

Project Narrative

Summary/Abstract: The grantee, Oregon's Division of Seniors and People with Disabilities (SPD) supports this three year ADRC grant in partnership with Northwest Senior & Disability Services (NWSDS), Oregon Cascades West Council of Governments (OCWCOG), and other key organizations. The goals of this project are: 1) expand ADRC services to 30 percent of Oregonians, 2) complete a 5-year Strategic Plan to operationalize ADRCs statewide, and 3) support the implementation of best practices to improve transitions of Medicare beneficiaries across care settings and reduce unnecessary hospital readmissions. For Goal 1, the main objective is to strengthen the capacity of NWSDS and OCWCOG to meet the criteria for a fully functioning ADRC. For Goal 2, the main objective is to complete a gap analysis that prioritizes the work that must be completed at the local and state level to ensure a statewide ADRC system. For Goal 3, the main objective is to host a Transitional Care Collaborative that promotes strategies to address care transition issues for representative from hospitals, physician offices, home health agencies, AAA staff and others. Main outcomes include 3 AAAs that meet the criteria for a fully functioning ADRC, a comprehensive Strategic Plan for AoA and for use in the 2011 legislative session, and an increase in referrals from hospitals and physician offices to local Options Counseling and Transition Coaches. The products from this project are documented "lessons learned" while phasing in new technology, services, and staffing requirements to support a local ADRC, change packages for implementing Transitional Care Best Practices, abstracts for national conferences, and any final reports required by the Administration on Aging.

Current Status of State's ADRC or ADRC-Type Programs

Since Fall 2007, SPD and Oregon's AAAs have been planning for a comprehensive, statewide system to provide Oregonians of all ages and income levels with easy access to information about long-term services and supports and guided assistance to choose those that are both important to and for the individual. In 2008, SPD was awarded a Real Choices Systems Change grant from the Centers for Medicare and Medicaid Services (CMS) to develop a prototype ADRC and person-centered hospital discharge model in Lane County. During the 2009 session of the Oregon Legislature, House Bill 2391

was introduced to fund statewide expansion of ADRCs. The bill remained active throughout the session but ultimately died due to the severe budget issues related to the economic downturn. Despite this setback, the issue received several hearings and was championed by several legislators who are committed to re-introducing the legislation in the next session.

The lessons learned during the first year of the Real Choices grant have informed us about the challenges we need to address to have a statewide system of fully functioning ADRCs. In the area of *Information and Awareness*, an evaluation of Oregon's current web-based resource database for consumers indicated that its current configuration falls short of meeting our needs for a fully-functioning ADRC. It also lacks a call module to support I&R/A services. We have convened a statewide IT Committee to determine end-user requirements for both products so that we can solicit bids for a statewide system that will meet our future needs. We also need to determine if regional call centers and call routing technology are feasible approaches to support smaller AAAs with limited I&R/A staff capacity. In the area of *Options Counseling*, we need to equip current staff with the knowledge, skills and mind-set to address the needs of private pay consumers and to meet the requirements for AIRS certification. In the area of *Streamlined Access*, we need to pursue IT capacity that supports on-line applications for publicly-funded programs at multiple sites and can "talk to" the state database that currently houses Medicaid recipient data. In the area of *Person-centered Hospital Discharge Planning*, we believe there is good evidence that the risk factors for a hospital re-admission are similar to those that put a person at-risk for a nursing home placement, and we think the model we will pilot in Lane County shows promise for addressing both concerns. However, AAA staff will need a core set of skills and competencies to be effective partners with health care providers. In the area of *Quality Assurance and Evaluation*, we have a statewide Real Choices Advisory Council composed of diverse stakeholders and consumers in place. (See Attachment A.) We need to expand their charge to include oversight for components of a statewide ADRC system such as mandatory core services, staffing ratios, performance goals, IT infrastructure, etc. We need to ensure that consumer satisfaction data that measures visibility, trust, ease of access and responsiveness is routinely collected at the local level, reported out and used for

quality improvement. We need to establish performance goals and indicators for efficiency and effectiveness.

New grant funds will enable us to address these challenges at the same time that we establish new ADRC services. To support the work described below, we intend to leverage resources from the Real Choices Systems Change grant in areas such as IT procurement, marketing, staff training and working with local health care systems to reduce unnecessary hospital readmissions or nursing home placements.

Proposed Project

Goal 1: Extend ADRC services to 30 percent of Oregonians.

Objectives:

Strengthen the capacity of two additional AAAs to meet the criteria for a fully functioning ADRC by:

- Installing the proposed web-based resource database and call module in nine counties.
- Preparing AAA staff to meet AIRS certification standards and function as Options Counselors.
- Investing in emerging telephone call routing technology to support regional I&R/A call centers.
- Providing summary qualitative consumer data to inform local marketing and outreach activities.
- Providing baseline consumer satisfaction data that measures visibility, trust, ease of access and responsiveness.

Outcome:

By January 2011, at least 3 AAAs meet the criteria for a fully functioning ADRC and are using consumer satisfaction data to measure visibility, trust, ease of access and responsiveness.

To achieve this goal, SPD will partner with OCWCOG and NWSDS. Together with Lane County Council of Governments (LCOG) these AAAs cover nine contiguous counties in the Willamette Valley. A combination of factors makes this an ideal partnership for moving the ADRC concept forward in Oregon. This geographic area includes a mix of urban and rural communities and is very representative of the rest of the state. (See Table 1, Attachment B.) These AAAs manage the existing OAA funding through contracts and through direct operation of the Information and Assistance and Outreach Services,

Senior Nutrition Programs, including Home Delivered Meals, and the Family Caregiver Program. They have a long history of maximizing their “buying power” by negotiating contracts for nutrition and in-home services through a consortium. All three AAAs also manage the Medicaid Long Term Care Program for both older adults and people with physical disabilities.

Based on their ADRC Readiness Assessment survey results, both OCWCOG and NWSDS have identified the need to address I&R/A, outreach and marketing, the complete array of Options Counseling services and concomitant staffing modifications in order to reach the goal of fully functional status. Both AAAs are moving toward an integrated I&A and Outreach service to more fully address the needs of both private pay consumers and those eligible for public benefits. Their work in this area will lead to the development of AIRS-certified staff units and the integration of short-term case management and enhanced community partnerships to assist consumers with complex financial, legal and medical questions that can be more appropriately addressed by other organizations. We can accelerate the AAAs efforts to become fully-functioning ADRCs by integrating them into the work already underway with LCOG. For example, the AAAs are ready to use a web-based call module that allows for easy and reliable uploading of community resources from external partners and that generates reports that document services provided and support program planning. They will benefit from access to staff training opportunities. Likewise, SPD will benefit from economies of scale related to training costs or negotiating licensing costs with IT vendors. SPD will benefit from having a larger population to draw on for social marketing activities. We will all benefit from the opportunity to test the use of emerging phone routing technology to support regional call centers or small, rural program offices.

Goal (2): Complete a comprehensive five-year strategic plan to operationalize ADRCs statewide for submission to the Administration on Aging.

Objectives:

- a) Complete a gap analysis that prioritizes the work that must be completed at both the local and state level to ensure a statewide system of fully functioning ADRCs and the dollars needed to achieve that goal.

- b) Ensure that the strategic planning process includes input from key stakeholders and consumers on all decisions that affect ADRC visibility and performance statewide.
- c) Ensure that the Plan includes a reliable methodology for determining and measuring performance goals and indicators.
- d) Implement the Strategic Plan.

Outcomes:

By February 2011, a five year strategic plan has been submitted to AoA and is available for use during the 2011 legislative session.

To achieve this goal, we will expand the existing Advisory Council's charge to include oversight for the strategic plan. We will align the planning process with the assessment of the state's aging network and service delivery system called for in Oregon's 2009-2013 State Plan on Aging. Oregon has already built a strong foundation for this work. In addition to the aforementioned SPD/AAA joint planning effort in 2007, Oregon Senate Bill 1061, passed in February 2008, codifies planning directives to SPD related to the development of a long-range plan for a non-Medicaid long term services and support system based on early intervention and prevention services, and providing a single point of entry to the entire aging and disabilities network.

Goal 3: Support the implementation of best practices to improve transitions of Medicare beneficiaries across care settings and reduce unnecessary hospital readmissions or nursing home placements.

Objectives:

- a. Host a Transitional Care Collaborative that promotes strategies for addressing specific transition issues for representatives from hospitals, physician offices, home health agencies, AAAs, and other community organizations that provide long-term care services to Medicare beneficiaries.
- b. Prepare AAA staff to function as Transition Coaches, as defined by the Care Transitions Program.
- c. Strengthen referral mechanisms between hospital and physician office staff and Options Counselors/Transition Coaches.

Outcome:

By August 2012, referrals from hospitals and physician offices to local Options Counseling and Transition Coach Services have increased 10 percent from a 2010 baseline.

To achieve this goal, we will partner with other stakeholders (e.g., Oregon Association of Hospitals and Health Systems, Oregon Patient Safety Commission, O4AD) to design and market the Transitional Care Collaborative and to plan and conduct a series of approximately 6-8 Shared Learning Sessions during the 36-month grant period. These Learning Sessions will be open to staff from hospitals, physician offices, home health agencies, AAAs, and other community organizations within the nine counties. Each session will address a specific transitional care topic (e.g., medication reconciliation, assessing patient health literacy, assessing caregiver capacity, communication links between hospitalists and primary care providers.) Keynoters will be drawn from health care providers who are working on solutions to transition issues. Learning session content and "success stories" from participants who have implemented best practices will be summarized into Change Packages and disseminated to participants and other interested parties.

Each session will also provide an opportunity for cross-fertilization of ideas for system changes in local communities. We will use the person-centered hospital discharge project already underway in Lane County as a model. Key features of that project include screening on admission to identify patients at high risk for readmission or nursing home placement, referrals to a hospital-based Medicaid case manager, post-discharge phone calls to assess the status of the hospital discharge plan and, when indicated, referrals to a "Community Health Navigator" (CHN) who can complete an on-site observation and initiate interventions to reinforce the discharge plan. In the current model, the CHN is an AAA staff member who is also connected to the prototype ADRC.

Concurrently, we will equip AAA staff members with the knowledge and skills to function as "Transition Coaches" through arrangements with the Care Transitions Program at the University of Colorado at Denver. We intend to leverage grant funds from the Real Choices grant with new grant dollars to host a Level 1 Care Transition Intervention Training for approximately 30 participants. By

having staff available that are trained in an evidence-based intervention, we can address any concerns that health care providers might have about their credibility as a trusted community resource. This will support efforts at the local level to build functional referral links between hospitals and physician offices to Options Counselors/Transition Coaches. To sustain this skills-set we also plan to identify staff that has the background and experience to advance to Level 3 as Train-the-Trainers.

The proposed Transitional Care Collaborative has the potential to improve transition services delivered to a substantial number of Oregon Medicare beneficiaries. Of the combined population (1,159,892) for the nine-county area served by the three AAAs, an estimated 13 percent (150,786) are 65 years and older. However, that percent ranges within the nine counties from a low of 11.3% to a high of 19.4%. (See Table 1, Attachment B.) The health care system that serves this Medicare population includes 19 hospitals of which 11 are affiliated with a not-for-profit entity that employs its own physicians to staff outpatient and specialty care clinics. (See Table 2, Attachment C.) These entities have implemented various care coordination models within their outpatient clinics with special focus on patients with chronic conditions. For example, two entities (PeaceHealth, Samaritan Health Systems) have dedicated staff to coordinate Stanford's Chronic Disease Self-Management program for their patients.

SPD is well-positioned to undertake the work for the following reasons: 1) we have the full support of key statewide partners as evidenced by letters of commitment. 2) Both OCWCOG and NWSDS have established relationships with their local health care systems and have already initiated discussions about co-location of staff. 3) We have a liaison with the CMS-funded "Stepping Stone" project in Whatcom County, Washington through our Real Choices hospital partner that provides an opportunity to share "lessons learned" across the two sites. And finally, the 2009 Oregon legislature created the Oregon Health Authority which will establish a common definition and standards for integrated health homes (i.e., medical homes) as well as processes to certify health care practices as integrated health homes. The goal is to strengthen the effectiveness of primary care services, improve care coordination and health outcomes, increase the focus on prevention and disease management, improve the

quality of care delivered, and contribute to reducing the cost of health care. This statewide effort will provide a supportive environment for our work with physician offices.

Summary statement of changes made as a result of this project:

In the area of *Information and Awareness*, the partner AAAs will have an integrated web-based resource database and call module that improves their capacity to respond efficiently to consumer requests. A public-facing web-site that meets current industry standards for accessibility, usability and security will be maintained for consumers. Current I&R/A staff competencies will be upgraded to meet AIRS standards and the services that staffs provide will assume a higher priority in organizational decisions. In the area of *Options Counseling*, using a standardized staff training curriculum the AAAs can ensure that consumers have access to consistent, objective, and trustworthy information to help plan for their needs for long-term services and support. In the area of *Streamlined Access*, the AAAs will have models for formalized agreements between local partners that provide a full range of services to support Options Counseling, common intake processes and shared standards for information and assistance. In addition, we will have a technical solution for migrating client eligibility data into the existing state Medicaid database. In the area of *Person-centered Discharge Planning*, health care providers will have access to credible community-based resources that can augment their patients' clinical care plans. In the area of *Quality Assurance, and Evaluation*, the proposed call module will produce reports that the AAAs can use for program monitoring and development purposes (e.g., volume, demographics, gaps in resources, etc.). They will have baseline data against which to measure performance.

Quality Assurance Evaluation and Reporting

We are aware that other ADRCs have developed effective methods, systems and tools for evaluating performance goals and indicators. Grant funds will be used to retain an evaluation consultant to review those best matched to Oregon's configuration of rural and urban AAA locations. The consultant will recommend a standardized set of provider and consumer satisfaction survey questions that address ease of access, visibility, trust and responsiveness as well as survey methods that will garner the highest response rates. The consultant will collect and summarize baseline satisfaction data within the nine-

county region. The consultant will review Oregon's existing methods for measuring the results of nursing home diversion and transition activities and recommend a methodology to support on-going measurement of effectiveness and efficiency performance goals.

The AAA partners have agreed to provide staff time and data to assist with completing the voluntary, semi-annual quantitative outcomes data.

Project Management

Key partners and their roles are as follows: *The State Unit on Aging (SUA)* will employ a full-time project coordinator who will be responsible for planning, organizing and managing the ADRC program activities in the AAA service areas. Other key responsibilities include oversight for any Requests for Proposal and subsequent contract management, acting as primary staff to the statewide advisory council, translating program findings and outcomes into policy and operations recommendations, and preparing and submitting required reports. (See Attachment D for a complete job description.) There are no known obstacles to filling the position within six months. *Oregon Cascades West COG & NW Senior and Disability Services* will be responsible for implementing the project in their multi-county service areas. Both AAAs have consumers representing their service areas on the statewide advisory council and are committed to maintaining this representation. Both agencies have identified key staff (e.g., quality assurance and IT support staff) to work directly with the SUA's project coordinator and will provide on-site work space for the project coordinator.

The partners will meet monthly, or more often as necessary, to review progress on work plan activities, identify barriers to completion, and assign responsibilities for related interventions. They will summarize "lessons learned" as key elements (e.g., web-based call module) are phased into local program sites that can be used to inform similar work as a statewide ADRC system is implemented.

Organizational Capability Statement

The Department of Human Services (DHS) Division of Seniors and People with Disabilities (SPD) will serve as the lead agency and fiscal agent for the project. DHS/SPD as the Medicaid agency and State Unit on Aging for the State of Oregon has demonstrated capacity to manage complex programs

Oregon's State Unit on Aging Application

and has internal controls in place to assure compliance with applicable laws and regulations. More information about the current capacity of SPD, OCWCOG and NWSDS and vitae for all relevant personnel can be found in Attachment E. The principle investigator/project manager will be Elaine Young, manager of the State Unit on Aging.