

Integrated Care Management

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Our Mission and Vision



For over 30 years, a leader in the long term care industry...

Agency Mission

THE AREA AGENCY ON AGING PROVIDES OLDER ADULTS AND THEIR CAREGIVERS LONG-TERM CARE CHOICES, CONSUMER PROTECTION AND EDUCATION SO THEY CAN ACHIEVE THE HIGHEST POSSIBLE QUALITY OF LIFE.

Agency Vision

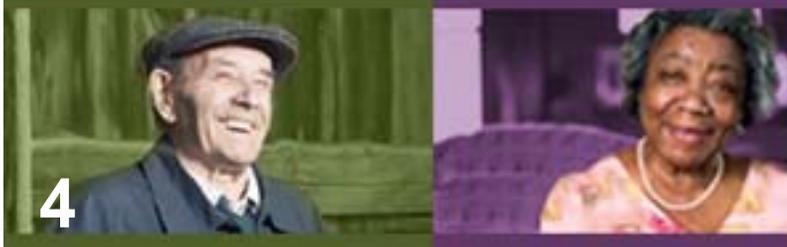
THE AREA AGENCY ON AGING WILL BE THE PREFERRED LONG-TERM CARE MANAGEMENT ORGANIZATION FOR OLDER ADULTS ACROSS ALL CARE SETTINGS.



Positioning for partnerships

- Mission
- Vision
- Values

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Integrated Care Management

Identified Shortcomings Of Traditional Case Management

Significant Growth Of The 75+ Population

Need To Individualize Care Based Upon Client Needs

Increasing Importance Of Quality Of Care Issues



Managed Care Issues For Older Persons In The 21st Century

Need To Balance Limited Resources

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Integrated Care Management

Blend of “Medical” & “Social” Models

Treat the whole patient
acute & chronic medical needs
psycho-social/functional needs
interdisciplinary approach

Build upon the existing strengths of both organizations

Maximize benefits without duplications or gaps in service delivery
Streamline communication among all entities involved

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Integrated Care Management: S.A.G.E.

S.A.G.E. is an innovative intervention that combines Medicaid-funded services with Medicare-funded services to provide comprehensive geriatric clinical and support services in an effort to prevent health and functional declines that lead to costly hospital and nursing facility use among older adults with long term care needs.

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Integrated Care Management: Hospital Assessor Program

Aligning stakeholder interests:

“50% of all nursing facility placements come from a hospital setting”

(Scripps-Long-Term Care in Ohio: A Longitudinal Perspective, 2001)

Purpose:

1. To identify potentially eligible individuals
2. To expedite the enrollment and service initiation process
3. To make in-hospital contacts with individuals going for short-term rehabilitation stays
4. To be a resource to hospital staff

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Integrated Care Management: Chronic Disease Self Management

- Administration on Aging 3 year grant
- Stanford model
- Evidence based prevention interventions
- Partnership with SummaCare
- Chronic disease self-management support—providing patients the education, motivation and equipment to make behavior changes:
 - improvement in health status,
 - increased patient satisfaction, and,
 - in some cases, reductions in health care use and costs.

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Integrated Care Management: High Risk Care Management

Objectives of High Risk Care Management System

- Identify the characteristics of high risk clients that are predictors of institutionalization.
- Create an appropriate Risk Factor Scale for use by staff in the identification of high risk cases.
- Develop a strategy for the stratification of caseloads, based upon risk factors, permitting greater focus on the specific needs of high risk clients.
- Develop protocols designed to establish appropriate levels and specific types of care management interventions.
- Design care plans based upon the specific needs of high risk clients, aimed at mitigating the impact of high risk factors.
- Integrate CBLTC high risk care management with Medicare Managed Care where appropriate (i.e., for common enrollees).

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AOA Managed Care and Aging Initiative

Phase I- Integration with Medicare Managed Care Organization

Area Agency on Aging and SummaCare shared enrollees

Barriers to successful integration

Resolution to identified barriers

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AOA Managed Care and Aging Initiative

Phase II- Integration with Medicare Managed Care

- Identify high risk enrollees using the Screening Tool developed in Phase I
- Apply service protocols and comprehensive care plan to the intervention group
- Monitor for 1 year
- Evaluate Detection Rate
- Evaluate Retention Rate

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AOA Managed Care and Aging Initiative

High Risk Case Management: Benefits and Advantages

- Risk-based case management can provide both parties with an opportunity to intervene immediately and effectively with appropriate levels and types of services
- Reduced likelihood of ED visits, acute admits, “permanent institutionalization” or premature death decreased length of stay if hospital or NF admission is required
- The provision of services is tailored to the specific needs of the individual consumer, rather than standard, bureaucratic protocols which fail to recognize the specific needs and complexity of high risk cases
- Focus upon secondary health promotion and prevention

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AOA Managed Care and Aging Initiative

High Risk Case Management: Benefits and Advantages

- Reduction in PASSPORT disenrollment rates
- Increased consumer, family, physician, and caregiver satisfaction
- Focused upon select populations with complex needs who require intensive services
- Promotion of cost-effective care by maximizing collaboration, minimizing fragmentation, and navigating through the client care system

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AOA Managed Care and Aging Initiative

Case Study- Phase I

- Mrs. C.
- 84 year old female, lives alone
- Diagnosis: CAD, hyperlipidemia, hypertension, diabetic, neuropathy
- Reduced hospitalizations from monthly occurrences to one occurrence in 6 months

Case Study- Phase II

- Mrs. P
- 78 year old female, lives alone
- Diagnosis: COPD, CVA, depression
- Reduced hospitalizations from monthly occurrences to one occurrence since discharged home from nursing facility

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Questions

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