# Unified Long-Term Care Systems Workgroup – Integration and Care Management Subcommittee

# DRAFT Recommendations

September 7, 2010

# Integration and Care Management Subcommittee

- Purpose –
  - Better coordinate acute and primary care services with LTSS
  - Better coordinate Medicare and Medicaid-funded services
  - Better integrate health and health-related services
- Nine meetings, special BH session

# Integration and Care Management Subcommittee

Implementation Key:

☺ Implement before the end of the 2012-13 Biennium

↔ Study, plan and/or partially implement in the 2012-13 Biennium

◊ Currently in-place at some level in Ohio

∞ Longer term implementation

# Strategic Direction

1. ☺ Identify existing forums where state agencies and stakeholders can discuss issues and opportunities related to care integration and management.
   - Develop a plan outlining strategic direction by the end of SFY 2012

# Dual Eligible Integration

2. ↔ Integrate the Medicaid acute benefit in dual eligible Medicare SNPs.

3. ☺◊ Education on the requirements for Medicare, Medicaid and other programs to ensure that program benefits are used to the fullest extent.

4. ☺ Work together to coordinate mailings and promotion aimed at informing dual eligibles of Medicare SNP option.

# Medical/Long-Term Care Integration

5. ↔ Provide care coordination of the Medicaid acute benefit for Medicaid HCBS waiver participants.
6. ☺◊ Deploy Long-term Care Consultants in hospitals, based on facility and patient characteristics, to meet the LTSS needs of adults.
   - Cross train hospital discharge planners to provide person-centered discharge planning to patients and families in need of LTSS.

# Medical/Long-Term Care Integration

7. ☺◊ Develop area agency on aging/health care partnerships and train to implement evidence-based health coaching programs.

8. ☺◊ Utilize and deploy existing resources such as Long-term Care Consultants in large Medicaid physician practices and patient-centered medical home to support patient access to available community-based programs and supports.

# Medical/Long-Term Care Integration

9. ☺◊ Expand and sustain evidence-based disease self-management programs.
   - Identify physical activity interventions and in-home interventions
   - Target persons with severe and persistent mental illness, and alcohol and substance use disorders.

10. ☺◊ Expand access to information, assistance/referral and Long-term Care Consultations through Aging and Disability Resource Networks.

# Medical/Long-Term Care Integration

11. ☺◊ Include long-term care/area agency on aging representation in the IMPROVE, StAAR and Enhanced Primary Care Home initiatives.

# Identify and Support Shared Consumers

12. ☺◊ Identify shared consumers/members and provide long-term tools (e.g., health information technology) and short term education (e.g., confidentiality requirements) to support coordination of services.

# Behavioral Health

13. ☺◊ Identify, support and deploy evidence-based behavioral health screening tools/protocols and self-management interventions (e.g., SBIRT, Healthy IDEAS, IMPACT) at transition points/critical pathways (e.g., primary care practices, hospitals, ADRN).