Care Management

PROBLEM STATEMENT:

Southeast WA Aging & Long Term Care care coordination program has two main goals:

1. To provide person-centered in-home long-term services and supports (LTSS) that are well integrated with the health care services for seniors and adults with disabilities in a manner that allows them to stay independent and safe.
2. To provide person-centered coordination of health and community supports for people who face significant health challenges in a manner that improves their health and reduces avoidable health care costs.

However:

a) The number of people 65 and older (who use 75% of LTSS) is growing.
b) People of all ages are living longer with disabilities, chronic conditions and treatment options.
c) The healthcare system provides fragmented care and is confusing, particularly for those with complex conditions.
d) Individuals in ALTC's Planning and Service area who need LTSS are accessing community-based in-home and residential options at a higher rate than the comparable Washington State average.
e) The rate of emergency room use among LTSS recipients in ALTC's region is higher than the comparable Washington State average.
f) The percentage of LTSS recipients in ALTC's s region with a mental health treatment need who obtained treatment is below the Washington statewide average.
g) Funding for the two main components of the care management program ALTC uses to achieve its goals --- case management for in-home recipients of LTSS, and Health Home services for the most medically impacted Medicaid recipients --- is approximately 20% short of what is necessary to adequately maintain those critical services.

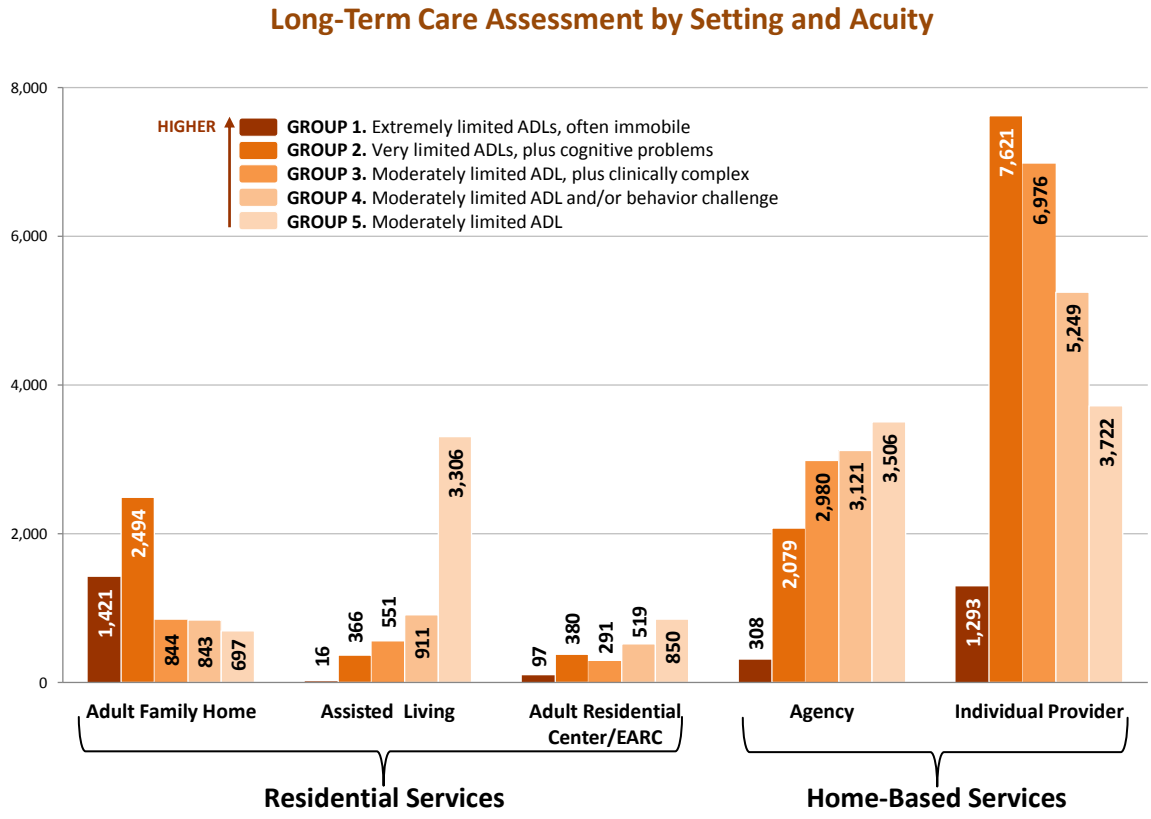
BACKGROUND:

Washington is a national leader in offering home and community-based LTSS for people with significant disabilities under the Medicaid program. Washington residents can choose to receive support in adult family homes, in assisted living, in their own homes, or in a nursing home. As would be expected, about 75% choose to receive care in their homes, either from an agency or an individual provider of their choosing. To make that choice viable, it has been essential that Washington's in-home program has grown in its capacity to support people with moderate to severe physical limitations as

well as those who are medically complex, often accompanied by significant behavioral and cognitive challenges.

Not only is in-home care the preferred LTSS option, it is the most cost-effective. It costs less than $2,000 per month, on average, for in-home care compared to over $5,000 per month for care in a nursing home. In-home care makes efficient use of funding rather than assuming the cost of full, 24/7 complete care, it supplements what individuals and families can do for themselves with intermittent, paid, gap filling services supports. To ensure success and safety, plans of care must be tailored to each situation because each individual and family differs widely in what they can do for themselves.

Supporting people of all acuity levels in community-based settings is key to accommodating the growing population



As the chart above demonstrates, statewide there are approximately 38,000 people in the home and community-based portion of Washington's LTSS system who face a broad range of challenges to their health and independence. All need assistance to accomplish daily activities such as bathing, dressing, preparing meals, personal hygiene

and moving about. About 30% (11, 300 people) of those have very little ability to accomplish daily activities in combination with cognitive limits and extremely limited mobility. That is roughly equal to the number of Washington's nursing home residents with similar conditions who are covered by Medicaid. Another 30% are slightly more able to accomplish daily activities but are challenged by a complex combination of difficult to manage diagnoses and health conditions. Those levels of acuity have continually increased over the past decades and require increasingly sophisticated service planning, coordination, and monitoring to maintain independence, health, and safety.

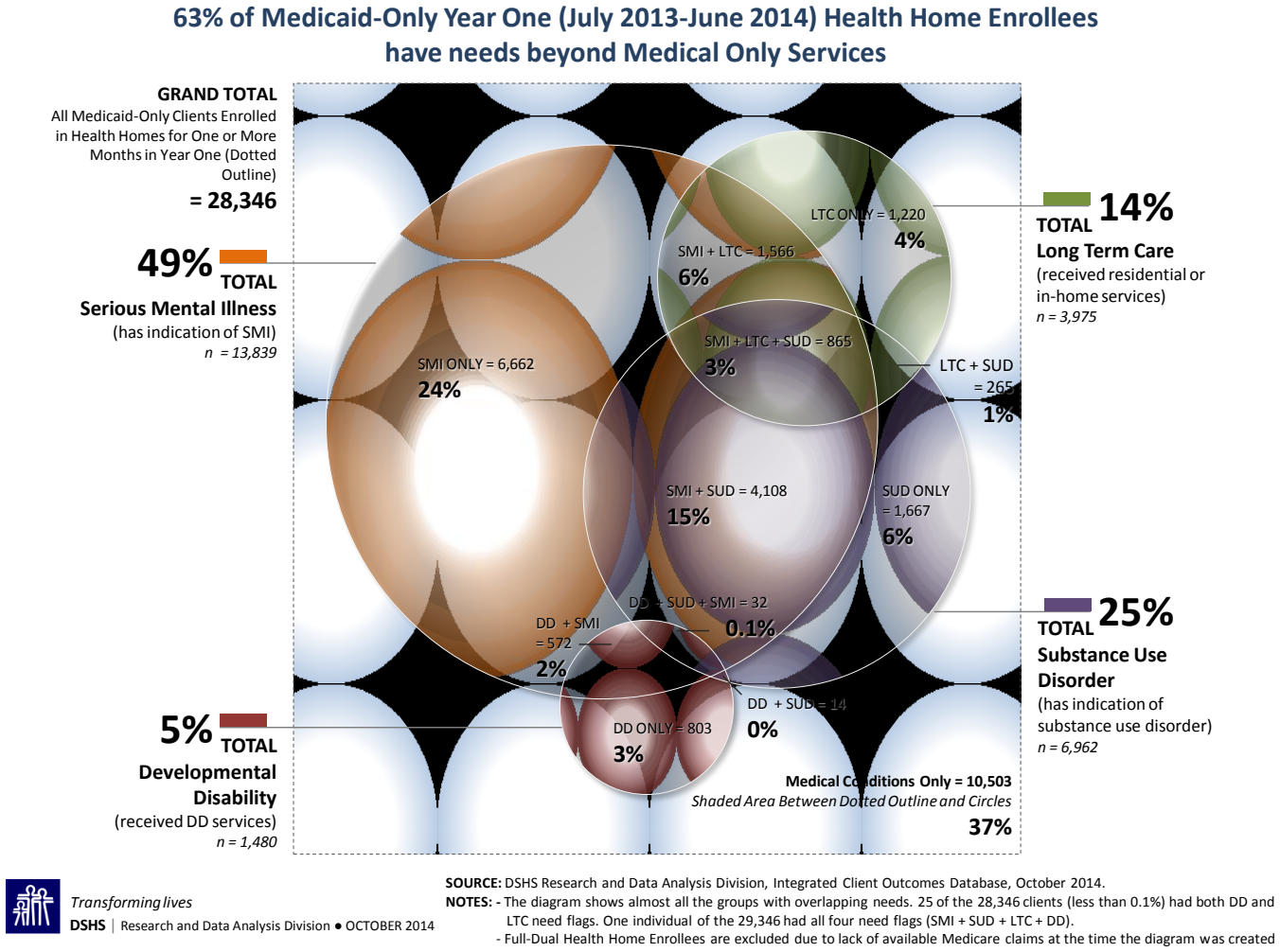
Beyond the effect of disability on the need for LTSS, for all people the average per capita cost for medical care is significantly higher for individuals with one or more chronic conditions. Care for people with chronic conditions accounts for 77% of Medicaid spending for beneficiaries living in the community. Among the Medicaid population the costs per capita are more than double the average and for people age 65 and older the costs are more than five times higher (Mollica and Gillespie, 2003).

Fragmented care escalates medical cost for adults with complex, chronic medical conditions who must rely on a cross sector mix of medical, long-term care, behavioral health and social service supports. In 2013 Washington's Health Care Authority launched the Health Home program to improve cross-sector care coordination, modeled on a pilot that was shown to have positive effect on health (including mortality) while at the same time lowering inpatient hospital costs and overall health costs in general. The pilot (in which ALTC participated) provided frequent face-to-face contact with high cost/high risk clients, facilitated exchange of information among the wide range of their providers, connected them to community social service supports, and used patient education and behavior changing techniques such as motivational interviewing to empower clients to take better charge of their health and use of healthcare series.

The Health Home program is targeted statewide to over 50,000 individuals enrolled in Medicaid or dually eligible for Medicare and Medicaid in Washington State constitute the top 20% of high-health risk, high-cost clients who could benefit from care coordination services across multiple provider types.

The chart below demonstrates the complexity of need among Health Home clients who received services solely funded by Medicaid during the first year of statewide implementation. All are among the top 20% in terms of overall Medical cost. Almost half have evidence of serious mental illness and a quarter have an underlying substance abuse disorder --- which underscores the importance of engagement in and close integration of supports from the medical, mental health and substance abuse providers. Data for seniors and people with disabilities who are

dually eligible for Medicare and Medicaid is not yet available, but it is expected to show 80% of high cost/high risk duals also have need for LTSS.



EXISTING EFFORTS:

- **Case Management of In-home LTSS:** In any given month ALTC manages around 3,570 in-home LTSS cases. With turnover, ALTC supports about 4,516 individuals over the course of a year. Clients receive a comprehensive assessment of their functional and health support needs. After assessment they receive an individual service plan that authorizes personal care help with activities of daily living such as bathing, personal hygiene, ambulation and meal preparation.

  In addition, the case manager can authorize other supportive services such as training on anger

management from a behavioral specialist or a dietician who may train the client or care provider on how to cook diabetic meals and appropriate serving sizes. On average, Case Managers authorize about $2,000 per month in supportive services.

Beyond what is directly authorized for payment, the case management team (which includes nursing and social services professionals) helps people access healthcare and other services in the community. To monitor care and maintain safety of this very vulnerable population the case manager does home visits and maintains contact with family and providers to monitor the effectiveness of the plan of care.

- **Health Home Care Coordination:** As noted above, between 2005 and 2012, the ALTC participated in the Washington State Chronic Care Management (CCM) pilot program which resulted in statewide savings of $2.5 million in medical costs with an intervention cost of only $1.7 million (DSHS Research and Data Analysis Division, February 2014). The current Health Homes program model builds on the success of the CCM pilot and expands access to all high-risk Medicaid beneficiaries.

  The Health Home program emphasizes person-centered care that places the beneficiary in a pivotal role. The beneficiary is involved in improving their health through the development of an individualized Health Action Plan (HAP). Beneficiaries may choose include their families, caregivers, or others as part of their Health Home team. Each beneficiary is assigned a Care Coordinator (CC) who provides health coaching, community and health care service referral assistance, and care coordination to link efforts of the medial, mental health, substance abuse, long-term services and supports, and community social service delivery systems together to meet the beneficiary's identified healthcare needs in a coordinated manner. CCs help the beneficiary to establish health goals and then work with them to assume greater levels of responsibility and confidence in the management of their own health care conditions, which is critically important to individuals with chronic illness.

  The Health Home program is a key building block in Washington State for innovation models promoting health, preventing and managing chronic disease, and controlling health care costs. ALTC started as a Lead Entity for the program in July 2013 with a network of providers to serve a broad population of clients. In early 2015 this network of providers includes the ALTC, mental health specialists, local community-based providers, and community

health centers. At the end of January 2015, ALTC and partners have engaged 775 high risk clients and are working with them to implement plans to improve their health.

PRINCIPLE STRATEGIES:

1. To allow an increasingly greater number and proportion of people who need long-term services and supports get them in their home or in a community-based setting (HCBS);
   a) *Increase individual and family member awareness, education and understanding of community-based LTSS options.*
   b) *Increase the number of eligible individuals who apply for community-based LTSS.*
   c) *Achieve full funding to maintain quality in-home case management so that individuals are receive stabilized care that allows them to stay in home services as long as that is their choice.* Note: At current levels of funding in-home monitoring of care, inclusion of nurse expertise on the care team, supervisory quality control and quality of care planning have suffered. If not rectified by FY2017 it will be necessary to reduce or eliminate related quality assurance benchmarks.

   Metrics:

   1) Each year 3,570 more people each month will receive LTSS.
   2) The proportion of people who need long term services who are served in community-based settings will increase by 5% each year.
   3) The other metric is the percentage of people in home care who transfer to other settings.
   4) The rate will be increased to cover costs.

2. To provide person-centered coordination of health and community supports for increasing numbers of people who face significant health challenges in a manner that improves their health and reduces avoidable health care costs.
   a) Increase availability of care coordination throughout the region.
   b) Increase engagement and effectiveness of care coordination services.
   c) Increase awareness of local health care options including Urgent Care Centers.
   d) *Increase palliative care options and support for people at the end of life.*
   e) *Initiate and sustain partnerships with other care providers*.
   f) *Achieve full funding to maintain quality health home care coordination.* Note: At current levels of funding it will not be possible to accomplish the above activities.

Metrics:

1) 500 or more people each month will receive Health Home services from ALTC's Health Home Network.
2) The Health Home engagement rate ALTC CCO direct service will increase to 28%.
3) The rate will be increased to cover costs

Resources: Washington State Health Care Authority: Health Homes website