ST. JOSEPH HEALTHCARE SYSTEM

Partners in Care

Cora, a 69-year-old recovering alcoholic, has chronic obstructive pulmonary disease. She currently lives with her daughter, Kay, but the two are not getting along and have decided Cora should move out. Kay is worried, though, about how Cora would fare on her own, and she has discussed her concerns with Cora's physician.

At one time, physicians like Cora's could have referred Kay to various home health and social services agencies to monitor Cora's needs. At best, Cora would have received fragmented care. Today, however, there may be another option. St. Joseph Healthcare System, Albuquerque, has initiated a collaborative partnership with some of its physicians to provide medical and social case (care) management for chronically ill elderly patients like Cora.

St. Joseph established Care Partnership to enhance the quality of care for elderly patients by fostering a continuum of care.

Healthcare and Social Service Needs

A pilot case management program, Care Partnership was launched this past April. "The program is designed to detect participants' daily living and healthcare needs and to provide appropriate in-home care and social services for the prevention of serious and costly medical problems," explains Lynne Anker-Unnever, St. Joseph Healthcare System director of senior and community services. St. Joseph established Care Partnership to enhance the quality of care for elderly patients by fostering a continuum of care and to strengthen its relationship with physicians, according to Anker-Unnever.

St. Joseph's partner in the program is MED-NET, an integrated physician practice network that is one of the system's four operating divisions. The system—a member of the Sisters of Charity Health Care Systems, Cincinnati—has four hospitals in the Albuquerque area. MED-NET physicians from family practice and internal medicine partnerships serve as patients' initial contact with the Care Partnership.

The program helps the physicians involved detect problems in patients' homes, set treatment plans, and monitor their frail elderly health maintenance organization (HMO) patients. "Through implementation of this program, St. Joseph Healthcare System expects an increase in patients' use of primary, preventive, educational, social, and other services, in addition to lower healthcare costs through a reduction in emergency room visits, hospital admissions, and length of stay," says Anker-Unnever.

The St. Joseph Healthcare System

Eligibility

Three pilot MED-NET primary care physician practices, each served by two physicians, are participants' entry point to the Care Partnership. The physicians and Anker-Unnever collaboratively developed the following requirements that must be met by Care Partnership participants:

- Be members of an HMO Medicare plan
- Be aged 65 to 80 (when they enter the program)
- Be diagnosed with one or more of the following: congestive heart failure, cerebral vascular accident, diabetes, chronic obstructive pulmonary disease, or hip fracture

Case management is provided by a team that comprises a nurse, a social worker, and an assistant. Anker-Unnever notes, "Care Partnership expects to screen at least 500 persons a year, with a minimum of 200 needing case management intervention."

To determine the need for case management, the assistant case manager conducts a telephone interview to screen for:

- Ability to perform basic activities of daily living (ADLs) and assistance required
- Risk of falls
- Appointments with physicians outside Care Partnership (if any)
- Weight loss or gain of more than 10 pounds
- Use of ambulance service, hospital emergency departments, and urgent care centers
- Medications taken now compared with a year ago
- Completion of advance directives
- Frequency and quality of contact with family
- Presence of sleep disorders
- Indicators of depression

Results of this screening indicate whether a patient needs an in-home assessment. "Participants who do not need active case management are contacted quarterly to assess changes in their status and to determine whether intervention may be necessary at a later time," explains Anker-Unnever.

During an in-home assessment the case management team evaluates a participant's home setting and safety, formal and informal support systems, ability to perform ADLs, psychosocial status, and community resource utilization.

The case management team gathers information from the participant and his or her family and care givers and works with them and the physician to develop a plan of care. The case managers monitor patients' status and receipt of services. The physicians in the pilot program and case managers are developing in-home

monitoring protocols (similar to clinical pathways for use in the home) for each area of chronic care management, which, according to Anker-Unnever, will include guidelines for referral back to physicians.

As the number of patients served by Care Partnership increases, St. Joseph Healthcare System plans to hire an additional nurse case manager and social work case manager to ensure the program reaches all persons in need of its services.

Eve DeMella-Rivera, Care Partnership social work case manager, visits client Ruth Landess to ensure she is receiving the appropriate in-home services to allow her to continue living independently.

Medicaid and Medicare

"Through Care Partnership, St. Joseph Healthcare System can identify persons eligible for Medicaid-funded case management and help them obtain such services," says Anker-Unnever. By working with physicians, St. Joseph plans to explore the use of Medicare as a payment source for case management through the resource-based relative value scale.

Funding and Evaluation

Early this year the New York City–based John A. Hartford Foundation, a philanthropic organization, awarded St. Joseph Care Partnership a $700,450 grant. The grant will cover a portion of case manager salaries and will fund an evaluation of the partnership's effectiveness in meeting geriatric patients' needs, as well as its effect on physician practice patterns and patient utilization of medical services, according to Anker-Unnever. Once the grant money has run out, she adds, St. Joseph Healthcare System will cover program operating costs through monies saved by reducing unnecessary utilization and by enhancing the effectiveness of MED-NET practices.

St. Joseph plans to explore the use of Medicare as a payment source.

St. Joseph is one of seven organizations approved to receive funding from the Hartford Foundation, which will spend $7 million over the next five years on case management pilot programs. Donna I. Regenstreif, PhD, senior program officer at the foundation, described the project at the American Society on Aging's annual conference in March. The studies will look at case management models that differ in many respects, including type of facility, care team composition, devices for team linkage, intervention strategies, and future financing plans. The results are expected to provide a better idea of what physician office-based practices of the future might look like.

Independence and Self-Confidence

Care Partnership offers chronically ill elderly persons the opportunity to continue living on their own. This program is a positive solution for persons like Cora who may be capable of living independently as long as someone monitors their health and provides referrals to needed social services.

Care Partnership is facilitating Cora's adjustment to living alone. Cora's case manager visits once a month and she has arranged for in-home services to support Cora's independent living. The case manager reports to Cora's physician on her health and her ability to function independently in her home.

Care Partnership is "just what the doctor ordered" for Cora and Kay. Cora feels a renewed sense of independence and self-confidence living on her own in an apartment with her dog, Sparky. Kay feels less stress knowing Cora's care is in good hands.

—Michelle Hey