BRONX VOICE

Aging Safely at Home: It Takes a Team

By Hany Abdelaal

The Value of Care Coordination

HEALTH NEWS– Living alone in his apartment, Tomas Castro was heading toward a downward emotional spiral—and nobody knew it.

Nobody, that is, except Elizabeth Almanzar-Wright, RN, his health insurance plan's care coordinator. She was regularly monitoring his health status and detected signs of depression and suicidal thoughts. Because Elizabeth knew what to look for, what steps to take, and which resources were available, Tomas was connected to the right care and is now on the path to better health.

Tomas is one of a rapidly growing number of disabled, chronically ill, or elderly Americans—including more than 213,000 New Yorkers—enrolled in Managed Long-Term Care (MLTC) plans.

Based on the coordinated services of clinicians from a variety of disciplines, these Medicaid plans enable the creation of a support team tailored to meet each patient's particular physical and emotional needs. With the security of this safety net, and the involvement of the care coordinator, vulnerable individuals are taking an increasingly active role in maintaining their health, improving their overall well-being and achieving peace of mind in the process. They are able to live as independently and comfortably as possible in their own homes—avoiding a stay in a long-term care facility.

VNSNY CHOICE Health Plans: Helping to Pioneer the MLTC Movement

MLTC programs were introduced some 20 years ago. But a blueprint for this home care model was pioneered in 1893 by the Visiting Nurse Service of New York (VNSNY), the company where I work. For 125 years, VNSNY's non-profit mission has focused on providing home and community-based care for New York's vulnerable populations, and it is this mission that continues to guide our efforts and is why we were chosen to offer one of the first MLTC plans, under a New York State Medicaid demonstration

platform. Today, VNSNY CHOICE, the MLTC program in which Tomas is enrolled, provides coordinated care to more than 34,000 members.

Surviving—and Thriving—through Coordinated Care Transitions

"Care transitions," or adjusting to a new level of care, can be traumatic experiences, producing a great number of questions, uncertainties, and concerns—like those faced by CHOICE MLTC member James Keene, who suffers from high blood pressure and coronary artery disease, and was discharged to his home following knee-replacement surgery. James's RN care coordinator arranged telephonically for physical therapy in the home and ensured that transportation was arranged for James' post-surgery doctors' appointments, in addition to supervising a VNSNY Home Health Aide (HHA) who picked up heart medications and a cane that were prescribed for James in the hospital.

Lucy Alvarez, an 81-year-old CHOICE MLTC member, faced a similar struggle when she came home from the hospital alone following a colostomy and could not manage the daily care she needed. Her MLTC plan arranged for a nurse from VNSNY to come in and teach Lucy and her HHA how to attend to her colostomy bag and clean the site, which they now do every day—keeping Lucy safe and healthy at home.

Care That Comes to the Home

That's the real difference with MLTC Care coordination is centered in the patient's home, the setting that best promotes healing and well-being. The MLTC plan connects the member with the appropriate mix of specialists, nurses, HHAs, social workers, behavioral health counselors, dieticians, and rehabilitation therapists, whose involvement is approved under a doctor's orders. All required services are overseen by a clinical care coordinator—usually a registered nurse or social worker—who assesses and considers all details, large and small, of each member's daily life.

Care coordinator Constance Washington has worked with our CHOICE MLTC population for 13 years and knows firsthand the difference care coordination can make in the lives of people who are often isolated and overwhelmed by health concerns and other needs.

"For an aging population, there are so many layers to healthcare. They may have multiple conditions, need multiple medicines, and see multiple doctors," Constance says. "They don't know where to start, so we help them navigate those layers."

The Value of Dedicated Personal Oversight

The beauty of an MLTC plan is that care coordinators do know where to start.

Take the experience of Tomas Castro, mentioned above. Before his nurse care coordinator, Elizabeth Almanzar-Wright, even met Tomas, she noticed in his records that he had not been keeping regular doctor's appointments for his chronic diabetes and depression.

After calling Tomas and hearing that he didn't think his doctors could do anything to help him and had feelings of despair, Elizabeth contacted his adult children. With their involvement, Elizabeth helped Tomas receive behavioral counseling and requested that his doctor re-evaluate the medicine he was taking.

Now Tomas's children know more about their father's depression, what red flags to look for, and how to access care when needed. They—and Tomas—are a part of his care team.

Below are five essential ways that MLTC care coordination anticipates and meets the needs of our nation's elderly as they age in own their homes and communities.

Building a home care team

Based on an initial assessment, the MLTC care coordinator assembles a clinical team with the specific skills needed to address the member's particular health issues. This interdisciplinary team comes into the home to assess and deliver personalized care, and can include skilled nursing, rehabilitation therapy, medical social work and other provider services, including HHAs to assist with the activities of daily living. While CHOICE MLTC does not cover physician services, we can work with any physicians belonging to any insurance plan, including a member's preferred long-term physician and other specialists. Care managers also emphasize preventive care and education, and help members set up regular check-ups and screenings—and make sure they show up for them and understand medical directives.

Connecting to community resources

Health care services are only valuable if the patient can easily access them. That's why MLTC care coordination includes door-to-door transportation for medical appointments at no cost to the member—a benefit that can determine whether or not a patient actually sees the doctor.

Focusing on the big picture as well as the small details, care coordination also helps MLTC members navigate government health coverage programs like Medicaid and Medicare and connect to community resources offering services from group activities for members facing loneliness to respite care for overburdened family caregivers.

Educating and empowering

A vital part of successful, sustainable care is patient education: empowering the plan member and family caregivers to make healthy choices and to know when to seek another level of care.

"The doctors are so busy, and a visit might be a quick in and out," says Constance Washington. "We make sure the member understands the doctor's instructions, and also discuss diet, blood pressure, and other things that go into taking care of themselves."

Once members understand factors that affect their chronic condition, they often use their new knowledge to take control. Someone with high blood pressure, for instance, will learn that too much salt can make them short of breath, and start monitoring their sodium intake.

Connecting with members' doctors

Care coordinators—available around the clock—are often the first health-related phone call a plan member will make in a non-emergency situation, because they know they will get a quick response. Coordinators then act as a bridge connecting members' and their primary doctors—an essential part of the team—often getting needed answers and clearing up miscommunication and confusion.

Monitoring and managing medication

More than one-third of Americans aged 65 or older are taking five or more medications. MLTC care coordinators monitor prescriptions and refills, explain to members what they're prescribed and why, and make sure that they're taking their medication properly. (The National Consumers League reports that nearly three out of four Americans do not always take their medication as directed.)

Measuring the Success of MLTC Plans

The success of the MLTC approach can be measured in statistics like the reduction in the number of days a patient spends in a costly facility, but its real value is best represented by the many ways in which it can materially improve patients' lives.

There is no way to quantify the benefit of being surrounded by the familiar sights and sounds of your neighborhood, sitting in your favorite chair, fixing your own meals, seeing old friends at your church service, or feeling in control of your day-to-day life—all the while knowing that if you need help with health-related issues, someone is there for you.

The choices we make today to maintain and protect our health largely determine our options for the future. I hear patient stories from VNSNY staff every day that reinforce for me how important it is for older individuals with multiple health needs to have access to MLTC programs that allow them to remain in the homes they love while getting the quality care they need. For me, offering people this CHOICE is what it's all about.