Summary of Wenatchee Provider Focus Group
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How can we improve coordination of care?

- PACE was described
  - Started in San Francisco from adult day health
  - Has been in Seattle for 16 years
  - Funding is from Medicaid and Medicare
  - Transportation is a benefit
  - Financially viable le because an interdisiplinary team determines care
  - Physical Therapy (PT), Occupational Therapy (OT), Activities Therapist, Masters in Social Work(MSW), Dr, Nurse are on team
  - Dr. and Nurse are leads
  - Teams decide who will be care manager
  - Each team has a facilitator that is a clinician
  - They use the phrase participant driven
  - 420 are in program and are COPES eligible, only 15 live in a SNF
  - 40 inpatient psychiatric days this past year and over 50% have a Mental Health (MH) diagnosis
  - Less than 10% of clients die in hospitals or nursing homes
- Wenatchee Valley Medical Center was described
  - Demo project, primarily over 55, average age is 79
  - Telehealth case management, clients put in the daily stats
  - Has cut costs over 5% for Medicare
  - They hold financial risk
  - Decreased 18% length of stay
  - Increased outpatient care over Emergency Room (ER) care
  - Decreased days of stay in Skilled Nursing Facility(SNF)
  - They use the Health Buddy System

- Want to put Care Management (CM) in with Primary Care (PC)
    - They brought in high cost patients and this is voluntary for participants
    - When orienting patient, build relationship, do home visits
    - Nurse Case Managers are Care Coordinators, they are the small group that uses the Health Buddy System
    - Currently doesn't have MSW on the team
    - They make referrals to behavioral health (BH)
    - Decreased cost for last six months after providing education
    - Electronic medical record results in success
- Who is care manager or care coordinator is an important issue, need to reduce duplication
    - Learn a lot by being in a person's home
    - Wenatchee is developing a BH campus
        - 1 wing will be houses
        - 1 wing recovery innovations
- These models fit with 1 cm or 1 care coordinator
- Example from UK
- Team is in community, they go to where the patient goes
- Team is OT, PT, MSW, Nurse, like Community Health Clinics (CHC)
- They are implementing Health Buddy
- Whoever is at risk will make sure there is a care coordinator
- Team can work with lead of whatever the care need is
- Collaborative effort
- Electronic medical record

How can reduce fragmentation of the system?

- Shared assessments
- 1 assessment
- Look at HIPAA (confidentiality rules) and make sure there is a balance
- Make sure there is a follow up call from ER/Hosp to cm within 48 hours
- Have someone see the person with 7 days
- Centralized system needs to notify upon discharge to cm
- Centralized system to be alerted of admit

- Unified utilization management (UM) system
- UM needs to be involved with hospitalization
- UM is centralized service
- When conned with team they can get a baseline on the person and communicate that to ER, Hosp
- Capitated model of care
- Require advance directives
- Reduction of people in Adult Family Homes (AFH)
- Providers all communicate with each other and work like a team
- Use self management for chronic disease
- Quarterly wellness days, bring PC in for presentation and questions
- Vendors form community, cardiac rehab for examples
- Have them at Senior Service Center
- ER utilization, this can be a failure of care
- Re-admit rates should be reduced as an outcome

How can we improve accountability?

- Risk has to follow money
- Without it there is no incentive
- Contracts would result in shared risk
- Duals, financial incentive to not cost shift
- Get partnerships developed in rural communities, less competitive
- Sharing information because of less competition
- Accountability for outcomes
- Take risk and be successful
- Make sure people use the services they need and not get those they don't
- Data to CMS, lots of outcomes are already sent to them
- Need to get real time date from Medicare
- Have encounter info from state and CMS (FEDS) in real time
- Additional regulatory oversight would be a waste
- Need something streamlined
- Eliminate duplication of oversight

- Require outcomes that include decrease in hospital stay, increase time in home
- Opt out later but initially require all dual to be in system
- Have to have fully risk bearing system
- Single contract then subcontract but pass down risk
- Funding source drives services
- Need single payer
- Payer in Olympia, pre-authorize services
- Hold providers to a standard
- Centralized referral center for duals
- If you want services used make sure you are on the list
- Care coordinator is really important so PC doesn't make decisions in isolation
- Full assessment by PC or ARNP, should be able to share assessments

What is the first step?

- Refer to paper on PACE
- Community Center, allow PACE to be built there
- State could take responsibility for risk
- Small cities have PACE
- Missoula MT has PACE
- Have to have integrated funding (this would take care of spendown)
- PACE program as example of blended funding
- Program like PACE is much more individualized
- Can't ease into it, put all services into one system
- 0 based performance budgeting
- Need to put all together soon and all at once
- Design a system with people's needs in mind and put budget together to meet those needs
- New York has done this with People First Waiver
- Can't use existing systems
- Make sure there is someone helping with spendown
- Ask CMS in proposal to waive spendown limit
- If one service provider, 1 pot of $ then no spendown, no cost shifting

- Centralized intensive, integrated care management