Chronic Care Management Model

And, it’s history and evolution in Washington State

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Part of Washington’s journey toward cost savings

- October 2001, ADSA Mobility Project
- 2002, Medical Assistance Administration (MAA), Care Enhance Disease Management Program
- 2006 ADSA, ICCM (Intensive Chronic Care Management Program)
- 2009 ADSA, Chronic Care Management
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% of Medicaid spending for beneficiaries living in the community.

Mollica and Gillespie, 2003
Who is 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

Why they need support...

- Five percent of WA 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.

ADSA CCM Power Point, Candy Goehring
CHRONIC CARE MANAGEMENT MODEL

“What is right with you is a lot more powerful than what is wrong with you”
FIVE PROJECT SITES 9/06

- 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 purpose of CCM is to provide care management services to eligible Medicaid enrollees residing in service areas to meet the following goals:

- Reduce the impact of the progression of illness and functional disability
- Maximize enrollee self-management skills/level of activation
- Promote access to needed healthcare services for enrollees with multiple chronic conditions
- Improve appropriate use and understanding of prescription drugs
- Reduce unnecessary emergency room visits
- Avoid unnecessary hospitalizations
- Engage the client caregiver with the Health Action Plan as directed by the client
- Achieve cost savings in the Medicaid program
- Bridge LTC services with medical care.
Purpose of CCM

• Provide a locally based Chronic Care Management (CCM) program to eligible Medicaid clients

• CCM includes - care coordination activities provided by Nurse Care Managers (NCM).

• It is a comprehensive, voluntary program that incorporates outreach, CCM, education and assistance to enrollees in self-managing their chronic conditions and provide coordination of medical, mental health and chemical dependency services, and other community services based on the needs of the individual enrollee.
The How’s of CCM

When eligible the AAA NURSE CARE MANAGER (NCM):

- contacts the client to describe the program and obtain their consent to participate; the client is enrolled if they choose.
- screens and assesses the new enrollee for risk factors, health status, self-management skills and confidence level, knowledge of his or her health care needs, and knowledge about prescribed medications.
- Evaluates client’s level of engagement to work towards self-management by using PAM tool.
- develops a Health Action Plan (HAP), based on the assessment, in coordination with the participant and others as directed. The plan includes:
  - education about self-management, appropriate use of medical and social services resources
The How’s of CCM

- maintains contact with the participant’s primary providers and other health care specialists via telephone, fax, or in person (by going with the participant to their appointments) to:
  - exchange information/Motivational Interviewing Techniques
  - obtain/provide updates on the participant’s conditions
  - ensure the participant knows how to ask appropriate questions and utilize the information provided by the health care professional
  - ensure both parties are aware of changes in the participant’s condition or health care plan.
  - make referrals to community support providers, and other health care providers.
The How’s of CCM

- how to navigate the health care system
- how to work with the participant’s provider to develop a plan of care and achieve self-identified health goals. (look at updated contract language for any changes)

- coaches the participant to ensure he/she understands the plan and provides instructions for self-management.
- helps the participant access services through the mental health or chemical dependency systems as needed.
- determines the amount and type (in person or by telephone) of contact by the participant’s level of need.
- provides services in the participant's home, his/her PCP office, other healthcare setting, or another setting selected by the participant.
ADSA'S ROLL OUT PLAN

WHAT'S TO COME

- July 1, 2011: 5 Initial AAA project sites who participated in the Pilot are charged with the initial ramp up of CCM Program.
- September 2011 (fingers crossed) dual Eligible (Medicare/Medicaid) clients may come onto CCM Program. (5,000 – 12,000)
- February 2012: Case load across the five AAA’s will be 1000 enrollees.
- September 2012: Remainder AAA’s across the state will bring on CCM.
- 2013: National/Federal evaluation This could go national.
RESOURCES

• Evaluation information on CCM project: http://www.adsa.dshs.wa.gov/professional/hcs/CCM; or http://publications.rda.dshs.wa.gov/1396/


Evidenced Based Sites:

• CDC Community Preventive Services www.thecommunitygude.org
• CDC’s Healthy Aging Program www.cdc.gov.aging
• AHRQ Evidence Based Practice Centers www.effectivehealthcare.ahrq.gov
• National Guidelines Clearinghouse http://www.guideline.gov
The End...Not Quite

Many Challenges
Many Health Concerns
Many Barriers
And An Evolving Program