

Developing Care Management Practice Protocols for Medicaid waiver older adults with a dementia
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Issue: Elder Independence of Maine (EIM) nurses and social workers care manage in-home services for older adults who are in the Medicaid waiver program because they qualify and choose to receive care at home instead of a nursing facility. Thirty-seven percent of these EIM consumers have a diagnosis of dementia. Given national projections that the population of persons with a dementia will triple in the next 50 years, the overall Medicaid budget and health and social service providers will be significantly impacted. Helping people remain in the community through high quality, cost effective service requires attention to both medical and psychosocial needs of the individual, including their family members. Most individuals with dementia have concurrent chronic conditions and are at risk for falls, hospitalizations, functional decline following hospitalizations, depression and institutionalization. The multiple needs and complications of care for people with dementia and their caregivers require identification of risks as well as coordination of the social services with the medical care. A March 2006 policy brief from the Alzheimer's Association reported positive results in two states' programs using special protocols for people with dementia to address such challenges.

Project: EIM strategic planning aims to develop their care management service to incorporate specific protocols for chronic illness intervention. Dementia as a chronic illness is chosen to pilot as it has both medical and social service dimensions that with concerted integration will lead to better coordinated care. Phase 1 through March 2010: Convene community partners, consumers, caregivers, physicians and EIM care managers to identify, develop, and finalize key protocols when working with someone with dementia in order to engage these stakeholders and consider factors unique to the Maine population, like living in a rural area. EIM staff will be specially trained in working with people with dementia and chronic disease self-management. Staff will be trained and the protocols piloted before taking to additional consumers. Identify, with physician input, specific consumer, family and case manager skills and communications that assist physicians in their role and assure appropriate and timely medical treatment. Phase 2, April 2010 through April 2011: Identify at least 75 consumers with whom to apply the standards. Collect data on current risk factors at baseline and 6 month intervals to assess impact of the protocol. Phase 3, October 2010 through June 2011: Focus group with involved parties for qualitative feedback. Review measurements collected and interpret data to determine sustainability.

Outcomes: A reduction in risk levels and increased consumer/caregiver satisfaction with the care management service are expected. Reduced risks can hold down costs of the health care and consumer/caregiver education may increase self-care activities which impact emotional costs. Improved integration of all services should enhance the quality of the care received.

Please [email Sharon](#) with any questions or comments regarding this project.