DISABILITY RIGHTS EDUCATION & DEFENSE FUND

WEBINAR: PROMISING PRACTICES: THE AGING AND DISABILITY RESOURCE CONNECTION (ADRC), A RURAL COLLABORATION BETWEEN THE INDEPENDENT LIVING CENTER—FREED, AREA 4 AGENCY ON AGING, AND OTHER LTSS AND SAFETY NET PROVIDERS, GRASS VALLEY, CALIFORNIA

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>> Mary Lou Breslin: Good afternoon, everybody. Welcome to "PROMISING PRACTICES: The Aging and Disability Resource Connection (ADRC), a rural collaboration between the Independent Living Center ‑‑ FREED, Area 4 Agency on Aging, and other LTSS and safety net providers, Grass Valley, California." Before we begin, please note that if you would like access to captioning for this webinar, those of you who are MAC users should please click on the Media Viewer which is located in the lower right‑hand corner of your webinar window. And for those of you who are logging on early, you might need to log out and log back in again in order to view the captioning window. Windows users, please click on the Media Viewer which is located in the upper right‑hand corner of the webinar window. You can read the transcript of the webinar in realtime from the captioning window.

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We'll be taking questions following Ana Acton's presentation. You can type your questions in the chat box. We will answer as many as we can as time permits. A transcript for this webinar along with the slides will be posted on the DREDF website, DREDF.org, within about one week of this presentation.

We're going to get started. I'm Mary Lou Breslin, a Senior Policy Advisor with Disability Rights Education & Defense Fund. We're a national policy organization located in Berkeley, California, and Washington, D.C. I'd like to welcome all of you to the first in the series of three webinars featuring promising collaborations between Independent Living Centers, Aging and Disability Resource Centers, Area Agency on Aging, healthcare providers and other partners. The Disability Rights Education & Defense Fund is presenting these webinars in collaboration with aging and disability partnerships for managed Long Term Services and Supports which was established by the National Association of Area Agencies on Aging as part of a project funded by the Administration for Community Living. The project partners include the National Disability Rights Network, Justice in Aging, Disability Rights Education & Defense Fund, and Health Management Associates.

The goal of the partnership for Long Term Services and Supports is to leverage the aging and disability networks' extensive infrastructure, service capacity, and expertise to ensure delivery of high‑quality managed Long Term Services and Supports to seniors and people with disabilities.

The purpose of this webinar series is to share three promising practices, collaborations between Independent Living Centers, Managed Care plans, healthcare providers and others.

 This first webinar in the series being presented today features a collaboration between the Independent Living FREED and Area Agencies on Aging partners who helped form the Aging and Disability Resource Connection in the rural area of Grass Valley, California. Subsequent webinars will feature partnerships between the Berkeley California Center for Independent Living, Medicaid Managed Care organization, and the federally qualified healthcare center LifeLong Medical Care. The third webinar will feature an innovative program of the Independent Living Center access to independence and Care1st health plan. Please check the website for these webinars.

 Our goals in presenting these webinars are to illustrate how collaborations between these groups and organizations have the potential to infuse the independent living philosophy and services into LTSS and managed LTSS, improved health outcomes and increased community living for older adults and people with disabilities. The collaboration holds the potential to generate cost savings.

 Presenters for our webinar today are Pam Miller, Executive Director of the aging and disability resource collaborative located in rural Grass Valley, California. Pam will be talking about the formation of the ADRC as a collaboration with FREED Center for Independent Living and the Area Agencies on Aging. Ana Acton, Executive Director of FREED, will be talking about three innovative collaborations: Care Transition Interventions and the integrated care coordination for family wellness project, specifically care transition coaching and patient navigation. Silvia Yee, Senior Attorney with DREDF, will conclude the webinar with a discussion of the policy implications for these programs. And I would like to extend our really deep appreciation to our presenters for working with us to bring this webinar to you.

 With that, I'm going to turn this over to Pam Miller. Hang on one second and we'll do that

>> Pam Miller: Thank you very much. We are happy to provide the collaboration. I think the first thing we need to talk about is the fact that Nevada County is a very rural county and, indeed, we are the only Aging and Disability Resource Connection in California that is in a rural area. It's a small county in the Sierra Nevada region and includes cities like Grass Valley, Nevada City and Truckee. So because it's a rural area, it certainly brings challenges to service delivery. There are isolated areas; there are remote areas; there are limited resources.

 As we go on to talking about what this means to form an ADRC, I want to talk about the fact that the key thing is really collaboration. About 15 years ago when the long‑term care implementation council in that area had a vision, and their vision was to take local and community‑based service organizations such as the Nevada County Health and Human Services, consumer leaders, other nonprofit organizations and to bring them together to form a consumer‑friendly access to long-term services and support. So we're talking about things like a single database resources, universal intake form, and increased informal and formal agency collaboration.

 In 2010, the council applied for an ADRC grant from the State Independent Living Council, the SILC and the ADRC using those funding was formed in January of 2011. This ADRC is not a bricks‑and‑mortar ADRC. We do not have a building. We don't have designated staff. We are simply a collaboration between the Area Agency on Aging and the Independent Living Center.

 Right after the ADRC was formed in January of 2011, the Long‑Term Care and Implementation Council renamed itself the Community Living Council or the CLC. And today it continues to exist as the Advisory Council to the ADRC. So the important key to this is that we were looking to have no wrong door approach in that area. So any Nevada County resident could go to any of the people who were involved in the ADRC and get services.

 As I said, the CoRR partners are FREED and the Agency on Aging in area 4. We initially had a third CoRR partner which was 211 in Nevada County but they have since just become an extended partner because it takes a lot of time to become involved in this collaboration. But they still are very, very key to the ADRC.

 So the executive team is made up of the Executive Directors of FREED and the Area Agency on Aging which is Ana and myself. We have frequent conversations. We formally have a meeting monthly to try to figure out how to navigate this system where we actually don't have any funding to do what we're doing but it just seems like it's definitely the right thing to do. I cannot stress how important the CoRR partnerships are. The strong partnership provides a strong foundation for the ADRC vision and I think it strategically places Nevada County in a position to have an improved coordinated system of care.

 Ana and I work very well together because we have similar visions. And just in terms of most ADRCs, they really typically involve the AAA and Independent Living because we have something called the first right of refusal. So when ADRC is forming, those should be the two CoRR partners unless one or the other does not want to participate.

 So with the ADRC, we got some new services in Nevada County. The ADRC target population is all ages and types of disabilities and their families. So this is including people with dementia, people with diverse and social, racial, and ethnic cultural groups, and, of course, it's regardless of income level and resources.

 We made sure that our partners were trade in options counseling. I think that probably FREED use that the most and also 211 and information and assistance. But we wanted to focus our services by people with long‑term chronic conditions and disabilities, people whose needs change frequently, and who without the community long‑term service and supports are frequently back into emergency rooms, stay too long in nursing homes; they're hospitalized too often.

 What the care transition program that Ana will be describing later -- it was a great collaboration between the Sierra Nevada Memorial Hospital, FREED, Western Sierra Medical Clinic and the Community Recovery Resources. It has done a great job in decreasing hospitalization.

We also have community transitions where the money follows the person. I think what we did was we brought new services to Nevada County to really answer a need in that rural area.

 This is some of the ADRC consumer demographics. The ADRC model makes sense because there are many overlaps in the aging and disability community. Many older adults have disabilities and all disabled people are aging. So this is a snapshot of who we are and who we serve. And this was actually taken from the Annual Report for the ADRC going from October 2013 to September 2014.

As you can see, we certainly serve a lot of older adults but we also serve people who are not older adults and we really have a lot of folks with physical disabilities but we also have some other disabilities included there also.

 This next slide talks about combined program data. The ADRC is a true collaborative with extended partners such as Salvation Army, 211, Nevada County, and many other very important critical organizations. So this slide is representing information from the same Annual Report as the last slide. But because this is a person‑centered system, the partners respond to the individual needs and goals and values of the consumer. The collaboration works in partnership to guarantee that each person's values, experiences, and knowledge drive the creation of a consumer action plan and a delivery of services.

 The strength of the collaboration, as I said before, is key. Collaborating in a rural community has its advantages because there are true relationships in a rural community. People tend to know each other. Providers know each other. And the smaller organizations that serve communities within Nevada County really know what those communities need. So this really helps in terms of coordination of service delivery.

 Once again, the key is having a consumer‑centered service and deciding what services ‑‑ allowing the person to decide what services they want or if they truly even want services, they certainly have the right to refuse services. But when the consumer does want a service, there is no wrong door to the access of these services.

 I think that the LTC, you know, a decade ago had a lot of forethought in forming the ADRC because it brought together the members of nonprofit communities, for‑profit communities, government agencies. And this collaboration has really benefited the Nevada County ADRC in the service that we provide today.

 I think now that Managed Care is coming to rural areas, it's even more important that we have this ADRC focus because I believe it's going to be the ADRC that is going to be the central contact to reaching out to the Managed Care agencies and working with them to really bring comprehensive and coordinated services to the residents of Nevada County.

 Now I want to turn this over to Ana Acton who will talk a whole lot about specifically the great things that we're doing.

>> Ana Acton: Thank you. My name is Ana Acton. We're one of the CoRR partners of ADRC. Can everyone hear me ok that is listening?

 Ok. I'll hope that you're all hearing well and can follow along. I'd like to start us off by kind of introducing a couple of programs that we have been developing and implementing over the last few years. So I'm going to talk first about the Care Transition and Intervention program and then the secondary collaboration as part of the ADRC that is focused on patient navigation.

 So I just want to start by saying that, you know, this particular program is housed under in our Independent Living Center or CIL for those in other states. The staffing that provides the direct service that we're going to be talking about are trained in Independent Living philosophy, person‑centered planning. They have training and motivational interviewing SBIRT, the screening brief intervention and referral to treatment, as well as they're trained in the Care Transition Intervention model.

 The focus of the CTI Program that we're going to talk about first is really to reduce hospital readmissions. To begin with, I'd like to talk about some barriers to care for individuals living in our rural community. These may sound familiar to you whether in a rural community or even in an urban setting.

In a rural Managed Care environment, long waits for primary care exist and there's limited access to specialty care. So we actually are seeing with the Affordable Care Act and the expansion of Medi‑Cal Managed Care that there's been an increased demand on our limited primary care services in our rural settings for those providers that take Medi‑Cal or Medicaid. And that's especially true in that it's really been limited now largely to just a few federally qualified health clinics or look‑alike clinics that are providing the majority of Medi‑Cal primary care services.

 We also tend to ‑‑ individuals living here tend to have to travel a long ways for specialty care. So it's not uncommon for individuals to be traveling to Auburn and Placer County, Sacramento, and Sacramento County or even down to San Francisco. So people could be traveling as short as a half an hour to as long as three‑plus hours to access specialty care services.

 Also, individuals with disabilities, chronic illness and complex health conditions frequently require care from multiple settings. Right? So many of the people that we work with, whether they're older adults or people with disabilities, and especially if they have chronic illnesses, they often tend to rely on healthcare providers and across multiple settings because of the complexity of their needs.

 Many patients also have limited ability to navigate the care delivery system. It's confusing. It's difficult for people to understand the processes needed, where they need to go first, who will take what insurance, and often have questions on how to access basic services and to really get their health and disability and aging needs met.

 Other barriers to care include individuals who are chemically dependent and who are low-income. They are not typically connected to any primary care and preventative services. We're going to talk about this more also in our patient navigation piece but we do see a correlation here in Nevada County around substance abuse, individuals who are low-income, individuals who are homeless who particularly have a hard time accessing preventative services or really services at all.

 The hospital, especially the emergency department, frequently becomes the focal point in the healthcare system when care is poorly coordinated and when individuals do not have access to preventative services. So as many of you are probably familiar with, this is where people typically will go for services. And this has especially been true in our current environment. Oftentimes there's long wait times for primary care providers. So there's a lack of urgent care opportunities often and so people end up in the emergency department to access services, which we find usually translates to, you know, it's not really what the ED is designed for, people don't get as comprehensive of care and aren't necessarily really getting their needs met. It's more of a Band‑Aid approach but people tend to go back again and again.

 The Care Transition Intervention program began in August 2012 in Nevada County. The ADRC launched the CTI Program, as I'll refer to it, with FREED and Sierra Nevada Memorial Hospital, our one and only local hospital in Western Nevada County. The goal was to reduce hospital readmissions and emergency department visits. And our objective was to help the individual and family caregiver gain knowledge, skills, and abilities to identify resources to prevent future decline and hospital readmissions. So our project duration, again, started in August 2012 to the present. And the initial funding was through the State Independent Living Center through federal funding through the Administration for Community Living. This was really critical to the start of our particular program because we had ADRC start‑up grant and there was funding specifically that allowed us to fund a full‑time care transition coach to implement the program and we had a program director that also helped us with developing that specific relationship with the 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.

 I'd like to talk about the Care Transition Intervention program specifically. The CTI Program is an evidence‑based program. You may have heard of it as the Eric Coleman model. It's actually based out of the University of Colorado at Denver. I'll just say that the CTI Program, when we looked at it, we looked at the Eric Coleman model. We quickly realized that this was Independent Living philosophy; this was person‑centered services. And Eric Coleman had the foresight and ability to take an Independent Living, person‑centered approach, and wrap it up into an evidence‑based model to reduce hospital readmissions.

 If you're curious about the Eric Coleman model, look at the University of Colorado at Denver. You can easily Google it and find a linkage to their website. Because it's evidence‑based, it is a costly program. I would say to some degree it is proprietary. You have to send your staff to a one to two‑day training, typically at the university at Denver, and it costs typically about $3,000 per individual to get the training.

 Also, the piece about the CTI Program is that it is goal‑driven which helps with the development of a plan. So, again, very Independent Living, person‑centered and looking at what the individual goals, preferences, and needs are of the individual and then having the individual ‑‑ working with them to develop the plan to improve their health and help them meet their goal.

 There are four pillars to the CTI programs. That includes medication self‑management ‑‑ again, it's self‑management. Our coaches don't necessarily have degrees in these kinds of things. They've been trained in the CTI model and motivational interviewing, like I mentioned before. But they're not there to manage or tell the person how to manage their medications. They're really doing skills transfer. So they're having the right conversations with the individuals. They're helping the individual reconcile their own medications. And I can't tell you how often it comes up that the individual, indeed, you know, may be taking their medication twice a day when the prescription on their bottle says four times a day. So the coach is there to help the individual look at those things and then develop questions and a follow‑up appointment with their doctor to reconcile some of those issues.

 The other ‑‑ the second pillar is the personal health records. So, again, the personal health record is where the individual develops a goal and a plan and they can use that health record to help them facilitate the conversations with their doctor. There's places to write their questions for their doctors or what their doctor said at the appointment. It really helps them facilitate having a more meaningful meeting with their primary care or specialty doctor.

 And then the third pillar is follow‑up appointments. So a big piece is to get that individual connected with the follow‑up primary care majority of the time or specialty care appointment as part of the program. So that, again, is going to help them get their needs met at more of a personal level with their local doctor rather than going to the emergency room or hospital for services unless absolutely necessary.

 The fourth is knowing the red flag. So identification of red flags really helps the individual think and identify what happened that made it so they ended up in the hospital. So that if they have those particular symptoms again in the future, they may do a call to their nurse or their doctor's office to walk through some of that to see if things can be medicated at a lower level. So they don't exacerbate into more serious issues.

 Identification of participants. As some of you may have heard, there has been a major focus around reducing hospital readmissions. This is coming from multiple different angles. I know our local hospital signed on with many other hospitals in California to make a path to help reduce overall hospital readmissions. And then, of course, we have the Medicare piece where there's certain diagnosis. Beneficiaries are disabilities including chronic conditions like heart attack, heart failure and pneumonia, COPD and stroke, who the hospital is actually penalized for readmissions for that individual being readmitted for the same diagnosis within 30 days. So we really have a target population for this program of those on Medicare, on Medi‑Cal, those with complex health issues including mental health and substance abuse disorders.

 The other target population, the highest users of the emergency department. So often the emergency department has their frequent users that maybe go in there because they can't get a primary care doctor. They're often low-income. It may be substance abuse related. It may be because they're homeless or they don't have good transportation and housing. So those typically are the frequent users of the ED.

 The other identification of participants is those that have been deemed by the hospital to be at high risk of hospital readmission. And there are certain ‑‑ the hospital actually has a system in place to identify risk of readmission. The referrals from them often are those that they've deemed to be at high risk for hospital readmission. And then it's also just people in need of community services and primary care is the other target for this program.

 So I want to talk about the intervention strategies and system for referral. Care transition coaching and referral improvements have really been improved with the dedication of staffing to this program, as you can imagine. So we have had anything from a one FTE dedicated to the program which is absolutely the recommended method to go if you can afford it. You know, there's also been ‑‑ it has ‑‑ we did see the capacity of the program go down.

 With a full‑time one FTE care transition coach dedicated to the program, it's typical to be able to work with 25 individuals a month on the program. So we do have a coach that's been trained, that's dedicated to the program.

 We receive referrals from the hospital. We have office space actually at the hospital where our coach can spend some time and develop relationships with the hospital staff for improved referrals.

The way the CTI Program ‑‑ I'm going to go into that ‑‑ works is that we see the patient while they're still in the hospital and then we do a follow‑up visit in their home. And then we provide at least three additional telephone contacts. The program, we get the referral directly from the hospital. We meet with the person while they're still in the hospital because that is going to drastically improve the likelihood that the person is going to trust us and sign up and enter into the program.

 We then, after they've been discharged from the hospital, we visit the person in their home which is beneficial on many different levels. Often people are more comfortable in their own home setting. You often can see other indicators or issues that might be going on that might spark the ability to ask them the right questions and have some of the right discussions with the individual.

 And then we do the follow‑up three phone calls. All of this is targeted to be done within a 30‑day period of time from time of discharge to when the person ‑‑ completes the program. The benefit of having this program in Independent Living Centers often if there's ongoing needs and services, then the individual is then referred to another staff member, another program within our organization, and often we have longer relationships than 30 days with the individual.

 So when we first developed the program, we developed an agreement with the hospital because as you may imagine, a lot of HIPAA issues. There are issues to work through about how you get the referrals from the hospital. Hospital staff are overworked. They have lots of things on their plate and so often it's hard to get the right champion within the hospital to actually make the program work as far as referrals go.

 So our particular program works in that we have the agreement where we can share information and just kind of generally go over that. It allows ‑‑ the hospital staff has to get explicit written approval from the patient for us to go into the room and see them. Once that's been obtained from the individual, then the nurse will alert us.

 We've tried a few different methods for that. It often ends up being a phone call. We've had an in‑box when our individual coach goes in there to pick up slips for the referrals that have been signed. And it's a constant relation‑building and improvement process.

 Then we go in there, we meet with the individual. We get them to hopefully sign up for the program. Not everyone does. Sometimes we're just providing patient navigation service that we'll talk about later. But hopefully they sign up for the program and then we can start the process.

 We really ‑‑ through over the last few years we've increased the referrals from the hospitals. We often have ‑‑ I guess right now we're having quarterly meetings with hospital staff to improve referral processes. That includes management of the hospital and the direct nursing, social work type of staff.

 We've really have developed some improved processes as well where the referral form that the hospital uses to get approval from the patient and refer to us list some information of what the specific needs of that person are as to why they might be referring them to us. And then there's other partners now identified in that referral so it's not just FREED and the Care Transition Intervention program; it's also some other partners that we're going to talk about a little bit later in the program that have been added to that that's helped with streamlining access of services.

 We also have an improved data collection system. The hospital has just gone through a major revision, as many hospitals are, to their data collection system. They have converted over to what's called Cirner. We're seeing improvement there in the data collection to tracking hospital readmissions as well as referral to services.

 We also have improved the process by adding the patient's phone number to their referral page from the hospital so that we actually have someone we can follow‑up with in case we miss them in the hospital and they've already been discharged.

 Ok. So just quick numbers for the CTI Program. To date, we have 451 referrals. So 2013 ‑‑ it started in 2012 but it was the very end of 2012 so our real data starts in 2013. 280 referrals. In 2014 we had 136 referrals, although we went from one full‑time staff a half‑time staff. We're back to a full‑time staff in 2015 and we have 35 referrals. It's a little slow getting going but that has to do with staff turnover and the hospital changing their data system I think has contributed to a lot of that.

We have had 141 individuals complete the CTI Program. That included 82 individuals in 2013, 46 individuals in 2015, and 35 individuals in 2015. Differences in referral and numbers are often owed to the staffing level change. So again, it depends on how much full‑time staff you can dedicate to it, will highly determine numbers and outcome.

 Preliminary outcomes. I think it's important to note that part of our agreement with the hospital not only allows for the referral ‑‑ remember, we cannot because of HIPAA look at their computers and go into their database and see who is in the hospital and read the case notes. I will say that there's other hospitals who have made that happen for the CTI Program, which has greatly reduced referral because then you don't rely on the nurse to refer the individual. Your staff can just go in and look at the data, look at who is in the hospital, what their needs are, what their score is for risk of readmission, and go and meet with those people. But our agreement also allows us the ability to track and report back to the hospital everyone who has been referred to us and everyone who has completed the program.

 We readmission data for the hospital track for 30 days. Now, many of us know a lot can happen after the 30‑day mark but as far as measurement for readmission both for Medicare as well as the hospital just measuring general readmission for everyone, they want to know who has been readmitted within 30 days. So we track readmission 30 days after discharge. Our average readmission rate is 7% from our program. So in 2013 it was 7%; 2014 it was 6.5%. And to date for the first six months it's 7% again.

 You may wonder if holding 7% is good or bad. So the hospital really wanted us to focus on their entire readmission rate. So their readmission rate right now for 30 days after discharge for all populations, regardless of diagnosis or age or paying source is 10 to 10.7%. It ranges around that time.

 It's important I think also to note, though, that those ‑‑ many of the referrals that we're getting from the hospital have much higher readmission rates than the ‑‑ they're the ones that are driving at that 10% readmission rate. So if you look at Medicare data, you'll see things for certain diagnosis, anywhere from 17% to 22% readmission rate for certain diagnoses. And we also just started tracking readmission rates for everyone who is referred to us, which is right around 17%. So readmission rate for everyone that they refer us. But those that enter the program and complete the program, we're at 7%. And the hospital really likes those numbers. They're very happy with them.

 So quickly, I'd like to kind of put a face to this program, tell a little success story for this CTI Program. So the CTI coach had an opportunity to work with the 77‑year‑old woman with multiple co‑existing health conditions. She lived alone and has no family in this area. She has experienced frustration with a lack of answers to her healthcare questions and medications and unease about being alone during an emergency.

 The CTI coach utilized the personal health record to facilitate organization of medications and questions that could later be presented to the primary care provider. Medication reconciliation exposed prescription concerns that were also addressed to the primary care physician on the next visit. Other questions were written down by a consumer so as to easily recall them during the next scheduled visit.

 The CTI coach facilitated initiation of life alerts so the consumer was more at ease, live alone. A referral to FREED's fix it program was initiated by the consumer so that grab bars could be installed in her bathroom to increase confidence in navigating the shower. And the consumer relayed and followed up calls that she felt accomplished and motivated to be her own advocate after reviewing concerns with the CTI coach.

 So I'm going to transition now into promising practices, integrated care coordination for family wellness. This is specifically collaborative coordination, part of the ADRC, that began in January 2014. So the Care Transition Intervention program was the start for this particular collaborative effort between FREED, Dignity Health Foundation, who is funding this program, which is the foundation for our local hospital, and Community Recovery Resources or CoRR, who is a substance abuse and behavioral health provider, and Western Sierra Medical Clinic, one of our federally qualified health clinics.

It focuses on the Care Transition Intervention program but also expanded into patient navigation where there's patient navigators at all three organizations. Currently our Care Transition Intervention coach is also the patient navigator. So not only is she doing the CTI specific program but she's also doing patient navigation.

 So the goal of this is a coordinated care across multiple settings and really support after discharge from the hospital, appropriate patient navigation between primary care, disability and senior services, substance use, treatment, and behavioral health services is the focus of this particular corroboration and grant.

 Again to talk about barriers to care, individuals with disabilities, chronic illness, substance abuse and complex health conditions have the same barriers as those we talked about with CTI with an emphasis on lack of trust in service providers and organizations, homelessness, mental health and behavioral health issues.

 We find that these particular communities are particularly struggling with access to services. And some of the changes with Managed Care, both with who is responsible for providing behavioral health services whether it's the county or the local primary care provider and also ‑‑ yeah, and who is eligible for what, and then there is also a large homeless population who also typically might have mental health issues as well.

 We, again, have long wait times for primary care appointments for Medicaid or Medi‑Cal beneficiaries. We find that there's poor care transition is often associated with hospital readmissions and emergency department visits, research documents ‑‑ research documents lower patient satisfaction and rising healthcare costs due to, one, medication errors, poor communication coordination between providers from inpatient to outpatient settings, and preventable adverse events post discharge.

 So care transition coaching and patient navigation again builds off the no wrong door approach to accessing services. Care transition coach and patient navigators between the organizations and services enable the no wrong door system of referral and care across organizations. And the goal of it is to secure a primary care appointment before discharge. So our hospital has been super interested in patient navigation in general.

 Not everyone's going to want to go into Care Transition Intervention programs. And, frankly, people in the emergency department often are not the target population for the Care Transition Intervention program. So patient navigation means that there are individuals at each organization that's helping the individual navigate not only the medical and healthcare side of it but also the social service, long‑term service and support side of it.

 What the hospital has really wanted to have an emphasis on is that the individual that's been admitted into the hospital, ideally even if they're just in the emergency room, would have primary care doctor appointments secured before being discharged from the hospital. And, indeed, that has shown to help improve readmission rates if that person has that connection. Unfortunately, due to long wait times that has been difficult but we are, through this collaboration, seeing major improvements in this process.

 Our Western Sierra Medical Clinic has done a number of things to improve processes to increase access to primary care doctors. And we're already seeing reduced wait times under our program for individuals to get into a primary care appointment. And just last week I want to say they opened up an urgent care system, which is huge. We did not have that in Nevada County. We had an urgent care but they did not take Medi‑Cal. And often we are talking about Medicaid, Medi‑Cal patients.

 In June 2014, FREED and Sierra Nevada Memorial Hospital developed a second agreement to expand services to include patient navigation. And then in August 2014, we did finally secure our actual office space at Sierra Nevada Memorial Hospital which has dramatically increased the referral process for both the Care Transition Intervention program and patient navigation.

 Patient selection criteria for CTI are that ‑‑ Medicare or actually Medi‑Cal beneficiaries with disabilities, chronic conditions including mental health and substance abuse. Again, the high users of the emergency department and regardless of source of insurance and they also have high rates of readmission to the hospital or recidivism for the emergency department and people in need again of community services and primary care.

 So the way the program works is because FREED has an agreement with the hospital, we already have space at the hospital, we end up being the place of first referral for most cases. So our care transition coach who does the patient navigation goes in meets with the individual while they are still in the hospital. If they identify a need for a primary care ‑‑ that the person needs a primary care or a medical home ‑‑ health home, really, then they refer that person and connect them to a warm handoff to the person navigator at Western Sierra Medical Clinic. If they are identified as having behavioral health or substance abuse issues, they are referred to the patient navigator at CoRR.

 So we, to date, we have 46 patient navigation referrals for this year, 18 to Western Sierra Medical Clinic, five to CoRR, six to other FREED staff, and 17 ‑‑ oh, those are from. 18 referrals to our patient navigator from Western Sierra Medical Clinic because patient navigation is both ways, five from the substance abuse provider CoRR, and six from other FREED staff, and then Sierra Nevada Memorial Hospital has given us 17 referrals to date.

 So we are, again, just beginning to measure readmissions and emergency department recidivism. The interesting, just initial, brand new measuring ‑‑ readmissions for anyone who is referred to the patient navigation program that's readmitted within the 30 days or visited the emergency department within 30 days and we're finding that there's been no readmissions ‑‑ just our initial first month's worth of data collection on that. So I think it's very promising.

 So again, I'm going to give you a quick story to kind of put a face to the individual. If I can find it.

 Ok. To give you an example of patient navigation, the patient navigator who is our care transition coach at FREED worked with a woman in her early 50s who has had a history of mental health issues and substance abuse and has had three brain surgeries. She has been readmitted to the hospital several times over the course of several of the previous six months. She was living in a home that she said was not safe due to her roommate and said that her current doctor wouldn't prescribe the only medication that she said helped her with her anxiety. She also did not have transportation as she crashed her truck while drunk driving.

 At the first home visit she said she wanted to give up. She was wearing a robe and said she didn't see any reason to get dressed. While working with the patient navigator and coach, she became a patient at Western Sierra Medical Clinic and said that she felt like she now has a doctor that not only prescribed the medication that she said works for her but one that truly listens to her. She signed up for Gold Country Lift, the local paratransit provider, and is now able to get to and from appointments. She's referred to CoRR and AA for substance abuse issues and called in June to say that she has been sober for four months and she found a home that she can afford to live in without a roommate. She said she finally feels like herself again.

 So that is a good example of the collaboration between the substance abuse provider, the primary care provider, and FREED.

 So I think it's important with these kinds of programs to really look at things like return ‑‑ potential return on investment. Some quick data. There is a link where you can get additional information. The average community with 50,000 beneficiaries, Medicare could save $4 million annually on hospital readmission costs for every $1 million spent on community‑based interventions.

So I would ask all of you that might be looking at this kind of thing, what's the return on investment?

 And also understanding the penalties involved specifically with Medicare. So the hospitals have been interested in this particular program because they are being penalized. Last I looked it was at .62% penalty at the regular Medicare reimbursement rate. Although I would look at the links for updated information. So to know it's costing the hospitals for readmissions for Medicare recipients.

 I would also ask what the cost savings is for other populations. So while we know that there's a great potential for cost savings for CTI or, I would say, actually patient navigation, for Medicare recipients with the specific diagnosis, associated with high readmission, I would also say that there is a great potential for savings for readmissions or recidivism for the emergency department visits. And also, there is, I think, a great benefit to these kinds of programs for both Managed Care health plans as well as the individual themselves who is on Medi‑Cal. In fact, many of the people we are working with are Managed Care members.

 As we all know, people are getting access to their primary care doctor and are being helped to navigate the system and not ending up in the emergency department or hospital, then there is reduced cost. Also, savings from long‑term increase in capacity and efficiency of community‑based long‑term services and supports. So the fact that we're developing through ADRC initiatives this kind of corroboration, we're leveraging each other's strengths. We're not duplicating services. We're leveraging the minimal funding that we have to create a more robust system with what we have. And I think there is a savings to not only our community and our individuals but to the organizations that are working together. And we see better, you know, individual outcomes from increased long‑term services and supports, collaboration, and coordination in our community.

 So things to think about with these programs is really looking ‑‑ working with the hospital to determine what your baseline readmission rate is going to be to measure your outcomes. So for our hospital, we're not focusing on the Medicare readmission rates because they want to drive down readmissions for everyone, for the entire population. They want to improve health outcomes not just the Medicare population.

 So for us, our baseline is that all readmissions regardless of age, paying source, or diagnosis. And then also looking at the ED visit rates as well. And this is a brand new focus for us that we're currently beginning to go into. We haven't spent a lot of time in the emergency department and our next year's funding will be focusing and shifting more towards emergency department visits or including the emergency department visits.

 Looking at HIPAA Compliant Agreement for sharing hospital readmission and emergency department visits, visit data. How are you going to track this kind of a program? I think what's really critical is that we're able to demonstrate outcomes with programs like this or else how can we tell a funder, tell a Managed Care organization, tell the hospital or our community in general that this is a worthwhile investment for us and our communities? So looking at things of how to track the names of the individuals, the dates for hospitals, original admission, readmission, and also looking for diagnosis for hospital admissions and readmissions.

 So you can really look to see how many of these people are being readmitted for the same diagnosis or maybe they were readmitted within 30 days for a completely different issue that wasn't ‑‑ the original reason they went ‑‑ wasn't the original reason they went into the emergency room and wasn't addressing with the patient coaching. And look at consumer satisfaction with increased access to LTSS. How do you measure the satisfaction of the individual that's going through this process and we're developing these systems for? And how do we through this process look at the gaps and services, the additional consumer LTSS needs? These kind of collaboratives show you the strength and what's working well and also gives you an opportunity to say ‑‑ to really identify where the improvements are needed in the processes.

 So looking ahead, think about a train the CTI coach, looking into getting someone trained in this model or motivational interviewing or SBIRT or other methods, options counseling that can help support the staff members in doing a good job with person‑centered planning and services.

 We're looking to improved referral process. That's always ongoing. It isn't just that you create a process and it works well. We find we create a process, we try it out, and then it's a moving target. There's new staff that come in. And really finding that champion within the hospital, for us we have a particular nurse that's been the champion that has helped make this I think really successful.

 You know, what is going to happen with the expansion of Medi‑Cal Managed Care and our move to managed LTSS? These are the things on the horizon. Right now for both ‑‑ for the patient navigation for FREED, for Western Sierra Medical Clinic, and for CoRR, patient navigation is not a billable service under Medi‑Cal. So we're all doing it because we know it's the right thing because we come across stumbling blocks every day where the doctors are saying: How can I treat the diabetes when the person doesn't have a roof over their head? They don't have access to healthy nutritious food and they don't have transportation. And that's where this collaboration can help that.

 But it's not necessarily a fundable program either. So we're having to ‑‑ under Medi‑Cal we have to look for resources to fund these kinds of initiatives or do some advocacy to get things like that changed.

 We also work closely with the Nevada County health collaborative in Nevada County which is also a group of healthcare providers specifically, some long‑term service and support providers that help us in being more effective with getting better access to specialty care and primary care. We're going to continue our collaboration with FREED, Sierra Nevada Memorial Hospital CoRR. And then we're going to look at investing more in our outcomes for patient navigation. Because we really believe that this is the best practice and that we can prove that we can reduce hospital readmissions or ED visits but we're just starting to collect the patient navigation side of the data and that's going to be critical for us to find to make this program sustainable. And, of course, looking for ongoing funding sources.

 So again, is this something that would be of interest to your local hospital if they're getting penalized, if they're seeing recidivism and readmissions for people on Medi‑Cal that they barely get reimbursed enough to cover costs? Is there Managed Care organizations that's going to be willing to fund these kinds of things through an ADRC collaborative or other foundations that might be interested?

 So with that, I know it's a lot of information, I am going to pass it back over to I believe Mary Lou and we can take some questions.

>> Dave Nold: Thank you very much, Ana. I'm going to pass it on to Silvia Yee. And we will be happy to take your questions. If you would like to type them into the chat box.

 At this point, Anna, if would pass the ball to Silvia, we'll move on with her presentation.

>> Silvia Yee: Hello, everyone. I hope you're able to hear me. We did get an excellent question as we were going through. We are welcome to chat ‑‑ to type in more. I realize we're at the very end. So if you're patient, we'll try to address any questions that come up.

 One person asked ‑‑ indicated that one of the barriers to care transition after discharge is the patient's lack of transportation. Is that addressed somehow by the transition team?

 I think, Ana, in your second example, you did bring up something about that, the patient who indicated that they had crashed their truck and had no more transportation. So I imagine that one of your extended partners are transportation providers.

>> Ana Acton: Yeah. Thank you for the question. I would say that as a major barrier to care. Often the biggest barriers to care besides some of the things I mention ready transportation, housing, which probably isn't a surprise to many of you. So as far as our ADRC partnership goes, we have ‑‑ the most engaged transportation partner is our fixed route, our Nevada County transit department. They are at the table every single meeting working. They understand that transportation is a big barrier. They contract to a paratransit provider. They are another partner of us, less engaged on a month‑to‑month, day‑to‑day basis but that's our major referral source. Many of the individuals we're working with, we are the patient navigator or Care Transition Intervention program is connecting them to paratransit or fixed route transportation services or transportation provided under the Managed Care plan to doctors' appointments.

>> Silvia Yee: Thank you, Ana.

 I'm going to run ahead a little bit. Again, your questions are welcome. This last couple of minutes ‑‑ we have some slides at the end. You can look at them when they're up on our web as well. I've tried to put a lot of citation and information in them.

 Nevada County in California, it's a mandatory Medicaid Managed Care county. It's not yet a managed long‑term services and support county. That is, the two plans that are in the county are not administering LTSS. Nonetheless, even though they aren't, I think collaborations such as the one that has been explored here are still going to be very important to Managed Care.

 One of the reasons ‑‑ I mean ‑‑ Ana and Pam have found their way in as such through hospital and through the hospital's desire to reduce readmission rates.

 In July of this year, CMS proposed a major revision of its Medicaid Managed Care rules. So these are rules that will apply to Medicaid Managed Care organizations. One of the those ‑‑ it's not soup yet. It's not done. It's a draft. There were 60 days of public comment on it. And now the comments have been received and CMS is going over it. Nonetheless, one of their proposals is around care coordination. And the section that you see on the screen talks about an expanded Managed Care organization coordination obligation. So Managed Care organizations have to provide coordination between care settings and with services that are provided outside of what the Managed Care organization is directly responsible for including fee‑for‑service Medicaid benefits such as long‑term service and supports.

 So with that kind of an obligation, I think there's clearly a strong incentive to link up with those organizations, especially community‑based organizations such as the ADRC, ILCs, the Area Agency on Aging, who have been in the community and providing services from a patient‑centered viewpoint for many, many years, to the degree that those organizations are already coordinating, are working together, and can provide a tangible service that Managed Care organizations need. That's a vital and important component of what Managed Care will have ‑‑ will be responsible for. Even if they're not directly administering long‑term service and supports themselves.

 Other implications for community‑based organizations are covered in the slides. Perhaps later in the webinar series we'll have a little more time to address them more fully. But these are just important points to consider and to think about as we move forward.

 One thing that Ana said that struck me as she was describing the process is how community‑based organizations such as the ILCs, the independent ‑‑ organizations that approach from the Independent Living perspective, in a way provide a kind of antidote to the learned helplessness that often comes about when you have institutionalization. It's just a way to address how do people become independent again. In a hospital, of course, or in an institution, they're responsible for making sure someone gets their medication not necessarily for teaching that person how to manage their medication. That's a very big difference. You can see both as patient‑centered. They're meeting the needs of that patient. But one of them has a much more Independent Living perspective and that's what community‑based organizations like ILCs, the AAA agencies, and ADRCs offer, a really invaluable service that way.

 So thank you again for all of your participation and for your patience as we've gone over a little bit. We hope that this webinar proves to be useful to you in your own work.