period, the VCCI reduced inpatient services use by 8%, reduced ED use by 4%, and decreased 30-day readmission rates by 11%.

## 4. HOW DOES THE AMENDMENT FILED TO CONNECTICUT HB 5762 (2013) COMPARE TO NORTH CAROLINA'S CHRONIC CARE COORDINATION ACT?

In 2013, a House amendment filed to an Aging Committee bill (HB 5762) would have required the Department of Public Health (DPH) commissioner, within available appropriations and in consultation with certain groups, to develop a chronic disease treatment and prevention plan to reduce the incidence of chronic disease and improve chronic care coordination. The amendment (LCO 7261) was not called, and the bill died on the House Calendar.

In 2013, North Carolina passed the Chronic Care Coordination Act (Session Law 2013-207). The act requires specified divisions of the state's Department of Health and Human Services, as well as the state treasurer's division responsible for the state health plan for teachers and state employees, to take various measures in collaboration to reduce the incidence of chronic disease and improve chronic care coordination in the state. These measures include (1) developing wellness and prevention plans tailored to each division and (2) identifying goals and benchmarks to reduce chronic disease.

Both the Connecticut amendment and North Carolina act require reporting every two years on implementation of the plans and related matters. Generally, both require the specified entities to report on the following:

1. the incidence and financial impact of the chronic diseases most likely to cause death or disability (such as cancer and diabetes);
2. an assessment of current prevention and care coordination programs and activities;
3. the source and amount of current funding for programs for people with multiple chronic conditions;
4. detailed recommendations or action plans to reduce the impact of chronic diseases, including (a) ways to reduce hospital readmission rates, (b) transitional care plans, (c) comprehensive medication management as described by the Patient-Centered Primary Care Collaborative, and (d) adopting quality standards meeting certain criteria;
5. expected results from implementing the recommendations or action plans;

6. goals for coordinating care and reducing the incidence of multiple chronic conditions; and
7. the costs of implementing such recommendations or action plans (the Connecticut amendment specifies an "estimate" of such costs and other resources, while the North Carolina act specifies "a detailed budget" identifying all such costs).

Some differences are as follows.

1. The Connecticut amendment specifies that the DPH commissioner must (a) develop the plan, and report on it, within available appropriations and (b) use existing programs funded by the Centers for Disease Control and Prevention in developing the plan. The North Carolina act does not contain such funding conditions.
2. While both measures require the plans to be developed by specified state agencies, the Connecticut amendment requires the DPH commissioner to consult with outside groups: (a) representatives of hospitals, other health care facilities, and local and regional health departments; (b) consumer representatives; and (c) patients with chronic conditions.
3. While both measures require reporting on the current level of coordination concerning chronic disease, the Connecticut amendment requires reporting on coordination between DPH and hospitals and health care facilities, and among facilities; the North Carolina act requires reporting on coordination among the state divisions listed above.
4. Connecticut requires the report to include recommendations on patient self-management training.

## 5. WHAT OTHER STATES IN NEW ENGLAND, NEW YORK, OR NEW JERSEY HAVE A CHRONIC DISEASE PROGRAM OR CHRONIC DISEASE COORDINATION LEGISLATION?

These states all have programs and various initiatives intended to prevent and manage chronic disease. They each have disease-specific programs focused on common chronic diseases. Some states also have undertaken efforts to coordinate their approach to chronic diseases generally, such as completing strategic plans and creating partnerships of various groups (both government and community-based) involved in chronic disease management. Some of these programs were created through legislation.

Some states use a form of the Chronic Care Model (CCM) or the Chronic Disease Self-Management Program (CDSMP) to coordinate services. The CCM emphasizes interaction between community resources, streamlined health care services, and informing patients to enhance the quality of services. The CDSMP focuses on patient knowledge and empowerment to manage chronic conditions.

Below, we briefly describe chronic disease programs in the other New England states, New York, and New Jersey. If you would like more information about a particular program or law, please let us know.

### *Massachusetts*

The Massachusetts Department of Public Health's Division of Prevention and Wellness has several initiatives focused on chronic disease prevention and management. For example, the division has prevention and control programs on particular diseases, including asthma, cancer, diabetes, and heart disease and stroke.

The division, along with more than 25 public sector and community partners, created a statewide coordinated chronic disease coalition in 2012, the Massachusetts Partnership for Health Promotion and Chronic Disease Prevention. The partnership has created the Massachusetts Coordinated Health Promotion and Chronic Disease Prevention Plan, containing 11 priority objectives, with targets for 2017 (e.g., "By 2017, increase the percentage of people whose blood pressure is within normal range by 2.5%").

The partnership is comprised of seven workgroups, called Communities of Practice (COP), in the following areas: (1) healthy eating, (2) physical activity, (3) built environment, (4) tobacco-free living, (5) clinical preventive services and population health management, (6) community and healthcare linkages, and (7) improved access to state and local data. Each COP works to achieve one or more of the plan's priority objectives.

In 2012, Massachusetts passed legislation on health care cost containment (Chapter 224 of the acts of 2012). Among other things, the legislation makes changes to payment models to better coordinate patient care and establishes a certification process for patient-centered medical homes. This document by the Massachusetts Public Health Council summarizes key features of the legislation.

### *New Hampshire*

The Chronic Disease Prevention and Screening Section (CDPS) within the New Hampshire Division of Public Health Services (DPHS) has programs focused on specific diseases (such as cancer and cardiovascular diseases) as well as other initiatives related to chronic disease prevention.

CDPS released a coordinated Chronic Disease Strategic Plan in August 2013. The strategic plan is the latest step in a process, begun in 2002, to coordinate the state's approach to chronic diseases. CDPS's website describes the plan as "the

result of three years of collaboration among the various chronic disease and related risk factor programs to integrate activities that will sustain the goals and strategies undertaken by" CDPS.

The plan focuses on three priority health goals: (1) reducing tobacco exposure, (2) reducing obesity, and (3) improving detection and management of chronic conditions. There are also five focus areas: (1) cancer, (2) oral health, (3) asthma, (4), diabetes, and (5) cardiovascular disease and stroke. The plan includes objectives and strategies to address each goal and focus area (e.g., reducing cigarette smoking by specified targets).

### *New Jersey*

N.J. Stat. § 26:1A-92-94, known as "The Prevention of Chronic Illness Act," establishes the Division of Chronic Illness Control for the "prevention, early detection and control of chronic illness and rehabilitation of the chronic sick." The law also directs the Department of Health in its responsibilities regarding care of the chronically ill. Among other things, the law requires the department to expand relationships between the state, municipalities, and private institutions to better collect data, distribute information, perform and analyze research, as well as to create chronic illness outreach programs (N.J. Stat. § 26:1A-97).

Chronic Disease programs are managed under the Department of Health, Division of Family Health Services.

Take Control of Your Health, run by the Department of Health, Office of Minority and Multicultural Health in conjunction with the Division of Aging and Community Service, is a CDSMP that aims to provide individuals with chronic diseases the information necessary to live a healthier, more active life. The program offers a course focused on providing participants with tools to help themselves and is offered at little or no cost.

ShapingNJ, run by the Department of Health, Office of Nutrition and Fitness, is a partnership program that involves more than 200 public and private entities. Shaping NJ is focused specifically on obesity and obesity related illnesses.

New Jersey Department of Health, Office of Cancer Control and Prevention runs 10 Regional Chronic Disease Coalitions, each focused on education, prevention, and control of chronic diseases with a focus on cancer. In addition, some municipal programs exist.

### *New York*

New York's Department of Health, Division of Chronic Disease and Injury Prevention focuses on reducing the rate and effect of chronic diseases as well as their risk factors. The division is divided into five bureaus specializing in tobacco, chronic disease prevention (for diseases such as diabetes and obesity), chronic disease care (primarily for cancer programs), cancer epidemiology, and evaluation and research. The plan uses existing fiscal resources and encourages collaboration with local community groups and municipalities. The program is an expanded version of a CCM.

Effective January 1, 2012, New York began taking advantage of provisions in the federal Affordable Care Act of 2010 that provide federal funding for states to develop health home programs to treat Medicaid recipients with a chronic illness. New York's Department of Health defines a health home as "a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner."

New York Public Health Law § 2700 establishes the Bureau of Chronic Disease and Geriatrics and charges it to "aid in the prevention, rehabilitation and control of degenerative diseases and chronic illnesses."

### *Rhode Island*

Rhode Island law establishes a long-term coordinating council to coordinate policy regarding long-term health care for adults with chronic illness, as well as a "healthy Rhode Island chronic care management program" (General Law §§ 23-17.3 and 23-17.22).

The Department of Health, Division of Community, Family Health, and Equity, Chronic Care and Disease Management Team focuses on reducing the incidence, burden, and associated risk factors of several chronic diseases. Its major programs include: the Arthritis Program, Asthma Control Program, Comprehensive Cancer Control Program, Living Well Rhode Island, and Women's Cancer Screening Program. Each program is a partnership between state and local initiatives.

Living Well Rhode Island is a CDSMP that consists of a series of workshops that helps individuals with chronic illness find the tools necessary to manage their symptoms.

Rhode Island Chronic Care Collaborative is a collaboration between the Rhode Island Department of Health and community and municipal partners. It is a CCM-based program.

### *Vermont*

Vermont's Department of Health has disease-specific programs for certain chronic conditions, such as cancer and diabetes. The department also has a Chronic Disease Epidemiology program that provides data analysis and related services for various department chronic disease programs.

One goal outlined in the department's Strategic Plan 2010-2013 is "effective and integrated public health programs." Among the strategies listed to achieve that goal is to "strengthen prevention efforts among chronic disease programs by integrating program settings, populations, workforce development and policies."

See above for information on Vermont's Chronic Care Initiative.

MF/JO/AR:ts