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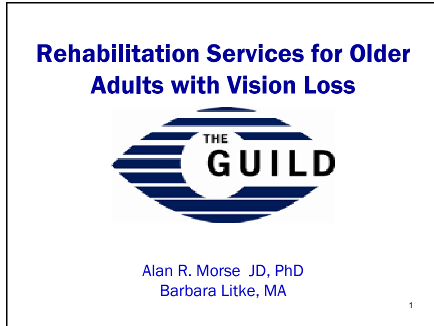
Rehabilitation Services for Older Adults with Vision Loss



Alan R. Morse JD, PhD
Barbara Litke, MA

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Disclosure Statement

Alan R. Morse
Barbara Litke

NO DISCLOSURES

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Acknowledgements

- NYS Commission for the Blind and Visually Handicapped
  Contract # CO24043, 1/1/05-12/31/08
- Linder Research Fund

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The Jewish Guild for the Blind

The Guild is a non-sectarian, not-for-profit health care organization serving visually impaired, blind and multi-handicapped persons for almost a hundred years.

Our range of services is the widest offered anywhere in the world and many of our services are unique.

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JGB Continuum of Services

- Diagnostic and Treatment Center-Medical, Vision and Rehabilitation
- Psychiatric Clinic
- Ryan White Case Management
- Continuing Day Treatment Program
- Day Treatment Program
- Adult Day Health Care Program
- Medicaid Managed Long-Term Care
- Residential Continuing Care Facility
- Early Intervention, Pre-School, School
- Rehabilitation Services

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WHAT WE KNOW

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Vocational Rehabilitation

- specific & discrete needs
- addressable with a defined set of services
- After service delivery is completed there is minimal additional contact
- rehabilitation needs are viewed as limited in duration, and remediable by relatively short-term intervention

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flaws with a vocational model for older adults

- Needs rarely end. They evolve into other needs
- Goals must be dynamic
- Needs that emerge are often those for which a vocationally oriented system does not have an appropriate solution
  - For example, help with management of complex medical situations such as vision loss from chronic diseases like diabetes

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The Challenge

- To develop a system that enhances well-being, while providing mechanisms for controlling cost
- Create a sustainable way to provide care for aged individuals who are blind and visually impaired

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The Guild's Experience

- The Guild has extensive experience with capitated delivery systems and operates a unique managed long term care program for almost 7,000 consumers
- Capitation is an essential element of cost control and one that will be used increasingly by governmental payers

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Capitation

- Service providers receive a fixed payment for providing a negotiated and defined package of services to a specified population
- Payments are based on services to be included, the cost of the service, its probability of being incurred or used, and the nature of the population

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Capitation

Capitation provides an incentive to be efficient since excess services will reduce the potential for positive margins and additional costs will not generate additional revenue

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Service Use & Cost Example

Service	Utilization	Cost	PM – Yr1
Assessment	1.0	$69	$69
Care Plan	1.0	$34	$34
Social Work	0.75	$40	$30
Low Vision Exam	0.6	$70	$42
Total		$203	$175

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Fee for Service

- the more service that is provided, the more that is paid for, regardless of the outcome or efficacy
- There is little incentive to be efficient, the incentive is to provide more. The focus is on inputs, not on outcome

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The Problem

- In 2004, the New York State Commission for the Blind provided Adaptive Living Program services to 4,206 seniors at a cost of $5,440,000, an average of $1,293 for each successful outcome
- These services were not vocational, but were designed to help people remain in the community

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Our Solution

- we proposed a 10% reduction in per capita reimbursement.
- $1230 per person for the first year and $360 for each additional year.
- To make our proposal more attractive, we did not include a trend factor increase.

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Design

- The Experimental group (E), received the capitated model.
- The Control group, (C), received the traditional model.
- E were contacted regularly
- C were contacted for reevaluation/assessment
- Reassessments were conducted 1 year after admission and yearly thereafter

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Measures

- Beck Depression Inventory
- Beck Anxiety Inventory
- Beck Anxiety Inventory
- Blessed Dementia Scale
- SF12V2
- Visual Function Questionnaire
- Wide range of descriptive and demographic data

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Expected Outcomes

- Better daily functioning
  - Remain independent longer
  - Longer time until NH placement
  - Less depressed, anxious,
  - More satisfied with services
- **OR, doing as well but with lower cost**

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Demographics

	N	Average Age at Enrollment
Males	436 (37.7%)	73.6
Females	719 (62.3%)	76.9
Total	1155 (100%)	75.6

- All subjects were legally blind
- There were no significant differences in educational level, cause of vision loss, primary language, race, or other characteristics

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Significant Results

Depression	Decrease from T1-T2-T3-T4
Anxiety	Increase from T1-T2; T1-T3
SF12v2 (mental score)	Decrease T1-T2; T1-T3; T1-T2-T3

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Advantages for the consumer

- Single entry point
- Full array of services
- Access to community resources
- On-going. Cases are not “closed”

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Advantages for Government (CBVH)

- Counseling and support staff concentrate on individuals whose goal is employment
- The shift of responsibility enables CBVH to realize significant cost savings
- Consumer needs, rather than program availability or requirements drives the individualized rehabilitation plan

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Advantages for Provider

- Immediate reduction in administrative cost
- Able to respond more quickly to consumer needs -- once the individual is enrolled without the need for additional authorization or governmental action

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Shifting the responsibility from payer to provider

- The consumer is enrolled and receives the services necessary to meet their needs
- The service may be minimal or comprehensive depending upon the presenting problem
- After a year the consumer benefits from an ongoing support network, which may include but is not be limited to tele-support groups, medical, vision, social services, adult day health care, and other specialized services

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Case 1

- A 65-year old female, Ms. B., sought rehabilitation services due to her total blindness from glaucoma. She is an insulin dependent diabetes with diabetic neuropathy, amputation of right toes, and hemodialysis three times per week for the past three years. She lives in a fourth floor apartment in a building whose elevator if frequently out of service. A wheelchair is required for all outdoor activities due to her poor endurance.

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Case Two

- Mr. T. is an 84-year old man who is legally blind with glaucoma and chronic arthritis. He participated in a CBVH sponsored Adaptive Living Program six years ago. He has lived alone for many years, and until recently, has been independent and active. As his vision declined, he began having difficulty shopping, preparing meals and distinguishing between medications. His doctor felt he was at increased risk for falls. Mr. T. had steadily lost weight over the last six months, became increasingly depressed and considered nursing home placement.

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Case 3

- Mrs. S. is a 64-year old woman with left field vision loss, weakness in her left hand, and speech deficits resulting from a stroke six months previously. She suffers from peripheral vascular disease and bowel dysfunction. She lives alone, but has 24-hour supervision in her home since her stroke. Rehabilitation was recommended to help Mrs. S. become more independent with activities of daily living, particularly with eating.