



**Evaluation of Washington State Medicaid
Chronic Care Management Projects
Qualitative Report**

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Submission Date:
December 31, 2008

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Executive Summary

As directed by Washington Substitute Senate Bill 5930, this report evaluates three chronic care management projects offered by the Washington State Department of Social and Health Services (DSHS):

- Aging and Disability Services Administration Chronic Care Management Project
- Health Recovery Services Administration AmeriChoice Washington Chronic Care Management Project
- Health Recovery Services Administration King County Care Partners Chronic Care Management Project

The purpose of the qualitative evaluation is to report findings of the start-up phase of the three chronic care management programs. It was specifically developed to evaluate the impact of offering a new program to a select group of high need, high-cost Medicaid clients. The projects are not comparable due to significant differences between essential project elements and client characteristics.

Key Findings

Aging and Disability Services Administration Chronic Care Management Project

Engagement rate was 43% of those targeted for the Aging and Disability Services Administration (ADSA) Project, similar to projects nationally. Clients' contact information was known to care managers since all were receiving services from ADSA. The engagement rate was limited by the enrollment capacity for each Area Agency on Aging.

Findings from the client record review showed that nearly half of the clients in the sample achieved improvements in health condition, living environment, or access to treatment. The greatest challenges appeared to be resource limitations, particularly in rural areas of Washington State.

AmeriChoice Washington Chronic Care Management Project

Engagement rate for the AmeriChoice Washington Project was 45% as measured by premiums paid during the study period. Engagement was actually less, at approximately 15%, due to an implementation problem identified through program monitoring and later corrected.

Client record review found evidence of self reported successes such as smoking cessation, use of preventive care, and completion of advanced directives. These findings were based on only 15 care management records with 5 corresponding physician records that were available for review out of 60 records requested.

King County Care Partners Chronic Care Management Project

Engagement rate for the King County Care Partners Project was 18% during the study period due to slow program start-up and difficulty reaching clients.

Findings from the client record review in the sample included referring clients to supportive health and social service programs, stabilizing mental health conditions through coordinating services for clients, and an increase in smoking cessation.

Conclusions and Recommendations

Comparison between chronic care management projects was not the intent of this evaluation, nor was it appropriate given the distinct nature of each project's population, focus, and interventions. Conclusions and recommendations from this evaluation are as follows:

- Client engagement is and will remain a challenge for programs targeting high-need high-cost Medicaid clients. Offering services does not guarantee client engagement. Increasing such client engagement may require a combination of strategies appropriate to each program and population.
- Limited access to resources diminishes the ability of the care manager to successfully impact the client's plan of care and was experienced by all projects. Examples of limited resources include: access to pain management specialists, emergency mental health services, chemical dependency services, and timely availability of interpreters.
- Expediting clients' continued enrollment in two of the three projects would improve care management efforts by reducing administrative workload.

Methods

The three chronic care management projects evaluated shared two major components:

- **Predictive Modeling**—a computerized program, ImpactPro™, was used to select potential enrollees at highest risk for future healthcare utilization based on analysis of demographics, healthcare claims, and utilization.
- **Care Management**—assessment and intervention provided to high risk clients by a care manager through telephonic and/or face-to-face contacts that results in a plan of care jointly developed by client and care manager.

Evaluation Design

Each project targeted a different client population. Clients from each population were then randomized to a treatment group to whom chronic care management was offered, and to a comparison group that could be offered chronic care management at a later date. The changes over time experienced by the two groups (treatment and comparison) were then compared to see if those offered chronic care management showed any differences in outcomes. Not all those who were offered chronic care management actually participated. Data was collected from reviews of care management and physician charts.

Review of Client Records

To understand the services, successes, and challenges in providing each model of chronic care management, a random sample of clients who were enrolled for at least 6 months was selected from each project. A minimum sample size of 50 clients in each project was thought to be representative of each project, though 60 client records were requested based on the assumption that some records would be difficult to access.

Data sources included interviews with key project leadership and staff, care manager records, and medical records where available. In total, 5 interviews, 121 care manager records, and 59 physician records were available for review. These included:

- Fifty-nine (59) care manager records with 42 corresponding physician records for the ADSA Chronic Care Management Project
- Fifteen (15) care manager records with 5 corresponding physician records for the AmeriChoice Washington Chronic Care Management Project
- Forty-seven (47) care manager records with 12 corresponding physician records for the King County Care Partners Chronic Care Management Project

Analysis consisted of identification of major themes through review of client records. Both care management and physician charts were abstracted for demographic information, client diagnoses, care management and provider problem lists, care management interventions, durable medical equipment needs, referrals, and challenges and successes as described in the charts.

Aging and Disability Services Administration Chronic Care Management Project Evaluation

Project/Population Description

The Aging and Disability Services Administration (ADSA) Chronic Care Management Project:

- Provided intensive care management services throughout Washington State that integrated acute and long-term care services using face-to-face care management focused on supporting existing ADSA clients living in their home
- Provided clients with a formal, state-paid caregiver to support their personal care needs
- Built on long-term care casework and in-home service delivery infrastructure through Area Agencies on Aging

Clients remained in the project for the period of time that they were eligible for chronic care management services.

The clients targeted for the ADSA Chronic Care Management Project were those who were eligible for aged/blind/disabled, categorically-needy, Medicaid-only medical benefits, and who were currently receiving home and community-based long-term care services care managed by 1 of 5 participating Area Agencies on Aging. Additionally, to be included in the project, clients had to be identified in the top 20% at risk of having future high medical expenses (as defined by the ImpactPro™ risk score¹) and meet one or more of the following five assessed risk factors based on a prior assessment of their need for long-term care:

- Living alone in their own home
- Experiencing isolating moods and behaviors (for example, agitated and irritable)
- Self-rating of health as fair or poor
- Having deteriorated self-sufficiency
- Taking more than six medications

Those with certain cancer diagnoses and treatments were excluded.

¹ For example, for an “average person” the risk score would be 1.0. A risk score of 7.5 implies that the individual is predicted to use 7.5 times more healthcare resources than the average person.

The project was funded at a 1:45 nurse care manager to client ratio. The project's focus was to integrate acute and long-term care services, as well as educate clients and caregivers in self-management skills. Each client developed a health action plan with their nurse care manager. Included in the action planning were the results of the patient activation measure (PAM) and care opportunities identified in ImpactPro™. Clients identified goals to work on with the nurse and the other members of their health and social services team.

Participants in this project lived at home and had a formal, state-paid caregiver to support their personal care needs. Clients often had multiple chronic diseases such as diabetes, heart disease, and mental illness.

Review of Client Records

Description of Care Management Interventions

For the client record review performed for the ADSA Chronic Care Management Project, 59 care manager records with 42 corresponding physician records were reviewed. Each chart contained documentation of home visits by the care manager.

Care managers conducted a range of interventions that included:

- Health-related interventions
- Patient education
- Referrals
- Advocacy and social service opportunities

Care managers provided the following types of health-related interventions:

- Physical assessment of the client as well as assessment of ongoing health problems
- Arrangement for home healthcare services or other ancillary healthcare
- Assessment of risk for falling and development of a fall prevention plan
- Transition assistance from the ADSA Chronic Care Management Project to hospice, when appropriate
- Assistance in locating and establishing care with a new Primary Care Provider
- Placement of personal medical alert emergency response service equipment (e.g., LifeLine) in the home for clients living alone or in remote areas

Care managers also provided patient education, including the following types of information and instruction:

- Dietary teaching
- Diabetic management for clients and caregivers
- Smoking cessation teaching
- Medication management
- Training on accessing and using the medical home and Primary Care Provider
- Alternative pain management strategies

Care managers made referrals for necessary services that would improve the client's ability to remain in their homes. Of the charts reviewed, only one client had a documented referral to a Primary Care Physician or other medical/surgical specialty physician during the study period. This may be a result of clients having established relationships with Primary Care Providers due to their chronic health conditions.

Charts for 5 of 59 clients receiving services documented referrals for either a mental health or chemical dependency evaluation, or to a chemical dependency support group. When a client died, the care manager occasionally assisted the family in accessing bereavement or grief counseling.

Care managers coordinated advocacy and social service opportunities. For example, care managers:

- Attended Primary Care Physician office visits with clients
- Worked to procure energy assistance
- Collaborated with other care providers to ensure continuity of care
- Worked with the client to keep the client linked to a medical home

Of the 59 clients whose charts were reviewed for this evaluation, 9 had no referrals provided to them as the availability of specialists varied by geographic region.

Successes

The majority of the reviewed records document some improvement in client condition over the course of the intervention, especially in the management of medications, diabetes, weight loss, wound care, and pain. Additionally, care managers helped to adjust the hours of state-paid caregivers to match the needs of clients.

The ADSA care managers were also successful coordinating client care among Primary Care Physicians and other healthcare providers. Care managers worked closely to update physicians when a client had a change in condition or a change in level of care. They also notified physicians and/or facilitated requests for ancillary services such as equipment, physical therapy, and occupational therapy assessments for their clients.

Challenges

Available resources for the ADSA Chronic Care Management Project appeared to vary by geographic location. This was most apparent in the rural areas of Washington State where care managers had a difficult time finding pain management resources. In addition, there appeared to be more frequent provider turnover for clients in rural areas of the Washington State.

AmeriChoice Washington Chronic Care Management Project Evaluation

Project/Population Description

The AmeriChoice Washington Chronic Care Management Project:

- Provided telephonic and in-person care management interventions throughout Washington State (except for King County) to clients not receiving ADSA long-term care services
- Focused on access to providers and receipt of health education

Clients remained in the project for 6 months with the opportunity to extend enrollment to a maximum of 12 months.

Clients targeted for the AmeriChoice Washington Chronic Care Management Project were those who were eligible for aged/blind/disabled, categorically-needy, Medicaid-only medical benefits and not covered by another similar insurance policy; who were not receiving long-term care services from ADSA; and who were residing anywhere in Washington State except in King County. The top 20% of clients, as identified by the ImpactPro™ risk score for being at risk of having future high medical expenses, were selected for the project. Clients with certain diagnoses (HIV/AIDS, hemophilia) were excluded, as were clients who were pregnant, clients with end stage renal disease, and clients receiving hospice services.

AmeriChoice Washington's project provided care management services to appropriate clients through a combination of telephonic and in-person care management services, although the project was designed to be primarily telephonic. Approximately 2,000 clients were determined to be suitable for the project each month by DSHS. A letter of introduction was sent to these 2,000 clients, after which attempts to reach the client by phone or in person were made. The executive director and the medical director for the AmeriChoice project reported an engagement rate of approximately 15%. Clients did not receive personal care services from a state-paid caregiver.

The AmeriChoice Washington project reported having five care managers (four registered nurses and one medical social worker) who live and work in Washington State. These care managers provided both face-to-face and telephonic care management services to clients. Face-to-face caseloads were up to 150 clients per care manager. In addition, there was one engagement specialist in Washington State responsible for assisting members with transportation, housing, and medical home issues.

The project also had four registered nurse care managers located in Indiana who provided telephonic screening, assessment, and care plan development for up to 200 clients. In addition, there were two health educators working telephonically from the Indiana location, providing patient teaching “scripts” for clients with conditions such as diabetes, hypertension, and heart disease.

The initial contact with these clients was made using an auto dialer that repeatedly dialed the client’s telephone number until someone was reached at that number. Once answered, the call was forwarded to a registered nurse care manager in Indiana who completed a telephonic assessment of the client’s current condition. After completing the telephonic assessment and the care plan, the Assessment Team care manager would refer the case to a care manager located in Washington State if the ImpactPro™ score was 5 or higher.

Upon referral to a care manager in Washington State, the client was assessed for additional care management intervention. If warranted, a home visit was conducted. AmeriChoice care managers provided at least monthly follow-up contacts with each client until the client’s condition stabilized. Clients “graduated” from the project once their condition had stabilized, or after 6 months. When necessary, the care manager requested an extension from the Health Recovery Services Administration to keep a client in the project.

Of the approximately 2,000 clients appropriate for the AmeriChoice Washington project each month, approximately 15% were eventually reached for the initial assessment. If a client was not reached by the auto dialer and therefore did not receive an initial assessment and care plan by the care manager in Indiana, then further attempts to contact the client were made for as long as the client remained eligible for the project.

Some barriers to reaching these clients included incomplete or inaccurate address information and the inability of the client to contact AmeriChoice due to either not having telephone access and/or because of frequent address changes.

Review of Client Records

Description of Care Management Interventions

For the client record review performed for the AmeriChoice Washington Chronic Care Management Project, 15 care manager records out of the 60 requested were reviewed with 5 corresponding physician records. The small number of records reviewed may not be representative of the services provided to the AmeriChoice treatment group. As a consequence, interviews with the project’s executive director and medical director played a more prominent role in information gathering. Of the records available for review, there was no evidence of home visits by care managers.

Care managers conducted a range of interventions. These health-related interventions included:

- Performing assessment of risk for falling
- Establishing a Primary Care Provider
- Helping clients identify and receive preventive service
- Assessing health conditions and providing education related to health conditions
- Identifying the Primary Care Physician and helping the client access transportation to and from appointments

Care managers provided patient education that addressed the following:

- Managing weight or diabetes
- Accessing and receiving preventive services, mental health conditions, and smoking cessation assistance
- Completing an advanced directive
- Accessing a Primary Care Provider
- Finding alternative forms of pain relief

Care managers made referrals for preventive services. Identifying referral sources was a particular challenge for clients in rural areas. Finding a specialist who accepts Medicaid clients was also particularly challenging.

Advocacy and social service interventions provided for clients included:

- Negotiating with providers to accept a pain management client
- Developing self-management techniques for clients to use to improve adherence to mental health medications

Successes

Examples of individual client successes include proactive use of the Primary Care Provider rather than using the emergency room and ongoing care management assistance and support for clients with pain management, mental health, and chemical dependency needs.

Challenges

Access to appropriate pain management services is limited in many areas of Washington State. A number of clients in this program had longstanding pain management issues and difficulty maintaining Primary Care Providers.

A challenge for the telephonic care management assessment model is client accessibility and engagement. Clients may also under-report their health issues during the initial assessment.

Record reviews revealed that some clients were “graduated” before reaching their self-management goals or before stabilization with their new healthy behaviors.

King County Care Partners Chronic Care Management Project Evaluation

Project/Population Description

The King County Care Partners Chronic Care Management Project:

- Provided intensive face-to-face care management services to clients not receiving ADSA long-term care services
- Was a coalition of The City of Seattle, Aging and Disability Services with other local agencies including Harborview Hospital, UW Informatics Research, many community health centers, and Senior Services of King County
- Provided linkages for clients in King County to a medical home and extensive coordination between behavioral health and physical health systems

Clients remained in the project for 6 months with the opportunity to extend enrollment to a maximum of 12 months.

Clients targeted for the King County Care Partners Chronic Care Management Project were those who were eligible for aged/blind/disabled, categorically-needy, Medicaid-only medical benefits and not covered by another similar insurance policy; who were not receiving long-term care services from ADSA; and who had previously been served at least once by a King County Care Partners organization in the past year. The top 20% of clients, as identified by the ImpactPro™ risk score for being at risk of having future high medical expenses, were selected for the project. Clients with certain diagnoses (HIV/AIDS, hemophilia) were excluded, as were clients who were pregnant, clients with end stage renal disease, and clients receiving hospice services.

After receiving the eligibility list from DSHS, initial contact was through an introductory letter followed by a telephone call from the registered nurse care manager. If the client agreed to participate in the project, then a registered nurse care manager either contacted the client to arrange an in-home visit or met the client at another location. As many of these clients received care at Harborview Medical Center, the care managers often met with the client there prior to or following a clinic visit.

Access to the electronic medical record at Harborview Medical Center was a feature unique to the King County Care Partners Chronic Care Management Project. The project was staffed by two registered nurse care managers who each managed a caseload of up to 75 clients. Additionally, the project employed a medical social worker and a health education specialist who assisted in helping clients with medical home interface, transportation, health education, and eligibility issues.

Review of Client Records

Description of Care Management Interventions

For the client record review performed for the King County Chronic Care Management Project, 47 care manager records out of the 60 requested were reviewed with 12 corresponding physician records.

Care managers provided a range of interventions. Health-related interventions were focused in these areas:

- Conducting a home visit to assess client condition and appropriateness for participation in chronic care management
- Assisting clients in establishing a medical home to receive necessary healthcare services
- Working with clients to obtain chemical dependency or mental health treatment
- Accompanying and transporting clients to healthcare office visits
- Assisting clients to find secure housing
- Assessing clients' durable medical equipment needs
- Assisting clients to access smoking cessation programs

Care managers also provided patient education. Nearly every client receiving services received some form of client teaching including:

- Medication management
- How to access a Primary Care Physician
- Use of specialized equipment such as self-blood glucose monitors and automatic blood pressure cuffs

Clients in the project were referred by care managers for:

- Transportation assistance
- Mental healthcare services
- Chemical dependency programs
- Smoking cessation
- Housing assistance
- Dental services

Care managers also coordinated advocacy and social service opportunities. One important area of advocacy involved helping appropriate clients remain in the project. Staff interviews revealed advocacy by assisting with initial and ongoing eligibility paperwork for clients at risk of losing project eligibility.

Successes

The majority of the records reviewed showed evidence of improvement in client condition or behaviors. Examples include admission to chemical dependency and mental health programs, attending physical conditioning classes resulting in improved activity tolerance, achieving weight loss through dietary counseling, and connecting with a Primary Care Provider for effective diabetes management.

Challenges

Challenges for the project included:

- Maintaining enrollment for clients who were benefiting from the project
- Adequately addressing the complexity and intensity of social and healthcare needs for this population
- Obtaining timely interpreter services for non-English speaking clients

Examples of the complexity of these social and healthcare needs include findings that 44 of 47 clients reported they use the food stamp program for food purchases and that 12 of 44 clients reported either running out of food or skipping meals to make their food last until the end of the month. Additionally, 24 clients in this project were described as living alone, transient, or homeless.

Discussion

In January 2007, the Department of Social and Health Services (DSHS) implemented a chronic care management program targeted to helping a segment of Medicaid clients with high-risk and expensive chronic conditions to access earlier interventions and more appropriate healthcare. The project coincided with Governor Chris Gregoire's healthcare initiatives calling for DSHS to focus on improved ways of dealing with chronic care since a relatively small percentage of Medicaid clients typically account for a majority of Medicaid healthcare expenditures. Washington State spends nearly half of all Medicaid funds on just over a fifth of the Medicaid enrollees, the elderly, and the disabled².

This qualitative evaluation reports on the preliminary findings in three chronic care management projects with Medicaid clients in the State of Washington. The projects are not comparable due to significant differences between essential project elements and client characteristics.

Limitations

Engagement

A large percentage of those clients who were randomized to the treatment group and analyzed as such did not actually receive care management services. This low engagement rate may have diminished the ability of the study to detect significant differences between treatment and comparison groups.

Barriers identified to engagement include caseload limitations of care managers, difficulty contacting clients due to outdated address and phone information, mobility of the population, lack of understanding of the program by clients and providers, and more urgent basic needs of clients such as housing or food.

The record review was based on a limited sample of the clients believed to be engaged in the intervention. It covered a relatively short period of time and in many cases records were incomplete. The results should be interpreted as a glimpse into the nature of the care management activities and interaction with Primary Care Providers, with limited ability to generalize to the group as a whole.

Time Frame

The study findings reflect the earliest stage of the programs based on the data available at the time of this qualitative report. The findings do not reflect a mature program, nor do they identify longer term effects of providing such a program.

² Kaiser Commission on Medicaid and the Uninsured, FY2005 data.

Recommendations

Much more needs to be done to increase client engagement in DSHS chronic care management programs. Priority should be given to identifying and using evidenced-based best practices, if available, for increasing engagement. At a minimum, chronic care management programs should develop strategies and measurable goals for increasing and maintaining client engagement.

Chronic care management programs could benefit from increased use of validated tools, such as the Patient Activation Measure and ImpactPro™ risk assessment, that help target interventions appropriate to the client's readiness to change and their areas of greatest need.

The intervention time for clients participating in two of the projects evaluated needs to be extended to allow more time to work with clients on changes that can affect future health outcomes and healthcare costs.

Access to critical resources needs to be improved. In many rural areas of Washington State, chronic pain management resources are limited or entirely lacking. Improved access to interpreters is needed in King County. All regions of the State could benefit from improved coordination of emergency mental health and chemical dependency treatment for Medicaid clients.

This evaluation used a single set of cost and health outcome measures to evaluate three distinct chronic care management projects. While this approach is justified in a first time evaluation, future evaluations may benefit by tailoring measures based on what is already known about project goals and populations.

Conclusions

The randomized controlled design used for this evaluation allows us to have more confidence in the findings than would have been possible with a purely observational design. Results can be used to estimate the short run effect such programs would have if implemented in other areas of the State, with similar clients and similar interventions.

For chronic care management programs, many challenges remain in the areas of engagement, client identification, and measuring short- and long-term effects of care management. There are, however, very preliminary indicators of a positive trend in health outcomes for using care management interventions with a medically and socially complex population. With continued effort by public and private partnerships, increasingly effective strategies will be developed to reduce healthcare costs and improve client health.