Care Coordination for People with Chronic Conditions

By

Robert L. Mollica
Jennifer Gillespie

National Academy for State Health Policy
Portland, ME

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Contents

EXECUTIVE SUMMARY

The number of Americans with one or more chronic conditions is expected to increase from 125 million in 2000 to 157 million by 2020, and the number of people with multiple chronic conditions will rise from 60 million to 81 million. A chronic condition is one that is likely to last more than one year, limits a person's activities, and may require ongoing medical care (Partnership for Solutions, forthcoming chartbook). People with multiple chronic conditions typically receive health and home care services from different systems, often from multiple providers within each system. As a result, the health care delivery system for those with chronic conditions is complex and confusing, and care is often fragmented, less effective, and more costly. States are seeking to develop and sustain integrated care coordination models that help ensure that services are consistent with the complex needs of beneficiaries and that providers are aware of the services received from other parts of the health and long-term care systems.

States are also interested in controlling Medicaid spending. Care for people with chronic conditions accounts for 77 percent of Medicaid spending for beneficiaries living in the community. Eleven million, or nine percent, of the people with chronic conditions rely on Medicaid for coverage, and two and a half million, two percent, are dually eligible for Medicaid and Medicare. The average per capita health care 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 age 65 and older who are dually eligible for Medicare and Medicaid, costs are more than five times higher.

Care coordination for people with chronic conditions who participate in what has come to be known as the **social model** of home and community-based service programs (including coordination in subsidized elderly housing sites) has been narrowly focused on supportive services. At the same time, a **medical model** of care coordination has begun to emerge in the fee-for-service health care system and in managed care programs. As these care coordination efforts develop, there seems to be increasing recognition that a gap between supportive and medical services exists and needs to be addressed; a hybrid or integrated model is beginning to emerge. This paper explores the components of care coordination and a sample of state initiatives that bridge the health and supportive services systems.

A literature review found many variations among organizations providing care coordination for people with chronic conditions. While it is not known how many community-based, single entry systems are developing linkages to primary care providers and other health services, the literature review revealed a number of demonstration programs that have the potential for broader replication. While this paper includes some description of the development of care coordination in health plans, it is primarily focused on state initiatives involving public programs such as Medicaid.

State strategies can be arrayed along a continuum with five categories: social, social/medical, medical, partial integration, and full integration.

- Social models focus primarily on supportive needs and have limited collaboration with primary care physicians;
- The social/medical model develops closer working relationships between health and supportive services systems, sometimes through the location of social services care coordinators in physician offices, but does not include the authority to authorize services of both systems in one agency;
- Medical models coordinate services through disease management programs, serving beneficiaries with a specific diagnosis, and primary care case management services for beneficiaries with complex social and medical conditions that place them at high risk of hospitalization and adverse outcomes;
- Partially integrated models allow the organization to authorize Medicaid medical and supportive services; and
- Fully integrated models include all Medicaid and Medicare medical and supportive services.

Models can be compared based on the setting in which care coordination occurs, the scope of authority for managing services, and the relationship between long-term care services and health services.

State strategies for bridging the long-term care and health systems for the majority of low-income people with chronic conditions could be informed by convening state policy leaders, advocates, and stakeholders. These forums could enable participants to review barriers to care coordination, identify promising program models, and discuss possible reforms and initiatives that states could embrace to better serve the chronically ill.

OVERVIEW OF CHRONIC CONDITIONS AND IMPLICATIONS FOR THE HEALTH CARE SYSTEM

As the nation makes significant advances in the treatment of chronic conditions and the expansion of supportive services to maintain the independence of people with functional limitations, navigating and accessing services has become more complex. The Partnership for Solutions has issued a series of profiles describing people with chronic conditions (2002a,b,c,d,e). Among its findings:

- An estimated 125 million Americans had at least one chronic condition in 2000, and the prevalence of chronic conditions is projected to increase to 157 million Americans by 2020.
- In 2000, 60 million Americans had multiple chronic conditions, and by 2020, a projected 81 million people will have multiple conditions.
- The prevalence of multiple chronic conditions increases with age. Among people age 65 and older, 62 percent have two or more chronic conditions. By age 80 and older, 70 percent have two or more chronic conditions.

For purposes of this paper, a chronic condition is defined as one that is likely to last more than one year, limits a person's activities, and may require ongoing medical care (Partnership for Solutions, 2002 e). Examples of chronic conditions include arthritis, asthma, congestive heart disease, diabetes, eye disease, hypertension, cancer, and cardiovascular disease.

Chronic conditions do not always limit the person's functional capacity. Twenty-five percent of people with chronic conditions have some type of activity limitation. Typically, people with functional limitations have difficulty performing activities of daily living (ADLs) such as a bathing, dressing, eating, toileting, and mobility. At the same time, they can struggle with instrumental activities of daily living (IADLs): preparing meals, doing housework, using the telephone, managing medications, paying bills, and getting around outside the home. Nearly three million adults living in the community have severe functional impairments and need assistance with three or more ADLs (Feder, et al., 2000). People with functional limitations often require supportive services to maintain their independence. Care can be provided informally by a spouse, family member, or friend or formally through a network of community-based long-term care programs and agencies. People with multiple chronic conditions receiving medical care and supportive services from separate delivery systems and providers are at risk of poor outcomes if care is not coordinated (Anderson and Knickman, 2001).

The Partnership for Solutions (2002e) analysis of data from the Medical Expenditure Panel Survey (MEPS) shows that people with chronic conditions use more hospital care, physician services, prescription drugs, and home health visits than people without chronic conditions. Care for people with chronic conditions consumes 78 percent of all health care spending, 95 percent of Medicare spending, and 77 percent of Medicaid spending for beneficiaries living in the community. Eleven million, or nine percent, of the people with chronic conditions rely on Medicaid for coverage, and two and a half million, two percent, are dually eligible for Medicaid and Medicare. The average per capita health care 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 age 65 and older who are dually eligible for Medicare and Medicaid, costs are more than five times higher. Out-of-pocket spending also increases with the number of chronic illnesses, especially among those 65 and older. People with five or more chronic conditions average 15 physician visits and fill almost 50 prescriptions in a year.

WHY COORDINATE CARE FOR PEOPLE WITH CHRONIC CONDITIONS?

Concerns over how best to serve people with chronic conditions have grown in recent years among both practitioners and policymakers. As noted above, this population is vulnerable to adverse outcomes, their care generally results in high medical costs, and the number of individuals with chronic conditions is expected to grow markedly over the next 30 years (Thornton, et. al., 2002). The implications for the country's health care system are significant; for states and their Medicaid programs and for Medicare and housing programs, they are enormous.

Historically, health care providers have devoted little time to assessing a patient's functional ability, providing instruction in behavior change or self-care, or addressing emotional or social distress. Care is often fragmented, with little communication across settings and providers (Chen et. al, 2000). People with multiple chronic illnesses often have to navigate a system that requires them to coordinate several disparate financing and delivery systems themselves, making it more difficult to obtain the full range of appropriate services. In addition, persons who need access to different programs are most likely to find that each program has different eligibility criteria, sets of providers, and providers that are not linked organizationally (Anderson and Knickman, 2001).

People who need supportive services often delay seeking care until some acute exacerbation of their condition occurs, a crisis that might have been avoided if the person had sought assistance earlier (Anderson and Knickman, 2001) or if care coordination had been available. In fact, an analysis conducted by the Partnership for Solutions suggests a correlation between the number of chronic conditions a patient has and the frequency of ambulatory care sensitive conditions (ACSCs). ACSCs are conditions for which timely and effective outpatient primary care may help to reduce the risk of emergency room use and hospital and nursing home admissions (such conditions include angina, asthma, diabetes, congestive heart failure, and hypertension). With each additional condition, the hospitalizations associated with avoidable illness increase dramatically.

Care coordination is beginning to emerge to help beneficiaries access and negotiate complex delivery systems, arrange and schedule services, facilitate communication among multiple providers, and monitor changes. When successfully implemented, social, medical, and hybrid models have the potential to increase significantly the quality of care for those with chronic conditions and to reduce costs.

MODELS FOR COORDINATING MEDICAL AND SUPPORTIVE SERVICES

Care coordination is a generic term that is sometimes used interchangeably with case management, care management, and disease management. Several variations of care coordination have emerged to improve care, promote independence, and reduce unnecessary service utilization. This coordination occurs along a continuum from social to medical in a range of settings that include independent care coordination agencies, provider agencies, health systems, group practices, and integrated networks.

Care coordination models include:

- Social models that assess and authorize institutional, residential, and in-home long-term care services;
- Medically oriented models that coordinate medical treatments for high-cost beneficiaries, disease management, and pharmacy management; and
- Integrated models that bridge the medical and long-term care systems.

One review of case management literature concludes that while there is professional agreement on the components common to most case management models (outreach, screening and intake, comprehensive assessment, care planning, service arrangement, monitoring, and reassessment), those components are implemented with considerable variation (National Chronic Care Consortium, 1997). These variations are often due to the location from which the case management is provided, the case managers' type and level of authority, and the purposes of the services being provided.

Rosenbach and Young (2000) studied Medicaid managed care programs in Colorado, Delaware, New Mexico, Oregon, and Washington and found that their case management programs also used different models. Some focused on health concerns while others extended beyond health care to social issues such as housing, income, and social supports. The study found that managed care organizations (MCOs) used three structures for care coordination: centralized teams, regional teams, and provider-based care coordination. The latter two structures used registered nurse/social worker teams more often than provider-based care management models and focused on problem solving and advocacy for their beneficiaries.

Social Models: Home and Community-based Care Management Systems

Care coordination models first emerged in case management systems to manage home and community-based long-term care services. These social models offer information and referral, screening, assessment, care planning, authorization, and monitoring. They are typically limited to long-term care services and do not usually address medical care.

Care coordination can be provided by independent agencies or by agencies that also provide services to the consumer. An AARP report reviewed Medicaid waiver programs for elderly beneficiaries that included case management. Among those programs, 13 used state personnel to provide case management, 19 used service providers, 3 used both

service providers and state employees, 12 used specific types of local agencies, and one used a statewide nonprofit agency (Folkemer, 1994).

Most states contract with or designate a single type of agency to administer the programs in order to standardize program management, according to Justice (1991). Local agencies most often designated are Area Agencies on Aging, county social service agencies, or local field offices of state aging departments.

Several states have created single entry point systems to perform care coordination activities for the broadest range of services possible in order to facilitate access to services by consumers, family members, hospitals, and other parties. In order to maximize access, single entry point agencies may have access to multiple funding streams: state funded services, Medicaid state plan and waiver services, social services block grant funds, Older Americans Act funds, and funds from other sources.

Care coordination may be focused on a single service or a broad range of services, and the specific components of care coordination can be organized for single or multiple populations. The scope of the authorization function depends upon the scope of services covered and the funding sources that are controlled by the care coordinator. Staff that have access to a single service or a limited number of services often coordinate their activities with other programs and agencies when consumers have multiple needs. This can result in a consumer having multiple care coordinators representing different funding sources, service programs, and organizations.

Social models are important for several reasons. They are common among states. They were designed to address the functional needs of frail elders. Typically, while they may obtain information from physicians about health status, diagnosis, medications, and treatments, they do not directly address health needs and services provided by physicians. Since they are often structured, statewide programs with considerable history, these programs offer an important base for building linkages with fee-for-service health providers.

Care coordination in elderly housing settings

The social model has also developed in elderly housing projects. An estimated 350,000 older people live in federally subsidized senior housing. As these tenants age, they typically develop functional impairments and need supportive services to continue to function independently (Pynoos, 1997). A 1996 evaluation by the Research Triangle Institute of the federal Congregate Housing Services Program (CHSP), which is funded under Section 202, found that most CHSP residents have lived in their buildings five years or longer and have had three or more impairments in ADLs (HUD's definition of ADLs includes what most home and community-based services programs would consider IADLs). The evaluation also indicated that many residents report "serious medical conditions" (Research Triangle Institute, 1996). In all, an estimated 20 to 30 percent of these elders are frail and at risk of moving to a nursing home or another location that provides more care (McNickle, 2000).

Federal initiatives have supported care coordination and supportive services to address the needs of aging residents in federally subsidized housing sites. The CHSP, implemented as a demonstration program in 1978, provides partial funding for services such as meals, personal care, counseling, and group activities. The 1990 National Affordable Housing Act allows public housing agencies to hire service coordinators in other Section 202 projects, and all federal housing projects were able to hire coordinators after passage of the 1992 Housing and Community Development Act (Golant, 2002). Federal grants fund 1,100 coordinator positions, yet their functions have proved so useful that housing sponsors and managers are finding other resources to support over 4,000 coordinators (Golant, 2002). In 1999, more than 33 percent of HUD Section 202 projects had service coordinators (Heuman, 2001).

Golant (1999) describes five models for delivering supportive services in elderly housing settings:

- The service coordinator model identifies tenant needs and uses community resources to meet them;
- The in-house staffing model hires staff to provide supportive services;
- The design modification model makes modifications that enable residents to perform tasks without human assistance;
- The collaboration model involves contracts between the housing site and local organizations to deliver services; and
- The conversion model involves remodeling and staffing to provide assisted-living services.

As with other social models, these and other initiatives focus on supportive services; linkages with the health care system have been slow to emerge.

Efforts to address the changing needs of tenants by coordinating services from multiple programs have been identified as an important issue by the Commission on Affordable Housing and Health Needs for Seniors in the 21st Century (2002). The Commission's report highlighted the lack of coordination and integration between housing and health care as an important concern and noted that different and distinct financing systems and regulatory structures often served as significant barriers to improving coordination.

Medical Models

As explained above, care coordination is an integral component of long-term care and supportive services programs, and many states have created managed care-like systems for delivering these services. But health care services for people with chronic conditions are delivered in a very different manner. By and large, states reimburse for health care services for Medicaid beneficiaries with chronic conditions, and this fee-for-service care is delivered very differently from states' managed long-term care and supportive services. In addition, states, in general, have less control over the delivery of these services as a significant percentage of Medicaid beneficiaries with chronic conditions are "dually

eligible" for services, covered by Medicaid and Medicare, with Medicare serving as the primary payer.

As the health system has evolved, providers have recognized the need for care coordination to manage the multiple treatments ordered for people with chronic conditions. The emergence of managed care drew attention to the complex needs of individuals with acute and chronic health conditions and to the challenges that functional and cognitive limitations, multiple funding sources, and multiple service providers pose to the traditional health and long-term care systems. Managed care has been a vehicle to develop coordination across settings and payers to produce preferred outcomes.

Much of the literature about medical models of care coordination focuses on provider initiatives to improve services for Medicare beneficiaries. States have developed medically-based approaches to care coordination through disease management programs serving beneficiaries with a specific diagnosis and primary care case management services for beneficiaries with complex social and medical conditions that place them at high risk of hospitalization and adverse outcomes.

A comprehensive study of best practices in care coordination (Chen et al., 2000) noted that both disease management and case management focus on education for members. The case management initiatives help members identify and manage symptoms, self-monitor their conditions, avoid things that trigger acute episodes, reduce stress, and comply with medications, diets, and follow-up regimens. Disease management programs use similar strategies focused on the diagnosis.

Chen concluded that effective programs have three major components: assessment and planning, implementation and delivery of services, and reassessment and adjustment of interventions. Care coordination activities require clear goals to prevent health problems and crises by detecting problems early. Disease management programs should follow evidence-based treatment and management guidelines.

Integrated Medical and Supportive Services Models

While the medical and long-term care systems have historically developed very different models for coordinating care, newer systems, often developed under managed care, have begun to bridge the health and functional dimensions. These integrated systems offer significant promise for states seeking to improve the care provided to low-income elders living with chronic conditions.

While integrated models have only recently begun to emerge in states, two types of these models seem most common: partially integrated models integrate all Medicaid services while Medicare remains fee for service. Fully integrated models are able to coordinate the full range of Medicare and Medicaid services.

Initial efforts to integrate medical and supportive services (either partially or fully) were targeted at individuals eligible for both Medicaid and Medicare, those dually eligible for

services. Case studies (Mollica, et al., 1997) of Medicaid managed care programs in four states (Arizona, California, Oregon, and Tennessee) found that:

- Dually eligible beneficiaries are more likely to require coordination and case management services than Medicare only beneficiaries because they have a greater incidence of acute and chronic conditions.
- Care coordination staff who created links with the long-term care system were reported to improve care for dually eligible beneficiaries who are more likely to use a range of medical and non-medical services.
- Coordination is more difficult when beneficiaries receive care from different systems, e.g., Medicaid managed care and Medicare fee for service, except in Oregon where all services are directed within the same plan.
- Because of the complexity of coordinating services from multiple providers and payers, consumers should be partners in the process.

Among the four states, the Oregon Health Plan has a well-defined case management service. All beneficiaries are required to enroll in a managed care organization for Medicaid primary and acute care services. Long-term care services are delivered through a separate system that locates care coordination functions in Area Agencies on Aging and state regional offices. To coordinate services across systems, health plans are required to create Exceptional Needs Care Coordinator (ENCC) positions. The ENCC role has two dimensions: case management of medical services and coordination between the medical and social service systems.

The Arizona Long Term Care System (ALTCS) is a Medicaid managed care program for elderly and disabled beneficiaries who meet the nursing home level of care. Medicare services remain fee for service. Services are provided through ALTCS contractors in each county. Care coordinators are responsible for coordinating services with primary care physicians. The case manager develops a service plan for institutional services, home and community-based services, behavioral health, durable medical equipment, medically necessary transportation, therapies, and individual/group and/or family therapies. Primary care physicians are contacted to discuss changes in the client's condition and to determine whether any changes are needed in the physician's orders concerning the level of care, care plan, medical services, behavioral health services, prescription drugs, or medical equipment. Case managers use a pre-admission assessment survey as a guide in determining when to contact the physician. Disagreements between the case manager and the physician are referred to the contractor's medical director.

Other models have established interdisciplinary care coordination teams and have fully integrated acute and long-term care services from both Medicare and Medicaid. The provider-based Program for All Inclusive Care for the Elderly (PACE) programs—supported and sometimes initiated by states—contract with Medicare and Medicaid programs and provide all Medicare and Medicaid services to people age 55 and older who qualify for admission to a nursing home. Provider enrollment in the PACE program is voluntary. The interdisciplinary team of professional and paraprofessional staff conducts assessments of a participant's functional and health status, determines his or her needs, develops care plans, and coordinates the delivery of all acute and long-term

care services. Members of the PACE team include: primary care physicians and nurses, physical and occupational therapists, social workers, recreational therapists, home health aides, dietitians, and drivers. Other services and providers— medical specialists, laboratory and other diagnostic tests, and hospital and nursing home care—are used when needed. Most PACE programs require that participants use adult day care centers as the primary service location. In addition, in-home services and visits by a nurse practitioner or registered nurse are also provided.

The Wisconsin Partnership Program (WPP) is similar to PACE but does not require enrollees to attend adult day care centers and allows the member's primary care physician to enroll as a provider. WPP operates in four sites that use interdisciplinary teams to assess, authorize, and coordinate care. Each team consists of a nurse practitioner, registered nurse, social worker, or independent living coordinator (as appropriate), and the beneficiary. Other professionals (personal care workers, therapists, pharmacists, dieticians, and durable medical equipment specialists) are included as needed.

The Minnesota Senior Health Options program (MSHO) also combines Medicaid and Medicare services and funding for dually eligible elderly beneficiaries in selected counties who choose to enroll. The state contracts with care systems that are responsible for subcontracting with service providers. Two models of care management have emerged. Care management is generally done by geriatric nurse practitioners (GNPs) for nursing home residents. GNPs work with primary care physicians, nursing home staff, and others as needed to coordinate care. Registered nurses and master's-level social workers are generally used to coordinate care for members living in the community who need long-term care services.

Care coordination in PACE, WPP, and MSHO is comprehensive. Care coordinators work with existing programs to access services and have flexibility within the capitation payment to authorize services that cannot be obtained under fee-for-service programs.

Finally, a recent study (Thorton et. al., 2002) looked at innovation in managing care for high-risk seniors in four Medicare+Choice plans. This case study identified care management as a key innovation to improving care delivery for elderly Medicare beneficiaries with chronic illnesses and functional limitations. Care managers coordinate access to medical care and community support services by working with patients who are at risk for hospitalization, or who have been hospitalized, to ensure timely access to services, such as home health care and both primary and specialty physician care. This study emphasized care coordination programs serving Medicare+Choice members and did not examine programs for "dually eligible" beneficiaries. However, dual eligible programs have similar characteristics.

The managed care organizations used care management programs to assess the needs and capabilities of seniors at high risk for adverse health and functional outcomes. The assessments often included home visits to assess seniors' needs and living arrangements followed by efforts to coordinate care delivered by the MCO network and to educate elders about their conditions and treatments. Care managers also referred elders to community-based social service agencies when they needed assistance and services beyond what was covered in the MCOs' Medicare benefit package. After the referral, the

care managers typically followed up to see that members had been contacted by the service agency and to check on the status of the service plan.

Fully integrated models have been time consuming and complex to plan and implement and have generally achieved modest enrollment. Yet they have been the proving ground for perfecting care coordination and continue to draw interest from federal and state policymakers. The Centers for Medicare and Medicaid Services and the National Association of State Medicaid Directors have formed a technical advisory group on dual eligibles in order to identify and address the barriers to implementing fully integrated programs. The discussion that follows covers the spectrum of state care coordination programs and includes one fully integrated program in order to present the full array of models. More attention has been paid to models that have the potential to serve large numbers of beneficiaries.

DISCUSSION OF STATE CARE COORDINATION PROGRAMS

To identify and examine new and emerging care coordination programs in the states, and to learn how existing state home care programs are addressing health issues, the authors conducted phone interviews with staff from programs in Colorado, Georgia, Maine, Massachusetts, New Hampshire, Vermont, and Wisconsin. The programs included here represent different models and settings for providing care coordination. Colorado and Massachusetts have built their care coordination programs from traditional, socially oriented home and community-based service programs. Georgia, Maine, and Vermont have designed models to enhance coordination in the fee-for-service system, while Wisconsin has implemented a fully integrated managed care program. As mentioned earlier, the social models initiated by states operate statewide and have as much as 25 years of operating experience. State efforts to build linkages between supportive and health care services are more recent, smaller scale initiatives that serve modest but growing numbers of beneficiaries. These models have different objectives based on their locations and the scope of services controlled by the entities providing care coordination. Table 1 compares the seven programs, and they are summarized in the discussion that follows. More detailed summaries are included in the appendix of this report.

- Colorado's and Massachusetts's models are perhaps the most traditional, with limited or emerging links to health services.
- New Hampshire, where a public housing authority has created a licensed home health agency to serve elders living in subsidized housing, is exploring innovative approaches to strengthening linkages between the housing and supportive services systems.
- Maine uses claims data to identify high-risk beneficiaries. A health educator, who has access to medical and pharmacy consultants, provides physicians with data on the target population.
- Georgia combines access to primary care and home and community-based services in a single organization to connect medical and supportive services.

- Vermont has two programs. One is part of the primary care case management system, and the other is a pilot program that locates case managers from Area Agencies on Aging in physicians' offices to build links between primary care and community services.
- Wisconsin's fully integrated model uses interdisciplinary care teams to coordinate all medical and long-term care services.

Each of the programs differs from the others and is shaped by a variety of factors, the most important of which include: setting, scope of authority, and relationship to primary care providers.

Setting

Among the seven programs profiled in this section, care coordination occurs in a range of settings, among them: independent case management agencies, physician networks, senior housing sites, and fully integrated managed care models.

In Colorado, single entry point agencies perform care coordination activities for home and community-based services. Coordinators contact physicians to obtain the client's medical history and may provide information to physicians about care plans, but no structured mechanism for exchanging information or working together exists.

A pilot program launched in Massachusetts within an independent case management agency is testing a model that is designed to build stronger ties to primary care physicians.

The Vermont Independence Project locates case managers from Area Agencies on Aging in physicians' offices.

In Georgia, the Medicaid program contracts with health provider systems to link primary medical care with supportive services through case managers who work in the offices of primary care physicians.

Maine's program has evolved into a disease management initiative that focuses on beneficiaries with diabetes, heart disease, and congestive heart failure and offers educational materials to beneficiaries and physicians. Health educators meet face-to-face with physicians to discuss patient profiles and interventions.

In Laconia, New Hampshire, the Housing and Redevelopment Authority has located its care coordination within two elderly housing sites and has created a certified home health agency to deliver services.

Care coordination in the Wisconsin Partnership Program is located in community-based organizations that are responsible for providing all acute and long-term care services under Medicaid and Medicare.

Scope of Authority

Among the seven programs, care coordinators' scope of authority varies from limited to extensive.

Care coordinators in Colorado can authorize a full range of Medicaid and state funded home and community-based services but have limited involvement with physicians. A pilot program in one site in Massachusetts will establish more structured and regular communication between physicians and care coordinators in the social model. Care coordinators have access to a broad range of Medicaid and state funded community-based services.

Staff serving tenants in elderly housing in Laconia, New Hampshire, are able to authorize Medicaid home and community-based waiver services because the housing owner has created a licensed home health agency that authorizes and delivers services (home health care, nursing, and supportive services) funded by several programs. Typically, coordinators in elderly housing sites help tenants access services available in the community depending upon their eligibility and the services that can be organized by the housing owner itself through fund raising, resources available to the owner, or tenant fees. Nurses do not have authority over other medical but maintain frequent contact with physicians, nursing home staff and hospital discharge planners.

Coordinators in Georgia and Wisconsin have similar authority over home and community-based services and, through structured relationships with physicians and nurse practitioners, they have more direct access to primary care physicians. Wisconsin Partnership Program contractors have the broadest authority because they receive a capitated payment for all Medicare and Medicaid services that gives them the flexibility to use funds in a manner that best meets the needs of beneficiaries.

Vermont's care partners serve non-waiver eligible participants and access services available under the Older Americans Act and other community resources.

In Maine, a health educator receives pharmacy claims data from the Medicaid Management Information System. These reports identify beneficiaries who receive nine or more prescriptions, use three or more prescribers, or who have not filled their prescriptions within the last three months. The health educator works directly with physicians to review pharmacy utilization patterns and provides physicians with information that is not generally accessible, such as medications prescribed by other physicians and specialists. Meetings with physicians are scheduled to review utilization patterns and discuss interventions. Physicians receive $100 an hour for time spent meeting with the health educator.

Relationship to primary care and health services

Integrated models such as the Wisconsin Partnership Program are characterized by a close working relationship among members of the interdisciplinary care team who manage access to the full range of primary, acute, and long-term care services. Physicians, who maintain their independent practices, are not active participants in the team discussions. Nurse practitioners lead the team and serve as the liaisons between the team and the physician. Nurse practitioners from the interdisciplinary care team usually accompany the member to the office visit with the physician and review assessment and care planning information and changes in the member's health status.

Georgia's primary case management model (CHOICE) serves members with multiple chronic conditions who are nursing home eligible and those who are at risk of admission to a nursing home. CHOICE currently operates in ten demonstration sites that include hospitals, nursing homes, and area agencies on aging. The program may be expanded statewide. Georgia's program was built on a mandatory primary care case management program that offered enhanced services to members. Communication with physicians occurs frequently and information obtained by the case manager is shared with the physician prior to office visits.

Colorado, Maine, and Massachusetts have comparable, well-established, single entry point models that manage access to institutional, community, and in-home long-term care services. These systems provide the following services: information and referral, assessment, eligibility determination, care planning, service authorization, monitoring, reassessment, and arranging for access to services that are outside the service package. Each state's program manages services funded through Medicaid and state general revenues.

Single entry point staff in Colorado contact physician offices to obtain medical history information. While no regularly structured interaction exists between case managers and primary care physicians, case managers do contact physicians when they observe a change in health status or have concerns about clients taking multiple medications prescribed by multiple physicians.

Located in nine primary care practices, case managers from Vermont's Area Agencies on Aging receive referrals from physicians of beneficiaries who are dually eligible, or are eligible for Medicare and Vermont's pharmacy program, and have complex medical and social service needs. The case manager develops a care plan for home and community-based services that reflect the medical needs being addressed by the physician. The care plan is reviewed and signed by the beneficiary, the physician, and the case manager. Most care coordinators have not been present when the beneficiary sees the physician. Instead, information about the status of the beneficiary is provided by phone or in writing between the care coordinator and the physician/staff, and care coordinators make home visits.

Maine and Massachusetts are testing new approaches to building linkages between single entry point agencies and primary care physicians. Maine unsuccessfully attempted to link home care services with primary care physicians. Under the original model, the case

manager was to be an employee of the community-based organization responsible for managing home care services. Participation by beneficiaries was voluntary. Maine does not operate a primary care case management system from which to build linkages with the long-term care system. Beneficiaries in Maine did not perceive any advantage to enrolling, and physicians expected care coordinators to perform some tasks normally performed by office staff. In view of the state's budgetary environment, statewide expansion was not considered likely because of the smaller caseloads required and difficulties in enrolling participants. The program was halted shortly after implementation and did not have the opportunity to evolve and adapt to lessons learned. The current program, though more narrowly focused, emphasizes the importance of providing physicians with information about medication use and offers payment for the time physicians spend with the health educator.

A pending pilot program in Massachusetts has been designed to improve the coordination of primary, acute, and community long-term care services and to increase access to preventive and primary care services. One single entry agency will enroll 50 frail elders who will receive additional case management services. The state Medicaid program will pay both the single entry point agency and physicians who agree to participate $25 per month per client for coordination services. Case managers will:

- Work with home health care agencies;
- Conduct risk management activities in collaboration with physicians and communicate at least monthly with the physician or a member of his or her staff to provide information about the client's social supports and environmental and housing circumstances and to alert physicians to significant changes;
- Discuss long-term care planning;
- Make recommendations about community care options using less medically intense home and community-based services; and
- Coordinate services, including transportation.

Participants will be compared to a control group to analyze service utilization and related costs and benefits to participants. Protocols to enhance communication between physicians and case managers will be tested.

Elderly housing sites offer unique opportunities to serve people with chronic conditions. The literature shows how housing managers have created care coordinator positions to organize and obtain funding for services or to access services available from existing community programs and resources. The Laconia Housing and Redevelopment Authority in New Hampshire, evolved from a service coordinator to a coordinator and service provider model. While the model does not include physicians as members of a professional assessment committee, the model has ongoing formal contact with nursing homes, hospital discharge planning staff, and other community agencies. Creating a home health agency and a health clinic on-site allows a registered nurse to regularly screen and monitor tenants for conditions that require intervention and to contact physicians, create or adjust home and community-based services plans, or make referrals to other providers as necessary.

Current state efforts at coordinating integrated care vary greatly. As states continue to develop and evaluate their efforts to coordinate care for the chronically ill, attention should be given to the programs' settings, the scope of authority of care coordinators, and the relationship of the programs to primary care services.

Continuum of coordination

The models described earlier can be arrayed along a continuum from social to fully integrated. On one end of the continuum are the social models that focus primarily on supportive needs. In the middle are the medical models that deal primarily with health conditions and treatments while on the other end are the fully integrated models that combine supportive services and health needs. The social/medical model develops closer working relationships between health and supportive services systems, sometimes through location of social services care coordinators in physician offices, but does not include organizing the delivery of services from both systems through one agency. Partially integrated models allow a single entity to authorize Medicaid medical and supportive services, while fully integrated models organize all Medicaid and Medicare medical and supportive services. Placement of a state's program is based on the extent to which long-term and supportive services coordinators and health professionals work together in a structured way.

Social	Social/medical	Medical	Partially integrated	Fully integrated
Colorado	*Massachusetts* *New Hampshire* *Vermont*	*Maine*	*Georgia*	*Wisconsin*

RECOMMENDATIONS

The challenge to care coordination in these models is to bridge or balance the health care and supportive services systems. Traditional care coordination systems have emerged from very different origins. The social model values independence and consumer choice by managing a menu of services that provide: personal care, home-delivered meals, chore services, respite care, homemaker services, personal emergency response, and others. Case managers have limited health backgrounds, and contact with physicians is usually limited to requesting background information.

Care coordination in the health care system values safety and compliance with treatments ordered by physicians. Health care providers are less likely to know about the individual's home environment, functional capacity, and the array of community resources available to support them. Over time, health system professionals have recognized the complexity and interrelationship between health conditions and functional limitations, and models that bridge both systems to address the health care needs of people with chronic conditions have emerged through:

- Creation of care delivery systems promoted by the National Chronic Care Consortium;
- A range of state-sponsored managed care initiatives, and
- The evolution of state home and community-based services systems.

However, less is known about changes in home and community-based services programs. It is still difficult to build and maintain contact with primary care physicians. Anecdotally, state comprehensive entry agencies seem to be hiring more nurses as care coordinators. Washington's Aging and Adult Services Administration is revising its comprehensive assessment and collecting far more data about health conditions and treatment needs. Care coordinators are able to observe and monitor chronic conditions, report to primary care physicians, and make referrals as appropriate. The programs reviewed here offer a range of interactions between care coordinators, physicians, and, in fully developed models, other members of an interdisciplinary team. Fee-for-service-based programs face significant challenges to forming working relationships with physicians and their staff. Expectations about care coordination and the amount, frequency, and form of interaction between physicians and care coordinators varies. More work is needed to understand the costs and outcomes of care coordination as well as the practical aspects of these programs, including workloads, paperwork, financing, and the perceived impact of the value of coordination.

The literature and discussions with state policymakers and program managers demonstrate the range and diversity of care coordination for people with chronic conditions. Our interviews found support for coordination between health and long-term care systems and some data that document that integrated models are achieving the goals set out for the programs. However, many questions remain about the extent of care coordination and linkages between home and community-based services and clinical care and the characteristics of these efforts.

There are many issues that need to be addressed by states and for which further research is needed. The issues may be grouped into three categories: the extent, goals, and approaches to care coordination efforts; involvement of primary care physicians; and the specific components and data elements of care coordination.

Extent, goals, and approaches to care coordination efforts

- For beneficiaries with multiple chronic conditions receiving health and long-term care services, how are states responding to chronic care needs?

- What are the primary goals of care coordination – reducing emergency room use, reducing hospital and nursing home admissions, and improving health/functional status?

- What are the most effective ways of coordinating health and long-term care services?

- For whom are care coordination services most effective, and how do programs identify and enroll beneficiaries?

- What models can be developed by states to serve the vast majority of people with multiple chronic conditions who are not members of a managed care network or an organized system of care?

Involvement of primary care physicians

- Are states designing programs that build working relationships with primary care physicians? How effective are these relationships, and what criteria should be used to measure them?

- Do primary care physicians actually coordinate clinical care from multiple providers in systems that expect them to do so?

- What are the best ways to gain the support and commitment of primary care physicians and other health providers?

- What types of communication do care coordinators have with physicians: phone, in person, through office staff?

- What is the role of the beneficiary in the development of a care plan?

- What strategies have been used to establish regular communication between physicians or their staffs and care coordinators about care plans?

- What is the role of specialists in care coordination and care plan development?

- Current evolving models stress the prominent role of supportive services. How do these models compare with those that place greater emphasis on medical services?

Specific components and data elements of care coordination

- What types of health information should assessment tools used by long-term care case managers collect in order to improve care planning, monitoring, and coordination of services?

- Should care coordinators in the long-term care system be registered nurses or social workers?

- What is the optimal type and amount of training care coordinators should receive?

- How does the size of a care coordinator's caseload affect his or her ability to work effectively with service providers and systems?

- What types of data do states or organizations providing care coordination collect routinely, and how are they used?

- What additional types of data and analyses are needed to monitor and evaluate care coordination efforts over time?

While the literature supports the conclusion that more needs to be done to integrate care, the barriers that exist to doing so and the strategies for overcoming these barriers on a broad scale are not fully understood. An examination of these issues would be informed by convening a group of interested states, advocates, and experts in chronic care to review specific program models and discuss possible reforms and initiatives that states could embrace to better serve the chronically ill. The results could assist states in identifing promising practices and adapting them to their own situations.

Table 1: Comparison of Care Coordination Models

State	Setting/Sponsor	Scope of Authority	Primary Model	Linkage
CO	Community-based single entry point	Medicaid and state HCBS services, coordinates access to services outside service package	Social: Care coordinator	Case manager makes routine annual contacts with physician offices to obtain health information.
GA	Hospitals, nursing facilities, area agencies on aging	Medicaid HCBS and primary care services	Partially integrated: Care coordinator and physician	Regularly review assessment and care planning information with physician using standard protocols (care paths). Meet monthly with HCBS service providers to review client needs and performance issues.
ME	University of Southern Maine	Education	Medical: Health educator and physician	Provides utilization data and education materials to physicians to influence treatment plans and medication usage. Physicians receive payment for time spent with the health educator.
MA	Community-based single entry point	State and Medicaid HCBS services, coordinates access to services outside service package	Social/medical: Care coordinator and physician/staff	Case manager will have monthly contact with physicians to review participants' needs, care plans, and changes in conditions.
NH	Elderly housing site	CHSP and Medicaid HCBS services, coordinates funding sources and access to services outside service package	Social/medical: Professional Advisory Committee (local service providers, organizations and state aging office)	An on-site RN from the Housing Authority's home health agency maintains contact with physicians and hospital discharge planners. A consulting pharmacist is available.
VT	Area Agencies on Aging/physician group practices	Coordinates funding sources and access to services	Social/medical: Care coordinator and physician/staff	Care coordinator is available at scheduled times in physician offices. Receives referrals and updates the status of participants' needs and services.
WI	Community-based organizations	All Medicaid and Medicare services	Fully integrated: Interdisciplinary care teams (GNP, RN/SW, service coordinator)	Team is led by GNP who serves as liaison to primary care physician. Teams meet weekly. GNP/RN accompanies member to office visits and discusses care plan with the physician.

HCBS = home and community-based services; CHSP = congregate housing services program; GNP = geriatric nurse practitioner; SW = Social Worker

Appendix

Summaries of Selected State Care Coordination Programs

Colorado
Georgia
Maine
Massachusetts
New Hampshire
Vermont
Wisconsin

Colorado

Overview

Colorado implemented its single entry point (SEP) system statewide in July 1995 following a pilot program that began in July 1993 in seven districts, with an eighth district added in February 1994. All 25 districts were operational by July 1995. The 25 SEP agencies include county social services or human services departments (13), county nursing services/health departments (7), Area Agencies on Aging (2), private nonprofit agencies (2), and private for-profit agencies (1). SEP agencies are not allowed to provide services unless they have approval from the state's Department of Health Care Policy and Financing and there is either a lack of providers of the service in the district, or within a sub-region of the district, or the SEP agency can provide services more cost effectively.

Purpose

The single entry system was developed to simplify access to long-term care for consumers, reduce fragmentation, and eliminate duplicate assessments and duplicate administrative costs.

Services

Single entry point agencies authorize home and community-based waiver services (personal care, homemaker services, adult day care services, alternative care facilities such as assisted living, home modification, electronic monitoring, non-medical transportation, and respite care); Medicaid long-term home health services; Home Care Allowance (HCA), a state-funded program; and adult foster care. HCA funds are approved to purchase non-skilled assistance with ADLs and IADLs and supportive services such as medicine management, appointment management, money management, access to resources, and help using the telephone. The beneficiary's score on the assessment tool determines the amount of HCA funding approved by the SEP agency. The SEP agencies serve approximately 16,500 clients a month who are elders, adults with disabilities, individuals with brain injuries, and people living with AIDS.

Care coordination

SEP case managers conduct an assessment of applicants using a standard assessment instrument (ULTC100). A physician completes the medical information, including diagnosis, prescriptions, last hospital admission, and other data. The case manager completes the functional assessment of the client. During the assessment, the case manager asks to look at the client's medications and records the prescriptions used, the authorizing physicians, and the purposes for the medications. While there is no formal relationship between case managers and primary care physicians beyond the annual assessment process, case managers contact the beneficiary's primary care physician when

they note a change in the client's condition or have concerns about clients taking multiple medications prescribed by more than one physician.

Completed assessments are submitted to the Utilization Review Contractor who determines whether the person meets the nursing home level of care criteria. Once approved and enrolled, the SEP case manager develops and implements a care plan for beneficiaries who are eligible for home and community-based waiver services and HCA services.

Each SEP agency must employ or contract with at least one registered nurse or physician. Many nurses are also care managers. In addition to their case manager role, they review requests for Medicaid long-term home health services, consult with other case managers, as needed, and may present information about new medications or treatments.

Case managers receive training on the SEP system. A performance measure in the SEP contract includes 16 hours of training for the fiscal year on health and medical issues. SEP nurses may provide training on health issues. The Department of Health Care Policy and Financing also conducts one or two training sessions a year. Topics are determined through a survey of SEP agencies and always include some medical topics. Topics on the training agenda for June 2002 included multiple sclerosis, fibromyalgia, and hepatitis C.

The average caseload per case manager is 63, although caseloads range from 47 in rural counties to 85 in larger urban areas.

SEP agencies receive $855 a month per client for case management and administrative costs. Agencies receive the payment only after a person has been approved and services are started. Services are reimbursed separately from case management. SEP agencies serving multiple counties receive an additional $8,000 per county per year to support the added costs of coordinating with other counties and stakeholders and added administrative costs, including additional travel.

Results

The single entry point system has assisted clients in obtaining needed services. Clients can obtain information and referrals about the full range of long-term care services by contacting one agency.

Next steps

In 2002, a pilot disease management program using SEP nurses is being evaluated for possible implementation.

The method for paying SEP agencies for case management will be evaluated in FY 02-03. A new payment method will address concerns that SEP agencies have an incentive to increase their caseloads. Services will be reimbursed according to the approved care plan.

A pilot project to revise the assessment instrument and computerize the assessment process is expected to begin in FY 02-03. The process will automatically convert the assessment to a score that determines eligibility. The current instrument is used across HOME AND COMMUNITY-BASED programs and does not adequately address the needs of children and people with mental illness.

Georgia–The SOURCE Program

Overview

Service Options Using Resources in a Community Environment (SOURCE) is an enhanced case management program that serves frail elderly and disabled beneficiaries and is designed to delay or prevent the need for preventable hospital and nursing home admissions. The demonstration builds on the state's primary care case management program, the Georgia Better Health Care Program. SOURCE is administered by the Division of Medical Assistance in the Department of Community Health. The demonstration operates in ten sites and served 1,626 elderly and disabled beneficiaries in 80 counties in May 2002. Georgia serves 80,000 Medicaid beneficiaries in nursing homes and 25,000 beneficiaries through its home and community-based services program.

Purpose

SOURCE integrates primary medical care with supportive services through case managers who work with primary care physicians. Beneficiaries who meet eligibility criteria enroll with a provider organization for their primary care. The program was established to:

- Integrate primary care, specialty care, and home-based care to eliminate fragmentation;

- Reduce inappropriate emergency room use and hospital and nursing home admissions caused by preventable medical complications;

- Stabilize social and lifestyle factors that affect compliance, health status, and quality of life;

- Ensure that current gaps in Medicaid benefits for medical and supported living services are addressed so they do not negatively affect health outcomes and cost; and

- Reduce the need for long-term institutional placement.

Services

Case managers work closely with primary care physicians to complete assessments and care plans and to authorize supportive services. Case managers can authorize home-delivered meals, emergency response systems, adult day health services, personal support services (including respite care), skilled services, home health services, services in personal care homes (assisted living), and 24-hour medical access based on a plan of care that supplements informal supports. Case managers include nurses and social workers. Program administrators indicated that sites with case managers from different disciplines are most effective.

Care coordination

SOURCE programs receive $150 per member per month for care coordination activities. After enrollment, the case manager completes an assessment during a home visit and prior to the appointment with the primary care physician. Case managers work closely with physicians. The assessment provides more extensive information to the physician about the beneficiary's social history, home environment, and functional status than would be obtained during an initial visit to obtain a medical history. Case managers contact participants at least once a month and make home visits at least once every quarter. The care path protocols (see below for more details about care paths) are completed at each quarterly home visit. Physicians indicated that the program makes it easier for them to care for people with multiple conditions, and they are more confident that beneficiaries will receive additional services that are needed.

Case managers and physicians follow standard protocols for monitoring outcomes. Following an initial assessment, the Level of Care checklist is completed to determine which level of care the patient needs. There are four levels of care with four corresponding care paths. Levels one and two include people with substantial cognitive and/or physical impairments who meet the nursing home level of care criteria. Levels three and four include people who have at least one chronic condition but fewer ADL impairments. The program responds to the participant's risk factors in an effort to maintain functional capacity and prevent the progression of chronic conditions.

Each care path has goals (expected outcomes) and is customized to the needs of the beneficiary. Care paths are based on functional ability, not diagnosis, and cover community residence, skin care, medical compliance, transfers, informal supports, nutrition/weight, key clinical indicators, ADLs/IADLs, and problem behaviors. Each path delineates the roles and responsibilities of the member, primary care physician, and the case manager.

The Level four care path includes the least number of goals, an example of which is, "patient keeps scheduled medical appointments." The level one care path contains 13 goals, the maximum number of goals in a care path. The level one care path includes all the goals of the level two, three, and four plans as well as some additional goals

including, for example, "patient has no skin breakdown requiring clinical intervention." The customized plan of care details how the goals will be achieved.

SOURCE contractors limit the number of providers and meet monthly with each provider to review performance against benchmarks. Providers who fail to meet benchmarks have an opportunity to improve but will be replaced if they fail to do so.

Participants have been willing to enroll and change their primary care physician in order to access long-term care services. Many had lacked access to a physician prior to enrolling and used emergency rooms instead.

Results

Total Medicaid costs over two years were lower for SOURCE nursing home eligible members than comparable beneficiaries who received home care services that were not coordinated with primary care. Average costs for two years were $15,350 for SOURCE members and $19,751 for non-SOURCE individuals. SOURCE participants have fewer nursing home placements and shorter lengths of hospital stays than participants in the regular HCBS program who receive less frequent reassessments and home visits and who do not receive monthly reviews by a care coordination team.

Next steps

State officials hope to expand SOURCE statewide, offer enrollment to all beneficiaries with disabilities, and limit the number of providers.

Maine–The MaineNet Program

Overview

MaineNet was originally implemented as a primary care case management model in three counties to improve clinical and administrative coordination of primary, acute, and long-term care services for elders and adults with disabilities. A "partnership" component was developed to serve Medicaid beneficiaries needing long-term care services. Under the partnership, a case manager from the organization responsible for long-term care services was located in the physician's office to improve coordination and planning.

The partnership model of individual care coordination from the physician's office was deemed impractical for replication. Case managers in the regular HCBS program served about 100 Medicaid beneficiaries each. Partnership case managers felt overwhelmed with 35 beneficiaries due in part to such additional tasks as handling phone calls normally done by the physician, nurse, or office staff, participating in office visits, and making more home visits. Although the activity was considered valuable, it was also unlikely that the program could be expanded due to the cost of replication statewide.

After a brief implementation, the program transitioned to a population-based model for improving outcomes. The revised program focuses on helping Medicaid beneficiaries with diabetes, heart disease, and congestive heart failure and offers educational materials to them and their physicians.

Purpose

The primary goals of the new demonstration project are to:

- Provide physicians with data reports tracking utilization of services central to chronic care management and key quality-of-care events;

- Establish baseline data regarding chronic care utilization and provide benchmark data from within the project as well as from national standards of care;

- Encourage and assist physicians to develop interventions to improve outcomes; and

- Engage physicians to develop and participate in educational opportunities to address chronic care management.

The demonstration project

Ninety physicians practicing in six physician groups are involved in the project. Together they serve 2,000 elderly and disabled Medicaid beneficiaries. These beneficiaries receive all Medicaid state plan and, if eligible, waiver services. The MaineNET program manager from the University of Southern Maine, Edmund S. Muskie School of Public Service meets regularly with the physician leader or administrator of each participating group. Physicians receive reports based on Medicaid and Medicare claims data and meet periodically with the program manager (a health educator with quality improvement, patient education, and physician practice management experience) to review data and discuss interventions. A pharmacy consultant is also available to provide additional academic detailing services to the pilot sites.

Aggregate data are presented for all patients of the participating group. The data include people receiving prescriptions from more than three physicians, people with nine or more prescriptions, people with prescriptions that may be inappropriate for people over age 65, and beneficiaries who had not had their prescription filled within the last three months. For example, a quarterly review of pharmacy claims revealed that more than 29 percent of the target population received one or more potentially inappropriate prescriptions. Participating physicians were offered an educational meeting with the project's consulting pharmacist to review the findings and discuss alternatives to these medications. Physicians indicated that under the fee-for-service system, beneficiaries often receive care from multiple sources, and primary care physicians receive little, if

any, information about treatments from other providers. The Medicaid data review gives physicians more information about how other professionals are serving the same beneficiaries and offer opportunities for responding to and coordinating care. Physicians are compensated at the contractual rate of $100 per hour for the actual time spent in academic detailing or in-service meetings with project staff.

The MaineNet staff is developing materials that identify and facilitate referrals to available community resources. These efforts include producing a community resources guide and convening a community resources fair for clinical staff. Strategies to address chronic care management are reviewed with the participating physician groups. These include disease registries and other software tools, group visits, self-management education, disease flow charts, and tracking tools. The physicians are directed to free or low-cost resources that assist in the coordination of care for individuals with chronic illnesses. The state Medicaid agency sends educational materials directly to beneficiaries concerning management of their conditions.

Results

The new demonstration began in early Spring 2002. Utilization data will be tracked to determine the impact. A series of outcome measures have been established that includes quality-of-care indicators, pharmacy utilization, and cost measurements. A pre-post analysis will be conducted as well as a critical review of the academic detailing process.

Next steps

Grant funding for the program ends in July 2003. During the remaining time, options for incorporating the program into the regular Medicaid system will be explored.

Massachusetts–Aging Services Access Points/Physician Program

Overview

The Division of Medical Assistance (DMA), the state Medicaid office, and the Executive Office of Elder Affairs (EOEA) have jointly initiated a pilot project to establish formal collaborations between physicians and elder services organizations. The pilot will be geographically based and evaluated before the planned statewide implementation.

EOEA administers a statewide system of 27 organizations called Aging Services Access Points (ASAPs) that function as single entry points for long-term care services. The ASAPs serve distinct geographic areas and coordinate a wide variety of home and community-based services (HCBS). The ASAPs currently serve about 40,000 seniors age 60 and over, funded by state general revenues and a Medicaid HCBS waiver.

Purpose

The goals of the program are to:

- Support and enable elders to live in the community as long as appropriate;

- Improve the coordination of primary, acute, and community long-term care services;

- Introduce new strategies to maintain optimal functional status; and

- Increase access to preventive and primary care services.

Services

Approximately 50 participants are expected to receive enhanced case management services during the one-year pilot period. Participants will have access to a full menu of Medicaid state plan and home and community-based services, including home health, personal care, chore services, homemaker services, respite care, adult social day care, adult day health transportation, home-delivered meals, supportive home care aides, laundry services, emergency response services, adaptive housing equipment, medication dispensing, habilitation therapy, grocery shopping, and vision rehabilitation.

Care coordination

Medicaid and "dually eligible" beneficiaries who are medically stable yet qualify for nursing home admission and meet criteria for "high risk" will be offered an opportunity to participate in the program. ASAP staff and physicians or their designated staff members will be expected to communicate at least monthly to exchange information about the client's status. Information sharing will include health status, social supports, and environmental and housing circumstances. In addition, ASAP staff will alert physicians to significant changes, discuss long-term care planning, make recommendations about community care options using less medically intense Home and Community-Based services, and coordinate services, including transportation.

ASAP staff and participating physicians will also work closely with home health agencies, conduct risk management activities, improve coordination during transitions from hospitals and nursing homes, and educate and support clients about compliance with medical care instructions, including medications, diets, hygiene, and specialist visits. During the pilot, Elder Affairs will pay ASAPs (and DMA will reimburse physicians) $25 per client per month.

In order to evaluate the pilot, a combination of quantitative and qualitative measures will be used. Participant outcomes will be compared to a control group, and service utilization and related costs and benefits to participants will be analyzed. Satisfaction surveys will

be conducted with clients and/or family members, physicians, and other community agencies.

Next steps

The pilot was scheduled to be implemented in October 2002. The pilot site at a single ASAP has been selected, and the eligibility criteria and protocols for communication between case managers and physicians are being established. A targeted case management state plan amendment will be submitted to cover the activities of the pilot initiative.

New Hampshire–Supportive Services in Elderly Housing

Overview

The Laconia Housing and Redevelopment Authority (LHRA) operates two Section 202 sites that provide supportive services to tenants. Sunrise Towers is a 98-unit public housing complex for elderly and disabled people that receives funding under the U.S. Department of Housing and Urban Development's Congregate Housing Services Program (CHSP). Stafford House—which has 50, one-bedroom units—received a state Health Care Transition Fund grant to start the Tavern Alternative Housing Program (TAHP) to prevent nursing home admissions and to relocate existing nursing home residents.

The LHRA Home and Community Based Care (HCBC) program is available at both buildings.

Purpose

The CHSP program began in 1993 to address the needs of tenants who were aging-in-place and needed support to maintain their independence. Thirty of the Sunrise Towers residents receive services. Stafford House provides supportive services to ten residents under the nursing home transition program. A total of 15 residents in both buildings participate in the Medicaid HCBS waiver program.

Services

The service package includes two meals a day, personal care, housekeeping, laundry, transportation to medical appointments, and personal emergency response. Services are available from 8 a.m. to 6 p.m., Monday through Friday, and weekends from 8 a.m. to 2 p.m. About half the residents receiving services at Stafford House are eligible for Medicaid HCBS waiver services and the remaining receive services from the CHSP program. The Housing Authority created its own home health agency that provides services to residents. An agency nurse staffs a health clinic two hours a week.

Information about the clinic is included in newsletters and posters, and sign-up sheets are available for residents who wish to see the nurse. There are no charges for clinic visits.

CHSP funds are only used in the CHSP program at Sunrise Towers. Medicaid funds are only utilized for LHRA HCBC participants. TAHP is funded from a range of sources including the United Way.

Care coordination

All CHSP sites are required to form a Professional Assessment Committee (PAC). The PAC at Stafford House includes a representative from the State Division of Adult and Elderly Services, a pharmacist from a local hospital, social workers from the county nursing home and Community Services Council, the county long-term care coordinator, and a representative from the county mental health agency. The PAC meets monthly to review assessments for new applicants and the status of current participants. All three programs use the same PAC.

The pharmacist is available and will be able to teach staff about the proper medication-monitoring program once the State Board of Nursing publishes the regulations regarding this service. The pharmacist also conducts medication reviews whenever requested.   The registered nurse of the LRHA home health agency does medication set-ups for the individuals on the LRHA HCBC program. CHSP and TAHP are social model programs. Individuals can pay privately for these services if they are not Medicaid HC/BC eligible. They are also able to see the nurse at the weekly clinics.

The county nursing home representative noted that because of programs such as CHSP, people have been able to delay admission to a nursing home. Hospital discharge planners note that the availability of the on-site nurse, supportive services, and the PAC help prevent readmissions due to inadequate nutrition, lack of fluids, and falls that often occur within 24 hours of a hospital discharge. The weekly reviews and staff presence allow detection of changes in the resident's condition that warrant intervention.

Results

An evaluation, conducted by the University of New Hampshire, of the initial implementation of the grant from the Health Care Transition Fund found that the program achieved cost savings of $8,100 per participant and prevented admissions to nursing homes. Three participants relocated from nursing homes. The remaining participants were existing residents who were either at risk of a nursing home admission or recently discharged from the hospital or were residents from other elderly housing or community settings. Nineteen applicants were screened but did not meet the criteria for entering the program.

Next steps

The original plan included forming a certified home health agency. This has been accomplished. The agency's services are now being expanded to serve other properties owned by the LHRA.

Vermont

Overview

In 1998, the Department of Prevention, Assistance, Transition and Health Access (PATH) began to enroll SSI beneficiaries who were not receiving long-term care services and were not eligible for Medicare in managed care plans. Because of concerns about managed care voiced by advocates and family members, and rising expenditures, SSI beneficiaries were transferred to the state's mandatory primary care case management (PCCM) program, Vermont Primary Care Plus (PC Plus). However, policy staff recognized that SSI beneficiaries required a different PCCM model. A planning grant from the Center for Health Care Strategies allowed the staff to design practice-based strategies for children with special needs, children in foster care, and beneficiaries with severe and persistent mental illness.

In March 2001, the state also began operating the Vermont Independence Project (VIP) to bridge the long-term care and primary/acute care systems for elderly and disabled Medicaid beneficiaries and those dually eligible for Medicaid and Medicare. Care coordinators, or "care partners," from the Area Agencies on Aging are co-located with the primary care providers.

Purpose

PC Plus provides a medical home for coordinating clinical services. The program's goals are to enhance health status using a unified point of service coordination, communication, and oversight; to maximize funds for care rather than administration; and to increase consumer involvement in care planning.

VIP, which links long-term care and primary/acute care delivery systems for elderly and disabled beneficiaries, aims to control costs and improve quality through enhanced case management.

Services

PC Plus members have access to all Medicaid state plan services. Primary care providers receive $5 per member per month for coordinating services and authorizing visits to specialists and $40 to develop or revise an annual care plan.

VIP combines gatekeepers for health and long-term care services. Participants receive enhanced case management that includes an assessment and help accessing community services. The assessment covers demographics, financial eligibility, and functional assessment of medical and social service needs. Physicians also receive a quarterly Prescription Drug Report listing all of the prescriptions paid for by Medicaid to assist in the care planning process.

Care coordination

Eight provider groups are participating in PC Plus. They include community mental health centers, federally qualified health centers, and hospital-owned practices. The program uses a web-based assessment tool developed by the Dartmouth COOP Clinical Improvement System, "How's Your Health," to obtain initial information as a basis for developing a care plan. Many beneficiaries have severe and persistent mental illnesses, and the program has adapted a self-management tool used in a disease management program for use with these beneficiaries. For example, new anti-psychotic medications can cause significant weight gain that can lead to diabetes. As appropriate, each beneficiary's self-management plan includes strategies to manage diabetes as well as other aspects of the person's mental illness.

In VIP, care coordinators, called "care partners," are co-located in nine primary care practices at specified times during the week. Referrals are made by the primary care physician or the physician's staff. Working with the client, the physician and care partner develop and implement a care plan that includes the client's medical and social services needs. The primary care physician and the care partner also work together to coordinate the client's pharmaceutical needs. Interaction between the doctor and the care partner are informal and are conducted on an "as needed" basis. Anecdotally, the state program staff noted that the more successful efforts also have buy-in from the physicians' front office staff.

Results

The VIP project has served 60 beneficiaries in the first year. The most common reasons for referring beneficiaries are: presence of multiple chronic diseases, lack of support systems, complex psycho-social needs, financial needs, and living alone or with someone unable to act as caregiver. The project found that assigning case managers with social service backgrounds rather than registered nurses helped clarify the expectations of physicians. Physicians and their staff gave mixed reviews to the program. One physician said it helped him deal with very difficult patients. Several physicians spent time with the care partner to review the status of participants. Others spent little time with care partners who must then work with the office staff.

Next steps

PC Plus will implement a global clinical record system to track prior authorizations, develop health indicators, and prepare reports for physician practices. The program will also examine options for reimbursing providers for their care management activities once the two-year demonstration period ends. Expanding the use of targeted case management under the state Medicaid plan and building care management costs into rates paid for primary care activities are two options that will be explored.

The VIP project plans to track changes in functional capacity, medical utilization, referral patterns, and service plans. VIP will also conduct a cost-benefit analysis for case management services. Staff expect to provide more training to care partners on how to work with physicians and conduct further interviews with physicians to determine their perceptions of the effectiveness of the program.

Wisconsin–The Wisconsin Partnership Program

Overview

The Wisconsin Partnership Program (WPP) is a voluntary, fully integrated, comprehensive program serving elders and people with physical disabilities who meet the Medicaid criteria for admission to a nursing home. It combines all Medicaid and Medicare acute and long-term care services. WPP began in 1995 and operates as a demonstration program in four areas of the state. The state contracts with four community-based organizations for care coordination. The organizations contract with physicians, hospitals, and other providers to offer a comprehensive benefit package. Two sites serve elders, one serves adults with physical disabilities, and one site serves both. In July 2002, the program served 1,260 beneficiaries.

WPP is similar to the PACE model with two primary differences: participants are allowed to retain their primary care physician if the physician agrees to join the program, and participation in an adult day care program is not required.

Purpose
The primary goals of WPP are to:

- Improve the quality of health care and service delivery while containing costs;

- Reduce fragmentation and inefficiency in the existing health care delivery system; and

- Increase people's ability to live in the community and participate in decisions about their health care.

WPP also has developed a set of guiding principles. They are to:

- Deliver and coordinate health and long-term care through an interdisciplinary team;

- Treat its members as dignified individuals who are accountable for their responsibilities and entitled to their rights;

- Allow members to manage their own services to the greatest extent possible or to the extent they desire;

- Offer members the information necessary to make informed decisions;

- Deliver quality services that are both member and provider friendly, on a timely basis;

- Improve the attitudes and practices of the health care profession toward frail elderly and people with disabilities;

- Maintain physical and mental health standards to assure optimal levels of health and functioning for members;

- Support its members to develop and maintain friendships and participate with their families;

- Consider the changing needs of its members and to flexibly adapt services as necessary;

- Emphasize members' self-reliance and sense of self-worth, and

- Carry out the member service plan by utilizing effectively and equitably the available public.

Services

The capitation payment covers all services available through Medicare, the Medicaid state plan, and Medicaid HCBS waivers. Services are provided in the setting of choice by the beneficiary. The capitation payment gives sites the flexibility to approve non-traditional services that help a beneficiary maintain his or her independence. The sites have expanded access to full dental care for all members.

Care coordination

An important feature of the WPP delivery system is the use of interdisciplinary care coordination teams. The teams include a geriatric nurse practitioner (GNP), social worker/social services coordinator, and a registered nurse. The GNP serves as the liaison to each member's primary care physician. Assessment and care planning is a function shared between the teams and each member. The process includes identifying health and social service needs, services to support the member in the context of their own resources

and capabilities, and goals regarding work and participation in the community. Each site uses an operation protocol developed by the Department of Health and Family Services, Division of Systems Delivery Development that describes the procedures for teams to work with the member. The protocol emphasizes the role of the member as a critical part of the team. Teams met weekly and review member service plans every six months, or more often if necessary.

GNPs or registered nurses attend primary care visits. During the meeting, they discuss the care plan and the physician's previous orders to treat or manage chronic conditions. Physicians have been willing to work with the team if the GNP is well prepared. For example, during an office visit, the GNP might list the last six changes in the member's blood pressure.
Developing effective interdisciplinary teams takes time. Teams have worked to create a shared vision of the model and the role of the team and each member. With experience, members from different disciplines come to understand the perspective and professional judgment of other team members.

The GNP serves as the link to the primary care physician, whose involvement in the overall care plan varies widely. In some cases, the physician may communicate actively with the team, while in others there may be little direct communication. Coordination depends heavily on the relationship between the GNP and the physician and the physician's willingness to delegate responsibility for ongoing care oversight.

The social worker team member provides information about benefits and services available outside of WPP. The social worker will often accompany the member when applying for benefits such as food stamps or SSI.

Results

A formal evaluation of the program is under way. The state agency tracks and analyzes information on WPP and PACE enrollees. A review of encounter data has found a very low incidence of emergency room visits and hospital admissions for ambulatory care sensitive conditions. Hospital days dropped from between four to five days per year per thousand to 2.1 days after enrolling in WPP. Nursing home days also declined, and emergency room visits were basically unchanged. WPP and PACE enrollees use far less nursing home care than Medicaid beneficiaries who have not enrolled in WPP or PACE.

Next steps

None identified.

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