Department of Health & Human Services

Administration for Community Living

For seniors and people with disabilities

How Care Transitions Impact MOW Programs

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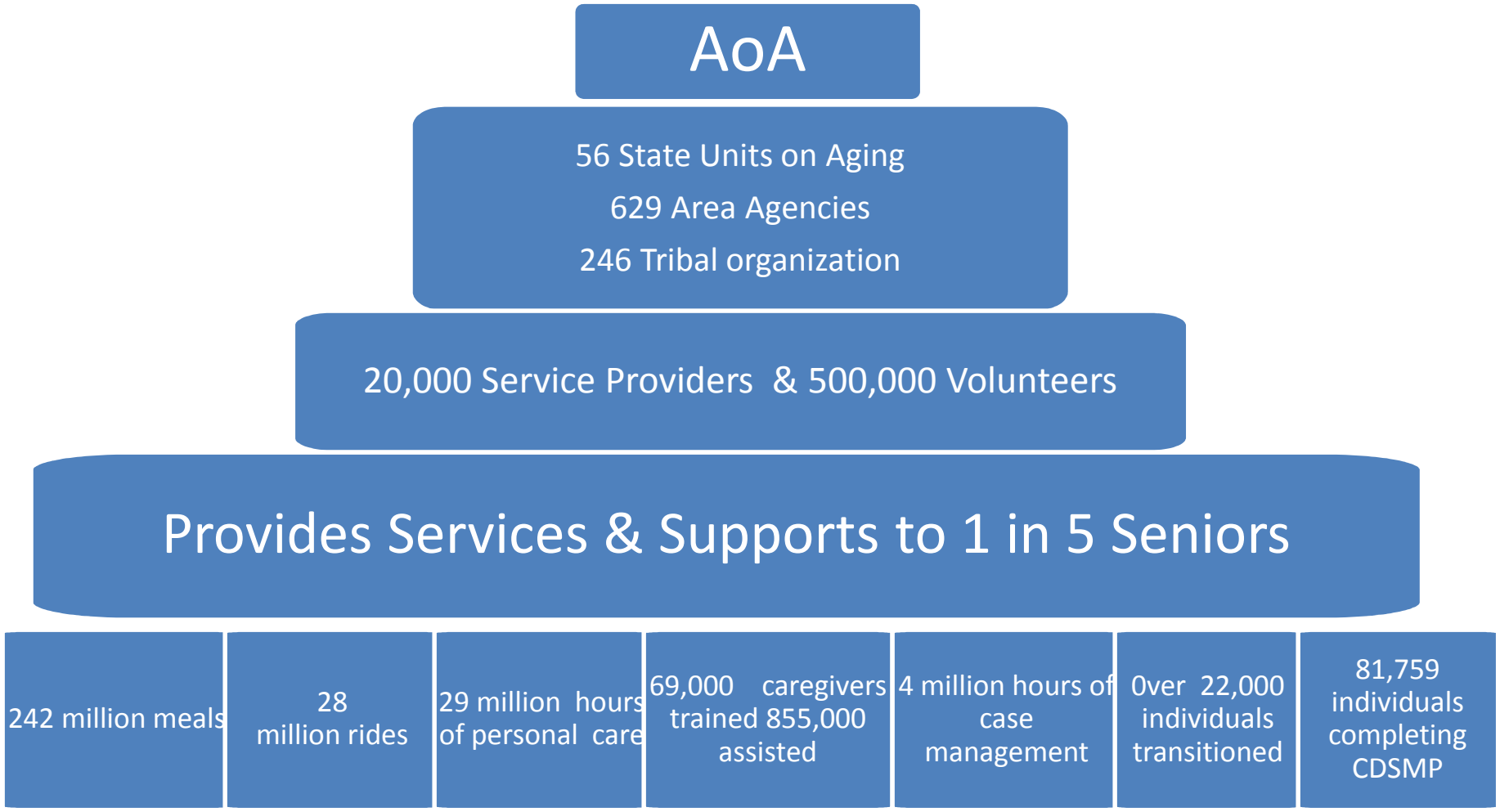
"For too long, too many Americans have faced the impossible choice between moving to an institution or living at home without the long-term services and supports they need. The goal of the new ***Administration for Community Living*** *will be to help people with disabilities and older Americans live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

Overview

- This new HHS Operating Division brings together the Administration on Aging (AoA), the Office on Disability (OD) and the Administration on Developmental Disabilities (ADD)
- This single agency is charged with developing policies and improving supports for seniors and people with disabilities.

AOA and the Aging Network – An Infrastructure that Supports 11 Million Older Adults and Caregivers



Who We Serve:
The Poor and Near Poor

The Aging Network Serves Nearly 1 in 5 Older Adults

	US Population	OAA Clients
60+	57.8 million	11 million*
Poverty	9.30%	**30%**
Near Poor**	15-20%	**73-85%**

*3 million OAA clients receive intense services such as home-delivered nutrition and homemaker services.

**Near poor is defined as below 150% of poverty.

Note: $77,000 per year for private room nursing home care,
$35,000 per year for assisted living (2007 dollars)

Who We Serve:
The Frail & Vulnerable

	US Population 60+	OAA Clients (In Home Service)*
Lives Alone	27%	55% - 69%
Diabetes	22%	26% - 35%
Heart Condition	29%	43% - 53%
Minority**	20%	25%
Rural**	13%	37%

* Includes such services as homemaker, case management, and home-delivered nutrition.
* *US Minority & Rural figure is for the 65+ population

Health & Independence: Nutrition Services

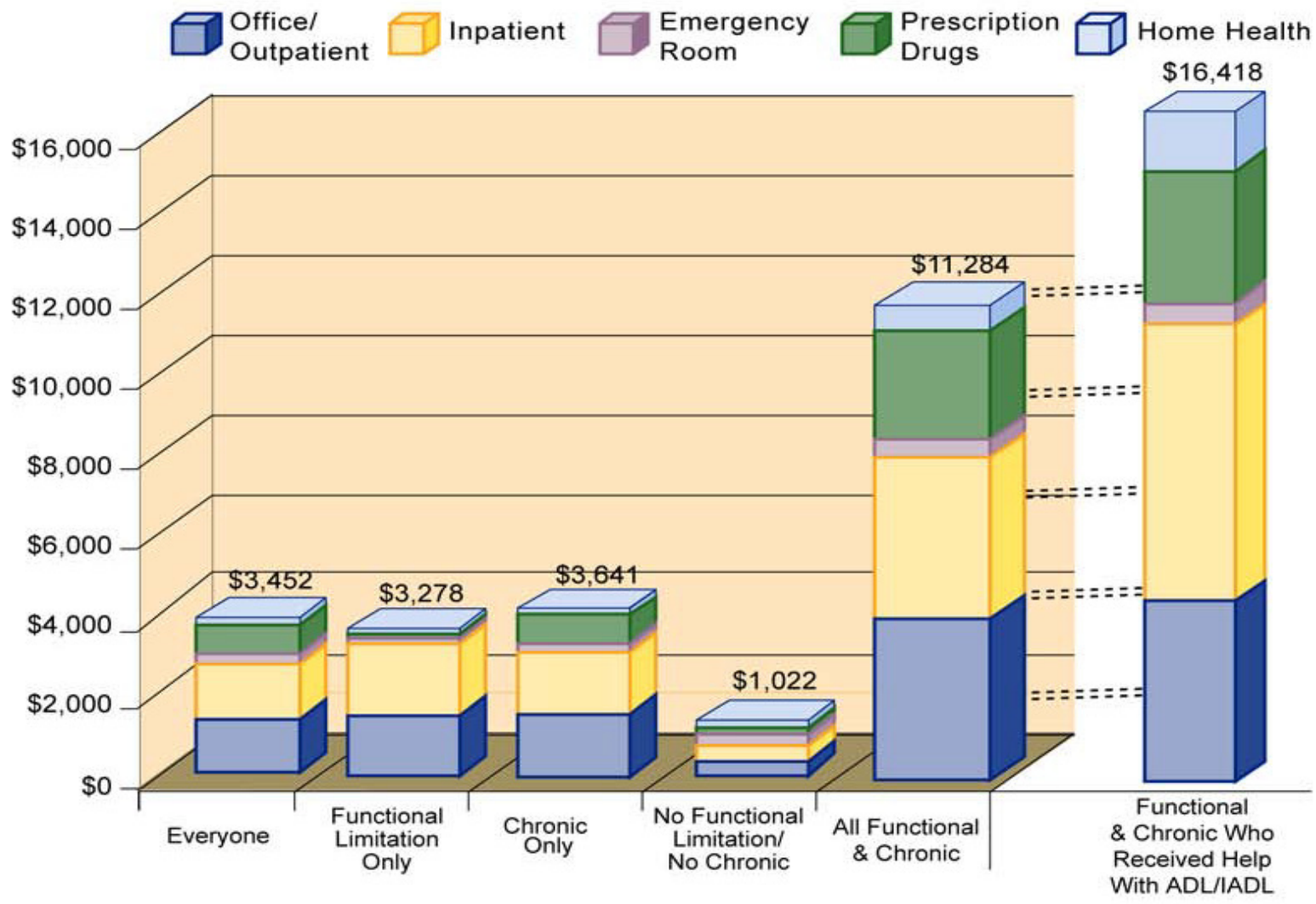
Congregate
Home-delivered
Nutrition Services Incentives Program

- **$1.4 billion in total Federal, State, local and private expenditures**
- **Expenditures/Meal: $6.64 (CN) $5.34 (HDN)**
- **Annual expenditure/Person: $370 (CN) $895 (HDN)**

- Adequate nutrition is necessary for health, functionality and the ability to remain at home in the community.
- 63% of Home-Delivered Nutrition Clients report the meal is half or more of their food for the day. 59% of Congregate Nutrition Clients report the meal is half or more of their food for the day.
- OAA meals are nutritious and meet the needs of seniors with nutrition ameliorated chronic illnesses (diabetes, hypertension, congestive heart failure)
  - Provide 33% of Dietary Reference Intake
  - Adhere to the Dietary Guidelines for Americans.

- In FY 2010, Home-Delivered Nutrition Services provided nearly 145 million meals to nearly 880,000 seniors and Congregate Nutrition Services provided over 92.4 million meals to more than 1.7 million seniors in community settings.
- In FY 2010, 48.5 thousand nutrition counseling and 2.5 million nutrition education sessions were provided.
- Researchers estimate that food insecure older adults are so functionally impaired it is as if they are chronologically 14 years older, 65 year old food insecure individual is like a 79 year old chronologically.
- Malnourishment declines upon receiving HDMs. Participants who no longer eat fewer than two meals a day decreased by 57%.

Average Spending by Type of Service for Select Groups
2006



Source: The Lewin Group analysis of 2006 Medical Expenditures Panel Survey, 2009

Source: *Individuals Living in the Community with Chronic Conditions and Functional Limitations: A Closer Look.* Report by the Lewin Group prepared for the Office of the Assistant Secretary for Planning and Evaluation. 2010.

Care Transitions: The Problem

- Transition from one source of care to another is a moment with high risk for communications failures, procedural errors, and unimplemented plan.
- People with chronic conditions, organ system failure, and frailty are at highest risk because their care is more complicated and they are less resilient when failures occur.
- Strong evidence shows that we can significantly reduce hospital readmissions caused by flawed transitions.

Home and Community Based Services and Hospital Readmissions

- In a study evaluating the home food environment of hospital-discharged older adults, 1/3 of participants reported being unable to both shop and prepare meals
- Greater volume of attendant care, homemaking services and home-delivered meals is associated with lower risk of hospital admissions

Anyanqu, Ucheoma O., Sharkey, Joseph R., Jackson, Robert T. (2011) Home Food Environment of Older Adults Transitioning From Hospital to Home. *Journal of Nutrition in Gerontology and Geriatrics* 30:105-121.
Xu, Huiping et al. (2010) Volume of Home-and Community-Based Medicaid Waiver Services and Risk of Hospital Admissions. *Journal of American Geriatric Society*

Safe, Effective Transitions Require:

- Patient and caregiver involvement
- Person-centered care plans that are shared across settings of care
- Standardized and accurate communication and information exchange between the transferring and the receiving provider
- Medication reconciliation and safe medication practices
- The sending provider maintaining responsibility for the care of the patient until the receiving clinician/location confirms the transfer and assumes responsibility.

Care Transition Themes: How Do They Relate to The Older Americans Act (OAA)

Interdisciplinary Teams & Service Coordination

- Coordination of services (medical/ human services)
- Workforce development and training
- Planning
- Partnerships
- Coordination of benefits

Enhanced Follow-Up

- Case Management/ Care Coordination
- In-home services
- Home-delivered meals
- Transportation
- Monitoring/assistive devices
- Medication management
- Disease prevention & health promotion

Patient/Client Activation

- Assessments
- Self-directed care/coaching
- Health/nutrition education
- Insurance counseling
- Family caregiver support, counseling, training

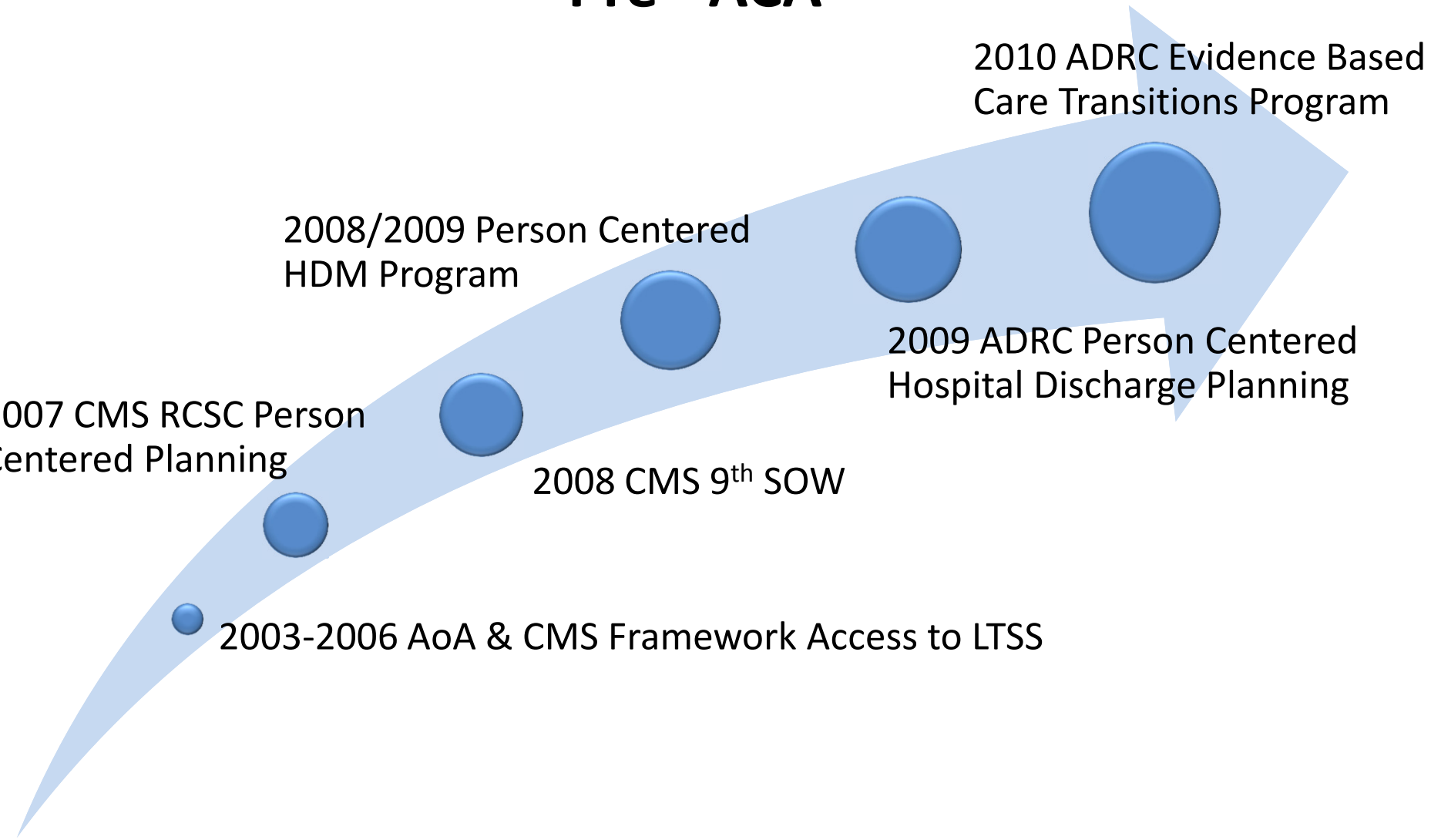
Why the Work of MOW is so Critical to Care Transitions

- Unique and trusted position in the community for over 30 Years
- Knowledge of community services
- Knowledge of elders and caregivers
- Service provision skills
- Quality assurance and outcomes

Why Care Transitions is so Critical to the Mission of MOW

- Core mission of maximizing independence for at-risk Elders
- Need to engage in changing long-term care landscape
- New revenue stream
- Existing program participants are high risk for Readmission

ACL CMS Investments in Care Transitions
Pre - ACA



ADRC Evidence Based Care Transition Program

- **Current Status:** 93 ADRC sites partnering with 242 hospitals in 27 states

- **ADRC Care Transition program readmission rate = 8.2% (n=17 sites)**

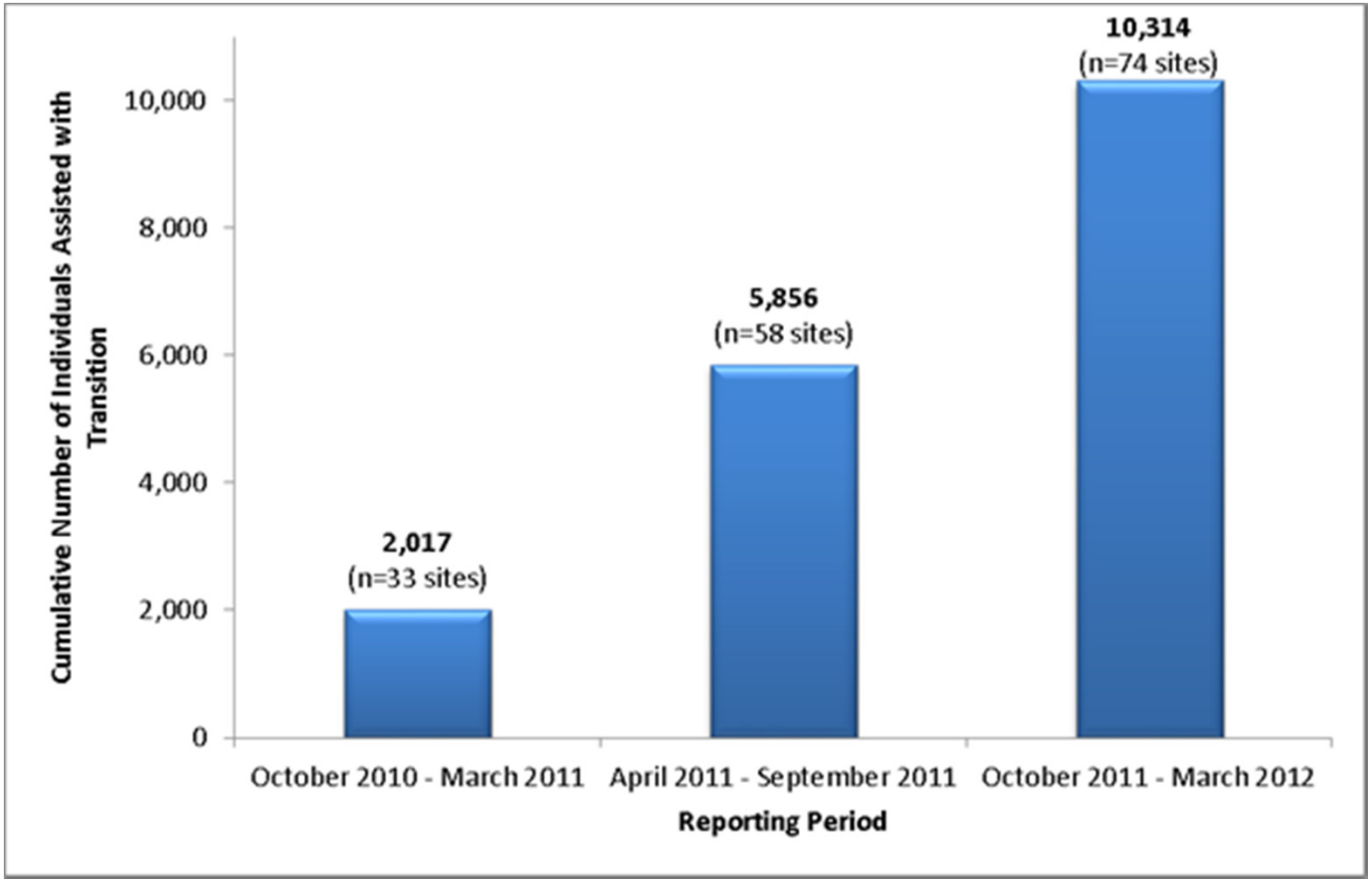
- ADRC Care Transition sites are implementing a variety of different evidence based programs, including:
  - Care Transitions Intervention®
  - Transitional Care Model
  - Project BOOST
  - Bridge
  - GRACE
  - Guided Care ®

- **2010 Option D: ADRC Evidence Based Care Transition Program**
  - 16 States received grants
  - Total Amount Awarded: $6.4 Million

Source: ACL Semi Annual Report Data October 2010- March 2012

Number of ADRC Evidence Based Care Transition Program Participants

(n=74 sites[1])

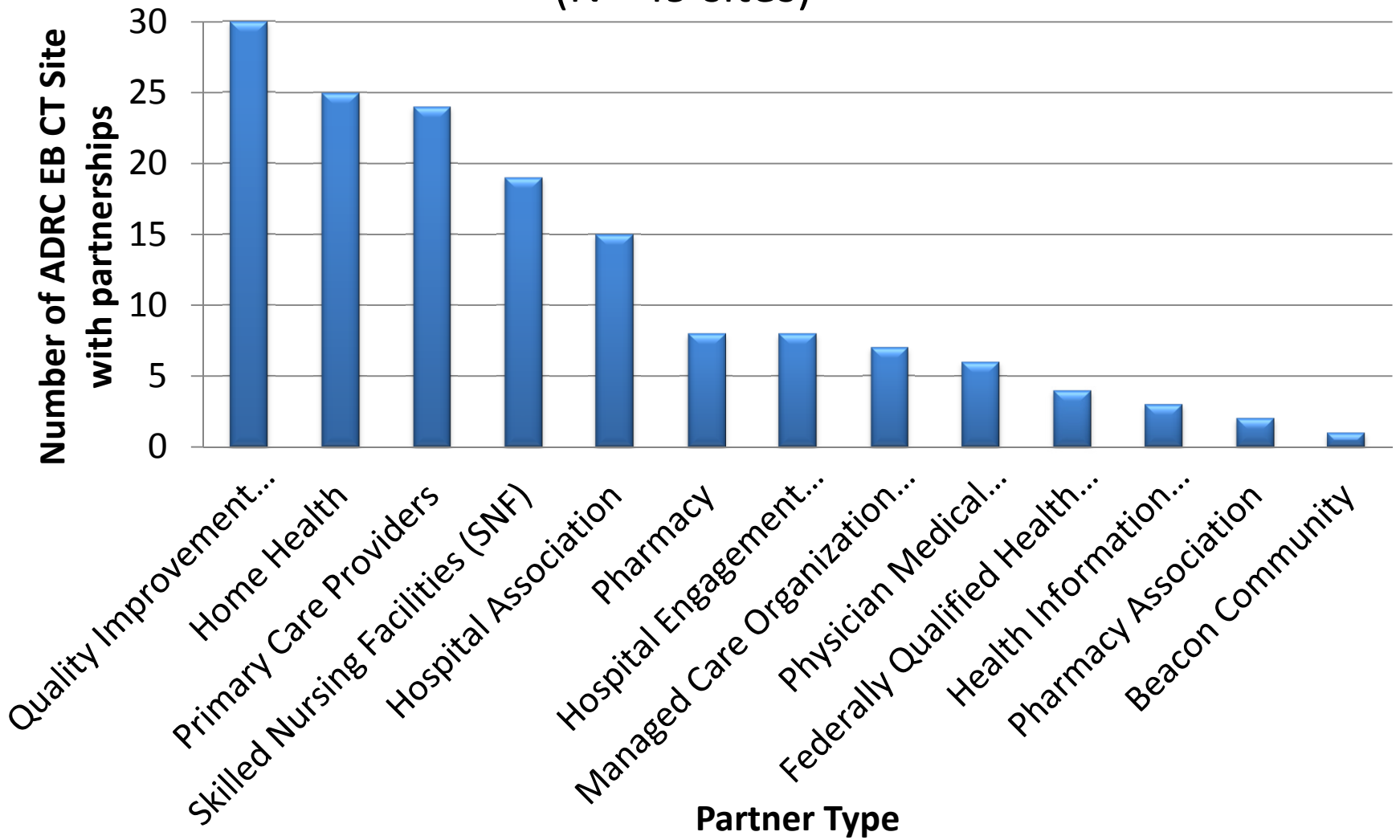


[1]Not all sites reported in all reporting periods

Source: ACL Semi Annual Report Data October 2010- March 2012

ADRC Care Transitions Partnerships

(N= 49 sites)



Source: ACL Semi Annual Report Data October 2010- March 2012

Referrals to Long Term Services and Supports

(n=64 sites[1], Total # Referrals = 7,515)

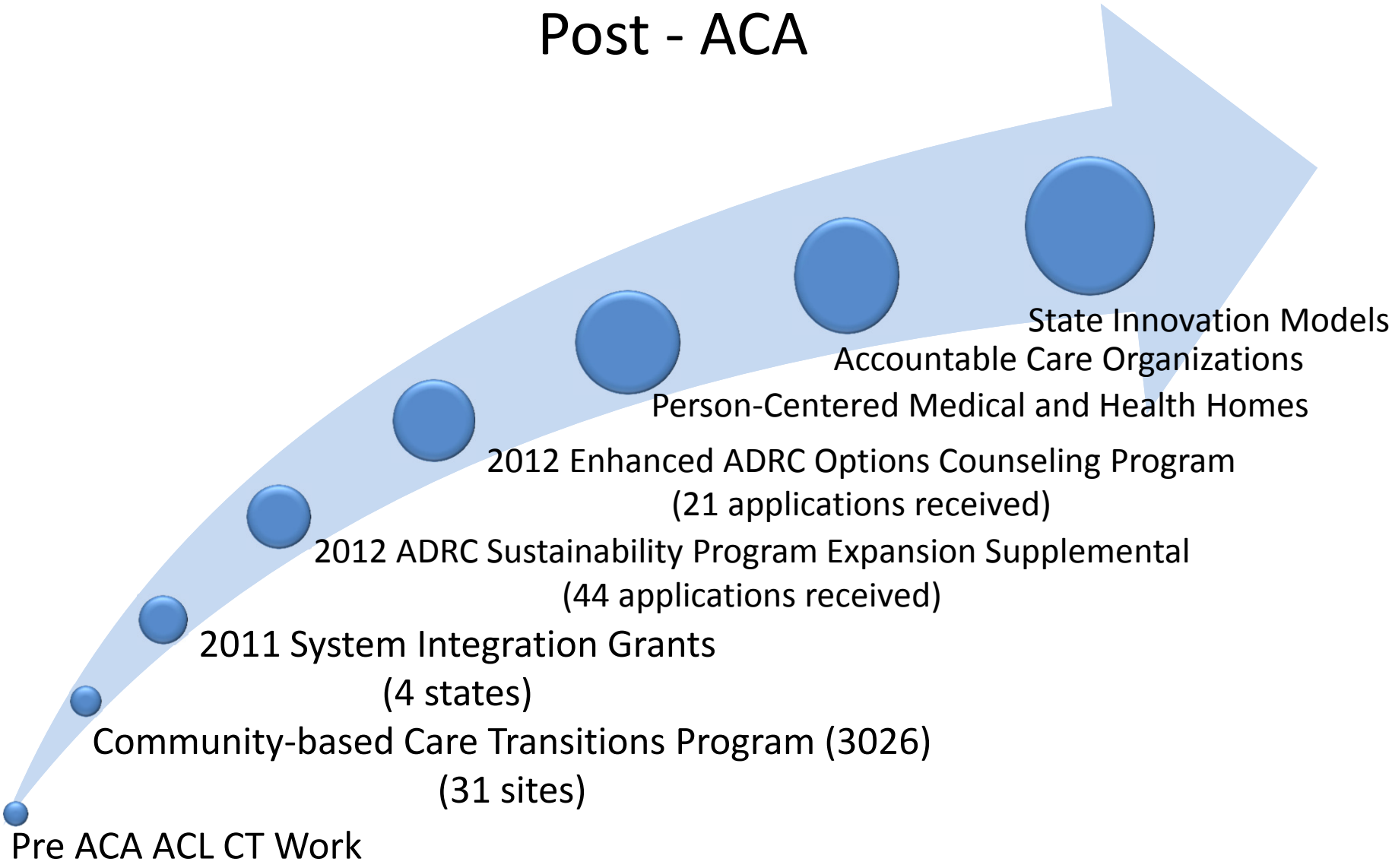
Adult Day Care	Home Health
Alzheimer's Programs	Home Injury/Risk Screenings*
Adult Protective Services	Housing Assistance
Blood Pressure Monitor	IHSS
Care Management	Legal Support
Caregiver Support*	Low cost RX program
CDSMP	LTC Assistance
CHF Education	Medicaid
Dental Care	Medication Management
DSMP	Mental Health and Substance Misuse*
Exercise Program	Nutrition Services or Counseling
Falls Management and Prevention*	Personal care/ homemaker/ choremaker
Financial Services	Rx coverage
Food stamps/food bank	Smoking Cessation
Health Eating	Social Security
Health Information	Telephone Reassurance
Home Delivered Meals*	Transportation*

Source: ACL Semi Annual Report Data April 2011-March 2012 [1]Not all sites reported in all reporting periods

Success Story: Pennsylvania

- Partnership between Delaware County ADRC and Crozer Keystone Health System
- Mary Naylor Transitional Care Model
  - Partnership designed a team based approach: Hospital provides Nurse Assessor, ADRC provides Options Counselor
  - Original 2 year goal was to serve 235 participants
    - Served 355 participants within 13 months
- ADRC CT Program Readmission Rate = 7%
  - 47% reduction from baseline
- **ACL investment of $400,000 yielded <u>$3 Million in Savings</u>**
- State provided special funding to purchase supplies, equipment, and services for participants not covered by existing programs
  - Examples: Talking scale for a consumer with a visual impairment and CHF to monitor weight; Air Conditioner; Stair Rides
- ADRC CT data was cited in successful CCTP application

ACL CMS Investments in Care Transitions Post - ACA



ACL Care Transitions Resource Page

- New webpage for organizations looking for care transitions program information within the Aging Network
  - Toolkit and webinars
  - Funding opportunities
  - Basics and background
  - Publically available technical assistance resources

Available from AoA's Tools and Resources webpage:
http://aoa.gov/AoARoot/AoA_Programs/Tools_Resources/index.aspx

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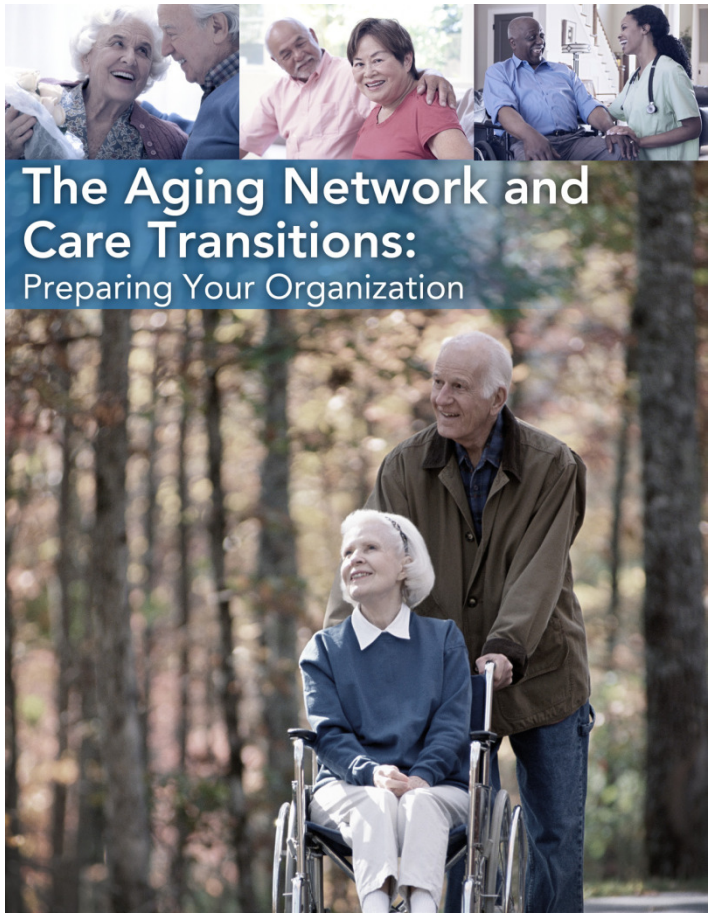
Care Transitions Toolkit



Chapter One: Getting Started

Chapter Two: Taking Time to Plan

Chapter Three: Developing Effective Partnerships with Health Care Providers

Chapter Four: Measuring for Success

Chapter Five: Building Organizational Capacity

Chapter Six: Implementation and Day-to-Day Operations

http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx

Technical Assistance:

Quality Improvement Organizations (QIO)

- Coalition/charter building
- Root Cause Analysis
- Social Network Analysis
- Measurement strategy and data analysis
- Logic model development
- Learning and Action Networks
- Webinar learning sessions and archives

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

ICPC
Integrating Care for Populations & Communities

http://www.cfmc.org/integratingcare/Default.htm

Resources: Care Transitions

- http://www.healthcare.gov/center/programs/partnership/index.html (Partnership for Patients)
- http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313 (Community-based Care Transitions Program)
- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform web page)
- http://www.adrc-tae.org/tiki-index.php?page=CareTransitions (AoA's Aging and Disability Resource Centers and care transitions)
- http://www.cfmc.org/integratingcare/ (Care Transitions Quality Improvement Organization Support Center)
- http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Innovative-Communities-Report-Final-0216111.pdf (Innovative Communities report from the Long-Term Quality Alliance)

Resources: Affordable Care Act

- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform web page)
- http://www.healthcare.gov (Department of Health and Human Services' health care reform web site)
- http://www.thomas.gov/cgi-bin/bdquery/D?d111:1:./temp/~bdsYKv::|/home/LegislativeData.php?n=BSS;c=111| (Affordable Care Act text and related information)