The Changing Landscape of Aging Services

Driven by the Coordinated Care Initiative and health care reform, the familiar landscape of Long Term Services and Supports that we've known for years is about to change, requiring consumers, healthcare providers and community based organizations to adapt. How can stakeholders shape new policies and service delivery models? How will providers of health and supportive services interact in this new landscape? How can community based organizations engage to *become* the change? These questions, and others, might best be answered through an exploration of possibilities and recent developments.

As part of the Senior Services Coalition's January 31, 2013 Policy Forum, we invited speakers with various perspectives on the above questions to participate on a panel discussion on "The Changing Landscape of Aging Services." Anna Rich, Senior Staff Attorney with National Senior Citizens Law Center, opened the discussion with an overview of the Coordinated Care Initiative that will be driving the transition of LTSS into managed care. The panelists that followed brought perspectives from managed care and from organizations and models of care that are working to adapt to the changing landscape.

Bay Area Community Services Assesses Readiness

BACS Executive Director Jamie Almanza described how a SCAN Foundation "Linkage Lab" grant is helping her organization prepare for change.

The goal of the Linkage Lab grant is to provide BACS with the necessary training and technical assistance to develop contracts with health care providers to deliver products or services that enable aging with dignity. BACS is one of six organizations selected to participate in Linkage Lab. This 24 month initiative will allow BACS to better coordinate its senior services with the healthcare sector, thus improving the quality of care for elders with chronic conditions and functional limitations while at the same time diversifying revenue streams for the organization.

BACS will begin by assessing their entire organization and infrastructure. They will identify both current and needed strengths and capabilities that would allow them to interface with health care partners; identify services and expertise that are valuable to managed care plans; and learn how to package those services and calculate their true cost. BACS will be building relationships with health care entities and following a practical path to partner and contract with local health plans to provide long-term services and supports for dual eligibles.

Recognizing the role BACS will play as a change agent in Alameda County, Ms. Almanza

will be sharing Linkage Lab training materials and tools with the supportive services community. Stay tuned as this project develops.

ValleyCare Demonstrates the Value of Home Delivered Meals

As part of SSC's January 31st Panel discussion on The Changing Landscape of Aging Services, Gabrielle Chow, Director of Community Nutrition, ValleyCare Hospital System, spoke about a project to prove the value of home-delivered meals in reducing hospital readmissions among patients with congestive heart failure (CHF). ValleyCare produces therapeutic diet meals for Meals On Wheels in Dublin, Livermore and Pleasanton, which are then delivered by Spectrum Community Services.

The project began with a grant that allowed for a CHF Coordinator to work with patients after discharge, an effort that yielded positive results but did nothing to change the dismal hospital readmission rate of the patients. Recognizing that low sodium diet plays a critical role in managing CHF, and that patients were overloaded with information at discharge, Gabrielle's team added home delivered meals as an additional component to the project.

Patients were offered the chance to enroll in the meal plan. ValleyCare and Spectrum collaborated to deliver two meals a day for seven days for both the patient and spouse. ValleyCare pays for the first seven days and then Spectrum assesses patients' for Meals On Wheels program eligibility (so far, 40% of the patients have stayed on beyond seven days). The initial results were startling: readmission rates for patients receiving meals decreased by 40%. Now, ValleyCare is planning to add more comprehensive data collection and expand the project beyond patients with the primary diagnosis of CHF.

ValleyCare's experience is an example of an organization taking concrete steps to document the measurable health outcomes of a LTSS intervention – uncovering a "bottom line" outcome that hospitals and managed care plans will understand and can assign a value to.

Alameda Alliance for Health Uses Key Principles to Inform Planning

In a proactive response to the changing managed care environment, Alameda Alliance has created a new LTSS unit that will be primarily responsible for the Long-Term Supports and Services that are moving under managed care when the Coordinated Care Initiative launches. At the January 31st SSC Panel Discussion, Alameda Alliance's Director of Outreach and Education for LTSS, Elizabeth Edwards, outlined five guiding principles which the Alliance is operating from as they prepare for the Coordinated Care Initiative:

1. Honor consumers' existing relationships with medical and LTSS providers.
2. Supplement medical care through a robust assessment process and by developing plan based and community based care coordination activities.

3. Engage CBOs that provide significant services to the Duals Demonstration population.
4. Enhance scarce resources but not supplant existing funding sources.
5. Define and measure success as no disruption in care.

To realize these principles, the Alliance will be connecting with medical providers, supportive services providers over the next several months and beyond:

- Medical Providers - The Alliance's work will include determining which medical providers are significant to consumers, and reaching out to these providers to create contracts and continue information sharing. (Community based organizations can assist in this process by sharing medical provider contact lists with the Alliance.)

- LTSS Providers - The Alliance will contract with the MediCal LTSS providers (IHSS, MSSP, SNFs) much like they are currently contracted with CBAS/ADHC providers. These contractual relationships will allow the providers to share any recent in-depth assessments of consumers upon enrollment in Alliance, allowing Alliance to be better informed about new members' status and service needs. Elizabeth described the assessment as key to ensuring that Alliance is able to "get folks into care that need it and find the people who are not getting the services that they actually need and make that transition easy for them."

From the CBAS transition, the Alliance learned that the expertise currently existing within the community is an incredible asset. The Alliance wants to "make it possible for those community providers to… do what they've been doing." Yet, Elizabeth acknowledges that resources are scarce in the county and waiting lists abound, and that the Alliance cannot provide funding to fill all these gaps.

Adult Day Health Care Benefit Transitions to Managed Care

It's been 15 months since a court-mediated settlement preserved Medi-Cal coverage for Adult Day Health Care and created a new ADHC benefit called Community-Based Adult Services (CBAS). Since then, the Adult Day Services Network of Alameda County (ADSNAC) has been working with its members (six organizations that run thirteen adult day programs throughout Alameda County) and with the county's two Medi-Cal Managed Care Plans to transition programs and patients into Medi-Cal managed care.

Having experienced the transition of a Medi-Cal-covered LTSS into managed care, Anne Warner-Reitz, ADSNAC Executive Director, provided an informed template for the coming Coordinated Care Initiative.

Ms. Warner-Reitz acknowledged the CBAS implementation was complicated by the state's flawed eligibility process. About 35% of the people who had been receiving ADHC services in Alameda County were initially found ineligible for the new CBAS coverage. It took a year in a laborious and difficult fair-hearing process to reinstate eligibility for most of those participants. During that time, two ADHC centers closed and other providers were severely stressed as they worked to provide services under the double burden of rate cuts and delayed reimbursement.

One of the assets that eased transition difficulties was the goodwill and shared communications that occurred between the plans, agencies and providers. Early, the ADHC centers invited medical directors and other managed care plan staff to the centers. The plans and centers executed data-sharing agreements, then shared assessment and outcome information on patients they had in common, discovering that ADHCs knew significantly more about patients' health and had played a clear role in stabilizing patient's with complex medical conditions. These conversations allowed the plans to recognize ADHC's value and its role in a patient's care plan, and built relationships, good will and common understanding that proved helpful as they developed the business relationships, protocols and procedures to implement CBAS.

Now, with a few exceptions, Medi-Cal CBAS coverage is available only through a Medi-Cal Managed Care Plan. There is an expedited enrollment process so that people who need ADHC services can be enrolled in a plan quickly. ADSNAC has developed a guide to help navigate the eligibility and enrollment process, available at http://www.adsnac.org/cbas.htm.

Managed Care 101

The SCAN Foundation's January 8, 2013 webinar helps community based service providers and advocates understand the fundamentals of managed care, and what is involved in integrating long-term services and supports into a managed care model. The webinar will orient you to the brave new world of managed care, and is an essential start in preparing your organization for the 2013 launch of the Coordinated Care Initiative in Alameda County. Click here to go the SCAN Foundation web page and watch the recorded webinar.