Building a Business Case for Chronic Disease Self-Management Programs
November 2, 2010

HCBS Waiver for Self Management Programs
Chronic Care Management and CDSMP
Washington DSHS
Aging and Disability Services Administration

- What is the Stanford University Chronic Disease Self-Management Program?
  - "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 senior centers, churches, libraries and hospitals. 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 a chronic diseases themselves."

http://patienteducation.stanford.edu/programs/cdsmp.html

What is Self-Management Support ?

Patient Education

1. Information and skills are taught
2. Usually disease-specific
3. Assumes that knowledge creates behavior change
4. Goal is compliance
5. Health care professionals are the teachers

Self Management Support

1. Skills to solve pt. identified problems are taught
2. Skills are applied across conditions/needs
3. Assumes that confidence yields better outcomes
4. Goal is increased self-efficacy
5. Teachers can be professionals or peers

What does CDSMP Look Like?

- Small group setting (10-15 people)
- Led by two trained leaders, at least one of whom is a peer with a chronic condition
- Standardized training for leaders
- Highly structured teaching protocol
- Standardized participant materials and companion book
- 2 ½ hours per week; 6 weeks
- Multiple chronic diseases and symptoms in the same group
- Focus on self-efficacy, action planning, problem solving, and communication

The Evidence Base

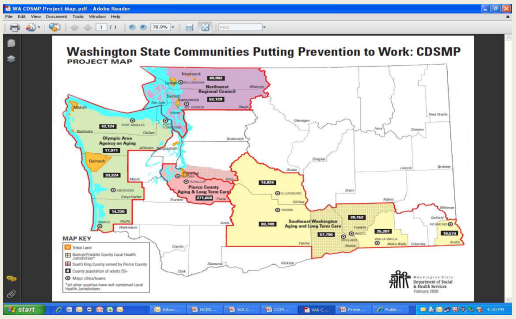
- Research indicates participants spend
  - Fewer days in the hospital
  - Fewer outpatient and ER visits
- Participants report
  - Improvement in self-reported health and health distress
  - Improvement in social life/activities
  - Improved energy/less fatigue
- Demonstrated cost-savings
- http://patienteducation.stanford.edu/bibliog.html

Where do I get more information about CDSMP?

- Stanford University
  - http://patienteducation.stanford.edu/programs/cdsmp.html
- Oregon Living Well
  - http://www.oregon.gov/DHS/ph/livingwell/index.shtml
- Living Well with Chronic Conditions in WA State
  - http://livingwell.doh.wa.gov

WA State ARRA CDSMP Grant Partners and Their Roles

- **State level**:
  - Aging and Disability Services Administration, State Unit on Aging (DSHS);
  - Washington State Department of Health, Diabetes Prevention and Control Program (DOH)
- Role: Lead and coordinate the ARRA CDSMP Grant, monitoring contracts, Master Trainer training, sustainability planning, policy discussions and planning.
- **Community Level**:
  - Four Area on Aging; Olympic Area Agency on Aging, SE WA Aging and Long Term Care, Pierce County ALTC, and Northwest Regional Council
  - Role: partnerships and dissemination, recruitment/advertising, sustainability planning, data gathering, Lay Leader training.



WA CDSMP Project Map

- Four Area Agencies on Aging
- 25 Host Organizations (including 8 tribes, Asian, African American, Hispanic communities)
- 39 Host Sites

Home and Community Based Service Waivers

- Aged, Blind and Disabled (ABD) HCBS Waivers
  - The WA State ABD waiver is titled Community Options Program Entry System (COPES).
  - COPES allows clients to choose to receive home and community based services instead of nursing facility care. Once a client is determined functionally and financially eligible for the waiver program, the client chooses where to receive services; at home, in a residential setting, or a nursing facility. Waiver services include personal care services and the categorically needy medical program.

WA State COPES Waiver Services Criteria

- In addition to personal care services, clients can receive *other* waiver services if they meet the secondary eligibility criteria for these waiver services.
- Federal rule requires that waiver services not replace other services clients have access to under Medicaid, Medicare, health insurance, LTC insurance, other community or informal resources available to them.
- Waiver services may not be used when the vendor refuses the reimbursement or considers the payment inadequate from these other resources.
- Waiver services may not supplement the reimbursement rate from other resources.

COPES Waiver Services Provider Qualifications

- Providers of these other waiver services must meet certain qualifications and be contracted through the local Area Agency on Aging (AAA) prior to services being authorized for a client.
- The local AAA maintains lists of contracted providers for Home and Community Services (HCS) (residential clients) and AAA (in-home clients).
- Either HCS or AAA workers authorize services using contracted providers from this list.
- Other waiver services can be authorized independently from personal care services, if that other waiver service meets the unmet need for personal care that made the client functionally eligible for the waiver program.
- **NOTE:** All of these waiver services must be indicated in a client's service plan prior to authorization and related to a therapeutic goal in the service plan.

What are the "other" waiver services?

- Personal Emergency Response System
- Home delivered meals
- Skilled Nursing
- Transportation
- Nurse delegation (in-home)
- Home health aide
- Environmental modifications
- Specialized medical equipment
- Adult Day Care
- **Client training** (includes RN, PT,OT,ST, behavior supports, pain management, exercise and **self-management programs)**

Client Training Service Definition

- Client training needs are identified in the long term care assessment or in a professional evaluation.
- This service is provided in accordance with a therapeutic goal in the plan of care and includes for example;
  - Adjustment to serious impairment
  - Maintenance or restoration of physical functioning
  - Self-management of chronic disease
  - Acquisition of skills to address minor depression
  - Management of personal care
  - Development of skills to work with care providers including behavior management.

Client Training and CDSMP Waiver Authorization

- CDMSP consists of 6 units, one unit per week, for 6 consecutive weeks.
  - The unit rate includes the cost of the 2.5 hour class, leader time and all workshop costs and materials.
  - Providers (individual or agency) must be contracted through the AAA as certified trainers for CDSMP.
  - The service is provided in accordance with a therapeutic goal in the plan of care.
  - The service is provided in a manner consistent with protecting and promoting the client's health and welfare, and appropriate to the client's physical and psychosocial needs.
  - The service is provided within the scope of practice of the contractors license and in compliance with professional rules

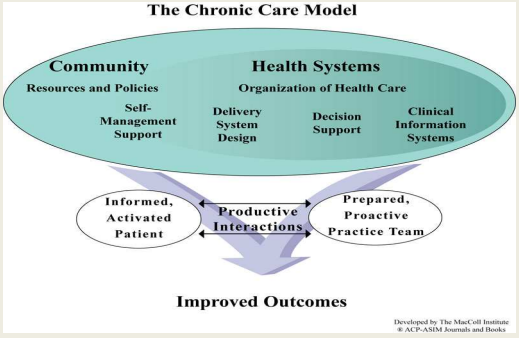
Making the Connection with Chronic Care Management

Washington State Medicaid Impact

- Five percent of WA Medicaid clients account for 50 percent of the costs.
- They are consumers of LTC
- Are diagnosed with depression and chronic pain.
- Current health care system is focused on acute care and misses working with clients with chronic conditions from developing complications.
- (Governor Gregoire Memo (01/06))

How did we frame the ADSA Model of Chronic Care Management?

The Chronic Care Model



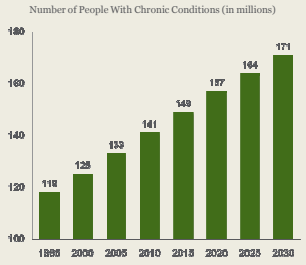
The Take Home Message for CCM

- "People with chronic conditions are getting services, but those services are not necessarily in sync with one another, and they are not always the services needed to maintain health and functioning."
  (Partnership for Solution 2004)
- Can HCBS make a difference in this synchronization of services with Chronic Care Management, improve health and reduce costs?

Section 1 – Demographics and Prevalence

The Number of People With Chronic Conditions Is Rapidly Increasing

- In 2000, 125 million Americans had one or more chronic conditions.
- This number is projected to increase by more than one percent each year through 2030.
- Between 2000 and 2030 the number of Americans with chronic conditions will increase by 37 percent, an increase of 46 million people.



Source: Wu, Shin-Yi and Green, Anthony. *Projection of Chronic Illness Prevalence and Cost Inflation*. RAND Corporation, October 2000.

CCM Risk Determinants

- High medical cost and risk client determinants
  – Predictive modeling risk score in Top 20%
- Comprehensive Assessment Resource Evaluation (CARE) LTC risk criteria (presence of one)
  1. Client lives alone
  2. High risk moods/behaviors (agitation/irritable)
  3. Self health rating is fair or poor
  4. Overall self-sufficiency declined in last 90 days
  5. Greater than six medications

CCM Tailored Client Coaching Approach

- The client:
  – Is in charge of the care plan;
  – Sets the pace for change based on perception of need and readiness for change.
- The nurse's role:
  – Encourage client confidence - that their actions can make an impact on their health and independence
  – Discuss and offer options and education that allow the client to increase their ability to manage their own care to improve quality of life and/or health outcomes using evidence based programs when available
  – Ask the client what ideas they have to better manage their health care.

CCM Evaluation Findings

- Copies of the key findings(October 2009) may be obtained at www.dshs.wa.gov/rda/
- CCM Full Report
  http://www.adsa.dshs.wa.gov/professional/hcs.htm

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