



2011-2013

Long Term Care Sustainability

DRAFT - Living Well at Home and in the Community

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Living Well at Home and in the Community
Projected Savings:	TBD
Proposed Implementation Date:	Spring 2012

Description: Increase the availability of timely and easy access to less intensive and more flexible supports to help people and their caregivers to remain healthy and safe at home and in the community without the need for more comprehensive LTC supports and services.

Main Message Points

- Aging and Disability Resource Centers (ADRCs) provide a central source of reliable and objective information about a broad range of programs and services and help people understand and evaluate the various options available to them. In particular, ADRCs:
 - Serve as the single point of access for publicly-funded LTC, providing eligibility determination and enrollment counseling.
 - Provide options counseling to identify other available programs and resources for those not eligible for Family Care, IRIS, PACE or Partnership.
 - Offer intervention activities such as programs to review medications or nutrition, teach people how to manage chronic conditions like diabetes or heart disease, or engage people in programs to eliminate home hazards and prevent falls.
- In identifying resources and making informed decisions about long term care, seniors and persons with disabilities can conserve their personal resources, maintain self-sufficiency, and delay or prevent the need for potentially expensive long term care.

Proposed Modifications

1. **Medication Compliance.** Provide automated, in-home medication dispensing systems for frail seniors, persons with disabilities, and high-risk persons on Medicaid to keep people living independently in the community and to reduce emergency room visits, inpatient hospital stays and nursing home and LTC residential admissions from non-compliance and errors in dispensing prescription medications.
 - Utilize existing data and analytical tools to systematically identify at-risk individuals on Medicaid with multiple medical conditions, multiple medications, some form of cognitive impairment, a history of negative health outcomes from not taking medications, and need for assistance in a relatively high number of activities of daily living.
 - Medication compliance by frail seniors is typically below 15%, but rises to about 98% with automated dispensing.
 - Research shows that up to 23% of nursing home admissions are due to medication non-compliance by seniors, while over 10% of hospital admissions are due to medication non-compliance.
 - Facilitate access to secure in-home medication dispensing systems with personal resources for seniors and persons with disabilities who are at risk of entering a residential or institutional placement or of becoming eligible for more costly LTC programs.

- Automated dispensing reduces the need for services in more intensive LTC settings; the inability to follow medication therapy is sufficient reason for admission in these settings.
 - Use supportive home care workers, families, nurses, and pharmacists to load prescriptions in machines.
 - The device holds a month's supply of prescribed drugs;
 - Visually and audibly notifies the person when it is time to take their medication;
 - Dispenses medications at the correct time of day, in correct combinations, in correct quantities, and with correct instructions (e.g., take with food); and
 - Sends warning alerts to caregivers over the phone line, continuously tracks medication compliance, and provides data for care management.
 - Implement the pilot within three months on a voluntary basis, and generate net savings quickly from avoidable hospital, ER and LTC placements in residential and institutional settings.
 - Proactively identify 40,000 Medicaid beneficiaries through predictive modeling of the high risk of hospitalization/institutionalization of those who are at extremely high risk of medication non-compliance due to a high number of active prescriptions, multiple morbidities, age, prior adverse events from non-compliance and other risk factors, such as cognitive impairment or functional limitations.
 - Certify qualified providers to provide automated dispensing, with savings used to fund implementation and ongoing costs for Medicaid eligibles and with competitive rates for those at risk of becoming eligible for LTC programs.
 - Explore the opportunity of a grant with the CMS Innovation Center to share the costs and savings from Medicare beneficiaries in the demonstration pilot.
 - Provide additional supports, such as ensuring home-delivered meals for individuals that need adequate nutrition for effective medication management.
- 2. Nursing Home and Assisted Living Intervention and Diversion.** Counsel new patients and their families in nursing home and assisted living about LTC services in the community, assist them in arranging those services and help existing institutionalized Medicaid residents leave a facility for services at home.
- Deploy staff in nursing home and residential facilities to provide information within seven days of admission to residents who are on Medicaid and those likely to become eligible for Medicaid within six months to conduct an assessment and discuss LTC options at home and in the community.
 - Intervene early in a stay, focusing mainly on those who continue to have available housing and willing support systems, providing assistance to remain in their own homes or delay or prevent residential or institutional placement.
 - Similar initiatives in Washington, Oregon and New Jersey have demonstrated savings of 35% to 60% from reduced nursing home admissions over a 10 to 15 year period.
- 3. Falls Prevention.** Expand the number of high-risk persons participating in evidence-based prevention programs to reduce hospitalization and/or need for long-term care.
- Reduce falling among older people in every county to reduce by 20% hospitalization and long-term injury among older people due to falls.
 - Develop outreach to health systems and to people to promote referrals and participation in falls prevention by 25% each year.
 - Support occupational and physical therapy participation in falls prevention.
 - Work with health systems and MCOs to develop additional programs for members.
- 4. Chronic Disease Self-Management.** Expand the number of high-risk persons with multiple chronic diseases that participate in peer-led chronic disease self-management.
- Support outreach to adults with chronic illness to participate in a seven-week peer-directed class in self-management of chronic conditions in order to improve health and well-being.
 - Increase participation by 25% each year in every county.
 - Focus efforts on diabetic and cardio-pulmonary conditions.
 - Work with health systems, MCOs, and other federal and state initiatives to promote referrals and to develop

additional programs.

- 5. Short-term Community Intervention.** Arrange for short-term practical community interventions to support people with modest means to remain at home.
- Problem solve with elders and people with disabilities who are at risk of moving to residential settings by arranging volunteer help; low cost technologies; minor home repair and cleaning or other affordable solutions to problems with the current home environment.
 - Identify and mobilize social supports and community connections to reduce isolation and risk for people living alone.
 - Secure affordable housing and arrange for low-cost services for elders, people with disabilities and their families that do not need residential care but who are struggling to maintain independence at home.
 - Conserve individuals' personal funds for people that do not require residential care by advising about purchasing in-home or community-based services.
- 6. Alzheimer's Disease and Other Dementia.** Screen and treat vulnerable individuals to identify those diagnosed with Alzheimer's disease or other dementia, to delay institutional placement by an average of 18 months.
- Conduct a brief screen at ADRCs to identify persons at risk.
 - Refer those who may be at risk dementia diagnostic clinics (21 available around the state) that are affiliated with Alzheimer's Institute.
 - Using the evidence-based model of Memory Care connections, connect individuals and families with social supports, education, caregiver support and respite.
 - Provide contact and help to caregivers using the evidence-based Mittleman model.
 - Engage persons with dementia and caregivers in a program of moderate physical and mental exercise to reduce isolation, improve function, and provide respite (LEEP model).
- 7. Care Transitions.** Assist seniors and persons with disabilities leaving hospitals and making a transition to home.
- Pilot the evidence-based Coleman model of effective hospital transitions with several major hospitals or health systems.
 - Provide for individuals who are screened at discharge as at risk of returning to the hospital by providing a transition "coach" to facilitate effective transition for the person and caregiver.
 - Using a combination of home visits and telephone contacts, monitor compliance with the discharge plan for up to three months.
 - Measure effectiveness and cost-savings and determine how to finance expansion of the model, if successful in Wisconsin.
 - Strengthen relationships between ADRCs and hospital discharge units to improve information and assistance about community resources.
 - Pilot the Peer Link model which uses certified peer specialists to assist with transitions from the hospital to the community for individuals with mental health concerns and which has shown a 46% decrease in hospitalizations for members in the program.

Effect of this change:

- Delay or prevent people's entry to long term care.
- Assist more people to manage within their own personal resources.
- Avert unnecessary hospitalizations, ER visits, and nursing home placements, reducing public and private expenditures for primary, acute and LTC.
- Ensure that caregivers receive critical support to be able to maintain their role as a caregiver while remaining healthy.