
MODELS FOR PRACTICE

FOCUS AREA: ACCESS (PRIMARY CARE)

Program Name: A Rural Minority Geriatric Care Management Model

Location: Charleston, South Carolina

Problem Addressed: Access to Primary Care

Healthy People 2010 Objective: 1

Web Address: None

SNAPSHOT

The Rural Minority Geriatric Care Management Model's purpose is to develop an innovative, integrative, and comprehensive service delivery system of care coordination and management for older African Americans in rural areas of South Carolina. The overall aim is to improve the quality of health, medical care, and social services available to older adults. Often, health center clinicians and staff are called upon to spend a large amount of time performing non-clinical tasks, such as helping patients find transportation, accessing indigent drug programs, or applying for public eligibility programs. To relieve the clinician of non-clinical requests, a new type of paraprofessional—a trained, paid geriatric coordinator—serves as a client advocate through case management, health promotion, and linkages with local social service agencies.

THE MODEL

Blueprint: The Rural Minority Geriatric Care Management Model operates in a Federally Qualified Community Health Center (FQHC), its satellite sites, and a rural health clinic in South Carolina. The program targets primarily African-American adults between the ages of 55 and 98, who have low incomes and are underinsured. The geriatric coordinators provide a number of services to the patients of these clinics, each having an expected caseload of 50-100 clients. They are responsible for tracking older clients' needs for primary care health services, assisting clients in making appointments while reminding clients about them as well, arranging transportation to health care, and monitoring their compliance with the medical care they do receive (i.e., medications, diets, lifestyle, appointments). In addition to assisting in health care utilization, the coordinator also facilitates home health care services as needed by the older patients, documents care management activities in a daily log, and attends meetings with the nurse project coordinator and health care providers to discuss client cases and updates. These individuals contribute significantly to the successful implementation of medical treatment in each client's life.

Making a Difference: Outcome measurements find these efforts to have significant success. These successes can be seen in the clients' physical and financial status. For health care, 50 percent of the clients are up-to-date on preventive health services such as mammograms, prostate checks, flu shots, and cholesterol checks; 88 percent have had home environmental safety assessments with referrals, and 42 percent have been diagnosed with diabetes and are receiving ongoing management and education for this condition. Financially, 100 percent of those eligible have been linked with Supplemental Security Income, Medicare Disability, or Medicaid, as opposed to the 54 percent who were eligible but were not receiving benefits prior to the intervention. Fifty-seven percent of the clients receive medications from indigent drug programs; 54 percent receive energy assistance; 30 percent receive food stamps, and 35 percent receive mobile/congregate meals. The impact on the communities in which the program operates has been one of great accomplishment.

Beginnings: In 1997, the South Carolina Department of Health and Human Services provided funds to the Medical University of South Carolina (MUSC) to establish a "Healthy Community Outreach Initiative." MUSC faculty submitted proposals for community programs that were peer reviewed by a panel of MUSC faculty. This community outreach model was chosen for funding for three years. In 2001, the program director submitted a request to the Duke Endowment and received funds to expand and extend the program an additional two years, with the goal of sustainability. The project director believes that a five-year time period is needed to facilitate infrastructure for community programs. The program targets primarily older African-American adults who have low incomes and are underinsured. This group was specifically targeted because of their need for education, advocacy in navigating the health care system, and assistance with linkages to public benefits and social services.

Challenges and Solutions: Maintaining funding for programs such as the Rural Minority Geriatric Care Management Model is challenging; however, the initiative has been successful in this area. A funding award from the Duke Endowment expanded the program to include five additional health center sites and extended the program for an additional two years. Also, the health centers were willing to pay a percentage of the coordinators' salaries over the two-year extension and currently, as the grant funding cycle nears completion, the health centers have committed to retaining the geriatric coordinators as full-time staff. This allows for 100 percent sustainability to be achieved after funding has ceased. Finally, to further ensure future success, the staff publicizes project outcomes, continues to develop ongoing linkages with community agencies and programs to enhance community capacity building, and provides a system of care for older adults.

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PROGRAM CONTACT INFORMATION

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