INNOVATION
IN HEALTH CARE
AWARD

UNIVERSITY OF CALIFORNIA, LOS ANGELES: ALZHEIMER'S AND DEMENTIA CARE PROGRAM

A partnership of eight community-based organizations (see below) and the University of California, Los Angeles delivers the comprehensive, coordinated level of care that people with Alzheimer's disease and dementia and their caregivers need. The partners developed the Alzheimer's and Dementia Care (UCLA ADC) program, a model that incorporates a nurse practitioner to deliver health care in coordination with physicians and integrates social services available by the CBO partners, such as adult day care services, counseling, and caregiver training. The partnership goals include minimizing caregiver strain and supporting greater independence, dignity, and function for older adults with dementia. Another goal is to decrease health care costs. To date, the program has successfully served over 2,000 individuals.

RESULTS

- Reduction in long-term care admissions (33%).
- Reductions in behavioral symptoms (12%) and depressive symptoms (24%).
- Tripled caregiver confidence in accessing CBO resources.

CAREGIVER:

"The program has turned my life around. I now have a grip on things. I do not feel totally overwhelmed. I have been given some counseling and adult day care. …I can honestly say it has sort of saved me."

INSPIRATION

Older adults with Alzheimer's disease and dementia have unique and significant care needs, often requiring substantial time and attention. Unfortunately, the typical physician schedule and skillset is not conducive for managing all health and social needs of this special population. Persons with dementia have a greater reliance on families and caregivers, who might not have the appropriate training and counseling. This results in individuals with Alzheimer's disease and dementia receiving a lower quality of care, being three times more often admitted to hospitals, and accounting for higher overall health care costs than older adults without dementia.

ORGANIZATIONS INVOLVED

The UCLA ADC was initiated in 2011 by the UCLA Health System (UCLA Health). The eight CBOs participating in the model include: OPICA Adult Day Care, Jewish Family Services, Alzheimer's Association Central Chapter, ONEgeneration, Coast Caregiver Resource Center, WISE and Healthy Aging, Alzheimer's Greater Los Angeles, and Senior Concerns.

PARTNERSHIP STRUCTURE

The UCLA ADC is a referral model, formalized with an agreement between UCLA and each of the CBOs. As part of the agreement, each CBO provides UCLA with a menu of services they can provide the UCLA ADC enrollees and their families, for which they might receive funding from UCLA. The model consists of a steering committee that includes the CBO partners, as well as caregivers and other key stakeholders. The steering committee provided guidance and expertise on the design and implementation of the program and now provides guidance on growth and sustainability.

MODEL DESIGN

Services provided by the UCLA ADC focus both on disease management and care coordination. The nurse practitioner Dementia Care Manager (DCM) completes a needs assessment for the participants and their caregivers, and develops and implements an individualized care plan based on the assessment. The DCM monitors the care plan on an ongoing basis,

making revisions as necessary. This is possible by having the DCM stay in close contact with the older adults being served, as well as with their primary care physicians. Numerous mechanisms of communication are used, including in-person office visits, telephone calls, emails, and text messages. When needed, the DCM sends referrals to specialist physicians for care, as well as to the CBO partners for services (e.g., training, home care, adult day care, counseling).

UCLA HEALTH:

"The goals of the program are to maximize function, independence, and dignity for individuals with dementia, minimize caregiver strain and burnout, and reduce unnecessary costs through improved care."

In addition to identifying necessary community-based services, the DCM determines if the costs are eligible for reimbursement by UCLA Health or the responsibility of the individual. This is determined on a case-by-case basis. Once referrals are made to the CBO partners, the DCMs follow up with the CBOs to ensure that services are initiated and maintained for the recommended duration.

FUNDING MECHANISM

The UCLA ADC was awarded a Healthcare Innovations Challenge Award from the Centers for Medicare & Medicaid Services, which provided funding to care for up to 1,000 older adults. Additionally, fee-for-service reimbursement from Medicare provides some funding for the services, such as in-person visits performed by the DCMs, and through recent changes also for a cognitive assessment and for non-face-to-face care coordination.

The CBO partners participating in the program are reimbursed on a fee-for-service basis via vouchers by UCLA based on the determination by DCMs of the needs. The vouchers define the appropriate amount, or length of time, for the services to be provided.

LESSONS LEARNED

- Mutual respect and responsibility among partners is essential for developing and sustaining relationships and for achieving success together, especially through building on each organization's strengths.
- Understanding the mission, vision, and resources of each organization involved in the partnership is critical.
- Partners need to monitor the relationships through regular communication, which allows for quickly identifying and addressing issues as they arise.
- It is extremely valuable to have all partners actively involved in the decision-making process for growing and sustaining the partnership.

FUTURE

The goal of the UCLA ADC program is to increase the number of persons served and expand the services provided. One approach is to increase the number of DCMs, which will allow them to staff additional clinics within the health system and serve more individuals. Another approach includes adding more CBO partners and expanding the services (e.g., languages other than English) offered through the program. The UCLA ADC will disseminate the model to other U.S. health care systems and has received support from The John A. Hartford Foundation and The Commonwealth Fund.

INNOVATION
IN HEALTH CARE
AWARD

COMMUNITY MEMORIAL HEALTH SYSTEMS: VENTURA COUNTY HOSPITAL TO HOME ALLIANCE

The Ventura County Hospital to Home Alliance (Alliance) – comprised of three health systems, seven skilled nursing facilities (SNFs), 10 home health agencies (HHAs), a community-based organization (CBO), a large managed care organization (MCO), and a Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization (QIO) – formed to change how care is delivered in Ventura County. The members of the Alliance have effectively implemented changes that improve communication, coordination, and accountability. In addition to developing solutions to improve the delivery of care and access to supports and services, the Alliance has also placed emphasis on policy and advocacy, looking to inspire legislative changes that better integrate care across the continuum.

RESULTS

- Reductions in home health readmissions (8%), and in readmissions for SNFs for one hospital partner (5%).
- Process for care transitions connects health and social services providers, allowing for seamless referral and delivery of services.
- Commitment from members to be held accountable for quality and outcomes performance.

INSPIRATION

Analyses of the 18 percent readmission rates of Medicare beneficiaries in California revealed a lack of coordination between care settings, especially during transition from the hospital to the community, or a post-acute care facility.

In response, the Alliance formed to find solutions for a seamless transition process for older adults, seeking not only to improve health outcomes but also to improve satisfaction and experience.

COMMUNITY MEMORIAL HEALTH SYSTEMS:

"The Alliance is very much a partnership – truly moving from competitors to collaborators – for the greater good of the community."

ORGANIZATIONS INVOLVED

Three health systems: Community Memorial Health Systems, Dignity Health Ventura County and St. John's Pleasant Valley Hospital, and Ventura County Medical Center. **A QIO:** Health Services Advisory Group. **A MCO:** SeaView IPA. **Seven SNFs:** Camarillo Healthcare Center, Coastal View Healthcare Center, Glenwood Care Center, Ojai Valley Care Center, Shoreline Care Center, Ventura Post-Acute, and Victoria Care Center. **Ten HHA partners:** Access Tender Loving Care, Allied Healthcare Professionals, Assisted Home Health and Hospice, Buena Vista Palliative and Hospice Care, Healthwise Home Care Solutions, Las Posas Home Health, Livingston Memorial Visiting Nurse Association, Los Robles Homecare Services, Mission Healthcare, and Summit Home Health. **A CBO:** Camarillo Health Care District.

PARTNERSHIP STRUCTURE

The Alliance uses a collaborative governance structure with equal representation from members. It has developed a charter, mission, vision, and goals and while no contractual relationship exists, members must pledge to uphold the defined expectations, such as service delivery commitments.

The Alliance meets on a quarterly basis to discuss issues and make decisions through a mutual decision-making process. In addition, several subcommittees meet more often to work through issues, such as data collection or skilled nursing transition. Once ready, subcommittees present findings to the larger group during quarterly meetings.

MODEL DESIGN

Through their collaborative platform, there is a commitment to work together to create new approaches within the Alliance organizations to improve integration of care within the system. By sharing their unique perspectives, Alliance members provide more effective solutions that address the medical and social needs of an individual throughout the full continuum of care. Each member organization is responsible for implementing solutions within its own workflows but there is often related accountability to the Alliance. Most commonly, the approaches address needs related to care transitions and case management.

One example of the Alliance's work has been the incorporation of post-acute partners (SNFs and HHAs) in the pre-discharge planning process at the hospital partners' locations to improve communication and better prepare the patient for the transition process. This includes having clinical liaisons that assist patients in the transition process. The Alliance created the standards and training manual for these liaisons, and they wear the Alliance logo to highlight the effort of the collaboration.

The Alliance has also focused on making numerous improvements to care delivery, including redesigning workflows, building connections between medical and community-based providers, and educating on clinical training as well as policy programs and legislation. The group actively engages in advocacy for policy changes, such as payment redesign to better integrate services along the continuum. Lastly, members share their expertise with one another to provide clinical competency training and development for acute and post-acute members within the Alliance.

FUNDING MECHANISM

The Alliance is financed through in-kind support of its member organizations, which includes time and resource commitments. There are no changes to the way organizations are reimbursed for the services they provide.

LESSONS LEARNED

- There is value in having numerous provider types involved. This was discovered after gaps were identified following conversations between hospitals and post-acute care providers. By bringing together perspectives, the Alliance has broader health system representation and knowledge to develop lasting solutions to address the full range of patient needs.
- Partners have found that learning each other's perspectives and roles in the health system has eliminated barriers and misunderstandings that previously existed. This has led to mutual accountability and trust within the Alliance, which members acknowledge as a critical component to success.

FUTURE

The Alliance aspires to continue and expand efforts in implementing new models and best practices for continual improvement of the care delivery system in their community. They were recently awarded participation in a three-year pilot to test person-centered care models.

INNOVATION
IN HEALTH CARE
AWARD

HEALTH PLAN OF SAN MATEO: COMMUNITY CARE SETTINGS PILOT

The Community Care Settings Pilot (CCSP) is a collaborative partnership between the Health Plan of San Mateo, two contracted community-based organizations (CBOs) - Institute on Aging (IOA) and Brilliant Corners (BC) - as well as the San Mateo County Health System and Housing Authority. Initiated by the health plan and launched in 2014, the partnership focuses on its most vulnerable members currently residing in skilled nursing facilities (SNFs) or at risk for placement. Partners collaborate to move eligible members into the community, or to avoid SNF placement altogether by providing care coordination, housing, and other needed services to improve desired results.

RESULTS

- Increased member satisfaction: 85 percent report maintained or improved quality of life; 90 percent are willing to recommend CCSP service to others.
- Decreased costs: 50 percent lower per member costs over a six-month period.
- Community-focused: 88 percent of members in CCSP remain in the community.

INSPIRATION

The Health Plan of San Mateo became increasingly concerned with the high costs of SNFs. Amplifying their concern, the largest SNF provider in the county announced potential closure. This led the health plan to explore relocation options for their members, and they struggled to find capacity inside the county or affordable options in neighboring counties.

The health plan then considered options to safely transition members to the community. Believing that a significant portion of this population could successfully transition, the health plan conceptualized this program to both reduce costs and mitigate unnecessary SNF use for its members.

HEALTH PLAN OF SAN MATEO:

"We aim to improve members' quality of life and health outcomes while delivering operational and financial benefits to our community's system of care."

ORGANIZATIONS INVOLVED

The health plan initiated the partnership through a Request for Proposals process, which sought CBOs with experience in care coordination and housing services. IOA and BC were selected.

INSTITUTE ON AGING:

"We believed in our potential as a partner for the health plan, given our history of providing services to individuals in the community with complex needs."

Over time, additional partners were added, including the San Mateo County Health System and Housing Authority. Other collaborating agencies include Meals on Wheels and the Alzheimer's Association.

PARTNERSHIP STRUCTURE

CCSP is built on a contractual, shared services model that includes an agreement between CBO partners and IOA. Contracts are reviewed, amended, and renewed annually and include expectations for services provided, communication, reporting, and outcomes. CCSP also has an incorporated operating governance body, seeking input from the multiple stakeholders involved.

MODEL DESIGN

Through joint efforts, eligible members are identified. These efforts primarily include targeting SNFs and CBOs to help identify members that might benefit from the services provided by CCSP, and other sources, such as the health plan's case management notes or case rounds at an acute hospital.

Once identified, potential members go through a prioritization and eligibility process established by the health plan that assesses level of care needed and caregiver support. Once enrolled a thorough bio-psychosocial assessment informs the development of an individualized care plan. The core care team – which consists of clinical and administrative staff from the health plan, IOA, BC, and other key CBOs – reviews the care plan twice a month. It is then the primary responsibility of IOA and BC to secure the right housing option and connect the client with additional needed services.

Communication between IOA and the health plan is critical while coordinating care, especially for authorizations or issues with medical needs. Post-case conferences allow for active management to transition back to the health plan. Quarterly, each partner reports data that highlights quality, cost savings, efficiency, and satisfaction.

FUNDING MECHANISM

CCSP primarily utilizes existing funding streams to address member needs, such as using health plan reimbursable funds, Section 8/Housing Choice vouchers, and California Community Transitions waivers. The health plan also invested internal funds to cover additional needs. Services provided by the CBOs are paid for by the health plan through a hybrid structure: fee-for-services and through an incentive program for each CBO, which holds them accountable to achieve annual targets related to quality, costs, and efficiency.

HEALTH PLAN MEMBER:
"This is a big change from where I used to live - a two-year stay in a nursing home. This feels like freedom."

LESSONS LEARNED

- There is value and a greater likelihood for success in achieving goals when starting out with a small population that is known to have consistently high costs of care.
- The needs of the individual should drive the care plan. Innovative solutions should be employed, such as conducting home modifications or providing a temporary rent subsidy to address the remaining gaps.
- Waivers, benefits, and other funding streams should be leveraged. All partners must adopt a "whatever it takes" mindset to achieve the goals for the program and for each individual member. The incentive payment program for the CBOs is an example of how each of the partners has taken on risk in the partnership to achieve the shared goals.

FUTURE

To achieve future growth of CCSP, the partners are pursuing additional sustainable sources of revenue. This includes consistent efforts to identify and utilize available waiver sources, advocating to the state on behalf of programs like Cal MediConnect and the Coordinated Care Initiative, and considering alternative paths for funding such as development or participation in new, overlapping programs. CCSP is also looking to expand by engaging new partners, particularly hospitals, recognizing an opportunity to move upstream and reduce acute inpatient stays that are costly to the hospital and potentially harmful to an individual's health.

INNOVATION IN HEALTH CARE AWARD

KAISER PERMANENTE SOUTH BAY GERIATRIC COGNITIVE ASSESSMENT CLINIC: DEMENTIA FOCUSED CARE MODEL

Kaiser South Bay's Geriatric Cognitive Assessment Clinic (Kaiser South Bay) and Alzheimer's Greater Los Angeles (ALZGLA) have co-designed and developed the Dementia Focused Care model that is improving care delivery and support to individuals with dementia and their families. This is primarily being achieved through coordinating and providing supportive services, such as individualized and group support programs, disease education, and respite care. Coordination also extends to enlist community organizations to provide additional supportive services when required. With improved access and greater attention to both the medical and psychosocial supports for these families, the collaboration strives to improve the health and well-being of older adults and their caregivers.

RESULTS

- Approximately 200 families are supported through the partnership annually.
- Improved well-being for individuals with dementia and their caregivers.
- Increased ability for family members to care for their loved ones with dementia due to improved access to resources and training.

KAISER SOUTH BAY:

"This collaboration improves the capacity of the health care system to provide quality health care services, including the social and non-medical needs of their members."

INSPIRATION

In the Kaiser South Bay region, an estimated 15,000 individuals currently live with Alzheimer's disease and dementia. With the population aging rapidly, the prevalence of this disease is steeply inclining. Individuals with Alzheimer's disease and dementia have greater health needs and contribute to a significant portion of health care spending. Challenges with dementia, such as lowered cognitive ability and difficulty conducting basic daily activities, often require caregiver support. Caregivers encounter significant strain in this role, often impacting their own health and quality of life.

The increasing prevalence of Alzheimer's disease and dementia is also burdening the health care system, requiring significant resources to meet the needs of older adults with the disease. The partners sought to find a solution that would efficiently provide better care and support for these individuals, and their families. They felt the ideal solution was one that detected dementia early, assisted in the identification of caregivers, and assessed and provided the health and psychosocial needs of the individual, as well as the caregiver.

ORGANIZATIONS INVOLVED

The primary partnership is between Kaiser South Bay (a part of Kaiser Permanente) and ALZGLA. However, additional community-based organizations are utilized to provide community resources.

PARTNERSHIP STRUCTURE

The partnership is an integrated referral relationship seeking to achieve a greater impact in the community, with no formal agreement between the two partners. The partners work together to develop and embed coordinated strategies within each other's organizations that create a better system of care delivery to individuals with dementia.

MODEL DESIGN

There are three primary offerings that make up the design of this model. First, there is the implantation and utilization of the *ALZ Direct Connect* referral program. Fully integrated within the operations of Kaiser South Bay, it results in effective collaboration between the two partners. With *ALZ Direct Connect*, older adults and their caregivers are directly linked to community supports and services, such as education, care coordination, and training. Feedback on activity is also sent directly back to the referring medical provider.

The second offering is *Savvy Express*, a three-part psycho-educational, evidence-informed class provided to Kaiser South Bay members in partnership with ALZGLA, which allows family members to explore the role of caregiver and learn more about the resources available. Finally, the third primary offering consists of referrals to ALZGLA for medical respite services.

CAREGIVER:

"Being connected to Alzheimer's Greater Los Angeles has provided my family with valuable education, support, and resources. I am so appreciative that my health care provider took the initiative to make this referral before my family was in crisis."

FUNDING MECHANISM

The primary funding for the partnership is provided by ALZGLA, available through donations and grant funding that the organization receives. With this funding, the vast majority of services and programs offered to older adults and their caregivers are provided for free.

LESSONS LEARNED

- Building a strong relationship between partners is critical for success. Part of building the relationship requires mutual effort by each partner, with the shared goal of benefiting those individuals they serve.
- Working together to find solutions that further improve the partnership model is necessary for sustainability. The implementation of the *ALZ Direct Connect* referral system in Kaiser South Bay, for example, required effort and support by both partners to operationalize but has resulted in vital efficiency for the model

FUTURE

The partners are committed to maintaining and expanding the services and programs that they provide, emphasizing the individualized care and specific needs that individuals and their families require to live healthy, happy, and independent lives. To achieve this, the leadership of the organizations meets quarterly to discuss additional opportunities. They also continually seek opportunities to replicate the model in additional Kaiser markets.

INNOVATION IN HEALTH CARE AWARD

LIFELONG MEDICAL CARE & ALTA BATES SUMMIT MEDICAL CENTER: COMMUNITY BASED CARE TRANSITIONS PROGRAM

Recognizing the potential to improve health outcomes, quality of care, and health care spending, Alta Bates Summit Medical Center (ABSMC) and LifeLong Medical Care, along with support from the Community Health Center Network (CHCN), established the Community Based Care Transitions Program (CBCT). This program provides care transition services for low-income older adults as they discharge from the hospital to the community, ensuring that the full scale of needs, whether medical or non-medical, are addressed. The program features a "warm hand-off" between the hospital and community health center prior to hospital discharge, at which point a Care Transitions RN (CTRN) manages care through the transition, making referrals to needed services. The partnership strives to achieve seamless transitions between care settings.

RESULTS

- Decrease in both emergency department utilization and hospital readmissions (17%).
- Increase in primary care provider follow-up within 30 days of discharge (32%).
- In 2016, 1,350 older adults received the care transitions services.

ABSMC:

"We're constantly looking at ways to provide better care to individuals while controlling health care costs. This [program] does both and it's a win-win for the East Bay community."

INSPIRATION

The hospital discharge process is a vulnerable time for older adults, as the historically fragmented system consists of numerous gaps and risk factors that can have a negative impact on their health and well-being. This is particularly true for low-income older adults who often lack the resources and support necessary for their recovery. This can lead to an increased risk of complications and poor health outcomes resulting in readmissions.

LifeLong, a leader among community health centers in serving low income elderly patients, had no system in place to track or support their patients when they entered the hospital. This resulted in missed opportunities to assist with post-discharge care needs. Payment and delivery reform initiatives, such as the Hospital Readmission Reduction Program that holds hospitals accountable for readmission rates, provided financial incentive for ABSMC to address this issue. This resulted in the collaboration between these entities and the joint development of the CBCT Program.

ORGANIZATIONS INVOLVED

The partnership includes ABSMC (a Sutter Health affiliate hospital), LifeLong Medical Care (a FQHC), and CHCN (a nonprofit MediCal MCO that provides FQHCs with administrative support and services).

PARTNERSHIP STRUCTURE

As a hospital/community health center partnership, Lifelong and ABMC are jointly leading the development of a system of care that better serves the health needs of vulnerable populations including low-income older adults. Leadership from partner agencies oversee CBCT program planning, implementation, and sustainability/growth initiatives. Representatives of the hospital, CHCN and health center partners meet monthly to discuss operational issues, system improvements and evaluation processes for data collection and reporting. Review of evaluation metrics guides program development.

MODEL DESIGN

Through the establishment of data sharing agreements and IT innovations and relationships between health center and hospital staff, LifeLong now identifies patients, on a daily basis, who visit the ED or are hospitalized. LifeLong CTRNs track these hospital admissions and initiate transition services, including a review of diagnoses and care needs, discharge instruction consultation, medication management, community support needs, and follow-up calls.

LIFELONG MEDICAL CARE:

"The CBCT Program has evolved as a win-win-win partnership that benefits older adults, the hospital system, and the primary care home."

This model is unique in that it directly links individuals back to the FQHC post-hospitalization to properly address immediate and long-term medical and social needs, ranging from medical follow-up and medication consultation to transportation services and case management. If services are not offered by LifeLong, direct referrals are made to community-based organizations to address the full range of needs, and reduce the risk of complications and readmissions.

FUNDING MECHANISM

Funding for the program is provided primarily by Sutter Health, with added support from LifeLong. Hospital funding is essential for this partnership as RN services are not billable for FQHCs. Each partner provides in-kind support for the program, including the staff, IT support and other resources.

LESSONS LEARNED

- Unmet healthcare needs of vulnerable populations and barriers related to real-time data sharing and program implementation inspired the organizations to streamline processes and systems.
- Optimal use of HIPPA compliant communication, IT tools and data sharing enables providers to quickly and effectively respond to medical and social service needs of patients transitioning out the hospital.
- Timely communication between the patient, hospital and primary care provider enables effective linkage back to the FQHC primary care home and to community resources.

COMMUNITY MEMBER:

"When the LifeLong nurse first reached out to me I was so relieved and felt that, finally, someone was looking out for me."

FUTURE

The partners are seeking to improve efficiency within their operations, such as connecting electronic medical records. They are pursuing additional funding streams for sustainability through partnerships with managed care organizations. They also seek funding for standardizing and developing resources to aid the expansion of the program to other centers. While the partnership was initially a pilot, three additional FQHCs in the CHCN network have joined the program to provide CBCT services for their patients.. Finally, the hospital and health center partners have expanded access to timely follow-up care and promote reduction in avoidable hospital and emergency services through a jointly funded urgent care clinic.

INNOVATION IN HEALTH CARE AWARD

MOLINA HEALTHCARE OF CALIFORNIA: DEMENTIA CAL MEDICONNECT PROJECT

Built as a partnership between Molina Healthcare of California and Alzheimer's Greater Los Angeles (ALZGLA), the Dementia Cal MediConnect Project provides care for older adults with dementia and their families. They accomplish this by building on their individual strengths to educate and train staff and caregivers, integrate processes for seamless referrals and communication, and develop tools and resources. The program is equipping each of its staff to be more confident and prepared to provide care to individuals with dementia, resulting in higher quality of care and quality of life. The partnership strives to improve the system of care for people with dementia and their caregivers, meeting needs beyond medical care through community-based services and supports.

RESULTS

- Reduction in caregiver stress levels.
- Improved systems and processes for screening individuals' needs through the adoption of validated tools.
- Increased confidence for Molina care managers to refer individuals to necessary services.

INSPIRATION

Caregivers play an essential role in managing the health and well-being of individuals with dementia. They manage medication, schedule appointments, and address or arrange other care needs. Poorly coordinated health and community-based services complicate caregiver efforts and fail to provide the support these individuals require. Innovations in health care are putting a spotlight on the need to better coordinate care, including social services. Many new initiatives and models allow health payers to adopt new models of coordinated care, particularly for those living with dementia.

The Administration for Community Living (ACL) Alzheimer's Disease Supportive Services Program created a grant program intended to develop a dementia-capable system of care for individuals with dementia in the Cal MediConnect initiative (California's dual eligible demonstration), which aims to better coordinate care for individuals eligible for Medicare and Medicaid. The California Department of Aging, recieved the grant for ACL, enabling ALZGLA to work with Molina Healthcare.

ALZGLA:

"Alzheimer's Greater Los Angeles' partnership with Molina shows how a national health plan can work with a local Alzheimer's community-based organization to make strategic and systematic changes to its system of care so it better serves the needs of families affected by dementia."

ORGANIZATIONS INVOLVED

ALZGLA and Molina Healthcare are the primary partners in this model. As part of the grant, they are engaging in shared learning, convening, and information-sharing with other organizations, including the California Department of Aging; the California Department of Health Care Services; the Institute for Health & Aging of University of California, San Francisco; and The John A. Hartford Foundation Change AGEnts Initiative Dementia Caregiving Network.

PARTNERSHIP STRUCTURE

The partnership is grant-supported; however, it does not require a formal agreement between the organizations involved. The partners have taken a collaborative approach to designing and implementing their partnership model, through consistent messaging and open communication.

MODEL DESIGN

The model has four key components: mutual education, care management training, technical assistance, and caregiver training and support. For mutual education, the partners have leveraged their individual skills by educating one another. For instance, ALZGLA taught Molina about the specific needs of individuals with dementia and their caregivers. Alternatively, Molina taught ALZGLA about their health care delivery system. The partners have also sought ways to disseminate their knowledge and experience to others by providing insights online or holding convenings for thought leaders.

ALZGLA has provided two levels of training to Molina staff, including training for Dementia Care Specialists (DCS). The training has covered areas such as screening processes, fundamentals of the disease, supportive care techniques, available resources and support services, and technical assistance with integrating tools and processes into Molina's care management system. In addition to initial training, ALZGLA provides frequent check-ins to care managers to reinforce training, address questions, and provide new tips. For the DCS training, ALZGLA has included valuable tools intended to prepare Molina staff to identify and support members with dementia and their caregivers.

Finally, the partnership model includes caregiver training and support. For example, Molina integrated the ALZ Direct Connect system into their operations, which is a direct referral system that allows for seamless referrals to ALZGLA to address needs. With this system, Molina has been able to easily connect individuals to support groups, counseling, and other services. ALZGLA also offers special caregiver training to Molina members that qualify.

FUNDING MECHANISM

The partnership is primarily funded by the grant from ACL. The funding does not pay directly for services, but it is used to educate caregivers, train staff, support families and implement technology systems and care processes.

LESSONS LEARNED

- There is high value in having shared goals and desiring the same outcomes.
- Partners must be accessible to each other for the purposes of open communication and growth.
- All partner perspectives should be considered, recognizing the benefit in incorporating each to identify a dementia-capable, model of coordinated care.

MOLINA HEALTHCARE:

"The impact of the above-mentioned results has also reached beyond our regional area. System changes adopted in this partnership will be integrated into our national medical care management system."

FUTURE

The partners intend to continue the development and growth of their partnership with additional tools and resources. The Ascertain Dementia 8-Item Informant Questionnaire (AD8), a cognitive screening tool, as well as a tool to test caregiver stress, are currently being implemented within the Molina clinical care management system to better identify and serve their members. They also seek to expand the partnership to Molina's other service areas within California by providing education and technical assistance.

INNOVATION
IN HEALTH CARE
AWARD

PROVIDENCE TARZANA: COORDINATED SUPPORT SYSTEM FOR OLDER ADULTS

To better serve the needs of the low-income older adult population in their community, Providence Tarzana Medical Center and ONEgeneration developed a partnership to create a unified system of communication and support services for this underserved, vulnerable population. As a health care entity and a community-based organization, the two partners are working to define a stronger, connected relationship. They serve the community through health promotion, prevention and wellness offerings, such as education seminars on disease prevention, meal delivery, mental health support and integrated discharge planning, all intended to positively impact health outcomes.

RESULTS

- Within the first year, the partnership served 750 individuals.
- Improved continuity of care with greater emphasis on wellness and health promotion.
- Improved relationships between partners, opening the door to future opportunities.

INSPIRATION

In 2016, Providence Tarzana conducted their Community Health Needs Assessment (CHNA), required as a nonprofit health system, and identified five primary needs for the community: food insecurity, access to health care and resources, senior care resources, prevention and management of chronic disease, and mental health services. They realized that the most effective way to address these areas of need was by developing partnerships with community-based organizations deeply rooted in the community and already providing essential services and resources for older adults.

ONEgeneration:
"Providing older adults with the support needed to age in a more healthy, vibrant, and dignified manner ultimately strengthening and building a healthier community is a shared mission."

ORGANIZATIONS INVOLVED

The primary partners in the model are Providence Tarzana Medical Center and ONEgeneration, one of the largest community-based organizations in the area serving over 70,000 older adults annually.

The partnership also receives support from numerous organizations in the community. For example, the Los Angeles Department of Aging provides funding for a significant portion of the delivered meals. A local farmers market also plays a critical role in donating fresh produce to be provided to older adults served by the program.

PARTNERSHIP STRUCTURE

The partnership is a collaborative relationship, with no formal agreement between the two organizations. The partners work together to determine which services and supports will best serve the community and address their needs. To do this, leadership of the two organizations and their staff communicate regularly.

MODEL DESIGN

The partnership involves three primary components. Food insecurity was the first component tackled through the partnership, which has been addressed through expanding meal delivery services to older adults in need. With the partnership, ONEgeneration has been able to expand on serving 100 older adults with a meal five days a week to also

serve weekend meals to the 25 most vulnerable older adults. Expansion also includes providing a bag of non-perishable groceries, along with fresh produce, each week to those identified as most vulnerable. Wellness observations are conducted as part of the delivery, and, if needed, ONEgeneration care managers follow up.

The second component addressed in the partnership is prevention and wellness. This involves quarterly seminars taught by Providence Tarzana clinicians at ONEgeneration's Senior Center that educate the community on key topics. Additional health care resources and screenings are provided at the Senior Center by Providence Tarzana staff. For example, application assistants are available at the center to assist eligible older adults in applying for nutrition assistance through the state's CalFresh program. Mental health services are provided by Providence Tarzana staff at the Senior Center or within individuals' homes.

Third, during care transitions from hospital to home, hospital discharge planners and ONEgeneration's care management team work collaboratively to ensure that the medical, social, and behavioral needs of individuals are supported.

FUNDING MECHANISM

The partnership is primarily supported by Providence Tarzana through their community benefit funds. Additional funding comes from external sources, actively sought by both partners. For example, the hospital secured funding through the state that allows them to place an application assistant in the clinic to help individuals enroll in the CalFresh program.

LESSONS LEARNED

- Collecting and using data to show the outcomes of the partnership has been an opportunity to not only strengthen the two groups' bond by building confidence and unifying efforts, but also to strengthen the business case. This may be valuable when receiving support from individual funders, who are often more interested in social impact projects rather than physical facilities and resources.
- Approaching the partnership with intentionality allowed for defining goals, roles, and responsibilities which have been critical for success.

FUTURE

The partners continue to further develop the program, including through the expansion of service offerings and the number of people served. E.g., they are expanding their current meal delivery services beyond older adults to serve families that are experiencing food insecurity. They are also exploring the potential of expanding their service area.

To ensure success and sustainability, the partners are working to improve their model, such as identifying gaps in the coordination between the organizations' staff at the time of hospital discharge and transition, and noting additional funding sources and relationships that will help expand the program.

PROVIDENCE TARZANA:

"This partnership leads the way toward becoming a progressive change agent in developing a natural communication between health services and community-based organizations with the intent to better serve our low-income, vulnerable, and underserved older adult population."

INNOVATION IN HEALTH CARE AWARD

SIERRA NEVADA MEMORIAL HOSPITAL: INTEGRATED CARE COORDINATION FOR FAMILY WELLNESS

Sierra Nevada Memorial Hospital (SNMH), FREED (an Aging and Disability Resource Connection), Community Recovery Resources (CoRR), and the Western Sierra Medical Clinic (WSMC) came together to create the Integrated Care Coordination for Family Wellness partnership. The partnership connects providers across the continuum, including community-based organizations providing services and supports through navigation services and care transitions coaching using the Coleman Care Transitions Intervention (CTI). Beginning in the hospital or clinic setting, CTI links medically at-risk individuals in the community to needed services. This includes behavioral health, disease management and prevention, primary care, and substance use disorder treatment. By improving access and coordination, the partnership strives to achieve better health outcomes, lower readmission rates, and lower overall health care spending.

RESULTS

- Over 700 individuals served in the first half of 2017.
- Increased access to primary care, behavioral health services, and specialty care.
- Average wait times for an appointment at WSMC reduced from five days to three days.
- Improved individuals' self-sufficiency to manage their own care needs after hospital discharge.

SIERRA NEVADA:

"By having multiple partners that serve this high-risk population, it is truly a community-wide effort that is capable of achieving greater, lasting results."

INSPIRATION

Medically at-risk individuals, such as those with chronic illness, complex conditions, chemical dependence, or low income are often high utilizers of health care services – including hospital care – and account for a significant portion of health care spending. These individuals experience poorer health outcomes than others, especially at the time of hospital transition when additional services and supports are needed to reduce complication risks.

The partners recognized an opportunity to work together to develop and implement a coordinated care transition intervention that proactively links individuals to the services and supports required to go from the hospital to home, or to prevent the hospital stay altogether by linking to the necessary support while in the clinical setting and decreasing complications.

ORGANIZATIONS INVOLVED

The partnership began in 2012 with SNMH and FREED. In 2014, seeking to incorporate additional care settings and services as well as to reach a greater number of high-risk individuals, the partnership grew to include CoRR and WSMC.

PARTNERSHIP STRUCTURE

The partnership is a grant-based relationship, in which SNMH has provided a grant to the other partners involved to participate in the program. The grant was initiated by SNMH's community grant program, which aims to provide grants to selected organizations to develop collaborative partnerships that enhance the continuum of care for populations with high needs. Though the grant program typically provides annual grants, SNMH chose to award a multi-year grant for this partnership, recognizing the time required to build relationships and integrate services. Through the grant, the partners enter into an annual grant agreement. This agreement requires the community partners to provide quarterly and final reports to SNMH.

MODEL DESIGN

The key goal of the intervention is to streamline and coordinate access to the services provided by each of the partners involved. To do this, SNMH and WSMC first identify eligible individuals. Once identified, FREED and CoRR work together to coordinate services and deliver needed services. CoRR provides services for substance use disorder treatment, including Medication Assisted Treatment (MAT) and mental health services. FREED provides CTI coaching and navigation, linking individuals to behavioral health care and aging and disability long-term services and support. FREED also provides individuals with services such as application assistance, disease prevention management, medication self-management guidance, and personal health record development.

When needed, WSMC provides primary care services. WSMC and CoRR have even developed a co-location by adding primary care to the CoRR campus to further coordinate care delivery. By doing this, the partners seek to reduce the wait times for individuals requiring primary care services in the intervention.

FUNDING MECHANISM

The primary source of funding for the partnership comes from the community grant program that SNMH awards to the partners annually. This community grant program is derived from the hospital's community benefit program. Though the services provided through the partnership utilize fee-for-service reimbursements (e.g., Medicare), when possible, the intent of the grant funding is to look beyond reimbursable services to meet the needs of the individuals served.

LESSONS LEARNED

- Having partners educate one another on their services and expertise builds more options for the collective care they provide individuals.
- Creating standardized forms leads to efficiency and good communication between partners.
- It is essential to identify key contacts for each partner, as well as establish a clear feedback loop, which allows for consistent and frequent communication among partners.

FUTURE

To achieve future growth, the partners are pursuing sustainable funding sources through contracts with additional health care entities, such as health care payers. To gain the interest of these entities, the partners are currently working to improve the data collection and analysis process of the intervention, seeking to tie reduced readmissions and other outcomes to a potential return on investment.

INNOVATION IN HEALTH CARE AWARD

ST. PAUL'S PACE: HOUSING FOR HOMELESS OLDER ADULTS

Recognizing an opportunity to address the issue of older adult homelessness and improve health, well-being, and independence, St. Paul's PACE (Program of All-Inclusive Care for the Elderly) and Bridge Housing are partnering to connect 63 homeless older adults with housing, medical, and social care. Bridge Housing provides affordable housing units, and St. Paul's PACE provides health and social services to adults that are older than age 55 and require a skilled level of care. St. Paul's PACE also leads the process of identifying and enrolling eligible individuals for this partnership, which not only involves ensuring eligibility for PACE but also for the affordable housing unit. Through integrating health and housing they strive to improve the physical and mental health, independence, and dignity of those served.

RESULTS

- Majority of residents housed in the units remained after one year (97%), in comparison to a national average success rate (80% to 85%).
- Reduction in hospital readmissions, emergency department visits, and inpatient stays (93%).
- Reduction in depression symptoms and increased independence for performing activities of daily living.

PACE Member:

"I am no longer on the street. I am getting medical attention. I have a nice, quiet place to live."

INSPIRATION

In San Diego, over 25 percent of the homeless population is aged 55 or older, accounting for the fastest growing segment of homeless individuals. Older adults that experience housing insecurity are more vulnerable to chronic disease, health complications, and behavioral health issues than older adults with housing. Though PACE was developed as a health plan dedicated to integrating health and social services for older adults in need of a higher level of support, housing costs have never been included in the program. St. Paul's PACE and Bridge Housing saw a significant opportunity to address this issue through integrating their offerings of health and housing.

ORGANIZATIONS INVOLVED

The partnership is between the St. Paul's PACE program and Bridge Housing. However, other community organizations have provided additional support, such as Father Joe's Villages – a transitional housing agency – that assisted in the identification of individuals eligible for the housing units.

PARTNERSHIP STRUCTURE

By partnering with a community-based organization to fill 63 of their 240 housing units, Bridge Housing became eligible for additional government funding and tax credits. The first step in the partnership was going through this application process, which required St. Paul's PACE to provide a Memorandum of Understanding. Eighteen months later when funding was received, St. Paul's PACE signed an agreement committing to initially fill and maintain the 63 housing units with PACE members.

The two organizations learned from each other's expertise to address challenges and ensure that the needs of those served by the partnership are considered at every step. This has required frequent communication, as well as consistent meetings with the management group that Bridge Housing engages for the affordable housing property. The partners are also in regular communication with the homeless housing commission in the community for additional support in identifying issues and eligible individuals.

MODEL DESIGN

The partnership efforts began with St. Paul's PACE leading the process of identifying eligible individuals. They worked with other organizations in the community to find those in need and coordinate the transition process, which at times required extending stays in transitional housing units. This process also required creating new staff positions and programs to better meet the needs of the vulnerable population being served, which included intensive case managers and mental health assessments and programs. Significant planning occurred to prepare for the move-in and start of services for residents, such as preparing units with furnishings, equipment and food. A Supportive Housing Manager led the oversight of the move-in process. Regular meetings between the leadership of the two partners occurred throughout the development process.

Now that residents have moved into the units, St. Paul's PACE offers onsite weekly social work hours and coordinates recreational activities and programs each week, in addition to other PACE healthcare services.

FUNDING MECHANISM

Partnership services are primarily funded through the organization's traditional funding streams. For example, the housing provided by Bridge Housing is covered by government funds and tax credits, which were secured by Bridge Housing at the onset of the partnership. Partnering with a nonprofit organization provided an avenue for additional funding. Health and social services provided through the model are fully funded through the St. Paul's PACE program.

This partnership also relied heavily on donations to prepare each of the 63 units with furnishings. Local churches also provided ongoing support to the partnership through their outreach programs by providing food donations for new residents.

ST. PAUL'S PACE:

"This innovative partnership with low-income housing developers allowed us to intervene and provide these individuals with the all-inclusive support services they need to avoid returning to the streets."

LESSONS LEARNED

- It is necessary for organizations to learn more about each other to work collaboratively and successfully.
- It is important partners have the willingness to adopt new practices to address each other's needs. For example, St. Paul's PACE developed new intake criteria to ensure requirements set by the San Diego Housing Commission.
- There may be a need to hire and train staff, as well as develop new programs, to better serve individuals with mental health and substance abuse issues, as these individuals had not been traditionally served by the program.

FUTURE

Moving forward, the partners continue to meet regularly to ensure relationships are maintained and to seek additional ways in which they can better serve individuals. The partners also continue to look for ways to improve the enrollment process for getting prospective residents enrolled in PACE and eligible for the housing.

St. Paul's PACE has also been expanding their efforts to duplicate the model with additional low income housing providers. Father Joe's Villages will be providing a grant for housing of an additional 25 homeless older adults.

INNOVATION
IN HEALTH CARE
AWARD

UNIVERSITY OF CALIFORNIA, LOS ANGELES: COMMUNITY BASED CARE TRANSITIONS PROGRAM

Recognizing the potential to achieve better health outcomes and improve the lives of older adults through integrating health care and social services, the University of California, Los Angeles Health System (UCLA Health) and Partners in Care Foundation (Partners), a community-based organization, established the Community Care Transitions Program (CCTP). Launched in 2010 through the Centers for Medicare & Medicaid Services (CMS), CCTP is a demonstration to evaluate the effectiveness of hospitals and community organizations partnering to improve care transitions and reduce readmissions. Today the partnership serves Medicare Fee for Service, Medicare Advantage, and select Accountable Care Organization (ACO) members. Caring for approximately 4,000 individuals each year, services include care transitions coaching, community-based care coordination, and medication reconciliation.

RESULTS

- Reduction in readmissions for the intervention group (19%).
- Improvement rate for physician follow-up visits within seven days of discharge (14%).
- Improved medication safety through HomeMeds risk screening and MyMeds pharmacists intervention.
- Older adults have greater access to resources in order to reduce risks that might negatively impact health.

INSPIRATION

At the time of a hospital discharge, individuals are in greater need for services and support to navigate the transition and to manage their own care within the home. Times of transition enhance the risk of adverse outcomes, such as unnecessary readmissions and emergency department visits. UCLA and Partners saw an opportunity to collaborate at the hospital discharge. They believed that by integrating health care and social services they could achieve reduced readmissions and emergency department visits and improve outcomes, lower health care costs, and improve satisfaction.

UCLA HEALTH SYSTEM:

"UCLA Health's long-standing and successful collaboration with Partners in Care Foundation has been mission-critical for both organizations and has helped thousands of older adults return home from the hospital safely."

ORGANIZATIONS INVOLVED

The primary partners include UCLA Health and Partners. However, the partnership collaborates with many other community organizations, including Health Net, Durable Medical Aid Society, and WISE & Healthy Aging.

PARTNERSHIP STRUCTURE

The partnership is primarily a referral relationship and is formalized with a contract between UCLA Health and Partners for the delivery of services to individuals beyond the CCTP demonstration. The partners entered into a two-year agreement with CMS for the CCTP demonstration, which was then extended annually through the life of the demonstration.

MODEL DESIGN

Building on the success of the transition model developed for the CCTP demonstration, UCLA refined the model and secured it as a benefit for their Medicare Advantage and select ACO populations. The model begins with identifying eligible individuals. To do this, they use the LACE criteria (which looks at Length of stay, Acuity, Comorbidities, and admission

through the Emergency department). Those with a qualifying score receive a referral to Partner's coaches, who then perform psychosocial, environmental and functional assessments, and develop a community care plan while they are in the hospital or other institutional care setting, such as a skilled nursing facility. Medication reconciliation – utilizing the evidence-based MyMeds intervention as well as UCLA's team pharmacists – is also a critical part of this process.

Once the older adult is discharged from the hospital, Partners maintains a connection with them through home visits and calls to ensure their care plan stays on course. If needed, referrals to additional community organizations are made for services, such as meal delivery or transportation.

CAREGIVER:

"I am so appreciative of this service. I cannot put into words what it meant to not only get the assistance and guidance; the personal touch and kindness made the process so much easier!"

FUNDING MECHANISM

The primary funding source for the model is provided by UCLA Health, in which they provide Partners with a per-case payment for their transition services.

During the CCTP demonstration period, the partners received funding from CMS for eligible Medicare beneficiaries receiving the transition services.

LESSONS LEARNED

- Partners must be adaptable—open to change and new ideas. For instance, many adjustments have been required by both partners to continually improve their operations, including new workflows and information exchanges.
- Partners should use data to highlight the successes and opportunities within the model to capture the interest of additional partners and funders. For instance, partners expanded the data measures being recorded to better display the results achieved. The willingness of UCLA Health to share their data with Partners has been instrumental for partnership success.

FUTURE

The partners continue to focus on improvement in efficiency and quality for the care transition model to better serve individuals and ensure sustainability. They are working to improve and streamline the data collection and coaching process.

Additionally, the partners seek to expand their partnership to new organizations and funders, such as foundations and health plans.