



# THE ROLE OF I&R IN MANAGED CARE CONTRACTS

Maureen Widner, COO

Katie Hougham, Care Transitions Supervisor

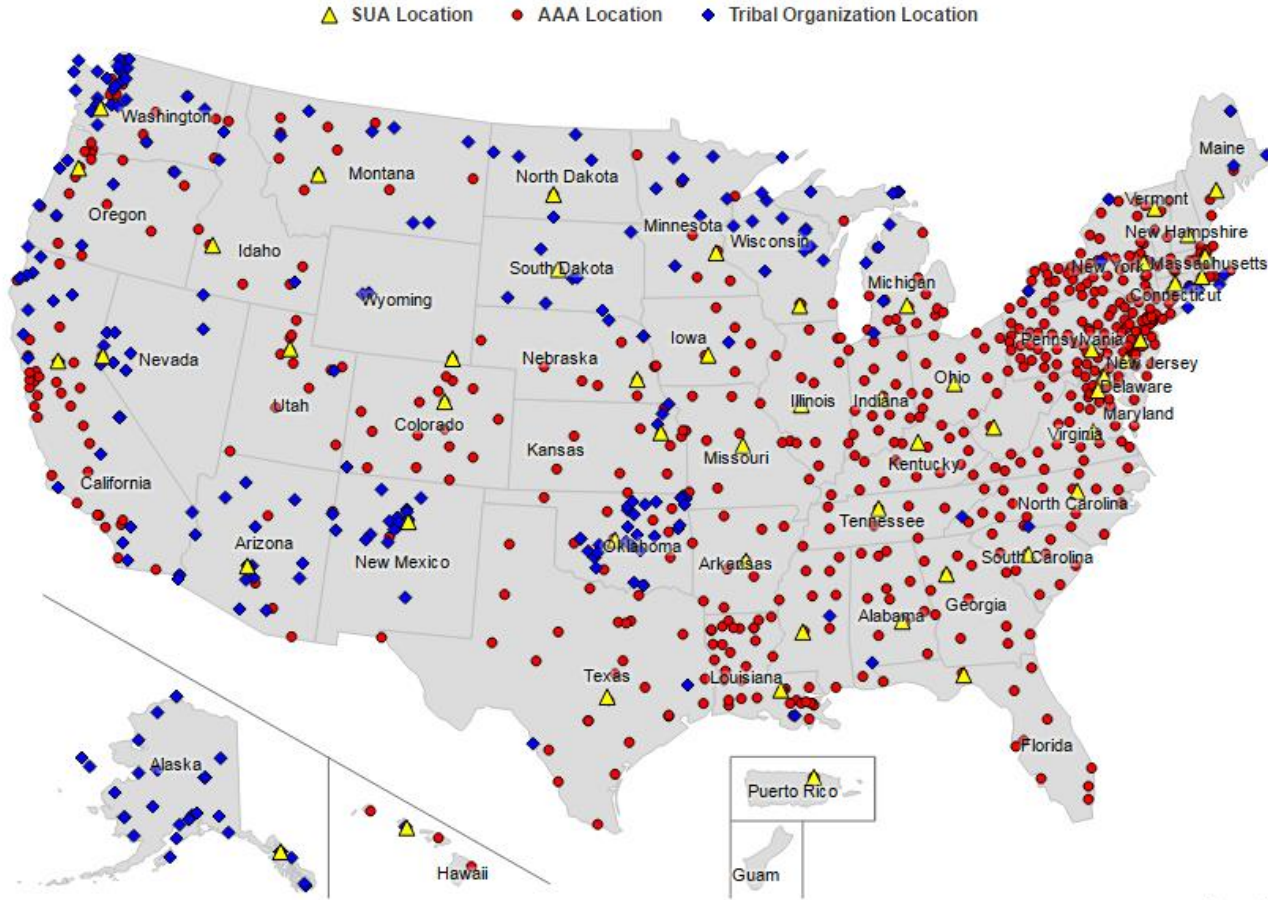


Aging & In-Home Services  
OF NORTHEAST INDIANA

# Older Americans Act Signed July 14, 1965



# Nationwide Network In Every County in Every State



Source: 2017 Administration for Community Living

# National Aging Services Network



U.S. Department of Health and Human Services

U.S. Administration on Aging

State Units on Aging (56)

Area Agencies on Aging (629)

Aging and Disability Resource Center

Consumers



**INFO/NEED**



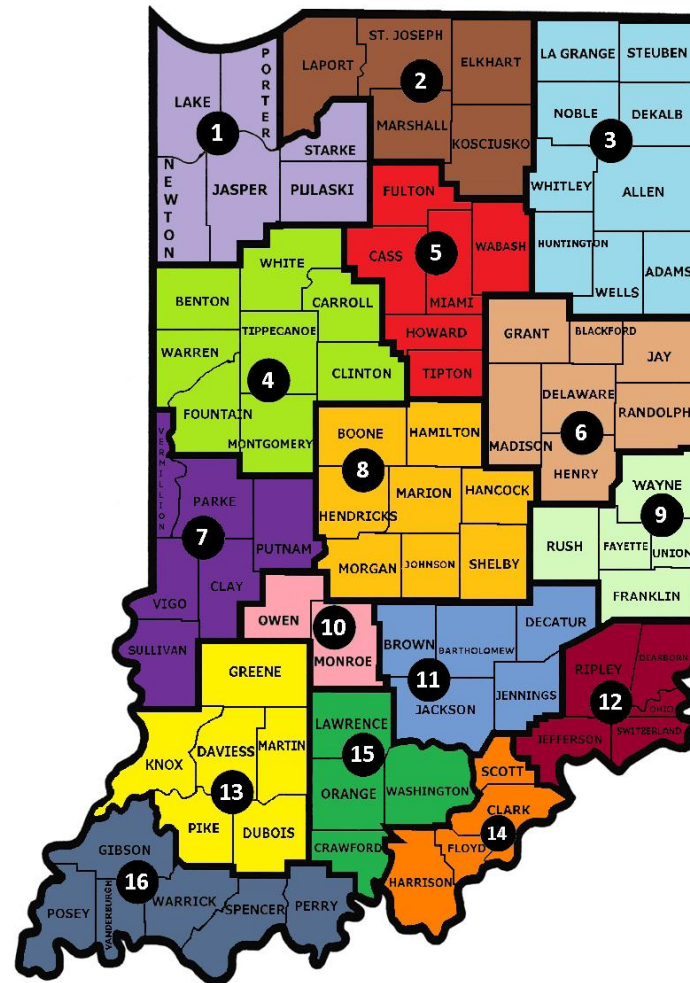
Aging & In-Home Services  
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# Our Role as an Area Agency on Aging (AAA)

- Regional Assessment of Needs
- Area Plan
- Indiana State Plan
- Administration for Community Living



# Indiana Association of Area Agencies on Aging



# Our Region

## Main area for most services







## Mission Statement

Our mission is to promote independence, dignity, and advocacy for all older adults, persons with disabilities, and their caregivers.



Aging & In-Home Services  
OF NORTHEAST INDIANA





# If you know someone in need of assistance, just call us.



1-800-552-3662 • 1-260-745-1200

[www.agingihs.org](http://www.agingihs.org)

Aging & In-Home Services  
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## Aging & Disability Resource Center

To inform, empower, connect

- Information & Assistance
- Options Counseling
- Benefits Enrollment
- Senior Health Insurance Program (SHIP)
- Community Education Series
- Care Transitions Support

## Programs for Productive Aging

Health, wellness, and community engagement

- Health Education Specialist
- Preventive Health
- Chronic Disease Self Management
- Consumer Education Seminars
- Retirement Planning

## Family Caregiver Center

Helping you care for the ones you love

- Caregiver Assessments
- Caregiver Consultation
- Family Counseling & Mediation
- Respite Care
- Men as Caregivers Initiative

## Home & Community Services

Supporting you where you live

- Senior Dining
- Meals on Wheels
- Transportation
- Homemaker & Chore
- Legal Services

## Geriatric & Disability Case Management

Easing the burden of long term care

- Comprehensive Assessments
- Care Planning, Referral & Monitoring
- Enrollment Assistance for State & Federal Programs
- Consumer-Directed Care Management
- Pre-Admission Screening for Nursing Home Care



Division of  
Aging



Aging & In-Home Services of Northeast Indiana, Inc. (AIHS) promotes independence, dignity, and advocacy for all older adults and persons with disabilities. As the Area III Agency on Aging, AIHS is the primary resource for aging and disabled populations and the largest funder of services including support for the Council on Aging in the following nine counties:

**Adams, Allen, DeKalb, Huntington, LaGrange, Noble, Steuben, Wells, Whitley**

Aging & In-Home Services  
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40  
1975-2015  
& FORWARD

2015 Annual Report

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260-745-1200 800-552-3662



Aging & In-Home Services  
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# Affordable Care Act

## The Game Changer



# Health Care

## Health-Related Care



# Health Happens at *Home*

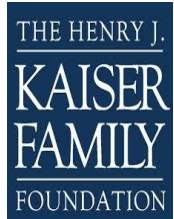
– *own it!*



# Upstream Impact on Health Outcomes

## Social Determinants of Health

Economic Stability	Neighborhood & Physical Environment	Education	Food	Community & Social Content	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expense	Safety	Early childhood education		Community engagement	Provider linguistics & cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

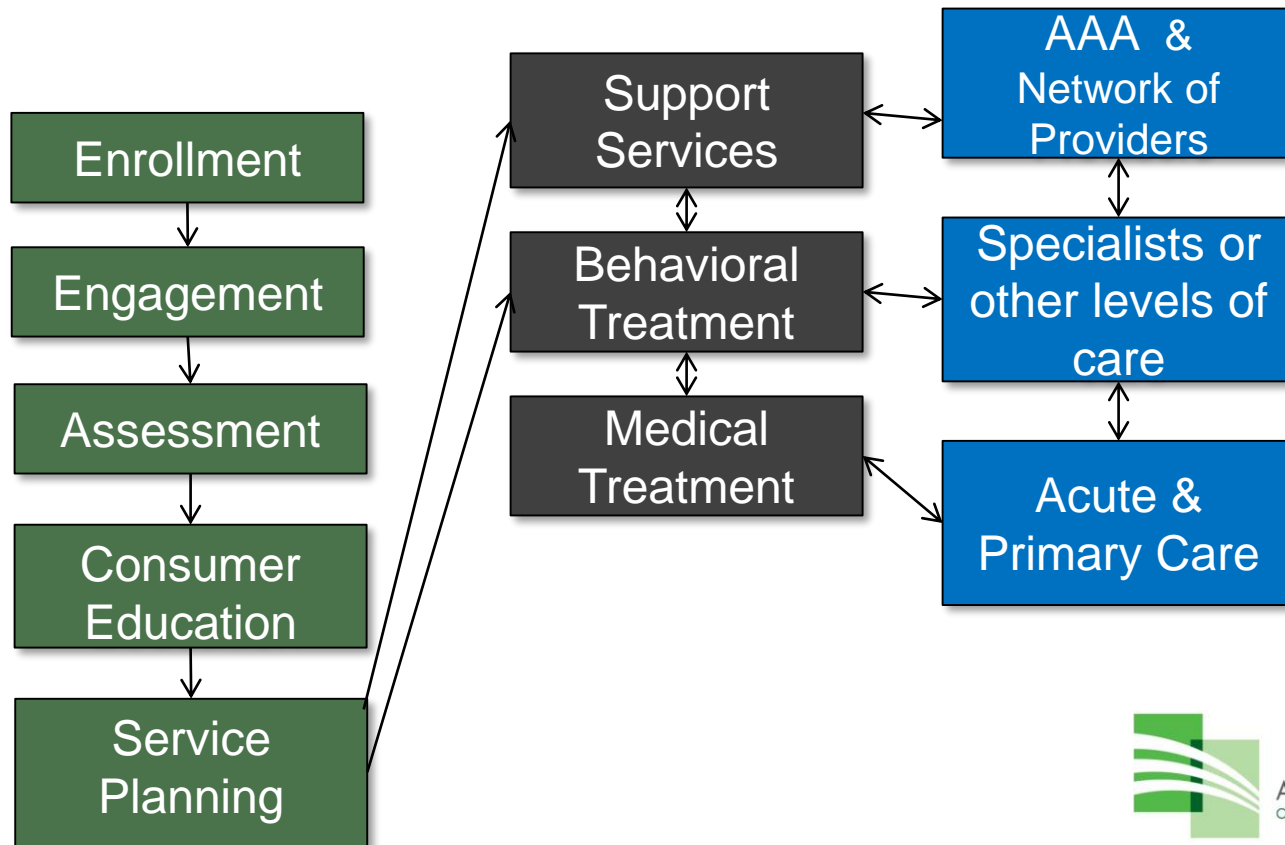


**Health Outcomes**  
 Mortality, Morbidity, Life Expectancy, Health Care Expenditure, Health Status, Functional Limitations



# Integrated Care – As we see it

Integrated care is not just between physical and behavioral health. A truly integrated care system is one that manages and optimizes each phase of the health care process with long term services and supports – seamlessly managing care through all transitions.



# AIHS Single Point of Entry Aging & Disability Resource Center



If you know someone  
in need of assistance,  
**just call us.**



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# National Single Point of Entry Aging & Disability Resource Center

The Aging and Disability Resource Center (ADRC) initiative is a collaborative effort



This initiative seeks to streamline access to long-term services and supports (LTSS) for older adults, all persons with disabilities, family caregivers, veterans, and LTSS providers.

# Aging & Disability Resource Center (ADRC)

*To inform, empower, connect*

- Information & Assistance
- Options Counseling
- Benefits Enrollment
- Insurance Education
- Care Transitions Support



# Aging & Disability Resource Center

## Client Profile

- 67% of calls for someone over age 60
- 33% for someone under age 60
- Majority of callers (61%) for themselves
- 19% of total calls from caregivers
- 14,953 clients served annually
  - (compared to 13,582 last year)
- 23,235 units provided annually
  - (compared to 20,027 last year)



# Most Requested Services

- Meals on Wheels
- Benefits Enrollment
- Medicare & Long Term Care Insurance
- Case Management
- Family Caregiver Support
- Emergency Response System
- Advance Directives
- Home Health Aide
- Transportation
- Homemaker/Chore Assistance
- Assisted Living





# Our Services Represent a Continuum of Care

## Consumer & Community Engagement Services

- Aging & Disability Resource Center
  - I & A
  - Options Counseling
  - Benefits Enrollment
  - Healthy Aging
- Care Transitions
- Family Caregiver Support

## Community Assistance Services

- Nutrition
  - Congregate
  - Restaurant Vouchers
  - Meals on Wheels
- Transportation
- Homemaker
- Handy Chore

## Long Term Services & Supports

- Case Management
  - Vendor Management
  - Participant Directed Care
- Pre-Admission Screening
- Ombudsman



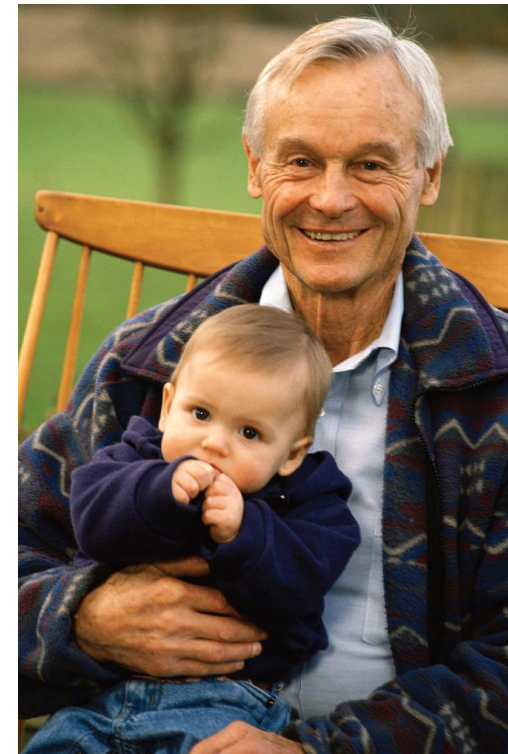
# AAA Client Profile

## Age range (Under 1 year - 103 years old)

85+	17%
75-84	20%
65-74	18%
Under 65	45%

Gender	31% Male	69% Female
Ethnicity	22% Minority	78% Caucasian

Living Below Poverty	50%
Living Alone	50%



# Database Partnership



# AIHS No Wrong Door

Allen County Case Coordination System  
Established 1999



# AIHS' Managed Care Contracts

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Katie Hougham, Care Transitions Supervisor

# Managed Care Contract #1

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# Managed Care Contract #1

## Our “average” client

- Medicare Fee for Service (Part A&B)
- 65 years old or over
- Discharging home or SNF
- Admission diagnoses: AMI, CHF, PN, COPD, Diabetes

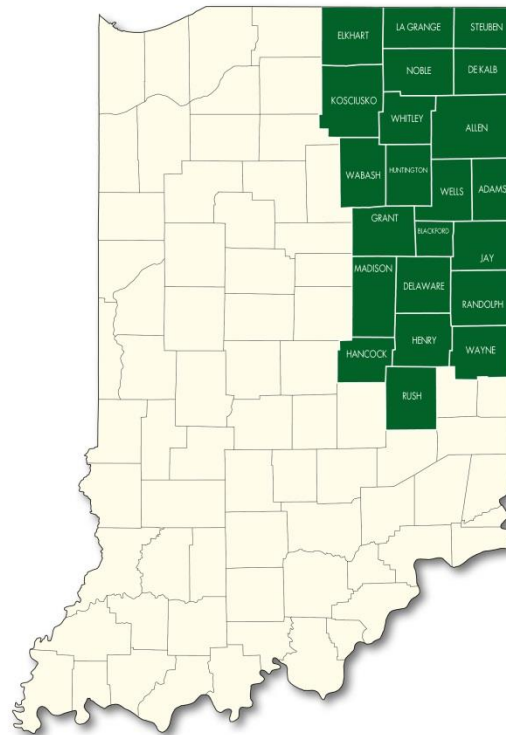
### **Excludes:**

- Dementia with no live-in caregiver
- Active addiction
- Enrolled in Medicare hospice



# Managed Care #1 Coverage Area

**Michigan**



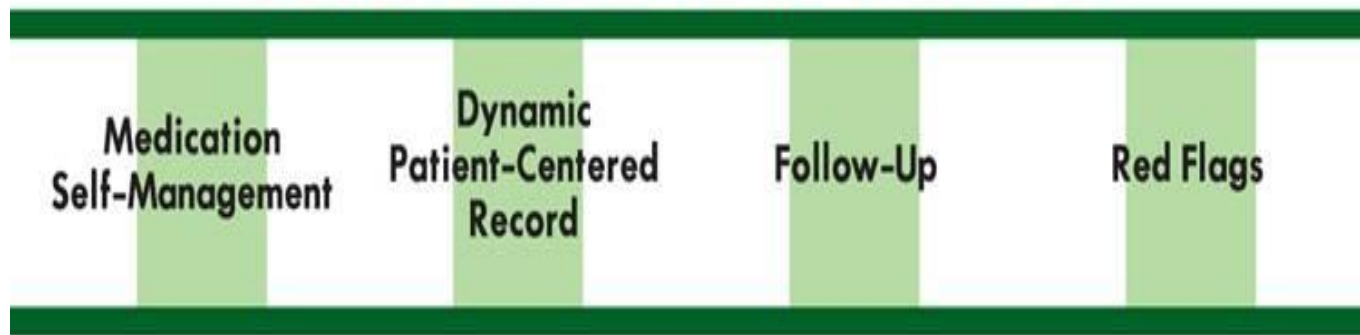
**Ohio**

# Coleman Model

## Care Transitions Intervention (CTI)

- Developed by Eric Coleman, MD, University of Colorado, Denver
- Evidence-based 4-week program, where patients with complex care needs receive specific tools, are supported by a Transitions Coach<sup>®</sup>, and learn self-management skills to ensure their needs are met during the transition from hospital to home

### Four Pillars of Care Transitions Intervention<sup>®</sup>



# Managed Care #1 : Client Story

## Client

“Lucille”

62 years old

Diagnosis: AMI, Diabetes with uncontrolled blood sugars, chest pain, coronary artery disease, renal insufficiency

## Social Determinants of Health

- On Medicare due to disability
- Caregiver to husband just diagnosed with pancreatic cancer
- Caregiver to live-in mom, just returning home from SNF due to medical event
- Does not drive
- Husband’s driving ability compromised due to health issues

## Information & Referral

- Family Caregiver Support
- Transportation
- Palliative Care Program
- Blood Sugar Tracking Log
- Cancer Services Referral

# Managed Care Contract #2

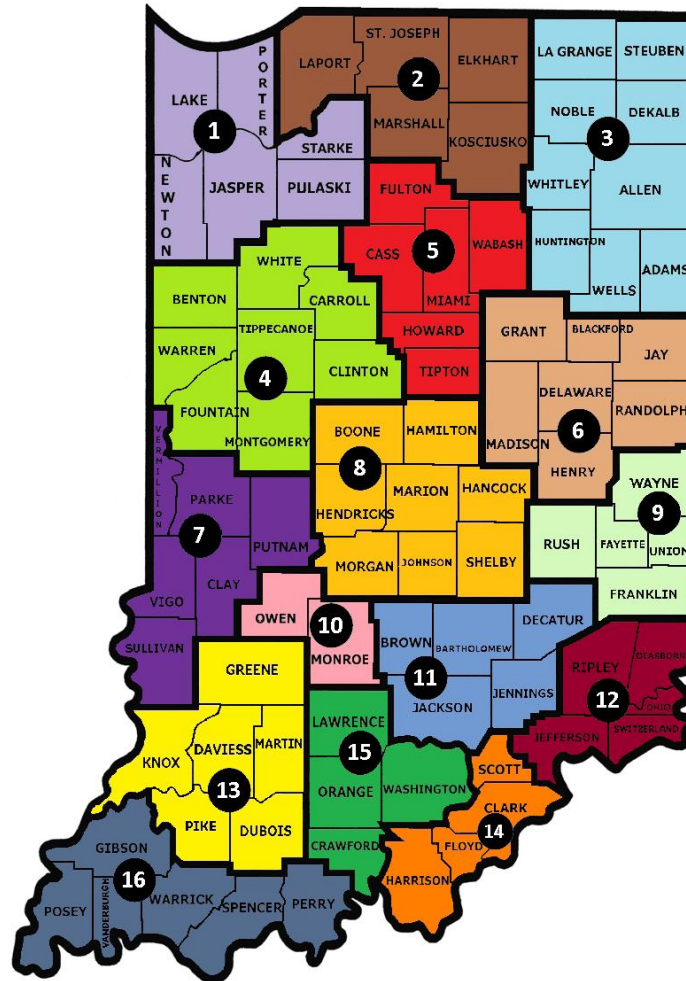
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# Managed Care Contract #2

## Our “average” client

- Current Medicaid recipients
- 30-45 years old (youngest client 8 weeks old)
- Referral made due to high number of hospitalizations or ER visits
- Prevalence of mental health issues and alcohol/drug dependence
- Unstable or poor housing conditions
- Lack of Family Support
- Varying diagnoses

# Managed Care Contract #2 Coverage Area







Member  
Engagement



Health  
Care  
Utilization



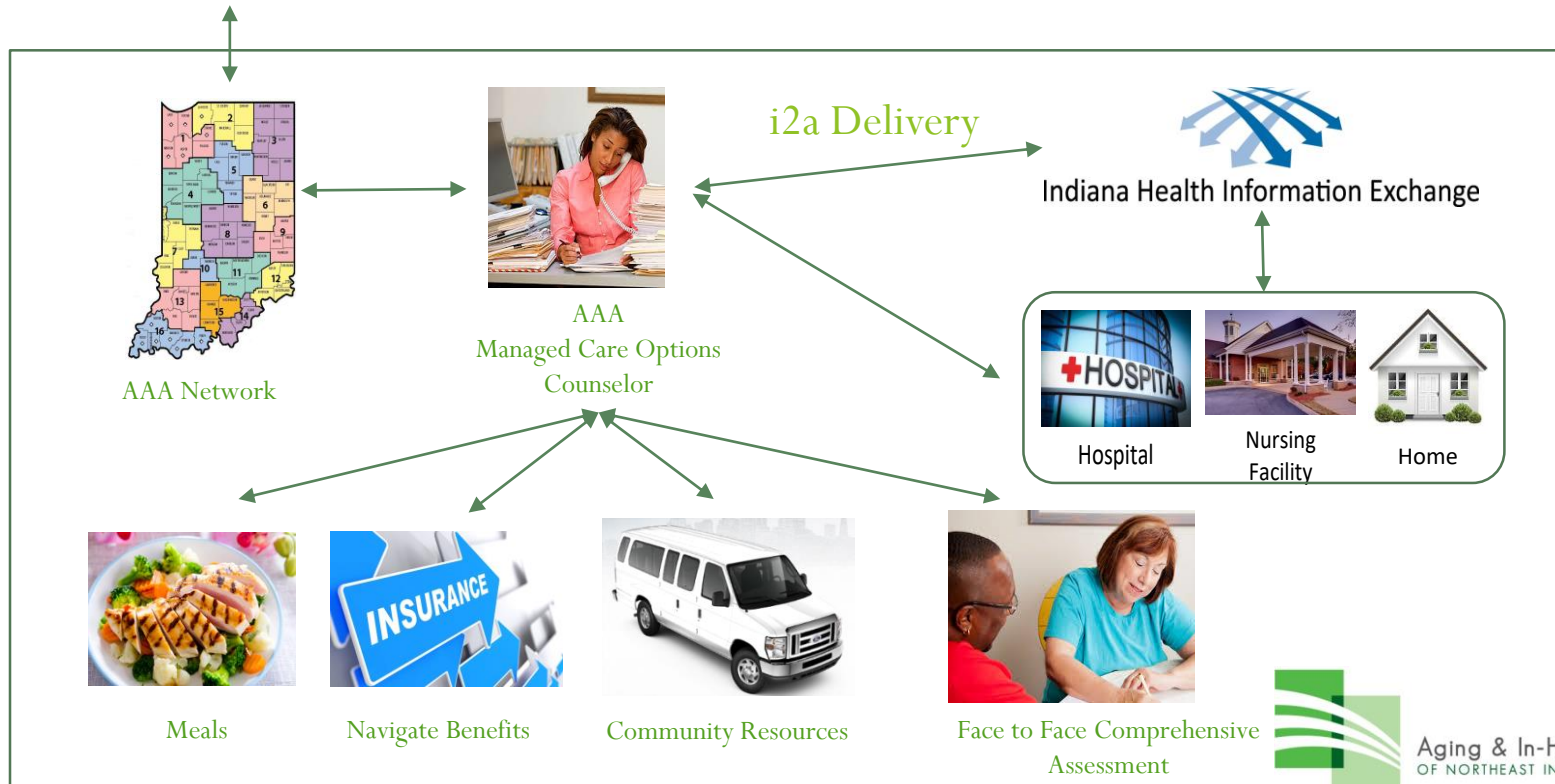
# MCC #2 – Care Coordination Model



Anthem Care Manager, (RN)



Anthem Member Identified for Services



# Managed Care #2 : Client Story

## Client

“Miss Miller”

35 years old

Uncontrolled Headaches

Diagnosis: Intracranial  
Hypertension with brain  
cavity shunt placement

## Social Determinants of Health

- Lives with mother
- Unable to drive
- No income
- Rural, isolated

## Information & Referral

- Pain Management
- Transportation
- Social Security Disability
- Food vouchers
- Caregiver support
- Churches and social groups

# Managed Care #2 : Client Story

## Client

“Suzie Q”

2 months old

Born Prematurely

Diagnosis: Seizures, g-tube placement

## Social Determinants of Health

- No father present
- No family support present
- Subsidized housing
- Mother is sole source of income

## Information & Referral

- Early Head Start
- Indiana First Steps
- Township Trustee – utilities and housing
- Daycares Accepting Medicaid
- Education on Post-Partum Depression & Pumping
- 24/7 Nurse Line Contact

# Managed Care Contract #3

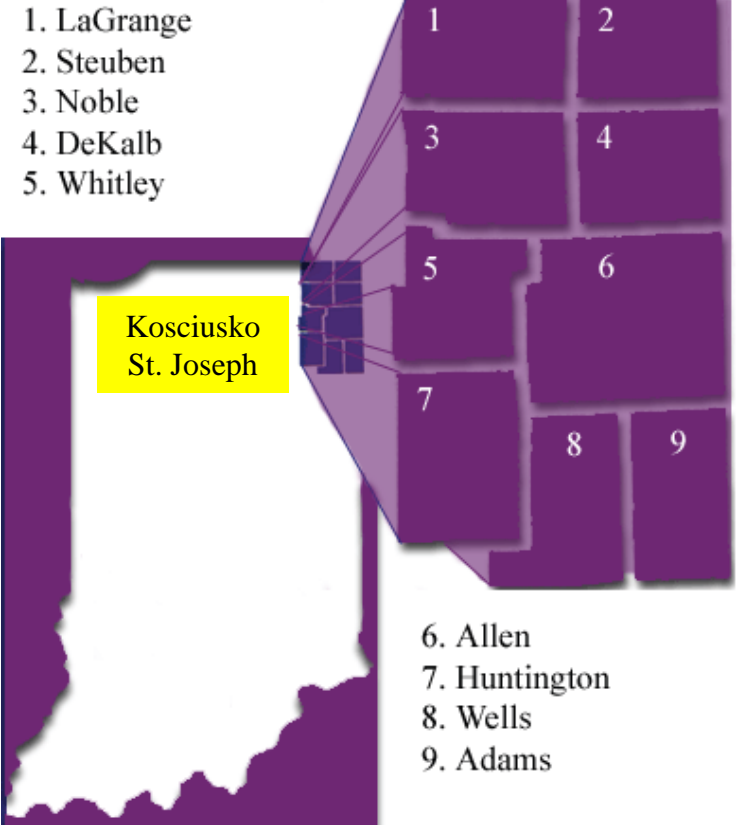
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# Managed Care Contract #3

## Our “average” client

- Many unable to return to work and need assistance finding new coverage/disability
- Age Range: 40-60 (youngest 8 weeks, oldest 67)
- Still working
- Limited family support
- Small towns with less resources and access to care
- Referred due to noncompliance (diabetes or smoking) or new diagnosis (cancer or stroke)

# Managed Care Contract #3 Coverage Area





# Managed Care #3 : Client Story

## Client

“Mr. Jones”

55 years old

Recent diagnosis of COPD with 12% lung capacity – requires 24/7 O2

Hospital readmission within 30 days due to mowing lawn without wearing O2

## Social Determinants of Health

- Unmarried, no family support
- No credit or bank account
- Unable to return to work
- No consistent support system
- Losing health insurance due to inability to work
- No primary care physician
- Current every day smoker & drinker (disqualifications for lung transplant list)

## Information & Referral

- Smoking Cessation
- Alcoholics Anonymous
- Medicaid application
- Food Bank
- Primary Care Physician
- Township Trustee Utility Assistance
- Non-profit Volunteer Lawn Mowing
- Social Security Disability
- RN & RD Education

# Managed Care #3 : Client Story

## Client

“Betty”

52 years old

Diagnosis: Swelling in abdomen – hysterectomy and ovarian cancer

## Social Determinants of Health

- Spouse is primary caregiver
- Sister is secondary caregiver while spouse is at work
- Uses walker
- Wants to return to work
- Unable to drive
- Rural community

## Information & Referral

- RD Referral
- Cancer Services for support group, medical supplies, supplements, etc.
- Transportation
- Reviewed process for applying for disability if unable to return to work
- Township Trustee – utilities & mortgage

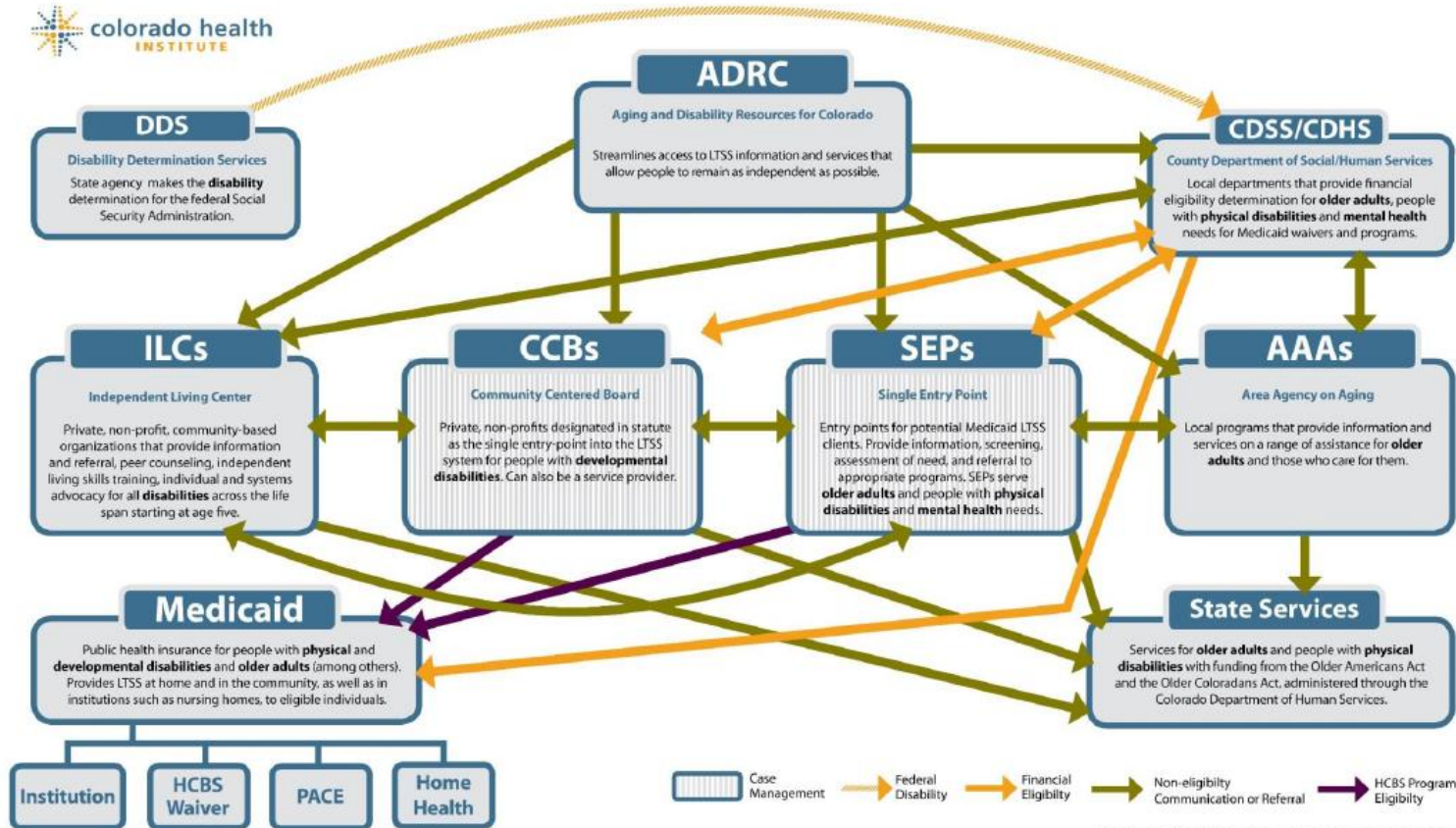
Maureen Widner, COO

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# One Size (database) Does Not Fit All



# Single Point of Entry?



SOURCE: Analysis by Tasia Sinn, Senior Analyst, Colorado Health Institute



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# No Wrong Door!



# No Wrong Door (NWD)

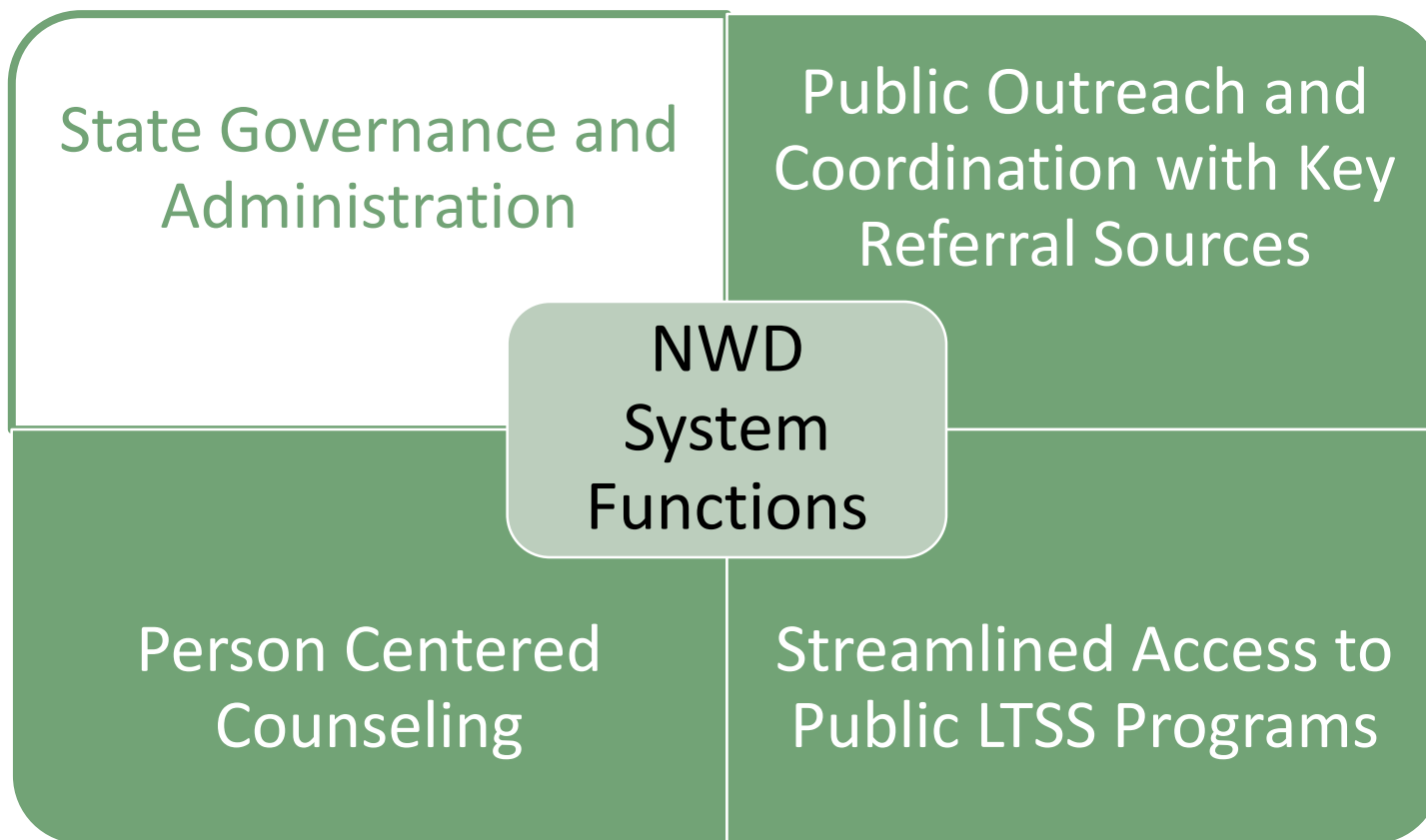
## A No Wrong Door (NWD) system:

- Recognizes that resources are limited and insufficient to address the growing need for long term services and support (LTSS) counseling and assessment;
- Identifies the many “doors” consumers already use in their attempts to access long term services and support (LTSS);
- Addresses all populations and all payers; and
- Creates tools and training to prepare the individuals and organizations that man those “doors” to provide assessment and supported decision-making to consumers and their families.



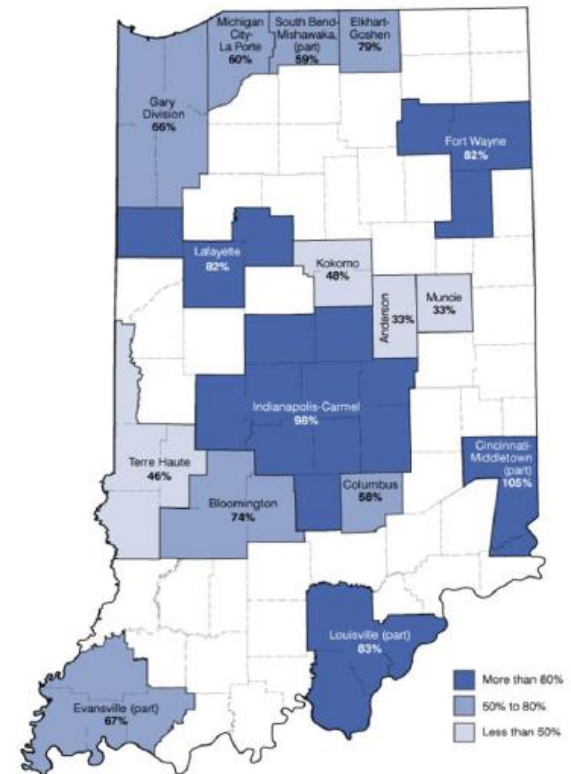


# ADRC and NWD



# Why Indiana Needs a No Wrong Door System

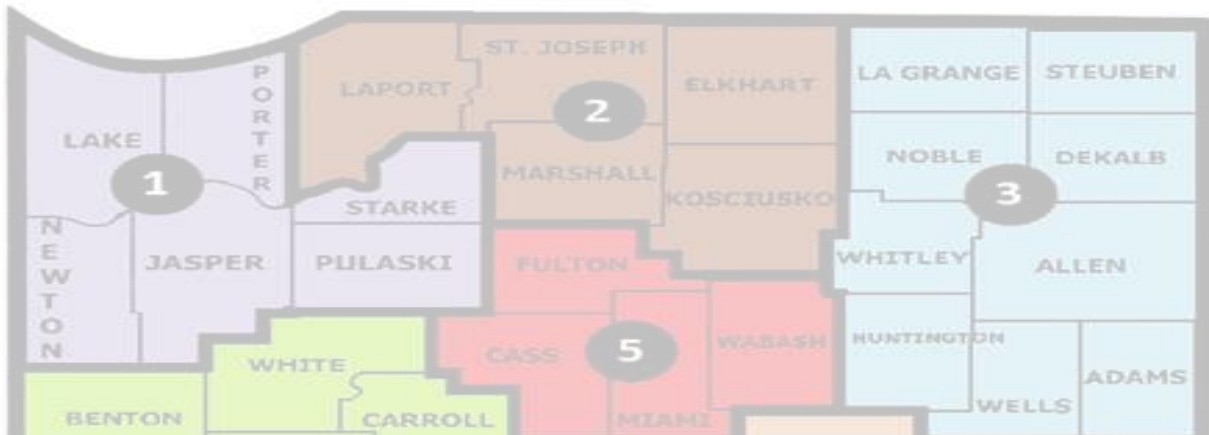
- An estimated 70% of persons ages 65 and over will use LTSS.
- Persons ages 85 and over – the fastest growing segment of the U.S. population – are *four times more likely to need LTSS* as compared with persons ages 65 to 84.
- Five of Indiana's metropolitan areas will see increases of more than 80 percent in the next 20 years.
- The baby boomer cohort will be of traditional retirement age by 2030.



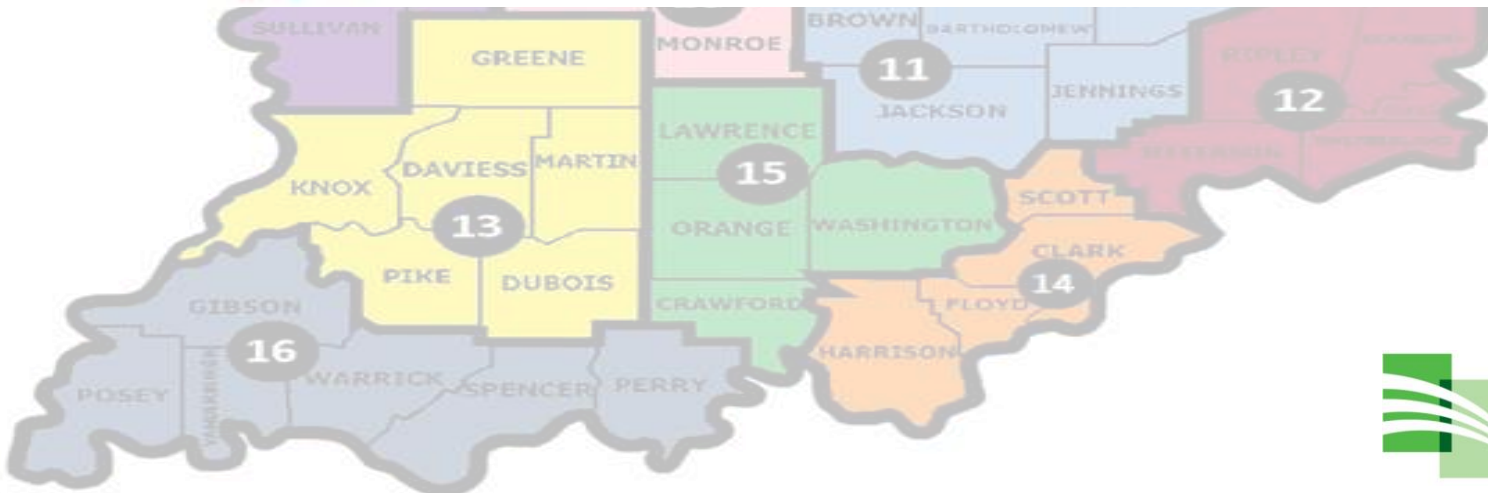
# Aging & Disability Resource Center (ADRC)

## **Core Goals of Indiana's NWD System:**

- Supporting rebalancing of public expenditures to home and community-based services by reducing or eliminating the highly fragmented systems of accessing those services.
- Putting the person at the center of the programs that serve them.
- Providing systems of access to the right care, in the right (least restrictive) place, at the right time.



# IN CONNECT ALLIANCE



# AAA Most Requested Services

- Meals on Wheels
- Benefits Enrollment
- Medicare & Long Term Care Insurance
- Case Management
- Family Caregiver Support
- Emergency Response System
- Advance Directives
- Home Health Aide
- Transportation
- Homemaker/Chore Assistance



# Expanding our Database

## AAA Most Requested Services

- Meals on Wheels
- Benefits Enrollment
- Medicare & Long Term Care Insurance
- Case Management
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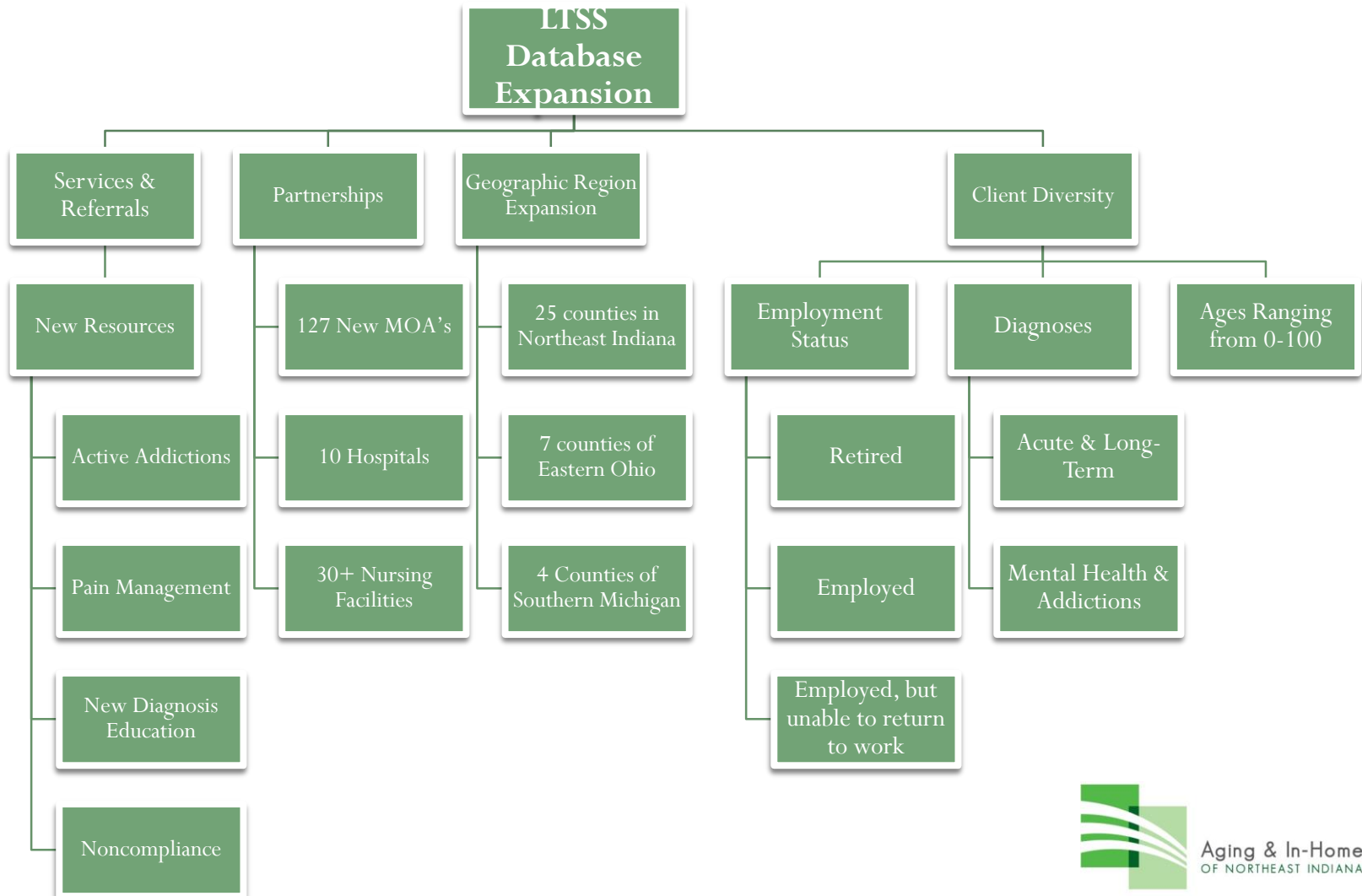
## Managed Care Contracts

- Township Trustee
- Cancer Services
- Social Security Disability
- Transportation
- Palliative Care Program
- Early Head Start
- RN referral & 24/7 Contact
- Food vouchers & Food banks
- Pain Management
- Smoking Cessation
- Alcoholics Anonymous
- RD referral



# Expanding our Database

## Long-Term Services and Supports (LTSS)





Success =

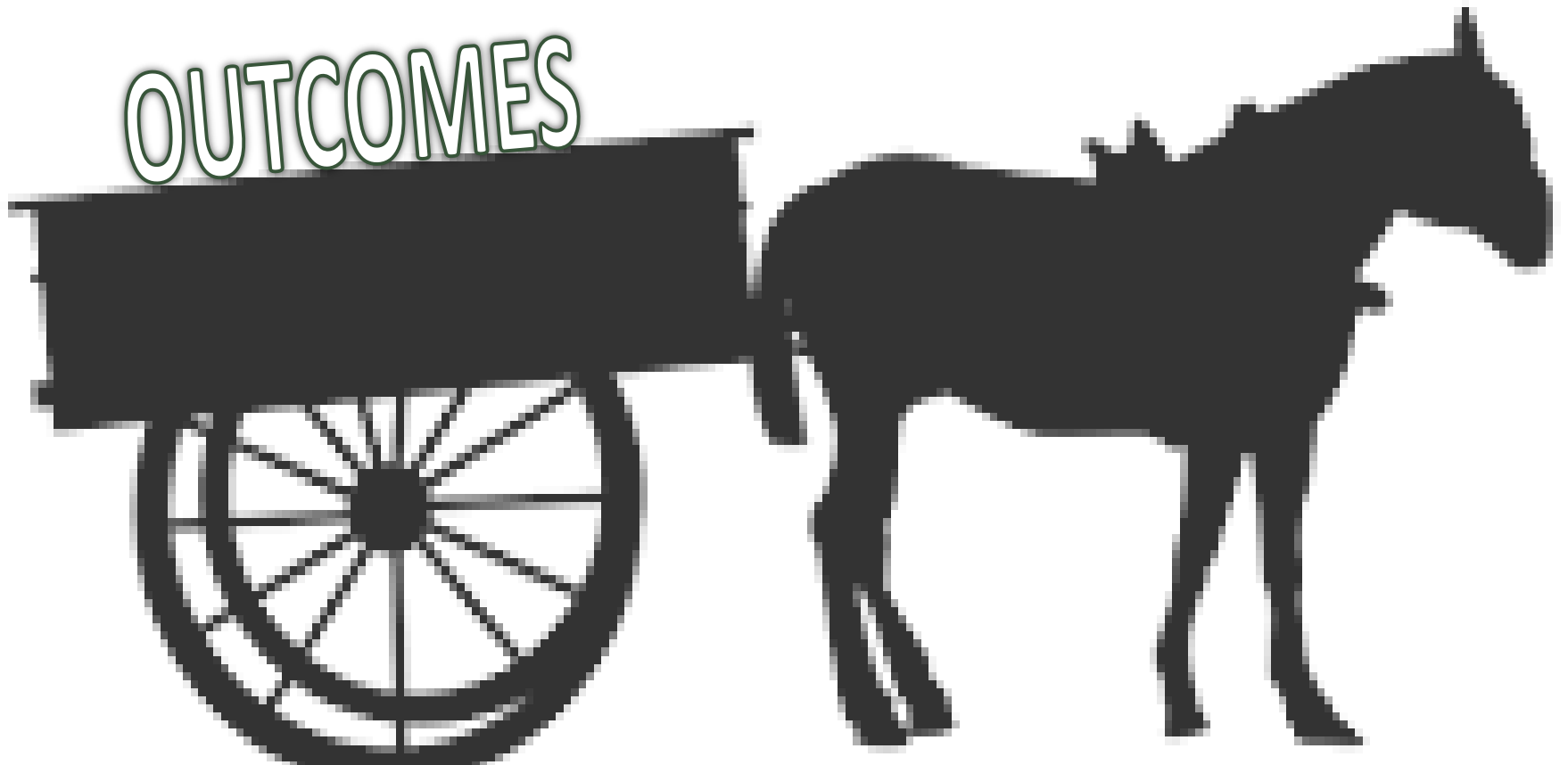
Enhanced Database

**Success in managed care contracting depends on the enhanced database; how you manage outcomes are dependent upon community resources and compliance**



= *Renewal*

OUTCOMES



# Vision

Longitudinal View of Client  
Electronic Referral Management  
Outcome Measures  
Fully Integrated and Interoperable IT Platform