SENATE HUMAN SERVICES COMMITTEE

TESTIMONY IN SUPPORT OF HB1033
AND PROPOSAL FOR AN AMENDMENT
"Pilot for Independent Home and Community Based Services
Case Management and Care Coordination"

Senator Lee and Committee Members. I am Jessica Thomasson, CEO of Lutheran Social Services of North Dakota. On behalf of Lutheran Social Services I am testifying today in support of HB1033, and would also like to ask that you consider an amendment that would pilot the addition of care coordination as an eligible Home and Community Based service that could be authorized by case managers based on individual need.

For more than 35 years, Lutheran Social Services has been serving older adults across North Dakota, primarily through the Senior Companion program, and starting in 2015, through the provision of Aging Life Care (a.k.a. care coordination) services.

Our experience tells us that it is possible for seniors to get the care they need, in their home communities, in a setting of their choice, if we work together. We are supportive of HB1033 because the addition of independent case managers will help move us to this desired outcome and further support the work of the current system in serving older adults and people with disabilities.

Our experience also tells us that serving the needs of people as they age, given the realities and opportunities of our present day, requires us to think differently about home and community-based care, including **non-traditional partnerships** between care systems, and recognition of how to strengthen a person's **natural supports** as an essential part of our joint search for individual well-being. This is why we are **asking you to consider adding a pilot that makes care coordination a component of our home and community based service system.**

For most people, it is a change in personal health, or in the health of a spouse, that precipitates the initial exploration of the types of supportive services that are available from public and private systems. The change in health status could be the result of a fall, or recovery from surgery, from symptoms that arise from a chronic disease, or from a loss of mobility. The person seeking services has found themselves – most often for the first time – unable to accomplish a "task of daily living". In other words, their health has made it so they can't continue living the way they had previously – they need to start looking for a "new normal".

This is the time when a person most often first encounters the aging services system. They reach out because they are looking for help in figuring out what they should do. If they go to a County office, and they are deemed eligible, they may get connected with a case manager – someone who very much wants to help them but most likely finds themselves with a large caseload to manage and not a lot of time.

Generally speaking people (and systems) assume that case managers help connect people who need help to resources and services. On many levels, this is true. However, it can still be difficult for someone who is trying to figure out how to make sense of their new life circumstances know what they should do and how they need to go about it.

A TYPICAL SCENARIO: "JOHN". I want to describe this situation as it would likely play out for "John" to help describe the difference between case management and care coordination, and how the work of one complements the other.

John is a widower in his early-80s who is having trouble keeping up with things at home. It's getting hard for him to get to the doctor for his appointments. He's struggling to keep track of his medications and has had a couple of health scares because of missed meds. And he's overall just

not feeling as steady on his feet. So he calls the number he finds on the internet for "Aging Services" in his County and gets connected to an eligibility worker who gathers information on his personal finances, to tell him what types of services he may be eligible for. If he meets financial criteria, John will be referred to a case manager.

1. The case manager works to determine if John is eligible for HCBS (based on his functional limitations and his household income).
2. It is determined that John meets criteria for nursing home level of care (based on his "functional limitations"), and he meets income guidelines (i.e., earns less than poverty level income), so is asked if he wants to receive care in a nursing home or in his own home.
3. John says he wants to stay in his own home, so the case manager develop a plan of care, authorizes the services (based on the assessment of his health) and assigns a number of "units" of service that John will qualify for (i.e., that state and/or county-funded HCBS will pay for).
4. At this point, the case manager hands John a lengthy list of who can provide the services. This list typically includes 50+ names of individuals and agencies who do chore services, personal care, environmental modifications, homemaker services, meal services, non-medical transportation, respite and adult foster care services, etc. And if John lived in a rural area, he would have a wholly different problem; instead of the list being too long to sort through, he may have 1 or 2 names to pick from, or no options at all.
5. John takes the list and heads home to start to sort through it.
6. He will start to call people from the list and attempt to put together a system of care that meets his needs, staying within the guidelines given to him by the case manager (i.e., what he's "eligible" for).
7. Typically, John can expect to get a follow-up phone call from his case manager approximately a month after the initial eligibility visit, with some contact at least quarterly and re-assessment of his continued need(s) every 6 months thereafter.
8. In the meantime, John will have tried to hire, manage, and facilitate the compensation of the in-home support workers and/or agencies he is contracting with for his care.

You can imagine, from this description, where John is going to struggle in this scenario. He has just had to access "system services", perhaps for the first time. Which means he is already dealing psychologically with what it means to "need" help. Then he is thrust into a complex world of acronyms and eligibilities and rules that can be very hard to understand, even in the best of times.

- The list of possible in-home service providers is long.
- His own understanding of what he needs to help him navigate this brand new state of being/life stage may not be fully developed.
- He likely does not know any of the providers.
- He doesn't know who to trust or where to turn, what to look for or how to negotiate for the type of services they truly need.
- In short, John is overwhelmed.

The end result. John may or may not get the help he needs to live well in his home.[1] His health may or may not deteriorate. His well-being may or may not be diminished. It may appear to those around him like there are no services available to help John. When in fact, the real gap is not that there are no services available, but that the system and the supports that are in place – and that the state has invested in – are not able to do what they are designed to do. Because John can't effectively access them.

DIFFERENCES BETWEEN CASE MANAGEMENT AND CARE COORDINATION.

The common assumption is that case managers do "care coordination" as part of their regular job. However, we know that this is not always the case. While there is no "bright line" between the two roles, Care Coordinators often pick up where Case Managers leave off.

Case Management focuses on completion of paperwork necessary to determine eligibility; assessing and re-assessing a person's needs; developing, implementing and monitoring a care plan; and providing options of in-home providers, ensuring client choice. *In many cases, case managers have 2-4 face to face client visits per year.*

[1] For this conversation we define "aging well" as living safely, with dignity, in a manner he can afford, in his home.

Care Coordination works alongside a client after a determination of eligibility has been made, to help them identify both formal and informal supports; access necessary resources, like transportation, medical needs, basic care needs; and assist with applications for eligible services, organizational skills, or bill paying. *Overall, care coordinators offer coaching and mentoring designed to help people overcome barriers and implement a plan.*

Case management and *in-home supports* are **essential** for well-being **but not always sufficient**. For many, *care coordination* is the **missing piece** and can help the existing system function better. Additionally, care coordinators are uniquely suited to help facilitate early intervention and prevention work with older adults, as they begin thinking about how best to address health needs and new functional limitations while remaining at home (or in the least restrictive setting possible).

It doesn't matter how much money we invest in services to help older adults in North Dakota age well in their homes and communities if the systems are too complex to navigate. Care coordination is increasingly viewed as an essential component of a modern system of care. But in North Dakota today, care coordination is not a service deemed eligible for reimbursement under most publicly-funded programs. Care Coordination as a service does exist in the marketplace today but, it is primarily available to people of higher than average financial means.

Adding this cost effective, brief intervention to the continuum of eligible services in the SPED and Expanded SPED programs will help older adults with a range of income levels access this type of system-enhancing support. It will facilitate the judicious use of appropriate home and community-based services and delay the need for more intense, facility-based care.

As such, I would like to ask that you consider an amendment that would add "care coordination" to the list of eligible services in the SPED and Expanded SPED programs.

Section 1, Line 11, suggest amending as follows:

And The department shall establish a pilot program for the provision of adding Care Coordination Services under the Service Payments for the Elderly and Disabled (SPED) as a type of home and community-based care that is eligible for reimbursement under current aging service payment systems.

Section 2, Line 17, suggest amending as follows:

And The department shall establish a pilot program for the provision of adding Care Coordination Services under the Expanded Service Payment s for the Elderly and Disabled (EXSPED) as a type of home and community-based care that is eligible for reimbursement under current aging service payment systems.

EVIDENCE THAT CARE COORDINATION IS COST EFFCTIVE. Lutheran Social Services Aging Life Care (ALC) has provided care coordination services via a private grant for three years. The pilot started in Cass County and later expanded to include Grand Forks and Ward Counties.[2] To date we have served approximately 100 clients; 78% live independently (58% of this group lives alone); 10% have utilized our assistance to transition from independent living to a higher level of care; and 12% transitioned from a higher to a lower level of care or reside in a facility setting. Our fees are based on a sliding fee scale. 88% of clients have qualified for free services and 11% qualified for reduced fees, indicating the high level of need for seniors with limited means (which to date, we have funded with grant dollars).

Data from LSS' 2015-2018 pilot project indicated an overall **reduction in healthcare usage** for seniors who utilized care coordination services. At the 6-month point, surveys noted a reduced

[2] Care Coordination offers the following types of services, which are not typically included in HCBS options: accompanying to appointments, providing/arranging for transportation, scheduling/reminding of upcoming appointments, ensuring understanding of health provider instructions regarding their condition, their medical equipment needs and using and taking medicine(s) correctly, and coordinating with other providers and with family members to ensure all are up-to-date on changes in the person's care needs. Note: "Connecting" and "Coordinating" services are the types of things family members request for their loved ones because they know these are the things that help them remain living independently.

amount of hospital and ER usage for approximately 20% of clients. By 12 months, 40% saw a decrease in hospital stays.

Before starting ALC, 30% of individuals surveyed experienced an **inpatient hospital stay** in the prior 6 months. After receiving care coordination services, the rate of inpatient hospital stay dropped to 22%. Using 2018 Medicare averages for inpatient claims, we estimate savings of $22,000 in inpatient hospital costs for those 27 clients in 6 months.[3]

Before starting ALC the 26 clients surveyed reported an average of one **hospital emergency department** visit during the prior 6 months. After receiving care coordination services they reported an average of 0.5 emergency visits, which means these costly visits were cut in half. Using estimates of a typical Medicare cost for an emergency department visit, the addition of care coordination services resulted in a savings of approximately $19,500 for this group of 26 clients.[4]

Our surveys also asked if care coordination had delayed or prevented the need for **nursing home placement**; 47% of the 45 clients surveyed answered "yes". When asked if care coordination had delayed or prevented the need for **assisted living placement**, 53% said "yes".

While you cannot predict with certainty what would have happened absent a particular service, taking the opinion of the people actually served at face value, you can reasonably conclude that some of them would have had to move to a skilled care facility sooner. If we conservatively assume that care coordination services helped to delay utilization of skilled care for just 10 seniors

[3] Based on the average amount paid by Medicare per inpatient claim at ND PPS or CAH hospitals in 2018 = $10,852. Expenditure of $86,816 before care coordination (8 clients x $10,852) as compared to $65,112 after care coordination (6 clients x $10,852). (An average savings of $815 per client, across the entire group of 27 clients).

[4] Based on the US Dept of Health and Human Services Agency for Healthcare Research and Quality Medical Expenditure Survey Panel estimate that the average Medicare cost (in 2014) of an ED visit ranged from $1,250 - $1,500. Expenditure of $39,000 before care coordination (26 visits x $1,500) as compared to $19,500 after care coordination (13 visits x $1,500). (An average savings of $750 per client across the entire group of 26 clients).

for three months, even if they needed the maximum amount of authorized SPED/Expanded SPED services during that time, you could assume a net cost savings of $174,810.[5]

SUMMARY. Delivering just the right level of service to people when and where they need it, and when and where that service has the most opportunity to do the most good, is an optimal approach to service delivery. Including care coordination as an eligible service in the continuum of aging services would help move the system forward quickly and efficiently.

Today our definition of aging well has changed, and our ability to financially meet the ever-growing cost of the most expensive deep-end interventions is quickly evaporating. We simply have to find new ways of working together. Both for the good of the financial health of the system as a whole, and for the health and well-being of the men and women we are called to serve as they try to find a way to age well in our state. Recognizing the added value of thoughtfully utilized care coordination services by including them in the approved system of care moves us in the right direction.

We would encourage your support of HB1033 and respectfully ask your consideration of the amendment that would add a care coordination pilot as well. Thank you for the opportunity to speak to you today. I would be happy to answer any questions you have.

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[5] 2018 Genworth Cost of Care study; the median cost of Nursing Home, semi-private room in ND is $11,027 per month. $330,810 in cost savings from delayed skilled nursing care ((10 clients x $11,027) x 3 months) would be offset by $54,000 in care coordination services ((10 clients x $1,800) x 3 months) and $102,000 in in-home supports ((10 clients x $3,400 (max SPED/ExSPED)) x 3 months), for a net savings of $2174,810.