

Intensive Chronic Case Management

W4A 5th Annual Development
Conference

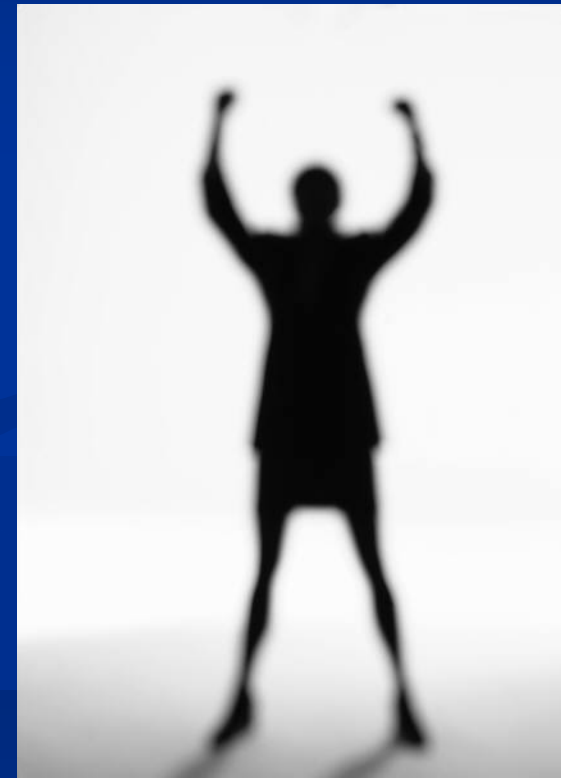
June 13, 2007

Intensive Chronic Case Management Project Expansion Sites

- Olympic Area Agency on Aging
- Northwest Regional Council
- Pierce County Aging and Long Term Care
- SE Washington Aging and Long Term Care
- Aging and Long Term Care of Eastern Washington

The Mobility Project grows up

- We started with a specific group of diagnoses that were high-cost and high-risk for both medical and home and community based services. (June 2004)
- We served over 100 clients with an average caseload of 65 active clients in Pierce and SE WA ALTC.
- HRSA supported ADSA in the project agreed to support ADSA in expansion of the project.



A quick look at the data

- The number of Americans with chronic conditions is expected to increase from 125 million in 2000 to 157 million by 2020.
- The number of people with multiple chronic conditions will rise from 60 million to 81 million.
- Care for people with chronic conditions accounts for 77 percent of Medicaid spending for beneficiaries living in the community.
- (Mollica and Gillespie, 2003)

Per capita health expenditures

- The average per capita medical expenditure is significantly higher for individuals with one or more chronic conditions than for those with no chronic conditions
- Among the Medicaid population the costs are more than double and for people over age 65 and older who are dually eligible the costs are more than five times higher.
- (Mollica and Gillespie, 2003)



And so what about care coordination...

- Care coordination for people with chronic conditions who participate in HCBS has been narrowly focused on supportive services.
- At the same time, a medical model of care coordination has begun to emerge in the FFS health care system.
- Yet... a gap exists between supportive and medical services and needs to be addressed.
 - (Mollica and Gillespie, 2003)
 - (Partnerships for Solutions, 2004)

Definition of a chronic condition

- A chronic condition is one that is expected to last more than one year
 - Limits a persons activities
 - May require ongoing medical care
 - Arthritis, asthma, congestive heart failure, diabetes, eye disease, hypertension, cancer and cardiovascular disease)
- (Partnerships for Solutions, 2004)

Definition of “chronic care management?”

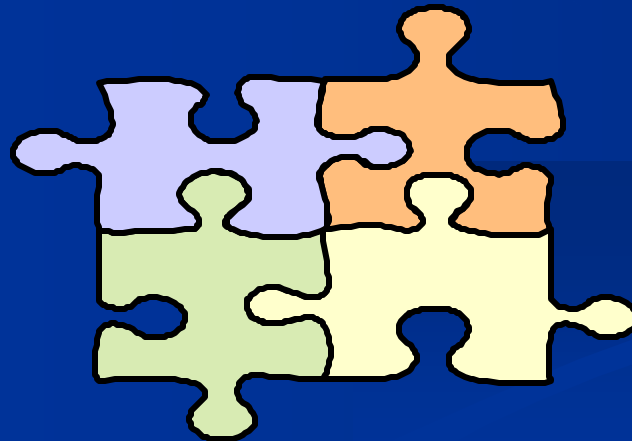
- “Chronic care management” means programs that provide care management and coordination activities for medical assistance clients determined to be at risk for high medical costs.
- “Chronic care management” provides evidence-based assessment and interventions, coordination of health care and other supportive 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.

LTC Task Force for the Blue Ribbon Commission

- 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;
- 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.

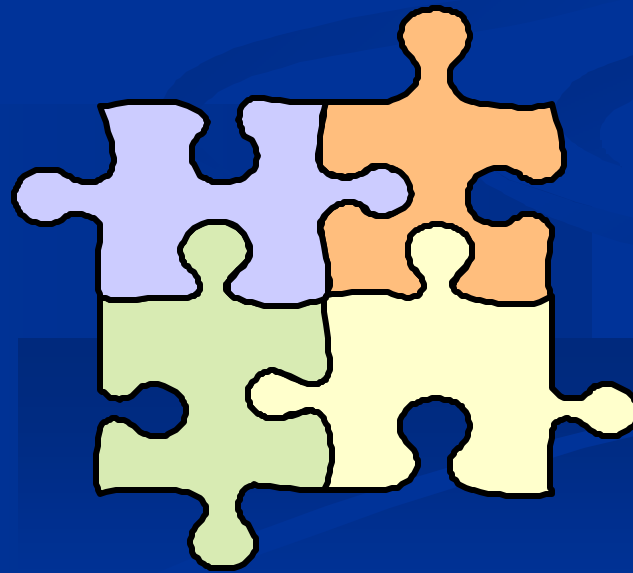
Goals of the ICCM

- Six Goals of project expansion:
 1. Improve or enhance case management interventions to allow the client to partner with health and social service providers to manage their care and services.



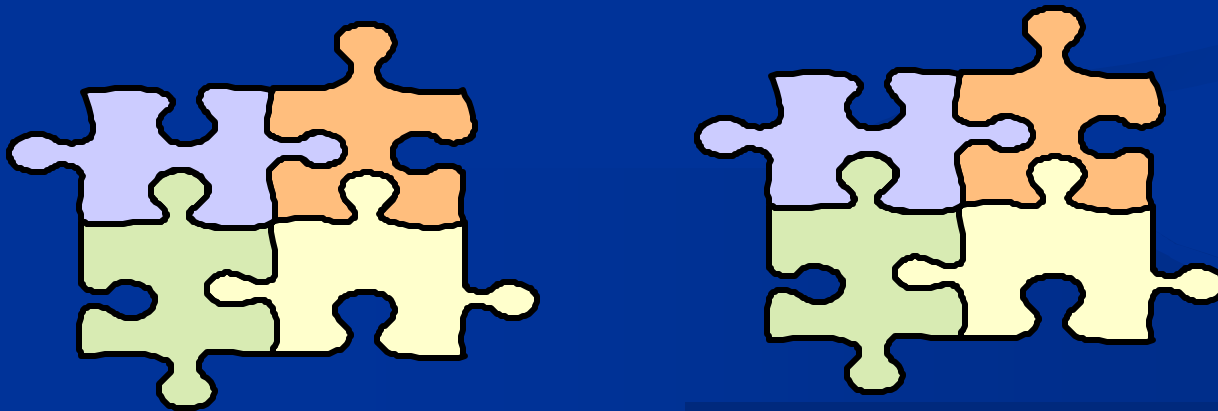
Goal # 2

- Implement evidence based preventive care measures that delay the decline or promote the abilities of the client to be able to achieve the highest level of health.



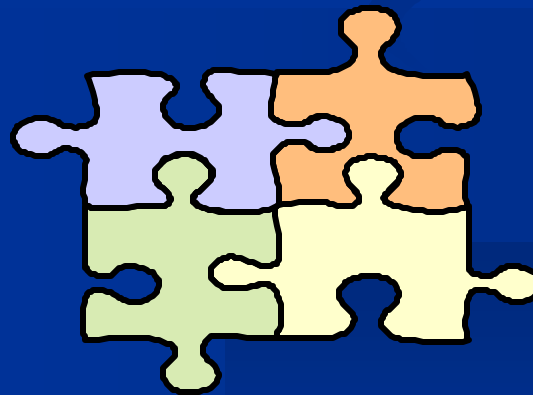
Goal # 3

- Develop or adopt protocols that enhance the client's options to manage their care and services to achieve individual goals.



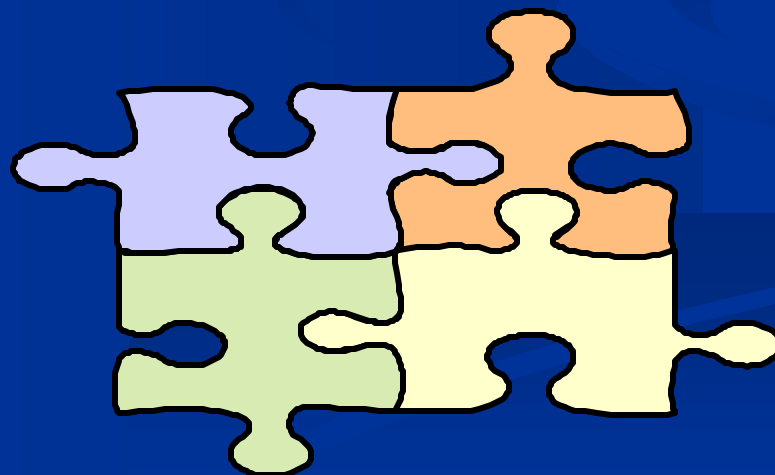
Goal # 4

- Identify individual health goals the client would like to achieve. The goals are expected to include principles of the IOM Chasm Report. These goals are established cross DSHS agency when possible.



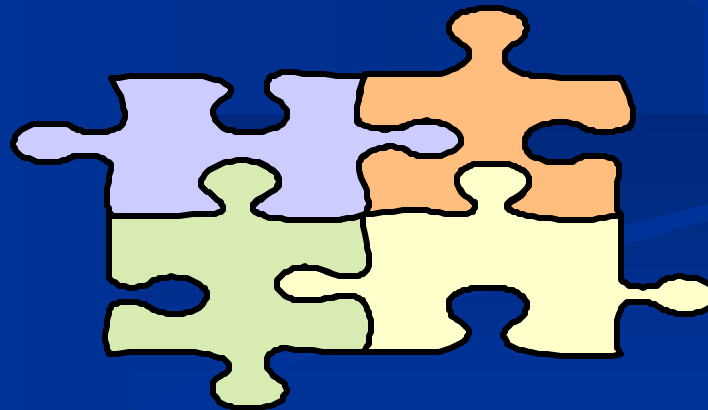
Goal # 5

- Combine medical and personal care services to improve cost and service utilization;
 - Create a medical home for the client.
 - Apply predictive modeling results for long term care planning with the client and their community.



Goal # 6

- Improve cost effectiveness and utilization to achieve individual client outcomes;
- Nurse case managers to have access to medical cost and provider utilization for each client in their respective projects and work with the client and their providers to address these health care issues.



Program Description

- The focus of the ICCM projects is:
 - An integration of acute and long term care services through coordination;
 - Consideration of adoption of evidence based practices that promote health outcomes;
 - Targeted to populations with high-cost and high-risk chronic conditions;
 - Recognition and interventions for the medical, social, economic, mental health, AOD dependencies, and environmental factors impacting health and health care choices.

Client demographics measures

These measures will be evaluated for the control and treatment groups:

Client demographics:

1. Diagnosis rates/co-morbid condition occurrence rates;
2. Age and gender;
3. Length of enrollment

Cost Effectiveness Measures

1. Per member per month costs
2. Outlier costs and standard deviation
3. Provider types and reduction in hospital and ER usage by diagnosis and costs
4. Pharmacy utilization
5. Mental health and DASA utilization (MMIS and RSN)

Clinical Effectiveness Measures (not all measures are noted)

1. Avoidable hospitalization rates
2. Overall health rating score
3. Overall self-sufficiency
4. Patient Activation Measure ©
5. Predictive Modeling Score Change
6. Classification Score Change
7. Pain Impacts and referrals for pain consultation
8. Depression score change and referral for depression
9. Tobacco cessation
10. Receipt of flu and pneumonia vaccine.

Incentives for ICCM

- Build community based models of care;
- Promote consumer self-determination, including recognition of health problems and social determinants;
- Integrating medical, mental health and supportive service links; and
- Developing a health care model designed specifically to meet the needs of the vulnerable with quality measures.
- Governor Gregoire's Chronic Care Improvement initiative.

The Governor's Memo (01/06)(4)

- Five percent of Medicaid clients account for 50 percent of the costs.
- They are consumers of LTC
- Are diagnosed with depression and chronic pain.
- Current health care system is focused on acute care and misses working with clients with chronic conditions from developing complications.



Who are the most vulnerable?

- 5 % have the most claim activity
- 60% female and 40% male
- Most are 25 to 64 years old
- Health services cross all agencies
- Common health risks;
 - Cardiovascular, diabetes, obesity, substance abuse and mental illness;
 - 60% are on narcotics and antidepressants
 - Their co-morbid conditions make all interventions challenging.

Theory and Research

- Institute of Medicine Crossing the Quality Chasm Report
- Center for Disease Control Syndemics
- Chronic Care Model
- Care Coordination for People with Chronic Conditions (Mollica and Gillespie, 2003)
- Partnerships for Solutions (2004)

IOM Chasm Report

- The US health care delivery system does not provide consistent health care to all people.
- “Between the health care system we now have and the health care that we could have lies not just a gap, but a chasm.” (IOM, 2001)
- How can we narrow this chasm to improve health outcomes and reduce expenditures?

Factors contributing to the chasm

- Medical and scientific advancements
- Growing complexity of health care –more to do, more to know, more to manage, more to watch.
- Changing public health care needs and prevalence of chronic health care conditions.
- Poorly organized health care systems with client hand-offs that slow down care and decrease rather than improve safety.

IOM Ten Rules for Redesign

1. Care is based on continuous healing relationships.
2. Care is customized according to patients needs and values.
3. The patient is the source of control.
4. Knowledge is shared and information flows freely.
5. Decision making is evidence-based.

IOM Rules for Redesign

6. Safety is a system property.
7. Transparency is necessary.
8. Needs are anticipated.
9. Waste is continuously decreased.
10. Cooperation among clinicians is a priority.

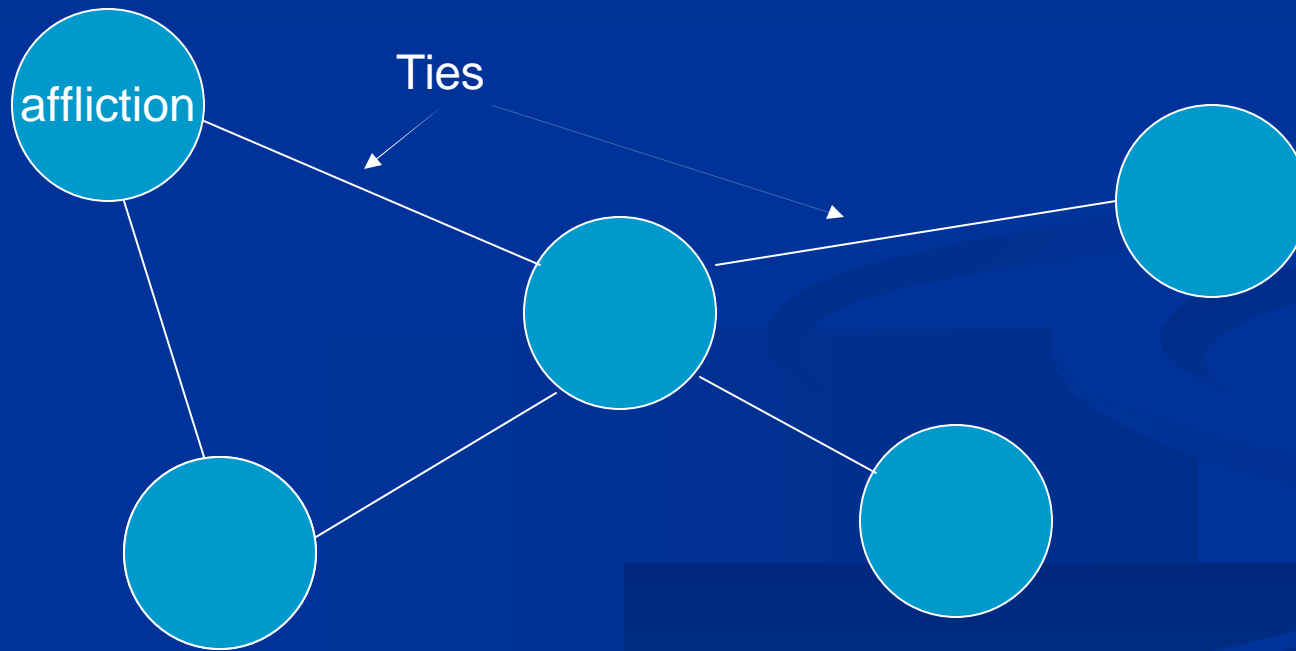
CDC Syndemics

- A syndemics is two or more afflictions, interacting syngeristically, contributing to excess burden of disease in a population.
- “You think that if you understand one, you understand two-because one and one are two. But you must also understand ‘and’.”

(Sufi saying)

A Syndemic Network (accounts of the environment)

- Ties and afflictions



Syndemic Network

- Syndemics occur when health related problems cluster by person, place or time.
- The problems, along with the reasons for their clustering, define a syndemic, and differentiate one from another.
- To prevent a syndemic one must prevent or control not only each affliction, but also the forces that tie those afflictions together.

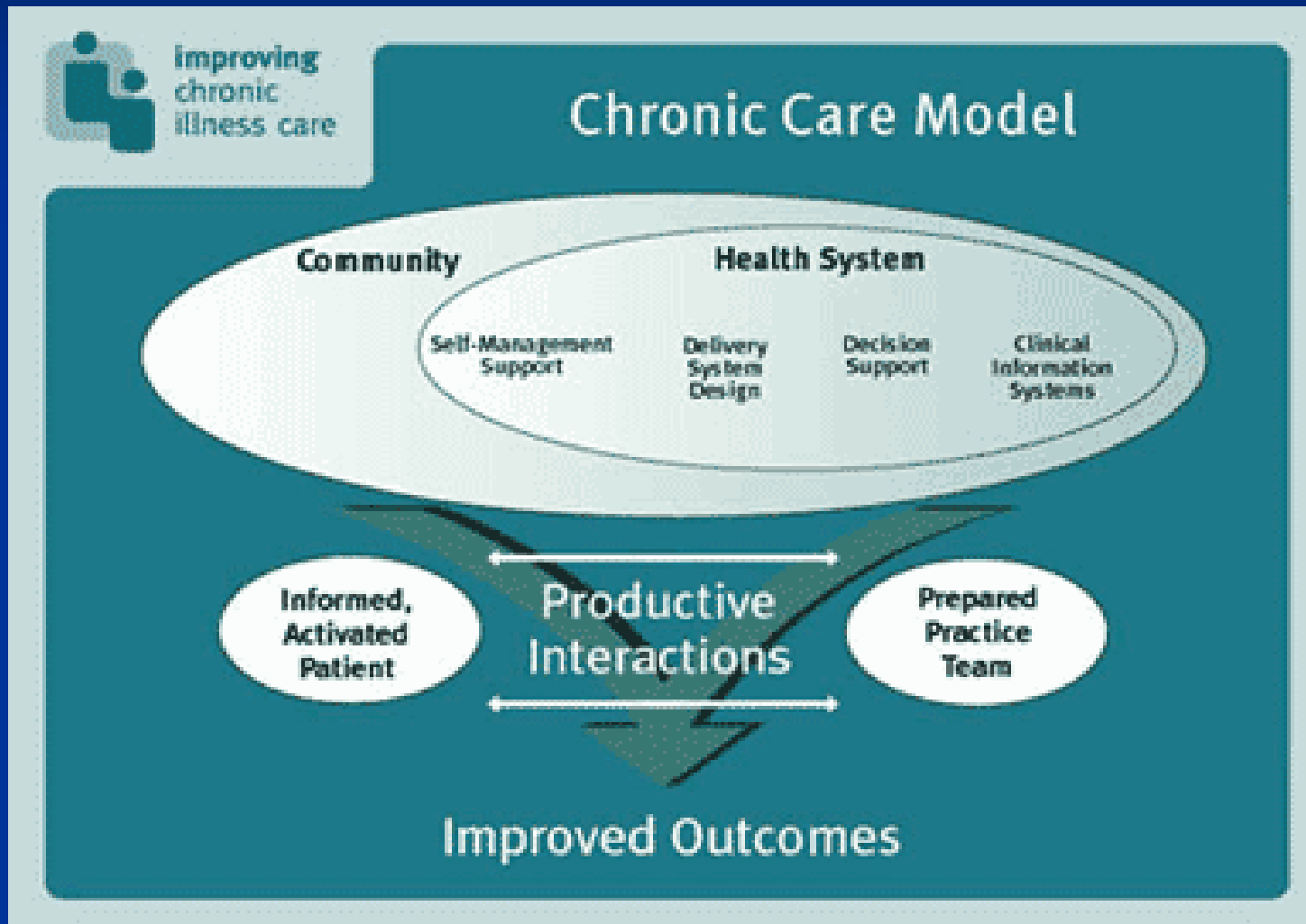
What should we then consider as the “ties” for our clients?

- Separate health concerns are linked if they:
 - Have the same biological agent (flu and pneumonia)
 - Share risk of protective behaviors (heart disease, obesity, emphysema)
 - Respond to similar environmental conditions (diabetes and asthma)
 - Have reciprocal or interdependent effects (alcoholism and depression)
 - Are managed by the same or similar organizations (public health, law enforcement, HCBS)
 - (CDC, Syndemics, 2005)

What we can learn for the ICCM from “syndemics:

- The clustering of health related problems for our home and community based clients occurs for many reasons and we need to take these into consideration when choosing our interventions.
- This is tied to the evidence-based care we select and the efficient use of our resources.

- **The Chronic Care Model** (Figure from Wagner EH. Chronic Disease Management: What Will it Take to Improve Care for Chronic Illness?. *Effective Clinical Practice* 1998:1:2-4.)



Care Coordination Models

- Mollica and Gillespie suggest there are three care coordination models
 - Social models that assess and authorize in-home, residential and institutional care;
 - Medically oriented models that coordinate medical treatments for high-cost clients; and
 - Integrated models that bridge the medical and long-term care systems
 - What will the ICCM provide for enrolled clients?

The Take Home Message

- “People with chronic conditions are getting services, but those services are not necessarily in sync with one another, and they are not always the services needed to maintain health and functioning.”

(Partnership for Solution)

- Our hypothesis:
- ICCM can make a difference in this synchronization of services with ICCM;
 - Health and long term care