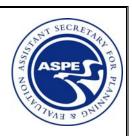U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

COORDINATING CARE IN THE FEE-FOR-SERVICE SYSTEM FOR MEDICAID BENEFICIARIES WITH CHRONIC CONDITIONS

May 2005

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This report was prepared under contract #HHS-100-03-0025 between HHS's ASPE/DALTCP and the Research Triangle Institute. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, Hunter McKay, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. His e-mail address is: Hunter.McKay@hhs.gov.

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EXECUTIVE SUMMARY

This report describes a range of approaches state Medicaid agencies use to coordinate health services and to coordinate long-term care services with health services for beneficiaries with chronic conditions. It then describes in detail two innovative programs.

Currently, 11 million people with chronic conditions rely on Medicaid for health and long-term care services and utilize a wide range of services from multiple providers in the health and long-term care delivery systems. A lack of service coordination can result in inefficient and unnecessarily costly care. This problem can be compounded when those needing services are dually eligible for Medicaid and Medicare, due to the different financing and reimbursement systems for these programs.

The number of individuals with chronic conditions is estimated to increase from 125 million in 2000 to 157 million by 2020. The projected increase in the number of Medicaid beneficiaries with multiple chronic conditions and complex medical needs has enormous implications for federal and state budgets, as states already devote more than three-quarters of their Medicaid budgets to this population.

In an effort to meet the growing demand for services--and to ensure their quality and improve outcomes while containing costs--states are implementing a range of service coordination approaches and are interested in finding the most effective models. Because the development and implementation of risk-based managed care programs is time consuming and costly, many states are attempting to coordinate services in the traditional fee-for-service setting. Several states have developed fee-for-service approaches to coordinate health care--and in some states both health care and long-term care--for persons with chronic conditions.

We selected two care coordination approaches to highlight in this report. Although many states support care coordination within the Medicaid fee-for-service health system, Georgia's SOURCE program was the only established program we identified that operates in the fee-for-service system, coordinates health and long-term care, and includes dually eligible beneficiaries. This report describes the SOURCE program in depth. We also describe the Indiana Chronic Disease Management Program, an innovative approach to coordinating health care for selected chronic conditions, which serves dually eligible beneficiaries.

Since most dually eligible beneficiaries receive Medicaid in a fee-for-service setting, these programs have the potential to serve a larger number of beneficiaries than risk-based managed care programs. Both programs have two important features that merit attention by other states: (1) they successfully involve primary care physicians in care coordination, and (2) they focus on outcomes.

Both programs have yet to be rigorously evaluated. However, preliminary results suggest that they can be successful in both improving outcomes and containing costs.

BACKGROUND

A chronic condition is one that is likely to last more than a year, limits a person's activities, and may require ongoing health care and long-term care.[1] The number of people with one or more chronic conditions is expected to increase between 2000 and 2020 by nearly 26 percent to 157 million, and the number of people with multiple chronic conditions is likely to rise 35 percent to 81 million.

States devote significant resources--more than three-quarters of their Medicaid spending--to provide health and long-term care services for people with chronic conditions.[2] These costs are driven in large part by two factors: utilization and lack of coordination in service delivery. Persons with chronic conditions utilize hospital care, physician services, prescription drugs, and home health visits at higher rates than those without such conditions. In addition, people with chronic conditions make extensive use of prescription drugs and services from medical specialists. Finally, many require ongoing long-term care services to address functional needs.[3]

The provision of a wide range of uncoordinated services from multiple providers in uncoordinated health and long-term care delivery systems is inefficient and costly. The problems can be compounded when those needing services are dually eligible for Medicaid and Medicare--the population more likely than others to have multiple chronic conditions--due to the different financing and reimbursement systems for these programs.

The projected increase in the number of Medicaid beneficiaries with chronic conditions has enormous implications for federal and state budgets. In an effort to meet the growing demand for services--and to both ensure their quality and contain their costs--states are implementing a range of service coordination approaches and are interested in finding the most effective models.

Risk-based managed care is a service approach with the potential to better coordinate care for Medicaid beneficiaries with chronic conditions.[4] Several states-- Arizona, Florida, New York, Texas and Utah--operate risk-based managed care programs that integrate the financing and management of Medicaid health and long-term care services. These programs generally serve a large number of beneficiaries. Texas serves about 60,000 people and Arizona serves all Medicaid beneficiaries in the state.

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[1] Partnership for Solutions. *Making the Case for Ongoing Chronic Care--Chartbook* (Baltimore, MD: Johns Hopkins University, 2002).

[2] Ibid.

[3] Ibid.

[4] 'Risk-based' means the provider receives a set (capitated) payment for each enrollee and must provide all contracted services. Depending on the program, providers have varying degrees of financial risk that the funds they receive will not be sufficient to provide all needed services.

Massachusetts, Minnesota, and Wisconsin also operate risk-based managed care programs that integrate Medicaid and Medicare financing and management of health and long-term care services. Programs for the All Inclusive Care for the Elderly (PACE), which also integrate financing and management of Medicare and Medicaid health and long-term care services, operate in many other states as well. However, to date, integrated programs like these have been complex to design and enrollment has been relatively modest. For example, only 8,800 people were enrolled in PACE programs nationwide in 2003.[5]

Table 1 lists several of these capitated Medicaid health and long-term care managed care programs and the populations they serve, differentiated by the type of Medicare financing they use.

Because the development and implementation of risk-based managed care programs is time consuming and costly, many states are attempting to coordinate services in the traditional fee-for-service setting. Several states have developed fee-for-service approaches to coordinate health care--and in some states both health care and long-term care--for persons with chronic conditions. The purpose of this study is to examine the literature to identify types of care coordination approaches, and to identify and describe innovative state approaches that other states might be interested in replicating.

TABLE 1: Examples of Medicaid Managed Care Programs that Integrate Financing for Health and Long-Term Care Services			
State	Program	Medicaid Population Served	Medicare Financing
AZ	Arizona Long-Term Care System	Nursing facility eligible older adults and adults with disabilities	Fee-for-service
FL	Long-Term Care Community Diversion Program	Nursing facility eligible older adults	Fee-for-service
NY	VNS Choice	Nursing facility eligible older adults	Fee-for-service
TX	StarPlus	Older adults and adults with disabilities	Fee-for-service
UT	Long-Term Care Managed Care Initiative	Nursing facility residents 18 and older	Fee-for-service
MA	Senior Care Option	All older adults	Integrated
MN	Minnesota Senior Health Options Program	All older adults	Integrated
WI	Wisconsin Partnership Program	Nursing facility eligible older adults and adults with disabilities	Integrated
Multiple	PACE	Nursing facility eligible older adults (55+)	Integrated

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[5] Care coordination for Medicaid beneficiaries enrolled in Medicare managed care plans may create administrative complications for states interested in coordinating care for dually eligible individuals. (See Walsh and Clark, 2002.)

METHODS

To identify innovative fee-for-service approaches to coordinating health and long-term care services for Medicaid beneficiaries, we reviewed the literature on care coordination. The publications we reviewed are listed in Appendix A.

The literature review and interview with experts revealed that while many states support care coordination within the Medicaid fee-for-service health system, only one state coordinates both health and long-term care services. Georgia's Service Options Using Resources in a Community Environment (SOURCE) program was the only established program we identified that operates in the fee-for-service system, coordinates health care and long-term care, and serves dually eligible beneficiaries.[6]

To develop the Georgia SOURCE case study, we consulted with Georgia Medicaid officials to develop a list of key informants representing local program sites, providers, and other stakeholders. During a two-day site visit to Georgia, the authors interviewed--individually and in groups--state policy staff, SOURCE program staff, Community Care Services Program (CCSP) staff (a waiver program), physicians, registered nurses, social workers, and Area Agency on Aging (AAA) administrators. Follow-up interviews were conducted by telephone.

The Indiana Chronic Disease Management Program (ICDMP) also operates in the fee-for-service system and includes dually eligibly beneficiaries. The program coordinates health care services for selected chronic conditions, but not--at present--long-term care services. However, program administrators indicate that the program design allows for the coordination of long-term care services in the future. We selected this program for a case study because it provides a model for improving health care coordination for states that are not able to implement more extensive health and long-term care coordination programs.

To develop the Indiana case study, we consulted with Indiana Medicaid officials to develop a list of key informants representing local program sites, providers, and other stakeholders. During a two-day site visit to Indiana, the authors interviewed--individually and in groups--state policy staff, ICDPM program staff, legislators, waiver program staff, physicians, registered nurses, social workers, and staff from the Regenstrief Institute. Follow-up interviews were conducted by telephone. A list of informants for both case studies is included in the acknowledgments section of this report.

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[6] One other state, Massachusetts, had a pilot program for 50 beneficiaries that met all three of these criteria. However, when NASHP began work on this project, the program had just begun and did not have enough operating experience to report.

OVERVIEW OF FEE-FOR-SERVICE CARE COORDINATION PROGRAMS

States have instituted a range of fee-for-service initiatives to coordinate care for Medicaid beneficiaries with chronic conditions. Based on our review of these initiatives, we identified four primary types of programs:

- Prescription drug monitoring programs,
- Disease management vendor programs,
- Health care coordination programs,
- Health and long-term care coordination programs.

Characteristics of these programs are summarized in Table 2. Although the programs differ substantially, each shares a common goal: to improve or maintain the health of Medicaid beneficiaries with chronic conditions and to control Medicaid expenditures.

With the exception of disease management vendor programs, the programs seek to involve primary care physicians and/or pharmacists in substantive ways. Because lack of physician involvement has been cited as one reason for the failure of many case management/disease management programs to achieve successful results, a number of programs compensate medical providers for their time.[7] Each of the programs supplement the physician's role in monitoring a beneficiary's medical status using different approaches.

Prescription Drug Monitoring Programs

Several types of prescription drug monitoring programs are found in Medicaid programs. These programs are designed to reduce inappropriate prescription drug use through a wide range of interventions, from physician education to analysis of Medicaid claims data. Some of these programs include dually eligible beneficiaries because Medicaid pays a significant portion of the prescription drug costs for this population.[8] At least three states--Maine, Virginia, and Mississippi--have developed prescription drug monitoring programs.

A Mississippi program reimburses pharmacists for patient counseling and monitoring if the physician refers the patient for this service. Virginia implemented its program by training Medicaid physicians in asthma care and paying pharmacists for

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[7] A. Chen et al., *Best Practices in Coordinated Care* (Princeton, NJ: Mathematica Policy Research, Inc., 2000).

[8] The new Medicare drug benefit created under the Medicare Modernization Act is likely to reduce incentives for states to include the dually eligible in prescription drug monitoring programs. While the states will retain some financial responsibility for prescription drug costs for the dually eligible, they may not have access to the prescription drug utilization data necessary to monitor use.

beneficiary consultation services if the physician refers the patient. Virginia subsequently replaced this program with a disease management vendor program.

Maine implemented a pilot program called *MaineNet* to educate physicians about appropriate prescribing practices for dually eligible beneficiaries with certain priority conditions or characteristics, including: diabetes, congestive heart failure (CHF), cardiovascular disease, or receipt of home and community long-term care services. Fifty primary care providers serving 1,100 beneficiaries with priority conditions--5 percent of the beneficiaries with priority conditions statewide--participated in the project.

TABLE 2: Typology of State Medicaid Fee-For-Service Chronic Illness Care Coordination Programs				
Program Characteristics	Prescription Drug Monitoring Programs	Disease Management Vendor Programs	Health Care Coordination Programs	Health and Long-Term Care Coordination Programs
Scope	Manages polypharmacy	Manages specific conditions	Manages medical care	Manages medical and long-term care
Structure	State involvement in program operation and development	State contracts with vendor for program development and operation	State involvement in program operation and development	State involvement in program operation and development
Dual eligibles	Included	Excluded	Included	Included
Involvement of physicians or pharmacists	Variable involvement	Minimally involved	Moderately involved	Highly involved
Care management	Physicians/ pharmacists (not supplemented by an additional case manager)	Call-in centers	Case managers	Case managers
Examples of states with programs*	Maine, Mississippi, Virginia	Approximately 17 states	Indiana, North Carolina, Texas	Georgia, Massachusetts
* Because states frequently modify their programs or replace them with other programs, those listed here may not be operational at the time of publication.				

The state provided physicians with reports of their prescribing practices based on claims data and the physicians met periodically with a *MaineNet* health educator to review data and discuss interventions. Physicians received $100 an hour for meeting with the health educator. An evaluation of the program found that the number of potentially inappropriate medications for the elderly declined by 36 percent over the 18-month intervention period. During the same period, the rate of new, potentially inappropriate, prescriptions for the elderly dropped 56 percent, suggesting a change in prescribing behavior.[9]

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[9] Muskie School of Public Service, Institute for Health Policy. MaineNet Project Description. Retrieved April 14, 2005. http://muskie.usm.maine.edu/projectbriefs/MaineNET.jsp.

Disease Management Vendor Programs

Disease management vendor programs are the most prevalent form of care coordination in state Medicaid programs today. They typically operate independently of physicians in the health care delivery system.[10] As of July 2003, 17 states had some form of disease management vendor program in its Medicaid fee-for-service system.[11] However, these programs generally exclude beneficiaries who are dually eligible for Medicare and Medicaid.

These disease management programs are characterized by: (1) a contract with a commercial vendor for services related to specific chronic diseases; (2) minimal primary care physician involvement; and (3) a focus on teaching individuals self-management techniques. They also tend to use call-in centers rather than home visits by local case managers as their predominant mode of teaching. At least one state, Washington, requires its vendors to work specifically with beneficiaries who lack social supports and to communicate with the state long-term care system.

Health Care Coordination Programs

Health care coordination programs operate in the existing fee-for-service delivery system. Their purpose is to coordinate care for individuals with specific diseases, including dually eligible beneficiaries. This category includes traditional primary care case management (PCCM) programs, such as North Carolina's ACCESS program. These programs are developed and managed by state agencies with significant involvement by Medicaid providers. They can also include a case manager to assist physicians and to help coordinate health care services and identify needs, typically using targeted case management services.

The Texas Catastrophic Case Management program supplements the services provided in a PCCM program for certain beneficiaries identified using a computer algorithm. They include people with asthma; diabetes; AIDS; high risk pregnancy; complex behavioral health issues; children with special health care needs; and individuals with service costs above $25,000 per year or multiple uses of emergency room services. Dually eligible beneficiaries are excluded.

The ICDMP, an example of a health care coordination program, is described in detail later in this report. The ICDMP promotes self-care for people with asthma, diabetes, and CHF, and engages and supports primary care providers to facilitate changes to the organization and delivery of health care for people with chronic conditions.

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[10] See Williams, 2004 for a discussion of Medicaid disease management vendor programs.

[11] Medicaid Disease Management & Health Outcomes. Retrieved February 8, 2005. http://www.DMNOW.org. The site lists about 23 states with disease management vendor programs. Not all are included in our count because a few of the states have DM contracting only within their MCO programs, and two states seem only to have pharmacist-based programs.

Health and Long-Term Care Coordination Programs

A review of published materials and other resources as well as a series of interviews with officials in several states, revealed that although many states support care coordination within the Medicaid fee-for-service health system, they typically do not coordinate both health and long-term care services. Georgia's SOURCE (Service Options Using Resources in a Community Environment) program was the only established program we identified that operates in the fee-for-service system, coordinates health and long-term care, and includes dually eligible beneficiaries.

The strength of the SOURCE program appears to lie in its highly active case management and physician involvement. The program provides a model for improving coordination of health and long-term care services for states that are not able to implement more extensive managed care programs. The model could be used to serve *any* Medicaid beneficiary with complex conditions including Medicaid-only and dually eligible beneficiaries. The next section presents an in-depth description of the program.

We also identified a pilot project that coordinates health and long-term care services--the Massachusetts Aging Service Access Points Physician Program. The project currently enrolls 50 dual eligible beneficiaries and others at high risk of admission to a nursing facility or hospital. Staff at the state's single entry point agencies work with physicians to coordinate health and long-term care services and physicians are compensated for their participation. The pilot includes a more formalized relationship between the state's health and long-term care systems to support treatment regimens to improve outcomes and increase the likelihood of remaining in the community. However, because it is still in the early implementation stage we do not feature it in this report.

Instead, we chose to highlight the ICDMP, which builds on the PCCM model used in many states. The unique aspects of this program are its emphasis on improving individual primary care provider practices and its focus on a statewide health care delivery system. The ICDMP provides a model for improving health care coordination for states that are not able to implement more extensive health and long-term care coordination programs.

The SOURCE program and ICDMP have two important features that merit attention by other states: (1) they successfully involve primary care physicians in care coordination, and (2) they focus on outcomes.

Physician Involvement. Past effort to coordinate health and long-term care have found it difficult to involve physicians because they operate primarily in the health care system and have little financial incentive to work in or coordinate with the long-term care system.

- Georgia's SOURCE model has been able to overcome these barriers by creating a financial incentive for physicians and then requiring them to perform specific functions, including meeting with case managers.

- Indiana's ICDMP provides practical decision tools and care management services designed to support physicians. Although only a small number of physicians are participating in the program, initial outcomes suggest improvements in provider practices and patient health outcomes.

Focus on Outcomes. Both SOURCE program and ICDMP focus on outcomes. The SOURCE Carepath identifies key outcomes for the participant and the parties responsible for achieving each outcome. ICDMP case management is designed to help individuals with chronic conditions determine their desired outcomes and manage their own care to achieve those outcomes.

Since most dually eligible beneficiaries receive Medicaid in a fee-for-service setting, the care coordination programs discussed in this paper have the potential to serve a larger number of beneficiaries than risk-based managed care programs. Formal evaluations are needed to determine their impact on health and long-term care costs and outcomes.

GEORGIA SERVICE OPTIONS USING RESOURCES IN A COMMUNITY ENVIRONMENT (SOURCE) PROGRAM

Georgia's SOURCE is a voluntary program that operates in a Medicaid fee-for-service delivery system. It coordinates all of the services typically covered in traditional home and community-based services (HCBS) programs, but also coordinates primary health care services for both Medicaid-only beneficiaries and for individuals dually eligible for Medicare and Medicaid. The Governor set a statewide enrollment limit of just over 5,500, and eight SOURCE sites currently serve about 4,100 members. SOURCE staff indicated that they hope to fill all the slots as soon as possible, and are currently negotiating with the Governor's office to increase the number of slots.

The program began in 1997 under Georgia's existing PCCM program. It was developed by the St. Joseph/Candler Health System's Georgia Infirmary with support and encouragement from the state Department of Community Health (DCH) and grew out of an effort to develop a PACE program.[12] Today, the SOURCE program is a hybrid, built on components of several different care delivery and coordination models including disease management and Medicaid PCCM.

The primary goals of the Georgia SOURCE program include:

- Reducing the need for long-term institutional placement and increasing community options for Medicaid eligible persons;
- Maintaining health and function and slowing the decline that can result from chronic conditions, and preventing the progression of chronic conditions;
- Eliminating service delivery fragmentation through managed care principles, outcome-based management, and relief from programmatic constraints; and
- Increasing cost-efficiency by reducing inappropriate emergency room use, multiple hospitalizations, and nursing facility placement caused by preventable health complications through the promotion of self-care and informal supports.[13]

Key components of the SOURCE program include:

- Physician involvement in coordinating health and long-term care services;
- Enhanced case management of health and long-term care services facilitated by smaller case loads and increased flexibility in authorizing and changing services;
- Person centered planning;

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[12] SOURCE is a trademarked name of the St. Joseph/Candler Health System in Savannah, GA. The St. Joseph/Candler staff provides technical assistance to the Department of Community Health (DCH) to develop best practices. Its contract with DCH includes development and refinement of the SOURCE program.

[13] Georgia SOURCE provider manual.

- Accountability of HCBS providers; and
- Expedited enrollment in HCBS.

In terms of other programs, SOURCE is most similar to traditional HCBS waiver programs, like Georgia's own long-standing and successful waiver program, the CCSP.[14] However, the two programs also differ in important ways. A comparison of the two is presented in Table 3. A key difference is that unlike traditional HCBS programs, SOURCE case managers work directly with primary care physicians to assure that participants' primary health care and long-term care services together promote health and physical functioning. The Georgia DCH pays the SOURCE site contractors a monthly fee for *enhanced* case management. Contractors receive $150 per month per enrollee for the services of the medical director and primary care physician and for case management services.

All other Medicaid services are reimbursed separately on a fee-for-service basis. The contractor typically pays 10-20 percent of this fee ($15-$30) to the primary care physician to cover additional administrative time required for effective medical case management of SOURCE's chronically ill and generally medically complex participants.[15]

In many communities, SOURCE operates side by side with the waiver program, and in some areas of the state, the AAA administers both programs. Due to waiting lists for CCSP services, the waiver program is a source of referrals to SOURCE.

Coordinating with Medicare is a central issue for states exploring programs that coordinate medical care for dually eligible beneficiaries. Georgia takes a long-term view of the effect of managing medical costs for Medicare beneficiaries. State officials expect that the timely provision and coordination of primary health care and LTC services can: (1) prevent or delay admission to a nursing facility, and (2) reduce medical spending through reduced emergency room use and fewer hospitalizations for ambulatory care sensitive events. The state also expects Medicaid savings from reductions in its payments for the Medicare inpatient deductible ($800+), co-payments, and emergency room visits.

Eligibility and Enrollment

Eligibility criteria for SOURCE are both broader and narrower than under CCSP, the traditional waiver program. The financial criteria are more stringent because SOURCE enrollees must be eligible for SSI, which has very low income criteria,

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[14] SOURCE is administered by the DCH, the state's Medicaid Agency. CCSP, the state's traditional waiver program, is managed by the Department of Human Resources' Division of Aging Services, through AAA single entry points.

[15] This compensation is considerably more than physicians receive for participating in the regular PCCM program. Physicians in hospital-based SOURCE sites typically do not receive this compensation because they are on salary. Payment arrangements vary by site.

compared to CCSP which serves individuals with income up to 300 percent of the federal SSI income level.[16] On the other hand, SOURCE's service criteria are less stringent because participants do not have to meet nursing home level of care criteria as required by CCSP, as long as they have a chronic condition or disability that requires medical management in order to avoid nursing home placement.

TABLE 3: Georgia SOURCE/CCSP Comparison		
Program Component	**Georgia SOURCE**	**CCSP**
Eligibility	(1) Financially eligible for Medicaid at 100% or below of SSI, and (2) meets nursing facility level of care criteria or has a chronic condition or disability that requires medical management to avoid nursing home placement	(1) Financially eligible at 300% or below of SSI, and (2) meets nursing facility level of care criteria
Service authorization	▪ SOURCE medical director approves care plan authorizing services at weekly case management team meeting	▪ Primary care physician approves care plan authorizing services within 60 days of receipt of the care plan
Services coordinated	▪ Physical exam ▪ Functional/environmental assessment ▪ Chronic disease management ▪ Medicaid waiver services ▪ Medicaid state plan services ▪ Medicare services ▪ All other necessary services regardless of payer (including Older Americans Act services available from the AAA)	▪ Functional/environmental assessment ▪ Medicaid waiver services ▪ Older Americans Act services available from the AAA
Physician involvement	Participating primary care physicians and the medical director agree to work directly with patient case managers in reviewing medical issues, plan of care, functional status, community care needs	Physicians approve participant plan of care annually and any changes to the plan of care as needed. There is no physician involvement in the delivery of services.
Participant/case manager contact	Face-to-face meeting every 3 months and once a month by phone. More frequent contact as needed or as directed by physician	At least every 3 months
Participant call line	Emergency response line and 24/7 access to case management agency	Emergency response line
Case manager/ provider contact	Monthly meetings with HCBS providers, quarterly meetings with primary care physicians, and more frequent meetings as needed	As needed
Case manager/ medical director contact	Weekly. Every case reviewed monthly	*Not Applicable*
Case manager caseload	Average of 40-50 clients	Average of 70-85 clients
Administrative agency	Department of Community Health	Department of Human Resources, Division of Aging Services

Individuals are referred to the program by AAAs, physicians in the community, hospital discharge planners, and informal sources. The majority of referrals come from

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[16]To receive SSI, a person must have an income level of about 74 percent of the federal poverty level or less and resources of $2,000 or less. In addition, he or she must be age 65 or older or have a disability if under age 65.

primary care physicians. The AAAs, which operate the traditional waiver program, CCSP, refer individuals who would otherwise go on a CCSP waiting list or who do not meet that program's nursing home level of care criteria. Individuals receive an assessment from and may be enrolled by the SOURCE contractor.

SOURCE Sites and Contractors

Eight SOURCE sites administer the SOURCE program in 120 of Georgia's 159 counties. The characteristics of SOURCE sites vary greatly. As shown in Table 4, the eight SOURCE contractors include an AAA, a private for-profit case management agency, two hospitals with outpatient clinics, two nursing facilities, an adult day center for rehabilitation, and a regional council on developmental disabilities. Each operates in a defined geographic area. State officials contend that the variety of SOURCE contractors allows innovation and accommodates local needs and conditions, from urban Atlanta to very rural communities.

The Georgia DCH selects contractors, who must meet its standards. Each is responsible for developing a network of physicians and HCBS providers. The contractor oversees budgeting and quality and, perhaps most importantly, provides health leadership through a medical director. The contractor may or may not directly provide the case management services; however, if case management is subcontracted to a different organization (a case management agency or AAA for example), the SOURCE contractor agency must maintain strong connections to individual case managers, particularly through the medical director.

TABLE 4: SOURCE Sites			
Contractors	**Location**	**Type of Organization**	**Enrollment (Feb. 2004)**
Albany ARC	Albany	Regional Council for DD	221
Blueridge (UHS-Pruitt)	Blueridge	Nursing facility	481
Columbus Regional Healthcare System	Columbus	Teaching hospital	445
Diversified Resources Inc.	Waycross	For-profit case management agency	394
Ethica	Butler	Nursing facility	1,056
Georgia Infirmary, St. Joseph/Candler Health System	Savannah	Adult day center for rehabilitation	721
Legacy Link	Gainesville	Area Agency on Aging	202
Wesley Woods, Emory Healthcare	Atlanta	Geriatric hospital	573
Total			**4,093**

Most contractors directly provide case management services, but at least one SOURCE contractor subcontracts with the local AAA to provide case management. This flexibility to provide or subcontract case management services is similar to the way the CCSP program operates. All of the contractors provide enhanced case management and assure the active participation of primary care physicians. In addition, each site has a medical director who provides leadership at the SOURCE agency and works directly

with all case managers. The medical director helps to tie the health and long-term care services together for each individual participant and helps case managers interact with the participant's primary care provider as well as other physicians who may provide care.

SOURCE Roles

Medical Director

The role of the SOURCE medical director is a significant and distinguishing feature of the program and cannot be subcontracted to a separate case management agency. Medical directors are employed or contracted by the SOURCE agency for a percentage of their time. Their primary responsibility is to lead the case management team, approve enrollment of new participants, and approve care plans. In addition, they review all issues case managers raise such as concerns with medical treatments, complications, participant non-compliance, and physician relationship issues. The medical director also reviews overall utilization data. A key role of the medical director is to help case managers address health care issues. For example, they may review treatment information provided by the case manager and determine that a conflict exists in the treatment regimens prescribed by a participant's two doctors. In such a case, the medical director then helps the case manager determine how to address these issues or intervenes directly with the physicians. Similarly, a medical director can work in tandem with a SOURCE physician to train case managers in the basics of disease self-management and to identify signs of deterioration or complications.

Primary Care Physicians

SOURCE primary care physicians play a major role in the program. Because SOURCE enrollees must choose one of the 533 SOURCE providers as their primary care physician, some observers have expressed concerns that potential enrollees who have an established relationship with a non-SOURCE primary care physician might be unwilling to enroll. In many cases, however, SOURCE staff indicated that enrollees lacked a regular primary care physician prior to enrollment and used emergency rooms to obtain primary care. Thus, in practice, enrollment in SOURCE has not usually required enrollees to leave their primary care physician. Rural physicians are often the only available provider in an area and feel obligated to care for Medicaid clients.

Physicians must provide a thorough exam or evaluation for new SOURCE participants who were not otherwise part of their practice prior to enrolling in SOURCE.[17] In addition, SOURCE physicians must be available to case managers, as needed, outside formal case review meetings. Physicians meet quarterly with the case manager to discuss each SOURCE participant. During these meetings, the care plan,

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[17] Payment for this clinical exam or evaluation differs by physician and SOURCE contractor. In some cases, the clinical evaluation might be considered covered by the monthly administrative fees. In others, Medicaid or Medicare might be billed.

treatment regimens, health and functional status, and long-term care services are reviewed. Physicians are expected to have appropriate medical records and relevant office staff in attendance at these meetings.

Physicians from both urban and rural areas were supportive of the program; several described SOURCE's case management as an extension of their practice. Physicians reported that SOURCE has the ability to improve chronic care and practice among physicians. The medical director of the Ethica site in rural Butler, Georgia, indicated that she participates in SOURCE because it helps her care for her more complex patients, many of them Medicaid beneficiaries. One physician indicated that the program made it easier for physicians to care for people with multiple conditions and that physicians were more confident that enrollees would receive additional, needed services.

Physicians who understand the complexity of treating patients with serious functional, medical, and financial challenges appear to highly value SOURCE. Participating physicians appreciate the highly interactive and assertive case management because it allows them to call on SOURCE to address treatment compliance issues and to provide information about the home environment, and other health-related information that might otherwise be unavailable. At a minimum, they appreciate that participants who have a medical or other problem are likely to call the SOURCE program first. SOURCE staff then assesses the severity of the situation and involve the physician only if necessary.

SOURCE site staff found that physicians generally became interested in SOURCE participation if they had ten or more likely participants in their caseload and that involvement might not be satisfactory for those with fewer than ten patients enrolled in the program.

Case Managers and Supervisors

The central function of SOURCE is case management. The *Case Management Team* comprises individual case managers, the supervisor, the SOURCE project manager, and the medical director. The team meets at least weekly to establish, review and revise care plans, monitor participant progress, and resolve issues. Currently 101 case managers work in the SOURCE program.

Case management supervisors oversee the entire case management team and provide oversight and assistance to individual case managers as needed. Supervisors review each case file monthly, provide feedback to case managers, and document the review. Supervisors must have a bachelor's degree in one of a range of areas from an accredited university and at least five years' experience planning and implementing health care and/or human services for elderly persons or persons of all ages with disabilities. They must also be able to demonstrate successful team participation in multi-disciplinary planning and management of healthcare and/or human services.

Program staff indicated that most of the case management supervisors are registered nurses or former case managers with experience in a care delivery setting.

Case managers are either employees of the SOURCE agency or employed by a subcontractor. No contractor uses both models. Case managers are required to be highly active in determining and addressing participant needs and are expected to use a range of resources to achieve these objectives. Case managers conduct an initial participant assessment and identify an array of services that would benefit the participant based on that assessment. They then arrange for services and follow-up with participants within two weeks of the start of services to ensure that appropriate care is being provided. Program administrators stated that case managers who are not registered nurses can provide quality case management services. Educational criteria are not established for case managers. The case managers we met with included a registered nurse, social workers, and one with a bachelor's degree but no clinical training. Program administrators believed that that the most effective sites typically employed case managers from a variety of backgrounds.

Caseloads average between 40 and 50 participants. Case managers contact each participant at least monthly and visit the participant at least quarterly. In addition, case managers are expected to accompany participants to medical appointments when needed to support compliance with treatment orders or disease self-management or to help enhance treatment in other ways.

Staff described the program enthusiastically and noted that SOURCE allowed them to make decisions, change the care plan, arrange all necessary services, and hold service providers accountable. Case managers and supervisors involved in both CCSP and SOURCE felt that SOURCE case managers have more flexibility, more responsibility, and more accountability than they do in CCSP. They stated that the flexibility of the SOURCE model allowed them to reduce the need for nursing home placement, maintain health and functional ability, and to slow the decline that can result from chronic conditions. Finally, people familiar with both programs felt that the high quality of care demanded for SOURCE participants benefits CCSP participants by raising the expectations of those involved in their care.

Consumer-Centered Approach to Case Management

The SOURCE approach to case management is grounded in person-centered planning. The SOURCE manual lists the "member centered approach" as one of the program's three major themes. Active participation by the enrollee and his or her family is encouraged. In-home service providers are required to honor the member's expectations for:

- Reliability of service (including timing of visits);
- Competency, compatibility, and consistency of staffing; and
- Responsiveness to member concerns.

Case managers indicated that few quality problems arose because only the higher quality HCBS providers were selected to be SOURCE providers. Additionally, while a consumer cannot fire a provider, the case managers have the authority to stop using providers at their own discretion or when requested by the consumer. Case managers indicated that, in practice, providers tended to improve service delivery in response to criticism and thus avoid termination. Dissatisfaction with services was largely related to individual preferences not being met (e.g., services not being provided at the time consumers wanted).

Services Coordinated

Because the Medicaid service components are fee-for-service, the care plan is based on desired outcomes rather than a set amount of funding. Case managers are required to utilize all services covered by Medicare and Medicaid as well as other publicly and privately funded services necessary to support the participant.[18] They also coordinate access to services that supplement the care plan, but do not generally control funding from other programs. For example, the SOURCE case managers can ensure that a participant receives Older American's Act services provided by the AAAs if needed. The most commonly used services are personal care services and meals. Transportation was cited as the most critical service provided.

Although services otherwise available in the community must be utilized, it is expected that some needs will not be covered by traditional third-party payers or generally available as community resources. In these instances, case managers are expected to work creatively to develop ways to address needs that reflect the individual's ability to pay. As a result, case managers often work with community organizations to develop new resources (for example, obtaining clothing, air conditioners, and other needed items through donations). SOURCE case managers we interviewed spoke often about the importance of building strong relationships within the larger community in order to leverage resources to support those most in need.

In addition, each SOURCE agency is required to reserve some SOURCE funds, or secure other resources, for essential items and services that are necessary to keep someone in the community but that are not otherwise covered or available without charge. The SOURCE provider manual lists a number of examples of such items and services, among them nutritional supplements and incontinence supplies. These services or supplies are only provided after review and approval by the medical director and are delivered on a case-by-case basis. The SOURCE sites document all services provided with these funds for review by state officials who periodically consider changes in the program's covered service package.

Local SOURCE contractors did not describe coordination with Medicare as a problem even though dually eligible beneficiaries are not restricted from seeing

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[18] This includes both Medicaid state plan services and waiver services including personal care, adult day health, personal emergency response, and homemaker services.

Medicare providers. Case managers actively discourage beneficiaries from setting up appointments without first notifying their SOURCE physician or case manager. Case managers and SOURCE administrators stressed that due to the high level of case manager involvement, they know when participants are scheduled to see other physicians or providers. Agencies work closely with local hospitals to educate them to recognize SOURCE participants and to notify the SOURCE agency when one of its clients is treated in the emergency room or admitted. SOURCE managers felt that they often had the cooperation of the hospital discharge planners because the coordination efforts of the SOURCE case manager often made the hospital discharge planner's job easier.

SOURCE case managers appear to build strong relationships with participants and their families who keep them informed about health and other important developments. Case managers did not express concerns about the lack of formal coordination with Medicare benefits or formal restrictions on participants' access to any and all providers. They felt it was their job to stay informed about their clients' service use and that it was quite possible to do a good job at this. With the implementation of the Medicare prescription drug benefit, SOURCE case managers will have an additional responsibility to assist participants to enroll in the most appropriate program, and to deal with coverage issues that may arise for their dually eligible participants.

Screening and Assessment

Potential SOURCE participants are screened to determine if they meet financial and service eligibility criteria. Screening for basic eligibility must occur within three days of referral. Case managers then conduct an assessment in the person's home, which must be completed within five days of the screening. As in the traditional waiver program, this assessment captures psychosocial and environmental information, and comprehensive health information. The assessment is used to prepare an initial care plan, which is reviewed with the participant and/or family caregiver. The assessment is also provided to the SOURCE physician with whom the client will enroll. The assessment provides information not always available to physicians, such as the names of other treating providers and a full medication list.

If new participants have no prior relationship with the selected SOURCE physician, they receive a physical exam, the results of which are incorporated into the care plan as appropriate. The program has found that participants have been willing to change physicians in order to receive the enhanced case management and coordination available through SOURCE.

Levels of Care

The case management team assigns a level of care and officially enrolls the individual in the program based on the assessment and recommended services. The

levels of care are not directly correlated to specific services; rather the assigned level is used to create a general budget framework and an expected level of service utilization. The program also uses these assignments in the care planning process, as discussed below.

The level of care assignment helps to finalize the service array into a detailed plan of care that is included in a *carepath* document (described in the next section) that serves as the primary tool for monitoring services. The medical director and the SOURCE primary care physician approve the carepath, which is essentially a standard protocol for case managers and physicians to monitor participant outcomes.

The program has established four levels of care with four corresponding carepaths. Levels one and two include people with substantial cognitive and/or physical impairments who meet nursing home level of care criteria. In 2002, about 70 percent of SOURCE enrollees met the nursing facility level of care criteria. Levels three and four include participants who have at least one chronic condition but do not meet nursing facility level of care criteria. Case managers indicated that Level 4 participants are high functioning and do not require many services. Their focus for this group is generally on education about disease self-management techniques and encouraging participation in wellness activities and programs.

Carepath

The carepath focuses on: (1) identifying key outcomes for the participant, and (2) identifying the parties responsible for achieving each outcome. Each carepath has goals (expected outcomes) and is customized to the unique needs of each participant. It addresses a wide range of health and long-term care issues, such as skin care, medical compliance, availability of informal supports, nutrition/weight, key clinical indicators, ADLs and IADLs, cognitive impairment and problem behaviors.

The carepath documents the participant's goals/outcomes and lists the specific services and the frequency with which they will be delivered as well as the providers who will support the attainment of a participant's goals. Each care path clearly delineates the roles and responsibilities of the participant, the primary care physician, and the case manager. See Appendix B for an example of a carepath form.

The carepath differs from traditional waiver care plans because it links specific levels of care to expected outcomes for that level. These outcomes include such key clinical indicators (depending on the chronic condition) as weight, ADL/IADL functioning,[19] and skin condition. The Level 1 carepath contains 13 goals, listed in Exhibit 1, the maximum number of goals in a carepath, and includes all the goals of Levels 2, 3, and 4. Each participant's customized care plan details how the goals will be achieved.

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[19] ADLs include bathing, dressing, eating, toileting, and mobility. IADLs include preparing meals, doing housework, using the telephone, managing medications, paying bills, and getting around outside the home.

Monitoring

While service delivery is monitored for timeliness, participant satisfaction, and quality, services are also reviewed to assess the extent to which they (or a specific provider) are facilitating attainment of the individual's goals. The carepath facilitates monitoring by specifying the responsibilities of the case manager and the physician as well as any informal or formal supports required to achieve desired outcomes. It also includes a guide for quarterly review and comment on the extent to which goals are, or are not, being met.

EXHIBIT 1: Level 1 Carepath Goals
1. Enrollee/caregiver contributes to the design and implementation of community-based services plan.
2. Enrollee keeps scheduled medical appointments.
3. Support services are delivered in a manner satisfactory to the SOURCE enrollee, informal caregivers, and case managers.
4. SOURCE enrollee's body mass supports functional independence and does not pose a critical health risk, or progress is made towards this goal.
5. Meals are generally balanced and follow appropriate diet recommended by the primary care physician.
6. Enrollee has no skin breakdown or decubiti requiring clinical intervention/wound care, or breakdown/decubiti measures smaller, or quality of tissue is improved.
7. Key clinical indicators and lab values will regularly fall within parameters acceptable to SOURCE primary care physician or treating specialist.
8. Enrollee/caregiver understands and complies with medication regimen.
9. No observations by case managers or reports from enrollee/caregiver/other providers (including SOURCE PCP) identifying problems with ADLs, IADLs, and/or patient safety.
10. Residential arrangements remain stable.
11. Mental health conditions or cognitive impairment will be adequately managed by informal or paid caregivers.
12. Patient has no falls due to unsuccessful attempts at transferring or mobility.
13. No reports or other indicators of caregiver exhaustion.

Case managers arrange for services and follow-up with clients within two weeks of the start of services to ensure that appropriate care is being provided. To the extent that client goals are not being achieved (carepath variance), the client's case is reviewed and, when necessary, adjusted during the weekly meeting of the case management team. Case managers also meet with HCBS providers monthly.

The case manager meets quarterly with the participant's physician to review the long-term care services care plan and the client's health conditions and treatment plan. During these meetings, they review treatments, services, and outcomes. The carepath document is then revised to reflect the findings of the physician/case manager meeting. The case management team then reviews the carepath changes, which require the approval of the medical director as well as the SOURCE physician.

This process of changing the care plan can occur whenever needed and is not limited to the quarterly review. As a result, SOURCE case managers and medical

directors have the flexibility to authorize changes in care plans and to have services provided without state pre-approval. In contrast, changes in a CCSP care plan require that the case manager send paperwork to the beneficiary's primary care provider, who has 60 days to approve the new care plan. After the physician approves the care plan, it must be approved by the state agency and entered into the state payment system before the services can be delivered.

Home and Community-Based Service Provider Accountability

Case managers are responsible for assuring that HCBS providers meet client needs and deliver quality services. When they do not, the case manager is responsible for replacing the provider. This differs from CCSP which, like most traditional waiver programs, utilizes all providers who meet the state standards, and rarely terminates providers because it requires a time-consuming and cumbersome process. While SOURCE must construct its provider list from those already approved for use in the CCSP program, SOURCE can decline to utilize low performers. Each SOURCE site has a process for terminating providers who do not meet performance standards. In practice, SOURCE staff members closely monitor performance and act quickly to terminate providers if their performance is not satisfactory. The SOURCE program staff also conduct scheduled and surprise visits to the member's home to monitor the quality of service delivery.

SOURCE tracks service utilization against authorizations by requiring HCBS providers to report services provided in a monthly report to each case manager. Case managers also use these reports to monitor general spending.

Replication

Georgia's experience suggests that agencies operating traditional waiver programs can build stronger outcome-driven case management models, like the SOURCE model, that include primary care physicians. SOURCE was implemented by overlaying a 1915(c) waiver on an existing 1915(b) PCCM arrangement and other states could adopt this approach. An additional coverage option is to use targeted case management under the state plan to contract with an agency to pay for the site coordinator, case managers, medical director, and primary care physician involvement. Information about various Medicaid coverage options for SOURCE and similar programs can be obtained from CMS regional offices.

States interested in replicating this or a similar program need to assure that they have an infrastructure of primary care physicians and case managers who understand how to manage chronic conditions, as well as a range of available HCBS to support individuals with chronic conditions. States with single-entry point systems already have the building blocks in place for forming linkages with primary care providers.

Single entry points that recognize the importance of health care and the need to better coordinate primary health care with long-term care, may be better able to build partnerships with health care professionals. Those that see their role as more limited--to address the functional needs of waiver participants--may have more difficulty arranging partnerships and working with medical providers. Primary care and other health care providers must be willing and able to collaborate with the single entry points as well.

Georgia Medicaid program administrators are confident that the SOURCE program helps delay or prevent nursing home placement, and reduces preventable hospital in-patient and emergency room use. However, sufficient data are not yet available to evaluate program outcomes. A preliminary analysis completed shortly after the program began suggested that SOURCE was slightly more effective than the traditional waiver program in reducing ambulatory care sensitive events and repeated inpatient hospital admissions. A formal evaluation is needed to determine the actual impact of the SOURCE program model on long-term costs and outcomes.

However, given the complex needs of people with chronic conditions and the complicated health and long-term care systems they must navigate, care coordination will always be a critical component of quality care for the growing number of people with chronic conditions.

INDIANA CHRONIC DISEASE
MANAGEMENT PROGRAM (ICDMP)

In 2003, the Indiana Department of Family and Social Services Administration in partnership with the Department of Health and other local stakeholders developed the ICDMP. The goal of the program is to improve patient self-management, primary care physician practices, and the health care delivery system infrastructure for people with chronic conditions.

The ICDMP program supplements care management services provided in Indiana's PCCM program for certain Medicaid-only and dually eligible beneficiaries with asthma, diabetes, and CHF. The supplementary services include phone-based care management--a common feature of Medicaid disease management vendor programs--and in-person nurse care management, the primary intervention associated with health care coordination programs.

The ICDMP is a health care coordination program with three levels of intervention: the patient, the provider and the delivery system infrastructure. (See Exhibit 2).[20]

- At the *patient* level, the program uses call center and nurse care management services to help participants develop self-management goals and skills. For a child with asthma, goals might include knowing and reducing exposure to asthma triggers, knowing how to use peak flow meters and spacers, and knowing when to take asthma management medications.

- At the *provider* level, the program supports learning collaboratives to help physicians provide better care to patients with chronic disease. A collaborative consists of workshops to help physicians design and implement changes in their practices to promote better chronic care management. Practice level changes could include using a patient registry, developing a system to flag patients' charts, using flow sheets to ensure that preventive services are completed during regular office visits, and scheduling planned visits--a preventive visit analogous to a well-child visit--for patients with chronic conditions.

- At the *infrastructure* level, the program has developed a Web-based patient registry and promoted decision support tools, which include guidelines for the three target conditions, examples of self-management goals, and patient

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[20] This program approach mirrors the Chronic Care Model developed by Dr. Ed Wagner, Director of *Improving Chronic Illness Care*, a national program of The Robert Wood Johnson Foundation. For more information, go to http://www.improvingchroniccare.org/change/index.html.

education materials.[21] The tools have been distributed to all primary care providers including non-Medicaid providers.

EXHIBIT 2: Indiana Chronic Disease Management Program Model

SOURCE: ICDMP, 2004.

Program Eligibility

EDS, the state's Medicaid fiscal agent, identifies Medicaid enrollees with the target diseases (diabetes, CHF (adults only), and asthma) by electronically scanning claims data for evidence of relevant diagnostic codes or related drug utilization. Participants are also identified through self or physician-referral, although referrals are infrequent. Persons who are not eligible for the program are those who are institutionalized; participating in a HCBS waiver; subject to Medicaid spend-down; diagnosed with end-stage renal disease; transplant recipients; or enrolled in risk-based managed care plans. As of March 2005, approximately 30,000 of the 800,000 Medicaid beneficiaries in Indiana were enrolled in the program.

Once eligible beneficiaries are identified, they are stratified into low and high-risk groups based on historical claims data including pharmacy use and inpatient episodes. The state and its partners identified program participants at the start of the program and now conduct quarterly reviews of the data to identify those recently diagnosed with

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[21] Prior to the implementation of the ICDMP, the Indiana Department of Health worked with physicians throughout the state to develop consensus based guidelines for asthma, diabetes and CHF. All of the provider materials are available at http://www.indianacdmprogram.com/.

target diseases or newly enrolled in Medicaid. The state forwards the list of eligible members developed by EDS to the call center disease self-management program.

Call Center Disease Self-Management Program

Low-risk participants--approximately 80-85 percent of the total targeted population --are enrolled in the phone-based disease self-management program operated by the call center. High-risk participants receive nurse case management, discussed in the next section.

The call center began operations on July 1, 2003.[22] AmeriChoice, the state's Medicaid enrollment broker and PCCM administrator, operates the call center. The state amended its enrollment services contract with AmeriChoice to include the call center services, which are billed at a fixed rate based on volume.

Using computerized scripts, AmeriChoice care coordinators make calls to the low-risk care management participants every three months. The Indiana-based Regenstrief Institute developed the scripts, which are programmed to guide the care coordinator through a series of questions based on the member's responses. Program and call center staff review the scripts to ensure that the language level and concepts are understandable to participants. Scripts have been developed for the first three cycles of calls, covering nine months. Scripts for subsequent calls are under development.

The first three calls cover an initial assessment and basic education on the target disease, medications, and self-care skills. The first phone call is designed to confirm eligibility, complete an initial assessment, and describe the program. Members are encouraged to talk to their physician about issues identified by the assessment (e.g. getting a flu shot, taking aspirin (for CHF), or monitoring blood sugar (for diabetes)). The coordinator educates the member about the disease process and offers educational materials. After this call, the members are sent a letter summarizing their responses and encouraging them to discuss its contents with their doctor during their next visit. A sample letter is provided in Appendix E.

The program is voluntary and most of the members contacted agree to participate. If a member declines to participate, she is called again after a month. Approximately 10-15 percent of eligible members cannot be reached by phone. If a member cannot be reached after three attempts, she is sent the introductory letter but no additional calls are made. By November 2004, all of the high-risk members and 30-40 percent of the low-risk members had been contacted by the program.

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[22] Call Center costs are billed as Medicaid services at 62 percent FFP.

EXHIBIT 3: Call 2 Flow Chart

Build Solidarity

Good Time To Talk → Reschedule Call

Any difficulties with meds? [AmeriChoice will use the answer a bit later in the call.]

CHF Branch → Determine Disease State → Diabetes or Both Branch → Diabetes Foot Care

Self Blood Glucose Monitoring

Weight Management ← Both ← Diabetes only, or both ← Aspirin Therapy

Weight Goal

Exercise ← Diabetes Only

Smoking

Depression

Member Should Not Be on Medications ← Medications Section → Member Should Be on Medications

Ask about helper and ask if keeps a list

Any difficulties with meds? → No

Yes ↓

No ← Did member ever run out of meds?

Yes ↓

Section on Supply Barriers

Trouble taking meds on schedule? → No

Yes ↓

No ← Unsure about doses or about how the meds work

Yes ↓

Educational materials about pills   Educational materials about all relevant meds

If diabetes or both — If CHF → Section on Insulin Treatment

Insulin Education Materials

Section on "overcoming hassles" and on other items about taking medications on schedule (e.g. re work/school/activities, organizer, side effects)

General Education Materials → Call Back Section

Flu Shot

Review Summary And Helpful Call Section → End Call

SOURCE: Regenstrief Institute.

The second call is much more detailed than the first, covering more topics and in greater detail. Respondents are asked questions designed to determine if the member is having problems with medications, doctor visits, or transportation. Education is also provided on (for example, diabetic foot care, self glucose monitoring, and insulin administration). Exhibit 3 on the next page illustrates the topics and sequencing of the second call.

The third call reviews and reinforces the topics addressed in the prior call. For example, if a member received a flu shot after being encouraged to do so during the second call, she would be congratulated and encouraged to continue to get a flu shot annually. This call also addresses smoking cessation and depression in greater depth than the prior calls.

As part of the call, care coordinators administer a depression screen and members are invited to discuss topics from a list that includes diet, exercise/physical activity, and preventing complications (for diabetes only). Afterwards, call center staff submit a report to the member's primary care provider.

EXHIBIT 4: Depression Screening from Call 3 Script
We are almost done with our call. I have just a few more questions about how you are feeling, "over all." Many people that I talk to that have chronic health problems feel down or depressed from time to time. This is important to know, because feeling this way can affect your life in many ways and can make it harder for you to take the best care of yourself. In responding to each of these next questions, I would like you to think about how you have been feeling in the last two weeks--just the last two weeks.

1. Over the last two weeks, how often have you been bothered by feeling down, depressed, or hopeless?
2. How often have you been bothered by little interest or pleasure in doing things?
3. How often have you been bothered by trouble falling or staying asleep, or sleeping too much?
4. How often have you been bothered by feeling tired or having little energy?
5. How often have you been bothered by poor appetite or overeating?
6. How often have you been bothered by feeling bad about yourself--or that you are a failure or have let yourself or your family down?
7. How often have you been bothered by trouble concentrating on things, such as reading the newspaper or watching television?
8. How often have you been bothered by moving or speaking so slowly that other people could have noticed. Or the opposite--being so fidgety or restless that you have been moving around a lot more than usual?
9. You just told me that you have been bothered by at least some problems during the past two weeks that could be related to being down or depressed. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

A lot of people with [Care Coordinator--say member's condition(s)] feel down or depressed from time to time. Sometimes these feelings come and go. Other times they stay around and can cause big problems. It is important to talk to your doctor about these feelings. She/he can help decide if you need to be treated to help make the symptoms go away. She/he can also help decide if the feelings are affecting how well you are able to take care of yourself. Your doctor might not know about these feelings unless you tell her/him. Be sure to write this down and talk to her/him about these feelings at your next doctor visit.

In addition to phone care management responsibilities, the call center is also responsible for assembling and mailing the Provider Toolkit (discussed later) to all Medicaid providers statewide, handling provider and self-referrals to the program, reporting program statistics to the state, and maintaining a website.

Call Center Staffing and Training

The call center staff consists of a manager, two supervisors, a trainer, and 26 care coordinators who handle all the calls. The supervisors and trainer must be registered nurses. Most of the care coordinators have call center experience and often an associate or bachelor's degree. Care coordinators receive three weeks of introductory training, which includes pre and post-test components. Physicians from the Regenstrief Institute developed and tested the training curriculum, phone scripts, and the Chronic Disease Management System (CDMS) software used by the call center. The call scripts are highly detailed and designed for use by non-clinical care coordinators.

The training curriculum includes information about the target diseases, Medicaid eligibility, and the enrollment broker software. The call center care coordinators are also trained to identify markers indicating the member might have an acute health care need requiring more intensive and immediate care management or physician intervention. In such cases, one of the registered nurses on staff follows up with the member and has the discretion to elevate the member to the high-risk group. Call center hours are staggered and include Saturday mornings to accommodate the schedules of working families.

Nurse Care Management

In addition to the services provided by Call Center staff, the ICDMP includes a comprehensive nurse care management program for high-risk participants, which provides local, personalized, and intensive care management. The nurse care management component of the program began operating August 1, 2003. High-risk participants are first contacted by care coordinators, who confirm eligibility, complete an initial assessment, and describe the program. Following the call, members are sent a letter indicating that a nurse care manager will make the next contact. Members typically remain in the nurse care management program for 4-6 months before "graduating" to phone-based care management.

Nurse Care Management Organizations

The state contracted with two organizations to provide nurse care management-- the Indiana Primary HealthCare Organization and the Indiana Minority Health Coalition. They were selected based on their active engagement in and knowledge of local health care systems and their ability to provide services statewide. Each county in Indiana is assigned to one of the two organizations. Indiana Primary Healthcare--the association

of federally qualified health centers--is responsible for the rural counties, while Indiana Minority Health Coalition focuses on urban counties, primarily in central Indiana. The organizations are required to have a program director and a supervisor.

Each organization employs 15 nurse care managers and is paid an annual fee of $100,000 per nurse.[23] This fee includes the salary of the nurse, training, mileage, and any other costs incurred by the organizations in fulfilling its scope of work. The program director and supervisors at each of the organizations meet monthly with the nurses, conducting group consultations on some of the more difficult and complex cases. The program director and supervisors from both organizations meet weekly with the state ICDMP staff to discuss progress, issues, and challenges.

Nurse Care Managers

The scope of work for both care mangers and supervisors is outlined in a contract between the state and the care management organizations. (See Appendix C. Appendix D describes minimum qualification for care managers.) The nurses hired by these organizations often know and have worked with members' primary care doctors and are familiar with referral networks and community resources. The program directors and supervisors indicated that many of the most effective nurse care managers have many years of experience and are mature and flexible. Nurse care managers are currently responsible for an average of 70 clients.

Nurse Care Management Process

Once the call center has made the first contact with a member, the member's contact information along with a summary of the initial assessment is forwarded to the appropriate nurse care management organization, and the member is assigned a specific nurse care manager based on the location of his or her primary care provider. (Members with the same provider are assigned to one nurse).

The assigned nurse's first step is to set up a time to visit the primary care provider's office to review the member's chart and to identify conditions, risk factors, and any existing care plan. The nurse also tries to meet with the physician during the visit to discuss any specific issues or barriers the physician would like addressed through the care management process. Once the nurse completes the chart review, she initiates contact with the member by phone to introduce the program and set up a home visit.

Nurse care management is delivered in three ways: in-person home visits, office visits to primary care providers, and phone-based counseling. Home visits are an especially critical component of the program, helping nurse care managers assess the member's environment, resources, and state of mind, and permitting a more tailored and personalized care management approach. While the initial visit is made to the home, many of the subsequent contacts, which occur about once a month, are made by

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[23] The state receives 75 percent federal financial participation for this fee.

phone. In denser urban areas, where the costs and time required to travel to a member's home are minimal, subsequent visits also frequently occur at the member's home.

The main concern members voice about the program is that it is too short. But the short duration of the intervention--4-6 months--is by design. The program was carefully crafted to help members identify and act on their own care management concerns, not to manage care on their behalf. The care management process teaches members how to be more engaged in their own health and health care, including developing the skills to manage their care, and the knowledge and confidence to discuss concerns with providers or Medicaid staff when the intervention ends.

For example, when members have concerns about their interaction with a physician, if nurses observe the member is not getting appropriate care, or when the member has been incorrectly told that items such as peak flow monitors and spacers (medical devices to treat asthma) are not covered by Medicaid, the nurse does not immediately get on the phone to resolve the issue. Instead, she discusses the issue with the member and encourages him to discuss issues and concerns directly with the provider or Medicaid staff. The nurse follows up with the member or the provider to make sure the member was able to get his concerns addressed and his needs met.

The concept of improving self-care by empowering members is central to the program's design and operation. However, if the program expands to include HCBS waiver participants, traditional care management services may also be required to meet their more complex needs and to assist those who are not able to care for themselves.

Interaction with Primary Care Providers

In addition to working with members on self-care skills and providing education, nurses also help implement care plans developed by providers, highlighting the important relationship between nurses and primary care providers. Nurses make an initial contact with physician practices to review member charts and then schedule one of the care management sessions in conjunction with an office visit to give the care manager, the member, and the provider a chance to jointly discuss chronic care issues. The nurse provides written feedback to the physician after the initial home visit and at the end of the 6 month intervention. Because one care manager is paired with each practice, the nurse has multiple opportunities to interact with physicians and their staff, in order to develop a flexible and collaborative relationship.

The relationship between the care manager and the provider can take many forms. In some cases the nurse care manager communicates mainly with the office manager; at other times, she works directly with the physician. Nurses often remind doctors about the resources included in the Physician Toolkit. Physicians did not immediately embrace these resources, but after the program had been operating for a year, ICDMP has noticed increasing openness and engagement from physicians who are starting to ask more questions about the program.

Co-morbidities

Many members enrolled in ICDMP have multiple chronic conditions. The program officially enrolls a member for only one disease; however, in practice, the nurse care manager will often address both CHF and diabetes. This has worked fairly well for members with both conditions, probably because the behavior change goals are often similar for the two diseases.

Seventy percent of people with diabetes also have depression. Care managers found addressing depression and other mental health co-morbidities more challenging due to the complex nature of mental illness. Nurses and their agencies have developed strategies to address mental health issues. In some cases, the nurse care manager will discuss the member's condition first with the primary care physician or psychiatrist to determine if the member is ready for the ICDMP or if mental health treatment is needed first. If the person is particularly fragile, the nurse care manager will sometimes contact the mental health care manager to see if the first visit can be conducted jointly, lessening the stress for the member. The focus is on effective implementation of the nurse care management intervention not on treating the mental health condition.

Completion of Nurse Care Management

When high-risk participants have completed their 4-6 month participation in the nurse care manager program, they are transferred back to the call center for ongoing care management. The care plan is forwarded to the call center, including notes about the member's care management goals, and suggestions and pointers for how to work with the individual. The call center calls them two weeks after their "discharge" and follows up again a month later. If any issues or complications arise during the transition phase, the member is re-enrolled in the nurse care manager program. After this transition phase, members continue on the regular call center cycle of quarterly calls.

Physician Collaboratives

Physician learning collaboratives are designed to help physicians provide better care to patients with chronic conditions. The use of collaboratives is based on the idea that by working collaboratively, organizations and providers who share similar goals can accelerate change. To date, the state has implemented four collaboratives as part of ICDMP. Each involved 2-3 in-person learning sessions.

The program provides time between sessions to allow for the development and testing of practice level changes, and the final session is focused on sharing lessons learned. To date, 48 practice teams, composed of a physician, a nurse, and an office manager, have participated in collaboratives in different parts of the state. Exhibit 5 summarizes one physician's experience in a collaborative.

The first collaborative included 25 practice teams and focused on CHF and diabetes; the second focused on CHF, diabetes, and asthma; the third on asthma only; and the fourth on CHF, diabetes, and asthma. The state is planning a fifth collaborative in the Fall of 2005.

While collaboratives can addresses all three chronic conditions, each provider team may select one or more conditions as the focus of its efforts, and relays monthly progress reports to ICDMP. These reports track team performance on the state's mandatory measures (one for each condition) and on 3-4 additional goals providers have chosen.

Early participants were enthusiastic about the collaborative; however, the initiative has faced challenges. The original collaborative design called for three, two-day learning sessions and a final meeting over a 12 month period. The period was shortened because physicians said they could not be absent from their practices that long. As an incentive to participate, the program is free and physicians get continuing education credit. Yet, only about half the practice teams make it through the whole process. The initiative is also time and resource intensive for state managers.

EXHIBIT 5: Provider Case Study--Results of Collaborative
Provider profile. The provider is one of the largest safety net providers in Indianapolis with several sites and a previous commitment to care management (asthma coordinators are on staff). Eighty percent of patients are covered by Medicaid.
First steps. The provider completed a chart audit to identify all children with asthma.
Goals. To get asthma patients on control medications, establish home and school action plans for these patients, and establish care improvement goals.
Care delivery changes as a result of participation in the collaborative. The provider added a bright chart label to identify patients with asthma and attached pre-printed post-it notes with questions on severity for the physician to probe. These visual reminders prompt the physician to follow-up with the patient, even if she has visited the office for another reason. The asthma coordinator, who participates in every office visit with asthma patients, conducts post-visit follow-up.
Issues. (1) The high-rate of visit no-shows made it hard for the provider to introduce prevention activities and trace progress. (2) The asthma coordinator found that if asthma was under control (the patient did not complain) the physician would not address asthma management in the visit (eroding progress on prevention). (3) The provider cannot bill Medicaid for the asthma coordinator's participation in the well child visit.
SOURCE: Adapted from a presentation by Thomas Inui, 2004.

The mandatory measures are:

- **All diseases:** Percent of patients with at least one self-management goal.
- **Diabetes:** Percent of patients with HbA1c level of less than eight.
- **CHF:** Hospital readmission rate.
- **Asthma:** Percent of patients with persistent asthma who are treated with anti-inflammatory medications at effective doses for appropriate durations.

The figures reported by the physicians who participated in the first collaborative are promising. Between June 2003 and July 2004, the percentage of diabetes patients with HbA1C less than 8 percent increased from 28-59 percent. The percentage of patients with CHF who had at least one self-management goal increased from 14 percent to 86 percent.

Chronic Disease Management System

All Medicaid providers in Indiana have access to the state's electronic patient record and disease registry, the CDMS. This system is housed at the Department of Health and was developed from a template created by the Montana Quality Improvement Organization. The state downloads claims data into CDMS for all care management participants. The call center and the nurse care managers enter care management summaries into the system.

Physicians can use CDMS to generate alerts, identify subsets of patients, and track their progress toward goals. They can also enter their own care management information to CDMS, making the registry a complete chronic care record. To date, however, few physicians have used CDMS as a tool to document and manage office-based care. The state is launching a physician survey to investigate the reasons and explore examples of when and where physicians are using the system.

Even without formal study, however, it is clear that the burden of data entry is one reason for low provider participation. In addition, the system cannot be used for other office functions such as claims submission or as a complete electronic patient record, as it only includes information related to the patient's chronic condition. A final issue is that providers do not have full access to the CDMS; they can see information entered by nurse care managers but not notes from the call center.

Evaluation

The program is planning a two-part evaluation. The first part is a randomized controlled study that will include analysis of clinical and claims data for providers in the Indianapolis area using the Regenstrief electronic medical record.[24] The second part will include analysis of claims data for all members statewide and a phone survey of a random sample of providers and members.

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[24] The providers of about 15 percent of Medicaid members in central Indiana use the Regenstrief electronic medical record.

Evaluating this program presents many challenges. Indiana is fortunate to have electronic clinical data available for some of the participants. However, clinical data will not be available for the statewide evaluation, and claims data pose certain limitations.[25]

The state contracted with the Regenstrief Institute to conduct the evaluation and to design, implement, and provide ongoing quarterly maintenance of the following services for a total cost of $1 million over a two-year period (August 2003-July 2005):

- CDMS software, member selection, and risk stratification;
- Call center scripts; and
- Nurse care manager training materials.[26]

Replication

ICDMP was implemented under the authority of a 1915(b)(4) waiver of the Social Security Act. The medical state plan services provided by the ICDMP are eligible for federal financial participation at the state's regular federal medical assistance match rate.

The program has required substantial time and attention from the state's Medicaid agency staff, both during the initial design and implementation. Once operational, however, the program only requires one full-time state employee to serve as the program director. Nonetheless, many states may feel they lack the programmatic expertise, management capability, or local partner organizations to make such a program work.

CMS has made available a State Medicaid Director Letter dated February 25, 2004, for guidance on the available approaches to financing disease management and health care coordination programs.[27]

The ICDMP offers a promising health care coordination approach to address cost and quality issues. However, the outcome of the formal evaluation is needed to determine the actual impact of the model on costs and outcomes.

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[25] E. Walsh, D. Osber, C. Nason, et al., "Quality Improvement in a Primary Care Case Management Program," *Health Care Finance Review* Vol. 23, No. 4 (Summer 2002): 71-84.

[26] The Regenstrief Institute is a 25-year-old research foundation located on the Indiana University School of Medicine campus, and is dedicated to the study and improvement of health and health care delivery. For additional information about the Institute, see: http://www.regenstrief.org/.

[27] Available at: http://www.cms.hhs.gov/states/letters/smd022504.pdf.

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APPENDIX B. GEORGIA SOURCE CAREPATH

Service Options Using Resources
In
Community Environments
SOURCE
LEVEL ONE CAREPATH

Member_____

Medicaid No. _____

SOURCE Case Manager _____

Signature _____ **Date** _____

SOURCE Case Management Supervisor_____**Date**_____

SOURCE Physician _____

Signature _____ **Date** _____

SOURCE Medical Director _____

Signature _____**Date** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS

Member resides in community, maintaining maximum control possible over daily schedule and decisions.
 	
GOALS:
 	
A. Member/caregiver contributes to the design and implementation of community-based services plan.
 	
Key member responsibilities:
• Accept services as planned with case manager;
• Provide accurate information on health status and service delivery; and
• Maintain scheduled contact with case manager.
	Stabilize chronic conditions and promptly treat episodic/acute illness through long-term management by a SOURCE PCP/case manager team. The team will monitor risk factors for institutionalization, responding with medical and support services provided at the time, setting and intensity of greatest effectiveness.
	
	PCP: _____Case Mgr._____
	
	SOURCE PCP role:
	Evaluate and treat episodic /acute illness
	Manage chronic disease, including:
	  Risk factor modification/monitoring of key clinical indicators
	  Coordination of ancillary services
	  Education for members/informal caregivers
	  Medication review and management
	Conference/communicate regularly with case manager
	Review support service plans
	Refer/coordinate/authorize specialist visits, hospitalizations and ancillary services
	Promote wellness, including immunizations, health screenings, etc.
		GOALS:
		
		1st review period (__/__/__):
		A. __met __not met
		B. __met __not met
		C. __met __not met
		
		2nd review period (__/__/__):
		A. __met __not met
		B. __met __not met
		C. __met __not met
		
		3rd review period (__/__/__):
		A. __met __not met
		B. __met __not met
		C. __met __not met
		
		4th review period (__/__/__):
		A. __met __not met
		B. __met __not met
		C. __met __not met

B. Member keeps scheduled medical appointments.		

C. Support services are delivered in a manner satisfactory to SOURCE members, informal caregivers and case managers.
 	
Key provider performance areas:
• *Reliability of service*
• *Competency and compatibility of staffing;*
• *Responsiveness to member concerns and issues; and*
• *Coordination with case manager.*
	SOURCE Case Manager role:
	Maintain contact with member, for ongoing evaluation:
	  Monthly by phone or visit (minimum)
	  Quarterly by visit (minimum)
	  PRN as needed
	Educate members on patient responsibilities
	Encourage/assist member in keeping all medical appointments
	Conference/communicate regularly with PCP
	Encourage/assist member in obtaining routine immunizations, preventive screenings, diagnostic studies and lab work
	Coordinate with informal caregivers and paid providers of support services
	Educate or facilitate education on chronic conditions
	Assist members in ALL issues jeopardizing health status or community residence
	
	NOTES: _____
	_____
	
	_____
	
	(Providers and units/schedules listed on Member Version)	

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS

A member's diet will be balanced and appropriate for maintaining a healthy body mass and for dietary management of chronic conditions
 	
GOALS:
 	
A. SOURCE member's body mass supports functional independence and does not pose a critical health risk OR progress is made toward this goal (PCP, ADH or other report).
 	
B. Meals are generally balanced and follow appropriate diet recommended by PCP (observed by case manager or provider, self- or caregiver report).
	MEMBER EDUCATION:
	___SOURCE PCP/PCP staff
	___SOURCE educational material
	___Candler Dietary Department
	___other _____
	
	MEAL PREPARATION:
	___self-care (total)
	
	___assistance by informal caregiver(s)_____
	
	_____
	
	_____
	
	___home delivered meals
	___ALS (alternative living service)
	___ PSS aide (includes G-tube)
	
	MEAL PREPARATION SCHEDULE: (Indicate SELF, INF, HDM, PSS or ALS):
	
	Mon _____B _____L _____S Thurs _____B_____L_____S
	Tues _____B_____L_____S Fri _____B_____L_____S
	Wed _____B_____L_____S Sat _____B_____L_____S
	
	                    Sun _____B_____L_____S
	
	NOTES: _____
	
	    _____
	
	    _____
	
	    _____
	
	(Providers and units/schedules listed on Member Version)
		GOALS:
		
		1st review period (__/__/__):
		A. __met
		    __not met
		B. __met
		    __not met
		
		2nd review period (__/__/__):
		A. __met
		    __not met
		B. __met
		    __not met
		
		3rd review period (__/__/__):
		A. __met
		    __not met
		B. __met
		    __not met
		
		4th review period (__/__/__):
		A. __met
		    __not met
		B. __met
		    __not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Member's skin will be maintained in healthy condition, avoiding breakdowns and decubiti. **GOALS:** **Member has no skin breakdowns or decubiti requiring clinical intervention/wound care.**	**MEMBER/CAREGIVER EDUCATION:** ___SOURCE PCP/PCP staff ___SOURCE educational material ___other _____ **MONITOR SKIN** for integrity: ___SOURCE PCP ___self care ___informal caregiver _____ ___ADH ___specialist _____ ___PSS aide/PSS RN every 62 days ___ALS ___skilled nursing provider:_____ Dates of Service: Assistance required: ___turning/repositioning (see page_____) ___continence (see page _____) ___nutrition (see page____) NOTES: _____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS

Key clinical indicators and lab values will regularly fall within parameters acceptable to SOURCE PCP or treating specialist.
 	
___blood pressure
 	
___blood glucose
 	
___weight (as indicator of illness)
 	
___lab values
 	
___other_____
	MEMBER/CAREGIVER EDUCATION:
	   ___SOURCE PCP/PCP staff
	   ___SOURCE educational material
	   ___other_____
	
	MONITOR CLINICAL INDICATORS:
	___SOURCE PCP (OV)
	___self care
	___ASSISTANCE REQUIRED
	
	   ___informal caregiver_____
	   ___ADH
	   ___ADH mini-clinic
	   ___PSS aide
	   ___ALS
	   ___RN
	   provider: _____
	   Dates of Service:
	
	___other _____
	
	NOTES:_____
	
	  _____
	
	  _____
	
	  _____
	
	(Providers and units/schedules listed on Member Version)
		GOALS:
		
		1st review period (__/__/__):
		  __met
		  __not met
		
		2nd review period (__/__/__):
		  __met
		  __not met
		
		3rd review period (__/__/__):
		  __met
		  __not met
		
		4th review period (__/__/__):
		  __met
		  __not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS

Member/caregiver understands and complies with medication regimen (self- or caregiver report, physician/RN report or observation by case manager).	MEMBER/CAREGIVER EDUCATION:
	___SOURCE PCP/PCP staff
	___SOURCE educational material
	___other_____
	
	MEDICATION ADMINISTRATION/MANAGEMENT:
	___self care
	___informal caregiver _____
	___ADH/DHC
	___ALS
	___PSS aides (cueing)
	___RN provider_____
	Dates of Service:
	
	OBTAINING MEDICATIONS:
	   ___self care
	   ___informal caregiver
	   ___pharmacy delivery _____
	   ___other_____
	
	PHARMACY:_____
	
	NOTES:_____
	
	   _____
	
	   _____
	
	   _____
	
	(Providers and units/schedules listed on Member Version)
		GOALS:
		
		1st review period (__/__/__):
		  __met
		  __not met
		
		2nd review period (__/__/__):
		  __met
		  __not met
		
		3rd review period (__/__/__):
		  __met
		  __not met
		
		4th review period (__/__/__):
		  __met
		  __not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS

Regular performance of ADLs and IADLs is not interrupted due to cognitive or functional impairments.
 	
GOALS:
 	
No observations by case managers or reports from mbr./caregiver/other providers (including SOURCE PCP) identifying problems with ADLs, IADLs and/or patient safety.
	___**ASSISTANCE REQUIRED:** (S=SELF; INF=informal support; PSS=PSS aide; HDM=home delivered meals; ALS=alternative living service):
	
	_____bathing _____dressing _____eating _____transferring
	_____toileting/continence _____turning/repositioning
	
	_____errands _____chores _____financial mgt. _____meal prep.
	
	__**informal caregiver(s)** providing assistance:
	
	_____
	_____
	
	___**home delivered meals**
	___**ADH**
	___**ALS**
	___**ERS**
	___**incontinence carepath**
	___**PSS aide**
	  Total hours/week: _____ Indicate no. of hours:
	
	Monday _____AM _____PM Thursday _____AM _____PM
	
	Tuesday _____AM _____PM Friday _____AM _____PM
	
	Wednesday _____AM _____PM Saturday _____AM _____PM
	
	           Sunday _____AM _____PM
	
	NOTES:_____
	
	_____
	
	_____
	
	(Providers and units/schedules listed on Member Version)
		GOALS:
		
		1st review period (__/__/__):
		
		__met
		
		__not met
		
		2nd review period (__/__/__):
		
		__met
		
		__not met
		
		3rd review period (__/__/__):
		
		__met
		
		__not met
		
		4th review period (__/__/__):
		
		__met
		
		__not met

KEY PARTICIPANT OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS

Problem behavior will not place the member at risk of social isolation, neglect or physical injury to themselves or others.
 	
Diagnosis:
 	
___depression   ___substance abuse
 	
___bi-polar disorder   ___schizophrenia
 	
___Alzheimer's   ___other dementia
 	
___other _____
 	
GOALS:
	ROUTINE AND PRN MONITORING AND EVALUATION by SOURCE PCP for signs of changes in mental status
	
	MEMBER/CAREGIVER EDUCATION:
	  ___SOURCE PCP
	  ___other_____
	
	__**ongoing management of condition** by mental health professional
	provider:_____schedule_____
	
	___**supervision** by informal caregiver(s):
	
	_____
		GOALS:
		
		1st review period (___/___/___):
		A. _ met
		  _ not met
		B. _ met
		  _ not met
		
		2nd review period (___/___/___):
		A. _ met
		  _ not met
		B. _ met
		  _ not met

A. Residential arrangements remain stable.		3rd review period (___/___/___):
		A. _ met
		  _ not met
		B. _ met
		  _ not met

B. Mental health conditions or cognitive impairment will be adequately managed by informal or paid caregivers. Indicators of inadequately managed behavior include:
 	
• hospitalization for condition
• discussion of potential institutionalization
• increased level of caregiver stress
• physical danger to self or others posed by behavior
• discharge from a program or service due to behavior
Examples of problem or symptomatic behavior:
wandering   profoundly impaired memory
substance abuse   profoundly impaired judgment
physical aggression   suicide attempts or threats
	___**ALS** for supervision and monitoring
	___**PSS** aides for supervision and monitoring
	___**day program** for supervision and monitoring of mental status when or if informal support is unavailable
	 provider: _____
	 schedule: M T W Th F
	
	NOTES: _____
	
	   _____
	
	   _____
	
	   _____
	
	   _____
	
	(Providers and units/schedules listed on Member Version)
		4th review period (___/___/___):
		A. _ met
		  _ not met
		B. _ met
		  _ not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Transfers and mobility will occur safely. **GOALS:** **Member has no falls due to unsuccessful attempts at transferring or mobility.**	**MEMBER/CAREGIVER EDUCATION:** __SOURCE PCP/PCP staff __SOURCE educational material __other_____ **ASSISTANCE REQUIRED:** ___i**nformal caregiver(s)** to provide assistance with transfers and mobility: _____ _____ ___**PSS aide** for assistance if/when informal support is unavailable ___**ALS** ___**ADH program** for assistance if/when informal support is unavailable ___**Adaptive equipment** as indicated, with training as required (specify): _____ _____ _____ ___**Home modifications** as indicated (specify): _____ _____ NOTES:_____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS

Informal caregivers will maintain a supportive role in the continued community residence of the SOURCE member.
 	
GOALS:
 	
No reports or other indicators of caregiver exhaustion (self-report, observed by case manager, etc.).
	___**Ongoing SOURCE case management/support service plan**
	
	___**Referral to support group** _____
	
	___**In-home respite** Extended Personal Support (EPS) schedule:
	
	    _____
	
	___**Out-of-home respite**
	
	provider: _____
	
	schedule/dates: _____
	
	_____
	
	___**ADH** for respite purposes for informal caregiver
	
	NOTES:_____
	   _____
	
	   _____
	
	(Providers and units/schedules listed on Member Version)
		GOALS:
		
		1st review period (__/__/__):
		  __met
		  __not met
		
		2nd review period (__/__/__):
		  __met
		  __not met
		
		3rd review period (__/__/__):
		  __met
		  __not met
		
		4th review period (__/__/__):
		  __met
		  __not met

MEMBER_____ DATE _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
		MEASURES:
		1st review period (___/___/____): _ met _ not met
		2nd review period (___/___/___): _ met _ not met
		3rd review period (___/___/___): _ met _ not met
		4th review period (___/___/____): _ met _ not met ----------------------
GOALS:		1st review period (___/___/___): _ met _ not met
		2nd review period (___/___/___): _ met _ not met
GOALS:		3rd review period (___/___/___): _ met _ not met
GOALS:		4th review period (___/___/___): _ met _ not met

APPENDIX C. INDIANA CHRONIC DISEASE MANAGEMENT PROGRAM (ICDMP) CARE MANAGEMENT ORGANIZATION SCOPE OF WORK

Nurse Care Management Organization Contractor(s) shall:

1. Hire, train, and maintain qualified nurse care managers in numbers sufficient to manage caseloads with up to 150 participants actively in Intervention Phase, participants are followed through the Reinforcement Phase. Contractor shall require a Bachelor's Degree in Nursing and 1 year experience in Community Health setting or Chronic Disease management; or Bachelor's work equivalent of formal nursing certificate and 3-5 years in Community Health setting or Chronic Disease management preferred. OMPP will provide initial training to Contractor on program components. Contractor shall provide ongoing training to nurse care managers on program components. Contractor shall utilize OMPP Nurse Care Manager Performance Expectations (Exhibit B) for description of Position Summary, Key Responsibilities, Critical Skill, Knowledge and Behaviors, Education and Experience, and Special Licenses or Transportation Demands to fulfill the terms of this contract.

2. Train nurse care managers in the use of the chronic disease data management system (CDMS). OMPP will provide initial training to Contractor, further training will be the responsibility of the Contractor.

3. Establish and maintain relationships with participating doctor offices and coordinate participant care information.

4. Make appropriate case assignments to nurse care managers, based on caseloads assigned by the call center.

5. Initiate care management with participants as quickly as possible after assignment to the network has been made by the call center.

6. Provide a computer with Internet access to each nurse care manager.

7. Prepare monthly monitoring reports, as directed by OMPP and meet OMPP performance measurement standards.

8. Coordinate activities with other Chronic Disease Management Program partners.

9. Meet semi-weekly with OMPP or more often at the sole discretion of OMPP.

10. Maintain an appropriate number of supervisors consistent to assure compliance with performance expectations of the contract. Supervisory duties are not separately reimbursable under this contract and considered inclusive within the nurse care manager payment.

11. Provide one program director who serves as a representative for the Contractor. Program director will act as liaison to OMPP. Program director duties are not separately reimbursable under this contract and are considered inclusive within the nurse care manager payment.

12. Any travel necessary to perform the duties of this contract is not separately reimbursable.

Reporting requirements shall include but not be limited to the following:

1. Contactor shall provide monthly reports on the number of disease management participants in the network as well as the number served by each nurse care manager. The participants shall be counted in either the intervention phase or reinforcement phase. Any request to increase nurse care manager staffing must be included in this report on current caseloads.

2. Contractor shall submit a monthly roster for each nurse care manager, detailing progress on their individual caseload. The Contractor's operating efficiency will be measured and reported monthly, including but not limited to the following criteria:

   a. Nurse care managers will successfully complete 100% of calls/visits with program participants, as detailed in Exhibit B--Nurse Care Manager Performance Expectations,
   b. Nurse care managers will successfully complete 100% of calls/visits with the participant's PMP as detailed in Exhibit B--Nurse Care Manager Performance Expectations,
   c. Nurse care managers will record all contacts with participants and providers in CDMS, including participant's clinical data.
   d. Nurse care managers will complete participants' care plans within the required time frame,
   e. Nurse care managers will respond to inquiries/contacts from program participants and providers within one business day.

3. Contractor shall provide written quarterly assessments of operating efficiency, including proposed strategies for improving efficiency.

APPENDIX D. INDIANA CHRONIC DISEASE MANAGEMENT PROGRAM (ICDMP) NURSE CARE MANAGER PERFORMANCE EXPECTATIONS

Position Summary. The primary responsibility of this position is the day-to-day management of the more severely classified participants of the Chronic Disease Management Program. This includes face-to-face encounters and telephonic encounters with these participants. Care Management is defined as on-going self-management support, referrals/reminders for appropriate testing and physician visits, on-going assessment of participant status, and working with Primary Medical Providers of the participants to ensure proper management during and after the nurse care manager intervention.

Performance Expectations

1. Manage caseload of up to 150 participants actively in Intervention Phase and follow those participants through the Reinforcement Phase.

    a. Intervention Phase is defined as lasting 4-5 months and includes the following activities:
    - Participant assessment--face to face encounter in the home, physician office, care management vendor location, or community location;
    - Nurse Care Manager contact with Primary Medical Provider (PMP);
    - Plan development/clarification--face to face encounter preferably done in conjunction with a PMP visit;
    - Home assessment if first assessment was done outside of the home;
    - Education/Training--telephonic contact with participant at a minimum;
    - Problem Identification/Problem Solving--telephonic contact with participant at a minimum to provide self-management support training at point of first contact which includes problem identification, collaborative goal-setting, problem solving and regularly scheduled follow-up to assure goal attainment and setting of new goals;
    - PMP contact by Nurse Care Manager to transition participant to Reinforcement Phase.

    b. Reinforcement Phase is defined as lasting up to 2 months and includes the following telephonic activities to check on participant's self-management activities, problem-solving barriers, and set new goals as appropriate.
    - Follow up calls--minimum of one call a month for two months;
    - Transition to Call Center Management.

2. Prepare care plan with participants and their families based on clinical guidelines endorsed by the Indiana Chronic Disease Management Program.

3. Establish and maintain in-depth knowledge of the chronic disease data management system (CDMS).

4. Enter participant data in CDMS within one business day of every contact with participant.

5. Work with Call Center staff to receive messages, new participants to be case managed, and utilize Call Center staff for appropriate out-going calls as needed.

6. Conduct health assessment of participants based on a tool provided by OMPP.

7. Encourage participants to follow care plan by addressing any identified barriers. This would include information on Community Support Resources that may be needed.

8. Assist participants to understand their condition and set goals and achieve self-selected outcomes through education, counseling, and on-going support.

9. Coordinate activity with the participant's PMP through regular contact with the PMP.

10. Develop an action plan in concert with the PMP for use upon release from care management.

11. Work to develop and maintain relationship with primary care practices consistent with the goal of obtaining a systemic change of caring for the chronically ill:
    a. Assist in building care management into primary care,
    b. Communicate with PMP offices for updates of relevant lab tests and values, procedures, medications, etc. and update CDMS with this information,
    c. Assist PMP office staff with working in CDMS as necessary,
    d. Do case list review for each primary care physician,
    e. Build trust based on one-on-one case review and planning, participant supports by care manager to alleviate work for practices,
    f. Support guidelines by identifying medication change needs and communicate to participants' physicians,
    g. Serve as resource for Primary Medical Provider in managing Medicaid participants with chronic disease.

Critical Skill, Knowledge and Behaviors

Success in this position requires that the Contractor's employee will:

1. Exhibit in-depth knowledge of the consensus guidelines developed by the Chronic Disease Management Program.

2. Possess strong communication, teaching/education, patient-centered counseling skills to create collaborative relationships with participants and physicians.

3. Encourage patient empowerment that allows participants to help themselves and display respect for participant choice and preference.

4. Demonstrate excellent verbal and interpersonal communication skills.

5. Be capable of working within a highly matrixed environment.

Education and Experience

1. High school diploma; Bachelor's Degree in Nursing and 1 year experience in Community Health setting or Chronic Disease management; or Bachelor's work equivalent of formal nursing certificate and 3-5 years in Community Health setting or Chronic Disease management.

2. Case management experience with chronically ill patients, one year preferred.

Special Licenses or Transportation Demands

1. Current State of Indiana licensure as Registered Nurse.

2. Individual will cover territory as determined by Chronic Disease Management Program criteria.

APPENDIX E. INDIANA CHRONIC DISEASE MANAGEMENT PROGRAM (ICDMP) SAMPLE LETTER

Here is a list of topics that we discussed during our recent call. Some were areas that caused you some difficulty. Others you wanted to learn more about. Please take this list with you to your next doctor's visit and show it to your doctor. This list may help you and your doctor talk about questions or concerns you may have.

We talked about these areas: [*Only those items discussed on the previous call would be listed.*]

- **Sometimes having difficulty with medicines.**
- **Sometimes having difficulty taking your medicines on schedule.**
- **Keeping track of your weight.**
- **Talking with your doctor about what the best weight for you would be.**
- **Cutting down on salt in foods.**
- **You are not very likely to start doing more physical activity in the next 6 months.**
- **Likely to start doing more physical activity in the next 6 months.**
- **You would like to learn more about physical activity.**
- **Sometimes having difficulty testing your blood sugar every day.**
- **Sometimes your blood sugar is above 300.**
- **Sometimes having difficulty checking your feet every day.**
- **It's time for your check-up this year at the eye doctor.**
- **Sometimes eating sweets.**
- **Sometimes drinking sodas, lemonade, fruit juices, or coffee with sugar.**
- **Wanting help with food choices--more fruits and vegetables.**
- **Wanting help cutting down on fat when cooking.**
- **Wanting help cutting down on fast foods.**
- **Trying to do more physical activities, but finding it hard to do them regularly.**
- **Thinking about trying to start regular physical activities in the next 6 months.**
- **Wanting to know more about regular physical activities.**
- **You would like help to quit smoking.**

If you have any questions about this list, you can call us at the toll-free number above.

Thank you again for taking the time to talk with us and to answer our questions. Remember: We will be calling you again in about three months to check on you and find out how you are doing. If you have questions before then, call the toll-free number. There is someone at this number **Monday through Friday from 8 A.M. to 7 P.M.** and on

Saturdays from 8 A.M. to 1 P.M. To get more information about the program and your health, you can also visit our website at http://www.indianacdmprogram.com.

Sincerely,

Care Coordination Services, Indiana Chronic Disease Management Program