



Health System Transformation & the Long-Term Care System

Partnering for Success and Savings

February 2012



Health System Transformation and the Long-Term Care System

Meeting the ambitious goals of health system transformation in Oregon is a significant undertaking. Never before have the many providers within the acute health care system had a reason to collaborate and work cooperatively as they do now.

Coordinated Care Organization Implementation Proposal *Principles & Values from an Area Agency on Aging & Disabilities Perspective*

As we look at how long term care will interface with the CCOs, OAAAD has started with the development of the principles and values that we feel are most important in this partnership.

Person Centered: In order to meet the triple aim goals, it is critical to keep the total person and their needs at the center of any type of care plan. We have to meet them where they are – that is our starting point. The individual has to be involved and has to have choice within their options for care. They are the drivers of the plan.

While the individual client is the driver of the plan, it is the responsibility of the CCO and of the long-term care system to help educate the client in their respective areas. When we talk about choice, many think this means simply presenting all options for care. However this also means presenting a realistic look at the consequences of each option. **Personal responsibility** is necessary from the client and it is the goal of health system transformation to promote better health through prevention and early intervention. Empowering an individual to educate him or herself, to invest in the outcome of their own health care plans is good for the person but also good for providers. A client engaged in their care and health is more likely to weigh carefully the possibilities for care and have a better idea of how activities and choices outside of medical care will impact their health.

Education, support and incentives are methods to incorporate personal responsibility into the equation.

Supports that are person centered will impact the success of CCOs and long-term care partnerships. These supports include:

- Medical
- Social
- Housing
- Community
- Behavioral health
- Dental
- Family or other natural supports.

Intersection of the social and medical models: Recognizing that the overarching principles of medical care and long-term care are very different will help with the formulation of care plans for dual and triple eligibles. The medical model functions to meet a goal of stopping an illness. It is about care when a person is sick and the best outcome is a return to health. The medical model works with tests and quantitative data in large part. It is, in general, episodic care.

Long-term care is based on a social model. It operates to work with a person's functional ability. Long-term care assumes the client has a chronic care issue. In long-term care, a removal of the illness or sickness is not the outcome as that is not possible. As an individual ages, their physical self adjusts to increasing limitations. One does not reverse those limitations that come with aging. Those with physical disabilities will likely not have a reversal of their disability; rather they will adapt to the disability and develop other ways to attain any lost functionality, as much as possible. This is a very important difference in medical care versus long-term care. Success or meeting goals cannot be measured in long term care by a return to health. Instead, long-term care is dealing with finding the best ways to age with health, with management of chronic conditions and with the highest level of quality of life. The end goals are significantly different.



In the social model of care that long-term care operates under, the total person is at the center of care. Their ongoing needs are the consideration in order to help them manage their conditions in the *long term*. Housing, transportation, income, access to healthy food, family and others relationship, employment all define a quality of life for the individual.

Flexible: In order to meet the goals of long-term care, operating under the social model, flexibility is key. Flexibility is not only key to allowing greater choice for the individual client, but it is also key to lowering costs of care overall. The flexible use of funds that can be used for the person centered care plan will impact the overall health outcomes for the individual. Entitlement programs are in general very rigid in their requirements for use. However, this rigidity does not allow room for modification or innovation in care. If there is a better way to provide care for the individual but it falls outside of what can be offered via the Medicaid system, even if its at a lower overall cost, there is no choice but to go with the higher priced option. The individual client does not have the funds to pursue an alternative option outside of what Medicaid will provide thus it is a vicious cycle – you can see the care you could have but you can't access it so you will spend more Medicaid dollars overall. This approach does not make sense.

Flexibility is often viewed with skepticism. A call for flexibility is often considered a call to be able to spend more dollars for administration or other types of non-program costs. However, the principles of the CCO design require flexibility in order to meet the needs of the client and to coordinate care across systems. Long-term care would benefit from flexibility in order to better meet needs more efficiently.

The ability to try new things in long-term care is dependent on the flexibility. As has been suggested with CCOs, development of standards rather than detail can provide the ability of local regions and health systems to meet needs and think 'outside of the box' as they work to provide:

- Emphasis on primary prevention
- Person centered approach
- Building a seamless continuum of care
- Building community capacity
- Emphasis on disproportionate unmet, health--related needs.

These principles apply to the needs of the long-term care system. A similar approach that is driven by goals rather than by detail could provide far greater benefits to the client, to the long-term care system and to the overall strategy of care for dual and triple eligibles.

Build on successes: When creating the system of CCOs, there is a key opportunity through coordination with the long-term care system to build on things that are already working. Long-term care in Oregon has been known as an innovative system that focuses on care in the home and the community that realizes greater savings than automatically placing a client in a more restricted level of care such as a nursing facility. Long-term care has continually brought savings to the state – to demonstrate this, simply multiply even a small percentage of the Medicaid long-term care Medicaid case load that is currently receiving care in their home by the cost of nursing facility care and you will quickly see the savings that are realized daily.

The long-term care system, however, has suffered from continual cutting to the very foundation that brings these savings to the state. As Oregon begins this investment in acute healthcare, it is important to not take the savings from long-term care for granted and continue to lose ground through constant cuts to programs, services and necessary administration. Rather, as is being requested by OHA to CMS, the opportunity to reinvest savings from long-term care back into long-term care should be considered as this system is being asked to not only coordinate with CCOs, but to also continue to realize budget savings and to increase those savings through this new level of coordination.



HB 5030 Budget Note to the Legislature – Department of Human Services

Recommendation for the Triple Eligibles

Alignment and Coordination: While the budget note report suggests that, “two separate systems will continue to produce misaligned incentives, cost-shifting between CCOs and the LTC system and poor outcomes for beneficiaries.” Experience at the Transfer Area Agency level, serving over 50% of the Medicaid long-term care caseload, shows that alignment and coordination are not only possible but also very productive.

Staff from each system, CCO and LTC can work together in concert for the benefit of the client in the following ways, which have been tested or demonstrated in Transfer Area Agency service areas:

- Location of a long-term care staff person in a medical/health home setting
- Long-term care staff working as a member of the overall health care (acute, mental health, etc) team to address issues in a coordinated way
- Access to data and client documentation by long-term care staff and by CCO staff – in order to truly understand the facets of care that are being provided and the gaps that are not being met
- CCO staff co-located with long-term care staff
- Non-service clients. Those individuals who are seeking care but do not qualify for entitlement services will still need staff to help them with their concerns. In order to bend the curve of health and long-term care costs, those individuals who are at most risk of premature or unnecessary entrance into the Oregon Health Plan or the Medicaid long-term care system need help to meet emerging needs. Programs such as Oregon Project Independence and Aging & Disability Resource Centers provide a blueprint for cost efficient and effective interventions to address those needs.

Mutual Accountability: The need for mutual accountability is an opportunity to not only avoid inappropriate cost shifting but to establish the necessary communication to devise a new system of integrated care. Integrated service plans and interdisciplinary teams can provide not only client information but also shared support in the goal of better client health and care.

Mutual accountability is also mutual support. Mutual support and coordination will help alleviate the concerns around cost shifting due to communication.

Suggested areas for mutual accountability and support from the experiences of Transfer Area Agencies include:

- Education and training
- Health promotion activities
- Vetting of communication issues – and devising solutions
- Supporting long-term care providers in new ways – from both CCOs and LTC
- Vetting of long-term care provider and placement issues, level of medical need and risk of failure in living situations by the interdisciplinary team – comprised of CCO and LTC staff
- Care planning that takes into account costs – and the efficient use of funds
- Support provided for long-term care providers or clients of a CCO
 - Telephone support line
 - Check list for ALF (Assisted Living Facility) triage
 - On-call Registered Nurse
 - Home visits from medical professional

In order to avoid cost shifting, there is also a need for more behavioral support for providers. The rise of mental health and behavioral issues in clients utilizing Medicaid, in long-term care or acute care, has a dramatic effect on the success of any care plan.

Taking treatment into the community is another strategy to avoid cost shifting. With methodology in place to provide payment to the provider for the visit, treatment in the community avoids unnecessary transport to an emergency room, hospital or urgent care office when perhaps a significantly lower level of intervention is necessary.



Specific Areas of Transfer Area Agency Expertise

Care Transitions: Currently, there are care transition pilots in place through various Transfer Area Agencies. To maximize on that experience, agreements need to be in place between CCOs and Area Agencies to address the provision of care transitions. The Transfer Area Agencies have the expertise in pilots, training and grants that have all been a part of implementing care transitions. We are very aware of the cost issues and failures that can be a potential challenge to the overall success.

Recommendations for seniors and people with disabilities to retain their independence for as long as possible to delay or prevent their entrance into the Medicaid system.

The budget note report endorses the importance of the Aging & Disability Resource Centers (ADRCs) as a vital part of health reform success. However, it is important to remember that the current fully functioning ADRCs are funded through pilot project federal grants that are coming to a conclusion. The ADRC model is considered a best practice nationwide for bending the curve of people entering Medicaid funded care. In order for the successes of the ADRCs that are existing in Oregon to continue, funding will need to come from the Health System Transformation initiative. Unlike other states, Oregon currently does not invest any funds in the ADRCs.

There is the possibility of expanding the use of state general fund for Medicaid match to fund ADRC programs. This will only be possible through the continuation of ADRCs in the state.