

Community-Based High Risk Care Management (HRCM)
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Nature of the Problem: Community-based care management for Medicaid Waiver programs has historically centered on the care management (CM) authorized services provided by the elderly Medicaid Waiver program. Nursing facility placement is the primary reason in the State of Ohio for disenrollment from the Medicaid home and community-based program, averaging at least 37% per year. In tandem, emergency department (ED) visits and hospital admissions increase prior to the disenrollment.

Approach: The project is designed to improve care management practice by utilizing the results of various studies of risk factors for disenrollment due to nursing facility placement. The project introduces medical evaluation and CM protocol application to recognize and avert the trajectory of decline that may lead to institutionalization. The project includes screening, assessment, calculation of risk scores, and interventions resulting from care plan protocols that reflect identified risk factors. The project entails developing and applying a statistically valid high risk screening tool for patient stratification, in addition to development of clinical interventions enabling focused member goals, interventions and outcomes. Case stratification will identify the high risk members for application of established protocols and interventions. Protocols will be applied to members moving into or staying in moderate to high risk category. A data system will be developed to enable the CM to manage the members more effectively, relying on an interdisciplinary team (IT) approach. In addition, efficiency will be improved as a result of risk scoring and easy to follow step-by-step protocols for managing high risk patients. Reference materials will also be provided. The IT will hold weekly care conferences.

Target Population: Area Agency on Aging 10B has 3,500 members on its elderly Medicaid Waiver program. The IT will apply the protocols to guide further assessment, intervention, and monitoring of the at-risk member. Additionally, the HRCM-Registered Nurse will collaborate with the Primary Care Physician.

Outcomes Demonstrating Successful Implementation: Analysis will be conducted quarterly to measure length of stay on the program, institutionalizations, reason for disenrollment, and utilized protocols. By preventing a decline in health and/or function, as well as institutionalization and ED visits, members' quality of life will be enhanced, reflecting in part their ability to receive the services they need at home. At the end of the project, home and community-based HRCM will be introduced to 30,000 elderly waiver members statewide to enable a systemic implication of delaying trajectories of decline.

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