Complex Care Management Model Design

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Complex Care Management Model Design

Overview for Managing Long Term Support Services for Complex Populations Summit
October 25, 2016
Who We Are
Essential Steps in Model Design

- Step One: Identify the population
- Step Two: Determine the risk factors
- Step Three: Identify interventions
- Step Four: Develop Plan of Care
- Step Five: Monitor Outcomes
- Step Six: Continuous improvement
Medicaid Focused Complex Care Management

• Medicaid Administrative activity
• Focused on a defined population of medically complex individuals requiring skilled interventions
• Involves the facilitation of Medicaid funded long term services and supports (LTSS) to enable individuals to remain in the community and avoid institutionalization
Goals

• Provide LTSS benefit coordination of Medicaid State Plan services
• Streamline and simplify the prior authorization (PA) process by establishing a single point of entry to Medicaid LTSS
• Ensure that Medicaid is the payer of last resort for services by coordinating the LTSS needs of Individuals with those available from other insurance or other payers – including services provided by state/local agencies
Program Eligibility

• All individuals who require continuous skilled nursing services
• No age requirement
• Individuals must
  – Require a nurse visit of > 2 continuous hours of nursing services in the home
  – Have certain categories of Medicaid insurance
Member Characteristics

• Typical Primary Diagnoses:
  – Cerebral Palsy
  – Congenital Malformations
  – Neuromuscular Disease
  – Neurologic Disorders
  – Genetic Disorders
  – Trauma

• Age Range:
  – 0-97 years old

• Other:
  – Severe Developmental Delays
  – Guardianship Issues
  – School Issues
  – End of Life Issues
Process

- Step One: Referral to program
- Step Two: Telephone Screening
- Step Three: Comprehensive in-person assessment completed by RN
- Step Four: Develop Service Record (AKA Plan of Care)
- Step Five: Monitor Individual and Utilization Regularly
- Step Six: Adjust Service Record as needed
Single Point of Entry

• Once services authorized, nurse care manager becomes the primary contact for the Individual/Caregiver for ongoing LTSS needs and any issues that may arise
• Nurse care manager is responsive to Individual’s ongoing needs
  – Quick authorization of increased services during acute illness
  – Assist Individual/Caregiver to locate nurse providers
  – Referral to other state/local agencies
  – Connection to benefits support, including assistance with premium payments and other insurers
  – Attendance at hospital and facility discharge planning meetings to facilitate discharge
• Ongoing support through telephone calls and annual in-person reassessments (or more frequently if needed)
Single Point of Entry (cont.)

- Nurse care manager works in collaboration with Allied Health professionals
  - Occupational Therapists, Pharmacists, Physical Therapists, Rehabilitation Counselors, Respiratory Therapists, Social Workers, Speech Therapists
- Allied Health professionals provide ongoing support, including:
  - Clinical knowledge and decision making for other LTSS authorizations
    - Durable Medical Equipment, Orthotics & Prosthetics, Oxygen/Respiratory Equipment & Supplies, Therapy Services
  - Functional assessment for personal care services, home and community accessibility and other LTSS needs
  - Identification of communication needs
  - Collaboration with other community providers to identify and coordinate other support needs
Outcomes

• Member Survey
  – 2014 Surveyed a sampling of individuals in the program for at least 6 months (N-667)
  – Response rate 45.3%
  – Survey designed to assess perceptions across number of areas including needs assessment, communication with and coordination of services, interaction with allied health specialists and overall perceptions of the care approach.
– 91% overall satisfaction with care coordination
– Majority indicated assessment process which drives nursing authorization is thorough and clear
– 89% report the care coordination has resulted in having a positive impact on a person’s life
– 83% report it would be at least “somewhat difficult” to stay at home without this support

• Cost Avoidance
  – FY 04-16 > $84M
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Questions