Integrated Care: Chronic Disease Management

This project is a part of a multi-year project targeting capacity for services for vulnerable older adult population of dual eligibles with complex health needs. The project focuses on the second phase of implementation of a multi-prong long-term strategy for diversifying sustainable revenue sources for community-based programs and services aiming to improve the health of older adults and education of family caregivers. This strategy will ensure sufficient funding to sustain and expand capacity for the most needed services and interventions, addressing the social determinants of health and reaching out to the most vulnerable populations.

This is an innovative project, combining several evidence-based interventions into a wrap-around approach of various supportive services, addressing a variety of issues in an integrative way. This will include engaging and communicating with primary care practices and becoming a part of an integrated care team to serve the whole person. A client, part of our currently served pool of 850 clients per year and others in the community referred for services, and/or their family caregivers would receive consultations and choose interventions that would work best for them among the evidence-based tool kit of various interventions offered through the agency directly and/or through our partners. Provided services would be billed to Medicare and Medicaid plans through the Chronic Care Management benefit and/or Health and Behavior Assessment and Intervention (HBAI) benefit. Services included under this project are designed to enhance the health and quality of life of vulnerable older adults with limited resources and their family caregivers, and especially those from ethnic communities who often incur cultural and language barriers while accessing healthcare. The strategy employed by the project leader focuses on including a community-based organization--which has the expertise, necessary skills and infrastructure to serve these populations--into the integrated care team service delivery, imbedding key community-based services into integrated health care. An integrated care model which embeds services that address self-management and barriers to access to services will improve the quality of life of older adults as well as provide a more cost-effective approach to care.