

COMMUNITY SUPPORTS: BOTTOM LINE ADVANTAGE

Final Report from Administration on Aging Grant # 90-AM-2885: Partnership for the Integration of Community Supports with a Managed Care Chronic Disease Management Program

FEBRUARY 2006



Community Supports: Bottom Line Advantage

Project Partners:

Area Agency on Aging 1-B
Sandra K. Reminga, Executive Director
29100 Northwestern Hwy., Suite 400
Southfield, Michigan 48034
248-357-2255
www.aaa1b.com

Health Alliance Plan
Francine Parker, President and Chief Executive Officer
2850 West Grand Boulevard
Detroit, Michigan 48202
313-872-8100
www.hap.org

Principal Authors:

Kathleen Kirschenheiter, M.A.
Associate Director
Area Agency on Aging 1-B
Southfield, Michigan
248-262-9225
www.aaa1b.com

Melanie Hwalek, Ph.D.
President
SPEC Associates
Detroit, Michigan
313-964-0500
www.specassociates.org

February 2006

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Acknowledgements

This project could not have been accomplished without the contributions of many people. Sandra Reminga of the AAA 1-B and Francine Parker of HAP had the vision and sense of innovative risk-taking that provided the initial go-ahead for the effort. Especially important were the following individuals who took time from their usual work to be part of the Care Management Integration Project Advisory Committee. They generously shared their advice about ways to target HAP members for participation in the project; helped to develop referral, interview, documentation, and other data collection tools; planned and implemented staff trainings; helped to identify desired outcomes and measures; and gave valuable feedback on the data reports produced from the project:

Louanne Bakk, AAA 1-B Director of Access and Benefits Assistance
Anton Chastang, HAP Senior Project Coordinator
Jan Getty, President, Resource Link of Michigan
Kathleen Kueppers, AAA 1-B Clinical Quality Assurance Manager
Donna Lewicki, HAP Project Manager
Wayne Mackenzie, HAP Project Manager
Bruce Niebylski, M.D., HAP Senior Associate Medical Director
Richard Precord, HAP Director, Clinical Care Management
Nancy Ruhl, HAP AVP Health Management Services
Katherine Scher, Manager HAP CCM
Pat Slone, RN., Manager HAP CCM
Ron Tomas, MD., HAP Associate Medical Director

Kathleen Kueppers, as the project manager, provided essential guidance, back-up, and problem solving skills which greatly contributed to the project's success. The following staff directly implemented the project, and gave feedback regarding its strengths and limitations. They were both bold and dedicated in taking on this new effort and in working to assist individual participants in the best ways possible:

HAP Case Managers

Linda Bardoni
Joyce Benson
Irene Chyz
Beverly Cooper
Robin Johnson
Sybil Lyons-Davis
Bernice Morrison
Effie Nelson
Heidi Schollenberger
Rose Simono
Pat Slone
April Vitai
Millie Volbergs

AAA 1-B Care Managers

Elizabeth Czaplicki
Marie Mihaltan
Audrey Smith

Community Supports: Bottom Line Advantage

Executive Summary

Between October 1, 2004 and September 30, 2005, with an Integrated Care Management Grant from the U.S. Administration on Aging, the Area Agency on Aging 1-B (AAA 1-B) and Health Alliance Plan (HAP) implemented a pilot project for an HMO and a community supports organization to partner to holistically manage the health status of frail elderly with chronic diseases living in the community. The AAA 1-B is a private, non-profit organization serving older adults, adults with disabilities, and family caregivers in southeast Michigan; and HAP is southeast Michigan's dominant managed care organization.

HAP members' potential need for community supports was the impetus for developing a formal working partnership between HAP and the AAA 1-B. The partnership proposed the following outcomes: 1) Maintenance or improvement of participants' health status; 2) Participant satisfaction with the use of community supports; 3) Appropriate management of members' health conditions to avoid crises which necessitate hospital admissions or use of the emergency room; 4) Justification for a business model of collaboration between an area agency on aging and a managed care organization.

Forty-one at-risk HAP members were referred to the project, where they could receive telephonic care management from AAA 1-B, in-person visits if needed, and arrangement of community supports to address barriers to health maintenance or compliance. Participants received, on average, more than eight care management contacts and more than six community support referrals. Community supports included prescription assistance programs, assisted transportation, homemaking and personal care services in the home, and personal emergency response equipment.

Expected outcomes were achieved. Eighty-five percent of participants reported increased knowledge of how to manage their illness; and 91% reported greater satisfaction with their HMO after participation in the project. The cost of the project was \$165 per HAP member per month, which includes the provision of Information and Assistance, care management, and community services; plus operations, program development and other start-up costs. While use of this figure is limited due to the small sample size and short timeframe of the project, its impact on medical costs is compelling. By the end of the project, participants showed a 46.6% reduction in Emergency Room (ER) use, and a 34% reduction in hospitalizations. For the HAP members served through the project, the reduction in ER visits was valued at \$113.81 per member per month. Similarly, the reduction in hospital admissions was valued at \$892.80 per member per month.

Results from this project show that a partnership between an area agency on aging and a managed care organization can provide continuity and supports coordination for HMO members, with cost savings to the HMO and health benefits to the member that have long-term impact. For more information, contact the Area Agency on Aging 1-B at 800-852-7795.

Community Supports: Bottom Line Advantage

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Introduction

Seldom tested in today's managed care world, a relatively simple social intervention can result in dramatic savings in medical costs:

Ms. P, a HAP member with dementia and diabetes, was referred to the project because of multiple falls leading to multiple and costly emergency room visits. Ms. P revealed to the AAA 1-B care manager that she was not checking her blood glucose levels because her glucometer was broken. Working with the HAP nurse case manager, the glucometer was replaced, Ms. P's glucose levels were self-monitored and stabilized, and the emergency visits stopped.¹

With a typical emergency room visit costing \$843², this simple social intervention is saving significant medical costs, in addition to improving the individual's quality of life. This is the type of "bottom line" advantage that the Area Agency on Aging 1-B (AAA 1-B) and the Health Alliance Plan (HAP) expected when they partnered to integrate community supports with managed care chronic disease management. HAP is southeast Michigan's dominant managed care organization and has maintained its Medicare program since the 1980s. The AAA 1-B is a private, non-profit 501(c)(3) organization serving older adults, adults with disabilities, and family caregivers in six southeast Michigan counties.

Almost 75% of Medicare beneficiaries have one or more chronic diseases³, such as diabetes or congestive heart failure, and one of five beneficiaries has at least five chronic conditions⁴. Managed care organizations wishing to take advantage of the new Medicare Managed Care option under the recently enacted Medicare Modernization Act (2003)⁵ must be prepared to manage all aspects of chronic disease. Health Maintenance Organizations (HMOs) typically stop their services at the medical office, except when they provide in-home health care. Rare is the HMO that takes a holistic approach to assessing all of the factors – social and environmental as well as medical – that may contribute to the successful management of chronic disease. HAP is an exception to this and has been progressive in evaluating members for social needs and providing their members with assistance in obtaining these vital community

¹ Data source for this example is Minutes from the Staff Focus Group Session, October 24, 2005

² Estimate provided by HAP

³ <http://www.ahcpr.gov/research/elderdis.htm>. "Preventing Disability in the Elderly with Chronic Disease"

⁴ http://www.cmwf.org/publications/publications_show.htm?doc_id=280563. "Quality Matters: Chronic Disease Management in Medicare"

⁵ More information about the Medicare Modernization Act of 2003 can be found at <http://www.medicare.gov/MedicareReform>

services. HAP has offered programs for Medicare Beneficiaries for nearly 20 years and is acutely aware of the multiple needs of the frail elderly. HAP has also recognized that they do not have the extensive resource database used by AAA 1-B, the same amount of training required to best identify the appropriate community resource, or the time required to investigate/set up the resource(s). In addition, HAP is restricted in what can be accomplished telephonically, and with AAA 1-B involvement, a longer lasting impact on members at risk could be better appreciated.

Community care management organizations, such as the AAA 1-B, can provide the balance that HMOs need to offer the social and environmental supports to enable their chronically ill members to self-manage their diseases. The AAA 1-B offers many choices and resources for older persons that are not readily available, nor reimbursed by federal health care dollars, including a state-of-the-art telephone call center with information about a wide range of community resources, and a community care management program that provides access to long term, in-home assistance.⁶

***AAA 1-B and HAP partnered ...
to holistically manage the
health status of frail elderly with
chronic diseases living in the
community.***

Between October 1, 2004 and September 30, 2005, with an Integrated Care Management Grant from the U.S. Administration on Aging,⁷ The AAA 1-B and HAP implemented a pilot project to see what it takes for an HMO and a community supports organization to partner in order to holistically manage the health status of frail elderly with chronic diseases living in the community – and what outcomes occur for members because of this partnership. This report tells the story of how the partnership was designed, challenges faced in its formation, and what happened to staff and most importantly to older adults who were the beneficiaries of this business arrangement.

HAP's Chronic Care Management Program⁸

HAP's approach to helping members better manage their health is to first identify members with needs/gaps in care. This is done initially through a health risk assessment completed when a Medicare

⁶ For those who are financially and medically eligible, a large part of the community care management services offered through AAA 1-B are reimbursed through the Medicaid Home and Community-Based Waiver Program.

⁷ Administration on Aging Grant #90AM2885

⁸ Information in this section came from the Microsoft® PowerPoint presentation entitled; "Health Alliance Plan Disease Management" dated November 8, 2004.

member first becomes a HAP member and then through an automated process composed of six components, including evidence-based clinical practice guidelines that stratify risk. The member is then provided with interventions meant to address the level of risk. The interventions have been designed to arm the member with disease specific information, behavior change coaching, tools to monitor their health, and confidence to succeed in self-management. Members referred to this program typically have asthma, congestive heart failure, coronary artery disease, diabetes and/or depression. In this program, nurse case managers, pharmacists, case management associates, and behavioral health specialists identify members who are most in need or who appear not to be taking their medication. Depending on the member's risk level, interventions provided through the program are:

iStrive, an interactive online wellness program which is available to all HAP members. This innovative tool offers a free, confidential risk assessment and six online programs to help the member eat better, stop smoking, get active and learn how to engage in a healthier lifestyle. The program has personalized strategies for each member. The program also gives the member with asthma, heart disease, diabetes, and/or depression the option to be contacted by a HAP nurse case manager.

The *Health Chronicle Newsletter*, mailed to all members with a chronic condition. This newsletter is distributed quarterly, contains information on all chronic conditions mentioned above, and provides links to additional resources for chronic disease management.

Outreach through mailings and telephone calls to members who are medium risk. These members are also offered classes in Personal Action Toward Health (PATH), a chronic disease self-management program created by the Stanford University Patient Education Research Center that covers topics such as: symptom management, effective problem solving, goal setting, relaxation techniques, personal fitness, nutrition, medication management and working with the healthcare team.

High Risk member outreach starts with an in-depth telephonic evaluation to identify needs/gaps in care. The intervention is then tailored specific to that member. It could include telephonic case management from HAP nurse case managers, case management associates, and behavioral health specialists; telephonic pharmacy consultations; and the Health Buddy home monitoring tool. Health buddy is a home self-monitoring device that tracks clinical information, educates and encourages healthy behaviors. The HAP nurse case manager is able to monitor responses and intervene when necessary to help the member maintain their health and prevent hospitalizations.

In summary, HAP's disease management program focuses on educational interventions that can help members manage their chronic diseases. Once the needs are identified and interventions offered, the nurse case manager, pharmacist, case management associate, or behavioral health specialist disengages from the situation so that more members can be served, or until an acute episode would cause the nurse case manager, pharmacist, case management associate, or behavior health specialist to again become actively involved in helping the member coordinate care.

AAA 1-B's Community Care Services

The AAA 1-B offers two programs that expand beyond the interventions offered through HAP's disease management program. The AAA 1-B's Information and Assistance (I&A) and its Community Care Management (CCM) programs can help to fill the gaps in social and/or environmental needs that interfere with Medicare HMO members' ability to manage their health.

The AAA 1-B's I&A program provides a toll-free telephone number that community members can call to access, through trained call center staff, a computer database of information on nearly 2,000 service providers and 5,000 older adult and disability services in southeast Michigan. Information is available to callers about many different programs and services including:

Personal Care	Homemaking
Housing	Senior Centers
Adult Day Services	Support Groups
Assisted Living Facilities	Prescription Expense Assistance
Home Delivered Meals	Home Health Agencies
Chore Services	Legal Assistance
Transportation	Home Injury Control

The AAA 1-B's CCM program provides extensive in-home assessment of social and environmental barriers to health maintenance, by a nurse and social worker care management team. Using a person-centered approach to planning, the care managers work with frail elderly persons and their caregivers to complete a comprehensive needs assessment and to create a community supports plan. The plan identifies community service providers and programs to help frail elders remain at home rather than moving into a nursing home or other institutional care. The care managers then help link their

HAP members' potential need for social and/or environmental supports ... was the impetus for a formal working partnership between HAP and AAA 1-B.

clients to service providers and monitor that services were delivered as planned. Typically, the client is asked to pay fully or to share in the cost of services, and if the client's economic resources meet certain eligibility requirements, the AAA 1-B will pay for some or all of the needed services. Typical services provided through CCM are homemaking, home delivered meals, personal care assistance and home injury control.

HAP/AAA 1-B Integration of Community Supports/Managed Care Project

HAP members' potential need for social and/or environmental supports beyond the educational intervention they receive from HAP case management was the impetus for developing a formal working partnership between HAP and the AAA 1-B. The partnership was expected to achieve the following outcomes:

1. Maintenance or improvement of participants' health status
2. Participant satisfaction with the use of community supports
3. A reduction in participants' use or misuse of health care services
4. Justification for a business model of collaboration between an area agency on aging and a managed care organization

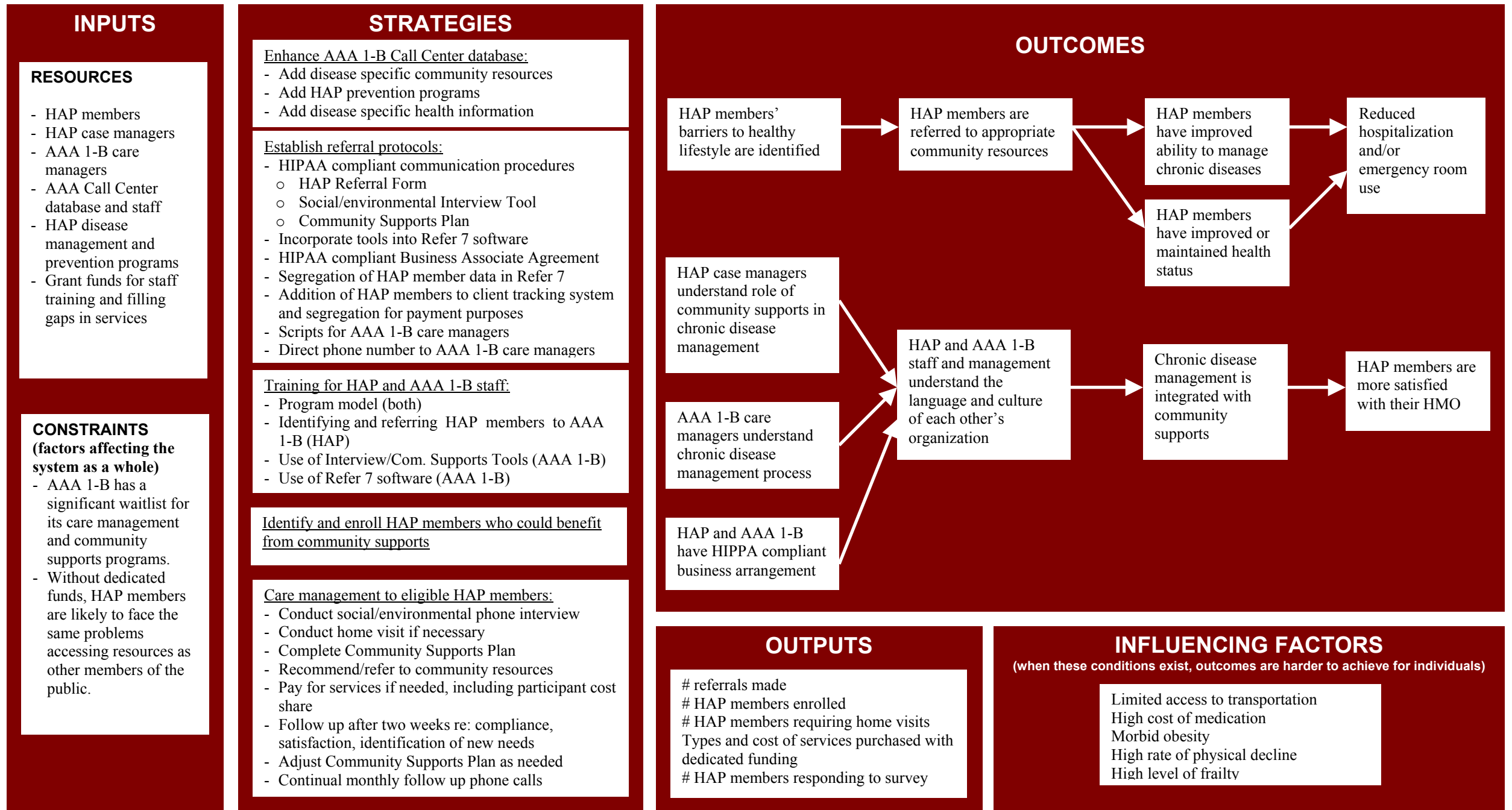
The model for this partnership is illustrated in Figure 1 on the following page. As the figure shows, the partnership involved the following five strategies:

1. *Enhance AAA 1-B's Call Center database to include disease-specific community resources, a list of HAP's own prevention programs and disease-specific health information.* Results from this effort revealed that the AAA 1-B's Call Center database was sufficiently comprehensive and included a wide range of disease-specific community resources and health information. The Refer software at AAA 1-B was used to find appropriate social and environmental resources for HAP members.
2. *Establish referral protocols.* Because HAP was sharing member information with the AAA 1-B, all databases and procedures for communications needed to have secure access and privacy protections in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA).⁹ For the first four months of the project, HAP and the AAA 1-B worked to develop HIPAA compliant forms and processes for referring HAP members by phone and email, for assessing their needs in order to develop a community supports plan, and for on-going

⁹ More information about HIPAA can be found at <http://www.cms.hhs.gov/HIPAAGenInfo>.

Figure 1: Program Model for HAP/AAA 1-B Integration of Community Supports/Managed Care Project

(Rev 12-20-05)

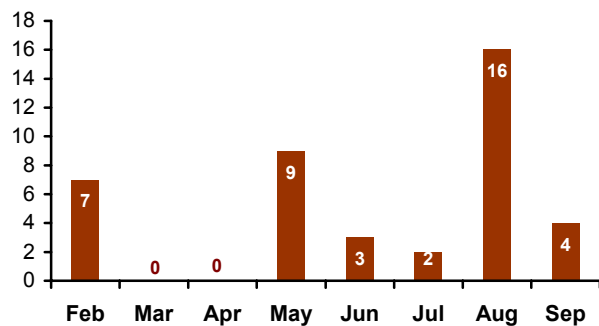


communication between the HAP case managers and the AAA 1-B care managers. The two organizations created a HIPAA compliant business associate agreement. In addition, the AAA 1-B made changes in its internal systems so that HAP member data was included but segregated within the Call Center and care management databases. Talking points were developed for HAP nurse case managers' use in describing to a member why s/he was being referred to the project. A phone number was also provided to the HAP nurse case managers so that they could directly connect to the AAA 1-B care managers who were involved with the project.

3. *Training for HAP and AAA 1-B staff.* Once the referral protocols and eligibility criteria were developed, HAP and AAA 1-B staff received training on the project model. HAP nurse case managers and support staff received training on criteria selected to identify eligible members and how to make a referral to AAA 1-B. In turn, AAA 1-B care managers were trained in when to refer members back to HAP's nurse case managers for the disease management program and how to use the Refer software to enroll HAP members in the integration project. AAA 1-B care managers also received training on the process for the initial interviews, documentation of all contacts, development of community supports plans and documenting members' outcomes and satisfaction. In addition a meeting was organized to familiarize HAP nurse case managers and AAA 1-B with each other's interventions and to allow each team to meet face to face.

4. *Identify and enroll HAP members who could benefit from community supports within two business days of the referral.* By February 2005, all systems were in place and the first HAP member was identified and enrolled into the project. While a total of 140 referrals were expected during the project year,¹⁰ between February and September 2005, a total of 41 HAP members were referred to the project. Figure 2 shows the number of referrals each month, from February through September of 2005.¹¹

**Figure 2:
Number of HAP Members Referred
February to September of 2005**



¹⁰ 140 referrals was the randomly selected target number in the original grant application to AoA

¹¹ Data source for Figure 2 is HAP Member Referral and Outcomes.xls

As the figure shows, initially and through April, only seven HAP members were referred to the project. The slower than expected rate of referrals may have been due to:

- a. HAP's expansion of its chronic care management in March;.
- b. HAP members' refusal to be referred;
- c. Competition from similar programs at Henry Ford Health System clinics; and
- d. Inability of case managers to find as many eligible members as had been expected in Oakland and Macomb counties, the areas initially targeted for the program.¹²

Between May and July 2005, at HAP's request, the AAA 1-B worked with the Detroit Area Agency on Aging to develop protocols, revise forms and instructions, and provide staff training in order to include Detroit residents in the project. During this time, HAP nurse case managers continued to refer eligible members from Oakland and Macomb counties, and in August of 2005, they began referring members from Detroit to the project. This is reflected in Figure 2 by the jump in referrals in August 2005.¹³

Sixty-one percent of referred members had chronic medical conditions and 39% were at risk for falls.

HAP nurse case managers were to refer members who had either a chronic medical condition or who were at risk for falls. Among the 41 referrals, 61% had chronic medical conditions and 39% were determined to be at risk for falls. The AAA 1-B was able to contact 36 (88%) of the 41 referrals. Four could not be reached after several attempts, and one member died before the initial interview could be conducted. Of the 36 who were contacted, 34 (94%) agreed to full participation in the program, including follow up calls; two refused follow up but did receive the initial interview with Information and Assistance.

Major problems of referred HAP members involved paying for medications, activities of daily living, and transportation.

¹² Taken from Semi-Annual Performance Report Reporting Period: October 1, 2004 – March 31, 2005 and April 1, 2005 – September 30, 2005 and from Minutes: HAP/AAA 1-B Integration of Community Supports/Managed Care Project Advisory Committee Meeting: May 16, 2005

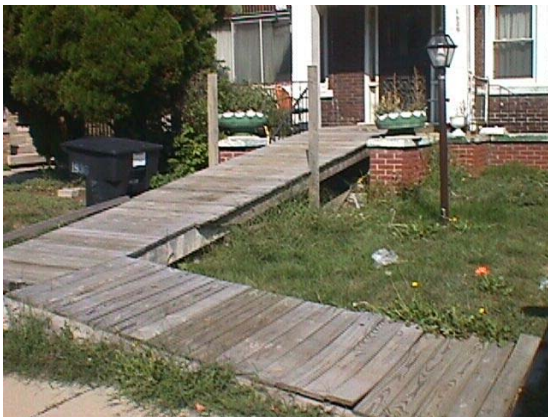
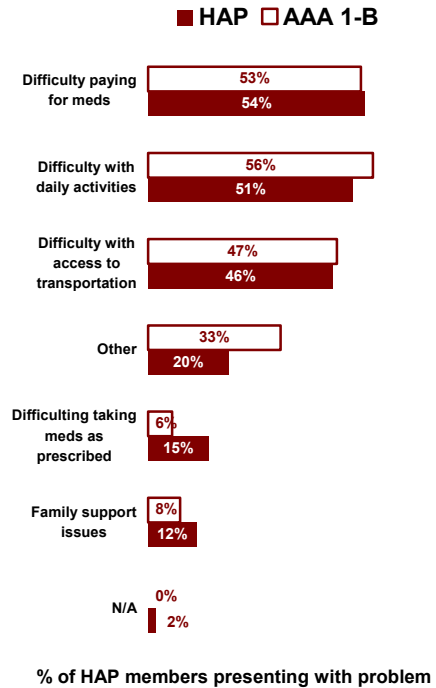
¹³ Taken from Semi-Annual Performance Report Reporting Period: April 1, 2005 – September 30, 2005

Figure 3 shows the presenting problems of the 41 referrals made by HAP and the 36 members who were contacted by the AAA 1-B. In general, both HAP and AAA 1-B data corroborate that the major presenting problems of HAP members at the time of referral to the program were: (1) difficulty paying for medications, (2) difficulty with activities of daily living, and (3) transportation problems.¹⁴

These non-medical problems likely had a direct impact on members' medical care. For example:

Mr. N was wheelchair bound and needed hemodialysis three times per week. The ramp that his son built for outside access was not safe. Mr. N had two falls from the ramp and once the wheelchair ended up in the street. The dialysis center would not transport Mr. N to treatment due to the unsafe ramp. Within a week of enrollment in the project, a new ramp with proper incline and handrails was installed, and the dialysis center began transporting Mr. N for treatment.

**Figure 3:
Presenting problems
identified by HAP and AAA 1-B**



Old Ramp



New Ramp

¹⁴ Data for this section came from AAA 1-B HAP Members Community Supports Data/Key (HAP Outcomes Key.doc)

5. *Care management for eligible HAP members, with a community supports plan completed within two days of enrollment.* When a referral was made to the AAA 1-B, the care manager conducted a brief social/environmental telephone interview with the HAP member, or with his/her caregiver if the member could not complete the interview and gave verbal permission to speak with the caregiver.

Fifty percent of referred members needed only telephonic information and assistance service.

Of the 36 HAP members initially interviewed, 18 (50%) needed only simple information and assistance (I&A). That is, the AAA 1-B care managers and 18 of the referred HAP members together determined that the members' needs could be met by referring them to appropriate community resources, completing a community supports plan and performing routine follow-up phone calls. No other interventions were needed.

An additional 13 (36%) participants required enhanced I & A, where the AAA 1-B care manager assisted the member in connecting with community services, or arranged the services for them. A community supports plan was completed, and follow-up phone calls were made, but often adjustments or additions to the supports plan were necessary. All but five participants were served through telephonic care management. That is, their assessment, care planning and follow-up contacts were all done by telephone. Only five (14%) HAP members were identified as needing in-home visits by a registered nurse care manager for the initial interview.¹⁵ There were some members who were visited after the initial interview, in order to obtain consent forms for the services to be placed, or for further assessment and enrollment in AAA 1-B Community Care Management programs.

Only 14% of referred members required an in-person care manager visit.

The HAP members who participated in the project received a substantial number of contacts from the AAA 1-B care managers. Among the 41 referrals there were a total of 323 contacts, averaging 7.87 contacts per member. Since most referrals were made in the last three months of the project, put in context, the data reveal that typically, almost eight contacts

Each referred member received an average of 8 contacts from AAA 1-B care managers.

¹⁵ These data include two HAP members who were contacted but did not want further assistance from the program. Data for this section was taken from AAA 1-B HAP Members Community Supports Data/Key, HAP Outcomes Key.doc

were made with, or on behalf of, the HAP member within a three-month time period.¹⁶ AAA 1-B contact data reveal that the majority of these contacts were directly with members (46%). One-quarter of the contacts were with the HAP case managers (24%), 16% were with caregivers and 14% were with vendors on behalf of the member.¹⁷

Only 28% of referred members required grant-funded services.

Ten members (28%) received in-home services paid for with grant funds, for a total service expenditure of \$13,636 over 129 member months:

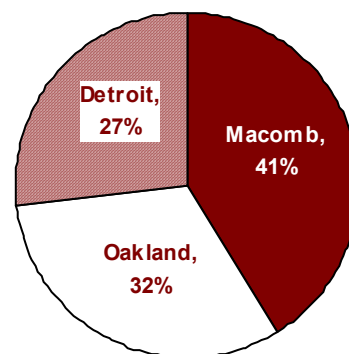
- 6 members (60%) received homemaking services - \$3,311
- 5 members (50%) received phone safety and emergency response equipment - \$614
- 3 members (30%) received transportation services - \$137
- 5 members (50%) received personal care services - \$2,554
- 1 member (10%) received in-home respite care - \$270
- 1 member (10%) received a ramp for house egress - \$6,750

Who Were the HAP Members Served by the Project?

As previously noted, of the 41 HAP members referred to the project, 36 (88%) were contacted and 5 (12%) could not be reached. Thirty-four (94%) of those who were contacted agreed to enrollment and full participation in the project; most of these members were served telephonically, with five needing an in-person assessment. The majority of participants resided in Macomb County (41%), followed by Oakland County (32%). There were a significant number of participants from the city of Detroit (27%) even though those referrals were not initiated until two months before the project ended (see Figure 4).

AAA 1-B care managers were unable to contact four (10%) of the originally referred members, and an additional referred member died before the initial interview could be scheduled. A total of four referred members (10%) died by the end

Figure 4:
Location of HAP Members Referred to the Program
(N=41)



¹⁶ This number was calculated from HAP Member Referral and Community Supports Plan Data HAP Member Referral and Outcomes.xls using months between date of contact and date of closure.

¹⁷ These data come from AAA 1-B AoA/HAP Integration Project Program Statistics HAP Program Statistics.doc

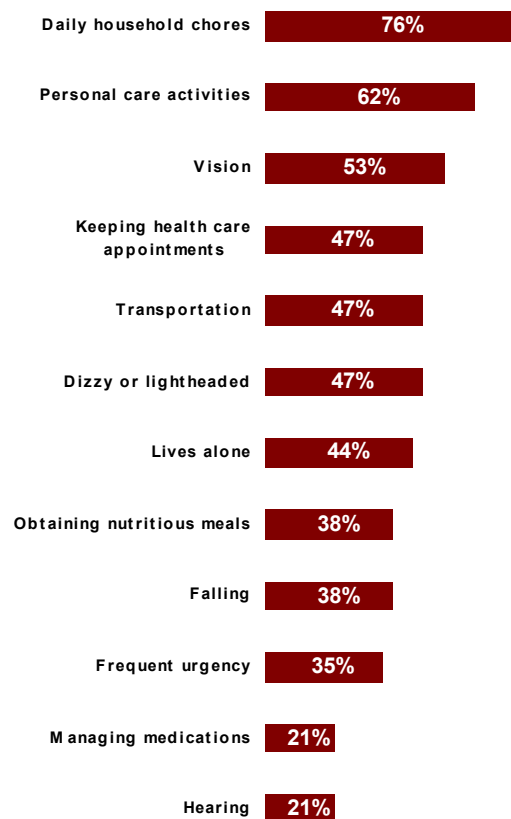
of the project. Two members (5%) did not want to continue in the project after the initial interview and after receiving information about community resources. At the project's end, 10 participants (24%) were subsequently enrolled in one of the AAA 1-B Community Care Management programs. These programs serve consumers in frail health, often requiring a nursing home level of care. Twenty-one participants (51%) were closed due to the project ending. Those closed because the project ended were given instructions to contact their HAP case manager or the AAA 1-B Information and Assistance Call Center for future needs.

A follow-up telephone survey was conducted with 18 HAP members and six caregivers from among the 34 who fully participated in the project (71% response rate). Survey results revealed that the 24 HAP members or caregivers who responded to the survey were almost equally divided in residence between Macomb County (33%), Oakland County (38%) and Detroit (29%).

Results also showed that most HAP members included in the survey were female (79%) and most were aged 70 or older (73%). In fact, almost one-third (29%) were aged 80 or older.

Forty-four percent were living alone. Most reported having difficulty with household chores (76%) and/or with personal care activities (62%) such as ambulation, dressing, toileting or transferring from a bed to a chair (see Figure 5).¹⁸ More than half (53%) reported having difficulty with vision; and almost half (47%) reported having trouble keeping health appointments, difficulties with transportation, and/or feeling dizzy or

**Figure 5:
% of HAP Members Reporting
Difficulty with...
(N=34)**



¹⁸ Data taken from AAA 1-B AoA/HAP Integration Project data tables dated Friday, December 09, 2005

lightheadedness in the past seven days. Ten percent of the referred members died within the eight-month project enrollment period.¹⁹ Data from the Social/Environmental Interview tool used by the AAA I-B care managers to assess member’s social and environmental needs, support that HAP’s current system for identification of high risk members (persons at risk for emergency room use and/or hospitalization) is on target.

What Were the Outcomes for HAP Members?

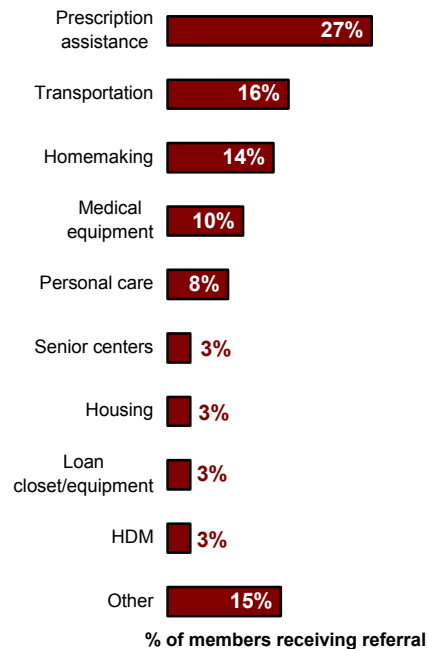
Referrals to Needed Services

The 34 members who agreed to continue with the project received information, referrals and, in some cases, home visits. Beyond the number of contacts indicated above, the participants received a total of 199 referrals to community services (averaging 5.58 referrals per member). As Figure 6 shows, prescription assistance (27%), transportation (16%) and homemaking (14%) were the most common types of referrals made.²⁰

One example of a referred HAP member is:

Mr. H was referred for assistance with medications and transportation. He was found to be living in a basement with three other gentlemen, each with his own small bedroom portioned off with plywood dividers. The bathroom and kitchenette were filthy. Mr. H had significant medical problems and was found to be eligible for the MI Choice Medicaid Waiver program. Through AAA I-B’s care management, Mr.

**Figure 6:
Types of Referrals Given to 34
HAP Members
(N=199 referrals total)**



Data support that HAP’s system for identifying high risk members is on target.

Each HAP member received an average of 6 referrals for community supports.

¹⁹ Calculated from HAP Member Referral and Outcomes.xls

²⁰ These data came from AAA I-B AoA/HAP Integration Project Program Statistics.doc

H. was enrolled in MI Choice and will soon be moving to an apartment. He is now being transported for his medical appointments and is taking his medications as prescribed.

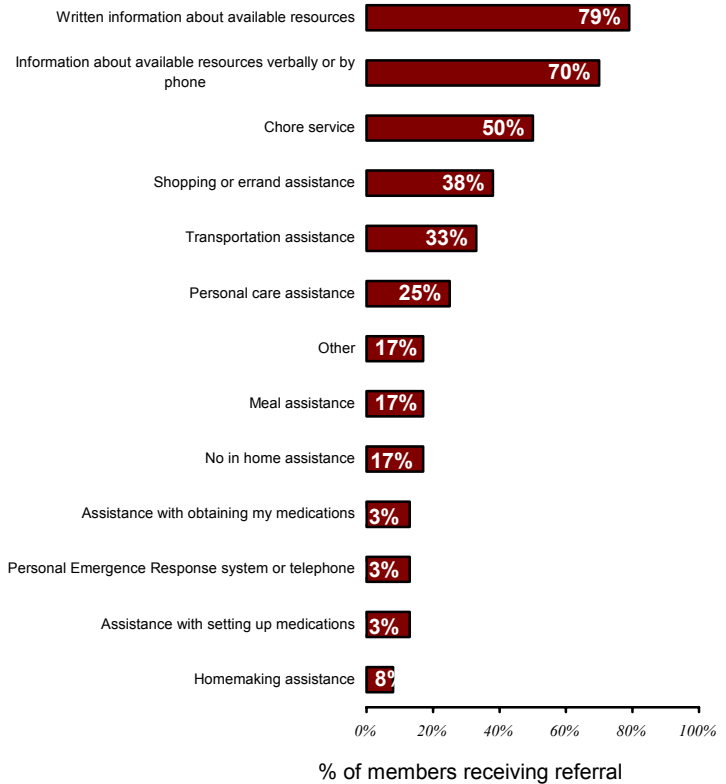
Services Received

Members or caregivers who participated in the telephone survey (N=24) were also asked about the services they received from the program. As shown in Figure 7, most (79%) reported receiving written information about resources, and most (70%) reported receiving information over the phone about resources. Half of the respondents said that they received chore services. More than one-third reported receiving shopping or errand assistance (38%) and/or transportation assistance (33%).

HAP member Ms. B’s case is an example of the kinds of services provided through the project:

Ms. B was referred to the project for transportation and medication assistance. She lived in one county, but her physician’s office was in a different county. She no longer drove, and had inconsistent family assistance to transport her to physician appointments. As a result, she was missing most of her appointments. The AAA I-B was able to provide transportation assistance and, subsequently, Ms. B had no more missed appointments.

**Figure 7:
% of survey respondents
who reported receiving ...
(N=24)**

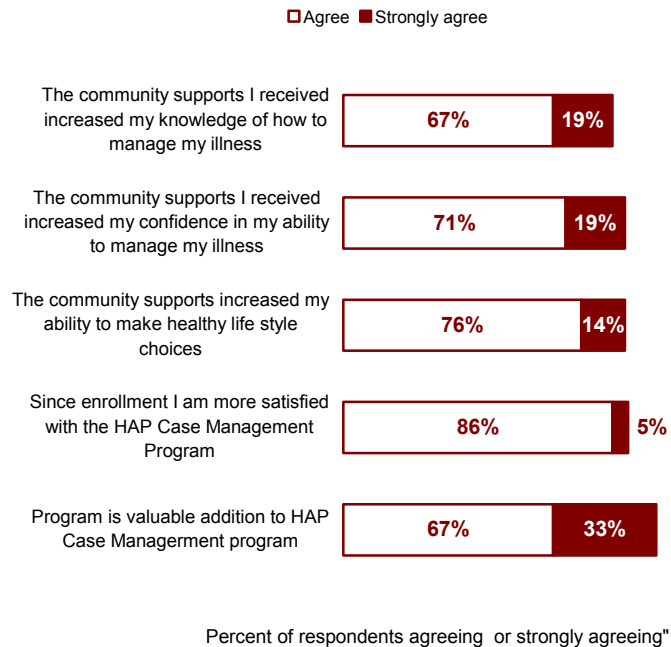


Improved Disease Management

Results from the telephone survey also show that HAP members or their caregivers feel that the project helped them to manage their illness. As shown in Figure 8:

- 86% agreed or strongly agreed that the project increased their knowledge of how to manage their illness;
- 90% agreed or strongly agreed that the project increased their confidence in their ability to manage their illness;
- 90% agreed or strongly agreed that the project increased their ability to make healthy life style choices.

**Figure 8:
HAP Members' or Caregivers'
Perceptions of Impact of Project
(N=24)**



HAP Member Satisfaction with the Project

As Figure 8 shows:

- 91% of the HAP members agreed or strongly agreed that they are more satisfied with the HAP Case Management program since enrolling in the project;
- 100% of the HAP members agreed or strongly agreed that the program is a valuable addition to the HAP Case Management program.

HAP members also expressed satisfaction with the AAA 1-B care managers. As Figure 9 shows, almost all of the survey respondents agreed or strongly agreed that they felt comfortable with the care manager (100%), that the care manager included them in planning for services (96%) and, that the care manager did a good job setting up services (100%). Almost all of the respondents also agreed or strongly agreed that the care manager was knowledgeable (96%) and, that they clearly explained the program during the initial interview (100%).

An example of a project member’s comfort level with the AAA 1-B care manager, and the unexpected benefits that can result:

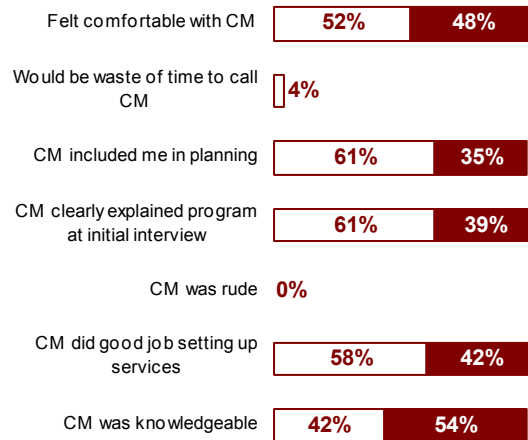
Ms. C was referred to the project for prescription payment assistance. Shortly after involvement in the project, she received a phone call from an out-of-state insurance company offering her a deal on prescription coverage, and asking for her bank account numbers to transfer funds for the program. She gave the numbers, then changed her mind and tried to call them back. The company hung up on her, and she called the AAA 1-B care manager. The care manager called the insurance company, and got a hang- up also. Ms. C was advised to notify her bank and stop payment to the company. She did, and the bank closed her account and the transfer of funds was thwarted. This incident was reported to authorities, who investigated and exposed the scam.

Most of the survey respondents also reported satisfaction with service availability. Figure 9 shows that only 22% of the respondents agreed that they “wish the care manager would have done more things that needed to be done.” Only 32% agreed that they “would have liked more choices about the types of services (they) received.” The participants’ desire that the care manager could do more things, or that they would have liked more choices about the types of services they received are indicative of existing service gaps in the community. Some programs have strict eligibility requirements that these participants may not have met. Some more popular programs, such as Home Delivered Meals or Chore Services, have waiting lists. And, participants may not have been willing or able to pay privately for services.

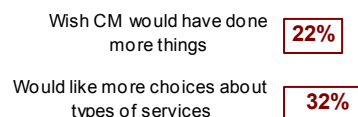
**Figure 9:
HAP Members' or Caregivers'
Perceptions of Quality of Care
Management
(N=24)**

□ Agree ■ Strongly agree

Quality of Care Manager



Service Availability



Percent of respondents agreeing or strongly agreeing"

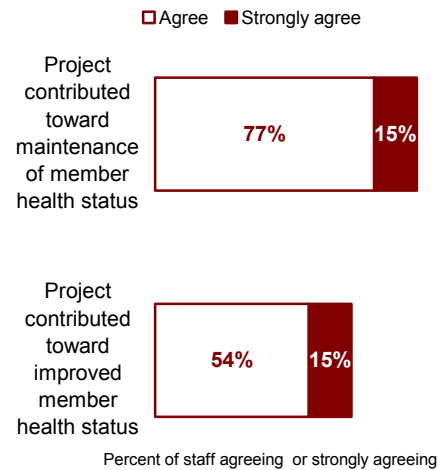
Maintained or Improved Health

HAP nurse case managers also believe that participation in the project contributes to improved or maintained member health. At the end of the project, the 13 HAP nurse case managers completed a survey about their opinions of the project and its outcomes for members. As Figure 10 shows, almost all of the case managers (92%) agreed or strongly agreed that the project contributed to the maintenance of members' health status. The majority (69%) also agreed or strongly agreed that the project contributed to improved health status of their members.

Were members' health conditions well managed as evidenced by reduced use of hospital and emergency services?

HAP's utilization data indicate that the group of members enrolled in the project had a 46.6% decrease in average per member per month (pmpm) emergency room visits, and a 34% decrease in average pmpm hospital admissions. Table 1 shows how these figures were derived. Figure 11 displays the key results graphically.

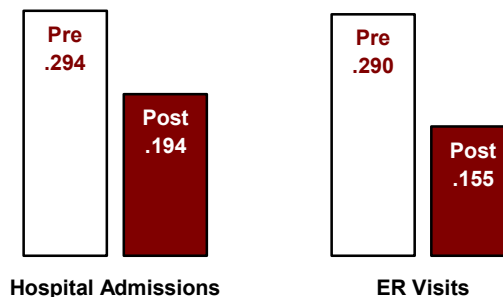
**Figure 10:
HAP Case Managers'
Perceptions of Impact of
Project on Member Health
(N=13)**



			Total visits*	Member months**	Visits per member per month***	Times 12 months (Annual)		% reduction in pmpm****
ER Visits	10/2003 - 9/2004	(pre)	80	276	0.290	3.478		46.6%
	2/2005 - 11/2005	(post)	26	168	0.155	1.857		
Hospital Admissions	10/2003 - 9/2004	(pre)	74	252	0.294	3.524		34%
	2/2005 - 11/2005	(post)	21	108	0.194	2.333		
*	Total visits were provided by HAP and include all visits by 36 members served through the program							
**	Actual member months reported for pre and post							
***	Visits per member per month were calculated as total visits divided by total member months							
****	% reduction was calculated as (pre) minus (post) divided by (pre) X 100%							

The “pre” data in this calculation are the total number of hospital admissions and emergency visits of the 36 interviewed HAP members in the 365 days prior to the project’s inception. The “post” data are the actual number of hospital admissions and ER visits between the date of first contact by the AAA 1-B care manager and November 15, 2005. As Table 1 shows, these HAP members averaged 0.290 ER visits pmpm, and 0.294 hospital admissions pmpm in the 365 days prior to project involvement. During their stay in the project, they averaged 0.155 ER visits pmpm, a 46.6% reduction; and, they averaged 0.194 hospital admissions pmpm, a 34% reduction. At an estimated cost of \$843 per ER visit, the savings, or value of the reduced ER visits for these HAP members, is \$113.81 pmpm. Similarly, at an average cost of \$8,928 per hospital admission pmpm, cost savings from reduced hospital admissions is \$892.80 pmpm for the project participants.¹⁹

**Figure 11:
Change in Average Hospital Admissions and
ER Visits
(per member per month)**



What Outcomes were Achieved for HAP and AAA 1-B Staff?

Successful Collaboration between HAP and AAA 1-B Staff

The business model of collaboration between HAP and the AAA 1-B was largely dependent on the collaboration between staff from the two organizations who worked directly with members. Their perceptions of project implementation provide lessons for the future development of business relationships between area agencies on aging and managed care organizations.

¹⁹ Cost savings from ER visits calculated as: $(0.290 - 0.155) \times \$843 = \113.81
 Cost savings from hospital admissions calculated as: $(0.294 - 0.194) \times \$8,928 = \892.80
 Estimates of average cost per ER visit/hospital admission provided by HAP data analyst

**Figure 12:
AAA 1B Care Managers' Perceptions of Effectiveness of
Project**

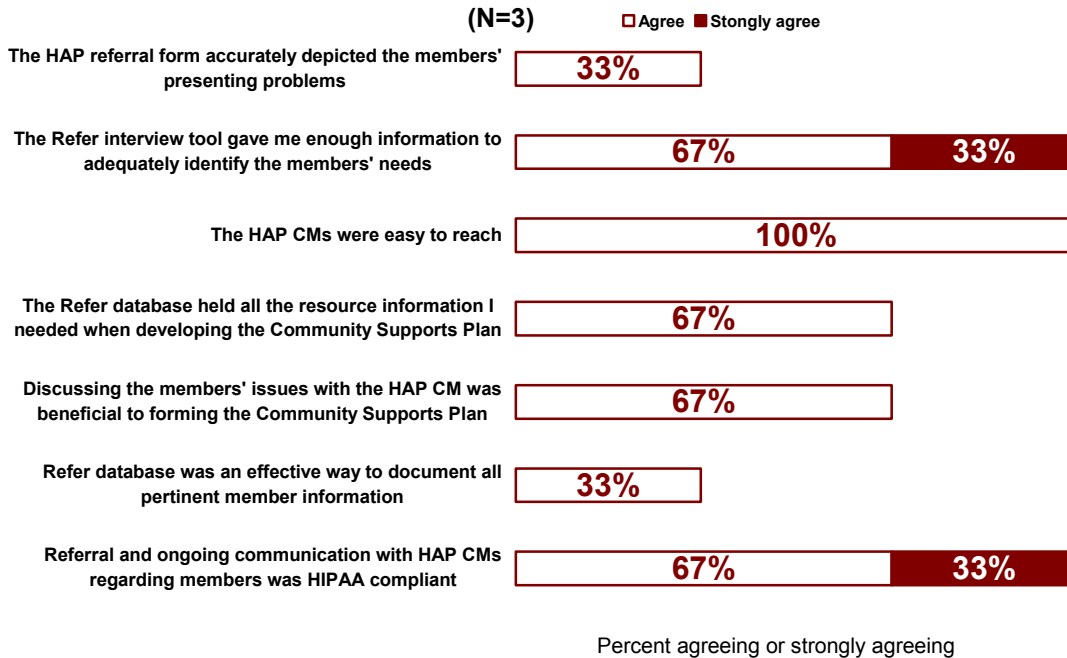
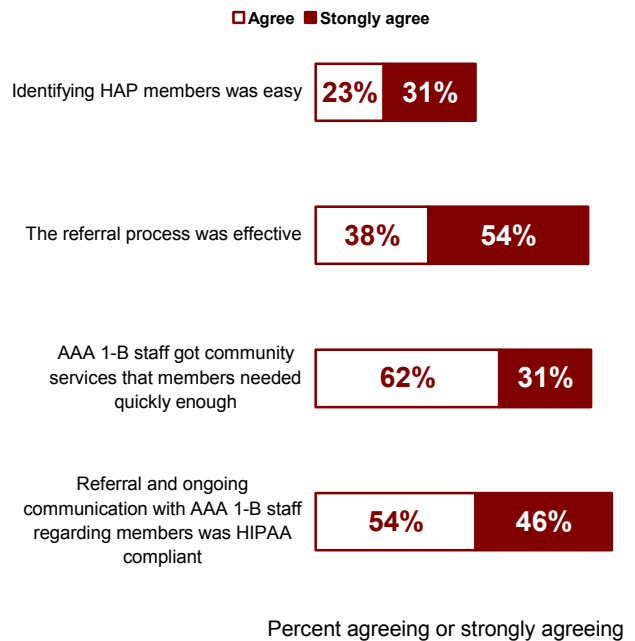


Figure 12 shows the three AAA 1-B care managers' assessment of the project infrastructure – its forms, protocols, data base information, and communications with the HAP case managers.²⁰ As the figure shows, the AAA 1-B care managers were generally very pleased with project implementation. All of the AAA 1-B care managers agreed or strongly agreed that the interview tool gave sufficient information to identify members' needs, that the HAP nurse case managers were easy to reach, and that referrals and communications with the HAP case managers were HIPAA compliant. Only one AAA 1-B care manager agreed that the HAP referral form accurately depicted the members' presenting problems. The HAP referral form had been kept brief so that HAP nurse case managers did not ask the same evaluation questions as the AAA 1-B care managers and to keep the HMO's referral process unencumbered in an effort to increase referrals. In retrospect, it did not convey enough information for the AAA 1-B care managers. Any future project would want to reevaluate the purpose of the referral form and make adjustments as appropriate. They all agreed that the interview tool developed for the project was more comprehensive for determining participants' needs than the HAP referral forms alone. Two of the three AAA 1-B care managers agreed that the Refer database held all the information they needed to develop the Community Supports Plan, and that discussing members' issues with their HAP counterparts was beneficial to care planning. One care manager was dissatisfied with the lack of Detroit resources in the

²⁰ This information taken from a written survey of AAA 1-B care managers at project end, CM Survey Output_2.xls.

Refer database. If a future project is to cover geographic areas external to an AAA region, sufficient resources would have to be researched and added to the database to cover the unfamiliar area. The AAA 1-B care managers are used to mobile technology, and two found the Refer database to not be user friendly, since it required them to be in the office in order to use it. Only one agreed that the Refer database was an effective way to document all pertinent member information. Any future project should develop an I&A database that can be used on laptop computers, to increase efficiency and accuracy. HAP nurse case managers also gave high ratings to the project procedures.²¹ As Figure 13 shows, more than 90% of the HAP nurse case managers agreed or strongly agreed that the referral process was effective, that the AAA 1-B staff got needed services to members quickly enough. 100% agreed that referrals and ongoing communication with AAA 1-B staff were HIPAA compliant. On the other hand, only 31% of the HAP nurse case managers strongly agreed and 23% agreed that identifying eligible HAP members was easy. These numbers reflect the difficulty experienced by the HAP nurse case managers in finding resources for persons not yet old enough to receive assistance from an AAA. These data also support the HAP nurse case managers' finding of a great need for services among Detroit residents, who were not initially included in the project.

Figure 13
HAP Case Managers' Perceptions of Effectiveness of Project
 (N=13)



Communication between HAP and AAA 1-B improved over the course of the project.

A future project should use a laptop information database for efficiency and accuracy.

²¹ This information taken from a written survey of HAP case managers at project end, HAP CM Pre-Post results output_2.xls.

Both AAA 1-B care managers and HAP nurse case managers also reported that their communications with each other improved over the course of the project. At the end of the project, staff from both organizations were asked to rate the quality of their communications. They were also asked to rate how their communication was “before” the project began. Figure 14 shows the percent of AAA 1-B care managers who reported communications with the HAP nurse case managers “now” was better than it was “before” the project began. As Figure 14 shows, two of the three AAA 1-B care managers reported a better ability to discuss member issues effectively with HAP nurse case managers, and that the HAP nurse case managers became more involved with the cases.

Figure 14:
% AAA 1B Care Managers who
Improved in Perceptions
from "Before" to "Now"
 (N=3)

Knowledge of Managed Care

I have a good understanding of how managed care works for members **100%**

I have a good understanding of how telephonic case management works **100%**

Knowledge of Disease Management

Disease management programs provide all the support a member needs to maintain or improve their chronic illness **0%**

Disease management programs focus only on the medical needs of a member **33%**

Communication with HAP

I feel I can discuss member issues effectively with HAP Case Managers **67%**

HAP Case Managers responded quickly enough **67%**

Figure 15 shows similar results comparing HAP nurse case managers’ perspectives of communication with AAA 1-B care managers at project’s end, and before the project began. When asked about their communications with AAA 1-B care managers, the majority of the HAP case managers improved in their ratings:

- when they call the AAA 1-B they can talk to the right person quickly enough (54%);
- they feel they can discuss member issues effectively with AAA 1-B care managers (62%); and
- they believe the AAA 1-B staff responded quickly enough to referrals of HAP members (69%).

These survey results were corroborated through a focus group conducted with AAA 1-B care managers and HAP nurse case managers after the end of the project.²² During the focus group the staff were

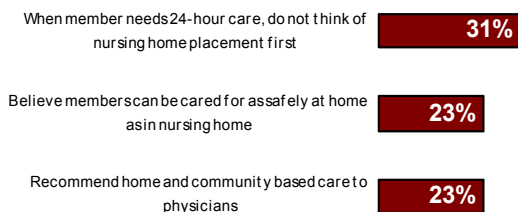
²² Data source is Minutes: HAP/AAA 1-B Integration of Community Supports/Managed Care Project Staff Focus Group Session, October 24, 2005

**Figure 15:
% HAP Case Managers who
Improved in Perceptions
from "Before" to "Now"
(N=13)**

Knowledge of Community Resources



Knowledge of Home and Community Based Long Term Care



Communication with AAA 1-B



overwhelmingly positive about the project, believing that:

- Communications between the two organizations were cordial.
- AAA 1-B staff went “above and beyond” the stated project objectives.
- The project gave HAP nurse case management staff peace of mind, knowing HAP members were getting needed services.
- The project resulted in fewer calls to 911.
- The project allowed HAP nurse case managers to meet their productivity goals.

- There was no duplication of services between the partner organizations.
- The direct line to the care managers and additional funding for services meant that the HAP members were not placed on a waiting list for services.
- The care management assessment identified additional needs of HAP members.
- Services were timely.
- Inexpensive interventions (e.g. a bath bar) could prevent expensive treatment (e.g. a hip fracture).
- Home care services do not generally provide the type of follow up done by the AAA 1-B care managers.
- HAP nurse case managers universally agreed that they would like to see the program continue.

Knowledge Gain

In addition to improved relationships between staff of the two organizations, the staff surveys also assessed perceptions of changes in knowledge about each other's programs, using the same method of comparing their perceptions "now" to "before" the project began. All three AAA 1-B care managers reported knowing more about managed care after participating in the project (see Figure 14). Similarly, (in figure 15) the majority of HAP nurse case managers reported that they:

- Know more about the types of community resources to assist members improve disease self-management (54%);
- Believe more that there are numerous community services for frail elderly (69%); and
- Know more about how to refer a member to AAA 1-B's call center (62%).

Impact Summary

Results from this pilot project demonstrate that there is a value for managed care organizations to link their members to community supports. As a result of this partnership, HAP members received an average of 5.58 referrals to community services and more than seven contacts with AAA 1-B care management staff. When needed, HAP members were provided with non-medical services such as chore, shopping, transportation or personal care assistance that helped them manage their chronic conditions. HAP nurse case managers believed that members had improved or maintained health; and HAP members themselves, believed that the program helped them manage their illnesses. HAP's internal data show that during their stay in the project, participants enjoyed a 46.6% reduction in ER visits and a 34% decrease in hospitalization. Furthermore, 100% of the HAP members who were interviewed in this project agreed that the program is a valuable addition to HAP's Case Management program.

The value of community supports within a managed care environment can be expressed in dollars saved. The cost of this project was \$165 per HAP member per month, for the 12-month project period. This cost includes the provision of I&A, care management and community services, plus operations, program development, and other start-up costs. While use of this figure is limited due to the small sample size and short timeframe of the project, its impact on medical costs is compelling. Most of the HAP members referred to the project were assisted through telephonic care management and only a fraction of participants needed the more costly in-home care management. Further, for the HAP members served through the project, there was a reduction in ER visits valued at \$113.81 per member per month. Similarly, there was a reduction in hospital admissions valued at \$892.80 per member per month. Although the per member per month savings figures are based only on the project population, the savings potential for the HMO is real.

HAP data showed a 46.6% decrease in ER visits and a 34% decrease in hospitalizations among project participants.

An area agency on aging (AAA) is the ideal organization to provide community supports to a Medicare managed care organization. This project found that the information and assistance and community care management offered through the AAA 1-B did not duplicate services provided by HAP. Its extensive resource database and experience in community care management gave the AAA 1-B the ability to probe about the social and environmental needs of HAP members from a different perspective than a disease management program. The AAA 1-B is the established link to home and community based services in the counties it serves. The AAA 1-B staff are experts in community care management and the development of services and service networks to meet needs identified for the elderly and disabled populations.

Through this project, the HAP nurse case managers were able to be directly connected to the AAA 1-B care manager, and funds were available to pay for needed services. It is only because of the grant funds, however, that the partnership worked seamlessly. Without the finances to support care management time and to pay for needed services, HAP members would likely be placed on waiting lists that exist for many community services.

HAP members live in geographic areas beyond the counties served by the AAA 1-B. This is likely to be common for other large HMOs also. A managed care organization will no doubt prefer working with a single point of contact rather than having separate business agreements with each AAA in its service area.

Therefore, the AAA 1-B envisions developing partnerships with other AAAs that offer similar I&A and care management services.

AAA 1-B envisions partnerships with other AAAs that offer similar community support services.

This project began the development of a HIPAA-compliant infrastructure in support of an HMO-AAA business agreement. To complete the relationship, the infrastructure must also include:

- Identification and credentialing of other AAAs and service providers in other regions served by the HMO;
- Benchmarks and measures for quality assurance, clinical health outcomes, health services utilization, and critical incident management;
- Information about services in other areas served by the HMO organized into a centralized and automated I&A.

A visionary managed care organization might embrace the results of this pilot project and realize the potential of an AAA being its eyes and ears in the community. Through the partnership, the managed care members become established within a holistic system of care, with easy referral to community services that can help them manage their chronic diseases. In this project, the AAA 1-B provided a safety net for HAP members, filling the gaps more effectively/efficiently with community supports. Because of the partnership, HAP members at high risk for ER and hospitalization had increased access to in-home monitoring by an AAA 1-B nurse care manager and telephonically by a HAP nurse case manager.

The time for partnership is now. Under Medicare Advantage, any health plan wishing to receive approval from the Centers for Medicare and Medicaid Services is required to provide “continuity and coordination of care”²³ using partnerships with existing agencies that provide community and social services for beneficiaries in need of chronic disease management. Results from this project show that a partnership between an AAA and a managed care organization can provide this continuity and coordination, with health benefits to the member that have long-term impact. Whether the “bottom line” is considered to be member satisfaction, improved quality of life for the member, or cost savings, this project shows that a community supports partnership can bring the advantage home.

²³Medicare Modernization Act, 2003, 422.112(b).