Southeast Washington ALTC Council of Governments

Section C-3:
PERSON CENTERED HOME AND COMMUNITY BASED SERVICES

Care Management

Problem Statement:
Southeast WA Aging & Long Term Care's 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 (PSA) who need LTSS are accessing community-based in-home and residential options at a higher rate than the comparable Washington State average.

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, but it is also the most cost-effective. In-home care makes efficient use of funding rather than assuming the cost of full, 24/7 complete care in a skilled facility. 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.

Statewide there are over 47,000 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. A substantial portion of this population's acuity levels are high, and some have behavioral health issues in conjunction to their functional needs. Acuity levels 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.

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. This is no longer a pilot but an ongoing program due to the success of the pilot. ALTC is a Lead Health Home and builds a network of providers to perform health home care coordination services.

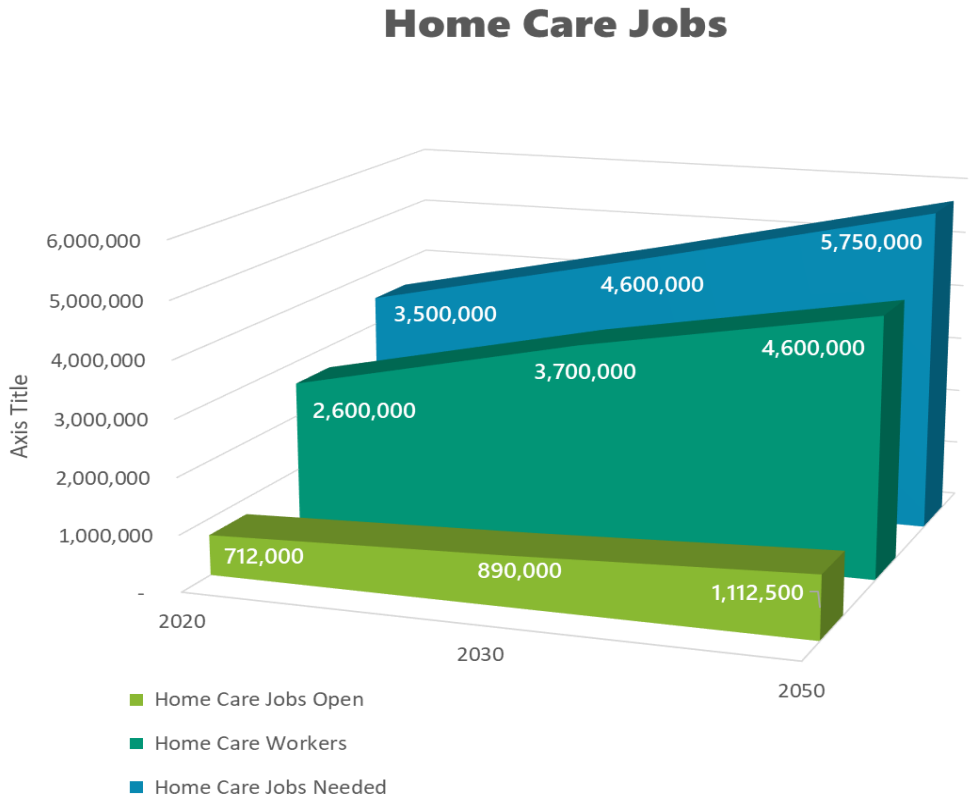
The Health Home program is targeted statewide to 21,185 eligible individuals, which 32% are enrolled in dual eligible for Medicare and Medicaid in Washington State as of March 2023. They are of high-health risk, high-cost clients who could benefit from care coordination services across multiple provider types.

When ALTC first started out as a Lead Health Home Care Coordinator Organization, they were 1,500 engaged clients that were being seen by the Health Home Care Coordinators. However, with third party insurance, primarily Medicare Advantage plans, clients who

would sign up for these plans, would find out they were no longer eligible for Health Home. ALTC has lost ½ of its caseload by 2023. This evidence based program continues to perform with excellent results for client outcomes and meets the quality metrics for good health outcomes. The numbers of eligible enrollees have been greatly reduced due to the third party insurance clause that makes clients ineligible for this evidence based program.

Another significant crisis the long term care service delivery system is facing is a work force shortage. The Federal Bureau of Labor Statistics estimate that the number of openings for home care workers will increase by 37% by 2028. This shortage has caused a crisis in long term services and supports, delaying wait times for those that qualify for family caregiver services or Medicaid Long Term Services and Supports.

This workforce has largely relied upon a female workforce, and over 50% of the workforce nationally are people of color and 25% of this work force were born outside the United States. The chart below illustrates the issues with the work for shortages.



The workforce shortage has also challenged the long term support system in recruitment and retention of qualified skilled nurses and those with bachelor's degrees in social services or related fields plus two years of experience. There are long vacancies when there are openings coupled with the fact that the T XIX home based client load continues to grow. This also places clients at risk as long term vacancies, coupled with turnover during a nation wide worker shortage leaves clients with a revolving clinical staff along with inexperienced staff with a high risk population that needs experienced and skilled clinical staff to oversee care plans, ensure appropriate referrals are made and followed up with and assistance with stable housing, food, and assistance with accessing needed social and health services.

Current Goal: SE WA ALTC will continue to support its person centered home and community based services by enhancing the skill and abilities of its front line Case Managers, ensuring a robust network or service availability in each area of its planning and service area and monitoring risk and quality of service to this growing network of service delivery systems.

EXISTING EFFORTS:

- ## ISSUE: Case Management of In-home LTSS

  In any given month, ALTC manages around 4,934 in-home LTSS cases. With turnover of clients, ALTC supports over 4,971 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. Case Managers authorize thousands of dollars per month in supportive services.

  Beyond what is directly authorized for payment, the case management team (which includes nurses 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.

- **ISSUE: Health Home Care Coordination**

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 to 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 medical, 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 and continues with this today. This network of providers still includes ALTC, mental health specialists, local community-based providers, and community health centers. Beneficiaries also indicated they wanted to get more engaged in their care, and many achieved their health goals by changing their own behavior rather than accessing additional services. 2023 marks 10 years of health homes with over 56,356 clients engaged throughout WA State (FS). In a report prepared by DSHS Research and Data Analysis Division and released December 2018, the Health Home Program had in its first 42 months demonstrated a 4:1 return on investments, producing $107 million in Medicare savings. In 2022, ALTC serves and engaged 685 beneficiaries (FS). Due to client's transition to Medicare Advantage Plans, Health Home numbers have decreased significantly over the last six years. SE WA ALTC is participating with the Health Care Authority on adding the Health Home Model to Medicare Advantage Plans to work on increased client engagement. As of 2023, this endeavor was successful for some of the third-party insurer whom clients may have signed up and would have otherwise lost Health Home Care Coordination services. Clients who have a third party Dual Eligible Special Needs Plans (D-SNPs) will be referred back to the community-based Lead Health Home entity for continued Health Home Care

Coordination. This required additional contracts with D-SNPs and the processes are being fine-tuned.

- **ISSUE: Home Care and clinical workers of long term services and supports (skilled nurses, case managers and health home care coordinators)**

The work shortage across the nation has created additional burdens on those who individuals who have chronic conditions with long term services and supports needs, some of our most vulnerable populations, who are even more challenged with access to health care and available home care staff for personal care in their homes. The worker shortages and turnover rates have exacerbated the situation as too there can be frequent revolving clinical staff and new clinical staff who are not as seasoned on home and community based long term services and supports to ensure higher quality case management and oversight of complex care plans. Paid Family Medical Leave in Washington State has challenged employers too in that, in any given month, ALTC has had 10% of their workforce out on PFMLA. Whilst this is a terrific benefit that has been long overdue, the workforce of trained clinical staff is not available to meet the need. During the nation's unprecedented worker shortages, this has created a trifecta of challenges—longer vacancy rates, higher turnover of employees and staffing unavailability due to being out on family leave.

ALTC has attempted to become more competitive with higher salaries and benefits, created higher supervisor to clinical staff ratios, revamped their training strategies for a more focused and robust training effort of clinical staff. They have also attempted to create "floater" clinicians that help cover for when employees are out on family leave throughout our large geographic area. The floater positions are not well suited for continuity for clients and clinicians often don't find the role satisfying as they are working with clients that are not well known to them, with a revolving caseload and spend a great deal of time troubleshooting issues. Additionally, the Washington legislature has attempted to help with the issue by adding additional funding to lower caseloads and to bring some parity funding so that Area Agencies on Aging can compete with the DSHS social worker salary and benefits package.

However, case managers are having to also manage unstable situations as there is a worker shortage with home care aides and clients who are very complex can go for a great deal of time without a paid care provider due to no home care aides available. The role for the case manager is becoming more complex due to a higher volume of clients

with complex care needs and longer amounts of time in finding a home care provider to meet the personal care needs of the client.

ALTC has worked with home care agencies to encourage best practices for recruitment and retention with their home care work force. During COVID-19 we lost capacity in the workforce both for women (lack of day care providers) and also there was a significant slowdown in immigration which hasn't recovered but the US is very reliant upon an immigrant work force.

ALTC will continue to illuminate the work force shortage at both the home care worker level and the clinical staff level. The solution is multi-faceted and some of which the longer term solve is at the national level requiring public policy changes.

Southeast Washington Aging and Long-Term Care is trying to make an impact in this area through:

- SE WA ALTC will continue to explore ways to recruit, retain employees and enhance their level of skill through an intensive clinical and programmatic training of Case Managers and Nurses.

- SE WA ALTC will continue to support contractors to recruit and retain home care workers and other clinical staff in all settings to help ensure that we continue to be able to provide timely response to older adults and adults with disabilities needs through technical support and advocacy.