**ULTCS Workgroup**
**Integration and Care Management Subcommittee**
**June 25, 2010**

## MEMBERS PRESENT:

Anita Allen, OPRA, Sande Johnson, ODA, Nilu Ekanayake, ODADAS, Sara Abbott, JFS/OHP, Subcommittee Co-leader, Kathleen Anderson (for Beth Foster), OCHC, Diane Dietz, OHCA, Gwen Toney, OHPCO/OHCO, Christine Kozobarich, SEIU 1199, Joe Ruby, AAA 10B, Marc Molea, ODA, Subcommittee Co-Leader, Hilary Stai, LTC Ombudsman, Pam Scuellerman, Alzheimer's Association; Linda Ferrell, JFS/OHP, Dr. David Reynolds, Cleveland Clinic, Judy Patterson, ODA; Janet Grant, CareSource

## DISCUSSION:

### Recommendations Review

Joe Ruby presented the Ohio Association of Area Agency on Aging (O4A) recommendations (attached) and responded to questions.

The subcommittee discussed both the O4A and dual eligible/managed care recommendations. Discussion included, what populations will be served, the role of the post acute care providers, whether recommendations should be implemented unilateral or piloted first, what we can done now without incurring cost and the role of behavioral health.

### Next Steps

The discussion generated the following next steps and tasks:

- Need to include columns on the matrix for "Population Served" and "What was needed to facilitate implementation" (Statute Change, Funding Redeployment of resources, Partnerships). Marc will modify the recommendation matrix and add these columns. Janet and Joe will complete from their respective recommendations.
- At the July 9 subcommittee meeting OCHC (Beth and Kathleen) and OHPCO/OHCO (Gwen) are invited to present recommendation important to post acute care/home health care providers.
- We will convene a group to develop recommendations around integration of behavioral health and long term care. The membership of the group will be made up of behavioral health representatives on the I & CM subcommittee and ULTCS Work Group. We will invite staff from the Health Care Coverage and Quality Council to attend because they are having similar discussions around integrating behavioral health in the Primary Care Medical Home.

We also discussed how we will transmit our recommendations to the ULTCS Work Group and whether we should vote on them. We discussed indicating on the matrix whether there was consensus among the members of the subcommittee for the recommendations, including possible subcomponents. There will be a broader discussion about recommendations during the plenary discussion on July 9th.

## NEXT MEETING:

- July 9, 2010, 12:00 – 3:00, Lazarus Building, 50 W. Town, Plenary Session: Rooms 621 A & B Room, Subcommittee: Room 601A (1:30 p.m.)

# O4A Recommendations to the

# Medical Long Term Care Integration Sub-Committee

# Friday, June 25, 2010

| | Issue | Recommendation | Desired Outcomes |
|---|---|---|---|
| **1** | Half of nursing home admissions from acute settings | ➢ Embed PASSPORT Long Term Care Consultants (Assessors) in hospitals | ➢ Move the needle to 50:50 |
| **2** | Medicaid beneficiaries' Emergency Department utilization rate | ➢ Expand Evidence-based Disease Self Management program | ➢ Reduce avoidable Hospital Admissions and Readmissions to best practice benchmarks<br>➢ Move the needle to 50:50 |
| **3** | Medicaid beneficiaries' Hospital Readmissions rate | ➢ Utilize an Evidence-based health coaching (hospital transition) program (i.e. Coleman model) | ➢ Reduce avoidable Hospital Readmissions to best practice benchmarks<br>➢ Move the needle to 50:50 |
| **4** | Medicaid beneficiaries' Primary Care Physician utilization rate | ➢ Identify large Medicaid physical practices and embed PASSPORT Long Term Care Consultants (Assessors) | ➢ Reduce avoidable Hospital Admissions and Readmissions to best practice benchmarks<br>➢ Move the needle to 50:50 |
| **5** | Coordination of health and Long Term Care benefits | ➢ Coordinate care planning for common members of Health Plans and Area Agency on Aging services (non-waivers, levies, care coordination) | ➢ Reduced Hospital Admissions and Readmissions to best practice benchmarks<br>➢ Move the needle to 50:50 |
| **6** | Non-Medicaid eligible individuals often become Medicaid eligible individuals through functional impairment or depletion of financial resources | ➢ Expand Evidence-based Disease Self-Management program<br>➢ Expand access to PASSPORT Information & Assistance (Screening) and PASSPORT (Assessment) | ➢ Improved access to Home and Community-based Long Term Care options<br>➢ Move the needle to 50:50 |