

Long-Term Care Planning Grants – Final Report

Department of Health and Family Services – Division of Disability and Elder Services

Section 1 – Identifying Information

Planning Group Name: West Central Wisconsin – Care Management Collaborative

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Current Planning Partners:

The original consortium included nine counties (Barron, Chippewa, Dunn, Eau Claire, Pepin, Pierce, Polk, St. Croix), two managed care organizations (Community Health Partnership, Inc., Group Health Cooperative of Eau Claire), and a consulting firm (The Management Group).

The final consortium membership that formed the care management consortium included five counties (Chippewa, Dunn, Eau Claire, Pierce, St. Croix) and Community Health Partnership, Inc.

In Fall 2006, four of the counties were ready to make a decision on the MCO model (a partnership model) and begin moving into preparation for transition to managed care. Five counties were continuing to explore alternative Family Care models and not yet ready to decide. In December, 2006, one of the five counties decided to join the four-county group. This left the Family Care group with too few potential members to form a managed care organization. Their options were to recruit other counties, join the Partnership planning group, or seek out other consortia to join. By April 2007, two counties requested admittance to the Northwest Consortium and two to the La Crosse Managed Care Organization. Group Health Cooperative of Eau Claire decided to focus their efforts with the La Crosse MCO. TMG was not invited to continue affiliation as a remaining WCW-CMC member.

Section 3 – Strategic Planning for System Change

Describe your approach and your progress to strategically plan for managed long-term care program development and implementation.

Privilege to fully participate in WCW-CMC meetings was initially limited to a designated representative from each partner. By late summer 2006, full participation was opened to other county agencies, advocacy organizations, county board members, and consumer/community representatives. The effort to be inclusive of this breadth of participation was welcomed by some and resisted by others. The more inclusive process was frustrating to those who wanted to tightly control the process, while it was welcome to those who wanted input from stakeholders throughout the process.

Core goals of the process were to try to keep communications open between partners and minimize conflict, to carefully examine each anticipated outcome from a perspective of providing high quality choices and services for the consumer, to minimize mis-information in the counties among county staff, providers, and consumers, and to pave the way for smooth transition for Waiver Clients and those on the waiting from county services to the MCO.

Meetings started out being held every 2 weeks for all consortium partners with workgroups meeting on the side. During the exploring of MCO model stage, each implementation group was meeting twice month with the full consortium meeting once a month. When the group reformed in spring 2007, the meetings reduced to once every 3 weeks. As the MCO application was finished and submitted, consortium work focused on the ADRC development. The ADRC application requirements guided the work and discussions. Barron County remained involved with the ADRC process to share their experiences as a Generation II ADRC. This was very helpful. As counties wrote their ADRC applications, the larger focus returned to beginning the transition process. Trouble-shooting groups were formed in partnership between CHP and the county that was coming into transition of Waiver Clients to the CMO. These groups began meeting several weeks (4-6) before transition was to begin to further familiarize county staff with the process, build relationships and bridges focusing on providing quality customer services, to identify gaps and concerns, and to create solutions.

“Lessons Learned” notes were taken by CHP staff which were shared with the upcoming counties and CHP staff to improve the process for each subsequent transition. Internally, CHP formed and Administrative Expansion Team which met at minimum weekly to anticipate and address challenges and roadblocks to a smooth transition and assuring quality services for consumers.

The MCO application and certification requirements became a guide for consortium work. While CHP was indeed the lead agency because of their anticipated role as the MCO, all consortium players were involved in working through the application, discussing concerns and developing protocols for transition to build ongoing relationships between the MCO and the counties.

Detail any needs assessments, mission, principles, goals, objectives and workgroups that your planning group established.

A mission statement, goals, timelines, product needed, etc. were created as needed to create consensus within the consortium. Workgroups were formed to address pertinent concerns and then retired as the work was finished. Workgroups that evolved and were then retired included the following focus areas: Meeting the needs of people with developmental disabilities; Communications and community involvement; Provider network development; ADRC Development; and Transition planning.

In spring 2007, funds were used to hire a researcher from UW-Stout to conduct a survey of current Waiver Clients to determine their perspectives on what is important to them regarding long-term care services. A parallel survey was conducted of current CHP members. Over 600 people responded to the survey throughout the five counties and CHP which was a much higher than anticipated response. The assessment results provided insights into what they most valued and their level of satisfaction with their services.

Report the membership of steering or executive committees and workgroups (name and affiliation), meeting schedule (weekly, monthly, etc.). For steering or executive committees, describe the procedural and decision-making model used. For workgroups, describe the scope of work, tasks and outcomes from each.

Initially, the steering committee consisted of elected members:

- One Representative from Community Health Partnership
- One Representative from Group Health Cooperative
- Chairperson of the Governing Board
- Four representatives from county partners
- One Representative from TMG, Inc.

The responsibilities of the steering committee included:

- Provide the direction for developing and implementing the work plan
- Develop detail of Collaborative work plan for Governing Board approval
- To review and prepare recommendations to the Governing Board
- Prepare budget recommendations and monitor budget.
- Authorize expenditures within budget parameters approved by Governing Board
- Recruit and supervise Local Project Manager
- Take action as necessary to manage the day-to-day operations of the WCW-CMC

At the same the consortium was beginning to make decisions regarding the MCO model, attendance at the steering committee diminished. The committee was becoming ineffective in providing the needed leadership to make decisions. By mid-spring 2007, a new chairperson was voted in (partly due to current chair moving to a State position) and it was decided to retire the steering committee and form an executive committee that would only meet if emergency decisions needed to be made. At this point the consortium was transitioning to five counties and the steering committee/executive committee layer of governance seemed unnecessary.

Identify and describe the involvement of paid or unpaid facilitators that guided your process. If your planning group hired a project manager, list the responsibilities of that individual and the skills he or she brought to your planning efforts. Describe the extent to which your group utilized consultative services, such as those offered by Community Care in Action (Gerry Born), the University of Wisconsin Extension, The Management Group or Organizational Skills Associates (Buck Rhyme).

A project coordinator began June, 2006 to facilitate discussion, planning, manage communication and information and provide written work as needed. The individual brought 25 years worth of experience in community planning, assessment and group facilitation.

Gerry Born was invited in one time to the committee working with addressing the needs of people with developmental disabilities. UW-Extension CRD Agent Pat Malone worked with us through mid-fall 2006.

TMG staff provided services for a bit less than the first year of the project. Their contributions to the process were sporadic in their assistance. Many concerns were raised during their participation in our process.

Buck Rhyme was found helpful by several of the counties in working with committees consisting of community, county board, Human Services and Aging staff to develop the infrastructure for the ADRC's. He was able to assist the counties in getting to resolutions that were passed by the needed committees and boards.

Describe the level of involvement of local elected or appointed officials in your planning efforts. Identify the timing and frequency of their involvement; for example, were they involved from the beginning and on-going basis, or not engaged in the planning efforts, but briefed at strategic intervals. Describe the official action taken by local elected officials and boards in regard to your planning or implementation process. *Attached is a sample MOU agreement developed by the consortium. Resolutions were developed within each county for county board action.*

Local elected officials were involved as full members in the discussion of MCO models and invited to stay involved until the governing council retired. Special efforts were made to include elected official from all nine counties beginning in August 2006. This was a particularly critical time for their participation as they were able to gain deeper insights into the discussions occurring at the consortium level which could then be taken back to their respective counties and further discussed at county committee and board meetings. Their participation also provided insights to the consortium members on what their key concerns were regarding long-term care reform and providing quality services to county residents. This provided the MCO's key information to assist with planning.

Template resolutions were developed once the MCO was chosen. Each county human service's agency then forwarded a customized version of the resolution through their government structure. This was required to occur prior to requesting the LTC-RFP. Four of the five counties were able to have this completed by mid-spring 2007. The fifth county struggled to attain consensus among human services, human services committee, and the county board. Planning to move forward with writing the RFP continued assuming the fifth county would ultimately decide to pass resolution which it did.

CHP and governing council leadership were available to attend county board and committee meetings upon request to entertain questions, explain processes, and build relationships. Human services directors worked very hard to fully understand and explain the financial implications of LTC reform on county BCA and levy monies. The delay of passage of the state budget held back the passage of the BCA resolutions. However, once the state budget passed, county resolutions also moved quickly through their respective systems.

Describe any legal assistance obtained by your planning consortium and identify the firm and attorney who provided these services.

Questions involving legalities focused mainly on how counties within the consortia were to interpret State Statute related to county responsibilities remaining during and after transition of Waiver care management to the MCO. Any legal advice that was required was obtained through the resources available to the partners: CHP's corporate attorney, county corporate council's, state affiliated organizations (WCHSA, etc.).

Section 4 – Consumer and Stakeholder Participation

Describe your approach to consumer and stakeholder participation in your planning (including involvement with UW-Extension LTC Planning and Stakeholder Project).

Identify dates, content and summarize outcomes of all consumer and stakeholder outreach events using a timeline (one-on-one contacts with individual consumers need not be enumerated). Describe stakeholder activities that you found particularly beneficial. Include copies of any consumer or stakeholder surveys (including provider surveys) that you conducted and summarize the results of those surveys.

UW-Extension assistance was provided for through November of 2006. The main product from this involvement was the production of a *Community Forum Guide*. This was copied and distributed in hard copy and via CD at the October 2006 Long-term Care meeting in La Crosse.

Each county was encouraged to hold forums for consumers implementing the protocols and materials provided for in the guide. All of the five counties that affiliated with CHP held at least two community forums throughout late 2006 and early 2007. These counties also had informational sessions pertaining to ADRC development. Press releases were distributed on a sporadic basis as consortium, however, some of the individual counties were very diligent at providing ongoing information through their county websites and newsletter.

Perhaps one of the most important community forums held was a listening session consisting of a panel of parents of children with developmental disabilities. Families from all nine counties were present to share their concerns and suggesting pertaining to long-term care services for their children. County Human Services and CHP staff were present to listen to what the parents had to say. This was organized by two community members involved in our planning process who also happened to be parents. (Listening Session notes attached)

Another important effort that provided quality feedback were kitchen table discussions. Community members organized opportunities for staff from CHP to have informal (literally around people's kitchen tables) discussions surrounding their concerns, challenges, and suggestions for best practice.

CHP will be conducting post-transition forums to gain insights as to how to best involve consumers in assessing strengths and gaps in the providing services.

Section 5 – General Communication

Describe the methods by which you distributed information about planning meetings, distributed meeting minutes, and notified the public about forums, training and information sessions. Provide a summary of contacts with media regarding your planning or issues related to the expansion of managed long-term care in your geographic area and photocopies of pertinent newspaper articles.

Early on the consortium decided to not invest in its own website for electronic information distribution. An agreement was reached with Disability Rights of Wisconsin (northern office) to create a page for the WCW-CMC on which meeting notes and completed documents could be posted. In reality, this soon became cumbersome and not a viable means of communicating. Press releases were written by members of the communications committee and distributed to county agencies. A contact brochure was developed and distributed throughout the nine counties for consumers to identify who to direct their questions to. The communications committee repetitively requested that County Human Services agencies post consumer information on their county websites – this was sporadically followed-through on.

There was a significant reluctance on the part of consortium partners to release specific information pertaining to the LTC Reform process until decisions on model choices and benefit packages were determined. Once the intent to contract with CHP was released, press releases were organized to share the process with the public. These feature articles included the voices of county Human Services administrators, ADRC Directors, CHP staff and consumers. Two public radio interviews were also conducted.

Section 6 – Program Development

Describe your progress toward identifying the program model that you selected to be the focus of your planning and implementation efforts. List the pros and cons of program models for your planning partners that your planning group identified in the course of your deliberations.

CHP started in 2007 as a pilot project in long-term care management reform. Coming into the current LTC reform effort, the organization had 8 years of experience and expertise in providing and integrated acute and primary care model for serving elders and people with physical disabilities who qualified for publicly-assisted services. Three counties (Chippewa, Dunn, and Eau Claire) had been partners with CHP during this time. The existence of CHP in the Chippewa Valley provided an alternative to waiting list for these two target populations in need of LTC services. Approximately 1300 people were being served by CHP in the Chippewa valley who may well have been on waiting lists. The pilot to fully integrate acute and primary care management within long-term care management realized a more streamlined approach to care for the members and saved money. This has been viewed as a successful pilot by members, counties, the medical and provider community.

This history of success provided a predisposition for Chippewa and Dunn to move forward with transitioning all of their Waiver caseload to the Partnership model. The other 7 counties needed more discussion and evaluation.

The journey toward deciding on a model meant understanding the concepts of risk reserve, needed information technology and claims reporting, the complexities of managing a large business, and, perhaps, most significantly, trying to ascertain what the ultimate role of the county and county board would mean in each of the models. Several of the players wanted to retain position in controlling quality management in the reformed scenario. It was important to determine what the checks and balances were in accountability for providing quality services. Some believed that the best way to do this was to have some form of controlling interest in the development and governance of a managed care organization. Others believed that there would be checks and balances present internal to CHP and through the official state grievance and appeals processes.

In the end, there were some of the counties that very much wanted to offer a Partnership model and did not want to be involved in creating a new business to manage long-term care. There were counties who wanted to offer Family Care only and wanted to be deeply involved in forming and governing a new managed care organization.

As the process moved forward, CMS had concerns about continuing to offer only Partnership. CHP responded by expanding to offer both the Family Care and Partnership benefit packages and self-directed support options within both of the packages. This greatly expanded the choices offered to consumers for managed long-term care within the five counties.

Describe the progress your planning group made in the following areas identified in your Grant Agreement, Exhibit 1:

- **Legal and Operational Platform for Regionalized Governance** – CHP, as the MCO, is the legal entity.
- **Establishment of Risk Reserve and Business Solvency Plan** – CHP, as the MCO, is responsible. CHP has provided long-term care management successfully for 10 years and has a Risk Reserve and Business Solvency Plan in place.
- **Coordination or Integration with Acute and Primary Health Care**– CHP, as the MCO, is responsible. CHP offers members the choices of Family Care, Integrated Acute and Primary Care (Partnership), and self-directed support options within both Family Care and Partnership. In addition, relationships have been established (throughout the past 10 years) with area primary and acute health care providers to promote smooth transitions of services within the systems of long-term care.
- **Establishing a Governing or Oversight Board** – CHP, as the MCO, is responsible. A well-established board of directors and advisory council provides the structure for oversight of this non-profit entity.
- **Implementation and Management Plan for Care Management Provision** – CHP, as the MCO, is responsible. CHP very intentionally developed a staffing plan to recruit and train staff to be ready for the increases in members. Teams of nurses and social workers were recruited. CHP has resource specialists on staff to address special needs of individual members such as substance abuse, mental health, behavioral health management, and specific developmental and physical disabilities.
- **Provider Network Development** – CHP, as the MCO, is responsible. A workgroup was established early on to identify providers that were not already in the CHP network. Ongoing efforts are made by CHP to develop relationships and write contracts with providers of services for current Waiver clients who are transitioning into CHP.
- **Administrative and Financial Systems** – CHP, as the MCO, is responsible. CHP recognized the need for expansion of administrative and financial expertise to be able to efficiently and effectively process the significant increase in numbers of members and staff.
- **Information Technology and Reporting Systems** – CHP, as the MCO, is responsible. CHP has spent the past 10 years developing their information technology and reporting systems to comply with state and federal requirements AND meet the needs of both organizational development and compiling information that assists care management staff in providing quality services to members. Adding of the Family Care Benefit package required modifications in this area, however, the changes were made in a timely manner and systems were in place for the transition of the first wave of Waiver clients to CHP.
- **Quality Management Systems** – CHP, as the MCO, is responsible. A quality assurance team has been in place within CHP for XXX years. With expansion, this team will also be expanded to include expanded member advocates, grievance and appeals resources for members.

- **Eligibility and Enrollment Systems** – CHP already had staff trained to perform functional screens and determine eligibility. CHP is now working with the ADRC’s to streamline this process without compromising the necessary firewall. Work continues in clarifying options and processes for presenting consumers the full range of choices for publicly-funded long-term within the region and transitioning them to receipt of said services as efficiently as possible. Communication between the CMO and ADRC’s continues to be important to professionally assist individuals who wish to change plans or dis-enroll for whatever reasons.
- **Coordination with Adult Protective Services and Statutory Requirements** – A template Memorandum of Understanding was developed through the consortium effort and approved by through the State certification process. The template was used as the foundation to create individualized Memoranda of Understanding for each county to address protocols specific to each county regarding issues of APS, certification of Adult Family Homes, and other statutory requirements.
- **Conversion of Present Waiver Caseload and Waiting Lists** – A very intentional planning effort was made between the counties and CHP to create a smooth transition for Waiver caseloads and the waiting lists. A transition spreadsheet was created using the State transition information as a foundation. Information was added to the local list to assist CHP supervisors in assigning new members to care management teams that would be best-equipped to work with the needs of the new members. CHP developed specialized teams for individuals with developmental disabilities. Specialists in a variety of fields have been hired to support the care management teams in working with members with unique needs. The transition time was spread over a 13 month period to allow counties to best manage staff and client needs and to allow CHP to be ready for the numbers of members coming into the organization. Careful attention was paid to the total numbers of people entering the CMO each month. In addition, it is expected that all people on the waiting lists will be served well in advance of the 24 month time period.

Section 7 – Aging and Disability Resource Center (ADRC) Planning

Describe involvement of your planning group in activities to achieve readiness for an operational ADRC or ADRCs within the counties or geographic area that is the focus of your planning. Describe the process of planning and the current state of readiness for each ADRC planned to serve consumers in the geographic area of your consortium. Describe the process used by your member counties to decide whether to pursue regionalized ADRCs.

The ADRC application, Exhibits I and II, and the DHFS ADRC Information Bulletins served as guides for the ADRC process. Each county decided to establish an ADRC. In three counties, the ADRC was developed within the Department of Human Services working with Aging and ongoing long-term care services staff to streamline services for county residents and to make most efficient use of limiting resources. In two counties, the ADRC became integrated into Departments of Aging.

Each county determined their ADRC model through discussions between their local county Human Services committees, Aging and Long-term Care committees, and county executives. Determining the financial feasibility of operating an ADRC was also taken into consideration. All of the five counties had seasoned staff that were interested in developing the ADRC and desired to be involved. A regionalized ADRC effort was not seriously considered although serious consideration was given to regionalized efforts such as publicity, websites, etc. However, at this time, it appears that each county is working independently on their ADRC effort, leaving the door open for potential future collaborations once they are through the Waiver transition process.

Websites, news releases and informational sessions were held to inform county residents of the upcoming changes. All ADRC's in the region were open for business by July 1, 2008. The timetable for providing services by county: Chippewa – March 1, 2008; Dunn – May 1, 2008; Pierce – May 1, 2008; Eau Claire – July 1, 2008; St. Croix – July 1, 2008.

Section 8 – Major Milestones

Provide a visual and narrative description of major milestones achieved by your planning group. Achievement may be in many areas: communication, group process, strategic planning, consensus on plans or issues, formation of business partnerships or governance structures, etc. Summarize the progress that your planning group has made, overall, toward planning for expansion of managed long-term care. Identify any significant deviation from the planning timeline that was included in your grant proposal. Describe challenges faced by your group as it proceeded through planning activities.

The greatest milestone is that the transition to long-term managed care by a care management organization began in May 2008 in the WCW-CMC and will be completed by May, 2009. The work is being done, gaps are being identified, challenges being met and people are receiving their care.

The process took considerably longer than anticipated due to unforeseen challenges:

- ✓ Challenges in coming to common understanding the work needing to be done;
- ✓ Challenges faced by the state in gaining authorizations and permissions from CMS;
- ✓ Challenges faced by the state and all consortia in doing something that's never been done before (needing to accommodate state statutes and protocols); and
- ✓ Challenges created by changes in staff (locally and statewide).

The delays gave us more time to think through and process the changes and their impacts on consumers. Hopefully, this allowed us to do a better job in the transition and will provide higher quality of services for the long-term.

Milestones

Date	What
4-25-06	Two day WCW-CMC retreat

5-23-06	Implementation A and B Workgroups formed to explore MCO structure options
	Communication and Stakeholder Involvement plan submitted to DHFS
7-11-06	Governing Council passes Vision/Mission Statement. Document posted on Disability Rights Wisconsin Website.
8-8-06	Implementation A announces a desire to move forward with Private Partnership Model
9-18-06	Passed governance flow chart and partner MOU
9-18-06	Distributed <i>Public Awareness Binder</i> to members.
10-12-06	Shared <i>Public Awareness Binder</i> with other counties and consortia throughout state at La Crosse conference.
10-30-06	Received notice from DHFS that Family Care would be required of all MCO contracts
11-16-06	Held <i>Listening Session</i> for county staff by a panel of parents of children with developmental disabilities.
12-6-06	<i>Best Practice Care Management Guidelines</i> presented by Committee on Developmental Disabilities
12-12-06	Chippewa County resolution of intention to transition Waiver Clients to <i>Private Partnership Model</i> passes
12-14-06	Letter sent to DHFS to request CMS to include fully-integrated benefit package within LTC reform
12-17-06	Pierce County Board passes intent to transition Waiver Clients to Private Partnership Model.
12-18-06	Pierce County announces intent to commit to Partnership.
12-18-06	All counties indicated intent to form individual ADRC's
1-16-07	Structural changes in governance made. Steering committee dissolved.
2-1-07	Implementation A members meet with DHFS Administration and key legislators to advocate for Partnership.
1-17-07	Dunn County passes resolution for Partnership
2-19-07	Reggie Bicha is appointed to DHFS Deputy Director position.
2-28-07	Implementation B meets with North West consortium.
3-7-07	Pepin County announces new affiliation with La Crosse Consortium. Barron and Polk announce new affiliation with North West Consortium.
3-20-07	Implementation B Dissolves
3-27-07	Pierce County passes County Board resolution to implement Partnership/Private MCO.

3-28-07	Letter to DHFS to request release of RFP.
4-23-07	Consumer survey on analysis of services received through County LTC Units and CHP.
5-17-07	St Croix County passes resolution to implement Partnership/Private MCO
6-1-07	MCO RFP released for five-county area.
6-25-07	CHP submits proposal to serve as LTC CMO for Dunn, Chippewa, Pierce, St Croix, and Eau Claire Counties.
9-6-07	Letter to award contract to CHP
10-20-07	Enrollment timelines determined.
11-15-07	Eau Claire County passes resolution to not implement a public model.
12-12-07	Chippewa County Board passes BCA resolution
1-18-08	Dunn County Board passes BCA resolution
1-22-08	Pierce County Board passes BCA resolution.
1-28-08	Transition Handbook completed and distributed.
3-1-08	Chippewa County ADRC opens
5-1-08	Chippewa County transition of Waiver Clients begins Dunn County ADRC opens. Pierce County ADRC opens.
6-1-08	Dunn County transition of Waiver Clients begins
7-1-08	Pierce County transition of Waiver Clients begins. Eau Claire ADRC opens. St Croix ADRC opens.

Section 9 – Budget Narrative

Attach a final budget showing detail of expenditures by item that reconciles with the final amount your consortium billed to DHFS on CARS.

Attached

Section 10 – Next Steps/Implementation

If not discussed elsewhere in this report, indicate when your planning consortia may be in a position to respond to an RFP from DHFS for managed long-term care, if you have not done so already. To the extent possible, describe the activities your group anticipates undertaking following the completion of this grant period. Identify information, technical assistance or support that would assist your group to achieve activities after the grant period.

By end of May 2009, all Waiver Clients within the 5-county area will have been transitioned to Community Health Partnership, Inc. The five ADRC's are expected to be fully functional. The WCW-CMC formally "retired" in June 2008.