

Issue Brief No. 2***A Promising Collaboration:****FREED Center for Independent Living, Grass Valley, California and the Area Agency on Aging, Sacramento, California**

This Issue Brief is the second in a series of three that explores how collaborations between Independent Living Centers (ILs)—community-based, cross-disability, non-profit organizations that are designed and operated by people with disabilities¹, —and one or more community partners can improve health, reduce unnecessary emergency department (ED) visits and hospital admissions, and promote safe and stable community living for people with disabilities and older adults while also reducing costs.² IL community partners in these promising collaborations include Managed Care Organizations (MCOs), Aging and Disability Resource Centers (ADRCs), medical and behavioral health care providers, and other community-based service organizations. (Visit dredf.org/healthcare-access/ to read the series.)

Context for Collaboration

The healthcare system in the United States is in a state of transition, as innovations spurred by the Affordable Care Act (ACA) disrupt longstanding practices and move healthcare providers toward shared accountability for health outcomes and value. New payment structures are spreading financial risk more widely, for example, by introducing new forms of capitation and incentive payments for reduced utilization, patient satisfaction, and positive health outcomes. Now, payers and providers who perhaps never gave much thought to

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patients' lives outside the formal healthcare system are beginning to see reflected in their own bottom lines the impact of social and environmental factors on health and access to care. In addition, there is an increasing focus on better care for people in high-risk situations, both to improve outcomes and reduce avoidable costs. In light of this changing environment, collaborations like the one between the FREED Independent Living Center and health care and other community services partners illustrate both the potential benefit for people with disabilities and older adults and opportunities for reducing healthcare costs.

Aging and Disability Resource Collaborative (ADRC)

In 2011, the Area Agency on Aging located in Sacramento, California and FREED Independent Living Center 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 long-term services and supports (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 primarily on people with long-term chronic conditions and disabilities. These individuals often experience support and LTSS needs that change frequently and that sometimes cannot be met adequately or in a timely way. Such service gaps can lead to frequent ED visits, hospitalizations, and skilled nursing facility referrals.

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
Traumatic Brain Injury (TBI)	7
Dementia	3
None	254
Unknown	1373

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

- **Care Transitions Intervention (CTI)[®] and Integrated Care Coordination:** A Collaboration to decrease hospital readmissions that initially included Sierra Nevada Memorial Hospital (SNMH) and FREED. Western Sierra Medical Clinic (WSMC) and Community Recovery Resources (CoRR) joined the collaboration later.
- **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 Transitions Intervention (CTI)[®] and Integrated Care Coordination programs.

Care Transitions Intervention (CTI)[®] and Integrated Care Coordination

Care Transitions Intervention (CTI)[®]

The Care Transitions 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 Care Transitions Intervention (CTI)[®] model, created by Eric A. Coleman, MD, MPH, also known as the Skill Transfer Model[™], The Coleman Transitions Intervention Model[®], and the Coleman Model[®] 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.³ ADRC's 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 following discharge. 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 Administration for Community Living (ACL) of the U.S. Department of Health and Human Services supported a full-time Care Transitions Coach[®]⁴ to implement the program and a program director who helped develop the critical relationship with Sierra Nevada Memorial Hospital. ACL serves as the Federal agency responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and people with disabilities across the lifespan.⁵

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

Individuals 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 (ACA) 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 travel time required to visit different healthcare practitioners.

Some people are especially isolated from care such as individuals with limited incomes 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 staff members who provide CTI[®] services have received training in the Independent Living philosophy and in person-centered planning.⁶ 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.⁷ These staff have also been trained in the Care Transitions Intervention (CTI)[®] 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.⁸

Care Transitions 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: Frequently people being discharged from the hospital misunderstand their prescription medication regimen and take doses either too frequently or not frequently enough, or mistakenly take them in addition to medications they were taking prior to hospitalization. Using SBIRT motivational interviewing techniques including asking the right questions, CTI Coaches[®] help program 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.⁹ 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 CTI[®] 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 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 that referred individual 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 Transitions 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 Transitions 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 diagnoses including heart attack, heart failure, pneumonia, COPD and stroke experience readmission rates from 17 percent to 22 percent, which are significantly higher than the project reports.¹⁰ Similarly, the 30-day readmission rate for those referred to the program but who did not participate was also 17 percent.

TABLE 3:

CTI[®] Participant Readmissions Within 30 Days Following Discharge 2013 – 2015

Year	Percentage (%)*
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 for Family Wellness

FREED and Dignity Health Foundation, the organizations that had first teamed up to launch the CTI[®] program under the auspices of the ADRC, launched the Integrated Care Coordination for Family Wellness program beginning in January 2014 by expanding the collaboration to include Community Recovery Resources (CoRR), a substance use disorder and behavioral health provider and Western Sierra Medical Clinic, a Federally Qualified Health Center. The program aimed to serve individuals who might not be interested in joining the CTI[®] program, but who nevertheless encounter difficulties navigating the complex health and social service systems following ED and hospital discharge. Using the no-wrong-door approach, the goal of the expanded collaboration was to increase integrated care coordination for these individuals across multiple settings including primary care, disability and senior services, and behavioral health services. One common goal was to secure a primary care appointment for the participant before discharge either from the ED or following a hospital stay. The program reports some success in reducing wait times for primary care appointments. Partner organizations helped individuals secure not only clinical care and follow-up, but also a wide range of LTSS.

The new collaboration made 46 patient referrals in the first nine months of 2015. While more study is needed, preliminary data reveals that none of the people who received 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 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.¹² Support provided 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 increase 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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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.

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ENDNOTES

² This Issue Brief summarizes material presented in the webinar, Promising Practices: Collaborations Between Independent Living Centers, ADRCs, Area Agencies on Aging, Managed Care Plans, Health Care Providers, and Other Partners, 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/>

³ Care Transitions Intervention (CTI)[®]. Website: <http://caretransitions.org/>. Accessed May 16, 2016.

⁴ “The Transitions Coach[®] is key to encouraging the patient and family caregiver to assume a more active role in their care. The Transitions Coach[®] does not fix problems and does not provide skilled care though she or he possesses these skills from prior health professional training. Rather, Transitions Coaches[®] model and facilitate new behaviors, skill transfer, and communication strategies for patients and families to build confidence that they can successfully respond to common problems that arise during care transitions. The patient's goal drives the agenda. Thus the role of the Transitions Coach[®] is to promote more effective care transitions through improved self-management skills, and enhanced patient-provider communication.” Website: <http://caretransitions.org/what-is-a-transitions-coach/>. Accessed December 12, 2016.

⁵ “ACL was initially established on April 18, 2012 by bringing together the Administration on Aging, the Office on Disability and the Administration on Developmental Disabilities. Since then, ACL has grown significantly. Through budget legislation in subsequent years, Congress moved several programs that serve older adults and people with disabilities from other agencies to ACL, including the State Health Insurance Assistance Program, the Paralysis Resource Center, and the Limb Loss Resource Center. The 2014 Workforce Innovation and Opportunities Act moved the National Institute on Disability, Independent Living, and Rehabilitation Research and the independent living and assistive technology programs from the Department of Education to ACL.” Website: https://acl.gov/About_ACL/Organization/Index.aspx. Accessed December 12, 2016.

⁶ Cornell University, Employment and Disability Institute. Person Centered Planning and Education Site. Website: <http://www.personcenteredplanning.org/>. Accessed June 21, 2016.

⁷ Substance Abuse and Mental Health Services Administration. SBIRT—Screening, Brief Intervention, and Referral to Treatment. Website: <http://www.samhsa.gov/sbirt>. Accessed June 21, 2016

⁸ Care Transitions Intervention (CTI)[®]. Website: <http://caretransitions.org/>. Accessed May 16, 2016.

⁹ 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 July 8, 2016.

¹⁰ 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%

¹² 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 June 21, 2016.