**CHCS WEBINAR:** Advancing Medicaid Care Management and Health Home Design: Lessons from Washington State

**Thursday, November 15, 3:30-5 PM ET**

- For audio, dial: **1-877-702-9054**; Passcode: **459710**
- You may also listen to this event online via streaming audio.

- A video archive will be posted on [www.chcs.org](http://www.chcs.org) following the event.
Rethinking Care Program

- Principal support from Kaiser Permanente Community Benefit
- Focus on improving care for Medicaid’s highest-cost, highest-need patients
- Include rigorous external evaluations to identify effective models worthy of replication
- 4 multi-year pilots -- in CO, NY, PA, WA -- tested innovative approaches to transform care delivery
The “5/50” Rule

Enrollees

Bottom 95% of Spenders

Top 5%

Children 0.3%
Adults 0.2%
Disabled 2.5%
Elderly 2.0%

Total = 62.6 million

Expenditures

Bottom 95% of Spenders

Top 5%

Children 3.7%
Adults 1.9%
Disabled 30.4%
Elderly 18.6%

55%

Total = $346.5 billion

SOURCE: KCMU/Urban Institute estimates based on data from FY 2009 MSIS and CMS-64, 2012.MSIS
FY 2008 data were used for MA, PA, UT, and WI, but adjusted to 2009 CMS-64.
Profile of High Risk WA Medicaid Clients

Percentage of Non-Dual Disabled clients* with HIGH MEDICAL RISK who also ...  

- 37% . . . had an indication of serious mental illness  
- 30% . . . had an indication of a substance use problem  
- 25% . . . received Long Term Care services and supports  
- 12% . . . received Division of Developmental Disabilities services  

*Clients with multiple service needs or risk factors are counted in each category.  
SOURCE: WA DSHS Research and Data Analysis Division, Integrated Client Database, January 2012. Data from State Fiscal Year 2009
Service Need Overlap Among High Risk Clients

TOTAL SUBSTANCE USE DISORDER = 30%

SUD ONLY = 10%
SUD + SMI = 12%
SUD + LTC = 3%
SUD + SMI + LTC = 4%

TOTAL LONG TERM CARE = 25%

LTC ONLY = 2,733
11%

SMI ONLY = 11%
SMI + SMI = 6%
SMI + LTC = <1%
SMI + DD = <1%

TOTAL DEVELOPMENTAL DISABILITY = 12%

DD ONLY = 8%
DD + SMI + LTC = <1%

TOTAL SERIOUS MENTAL ILLNESS = 37%

SMI ONLY = 11%
SMI + SMI = 3%
SMI + SMI + LTC = 4%

SOURCE: WA DSHS Research and Data Analysis Division, Integrated Client Database, January 2012. Data from State Fiscal Year 2009
Relevance in National Context

• Growing acceptance of need for better care coordination across the delivery system
• Heightened focus on high-need, high-cost populations
• New opportunities to encourage development of these models
  - Health Homes
  - Super-Utilizer Programs
  - ACOs
  - State Innovation Models
• Hunger for information on “what works”
Disease Management to Health Homes

Barbara Lantz
Section Manager
Division of Health Care Services
Brief History

• 2001 Legislature directed DSHS to implement a Disease Management program as a way to save money by better managing chronic health conditions

• DSHS conducted a Request for Proposals for qualified Disease Management Organizations (DMOs)
  – McKesson Health Solutions and Renaissance Health Care were successful bidders

• Major program component was face-to-face contact with enrollees if needed
Disease Management programs were implemented in April 2002

- McKesson Health Solutions provided services for enrollees with Diabetes, Asthma, Heart Failure
- Renaissance Health Care served those with End Stage Renal Disease and Chronic Kidney Disease

Each program provided telephonic and face to face services to enrollees with chronic conditions
The Transition to Chronic Care Management

- Disease Management focused on a single condition, even if the enrollee has multiple conditions
- Financial savings and quality improvements were minimal, mostly because of retroactivity in eligibility
- Telephonic program had no effect on financial or quality outcomes

- 2006 - RFP was issued to find Local and Statewide Care Management Programs to provide services to Categorically Needy clients with multiple conditions:
  - City of Seattle provided Local Care Management services and Medical Home – hands on care management for the whole person, along with primary care services via a network of Community Health Centers
  - Americhoice provided a Statewide Care Management via face to face and telephonic program
Rethinking Care

• 2009 – DSHS collaborates with the Center for Health Care Strategies to develop Rethinking Care:
  – City of Seattle’s Local Care Management continues with addition of mental health and chemical dependency services for enrollees
  – Cowlitz Comprehensive Health develops a chronic care management program through the mental health system to help improve access to medical services for enrollees with mental health conditions.
CHCS Rethinking Care Program: King County Care Partners’ (KCCP) Evaluation Highlights

Toni Krupski, PhD & Jutta M. Joesch, PhD
University of Washington at Harborview Medical Center
Seattle
KCCP Intervention Overview

- Randomized controlled trial

- Intervention clients
  - disabled Medicaid recipients in King County, WA
  - at least 1 chronic medical condition
  - at risk for future high medical expenses
  - mental illness and/or chemical dependency

- Intervention goals
  - empower clients to address healthcare needs
  - enhance service coordination, communication, integration

- Intervention approach
  - community-based, RN-led, multidisciplinary care management
KCCP Intervention Components

- In-person, comprehensive assessment
- Collaborative goal-setting
- Coaching in self-advocacy, self-management, system access & navigation
- Joint visits to physician appointments
- Frequent monitoring in person & by phone
- Care coordination across medical & mental health systems
- Connection to community resources (housing, transportation, social support)
- Staff trained in Motivational Interviewing
- Staff access to PRI SM—service use, Rx, risk
KCCP Client Recruitment

- State sent names of select clients to KCCP
- Recruitment team
  - searched state databases for updated contact information
  - sent clients letters inviting their participation and requesting a response
  - made timely call-backs when clients responded
  - made multiple attempts to contact clients who did not respond
  - offered clients $10 incentive to initiate assessment with nurse
Evaluation Questions

What is impact of KCCP for clients randomized to intervention?

What is impact of KCCP for clients who participated in intervention?
Evaluation Outcomes: Costs & Utilization

Medical
Total, ER, inpatient, outpatient, prescription drugs

Long-Term Care
in-home out-of-home

Chemical Dependency Tx

Mental Health
inpatient outpatient

Other
arrests, convictions homelessness death
Evaluation Time Frame

- Pre-period: up to 1 year before randomization
- Post-period: up to 2 years after randomization
Evaluation Analysis Approach

- Difference-in-Differences
  - pre-/post changes for intervention vs. comparison group
- Adjusted for
  - age
  - race/ethnicity
  - sex
  - baseline risk score
  - serious mental illness
  - need for chemical dependency (CD) treatment
- Weighted by months of post-period eligibility
Intent-to-Treat (ITT) Analysis

What is impact of KCCP for clients randomized to intervention?

- ITT includes all randomized clients, whether they participated in the intervention or not
- Policy Focus
  - What are overall savings to State Medicaid?
- Sample
  - 557 clients randomized to intervention
  - 563 clients randomized to comparison group
Among clients randomized to the intervention

- 51% completed initial assessment
- 45% set at least 1 health-related goal in collaboration with nurse care manager
ITT Analysis: Cost Results

- Few cost savings
- Negative return on investment at this time
- These results may be due to:
  - low participation
  - delays between randomization and assessment
  - short follow-up
  - intervention cost - $553 PMPM
Participant Analysis

What is impact of KCCP for clients who participated in intervention?

- Participants were individuals who set one or more health-related goal

Sample
- 251 participants
- 251 propensity-score matched comparison group

Mean length of client participation: 362 days
Mean number of contacts per client: 80
Preview: Participant Analysis Results

- No overall Medicaid cost savings
- Slowed growth in number & cost of hospitalizations preceded by emergency department visit
- Increased access to care, including
  - prescription drugs
  - in-home long term care
  - chemical dependency treatment
- Reductions in
  - homelessness
  - death
Smaller Increase in Inpatient Medical Admissions and Costs for Participants

**Mean Admissions with ER**
Visits Per 100 Members per Month
(-2.1; p=0.02)

**Mean Cost PMPM**
Admissions with ER visits
(-$321; p=0.02)
Larger Increase in Drug Costs for Participants

**Prescription Drug Cost**

**Mean** PMPM

($148; p=.05)

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- **Participants**: 21% Increase
- **Comparison**: 9% Decrease

Number of Participants: 27
Larger Increase in % of Clients with Any Long-Term Care, In-Home Support Costs for Participants

**Long-Term Care Cost**
- % Clients with Any
  - (OR=1.36; p=.04)

- Percentage:
  - Before: 37%
  - After: 45%

- Increase: 22%

**In-Home Support Services Cost**
- % Clients with Any
  - (OR=1.46; p=.03)

- Percentage:
  - Before: 28%
  - After: 38%

- Increase: 36%

- Before: 21%
- After: 25%

- Increase: 19%
Larger Increase in Chemical Dependency
Treatment Cost for Participants

CD Treatment Cost
Mean PMPM
($15; p=.03)

Before
After
Before
After

$52
$57
$47
$34

10% Increase
28% Decrease

Participants
Comparison
Larger Decrease in % Clients with 1 or More Months Homeless for Participants

Month(s) of Homelessness

% Clients with Any

(OR =0.45; p=.01)
Lower Odds of Death for Participants

Death in Post-Period
(OR=0.37; p=.06)

- Participants: 4% (n = 10)
- Comparison: 6% (n = 15)
Participant Analysis Results Summary

- No overall Medicaid cost savings
- Slowed growth in number & cost of hospitalizations preceded by emergency department visit
- Increased access to care including
  - prescription drugs
  - in-home long term care
  - chemical dependency treatment
- Reductions in
  - homelessness
  - death
Conclusion of Participant Analyses

- Despite absence of overall Medicaid cost savings, intervention appears to have positive impact on those who participated and, as such, holds promise
Recommendations

- Offer intensive case management services to high-risk, high-cost Medicaid clients
- Consider 3 to 4 year follow-up in future evaluations
- Carry out studies to better understand how to increase client engagement
Limitations

- Participant analysis based on propensity-score matched comparison group: potential for selection bias remains
- Large variation in cost
  - may make it more difficult to detect intervention effects
  - cost outliers may influence results
- Less than 24 months of follow-up data precludes analysis of longer-term impact
Evaluation Team

- Toni Krupski, PhD  University of Washington
- Janice Bell, PhD, MPH  University of Washington
- David Mancuso, PhD  WA Dept. of Social & Health Services
- Jutta M. Joesch, PhD  University of Washington
- David Atkins, PhD  University of Washington
- Beverly Court, PhD  WA Dept. of Social & Health Services
- Imara West, MPH  University of Washington
Looking towards 2014

- Chronic Care Management programs are being incorporated into Healthy Options as the Health Care Authority (HCA) adds health home services to the managed care benefit.

- With the addition of Categorically Needy Blind and Disabled enrollees into Healthy Options, Managed Care Organizations provide care management and care coordination services.
Lessons Learned in Chronic Care Management

• Focus on the whole person, not the condition
• Provider should be embedded in the community, have knowledge of resources
• Face to face care management services prove more effective than telephonic services
• Population based programs make it difficult to see measurable results
• Care should span systems as needed
Further Information

More Information:

http://www.hca.wa.gov/health_homes.html

Barbara Lantz, MN,RN
Section Manager, Quality and Care Management
Health Care Services
Barbara.lantz@hca.wa.gov
Tel: 360-725-1640
Questions?

To submit a question please click the question mark icon located in the toolbar at the top of your screen.

Your questions will be viewable only to CHCS staff and the panelists.

Answers to questions that cannot be addressed due to time constraints will be posted online after the webinar.
Advancing Medicaid Care Management and Health Home Design: The King County Care Partners Experience

Daniel Lessler, MD, MHA
Professor of Medicine, University of Washington
Senior Associate Medical Director, Harborview Medical Center
Medical Director, King County Care Partners
The Problem

A single clinic or clinic system often does not possess the expertise or resources to develop and implement an intensive care management model for its most severely medically and mentally ill.
KCCP Strategy

• Centralize intensive care management services for chronically medically and mentally ill patients in a community-based health care agency (Aging and Disability Services of Seattle and King County)

• Link community-based care management to primary care medical homes using integrating strategies
King County Care Partners Care Model

Family and Social Systems

Clinical Systems
- Primary Care
- Specialty Care
- Mental Health Care
- Addictions Treatment

ADS
Care Management Team
Assesses, Connects, Coaches, Models, Coordinates

Community Resources
- Housing
- Nutrition
- Transportation
- Interpreter Services

Client

Functional and Clinical Outcome
KCCP: System Building and Integration

• Information technology
  – Single web-based platform across KCCP
  – Clinical information shared across KCCP (e.g. patient goals; medications; care management contacts)
  – ADS clinical team has direct access to partner clinics EHR (HMC only at this point)
KCCP: System Building and Integration

• Operational integration
  – Monthly operational meeting with all partners (contractual requirement)
  – Weekly case conferences led by Medical Director
  – Monthly case conference with psychiatrist

• Community services integration
  – Mental health
    • KCCP RN’s maintain regular contact with mental health system case managers, coordinating services and reducing duplication
  – High utilizers
    • KCCP RN’s participate in King County “high utilizers” work group; focus on coordinating resources across community
  – Homeless
    • Regular communication/coordination with Healthcare for the Homeless
King County Care Partners: Strengths

- Lead agency is community-based
- Extensive and continual training of the clinical team
- Dedication, passion and skill of the clinical team
- Physician leadership
- Clearly articulated expectations of all partners
- Clinic-based “linkage” coordinators
- Explicit integration strategies (IT, operational, community)
- Web-based CIS enables sharing of clinical info across partners
- Clinic system EHR accessible to care management team (HMC only)
King County Care Partners: Challenges

• Ability to access real time information about clients (e.g. ED or hospital admit)
• Access to all clinic-based EHRs for care management team
• Caseload of care management team
• Lack of 24/7 availability of care management team
• Siloes of care management across the community
• Assuring buy-in and participation by PCPs and other treating physicians
• Team member “burn out”
Case Study #1

- A.G., 38 yo man with generalized anxiety disorder and alcohol dependence
  - Initial meeting with the RN care manager, A.G. begins by saying, “People have told me what to do; I don’t want you telling me what to do…”
  - RN care manager response: “I’m not going to tell you what to do; I’m going to walk beside you regardless of the path you take…”
  - On 3rd meeting, A.G. states: “I’m thinking about making a change…but I’m not ready today, and I’m not sure I will be in 2 days or 2 weeks…”
  - In subsequent meetings, reflections on ambivalence; affirmations for thinking about change; and ultimately problem-solving
  - Patient completes 30-day inpatient CD treatment (after 6 months of engagement)
  - Patient now has more than 1 year in recovery
Case Study #2

• Client 1 has significant cognitive deficits and substance dependencies (narcotics and alcohol). Because of his cognitive deficits the client needed a tremendous amount of feedback and reminding regarding his goals, care, and appointments. He called the RN-CM almost every day at times asking for reassurance and confirmation of appointments. On enrollment in RTC he did not have a primary care provider. The RTC team helped the client establish primary care. The RN-CM also attended a mental health appointment with the client and began the process of aiding the client in going to inpatient chemical dependency treatment by obtaining a letter of medical clearance for him. The SW-CM worked on helping the client get housing and ACCESS Transportation applications authorized by a medical provider...

The KCCP Evaluation: A Clinical Interpretation

- Slowed growth in number & cost of hospitalizations preceded by ED visit
- Increased access to care, including
  - Prescription drugs
  - In-home long term care
  - Chemical dependency treatment
- Reductions in homeless & death
- No overall Medicaid cost savings
Building the “Health Home:”
Lessons from KCCP

• What does it take?
  – Resources
  – Community partnerships
  – Leadership
  – *Time...*
    – Relationship building – with patients and with community partners
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For More Information

• Download practical resources to improve the quality and cost-effectiveness of Medicaid services.

• Subscribe to e-mail Updates to learn about new programs and resources.

• Learn about cutting-edge efforts to improve care for Medicaid’s highest-need, highest-cost beneficiaries.

[www.chcs.org](http://www.chcs.org)
Evaluation Data Sources

- **Medical Costs & Services**
  - State Medicaid claims and reimbursements (WA Medicaid Management Information System/Provider 1)

- **Drug & Alcohol Treatment**
  - State alcohol & drug treatment records (TARGET)

- **Psychiatric Admissions (State & Community Hospitals)**
  - State mental hospital and Medicaid records

- **Arrests, Charges, & Convictions**
  - WA State Patrol

- **Death**
  - State Department of Health vital records

- **Long-term Care**
  - State Aging & Disability Services Administration records
Characteristics of KCCP Sample

- 51 yrs. old (mean); range: 22-85
- 52% female
- 49% Serious Mental Illness
- 44% CD Tx need
- Eligibility pre-period
  - mean: 12 months
  - range: 5 - 12 months
- Eligibility post-period
  - mean: 20 months
  - range: 1 - 24 months