

Rhody Health Options Care Management

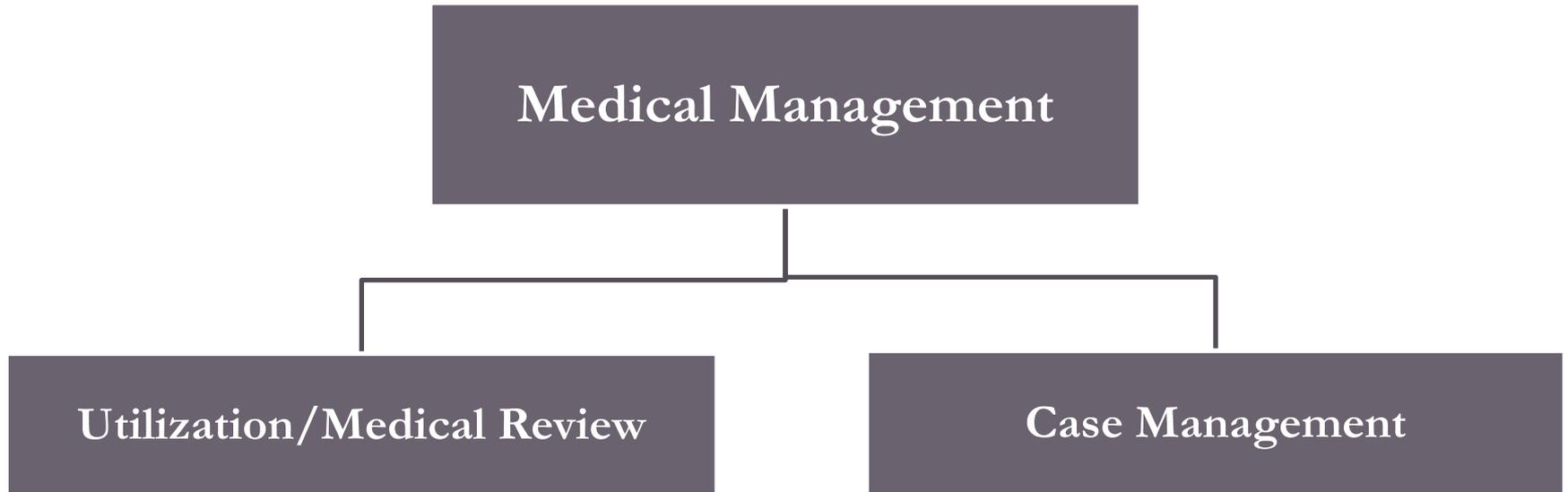


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ICI Consumer Advisory Council
April 2, 2014

Agenda

- Medical Management
- Teams within Case Management
 - Community Team
 - Waiver Team
 - Nursing Home Team
 - Ancillary Team
- Our Care Management Program
- Plan of Care
- Member Touches:
 - Community Strategy
 - Nursing Facility Strategy
- Provider Interactions
- Neighborhood Value
- Questions

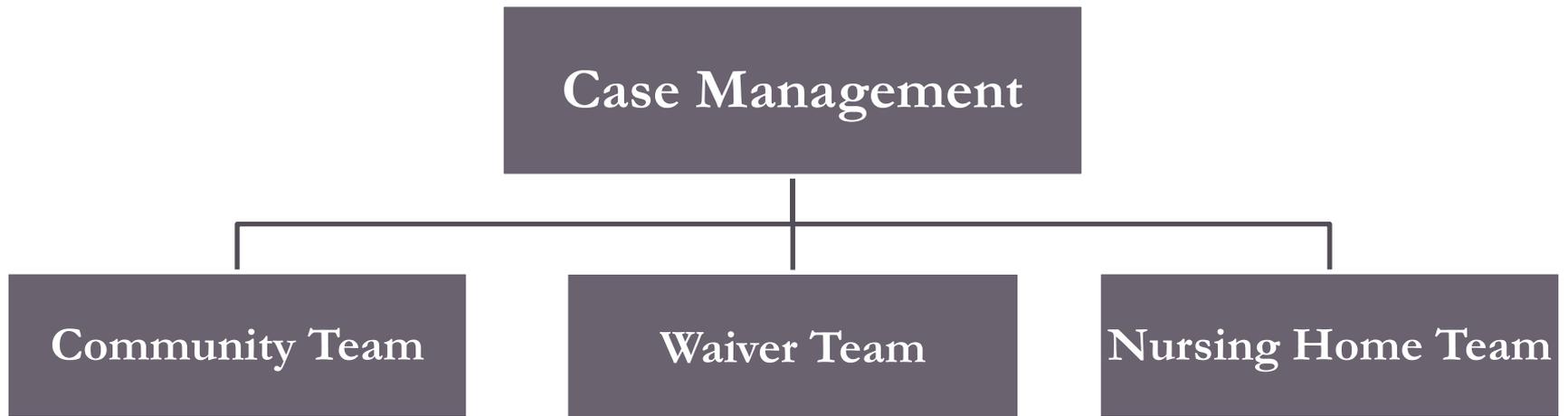
Medical Management



Our Care Management Program

- The goal is to work with our members and community partners to help members achieve their highest level of health and well-being in the most appropriate setting.
- Members **are involved** in all phases of assessment and plan of care development.
- **Program is person centered** with the member's goals at the forefront of service delivery.
- Neighborhood staff and partners assist members in identifying and connecting with medical, behavioral and social program providers, and to become engaged in their own care.

Teams within Case Management



Community Team

Community members – No LTSS only

Nurse Care Managers; Community Outreach Specialists

- These members are the majority of membership.
- They do not receive any formal, coordinated services in the community
- Neighborhood outreaches to each member
 - completes a telephonic Health Risk Assessment.
- If identified as ‘at risk,’ team
 - conducts outreach and arrange for face to face assessment to work with the member to identify what services they want/need to remain safe and healthy at home.
 - develops Plan of Care with member participation and approval.
- If not ‘at risk,’ member
 - receives Wellness Plan of Care.

Waiver Team

Community members enrolled in LTSS program

Nurse Care Managers; Community Outreach Specialists; Peer Navigators

- Each member is assigned a Lead Care Manager who helps to coordinate all aspects of their care.
- Neighborhood leverages community agencies to continue to provide case management. Partnership extends to LTC field offices, home care agencies, CAP agencies, etc.
- EOHHS continues to determine eligibility
- Comprehensive assessments and plans of care done with each member in a waiver program.
- Lead Care Manager ensures waiver services are meeting all of member's identified needs and goals.

Nursing Home Team

Nurse Care Managers; Housing Specialists

- Each contracted nursing facility is assigned a Lead Care Manager (LCM)
- Every member is assessed for an opportunity for discharge
- If member wants to return to the community and a safe plan can be developed,
 - LCM works with the member, family, facility and community providers to develop a transition plan.
 - Once a member is transitioned back to the community the LCM continues to be involved to ensure the transition is successful. An ongoing Plan of Care is developed with the member.
- If member does not want to leave facility, or there is no safe option, LCM supports member and facility in ensuring needs are met in the facility by remaining involved as the facility's and member's contact.

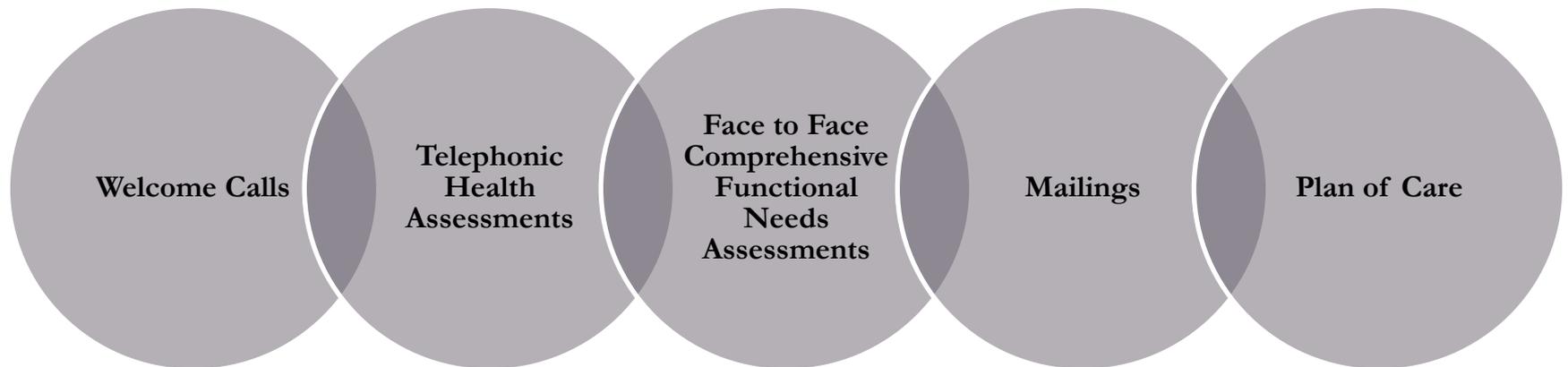
RHO Ancillary Team



Plan of Care

- All RHO Members are active participants in the development of their Plan of Care
- RHO members with LTSS –includes details of all services with names of providers & phone numbers
- Signed by member
- Copy sent to all participants of the ‘team’

Opportunities for Member 'Touches': Community Strategy



Member 'Touches' Nursing Facility Strategy



Provider Interactions

- Connect a member to a PCP or specialist
- Arrange appointments if necessary
- Refer for community services and supports
- Forward copies of the Plan of Care to providers
- Inform providers of changes/updates in a member's condition or situation

Neighborhood Value

ROLE	PERSON CENTRIC POC
Multiple outreaches to members	Develop and monitor individualized Plan of Care (POC) with the member's input
Waiver application assistance	Revise plans as a member's needs change
Integrated partner model with Beacon	Follow members through the continuum of care : home to hospital to nursing home and back home again.
Assist members in understanding their benefits	One point of contact for members, providers and partners
Arrange for services, equipment, home modifications	Respite to support caregivers

Questions