Best Practices for Care Coordination: The AAADSW Model

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Abstract

The Area Agency on Aging & Disabilities of Southwest Washington (AAADSW) works with the most vulnerable Medicaid and Medicare enrollees, coordinating comprehensive home and community-based services to maintain and improve their health. AAADSW has consistently outperformed similar organizations, with engagement rates several times higher than average, and greater focus on connecting participants with resources that address the effects of poverty and other social determinants of health. We describe the unique management, organization, and procedures that contribute to their success, and provide best practices guidelines that all community-based health organizations can use to improve service for their most vulnerable members.

Introduction

The team from the MBA program at the Oregon Health Science University (OHSU) School of Medicine has recently completed their review of AAADSW's work within the Health Home innovations program. Their independent evaluation of our CCO program provides a remarkable confirmation of what the AAA network can do to impact health outcomes in Washington State.

We have been asked several times "why is this program not broadcasted/publicized more? … this program has such remarkable, sustainable, and duplicable work outcomes". Of course that impression was reinforced by the January 2016 CMS study showing the cost savings. When I let

the Capstone group know that the CMS study was done in the first (and rocky) year of Health Home implementation -- without nearly 30% of the State of Washington participating – they were even more impressed.

It is our belief that by following the best practices outlined within this report the entire AAA network would produce an exponential set of dynamic and incredible results. As I have stated to my w4a colleagues, AAADSW has truly benefited from several highly favorable conditions that allowed us to energetically move forward to become what I believe is the largest active CCO in Washington State. One problem is that all statistics gathered by Washington State are done at the Health Home Lead level. This is unfortunate as the effectiveness of effort can best be ascertained at the actual level of service delivery to the client (the CCO level) and NOT at the referral level of service (the Home Health Leads)

I am convinced that Washington State's thirty years of work implementing and refining the Title XIX program has established an awesome foundation for this innovation program to improve the lives and health outcomes of those citizens we serve.

- Dave Kelly, Executive Director, AAADSW

Overview

The Area Agency on Aging & Disabilities of Southwest Washington (AAADSW) works with the most vulnerable Medicaid and Medicare enrollees, coordinating comprehensive home and community-based services to maintain and improve their health. AAADSW has consistently

outperformed similar organizations, with engagement rates several times higher than average, and greater focus on connecting participants with resources that address the effects of poverty and other social determinants of health. We describe the unique management, organization, and procedures that contribute to their success, and provide best practices guidelines that all community-based health organizations can use to improve service for their most vulnerable members.

The history of the Health Home initiative

Many Medicaid enrollees have trouble with housing, heating refrigeration, transportation, and other social determinants of health. Connecting these individuals with state and community resources that assist with their needs and remove obstacles to health management can greatly improve their well-being while avoiding expensive treatments for preventable consequences of unmanaged conditions. In Section 2703 of the Affordable Care Act, Congress authorized each state to develop Health Home programs for Medicaid populations at high risk of recurring hospitalizations, Emergency Department visits and exacerbations of chronic disease processes. This law *"...gives states an opportunity to improve care coordination and care management for Medicaid beneficiaries with complex needs through health homes." By better coordinating care and linking people to needed services, health homes are designed to improve health care quality and reduce costs* [1].

Like Medicaid expansion, Health Home programs are not mandatory. To date, twenty states have created 29 approved Medicaid Health Home models [2]. Washington's model targets

patients with chronic illnesses, providing care coordination to the high-risk enrollees who are responsible for more than 85% of Medicaid spending. Its purpose is to:

- Reduce duplication of services
- Provide smoother transition from inpatient and facility stays
- Facilitate more personalized and person-centered care
- Reduce the progression of chronic disease
- Reduce unnecessary and/or inappropriate emergency department utilization
- Reduce preventable hospital readmissions
- Improve overall health and self-management of conditions

The Washington State Health Care Authority (HCA) uses a predictive risk algorithm to identify which patients are most likely to require above-average health care spending. As potential participants are identified, their names are passed to one of several Health Home lead organizations – mostly large insurers and Managed Care Organizations (MCOs) – who subcontract with local Care Coordination Organizations. CCO staff make initial contact with potential clients and invite them to participate in the Health Home program. Most patients are not expecting the initial call, and convincing them to join can be very difficult. The percentage of potential clients who accept coordination services is the "engagement rate."

Almost 80,000 patients have enrolled in Washington's Health Home program, which represents an overall engagement rate of 12% [3]. Over half a million eligible individuals have not yet been enrolled, but Washington has been more successful than most states. The national average for Health Home program engagement is below 3% [4]. The Center for Medicare & Medicaid

Services (CMS) found that Washington's program reduced spending on dual-eligible enrollees by $26 million in its first eighteen months of activity. From these savings, CMS awarded $7 million back to the state [5].

The Health Home program at AAADSW

AAADSW provides the six core requirements of a Health Home program: care management, care coordination, support during care transitions, referral management, caregiver support, and health promotion. They create a client-driven Health Action Plan with person-centered goals, then perform assessments to identify and understand the client's barriers to health maintenance. They help clients learn about their options while gaining confidence and self-sufficiency, resulting in more active and engaged healthcare consumers. Their coordinators meet with clients in their homes and facilitate care via face-to-face contact. These services are provided at no cost to the client, never reducing their Medicaid and Medicare benefits.

By developing and refining innovative practices in care coordination, AAADSW has achieved an engagement rate of 30% – nearly three times greater than the state average, and ten times greater than the national average. Consumers who participate more fully in their healthcare tend to have better outcomes and reduced costs, and AAADSW's clients demonstrate a significant improvement in Patient Activation Measure (PAM) scores. In a random sample of patients who have been AAADSW clients for more than a year, we found that average PAM scores increased from 53 to 58. A study by the Washington State Aging & Disability Services Administration found that a similar increase in engagement[?] resulted in savings of more than $100 per member per month, while reducing mortality and improving health, self-sufficiency, and quality of life

[6]. Most AAADSW clients also demonstrate a significant reduction in predicted costs. To be eligible for the Health Home program, patients must have a PRISM score of at least 1.5, which means their future medical expenses are likely to be 50% higher than a similar reference group [7]. In a random sample of 72 AAADSW clients, we found that 30% now have PRISM scores below 1.5, and 18% have scores below 1.0, meaning that they are expected to require less healthcare spending than patients with similar conditions. These quantitative measures demonstrate the effectiveness of AAADSW's approach but do not tell the whole story. When asked for their opinions and observations, personnel at associated organizations universally praised the effectiveness of AAADSW's practices and extolled their positive effects on both clients and communities.

Best practices for care coordination

To achieve the greatest possible health benefit for their clients, AAADSW has continuously refined their practices to develop a unique and highly effective approach. The most important elements of their success include:

- **Face-to-face contact:** Care coordinators visit patients in their home environment and work directly with community resources, which greatly improves their understanding of the client's situation and their ability to orchestrate services. Many CCOs perform all coordination via telephone, which is much less effective.
- **Realistic case loads:** Each care coordinator has about 60 cases to manage. At organizations that rely on phone calls for all coordination, each case manager handles many hundreds of clients.

AAADSW: Best Practices For Care Coordination

- **Broad and diverse connectivity:** AAADSW works with local community resources to address the major issues of poverty and other social determinants of health. They partner with government and community organizations and broaden the care environment by involving a diverse array of professionals and resources.
- **Close ties to related organizations:** They work closely with Health Home lead organizations and community service organizations. They coordinate with hospitals to ease the transition from hospital to home. Referrals from other organizations are "warm hand-offs" that allow coordinators to increase the probability of further engagement and encourage the patient to participate in their own care.
- **Continuous refinement of practices:** All activities are extensively documented and scripted, which allows constant improvement based on feedback from staff, clients, and partner organizations.
- **Separation of financial interests:** AAADSW does not have financial stake in the patient's utilization of clinic and hospital services, so their advice is meant to better the patient's knowledge and engagement with health improvement opportunities, not to reduce costs under capitation or increase utilization under fee-for-service.
- **Staff training:** Staff are extensively trained to develop a unique, system-wide perspective. They learn to work with a much larger network of social services organizations than are used by other CCOs. They are taught to show respect for the client, minimizing the shame and negativity associated with the circumstances of poverty. Most coordinators have some secondary education, which helps them navigate systems that community-based "peer counselors" often find difficult to manipulate.

- **Task specialization:** Administrative staff perform functions that leave care coordinators free to concentrate on clients. Coordinators can specialize by working with existing associations like language groups and adult facilities, where they achieve higher engagement rates by seeing several clients at one location and gaining the trust of facility staff. "Cold call" specialists often have backgrounds in sales and service, which helps with the most difficult and tenuous stage of initial contact, when they offer an opportunity for active engagement and try to convince the patient to receive potentially life-saving services.
- **Staff retention:** Salaries are limited by government guidelines, but AAADSW provides an excellent benefits package. Staff get additional job satisfaction from seeing positive effects on the most vulnerable members of their community. Most coordinators remain with the agency for five to ten years.
- **Information technology:** Internal databases help manage, organize, and process referrals, maintaining due diligence while insuring that clients are not lost or forgotten.
- **Willingness to risk fund balance:** Many of their most innovative approaches, like support for transition from hospital to home, are not compensated. In general, outreach and startup costs are unfunded, so AAADSW must take risks to innovate, hoping that highly effective practices will eventually be recognized and included in the compensation system.

The passion, dedication, skill, experience, and excellence of AAADSW's staff is a critical element of their successful care coordination platform. *"If a client needs shoes, I go to the Goodwill and buy them a pair"* says senior coordinator Michelle Davis. Services manager Samantha Waldbauer says their success depends on their relationships. By pulling people together and coordinating diverse resources, they improve all aspects of their client's lives. *"We*

are government making society better" says David Kelly, AAADSW Executive Director, who used an innovative funding strategy to initiate their Care Coordination program.

The future of the Health Home program

Despite doing a stellar job of engaging clients and improving outcomes, AAADSW's Health Home program is not yet self-sustaining. Reimbursement rates are very low, and some services are not reimbursed at all. AAADSW has demonstrably reduced healthcare spending by many times more than the program costs, and this alone justifies additional funding. Washington's HCA has recently implemented a bonus program that plans to distribute shared savings from CMS directly to Health Home Lead organizations with above-average engagement rates, which as they are shared with successful CCOs such as AAADSW should help reduce operating deficits.

AAADSW is refining services to meet the needs of an expanding client base, keeping people healthy and in their homes, and improving the safety of older adults, while managing legislative uncertainty and frequent changes in funding [8]. Health Home programs are gaining momentum across the United States, saving the lives and safeguarding the health of millions of people. AAADSW's field-tested practices and procedures can help similar programs expand and succeed.

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Figure 1

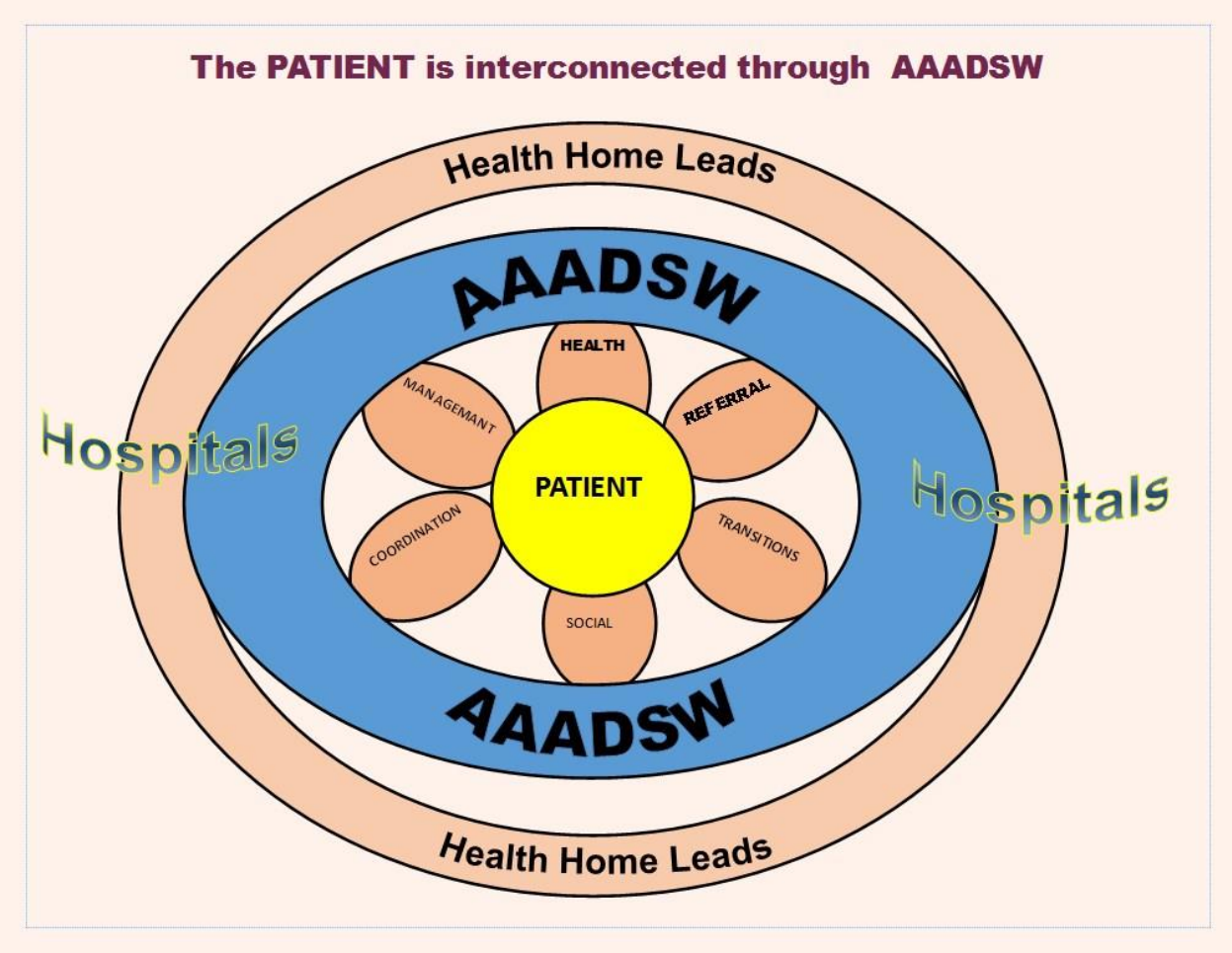
The PATIENT is interconnected through AAADSW
Health Home Leads
AAADSW
HEALTH
MANAGEMANT
REFERRAL
Hospitals
PATIENT
Hospitals
COORDINATION
TRANSITIONS
SOCIAL
AAADSW
Health Home Leads

Figure 2

State	Model Type	Target Population	HH Providers	Enrollment	Payment	Geographic Area
Washington **SPA approved (06/11/15)** **SPA effective (01/01/15)**	Chronic conditions	Individuals with one chronic condition and the risk of developing another: mental health condition, substance abuse disorder, asthma, diabetes, heart disease. Other chronic conditions include: cancer, cerebrovascular disease, chronic respiratory conditions, coronary artery disease, dementia or Alzheimer's disease, gastrointestinal, hematological conditions, HIV/AIDS, intellectual disability or disease, musculoskeletal conditions, neurological disease, and renal failure.	Clinical practices or clinical group practices, rural health clinics, CHCs, CMHCs, home health agencies, case management agencies, community BHAs, FQHCs, hospitals, managed care organizations, primary care case management, or SUD treatment providers	Opt-out enrollment	FFS rates built for three levels of payment using a clinical and non-clinical staffing model combined with monthly service intensity Encounters are submitted PMPM Incentive payment, PCCM managed care, and risk based managed care also included	Targeted to 37 counties, including: Phase I - Pierce, Clark, Cowlitz, Klickitat, Skamania, Wahkiakum, Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, and Yakima Phase II: Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, Thurston, Island, San Juan Skagit, Whatcom, Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, and Whitman.

(Washington State SPA at a glance, 2016)

APPENDIX

Medicaid Health Homes: An Overview

The Affordable Care Act (Sec. 2703) gives states an opportunity to improve care coordination and care management for Medicaid beneficiaries with complex needs through health homes. Health homes integrate physical and behavioral health (both mental health and substance abuse) and long-term services and supports for high-need, high-cost Medicaid populations. By better coordinating care and linking people to needed services, health homes are designed to improve health care quality and reduce costs

Not to be confused with patient-centered medical homes, health homes are specifically for Medicaid beneficiaries with chronic illnesses. In contrast to the physician-led primary care focus of the medical home, health homes offer person-centered, team based care coordination with a strong focus on behavioral health care and social supports and services. Some states are building health home models on a medical home framework by expanding links to providers and increasing the breadth of available support services.

To be eligible for health home services, an individual must be a Medicaid beneficiary diagnosed with the following according to state-defined criteria: (1) two chronic conditions; (2) one chronic condition and risk for a second; or (3) a serious mental illness. The statute creating health homes listed chronic conditions that include mental health conditions, substance use disorder, asthma, diabetes, heart disease, and overweight (body mass index over 25). States may propose other conditions to CMS for incorporation into their health home models.
Mandated Core Services The goal of the Medicaid health home state plan option is to promote access to and coordination of care. States have flexibility to define the core health home services, but they must provide all six core services, linked as appropriate and feasible by health information technology:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care and follow-up;
- Individual and family support;
- Referral to community and social services.

(CMS, Medicaid Health Homes: An Overview, 2016)