

2. PROFILE OF INFORMATION AND ASSISTANCE:

Della's Story

By Lisa Richards



Della and Lisa

I started having contact with Della in February of this year. She came into our office and was confused about her phone charges and coverage. We went into a conference room and I helped her contact Qwest to resolve the issues. I called Qwest and got the customer service rep on the phone. At that point she was able to talk with them and resolve the issues. After the call she started telling me about her living conditions. She felt frightened where she was staying. I told her we had a list of subsidized housing and that most of them charged 30% of the person's adjusted gross income for rent. She was very happy about the information and said she could start looking right away for a new place to live. A few days later, Della told me that she had gone to look at another senior housing complex and really liked the apartment, but that she had signed a lease at the apartment complex where she currently lived and the manager wouldn't let her move. I told her

that if she felt like she was in danger where she lived that she could always call 911 for help. She thanked me for the information, but thought she could take care of herself.

Recently, Della came into the office and said that her lease was up September 3rd and wanted to know if I had the list of subsidized housing. As I was showing her the list, she remembered that she had applied at a senior housing complex and that she really liked the apartment. While Della was in the office, we called over to senior housing complex. They still had her application on file and could use that to re-apply for an apartment. Della came into the office a few days later and was so happy! She got approved to move in.

The next challenge was that the apartment, where she was currently living, is furnished; and the new apartment complex is completely unfurnished. Over the next few days, I helped guide Della in accessing some furniture through the Mission on 1st and the Salvation Army on 6th. She got a bed, a microwave, a toaster and a lamp. After she moves, Sharon at the Mission said she can come back and pick out a TV. She wanted to know how much money the people wanted for all the items. I told her they were donating them to her so she could move into her new apartment. At the sound of this Della almost started crying and couldn't believe the generosity of the agencies in town.

The final challenge was getting her moved as she doesn't have any family here or a car to move herself. I helped her apply for moving assistance through the Catholic Family & Child Services Volunteer Chore Program. They said that they could have

someone move her, but that everything needed to be packed in boxes or bagged up. I asked Della if she had some boxes brought to her, would she be able to pack up her things. She said, “Most definitely yes.” I went and got some boxes from a local store in town and took them over to her at her apartment. When I greeted her, she met me with much enthusiasm and couldn’t get her smile off her face. I think it was finally setting in that she was going to get out of there. As I write this on Monday, Della is scheduled to be moved on Wednesday. After she moves I will follow-up with her to remind her of the TV and to see if she needs help with the transferring of her phone.

Information and assistance that the SE/ALTC office provides is a valuable service to the community. The help we provide takes many shapes in the course of a day.

This is an important aspect of what SE/ALTC provides to the community and we are proud of the service we are able to provide.

Senior Information and Assistance (I&A) is a gateway for individuals to obtain information, explore long term care options in their local area, and receive assistance in accessing these services. I&A staff help an individual to navigate through the maze of potential options and regulations accompanying such many services.

SE/ALTC has blended its Senior I&A and Case Management programs to realize an economy of scale, reduce administrative costs, and combine the best wisdom from both programs. SE/ALTC has nine direct

services and one contracted office throughout the Planning and Service Area (PSA) we serve. This provides community members with local access to information and assistance service delivery staff. This, in turn, reduces the need for dependence on federal and state programs and makes it possible for seniors to enjoy the benefits of their community. No one knows the resources (public and private) in the community better than staff that lives and works there.



Senior Information and Assistance presentations are held many times throughout the year.

Senior I&A contacts have remained high for our region. In 2008, the, SE/ALTC received 21,469 information request contacts from seniors or family members and provided 11,273 assists to seniors.

Senior I&A is funded by the OAA and the Washington State Senior Citizens Services Act (SCSA). It, too, is being impacted by the lack of inflationary increases and the cut to our Planning and Service Area (PSA) after the last census. SE/ALTC served thirty clients on SCSA case management, and 179 clients received Respite case management.

Individuals who do not qualify for state-paid in-home care services (called core services)

still may need case management services. Case management services through the OAA are not means-tested, thereby available to anyone age 60 and over in need of assistance in more than one area, regardless of income status. Changes in funding formula have resulted in a dramatic reduction in the number of individuals served. SE/ALTC went from providing regular (or non-core) case management services.

Information, assistance and regular case management services help to reduce escalation of medical issues and prevent premature institutionalization. These services aid individuals and their families by providing timely support and information on options to meet their needs. If desired, SE/ALTC staff can assist the client to access services within the local communities regardless, of whether they are public or privately financed.

Senior Information and Assistance is funded by the Older American's Act. It too is being impacted by the funding formula cuts. Southeast Washington in conjunction with the Washington Association of Area Agencies on Aging (W4A) is seeking state funding to expand its information and assistance services to disabled individuals under the age of 60, who would benefit from these services.



ALTC co-sponsored several Med D information seminars
BENEFITS CHECK-UP

There are many programs designed to assist seniors. Often seniors eligible for such services don't even know that they exist. BenefitsCheckUp.Org is a website designed to screen seniors for all state, federal, and local public and private services with one simple questionnaire. It is a free and confidential site. It is used by SE/ALTC in part to assist clients to determine the most beneficial Medicare prescription drug plan.



Seniors acquire information at a Medicare seminar sponsored by SE/ALTC

MEDICARE PART D

SE/ALTC remains a major partner with the local Social Security Administration and Statewide Health Insurance Benefits Advisors (SHIBA) volunteers who assist seniors with questions about the Medicare prescription drug benefit, Part D. I&A staff conducted many outreach and informational forums in 2006 during initial Part D rollout. Many offices had Medicare Mondays and Wednesdays to assist all Medicare clients in choosing a prescription drug program. Medicare assistance continues as new enrollees become eligible and the drug companies add and subtract medications from their coverage lists.

AGING AND DISABILITY RESOURCE CENTER (ADRC)

Washington State is seeking to expand its Information and Assistance role to all ages. The ADRC is being piloted in Pierce County by Pierce County Aging and Long Term Care's Senior I&A Program. The pilot has been successful, and now Aging and Disability Services Administration (ADSA) and the Washington Association of Area Agencies on Aging (W4A) are working together to expand ADRC(s) statewide. The ADRC is available to all seniors aged sixty and over and to anyone with disabilities regardless of age, providing them with information, referral, and assistance, helping them to access needed public and private resources.

Aging and Disability Services Administration's State Unit on Aging has applied for a grant with the Department of Health and Human Services to expand its ADRC(s) to three other Area Agencies on Aging in July of 2009 and listed SE WA

ALTC as an additional pilot program, along with two other Area Agencies on Aging in Washington State. Should this grant be awarded, ALTC will receive some start up funds to assist in piloting ADRC's in our region.

PROBLEMS RELATED TO INFORMATION AND ASSISTANCE:

I&A offices in rural communities have become the hub for all social service assistance. Many of these rural communities at one time had local Social Security Administration and Department of Social and Health Services (DSHS) offices. Due to centralization, these offices have closed, leaving rural elders no recourse but to travel or use an 800 number to receive assistance. As many elders prefer to receive face to face assistance, and cannot or do not want to travel, they seek out I&A staff to assist them with paperwork, answer questions, and act as the liaison. Although this is a very important I&A role, it has increased the work load. Funding for the expanded ADRC model that reflects the issues inherent in serving rural populations would be most welcome in our area. Current funding streams do not provide for staffing to serve the under age 60 population that encounter some of the same issues when they are combating serious illness or chronic health issues. Funding both for seniors and the under age 60 population makes wise policy sense. When people are aware of their options and choices early on, and have assistance in accessing service delivery systems, it can help divert further escalation of health problems, prevent premature institutionalization and offers services beyond just Medicaid options.

The OAA III-B and SCSA are the primary revenue streams for the I&A program. When there have been increases, they have been marginal at best. OAA funding has not kept pace with inflationary costs and more new programs now compete for these limited funds as well. Another fund that helps augment this program is SCSA. SE/ALTC has had to endure funding cuts due to the US Census in 2000, and the Washington State funding formula favoring “the dollar following the client.” At the same time as our funding was reduced, the SE/ALTC workload increased. Comparing year end 2004 to year end 2006, SE/ALTC had a growth of 27% in information contacts and a 42% increase in assists.

ALTC has had to reduce staff involved with the I&A component and reallocated time to the Home Care Referral Registry. Some vacated positions could not be filled due to budget constraints. I&A staff have had to handle a significantly larger volume of clients with significant needs. This was further impacted by the addition of the manifold Medicare Part D responsibilities, especially in 2006. Lack of adequate numbers of I&A staff to handle the increased workload has led to less involvement in many community events, networking and attendance at outreach events such as Senior Fairs. Allocation of staff time had to be honed down to primary services.

Although I&A and case management services are integral to the local community, they are funded by SCSA, thereby limiting this service to individuals age sixty and over.

As SE/ALTC has blended its programs to include the Title XIX Case Management, SE/ALTC's I&A program receives many information and assistance requests for

disabled clientele who have not yet reached age sixty. SE/ALTC has provided limited assistance in these circumstances but neither receives funding for or can we even credit our statistics. On the other hand, as this service is an unmet need in many of our communities, we cannot, in good conscience, deny these individuals the service because of their age. Right or wrong, the community views SE/ALTC as a resource that can assist the under sixty population, but without funding to adequately serve this population, SE/ALTC is unable to develop a good resource base to provide quality service to this population. If the ADRCs are funded, this will be an invaluable service that will help bolster the staffing in each office to help with quality and quantity of service.



Information Specialists Kari Potter, Walla Walla County and Rita Lenhart, Columbia County

GOAL: SE/ALTC will elevate public awareness of long-term care services and assist those in need of services to access choices that best fit their needs by increasing visibility and advocacy, ensuring a high quality Information and Assistance program.

OBJECTIVES:

- I&A staff will obtain training on areas of disability and resources available in order to prepare for serving clientele through the ADRC. January **2010 and ongoing**
- SE/ALTC will provide legislative advocacy for funding the ADRC in our communities. 2009 and 2010
- ALTC will feature I&A as an SCSA funded service to our state legislature, advocating for maintenance levels of SCSA. Ongoing 2009/2010
- I&A will continue to attempt to maintain an I&R Certified staff member in each SE/ALTC office and will keep staff recertified as funding allows. **December 2010.**
- I&A staff will continue to stay apprised of changes or developments in Medicare Part D to better assist clients. **Ongoing through 2010.**
- SE/ALTC will continue to work on staff development, offering internal and external training to ensure they are well versed in interviewing techniques, resource development, etc. **Ongoing 2010 and 2011**
- SE/ALTC will identify two specific areas for an ADRC to ensure success and increase the I&A staffing in those offices with an expanded focus, to include increased MOU and increased training on resources for the under 60 population.. **Ongoing 2010**
- ALTC will continue to expand its partnerships in local communities by

working on contracts or MOU with the MS Society, MOU(s) with local health clinics to increase dental and medical access to our client base, etc. Ongoing 2010.

- ALTC will develop some oral screening and referral protocols in its I&A intake form and education on oral health to ALTC staff. December 2010
- ALTC will partner with Radio KDNA a radio station serving the monolingual Spanish speaking community, to provide information and awareness of the services available to seniors and their families. **Monthly June 2009**
- SE/ALTC and the Columbia County Advisory Board will advocate for bus tours of the area and beyond in which seniors can participate at least once per month. **2008**
- SE/ALTC and the Garfield County Advisory Board will continue to advocate for staff development, internally as well as externally. **Ongoing**
- ALTC and the Garfield County Advisory Board will continue to advocate for salary increases for the SE/ALTC staff. **Ongoing**



Case Manager Tom Magers listens to a client describe her needs

PROFILE OF CASE MANAGEMENT:

Case management enables clients to mesh their needs with available services in their community to assist them to live in the least restrictive environment possible. It assists individuals in obtaining care and serves to monitor whether the service is meeting the needs of the client.

There are multiple in-home personal care programs which incorporate case management services. Services such as Chore, Community Program Options Entry System (COPEs), and Medicaid Personal Care (MPC), Respite and SE/ALTC's SCSA Personal Care program all require reassessment and reauthorization, verification of hours and service plan compliance. With the exception of SCSA Personal Care, these services benefit any qualified individual age eighteen and over. The small SCSA Personal Care program serves only those at least age sixty. The mandated visits for these programs are currently one annual reassessment per year and three additional contacts per year.

Other types of case management services performed by SE/ALTC beyond Title XIX (core) Case Management Services are OAA

or "Regular Case Management." OAA Case Management Services are for individuals at least sixty years of age who do not qualify for any of the core in-home personal care programs and who have more than one unmet need with which they require assistance.

HISTORY OF CASE MANAGEMENT IN WASHINGTON STATE

In 1995 the Aging Network case management program absorbed the additional responsibilities of reassessment and reauthorizing COPEs, MPC and Chore clients under age sixty. At this point caseload sizes rose from an average of 50 clients per case manager (CM) up to a high in one SE/ALTC office of 130 clients per CM. The workload was daunting and the potential risk to vulnerable clients profound.

W4A advocated with the Washington State Legislature for a client to CM ratio of 75:1. The case management caseloads slowly declined, when the 1998 Washington Legislature passed a budget that included a compromise ratio of 100:1. The 1999 Legislature further reduced caseloads by supporting a budget for 85:1. Currently, caseloads operate based on a budgetary formula that coincides with funding per case and a budget principle based on a ratio of 64 clients to 1 case touching staff.



ALTC's information table at the Walla Walla caregiver conference

CASE MANAGEMENT IN SE/ALTC

For purposes of economy of scale and lower administrative costs, SE/ALTC has combined the Information, Assistance, and Case Management programs (I&A/CM) and the Home Care and Referral Registry rather than operate them separately. SE/ALTC has been committed to ensuring that funding is allocated to direct service and has purposefully kept its administrative costs low.

The Medicaid in-home caseload has steadily grown each year since 1995. SE/ALTC has had to add additional case management positions to keep pace with this growth. This has resulted in the need to expand or change facilities and add supervisory staff.

Along with the steady growth in clients, ADSA has increased the quality standards for case management. This is due in large part to mandates from the Centers for Medicare and Medicaid services (CMS), the federal arm of Medicaid. A workload standard study conducted by independent contractor, Sterling and Associates, concluded that Area Agencies on Aging (AAA) were under-funded by 20%. This called for ADSA and the W4A to look at which activities could be eliminated as there

are no new additional funds on the horizon to cover this expense. SE/ALTC continues to focus on processes, creating efficiencies in all processes and continuously looking for quality improvement avenues.

LEGACY ASSESSMENT TRANSITION TO CARE

In 2003 SE/ALTC transitioned to a new assessment tool, training staff to quality standards and to the changes in policy. Transitioning to this new tool and the accompanying changes in policy and quality standards has been a primary focus for several years. In 2003, Washington State changed the assessment tool for the core in-home care services (COPEs, MPC and Chore) to one called CARE. This is an automated tool, designed to assess on the laptop in the home, and driven by an automated algorithm. It is a thorough review of the client's cognitive, psychological, social, and medical background and functioning. This data is factored along with an assessment of care needs and the assistance available to the client through non-paid support, resulting in a plan of care.

The CARE plan takes into account services provided by the core program for which the client may qualify, any non-state-paid resources, and also the informal support available. This tool was designed to reduce variability between assessors and provide a more comprehensive approach to data gathering, using the minimum data set. It was based on a national assessment that has been tested and used in other states.

POLICY CHANGES COINCIDING WITH CARE

As indicated, the change in the assessment tool was coupled with policy changes that had ramifications on service delivery. One significant policy change was a deduction in the algorithm for individual providers who had a shared living situation with the Medicaid recipient. In 2007, this shared living policy was changed due to the outcome of federal litigation. Another policy change coinciding with the new assessment tool, was the lifting of the “112 hour” rule. This rule prohibited clients who qualified more than 112 hours a month from using an agency provider. Since the policy was eliminated, growth in clients using agency providers (a \$5.00 difference per hour) has grown significantly.



The State Home Care Quality Referral Registry gets a boost from SE/ALTC publicity

HOME CARE REFERRAL REGISTRY

State lawmakers have indicated concern about growing costs in the in-home care arena. Contributing to this cost is the growth in the use of home care agencies versus individual providers (IPs). There are some options on the horizon to assist with rebalancing IP use. In the fall of 2005,

SE/ALTC applied for an eighteen-month grant via Home Care Quality Authority (HCQA) to establish an internet based Home Care Referral Registry. The grant was awarded starting January 2006 through June of 2007 and renewed with some supplemental services through 2009. SE/ALTC has established a referral registry for IPs who are seeking to become state contracted providers for Medicaid in-home services. The registry matches Medicaid clients with potential IPs from the referral registry. It is hoped that the user friendliness of the online registry will make the process of finding compatible IPs less complex for clients and therefore as appealing as choosing a home care agency.

In the last five years, several factors have impacted the way case management is performed:

1. Funding Challenges COPES and MPC are Medicaid services. This means these services are funded by Federal and State dollars. Medicaid is a large portion of the State’s budget. During times of fiscal crisis, with the downturn of the economy, the costs associated with war, and the passage of anti-tax laws affecting state revenue, coupled with the growing senior population, the State of Washington has to examine methods to reduce expenditures without making large program cuts.
2. Federal Compliance Washington State has been working with CMS to meet their requirements to ensure the continuation of Federal funds to match the State funds for in-home care services in the future. Part of this

requirement has resulted in CARE, a tool that better quantifies and justifies the need for hours of service, documents client preferences, and ensures unpaid support is not supplanted. It also involves a fairly significant quality assurance review process.

3. Studying Long Term Care Several studies mandated by the Washington State legislature have looked at Medicaid usage. One independent study indicated that the assessment tool being used had a problem with inter-ratable reliability. This simply means that different professional assessors could assess an individual using the tool and come up with very different hours on the same client. This was a primary impetus behind changing the assessment tool. From SE/ALTC's perspective, the tool has in fact resulted in rater reliability

4. Lewin Group Study Another study impacting services was presented to the 2002/03 Washington State Legislature on "Medicaid Cost Containment" by The Lewin Group, Inc. This study suggested several avenues for cost containment in the State budget. The report indicated that Washington State was among the easiest states to qualify for Medicaid long term care services. As well, it indicated that home and community based Medicaid services were "quickly accelerating in terms of participants and expenditures." The report recommended a cap on COPES and functional eligibility changes. It did however; acknowledge that, by

implementing these changes, Washington State would lose ground in being one of the most progressive states in developing public community-based services in the nation. The 2003 Washington State Legislature did impose a cap on COPES service growth, and made functional eligibility changes to Medicaid Personal Care services.

5. Pilot Programs Washington State has not changed core program eligibility, but it is seeking methods of cost containment. Several projects have been piloted in the metropolitan areas which incorporate health care and long term care delivered via a managed care concept. Other pilot projects are the Intensive Chronic Case Management (ICCM) program (previously known as the 'Mobility Project') and "New Freedom," all designed to control costs.

Southeast Washington is one of five AAAs participating in the ICCM pilot. The current approach is to utilize predictive modeling to identify future high Medicaid expenses for Medicaid only clients. A nurse case management approach helps the client identify personal health goals and develop a plan to meet these health goals.

Washington State remains one of the most progressive states in the nation in their commitment to providing quality home and community based long term care services, even through national economic fluctuation.

PROBLEMS RELATED TO CASE-MANAGEMENT:

Case management is complex. A CM must possess a broad based knowledge in aging and disability as well as human and social services. They must also have high levels of competency in trouble shooting issues related to conflict, family dynamics, environment, and psychology. They must assess a client's ability to perform activities with daily living. Increasingly, CMs are required to be well versed in medical protocols, disease guidelines, and have the ability to identify missing gaps in services to better support a plan of care. These same individuals must be highly organized and detail oriented in order to meet the long term care program requirements for follow-up, referral, and documentation of compliance with the copious amounts of requirements. Given the nature of the clientele with whom CMs work, their caseload is often very dynamic, requiring high levels of problem solving, creativity and efficiency.

There is a steep learning curve for CMs. Recruiting and retaining CMs that have the required level of education, knowledge, and skill and can manage the pressures of this role is a challenge. CM salaries have not kept pace with the market. Consequently, SE/ALTC has experienced significant turn-over coupled with growth due to increasing caseloads. As a result, the task of recruitment and training has become very involved and consumes a significant portion of supervisory time.

The requirements of CARE assessment and Service Episode Record (SER) documentation are time consuming and may detract from resource development. s find it difficult to meet the documentation requirements and develop preventative and

effective plans of care, that foster increased independence for COPES and MPC clients. Finding a balance between these two time competing components remains a challenge for the case management industry. Keeping a lower case management to client caseload may assist somewhat with this dilemma. As previously stated, there are a greater number of more vulnerable clients receiving state-paid in-home personal care services than ever before. This is due to limitations in hospital stays and the diversion and relocation of nursing home clients. At the same time, the number of in-home care clients is growing rapidly. SE/ALTC's Medicaid in-home client load has grown from being 9% of the State's Medicaid in-home care population to being 10%. Lower caseloads assist with accountability, creative resource development and reduce liability for the agency. However, paperwork within the system remains daunting. As SE/ALTC attempts to look at the overall Medicaid costs, it will take smaller caseloads to appropriately address health improvements.

Other programs, designed to prevent or delay medically vulnerable clients in our PSA from needing Medicaid services, continue to experience funding cuts due to the state's funding formula. SCSA Personal Care, for example, is capped in many of our counties. Respite care has been reduced by fifty hours per person annually and SE/ALTC has been forced to implement waiting lists intermittently, due to limited funding. It is difficult for CMs to find ancillary services to help these individuals.

Medicaid cuts remain a concern as the baby boomer population ages and the economy has not kept pace. There remains a large potential that the long term care system may become more problem-response or crisis driven versus a focus on improved outcomes

via more intensive case management. It is imperative that pilot projects make impact in cost containments, or the overall system may see dramatic changes to eligibility criteria and a shift to more of a case management model that is eligibility and significant change assessment only.

A care monitoring and service plan enhancement approach involves increased in-home case management visits. One benefit of these home visits is that they afford the CM an opportunity to identify and deal with small problems at that time rather than having to respond to a crisis later. Eligibility changes or higher caseloads have the potential of watering down the quality of care and may end up being more costly in the long run.

SE/ALTC has implemented the Home Care Referral Registry. The growth in agency providers has been substantial. There is potential that part of this growth in agency providers is case management driven. This is due in part to the additional supervision that a client receives from an agency when using one of their providers. In part, it may be the ease of obtaining an agency provider and the added benefit of having an agency back-up provider available. Secondly, the availability of having multiple agency providers increases the likelihood of quality issues or concerns about a particular provider being reported to the CM.

SE/ALTC has expanded options for clients with the Home Care Referral Registry. This has potential for balancing the use of agency and individual providers. However, the use of the registry has been somewhat slow. This may in part be due to Department of Developmental Disabilities (DDD), DSHS's Home and Community Services (HCS), and SE/ALTC CMs being reluctant to use the registry. Using the registry remains a bit

more involved than recruiting an agency provider. In addition, IPs do take more case management time because of the need to track training, troubleshoot issues, etc. Also, clients who want an individual provider tend to already have someone in mind, often a family member or friend.

GOAL: SE/ALTC will advocate and support quality in-home care services that emphasize choice and optimize effective and efficient service delivery.

Objectives:

- SE/ALTC, in conjunction with W4A, will advocate for community based in-home care programs to maintain these valuable services. *Legislative sessions 2010 / 2011*
- SE/ALTC will work with its case management staff to ensure a good client to CM ratio in our region, as long as funding allows. *Ongoing 2010 / 11*
- SE/ALTC will continue to recruit and add COPES ancillary contractors in all counties in order to provide in-home resources to assist clients with coping skills to include pain management, diabetes management, and learning skills to ensure emotional stability. Ten new contracts added in next biennium. *Ongoing 2010/11*
- SE/ALTC will continue to emphasize preventative care planning and resource development via training new employees, file review, and education on effective local resources at staff meetings. *2010/11*
- SE/ALTC will continue to work with the ICCM pilot project, identifying eligible clients and implementing the pilot per



State guidelines. Ten new clients in **2010/11.**

- SE/ALTC will continue to educate Case Management staff in DDD, HCS and SE/ALTC about the benefits of the Home Care Referral Registry via frequent presentations, and outreach to CMs. 10% increase in consumer matches per biennium. **2010/11**
- SE/ALTC will continue to hone the Home Care Referral Registry to better assist CMs in their role by obtaining feedback on areas of needed improvement and implementing policies and practices that are high quality customer service to CMs, clients, and IPs. **2010/11**