Making Community Connections

Karol Swartzlander

California Health and Human Services Agency

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Overview

- Setting The Stage – LTSS and Federal/State Reforms
- Federal No Wrong Door ADRC Vision
- California's ADRC Program
- ADRCs and Care Transitions
- Q&A/Discussion

PA1

Long-Term Services and Supports (LTSS)

- What are long-term services and supports?
  - A broad range of services needed by people who have limitations in their ability to care for themselves due to a physical, cognitive or chronic health condition that is expected to continue for an extended period of time
  - May include personal care services, adaptive technology, home modifications, transportation and more

Slide 3

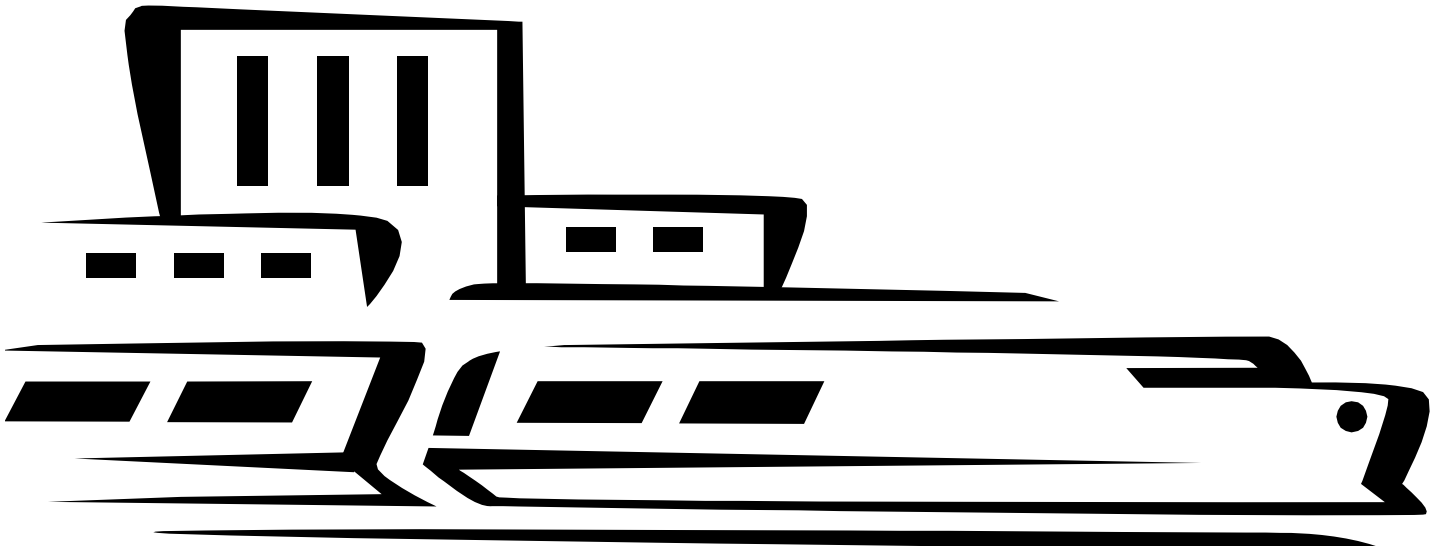
PA1 I would suggest a 3rd bullet such as "LTSS is currently funded in a variety of ways and available through multiple programs such as OAA, Rehabilitation Act and Medicaid (Medi-Cal in CA).

Paula Acosta, 9/16/2013

Olmstead Decision

- 1999 – Supreme Court Decision
  - requires states to eliminate unnecessary segregation of individuals with disabilities in facilities or institutions (nursing homes and other LTC facilities)
  - Underscores their civil right to receive services in the most integrated setting according to their needs

The Evolving Landscape of LTSS



- Demographic Shifts in Service Demand
- Budget Considerations and Resource Limitations
- Movement Toward Consumer-Directed Service Model
- Service Delivery Reforms

California Coordinated Care Initiative

- *Cal MediConnect* **Program**: A voluntary three-year demonstration for dually eligible (Medicare/Medi-Cal) beneficiaries to receive coordinated medical, behavioral health, long-term institutional, and home- and community-based services through a single organized delivery system
- **Managed Medi-Cal (MLTSS)**: All Medi-Cal beneficiaries, including dual eligible beneficiaries, required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including LTSS and Medicare wrap-around benefits

National Efforts to Reduce Readmissions

- Patient Protection and Affordable Care Act (ACA, P.L. 111-148)
  - Community-based Care Transitions Program (Section 3026 - provides funding to test models for improving care transitions for high risk Medicare beneficiaries)
  - ADRC Evidence-Based Care Transition Programs
  - Health and Human Services will create a quality improvement program for hospitals with high readmissions rates

Person Centered System

"For too long, too many Americans have faced the impossible choice between moving to an institution or living at home without the long-term services and supports they need. The goal of the new Administration for Community Living will be to help people with disabilities and older Americans live productive, satisfying lives." - Secretary Kathleen Sebelius

Administration for Community Living (ACL)

- Federal HHS brings together the **Administration on Aging** (AoA), the **Office on Disability** (OD) and the **Administration on Developmental Disabilities** (ADD)
- ACL oversees federal policies and system improvements for consumers of any age; including seniors and people with disabilities

Federal Collaboration

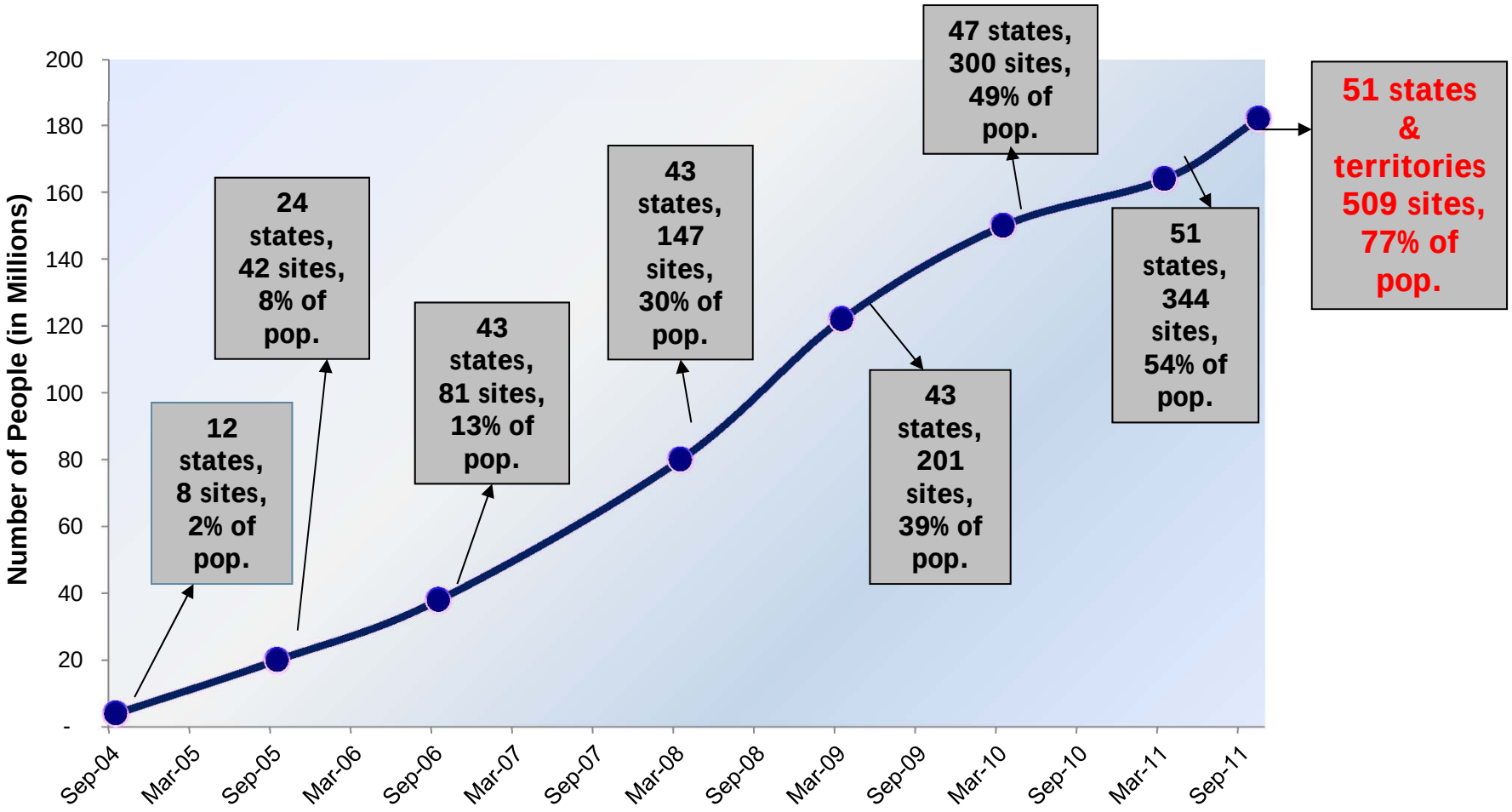
- Aging and Disability Resource Centers (or Connections) are a collaboration between:
  - **Administration for Community Living (ACL)**
  - **Centers for Medicare and Medicaid Services (CMS)**
  - **Veterans Heath Administration (VHA)**

Federal ADRC Vision

"The vision is to have Resource Centers (*or Connections*) in every community serving as highly **visible and trusted** places where people of all ages and income levels can turn for information and options counseling on their long-term care needs."

Aging & Disability Resource Center
An initiative of the U.S. Department of Health and Human Services

National Growth in ADRC Coverage



National Goal

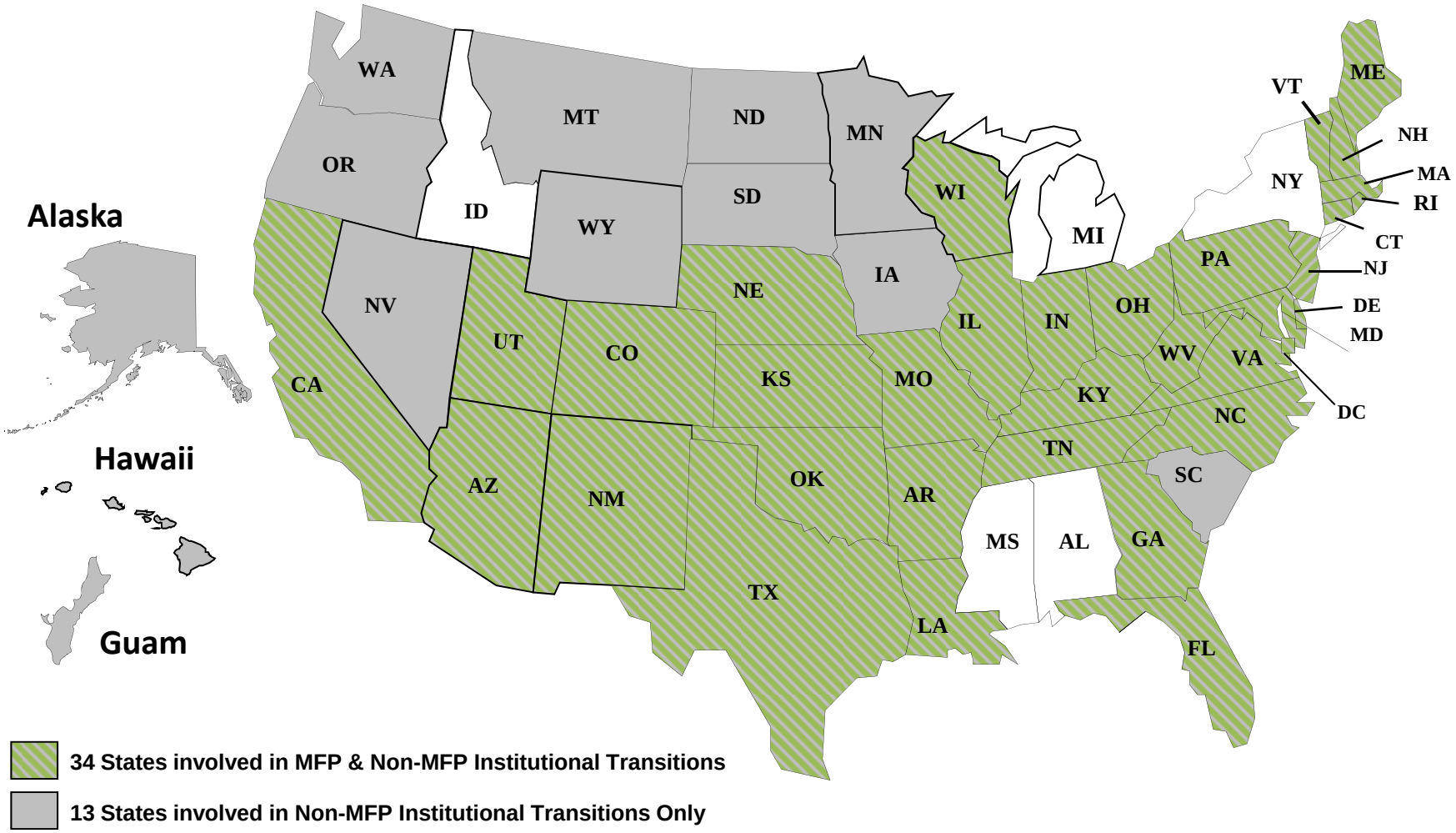
- In collaboration with states, develop a National *No Wrong Door System* for all populations and all payers which is person centered, financially sustainable and high quality that supports individuals to achieve their goals for community living

ACL, CMS and VHA view ADRCs as the platform to:

- Build stronger partnerships across siloed LTSS system and stimulate broader systems change
- Promote participant-direction
- **Assist with institutional transitions**
- **Intervene during care transitions from hospitals and other care settings**

ADRC Institutional Care Transitions Activity

312 ADRCs in 47 states are involved in institutional transitions:
219 in 32 states related to MFP and 274 in 45 states not related to MFP



ADRC Care Transitions Activities

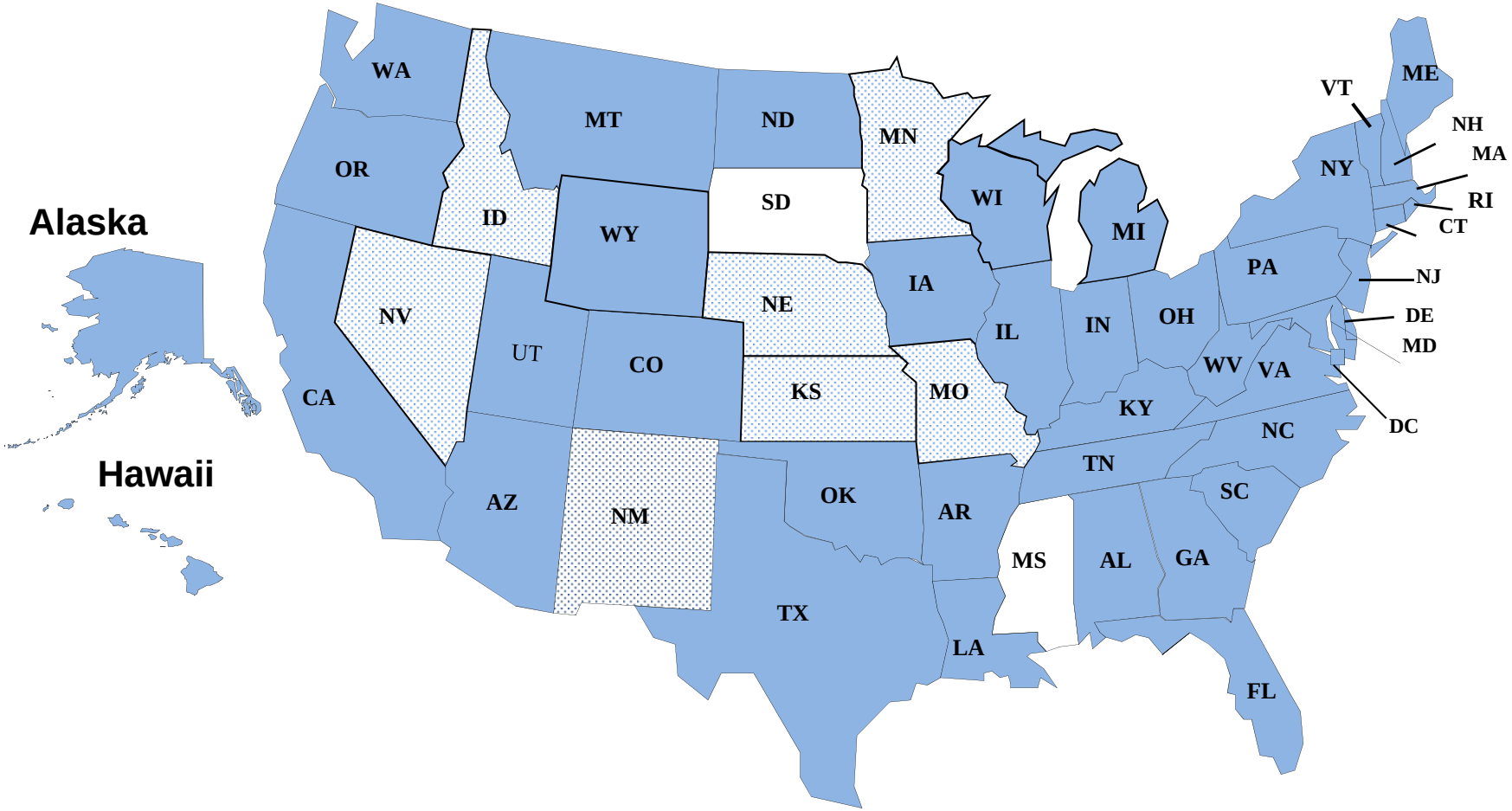
42 States currently conducting care transitions activities

7 States currently planning to conduct care transitions activities

2 States not reporting current or planned care transition activities

188 active sites, partnering with **517** hospitals

83 planning sites, partnering with **121** hospitals



Building the "No Wrong Door" for All Populations and All Payers

California Definition of an ADRC

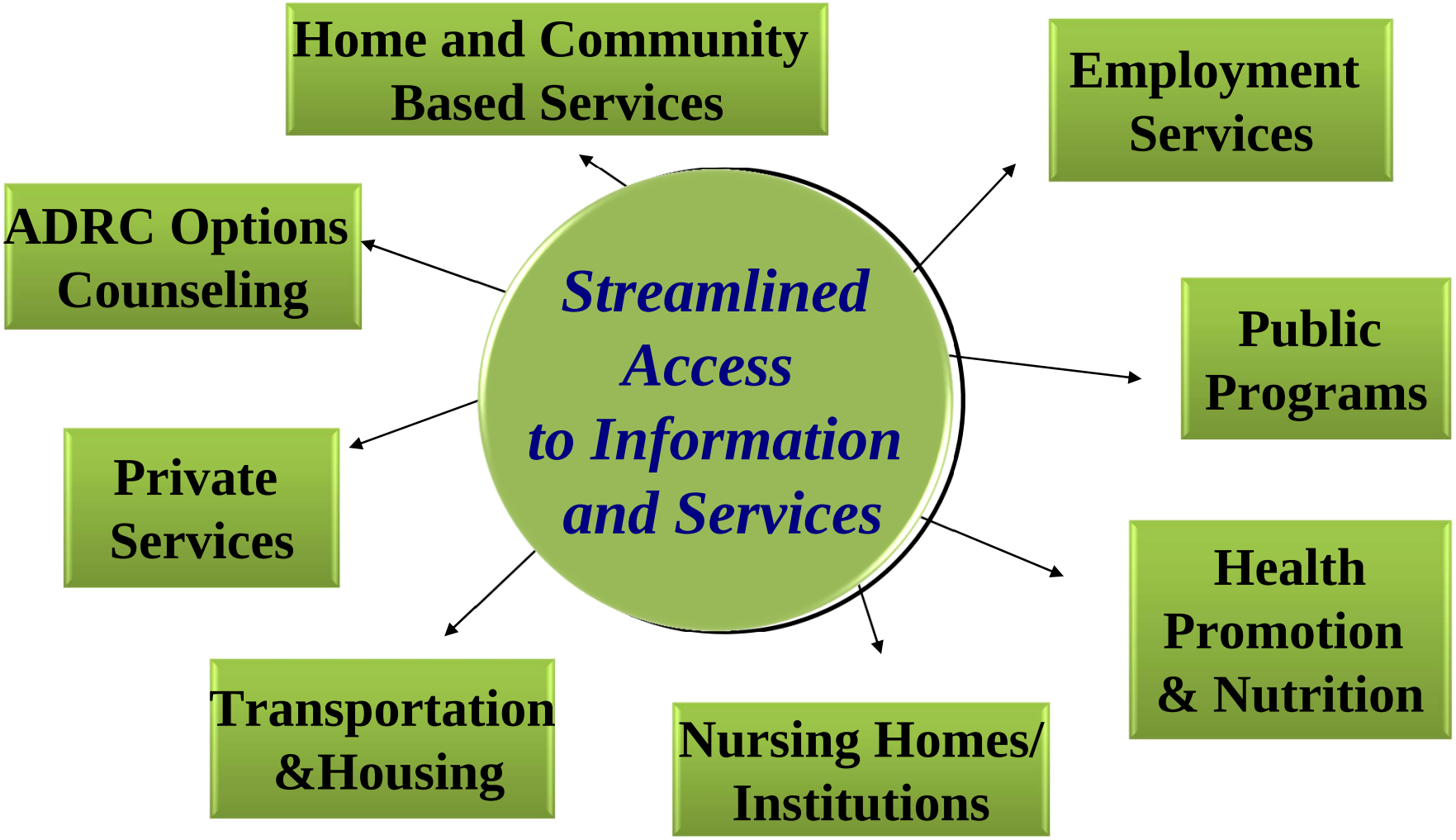
- An ADRC **partnership** is a new service delivery **model** that provides a coordinated system of information, referral and assistance for anyone seeking long-term services and supports (LTSS), regardless of age, disability or income
- Starts with a core partnership between an Area Agency on Aging (AAA) and Independent Living Centers (ILC), and then the broader LTSS network providers

Bringing the Vision to Life

It's all about building partnerships and making community connections….
New Systems….**NOT** New Programs

ADRC No Wrong Door Model

One-stop access from the Consumer's perspective



CA ADRC Core Services

1. Enhanced Information and Assistance/Referral
2. Options Counseling
3. Short-Term Service Coordination
4. Care Transitions
   - Hospital-to-Home Care Transition
     - Care Transitions Intervention (CTI)®
   - Nursing Facility Transition
     - Money Follows the Person (MFP) Demonstration

California's Aging and Disability Resource "Connection" Program

- Today, seven ADRCs serve 11 counties: Del Norte, Nevada, Orange, Riverside, San Diego, San Francisco, Butte, Glenn, Tehama, Colusa and Plumas
  - One ADRC under development in Alameda
  - All ADRCs to submit formal ADRC designation applications by December 2013
- Emerging partnerships: Los Angeles, Monterey Bay (Monterey, Santa Cruz, San Benito) and Santa Clara

Improving California Care Transitions

Care Transitions Intervention (CTI) ®

- CTI is designed to encourage patients and their caregivers to assert a more active role in their health care
- During a 4-week program, patients with complex care needs receive specific tools, are supported by a Transitions Coach®, and learn self-management skills to ensure their needs are met during the transition from hospital to home

Key Elements of CTI

- Referral Process
- Hospital Visit

- Phone call to patient after discharge from hospital
- Home visit within 2 days after discharge

- Phone calls to patient 7 days and 14 days after home visit

Four Pillars

Medication Management

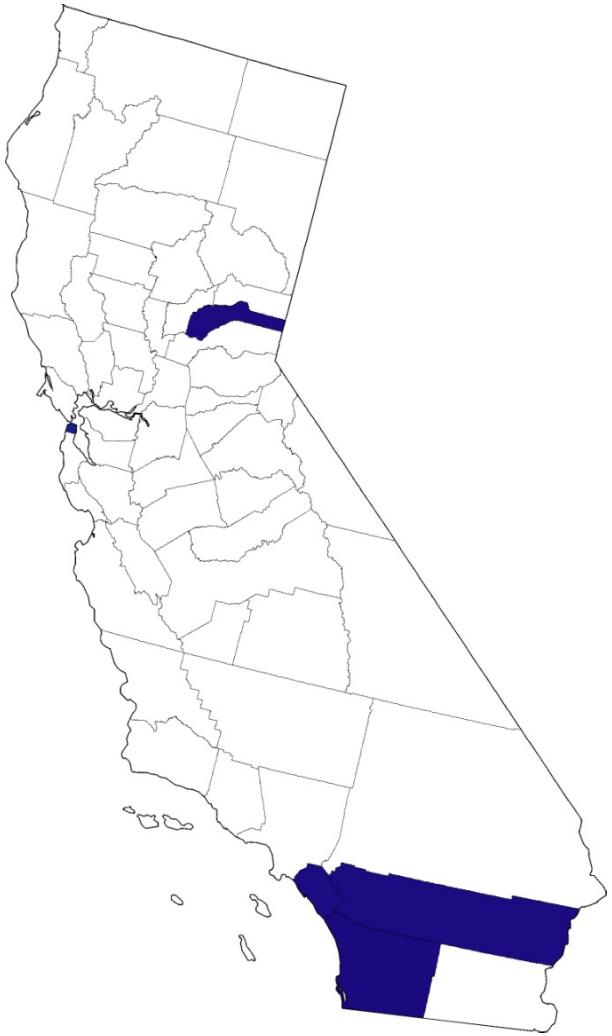
Patient Centered Record

Physician Follow-Up

Knowledge of Red Flags

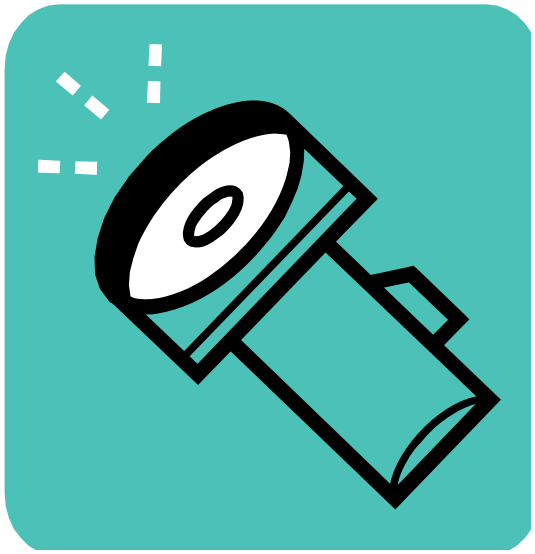
CA ADRCs Hosting CTI

- Five ADRCs participated in the implementation of CTI via Federal grants from 2009-2012:
  - San Francisco
  - San Diego
  - Orange
  - Riverside
  - Nevada



Profiles in Leveraging Successful Pilots

- Riverside
- San Diego



Riverside ADRC CTI Program

- Housed at the Riverside County Office on Aging
- Riverside County Regional Medical Center (RCMC): July 2011-June 2012 Pilot Readmission Rates
  - For those who completed the CTI program, the readmission rate was 9.88% (81 completed with 8 readmitted within 30 days)
  - For those who did NOT complete the CTI program, the readmission rate was 18.64% (59 did NOT complete with 11 readmitting within 30 days).

Riverside ADRC CTI Program

- Desert Regional Medical Center: October 2012-August 2013 Readmission Rates
  - For those who completed the CTI program, the readmission rate was 1.7% (57 completed with 1 readmitted within 30 days)
  - For those who did NOT complete the CTI program, the readmission rate was 15.7% (38 did not complete, with 6 readmitting within 30 days)
- Desert Healthcare District and Desert Regional Medical Center providing funding support for the CTI coach

Riverside CTI program –The Future

- Office on Aging is in talks with two additional hospitals, and will be hiring and expanding CTI throughout the county as contracts are secured

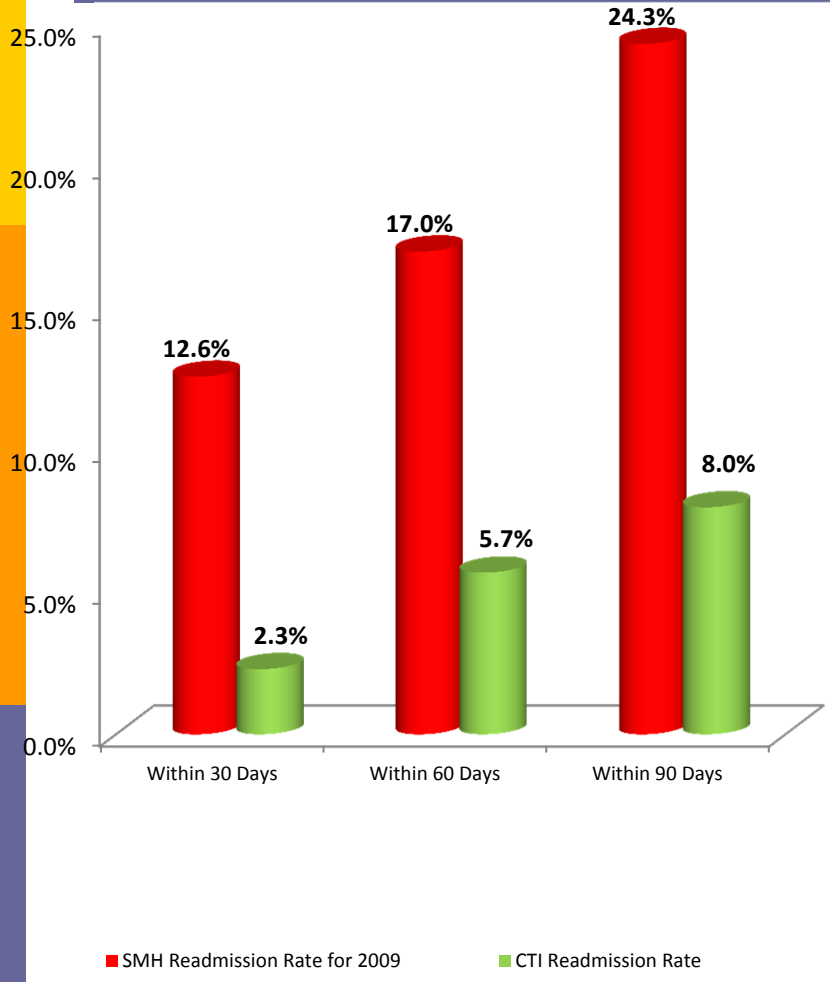
San Diego ADRC CTI Program

- Housed at San Diego Aging and Independence Services (AIS)
- 2010/2011 CMS/AoA ADRC Care Transitions Grant
- 2011 Tech4Impact Grant-Center for Technology and Aging
- 2011 Beacon Community Collaborative Award
- 2012 CCTP Award

San Diego CTI Pilot

- Partnership between AIS ADRC and Sharp Memorial Hospital
- August 2010-December 2011

CTI Pilot Outcomes



POPULATION: Patients who completed the four-week CTI program **and** were readmitted to Sharp Memorial hospital for the **same** diagnosis

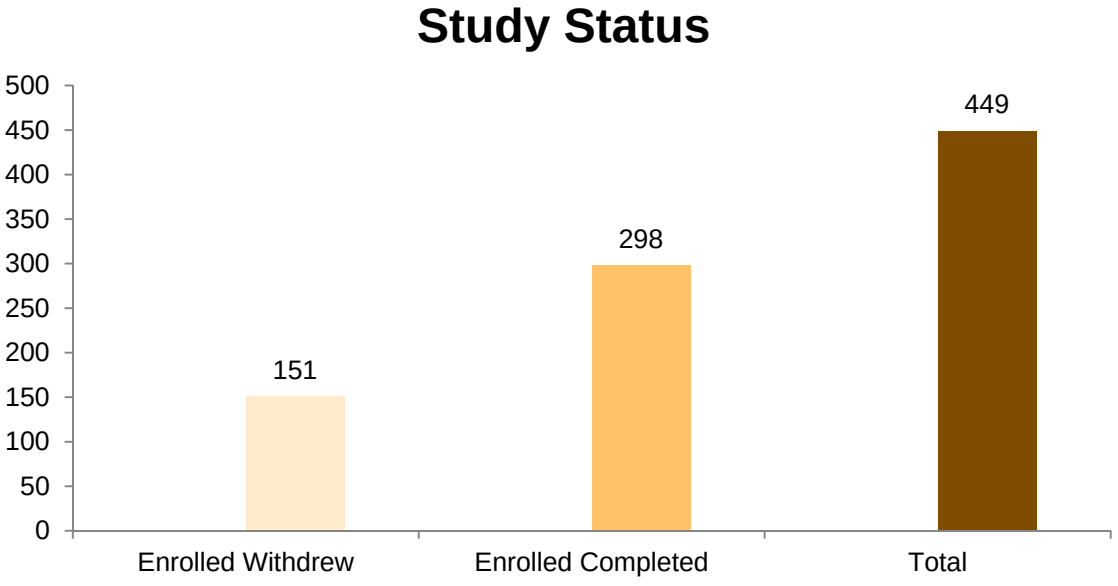
Comparison group: 88 patients who completed CTI and were at least 90 days post discharge and Sharp Memorial Hospital patients admitted during the 2009 calendar year with the same diagnoses as the CTI patients

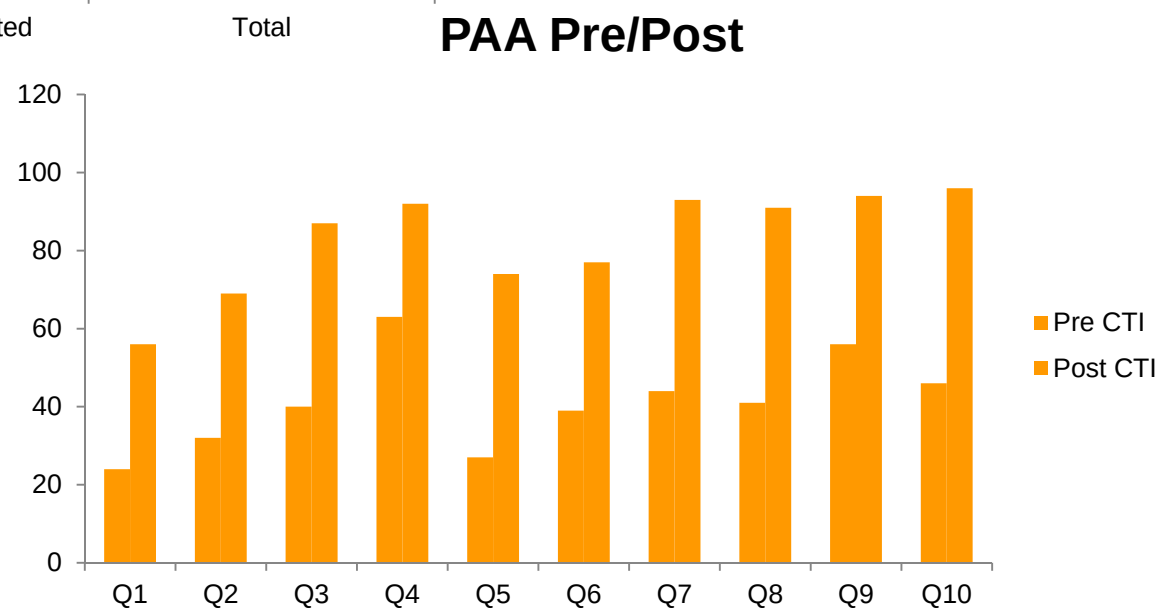
- A readmission was defined as an inpatient readmission for the same diagnosis to the same hospital
- Seven out of the 88 CTI patients were readmitted; for a total of 9 readmissions
- Expected number of readmissions would have been 21

Beacon CTI Pilot – San Diego

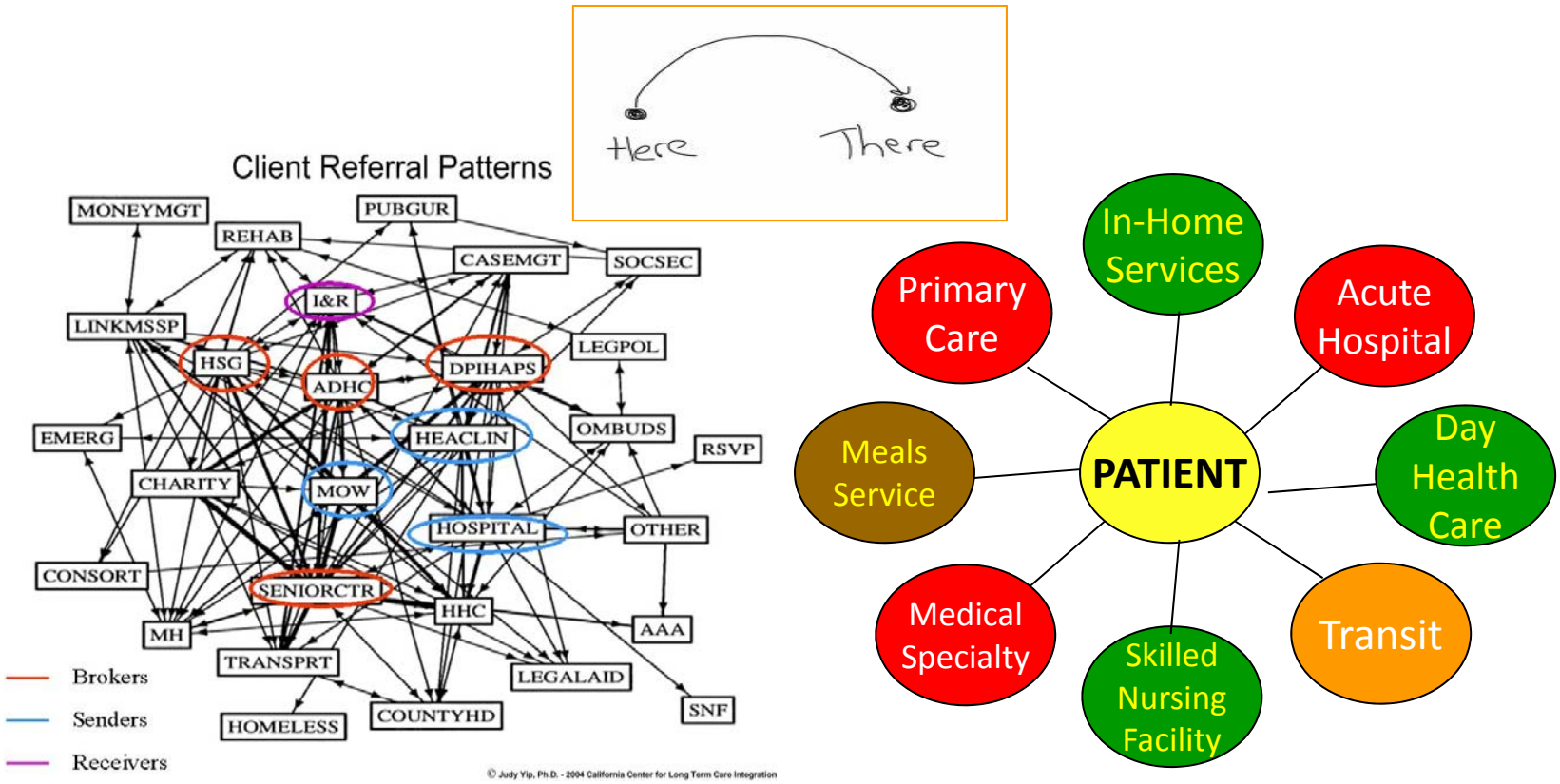
- Funded in November 2011 by Beacon Community Collaborative to serve indigent, medically and socially complex patients
- MOUs signed with University of California, San Diego Medical Center (UCSD) in December 2011 and with Sharp Memorial and Scripps Mercy in February 2012
- AIS staff-Nurses, Social Worker and Spanish Translator provided CTI and critical social supports from December 2011-March 2013

Beacon Outcomes



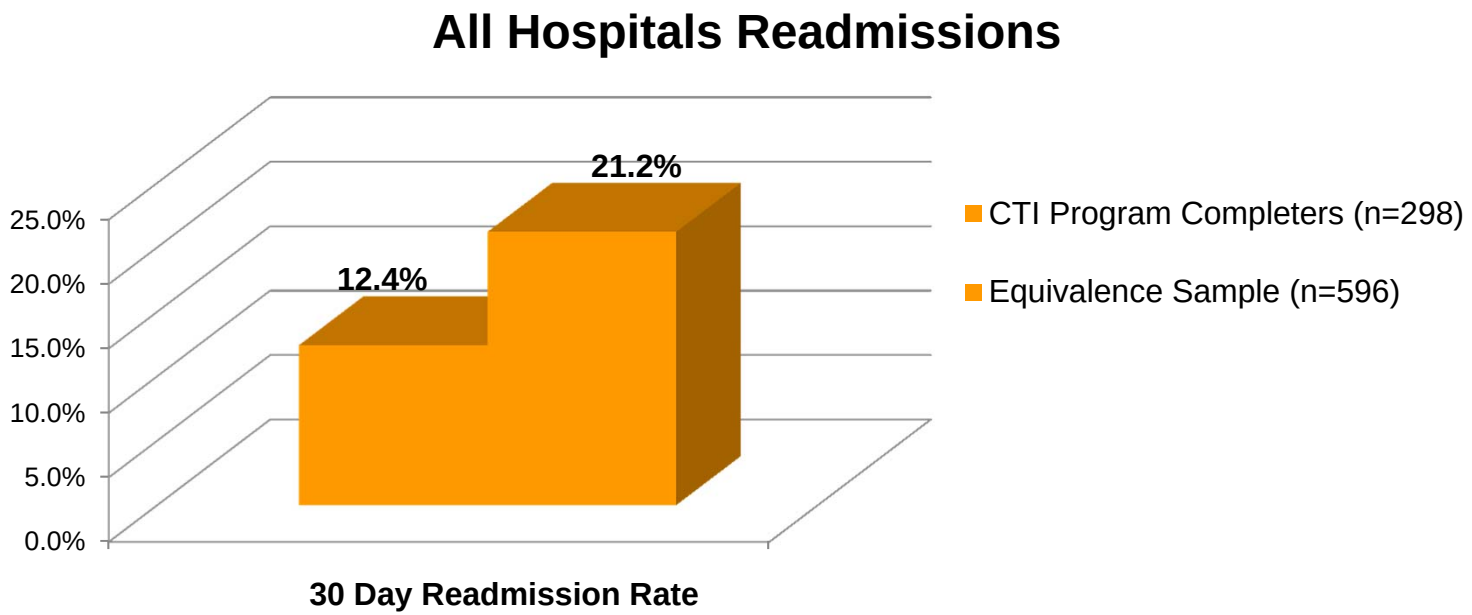


Care Coordination Added to CTI



Provided patients/caregivers critical social support services, either by referral or direct provision to reduce the risk of an avoidable readmission.

Overall Beacon Pilot Outcomes



- The readmission rate of 12.4 considerably lower than the estimated 21.2% readmission rate for an equivalence sample of patients
- If these 298 patients had not completed CTI, we would have expected to have 63 (298 x 21.2%) readmissions
- Among those who were provided CTI, only 37 patients were readmitted, resulting in an estimated 26 (63 - 37) prevented readmissions.
- Provision of CTI resulted in an estimated healthcare cost savings of $303,342 for these 26 avoided readmissions

The San Diego Care Transitions Partnership

- Partnership between the HHSA/AIS and Palomar Health, Scripps Health, Sharp HealthCare and UCSD Health System-13 hospitals
- Planning Process:
  - Each hospital system completed an Root Cause Analysis (RCA) and identified interventions based on RCA
  - Each hospital system established a rate for hospital-based interventions
  - HHSA /AIS established a rate for CBO interventions
  - Overall blended rate was established
  - CCTP Award received in September 2012 and Program Agreement executed in November 2012
  - CCTP services began on January 22, 2013

Current Interventions Provided by AIS

- CTI
- CTI Care Enhancement
- Up to 3457 patients will be served by AIS

Why are ADRCs Successful Transition Partners?

- Knowledge of the diverse and broadly defined LTSS population
- Connections to LTSS providers
- Person-to-person Options Counseling that includes self-direction, planning and personal responsibility
- Expertise in transition services (CTI hospital-to-home and nursing facility-to-home)
- Access to skills training and assistive technology, some of which could result in delaying or avoiding higher Medi-Cal costs, and
- Assistance and access to Medi-Cal eligibility application processes

California's ADRC Program Focus 2013-14

- Dissemination of New Technical Tools: ADRC business model(s)/business plan template
- Ongoing technical assistance and formally designating ADRCs under new Designation Criteria
- Encourage and support VA Medical Center/ ADRC Collaboration
- Monitor and collaborate with national ADRC developments and state initiatives
- Strengthen MFP Demonstration program
- Options Counseling Training Program

CHHS ADRC Team and Resource Websites

- Karol Swartzlander, karol.swartzlander@chhs.ca.gov
- Ed Ahern, edward.ahern@chhs.ca.gov
- Paula Acosta, paula.acosta@chhs.ca.gov
- Therese Llanes, therese.llanes@chhs.ca.gov

- http://communitychoices.info (state)
- http://www.adrc-tae.acl.gov (federal)

Questions?