



February 2010

In this issue: AACM Team, CEU Approved Courses, New Long Term Care Policies & Resources, Care Transitions

Did You Know?

**With AACM you have one
Care Manager but
a whole team of expertise**

Many people ask us, "What is the difference between Accountable Aging Care Management (AACM) and "Company X, Home Care Inc.? They say they provide care management too?"

The difference is normally in two main areas. First, some firms may be limited in the services they can recommend to just the services they provide, but AACM can connect you with any service provider you need. We are experts at finding the right solution for your situation. Beyond that, we work with you on an on-going basis to help transitions go smoothly and answer questions as your situation changes and progresses.

Second, working with AACM you have the benefit of one contact person for all your needs, whether those needs include questions on tax consequences of a decision, concerns about medication management, help with Medicare or long-term care insurance, or a guide to navigate through medical issues. At the same time, your one contact is backed up by a team of professionals on our staff that include experts in many areas from home care, rehabilitation, nursing, faith counseling, financial oversight, government benefits, gerontology and education. Although we work as a team, we provide a single point of contact for the care providers, elder and family. It just makes it easier for everyone.

Do Your Staff Members need Continuing Education Training?

AACM is approved to provide Continuing Education Unit (CEU) training for Nurses, Social Workers and Case Managers for 11 topics.

Whether you need the CEUs for your certification or you just want to keep your staff up-to-date on the latest Care Management topics, AACM can help. Check out these CEU topics:

- 1) Medication-Related Problems – Define, Identify and Manage
- 2) Multi-Disciplinary Care Management
- 3) The Patient-Centered Triad
- 4) Mitigating the Quality and Safety Risks of Care Transitions
- 5) The Three M's of Health Insurance – Medicare, Medicaid and Medigap
- 6) Common Questions about Social Security
- 7) Who's Got the Monkey?
- 8) Confrontation Skills for Helpful Change
- 9) Having "The Conversation:" Tools to start the sometimes difficult discussion with your parents about their future
- 10) Financing Sources for End-of-Life Issues
- 11) Strategies for Successful Long-Distance Caregiving

These courses are available in Austin, Dallas or San Antonio. Contact us soon to reserve your date today. Call the main office to reserve any date in any city: 512-342-9800.



Accountable PartnersSM

If you serve the eldercare community as a facility, home health or personal assistance service provider, and you didn't receive our request to join the Accountable Aging Partners Program, please go to our website now and fill out a survey (<http://www.accountableaging.com/survey/>) Having the most current information on your business helps us refer the right kind of clients to you. If you'd like to see what a sample Accountable Partners Report looks like, we've included a [sample here](#).

When a family doesn't know where to start with eldercare options, they start with us.

AACM Is a Wealth of Information

When we aren't helping clients, we are out gathering more information on how to better help our clients. Mick and Mary regularly attend meetings of local, state and national organizations that deal with all areas of aging and care management. Mary recently attended a meeting of the Long Term Care Guild (the local chapter of a nation-wide organization). She came away with information on two good Texas websites that have resources about planning for long term care. (see below) Mick attended a Care Transitions workshop in Brownsville, TX. The project discussed was a trial to manage care transitions better so as to avoid hospital readmission. (See page 3)

Texas Long Term Care Partnership

<http://www.completelongtermcare.com/states/texas/>

Long Term Care costs vary significantly depending on the level of care needed and where you are located. Most people prefer to receive care at home. In Texas, families can expect to pay an **average of \$106,750 for a year of assistance** from a Medicare-certified home health aide.

Paying for all these services has long been a burden to many families in Texas. Many pay out-of-pocket and then apply for government assistance through Medicaid for their continued care needs once they have depleted their assets. However, the Texas Medicaid program requires an **asset limit of not more than** \$2,000 for individuals and \$3,000 for couples in order to qualify.

The Texas Long Term Care Partnership is a joint program of the State of Texas and private insurance companies that aims to encourage Texas residents to plan for their future Long Term Care needs.

Under this Partnership program, insurers may be able to market and sell policies, called Partnership Policies. These policies provide an asset disregard benefit wherein policyholders can **keep assets** beyond the resource limit should they apply for Medicaid assistance after depleting their insurance benefits. Partnership coverage allows that every dollar paid by a Partnership Policy equals a dollar of assets that will be disregarded towards eligibility to Medicaid so that policyholders do not have to spend down their assets.

For more information, go to:

<http://www.completelongtermcare.com/states/texas/>

Texas Creates Website Resource for Long Term Care Information

<http://www.ownyourfuturetexas.org/>

It is never too early to begin preparations for a healthy and secure future. This website offers some good basic information on the Myths and Facts of Long Term Care as well as the levels of care and types of services. The site has tools that can help you assess your risk factors for needing long term care, your cost estimates and financing options. The site gives tips on talking with your family and planning steps. It also gives valuable information on coverage options and features of various long term care insurance policies.

We age by nature; we age well by foresight, preparation, and creativity.



AACM to present at ASA National Meeting

Mary & Mick Koffend and Deborah Roush, RN, have been invited to present the topic, *Preventing Medication-Related Problems: Targeting Sustainability in a Complex Adaptive System* on March 16, 2010 in Chicago, IL at the National meeting of the American Society on Aging.

This will be the third year AACM has presented at an ASA national meeting!

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Successful Care Transitions Vital

In January, Mick attended a Care Transitions workshop in Brownsville, TX hosted by the TMF Health Quality Institute. TMF, formerly the Texas Medical Foundation, has been a presence in Texas health care since 1971 as a private, non-profit organization of licensed physicians leading quality improvement and review efforts in the state.

The reason Mick attended the workshop was because the TMF Health Quality Institute is conducting a Care Transitions project in the Lower Rio Grande Valley to measurably improve the quality of care of Medicare beneficiaries who transition between care settings. The focus is on improving coordination of care between providers and across the continuum of care by promoting seamless transitions from the hospital to home, skilled nursing care, home health care or other providers to prevent avoidable re-hospitalization.

According to TMF, within 30 days of discharge 17.6 percent of patients are re-hospitalized, and the Medicare Payment Advisory Commission (MedPAC) estimates that up to 76 percent of these hospital readmissions may be preventable. Of Medicare beneficiaries who are readmitted within 30 days, 64 percent receive no post-acute care between discharge and readmission. TMF also reports that older patients with chronic illnesses often require care from a variety of practitioners in multiple settings, yet many settings are disconnected from others, creating potential quality gaps. AACM has seen this first-hand and Mick found this part of the study to be particularly interesting.

According to their website, TMF is working with health care providers in the Valley to implement interventions that result in process improvements and address issues in medication management, post-discharge follow-up, communication and coordination of care.

Care transitions are of particular interest to AACM and have been the topic of many seminars and workshops that AACM leads. It is our belief that having a trained Care Manager work with patients as they transition between care settings helps ensure they get the coordinated care they need, to avoid preventable hospital readmissions. Visit the TMF website for [more information](#).

As Mick says "At Accountable Aging Care Management, we take care transitions seriously for all our clients all the time, and have done so for years. We are pleased to note that a prestigious institution such as the Robert Wood Johnson Foundation has recently [reported the benefits of care management](#) in managing care transitions. It comes naturally to AACM because we are managers at heart."

Accountable Aging Care Management Team

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Visit us online: www.accountableaging.com

Accountable Aging Care Management is an eldercare consulting and care management firm.

Accountable Aging is a single source for seniors and their families to attain knowledge, resources and on-going assistance with the challenges related to aging or caring for an elder loved one. We serve seniors in Austin, Dallas, San Antonio and the surrounding areas.

With this newsletter, our aim is to provide a trusted conduit for eldercare information and resources and to highlight the services we offer that meet the needs of senior adults and their families.

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