Integration of Care Through Long-Term Care Case Management: Case Study

Meet Roy

Roy is an elderly gentleman who has lived in his duplex for 17 years. He has had evidence of possible cognitive deterioration. His neighbor brings him food and checks in with him regularly. Roy does not have a phone. He is incontinent of bowel and bladder and is living in an unsanitary home environment due to inability to care for his own self. Recently he began to discuss his need for assistance and his desire to stay in his home and not go to a nursing facility. Roy's neighbor talked about this with a friend who works in long-term care.

Long-Term Care Case Management

The friend contacted the long-term care case manager in the Type B Area Agency. The long-term care case manager scheduled a home visit, which confirmed an unsanitary living condition as well as poor health Roy is experiencing. The Case Manager also requested Adult Protective Services to assess the situation. A Nurse Practitioner was also arranged to visit with Roy and assessed him with mild dementia and is not thriving in spite of having received Meals on Wheels.

Coordination of Integrated Care

The long-term care Case Manger from the Type B Area Agency coordinated the following interventions for Roy:

- Consulted with agency nurse and procured in-home assessment by Community Support RN
- Arranged Medicaid services and authorized up to 10 hours of in-home care per week. 10 hours was all that Roy would initially agree to – even though his needs were significantly higher. The Case Manager has continued building the relationship and earning Roy's trust in order to educate him on options and resources to improve his health and living environments.
- Through this relationship, Roy agreed to more hours and to allow an in-home agency worker to accompany him to medical appointments. This was needed to ensure he accessed weekly procedures that improved his ability to swallow food and lower risk of choking and malnutrition.
- Facilitated purchase of gloves and cleaning supplies for the caregiver and delivered them to the in-home care worker on the first day on the job. Small interventions of this nature are critical to continuing forward progress
- Monitored progress of the home care worker and progress in improving the living environment for Roy. Roy agreed to assistance with bathing which is reducing his risk of falling while transferring to and from the shower bench and continues to be willing to accept help and counsel over time.
- Connected Roy with Money Management program for volunteer bill payer. Older Americans Act funding, accessible by Type B Area Agency, provides Money Management. The Case manager

helped the Money Management volunteer sort through mail and piles of paper. They sorted through mail that had been sitting in his home since 2004. Original birth certificate, paperwork from health system provider (an MCO) and dental services, a jury summons letter and piles of junk mail. Old junk mail and trash was discarded. Roy agreed to allow help with bill paying for electricity and other utilities (he cannot read or do math), accepted financial assistance for telephone service in order have Lifeline services in his home and for the home care worker to take him to the bank and allow the Money Management volunteer to write checks for his rent and care plan.

- Coordinated medical care – with regular contact to physician's office to coordinate office visits and prescribed medical procedures, coordinate with in-home caregiver to assure Roy complies with pre-procedure requirements (ex: no food by mouth), coordinate with in-home caregiver to assure Roy attended procedures and was monitored at home afterwards.
- Authorized and arranged for transportation to medical visits. Type B Area Agencies determine eligibility for para-transit services and contact with the local transit authority. This has included even serving as the contact person to facilitate the delivery of services – an example:

  > "Telephone call from transit provider at 8:06. Roy is home but refusing to leave the home. In-home caregiver not there as previously arranged. Telephone call to home-care agency, advised caregiver is on way. Call to transit provider who confirmed caregiver arrived and Roy was on his way."

- Options Counseling for Roy regarding available services and resources. The long-term care case manager has continued to work with Roy to let him know about options for resources and services such as possibility of a lift chair to allow for greater independence.

Maintain and Expand Type B Area Agencies to Reach Triple Aim Goals

Type B Area Agencies and their Long-Term Care Case Managers coordinate integrated services that facilitate seamless access for the individual as they deal with all of the social determinant factors in their life. With the ability to work with more than just the Medicaid system, the Type B Area Agency on Aging is working across systems such as medical, mental health, community and natural/family support to assure a seamless coordinated service plan. They can connect consumers with the services that help them best achieve improved health in a cost effective way. Health System Transformation needs to take advantage of these effective and efficient agencies and spread their work throughout the state to provide effective, efficient, and excellent outcomes-based care in conjunction with medical health program changes.

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