Issue Brief

Promising Aging and Disability Collaborations

As the population ages and people with disabilities are living longer lives, many states are turning to Managed Care Organizations (MCOs) to provide acute health care services under the Medicaid program and some are also incorporating Long Term Services and Supports (LTSS) into their clinical care systems. While MCOs have a long history of coordinating care and managing financial risks associated with health care, many do not have experience providing LTSS to people who have significant disabilities and who depend on LTSS to remain functional, safe and integrated in their communities. As LTSS is increasingly included as a component of managed healthcare, MCOs have the unique opportunity to gain the expertise they require by partnering with community-based organizations that have extensive experience providing such services for people with disabilities and older adults.[1, 2]

FREED Center for Independent Living, Grass Valley, California and the Area Agency on Aging, Sacramento, California*

In 2011, the Area Agency on Aging located in Sacramento, California and FREED Center for Independent Living located in Grass Valley, California, a rural area in Nevada County with isolated areas and limited resources, received funding from the State Independent Living Counsel (SILC) to establish the Aging and Disability Resource Collaborative (ADRC). The ADRC came about thanks to the vision of leaders in the older adults and disability communities who sought to form a streamlined and user-friendly method to access LTSS for consumers they served by bringing together community-based service organizations. While their vision emphasized a no-wrong-door approach so any Nevada County resident could ask for information and services from any of the participants in the collaboration, they focused

* This Issue Brief summarizes material presented in the webinar, "Promising Collaborations Between IL Centers, ADRCs, and Medicaid Managed Care Plans," organized by the Disability Rights Education and Defense Fund on August 27, 2015. The webinar along with a transcript and slides can be accessed at http://dredf.org/healthcare-access/training-policy-briefs-presentations/

significant attention on people with long-term chronic conditions and disabilities. These individuals often experience support needs that change frequently and they find themselves in emergency departments when LTSS is either unavailable or inconsistent. They are also often hospitalized or sent to skilled nursing facilities unnecessarily when the LTSS safety net fails.

The ADRC envisioned a single database of resources, a universal intake form, and increased informal and formal agency collaboration. This ADRC is unique in that it has neither a bricks and mortar building nor a designated staff. Rather it is solely a collaboration among existing organizations that strives to improve access to services for older adults and people with disabilities. The ADRC is managed by an executive team comprised of the executive director of FREED, Ana Acton and the executive director of the Area Agency on Aging, Pam Miller. Miller and Acton stress that the strong partnership between these agencies provides an important foundation for the ADRC vision and strategically places Nevada County as a leader in improving coordinated systems of care.

Upon launch, the ADRC identified 2300 individuals who were likely to require coordinated services. Among those whose age was known, over 1800 people were age 60 or older and 224 were younger than age 60. While disability information was not available for everyone, 470 people were identified as having a physical or mobility disability, 118 had multiple disabilities and 41 were identified as having a mental health disability.

TABLE 1:
2015 ADRC Consumer Demographics – Identified Disability

Identified Consumer Disability	Number of People
Physical	470
Intellectual/developmental	14
Mental health	41
Multiple	118
TBI	7
Dementia	3
None	254
Unknown	1373

Since it was established, the ADRC has launched several important new collaborations:

- **Care Transition Intervention (CTI) and Integrated Care Coordination, and Patient Navigation**: A Collaboration between Sierra Nevada Memorial Hospital (SNMH), FREED, Western Sierra Medical Clinic (WSMC), and Community Recovery Resources (CoRR) to decrease hospital readmissions
- **Options Counseling**: Staff with partner organizations are trained in a person-centered model of service to assist individuals plan for LTSS needs
- **Community Transition**: Money Follows the Person, California Community Transitions (MFP/CCT)

This Issue Brief presents the Care Transition Intervention (CTI) and Integrated Care Coordination, and Patient Navigation programs.

Care Transition Intervention (CTI) and Integrated Care Coordination, and Patient Navigation

Care Transition Intervention (CTI)

The Care Transition Intervention (CTI) program began in August 2012 in Nevada County. The ADRC launched the CTI Program with FREED and Sierra Nevada Memorial Hospital (SNMH), the only local hospital in Western Nevada County. The goal was to reduce hospital readmissions and emergency department (ED) visits for individuals who are at high risk of returning to the hospital for care. The main strategy used to reduce ED visits and hospital readmissions was to reduce barriers to care that individuals living in rural communities experience. Tactics for reducing barriers included helping the individual and family caregivers acquire the necessary knowledge, skills, and abilities to identify resources that can help prevent future decline leading to ED visits and hospital readmissions. The federal Administration for Community Living (ACL) augmented FREED'S ADRC funding and supported a full-time care transition coach to implement the program and a program director who helped develop the critical relationship with Sierra Nevada Memorial Hospital.

> *Looking back, I'm not sure where we would be today, in all honesty, if we didn't have the seed money to get our foot in the door with the hospital. There was nothing out of pocket for them. They didn't have to invest other than some time in developing agreements with us and developing systems for referral. But it really, I think, helped give an opportunity to prove the effectiveness of the program and gain their trust moving forward. (Ana Acton, FREED Executive Director)*

Barriers to Care in a Rural Environment

Patients often face long waits for primary care, limited availability of urgent care, and limited access to specialty care in rural Nevada County. Many people also have limited ability to navigate the complex care delivery system. They frequently have questions about what their insurance covers, which care providers they can see and how to access basic services. The 2010 Affordable Care Act also triggered the expansion of Medicaid eligibility in California, which placed further demands on limited primary and specialty care providers thus making it more difficult for some to obtain care. In Nevada County a few Federally Qualified Health Centers (FQHCs) provide most of the care for Medicaid eligible beneficiaries. Transportation also has been a long-standing problem that affects access to care. It is not uncommon for individuals to spend three or more hours traveling by car to access specialty care services. Moreover, people with chronic illnesses and complex health conditions frequently require care from multiple providers thus compounding the need to travel long distances to visit a provider.

Some people are especially isolated from care such as low income individuals who have substance use disorders, many of whom are not typically connected to any primary care physician or basic preventive services. Accessing any form of healthcare services also presents difficult challenges for those who are homeless. The ED therefore frequently becomes the focal point in the healthcare matrix when care either is not readily available or is poorly coordinated, and when individuals do not have access to preventative services. Advocates often refer to the ED as a Band-Aid for all health care needs because some people tend to return again and again.

Training

The CTI partners recognized the need for in-depth staff training in order to prepare FREED's staff to manage the program and deliver effective services. The IL Center staff members who provide CTI services have received training in the independent living philosophy and in person-centered planning.[3] They also have been trained in motivational interviewing techniques using the *SBIRT—Screening, Brief Intervention, and Referral to Treatment* model. SBIRT is an approach to the delivery of early intervention and treatment for people with substance use disorders and those at risk of developing these disorders.[4] These staff have also been trained in the Care Transition Intervention model, which focuses on providing patients and family caregivers with the skills, confidence, and tools they need to assert a more active role in their care and ensure that their needs are met.[5]

Care Transition Intervention (CTI)—Four Pillars

The CTI program rests on four pillars:

- Medication self-management
- Personal health records
- Follow-up appointments
- Recognizing red flags

Medication self-management: Typically participants frequently misunderstand their prescription medication regimen and take doses either too frequently or not frequently enough. Using motivational interviewing techniques including asking the right questions, coaches help participants to develop skills and techniques that enable self-management of medications.

Personal health records: Participants use personal health records (PHRs) as a tool to develop a plan that facilitates a conversation with their doctors and that promotes a personal health or wellness goal.[6] The PHR form provides a space where participants can write questions for their doctor and record what their doctor said during a visit. This tool helps people have more organized and productive encounters with their health care practitioners and encourages effective communication.

Follow-up appointments: Central to successfully reducing ED visits and readmission following hospital visits is the capacity to schedule an immediate follow-up visit with either a primary care or specialty provider. Sometimes follow up visits are difficult to arrange due to overcrowded provider appointment calendars or limited provider availability. High touch support that includes securing a hard-to-get follow-up appointment assures that the participant will have access to required medical attention when it is needed, thus reducing the likelihood of return visits to the ED and re-hospitalizations.

Recognizing red flags: Helping participants know what led to an ED visit or a re-hospitalization enables them to seek help before that same problem becomes a crisis. When it surfaces again, they know that they can and should call their nurse or their doctor's office first to seek advice rather than going to the ED.

Identification of Participants

Cost reduction is one of the broad goals of healthcare reform and reducing ED visits and hospital readmissions are two methods to reduce costs. Moreover, Medicare penalizes hospitals for readmitting a patient within 30 days following discharge for the same chronic disease diagnoses such as heart failure, pneumonia, chronic obstructive pulmonary disease (COPD) and stroke. Therefore, the program focuses attention on Medicare and Medicaid beneficiaries who have complex health issues including mental health and substance use disorders, who may be homeless and who tend to frequently visit EDs and be readmitted to the hospital.

The hospital is the source of most referrals to the CTI because it has a system in place to identify people who are at high risk of readmission or ED use. Because CTI coaches have an office at the hospital they are well situated to encourage referrals by building and sustaining relationships with the hospital staff. Typically nursing staff obtain patients' permission to share information with the CTI coaches and for the coach to enter the patient's room and discuss the program. After the hospital makes a referral, the CTI coach meets with the person while they are still in the hospital. This early contact helps build trust and encourages the patient to enter the program. Within 30 days after discharge, the CTI coach also meets with newly enrolled participants at their home and then follows up with that person at least three times by telephone. One full-time care transition coach typically can work with 25 individuals each month. If the participant requires additional Independent Living services, the CTI coach refers that person to those services, often provided by FREED, thus frequently extending relationships with participants beyond the 30-day period. The CTI focuses on quality improvement by meeting quarterly with hospital management and nursing staff to identify ways to improve the referral processes.

Participant Data

The CTI program received 451 referrals during the 30-month period following the launch in 2013. (Changing staff levels year-to-year based on available funding account for differences in the number of referrals as well as the number of participants enrolled in the program annually.)

FREED tracked and reported outcomes including hospital readmissions within 30 days for everyone who was referred and everyone who completed the program. CTI reports an average readmission rate of 7 percent for program participants over a 30-month period. During 2013, the participant readmission rate was 7 percent. Readmission occurred for 6.5 percent of participants in 2014. The readmission rate was also 7 percent for the first six months of 2015.

TABLE 2:
Care Transition Intervention (CTI) Participation*

CTI PROGRAM	Number of Referrals	Number who Completed the Program
2013	280	82
2014	136	46
2015 (6 months)	35	35
TOTALS	451	141

*Differences in referrals and number who completed the program year-to-year is attributed to varying staffing levels.

These readmission rates compare with a 10 percent to 10.7 percent readmission rate within 30 days after discharge for all populations, regardless of diagnosis, age, or source of insurance. Moreover, Medicare beneficiaries with certain diagnoses experience readmission rates from 17 percent to 22 percent, which are significantly higher than the project reports.[7] Similarly, the 30-day readmission rate for those referred to the program but who did not participate was also 17 percent. Acton reports that the hospital administration was pleased with the positive outcomes of the CTI including the benefits to patients as well as the cost savings.

TABLE 3:
CTI Participant Readmissions Within 30 Days Following Discharge 2013 – 2015

Year	
2013	7%
2014	6.5%
2015 (6 months)	7%

*Sierra Nevada Memorial Hospital overall readmission rate for all patients during 30 days after discharge: 10 percent to 10.7 percent

ALICIA

The CTI coach worked with Alicia, a 77-year-old woman with multiple health conditions. She lived alone and had no family in the area. The CTI coach used the personal health record (PHC) form to help organize a list of medications and questions that Alicia could later present to her primary care provider. Listing her medications exposed some prescription concerns that she raised with her primary care physician during the next visit. Other questions were recorded on the PHC so she could easily recall them during the next scheduled visit.

The CTI coach also enrolled Alicia in an emergency alert program so she was able to be more at ease living alone. Alicia also sought a referral to FREED's home access program so that grab bars could be installed in her bathroom, which increased her confidence in navigating the shower. After reviewing concerns with the CTI coach, Alicia spoke with her provider and reported that she felt more motivated to be her own advocate.

Integrated Care Coordination—Patient Navigation

A collaborative project between FREED, Dignity Healthcare Foundation, Community Recovery Resources (CoRR) and Western Sierra Medical Clinic, the CTI program was expanded to provide patient navigation beginning in January 2014. The goal was expanded care coordination and appropriate patient navigation between primary care, disability and senior services, and behavioral health services. Patient navigators are located at FREED, CoRR, and Western Sierra Medical Clinic. With an office at the hospital, FREED's CTI coach also serves as patient navigator. Care transition coaches and patient navigators together promote the no-wrong-door system of referral and care across organizations.

Patient navigators within each partner organization help the individual navigate not only clinical care and follow-up, but also social services including LTSS. One common goal was to secure a primary care appointment for the participant before discharge from the ED as well as upon hospital discharge. The program reports some success in reducing wait times for primary care appointments.

The collaboration made 46 patient navigation referrals in the first nine months of 2015. While more study is needed, preliminary data reveals that none of the people who received navigation referrals were readmitted to the hospital or visited the ED within 30 days of the initial ED visit or following hospital discharge.

JANEEN

FREED's patient navigator worked with Janeen, a woman in her early 50s who had a history of mental health and substance use disorder problems who had also had three brain surgeries. She had been readmitted to the hospital several times during the six months before joining the program. During the first home visit she said she wanted to give up. However, the patient navigator and coach helped her [find] a doctor who not only prescribed the medication that she said works best for her but who also listened to what she has to say. She signed up for the local paratransit service, and is now able to get to and from her medical appointments. After a few months of treatment, she called FREED to say that she has been sober for four months and she also had found a home that she could afford without a roommate. She said she finally felt like herself.

Individual and Community Benefits

Research has shown that care coordination and patient navigation assistance can help improve health outcomes and reduce healthcare costs for people with disabilities and older adults who have complex health problems and conditions.[8] The transition coaching and patient navigation support undertaken by the groups and organizations in Nevada County, California has produced important preliminary results showing that high-touch assistance and follow-up including LTSS can reduce both return visits to the ED and hospital readmissions for people with disabilities and older adults. Moreover, these coordinated services improve health and quality of life for participants and increases their opportunity for self-determination and community participation.

> *When people have access to primary care… and do not end up in the emergency department or hospital, then there is reduced cost. Also, savings flow from increased capacity and efficiency of community-based long-term services and supports. So, through this kind of collaboration, we're leveraging the minimal funding that we have to create a more robust system… there are savings not only to our community but also to the organizations that are working together. And we see better individual outcomes from increased long-term services and supports, collaboration, and coordination… (Ana Acton, FREED Executive Director)*

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Co-authors: Mary Lou Breslin, DREDF Senior Policy Advisor, Ana Acton, FREED Executive Director, and Pam Miller, Executive Director, Area Agency on Aging.

FOR MORE INFORMATION

Ana Acton
Executive Director
FREED Center for Independent Living
Grass Valley, California
ana@FREED.org

Pam Miller
Executive Director
Area Agency on Aging
Sacramento, California
pmiller@agencyonaging4.org

Mary Lou Breslin
Senior Policy Advisor
Disability Rights Education and Defense Fund
mlbreslin@dredf.org

ABOUT DREDF

The Disability Rights Education and Defense Fund (DREDF) is a national law and policy center dedicated to advancing the civil and human rights of people with disabilities through legal advocacy, training, education and public policy and legislative development.

Our Health Care Work

We advocate for state and federal laws and policies that chip away at the complex barriers people with disabilities experience when they try to access health care. We also conduct research, author journal articles, comment on federal and state health care regulations, train diverse health care stakeholders, develop model policies for accommodating people with disabilities in medical settings, and build alliances with colleagues in the health policy and aging fields.

Disability Rights Education and Defense Fund (DREDF)
Ed Roberts Campus
3075 Adeline Street, Suite 210
Berkeley, CA 94703
510.644.2555
tty/fax 510.841.8645
www.dredf.org

Follow us on Twitter @DREDF
On facebook.com/DREDF.org
www.DREDF.org

ENDNOTES

[1] National Council on Independent Living. Website: http://www.ncil.org/about/aboutil/. Accessed on May 16, 2016. Such organizations include Independent Living Centers (ILs/CILs), community-based, cross-disability, non-profit organizations that are designed and operated by people with disabilities. ILs are unique in that they operate according to a strict philosophy of consumer control, wherein people with all types of disabilities directly govern and staff the organization. ILs help people with disabilities acquire the skills necessary to recruit, train, hire, and manage personal assistance services (PAS) workers.

[2] U.S. Department of Health and Human Services, Administration on Aging (AoA), Aging and Disability Resource Center Program. Website: http://www.aoa.gov/AoA_programs/HCLTC/ADRC/ADRC_Program.aspx. Accessed July 8, 2016. The Aging and Disability Networks have a long history of assisting older adults and people with disabilities by assessing and coordinating their social care needs, as well as effectively delivering quality LTSS, care transitions programs and chronic disease self-care management trainings.

[3] Cornell University, Employment and Disability Institute. Person Centered Planning and Education Site. Website: http://www.personcenteredplanning.org/. Accessed June 21, 2016.

[4] Substance Abuse and Mental Health Services Administration. SBIRT—Screening, Brief Intervention, and Referral to Treatment. Website: http://www.samhsa.gov/sbirt. Accessed on June 21, 2016

[5] Care Transitions Intervention. Website: http://caretransitions.org/. Accessed on May 16, 2016.

[6] Mayo Clinic. Personal health record: A tool for managing your health. Website: http://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/personal-health-record/art-20047273. Accessed on July 8, 2016.

[7] Medicare.gov, Hospital Compare. Website: https://www.medicare.gov/hospitalcompare/profile.html#profTab=0&ID=050150&state=CA&lat=0&lng=0&name=SIERRA%20NEVADA%20MEMORIAL%20HOSPITAL&Distn=0.0. Accessed June 21, 2016. Less than thirty-days post-discharge readmissions for specific conditions: Sierra Nevada Memorial Hospital (SNMH) vs. National Rate:

Heart attack
- SNMH: 17%
- National: 17%

Heart failure
- SNMH: 22%
- National 22%

Pneumonia
- SNMH: 16.9%
- National: 16.9%

COPD
- SNMH: 20.2%
- National: 20.2%

Stroke
SNMH: 12.7%
National: 12.7%

[8] California Healthline Daily Edition. *Community-Based Care Reduces Readmissions, Cuts Costs, Study Finds.* Jan. 2013. Website: www.californiahealthline.org/articles/2013/1/23/communitybased-care-reduces-readmissions-cuts-costs-study-finds.aspx#ixzz2JOKPaVhj. Accessed on June 21, 2016.