

Why focus on chronic care?

Governor Gregoire in her 01/20/06 memo regarding Chronic Care Improvement to the Secretaries of DSHS, DOH and the HCA, cited that five percent of Medicaid recipients are responsible for roughly 50 percent of the programs' costs. Many of these recipients are consumers of long-term care services and more than half have diagnoses such as pain and depression that are indicative of co-morbid conditions. Nationally, seventy eight percent of all medical costs are for people with chronic conditions (AHRQ, 1996) and the number of people with chronic conditions is projected to increase by more than one percent each year through 2030 (RAND, 2000), so medical costs can be expected to continually increase. These basic facts underscore the importance of implementing and evaluating models of chronic care that will both improve the health of our state as well as utilize our resources more efficiently and effectively.

What is chronic care?

"Chronic care management" means programs that provide care management and coordination activities for medical assistance clients determined to be at risk for high medical costs. "Chronic care management" provides evidence-based assessment and interventions, coordination of health care and other supportive services, education and training that assists program participants in improving self-management skills to improve health outcomes, reduces medical costs, improve functional and self-care abilities, and slows progression of disease or disability. Chronic care management recognizes and provides interventions for the medical, social, economic, mental health and environmental factors impacting health and health care choices.

As noted by the LTC Task Force in their Advisory Committee Draft Recommendations dated 12/05/06, the transitions in care for clients between acute and long term care systems are of a particular concern, and clients are vulnerable to negative outcomes during these transitions. Inefficient, ineffective, and unsafe care provided to clients results in more expenses and poor health outcomes. Care management should be designed and evaluated to bring the consistency of care needed during these transitions. Health care providers, including physician offices are not always able or willing to provide all of the health care or coordination required to achieve optimal health.

What are DSHS and DOH doing?

DSHS

The focus of current care management projects at DSHS Aging and Disability Services Administration (ADSA) and the Health and Recovery Services Administration (HRSA) is to develop effective models of chronic care.

Aging and Disability Services Administration

The Intensive Chronic Case Management project is designed to provide integration of acute (medical) and long term care services through coordination of care and use of evidence based practices that promote improved health outcomes and reduce medical system interactions. The ICCM model builds on the ADSA's existing long term care casework and in-home service delivery infrastructure through Area Agencies on Aging.

The ICCM project is being piloted at five Area Agencies on Aging;

1. Olympic Area Agency on Aging;
2. Northwest Regional Council;
3. Pierce County Aging and Long Term Care;
4. SE WA Aging and Long Term Care; and
5. Aging and Long Term Care of E WA.

The target population:

1. Clients receiving in-home services case managed by one of the five AAA's;
2. Medicaid only/fee-for-service;
3. Identified at high risk for significant medical costs through the use of predictive modeling software combined with indications of risk from the long term care assessment tool (CARE).

ICCM Enrollment

1. The active total enrollment at each AAA will be 45.
2. The total population of in-home LTC clients estimated to fit program criteria in the pilot areas is 1900. The statewide universe of people who fit program criteria is 4,100 (15% of total in-home LTC clients).

The basis for the ICCM is a three way relationship – the client and their caregiving network, their medical practitioner and the ADSA nurse case manager. The nurse case manager works with the client, their personal care providers and families, and their medical home to facilitate communication and target activities that slow deterioration, and maintain or improve status. The activities are captured in a service plan that incorporates relevant aspects of the environment, client function, health care needs, cognition and psycho-social dynamics. The interventions are based on the IOM Chasm Report principles of client centered, safe, efficient, effective and timely care. The advantage of this model is the amount of face to face access to the client by the nurse case manager during both the acute and chronic phases of disease, the long term relationship with the client that extends for over six months to as long as they remain in long-term care, the presence of a personal care aide who provides 100 to 400 hours of care each month, and the time the nurse case manager has to work with the medical practitioner. The nurse-case manager assists the client as a navigator and interpreter of the medical system, which extends the medical care provided in the physician office into the client's home where health care really occurs between the client and their formal and informal supports.

Health and Recovery Services Administration

The HRSA Chronic Care Management (CCM) pilot project began January 1, 2007 aimed at helping Medicaid clients with high-risk and expensive chronic conditions in Medicaid clients get faster and more appropriate care. The goals of the project are to "Improve access, outcomes and cost-effectiveness for clients with chronic illness through care management interventions". The vendors providing CCM are:

- AmeriChoice – providing statewide care management. AmeriChoice identifies clients at high-risk for medical costs through predictive modeling techniques and care management to selected eligible clients outside King County.
- King County- Local Care Management Services. Seattle Aging and Disability Services is linking with partners to provide access to “medical homes” for SSI clients who are without them and care management interventions for a limited subset of eligible clients in King County.

CCM Enrollment:

Predictive Modeling = 65,000 clients

Potential Treatment Group = 4000 clients

Current care management group = 2000 (04/30/07)

Current Medical Home clients = 6674 clients

CCM assists clients to improve their self-management skills by providing education, training and coordination of services, with client specific interventions. Vendors are expected to provide coordinated services with other DSHS services including MHD and DASA.

DOH

DOH sponsors the Washington State Collaborative. Clinical teams participating in the Collaborative get tools to make it easier to manage care for people with chronic diseases. The patients in the collaboratives become active participants in their own treatment plans with the intent of lowering risk factors and reducing complications. More than 100 health care facilities across Washington have participated in one or more of the collaboratives and all have experienced health patients, improved care and increased provider satisfaction. The collaborative is team approach that uses the concepts of the *Chronic Care Model* and have focused on:

1. Diabetes care and complications
2. Cardiovascular disease; and
3. Adult Preventive Care

Comparison of key chronic care management components

Component	ICCM/ADSA	CCM/HRSA	Disease Collaborative/DOH
Predictive Modeling Risk Scores	Used to identify high risk clients and care opportunities for care management and service planning, including LTC needs, and in-home caregiver supports.	Used to identify high risk clients and care opportunities for care management and service planning.	Not used to identify clients. Physician practices provide collaborative services to all of their patients.
Care Management	No restrictions on	6 month enrollment in	Client receives the

	<p>length of project enrollment.</p> <p>Client receives in-home and telephonic supports from a local nurse care manager with access to LTC support systems and client formal and informal supports.</p> <p>LTC service planning for Medicaid funded services.</p>	<p>the project. Client is then disenrolled from the project.</p> <p>Client can receive telephonic or in-home support.</p> <p>To avoid duplication clients receiving LTC services are excluded from the HRSA CCM project.</p>	<p>services the physician office is able to provide. No formal care management component for the disease collaboratives.</p> <p>Designed using the <u>Chronic Care Model</u> (Wagner et al)</p>
Medical Home	<p>Coordination of services with all medical and community based care providers for all clients.</p> <p>Extension of medical home to client's LTC service planning.</p>	<p>Clients in care management will receive coordination with their medical providers as needed.</p> <p>Identification of medical home when needed for high-risk clients in the LCM project.</p>	<p>Clients are provided evidence based medical care by their physician provider for diabetes, cardiovascular disease and adult preventive services.</p>
Location	5 AAA's	Statewide with special pilot in King County	Statewide
Eligibility	<i>Medicaid-only Aged Blind and Disabled who use in-home LTC services</i>	Medicaid-only Aged Blind and Disabled with no use of LTC services	<i>All chronically ill clients through their providers' participation</i>
Diseases covered	<i>Any high risk client with chronic illness</i>	High risk clients with chronic illness, specific exception for Title 19 AIDS case mgt	<i>Diabetes, cardiovascular, hypertension, asthma. No funding for depression.</i>
Funding source	<i>Medicaid administrative funds through MOU with HRSA</i>	Medicaid medical funds through CMS benchmark benefits package	<i>Budget allocation, CDC, applying for grant support</i>
Outcome measures	<i>Avoidable hospitalizations, self-</i>	Avoidable hospitalizations, self-	<i>Specific to diseases such as lab tests,</i>

	<i>rated health status, self-sufficiency</i>	rated health status, self-management skills	<i>blood pressure, receipt of flu shots</i>
Cost-effectiveness measures	<i>Per member per month costs (change over time)</i>	Per member per month costs (change over time)	<i>Return on investment estimated</i>
Patient/provider satisfaction	<i>?</i>	Patient satisfaction will be collected	<i>Provider satisfaction collected</i>

Evaluation

For the coming biennium \$500,000 in funding is provided to study the efficiency and effectiveness of the Intensive Chronic Case Management project and other DSHS efforts to address chronic care, pursuant to Second Substitute Senate Bill 5930. The study will be guided by a group that includes representatives from HRSA and DOH. A preliminary report will be completed by June, 2008 and the final report completed by December, 2008.

Please see the attached grid for a preliminary comparison of measures of client demographics, cost effectiveness measures and clinical effectiveness measures for DSHS and DOH chronic care management projects. The key common elements will provide the basis for a control-group study of the effectiveness of the DSHS efforts. The DOH data elements are partial and included only for illustrative purposes.