C-1 Local and State/National Issue Areas

Southeast Washington Aging and Long Term Care's (ALTC) planning and service area is a geographically vast area that is rural in nature. There are many small towns and several metropolitan areas. It has some of the most economically disadvantaged counties in the State and its economic base is primarily agricultural. With this framework come many of its challenges with health of the population and limited resources. The incidence of individuals with chronic disease, poor health, lower levels of education, and limited resources exceeds the state average in this planning and service area. Health and human services are largely funded by State and Federal funds. Service providers struggle with economies of scale and local funding is minimal at best. There are few corporations within the service area from which to seek charitable donations. Local governments struggle to meet basic needs, thus most local government contributions are in-kind. It is an area that is tax adverse and thereby local governments tread lightly when trying to increase local taxes to augment health and human services programs.

ALTC's planning and service area is multi-ethnic with large populations of individuals of Hispanic origin in Yakima, Benton, Franklin and Walla Walla counties. Large numbers of individuals are limited English speaking. In order to ensure service access, service delivery must be tailored to meet the unique needs of the multi-ethnic populations in our region.

Considering the many challenges faced in provision of services, ALTC's PSA is uniquely positioned for innovative service delivery initiatives due to large pockets of populations who suffer from the outcomes of poverty.

ALTC has participated in and been a leader for many of the innovations in Washington State. Its aims align with the Federal and State initiatives to bend the Medicaid and Medicare cost curve downward and enhance health outcomes for clients needing long term services and supports, reducing unnecessary hospitalizations and emergency room visits. ALTC applied for and received the Care Transitions 3026 grant for two years. Because of the insufficient number of referrals from hospitals, we were unable to meet the application requirements as initially projected. However, ALTC continues to utilize the infrastructure put in play with this application and has two evidence-based programs it runs as a direct service: Care Transitions Interventions and Bridges. ALTC implemented a Chronic Disease Self Management Program (CDSMP) throughout its region. It is participating in Family Caregiver STAR-C and RDAD, two evidence-based programs that have been effective in working with caregivers of loved ones with dementia. It is now expanding these efforts through the Dementia Capable Program that will expand STAR-C and Options Counseling for early identification of dementia.

ALTC was the first pilot project (2003) for what eventually became known as the Chronic Care Management Program. It targeted high risk, high cost individuals on Medicaid Long Term Services and Supports. It was a high-touch care coordination model that used client-directed goals to improve health, utilizing a tool called the Health

Action Plan. It also actively sought to increase health literacy among its participants and get them more engaged in their health care planning and outcomes. Eventually six other Area Agencies on Aging (AAA) around the State also participated in the pilot. It became the only State program that bent the cost curve on the medical side downward, reducing hospitalizations, improving health and increasing life span. Participants also reported a higher quality of health. This model became the blue print for the State's duals demonstration grant called the Health Home. Health homes expanded from the Medicaid Long Term Services and Supports (LTSS) clients into dual eligible Medicare/Medicaid and included not only the LTSS delivery client but also included clients in behavioral health and those who were medically vulnerable. ALTC applied to be a lead organization as a Health Home and became a successful applicant. Over less than two years time, 764 health home participants were engaged through our lead health home in Southeast Washington. ALTC provides care coordination services directly and contracts with behavioral health, chemical dependency and Federally Qualified Health Clinic providers throughout the eight county area. Statewide, it appears that in the short run of the duals program, there is a 5% reduction in Medicare utilization, in which Washington State has great potential for Medicare shared savings as a result.

ALTC has been a partner in the planning grant of the Greater Columbia Accountable Communities of Health and has staff participating on both the Governing Board and the Leadership Council of this ACH.

Along with its counterparts and the Aging network around the State, ALTC has been a part of the proud history of rebalancing the LTSS system that has helped achieve significant federal and state savings. This was achieved by diverting and relocating clients from skilled nursing facilities into home and community based settings. AARP has tagged Washington State's LTSS service delivery system as second in the Nation and 34th in Medicaid costs. This categorization was not only because of the rebalancing and expansion of home and community based in-home care but also because of Washington's vision of expanding the Older Americans Act Family Caregiver Program with State funding that included individuals age 18 and over who were unpaid family caregivers caring for loved ones with disabilities who were aged 18 and over. ALTC has built, along with its AAA counterparts around the State, a robust service delivery system for unpaid family caregivers. This pre-Medicaid program has helped reduce morbidity and mortality rates of family caregivers and helped provide enough support to keep these family caregivers from placing their loved ones into a skilled facility.

In addition, ALTC was one of the first to pilot the Aging and Disability Resource Center (ADRC) in its eight-county area. This changed its traditional Senior Information and Assistance and Case Management programs from a service delivery system that served only those age 60 and over needing LTSS to a program that provides information, options counseling and assistance services to individuals with disabilities age 18 and over and their families.

ALTC has a long history of building community partnerships with its traditional Aging Network providers, transportation, nutrition, legal services, adult day care, adult

day health, foot care, home care agencies and other senior service providers and providers of ancillary services such as housing and human service providers.

These innovations and initiatives that ALTC has implemented have helped ALTC build partnerships and formalized coordination protocols between systems with health care providers, hospitals, behavioral health and chemical dependency providers, and Federally Qualified Health Care clinics. There is increased familiarity with navigating one another's systems, enhanced coordination and relationships at the direct service as well as at the administrative level between these systems. This creates an environment for the potential of shared skills and resources and better referral systems for clients, enhancing the opportunity to achieve the triple aim.

These innovative programs have made significant differences in the lives of clients receiving the services. Many have contributed to the triple aim of the right service, at the right time, in the right place. We have also experienced some positive health outcomes for clients that, as a collective whole, have helped with bending the cost curve. The challenge to these innovations is not that they are not implemented well, or that they have not had a positive impact. The challenge is that these are two- to five-year piloted programs that receive enhanced Federal funds. These programs have resulted in a slow but steady positive change for clients. However, the original concepts at the Federal and State level often are built on very ambitious timelines for cost savings and frequently do not take into account implementation issues that naturally occur from the top of the system (Federal and State Governments) to local implementation. There is an expectation that the culture that was created over a course of decades be shifted and transformed within two to five years, for a quick return on investment, versus longer run return on investments. They are built on unrealistic timeframes within a culture of immediate gratification. Another issue is that it is hard to isolate measurable improvements in social science, as it is not a hard science, so often the only measurement that bears any importance is the fiscal bottom line. Quality of life issues, slow paced progress and change in client behaviors (such as increased engagement in better managing one's own health) is not weighted highly, if at all. Thus, sustaining these programs that have involved incredible local investments is often overturned at a specific short term date. There is no political will for investing in longer term outcomes during challenging economic times and low enthusiasm for infusing more revenue. Thus, local providers who are committed to the program as they experience the small incremental changes in the lives of the people they touch, cobble together what they can to try to maintain these services, further watering down their bounded revenue. The service delivery loses some of its integrity and becomes a shell of its former self. Maintaining these programs often creates some fiscal competition with the AAA's traditional OAA programs once the funding for the pilots is no longer available. Meanwhile, innovators at the State and Federal government are busy creating initiatives for the next innovation in hopes of a quick fix and rapid return on investment.