

Long Term Care (LTC) Restructuring Initiatives in Virginia

Preventing or Delaying Long Term Care:

- The state provides Disease Management support to individuals who are receiving home- and community-based waiver services. Conditions covered include asthma, diabetes, congestive heart failure (CHF), coronary artery disease (CAD), and chronic obstructive pulmonary disease (COPD).
- In addition to the governor's actions, the legislature appropriated \$1.5 million in start up funds in 2006 for the creation of six separate Program of All-Inclusive Care (PACE) sites.

Strengthening the State Government Infrastructure:

- Governor Tim Kaine took two actions early on in his administration which had a major impact on the state long term care system: 1) In 2006, the governor directed the Department of Medical Services (DMS), which serves as the state's Medicaid Agency, "to develop a plan which will serve as the blueprint for moving towards an integrated acute and LTC delivery system for elderly and disabled Medicaid recipients," and 2) the governor created the Health Reform Commission under Executive Order 31, which was charged with improving access to competent, affordable general healthcare, as well as to address the specific affordability issues surrounding long term care.
- While making long-range plans for the integration of acute and LTC services, DMS began developing two, more immediate service delivery systems. One system was designed as a local "community" model for service delivery in collaboration with an Area Agency on Aging (AAA). The other "regional" model was developed by an existing Medicaid managed care organization.
- In 2007, the Health Reform Commission issued a Draft Report listing the following recommendations for improving LTC services in the state:
 1. Obtain funding to implement a Money-Follows-the-Person Program.
 2. Continue support of integration of Medicaid acute and LTC services through the PACE program and managed care models.
 3. Add assisted living as a service under the Medicaid Elderly and Disabled waiver program.
 4. By 2010, expand access to the "No Wrong Door" program (see below) LTC services model statewide.

Developing New Ways to Improve Quality:

- In 2005, the General Assembly gave the Department of Social Services new enforcement authority over Assisted Living Facilities (ALF). It also directed the Department of Health Professions to license facility administrators and medication aides, and increased the auxiliary grant rate – a financial subsidy to ALF residents with low incomes. The DSS regulations imposing minimum standards on ALFs became final in 2006 and the Board of Nursing regulations for medication aides became effective in July 2007.

Developing Public Information Campaigns:

- In 2005, the state created the “No Wrong Door” program, which is a web-based initiative using a one-stop service approach to simplify and improve long term care service delivery for the state’s population of elderly and disabled. Funding for this initiative was provided initially by an Aging and Disability Resource Center (ADRC) grant and subsequently (in 2006), by a Systems Transformation grant.

Evaluations of Virginia’s Restructuring Initiatives

- A study evaluating the success rates of Disease Management (DM) programs implemented in eight different states indicated that with regard to asthma patients, the Virginia program demonstrated a 41% reduction in ER visits from 1995-1997, as well as a 25% increase in the dispensation of recommended prescription drugs. The study also estimated that there was an average \$3 in savings per \$1 spent on care for DM services among individuals in this group.
 - In terms of the DM program’s effectiveness among patients with diabetes, CHF/hypertension, asthma/COPD, depression and gastroesophageal reflux disease (GERD), the study indicated that from 1997-2002, there was a \$700,000 savings in hospital costs, with an overall reduction in the number of “problems” noted in patient care.
 - The Health Management Corporation (HMC) administers the DM program in Virginia. As part of the quality management and evaluation measures of the program, HMC must issue vendor reports, which measure cost savings by developing a predictive model of expected expenditures and comparing them with the

actual expenditures, minus the program costs. HMC is required to issue regular reports on program outreach and participation, nurse call line activity satisfaction surveys and clinical outcomes, patient participation in self-management efforts, physician office visits and hospital utilization statistics including admissions, readmissions, and number of emergency room and ambulatory care visits.

Additionally, the state has recently contracted with an outside organization, the Michigan Peer Review Organization (MPRO), to monitor HMC and ensure that it is adhering to its contractual obligations, as well as to evaluate the cost effectiveness of the program. The state of Virginia itself will also conduct an internal review of the program.

- Another study conducted on the DM program in Virginia provided similar results. The findings indicated that the DM program significantly improved the compliance rates of Medicaid patients with chronic diseases in terms of prescription drugs and quality of life improvement methods, while also reducing the number of ER hospital visits, physician office visits, and other adverse events. The study also indicated that the average cost per hospitalization would have been \$42 higher for this consumer population without the intervention measures instituted by the program.
- In 2007, the American Council for Technology (ACT) honored the “No Wrong Door” program as the national winner of the ACT Intergovernmental Solutions Award. The Virginia Tech Center for Gerontology is also assisting in evaluating the No Wrong Door program.

Conclusion

- Although the aforementioned study did not specifically measure the effect that the reduction in hospital visits and the increase of prescription drug use had on nursing home intakes, these improvements can be viewed as likely preventive measures, delaying the deterioration of patients with these diseases, and, in turn, preventing or delaying their need for nursing home level of care and placement. Furthermore, the state’s efforts to simplify delivery of services and maximize access to LTC information through the “No Wrong Door” program, has enjoyed success in its initial phases. Future follow-up assessments by both internal and

external sources are recommended to determine whether this success can be perpetuated in the long term.

Resources

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