

Chronic Care Management Initiatives in Washington State

Sector	Strategy	Population Focus	Availability	Outcomes
<p>Private Sector Providers</p> <p>Washington Department of Health Chronic Care Collaboratives</p>	<p>Chronic Care Model for clinical practices</p> <p>Participating primary care practices utilize best practices and redesign their practice to focus on the delivery of evidence based, effective chronic care. People with diabetes, heart disease, and adult preventive services have been populations of focus to begin this work.</p> <p>Utilizing funding support from two federal grants and state tobacco funding, DOH provides training and technical assistance to clinics for improved chronic illness care:</p> <ul style="list-style-type: none"> • Better prepare practice team – clear roles • Support patient self-management – systematic support for self management • Redesign care delivery – planned care • Clinical information systems and registries remind, plan and management entire patient population 	<p>Patients with chronic diseases</p> <p>Total served to date: 70,000</p> <p>Total estimated in need: 307,000</p>	<p><u>140 clinical practices in:</u></p> <p>Klickitat Lewis Benton Mason Chelan Okanogan Clallam Pacific Clark Pierce Columbia Skagit Garfield Snohomish Grant Spokane Grays Harbor Stevens Island Thurston King Walla Kitsap Walla Kittitas Whatcom Yakima 5 Tribes</p>	<p>Measurable improvements in:</p> <ul style="list-style-type: none"> • Blood sugar • Blood pressure • Cholesterol • Patient goal setting • Tobacco cessation counseling <p>Directed by SB 5930 to conduct evaluation including cost benefit analysis</p>
<p>Public Sector Long Term Care Management</p> <p>Dept of Social and Health Services Aging & Disability Services Administration (ADSA)</p>	<p>Intensive Chronic Case Management</p> <p>Pilot project involving integration of medical and long term care services through care management, coordination of care among medical home, family and LTC providers, improved self management & use of evidence based practices that improve health outcomes and reduce hospitalization and the need higher levels of medical care</p>	<p>Medicaid-only clients receiving in-home long term care who are in the top 20% of risk for high future medical costs. Project currently piloted in five Area Agencies on Aging</p> <p>45 people in each pilot AAA</p> <p>Total served in pilot: 225</p> <p>Total statewide estimated eligible: 4,100</p>	<p>5 Pilot Regions</p> <p>Olympia Peninsula AAA Northwest Regional Council Pierce County Aging & LTC SE WA Aging & LTC Aging & LTC of E WA</p>	<p>Evaluate efficiency and effectiveness as directed under SB 5930</p>

Sector	Strategy	Population Focus	Availability	Outcomes
<p>Public Sector Medical Assistance</p> <p>Dept of Social and Health Services Health & Recovery Services Administration (HRSA)</p>	<p>Chronic Care Management</p> <p>Provide care management, education and self management training for medical assistance clients determined to be in the top 20% of risk for high medical costs</p> <p>In King County, piloting a “Medical home” model, a site of care that provides comprehensive preventive and coordinated care centered on the patient needs.</p>	<p>Medicaid-only clients who are not in long-term care with high-risk and expensive chronic conditions</p> <p>Total served: Under Care Management, 1,500 in statewide contract with Americhoice; 150 in King County pilot with Seattle Aging and Disability Services. Seattle serves a total of 7,000 in medical home through provider support.</p> <p>Total eligible: 5,000</p>	<p>High risk clients statewide</p>	<p>Evaluate efficiency and effectiveness as directed under 5930</p>
<p>Public Sector Health Insurance</p> <p>Health Care Authority</p>	<p>Chronic Care Management</p> <p>Implemented disease and care management strategies for Uniform Medical Plan enrollees, including healthy lifestyle incentives, asthma disease management. New strategies include care management procurement and polypharmacy program.</p> <p>Added new language for contracted health plans to identify top five diseases or chronic conditions of enrollees and target appropriate disease or care management programs.</p> <p>Requires Basic Health Plan contractors to conduct three quality improvement projects which may include a disease management program.</p>	<p>Public Employees and their families</p> <p>Basic Health Plan enrollees</p>	<p>State enrollees (Preferred Provider & Managed Care Organizations)</p> <p>Basic Health Plan enrollees</p>	<p>To be determined based on RFP results, contracted outcomes</p>

Sector	Strategy	Population Focus	Availability	Outcomes
<p>Publicly Funded Care Coordination</p> <p>DSHS/HRSA and ADSA</p>	<p>Washington Medicaid Integration Partnership (WMIP) and Medicare-Medicaid Integration Project (MMIP)</p> <p><u>WMIP</u>: A voluntary program for adults which operates in one county through Molina Healthcare of Washington. It supports the medical home by integrating four major service areas (medical, long term care, chemical dependency treatment, and mental health) and providing a care coordination team to augment primary care delivery. This program is in Snohomish County only.</p> <p><u>MMIP</u>: A voluntary program for dual-eligible adults which operates in two counties through Evercare. It offers integration of medical and long term care, and also provides care coordination. This program is in King and Pierce Counties.</p>	<p>WMIP: 21 and older, Medicaid and Medicaid-Medicare clients on SSI or SSI-related coverage</p> <p>About 6,000 eligible (target increased to 13,000 by legislature); 2,700 enrolled</p> <p>MMIP: 65 and older, Medicaid-Medicare clients on SSI or SSI-related coverage.</p> <p>Thousands of eligible clients; about 150 enrolled.</p>	<p>WMIP: Snohomish County</p> <p>MMIP: King and Pierce Counties</p>	<p>WMIP: early indicators of effectiveness at managing hospitalization and ER use; relatively greater disenrollment seen in clients with high medical utilization or long term care use.</p> <p>MMIP: too small to measure outcomes at this point</p>
<p>Community Based Programs – Falls and Fitness</p> <p>Senior Falls Prevention Programs Senior Fitness Programs Various community-based fall prevention coalitions</p>	<p>Communities can increase availability and access to strength and balance exercise programs to reduce fall risk. Best practices include Risk factor assessment and management, including medication review, vision exam, assessment of balance and gait, home safety evaluations and regular strength and balance exercise. Other strategies include:</p> <ul style="list-style-type: none"> Establish referral networks from hospitals to providers and community services for seniors discharged after a fall. Increase provider and inter-agency referrals to community services. <p>Two successful examples: Stay Active & Independent for Life (SAIL) fall risk reduction exercise and education program developed by DOH, Pierce County Falls Prevention Coalition, and the NorthWest Orthopedic Institute.</p> <p>Enhance Fitness is a highly adaptable exercise program offering levels that are challenging enough for active older adults and levels that are safe enough for the unfit or near frail.</p>	<p>Older Adults</p> <p>All adults age 65+ for prevention</p>	<p>SAIL Exercise & Education: 9 sites in Pierce & King Counties, with Wenatchee & Okanogan in fall 2007</p> <p>Enhance Fitness: 69 sites in Franklin King Kitsap Pierce Skagit Snohomish Spokane Thurston Whatcom</p> <p>10 community coalitions</p>	<p>SAIL & Enhance Fitness: measurable reduction in fall risk factors</p> <ul style="list-style-type: none"> Improved strength Improved balance Improved mobility <p>Enhance Fitness is also proven to:</p> <ul style="list-style-type: none"> Improved mood

Sector	Strategy	Population Focus	Availability	Outcomes

Sector	Strategy	Population Focus		Outcomes
<p>Community Based Programs – Chronic Disease Self Management Program</p> <p>DOH Master Trainer Initiative Group Health Cooperative</p>	<p>The Chronic Disease Self-Management Program is a workshop given two and a half hours, once a week, for six weeks, in community settings such as clinics and senior centers. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves.</p> <p>Subjects covered include:</p> <ol style="list-style-type: none"> 1) Techniques to deal with problems such as frustration, fatigue, pain and isolation 2) Appropriate exercise for maintaining and improving strength, flexibility, and endurance 3) Appropriate use of medications 4) Communicating effectively with family, friends, and health professionals 5) Nutrition 6) How to evaluate new treatments 	<p>People with chronic health problems</p>	<p>DOH Master Trainer Initiative has trained 65 master trainers (English and Spanish)</p> <p>15 active sites</p> <p>Also available throughout the Group Health Cooperative System</p>	<p>Cost to savings ratio: Approximately 1:10</p> <p>Significant improvements in:</p> <ul style="list-style-type: none"> • exercise • cognitive symptom management • communication with physicians • self-reported general health • health distress • fatigue • disability <p>Reduction in:</p> <ul style="list-style-type: none"> • days in the hospital • outpatient visits