



SEARHC ELDER CASE MANAGEMENT

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Overview of Presentation

- Introduction-Alaska Native Elder
- Elder Care Needs Assessment
- Management Plan
- Village Case Management
- Conclusion-Listen to the Voices



SEARHC

Elder Care Needs Assessment

- **Funded by IHS Elder Care Initiative LTC Grant in 2006.**
- **Assess the need for LTC services.**
- **Develop a comprehensive plan to meet the identified needs.**



Scope of Needs Assessment

- Eight non-hospital SEARHC communities of southeast Alaska.
- Native elders.
- Focus on need for home and community based services.

Elder Needs Assessment Activities

- Formulate Elder Services Planning Group.
- Consult with SEARHC Elders Council.
- Conduct demographic/statistical research.
- Survey within SEARHC.



Needs Assessment Activities Continued..

- **Survey local and regional service providers.**
- **Talk with elders, families, caregivers.**
- **Analyze state and national reports, trends.**
- **Participate in state and regional planning.**



SEARHC Elder Services Management Plan

- **Adopted November 2008.**
- **Tied to SEARHC Strategic Plan.**
- **Based on Chronic Care Model.**
- **A roadmap to develop better services for our elders.**



Goal 1 – Health Care Organization

Strengthen the health care organization to serve elders more effectively.

- Increase M/M enrollment among elders.
- Work with ATHS to develop political and regulatory climate.
- Promote focus on elders in new/existing prevention and wellness programs.
- Explore development of new services (home health, NH/ALH, home telehealth).



Goal 2 - Community Resources

Mobilize community resources to meet the needs of elders through a coordinated system of care.

- Formalize regular communication with agencies on a local and regional level.
- Facilitate environmental health assessments.



Goal 3 - Self Management Support

Empower and prepare elder patients to manage their health care.

- Provide elder patients and caregivers with tools and resources.
- Provide training and support for family caregivers and personal care attendants.



Goal 4 – Delivery System Redesign

Support delivery system redesign to focus more on the needs of elders.

- Address medication issues.
- Implement case management for all elders with chronic or complex health needs.
- Change travel and referral policies.
- Explore option for providing services at alternative sites or using different methods.

Goal 5 – Decision Support

Promote care consistent with scientific data and patient preferences.

- Embed evidence-based guidelines into daily clinical practice through development of elder care protocols.

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Goal 6 – Clinical Information Systems

Organize data to facilitate efficient and effective care.

- **Use new electronic health record to better monitor elder patient health status, provide proactive care, and reduce complications.**



Village Case Management

Improve the health outcomes of Alaska Native elders by providing comprehensive case management services that are integrated with and enhance the existing network of clinical, home and community based services in Kake and Angoon Alaska.

SEARHC VILLAGE CASE MANAGEMENT PROGRAM WORK PLAN AND TIMELINE

Goal 1: Formalize and strengthen relationships with other home and community-based service providers to meet the needs of elders through a coordinated system of care.

CCM Components: Delivery System Design, Self Management Support/Development and Community Resources

Objectives	Activities	Responsible Person	Time Completed	Evaluation Measure
<p>Objective 1:1: Promote regular communication and team relationships between home and community based providers, clinical staff, and case management staff on a local and regional level for services in Kake and Angoon.</p> <p>Output Measure: Description of collaborative case review system and communication methods.</p>	<p>Hire a Public Health Nurse Case Manager (PHN) to oversee and manage the SEARHC Village Case Management Program in Angoon and Kake Alaska.</p>	<p>CHCS Medical Director and Direct Supervisor.</p>	<p>March 2009 and April 2010.</p>	<p>PHN hired</p>
	<p>Review home and community based services currently available to the elders and develop plans to address gaps and weaknesses while maximizing positives in concert with partner organizations</p>	<p>PHN</p>	<p>June 2009</p>	<p>Meeting minutes and plan for elder services.</p>
	<p>Develop a system for collaborating case reviews.</p>	<p>PHN</p>	<p>December 2009</p>	<p>Schedule for case reviews.</p>
	<p>Develop and promote patient education materials to inform patients about existing resources and how to access them.</p>	<p>PHN</p>	<p>November 2009</p>	<p>Educational Materials</p>

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Work Plan Accomplishments

Elder registry

Audit tool

Home visits

Case management

Healthy Home survey



Work Plan Accomplishments

**Electronic form
Advance Directives
Home Tele-Health
Brochure
Resources**



Challenges

Public Health Nurse position
Grant funding
Travel
Systems transformation

Looking Forward

- Preventative care
- Home Tele-Health
- Self management skills
- Satisfaction survey
- Expansion



Conclusion

Listen to the Voices