Coordination of Services for Improved Health Outcomes of Older Adults: Solano County's Strive2BHealthy–Adult Health Promotion and Wellness Program

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EXECUTIVE SUMMARY

Over the next few decades, the growth of the older adult population needing physical or mental health interventions will overburden an already insufficient infrastructure. Solano County has developed a pilot program focused on improving health outcomes for older adults using coordination of services. The Strive2BHealthy–Adult Health Promotion and Wellness Program has been developed to provide an interdisciplinary approach to disease prevention and healthy living for older adults in Solano County. The team will provide home visiting services to low income adults with a focus on improving management of chronic disease through care coordination care and linkages to needed resources and services.

Managing the growth of the aging population will require more services and funding than any other time in history, necessitating a focus on prevention and promotion of healthy, independent living. The pilot program being initiated in Solano County is an innovative approach that illustrates how coordination of care services and disciplines will render improved health outcomes for the most vulnerable. This type of program can be implemented in Alameda County through collaboration between social services and health care services agencies.

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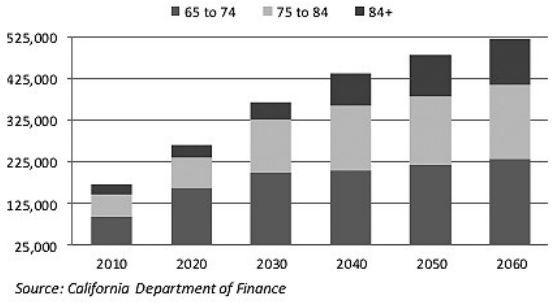
Introduction

America's older adult population is growing at an unprecedented rate with life expectancy greater than it has ever been in history. That is the good news. The challenge is that systems and resources are not in place to respond. The aging population has geriatricians and other providers actively working on solutions to identify and meet the unique needs of this growing population. In the United States, between 2010 and 2050, the number of adults age 65 years and older will double, those ages 80 years and older will triple, and those in their 90s and 100s is expected to quadruple.[1] Older adults have the highest care costs and require a myriad of services. Not only is there a need to ensure there are sufficient resources, but there is also a need for models of care focused on maintenance and prevention of chronic disabling conditions that often lead older adults to require crisis interventions. California counties lack the infrastructure to support the surge of folks who will require health care services for chronic physical and mental health conditions. The costs for these services will be unsustainable; therefore a coordination of services with a focus on prevention will be key. Solano County's implementation of their Strive2BHealthy pilot program is an innovative approach to accomplishing this goal.

FIGURE 1
Projected Senior Population Growth in Alameda County



Background

The Alameda County Social Service Agency is currently exploring models of care that enhance and coordinate services to most effectively address the rising needs of a growing, vulnerable older adult population. Alameda County is the seventh most populous county in the State of California, with a population of 1,510,271 according to the 2010 census. By 2030, one in five Alameda County residents will be in the 65-plus age group and by 2040, the number of older adults will substantially outgrow the number of children under the age of 18 (See *Figure 1*).[2]

1. *The Rising Cost of Living Longer: Analysis of Medicare Spending by Age for Beneficiaries in Traditional Medicare,* Henry J. Kaiser Family Foundation, January 14, 2015, https://www.kff.org/medicare/report/the-rising-cost-of-living-longer-analysis-of-medicare-spending-by-age-for-beneficiaries-in-traditional-medicare/, Web

2. *Alameda County Plan for Older Adults Fiscal Year 2016-2017,* http://www.alamedasocialservices.org/public/services/elders_and_disabled_adults/docs/planning_committee/Alameda_County_Area_Plan_Final.pdf, Web

According to the National Bureau of Economic Research, medical expenses double for older adults between the ages of 70 and 90, and lower income elderly use more medical services and goods. Medicare and Medicaid cover 65% of their medical expenses and in 2014, Medicare spending alone totaled $618 billion.[3] As adults live well past their 80s, they are more likely to live with chronic health conditions or functional limitations which leads to a greater likelihood of emergency room visits, hospitalizations, skilled nursing care and home health services which affects their quality of life and can be very costly.

Eighty-six percent of the nation's $2.7 trillion annual health care expenditures are for people with chronic and mental health conditions. Chronic disease, falls, and mental health management are challenges that create barriers for older adults to maintain health and safety, productivity, and a sense of independence. Approximately 80% of older adults have one chronic disease and 77% have at least two.[4] Preventable chronic diseases such as heart disease, cancer, stroke and diabetes cause two-thirds of all deaths each year among older adults. Falls are the leading cause of fractures. Every 15 seconds, an older adult is treated in an emergency room for a fall, and every 29 minutes, an older adult dies as a result of a fall. The United States spends over $30 billion each year treating older adults for effects from falls. In addition to chronic disease and falls, mental health disorders and substance abuse are common in older adults. One in four older adults experiences depression, anxiety and dementia. By 2030, it is expected that 15 million older adults nationally will suffer from one or more mental disorders. Substance abuse will affect 5 million older adults by the year 2030. Untreated mental health problems and substance abuse correlate to poor health outcomes, increased health care utilization and costs, increased functional limitations, impaired quality of life, and higher risk of suicide.[5]

As mortality rates increase and growing costs become unsustainable, systems must identify strategies and models of care focused on providing coordinated community-based supportive services to prevent premature institutionalization and the need for crisis based services. Alameda County Adult and Aging Services, under Alameda County Social Services Agency houses programs that provide services to the aging population: The Area Agency on Aging (AAA), In Home Support Services (IHSS) and Adult Protective Services (APS). Through Federal Older Americans Act, the AAA manages over 80 community based organization contracts, which provide services including, but not limited to, injury and fall prevention, nutrition services, case management, and legal services to seniors over age 60 in Alameda County.[6] IHSS provides assistance to eligible aged, blind, and disabled individuals who require in-home supportive assistance to prevent premature institutionalization and/or nursing home placement. APS investigates reports of abuse and neglect of elders (ages 65+) and dependent adults to correct situations involving abuse, neglect, or exploitation, and develop or arrange services to allow clients to remain safely in their own homes for as long as possible. APS links clients to community-based agencies that provide services to mitigate the abuse and minimize future vulnerability to abuse.

Recognizing the value in coordinated services, in 2015 Alameda County Social Services, Department of Adult and Aging Services, and Alameda County Health Care Services Agency, Public Health Department established a Memorandum of Understanding (MOU) to provide public health nursing (PHN) services to IHSS clients who have a variety

3. "Medical Spending of the U.S. Elderly," National Bureau of Economic Research Working Paper No. 21270, https://journalistsresource.org/studies/government/health-care/elderly-medical-spending-medicare, February 22, 2016, Web

4. "Healthy Aging Facts," National Council on Aging, https://www.ncoa.org/news/resources-for-reporters/get-the-facts/healthy-aging-facts/, Web

5. "Healthy Aging Facts," National Council on Aging, https://www.ncoa.org/news/resources-for-reporters/get-the-facts/healthy-aging-facts/, Web

6. "Area Agency on Aging," Alameda County Social Services, https://alamedasocialservices.org/staff/departments/adult_and_aging/aaa/index.cfm, Web

of medical and mental health issues.[7] The PHN's in IHSS manage a caseload, providing direct and indirect services to the client to ensure coordination of the clients' home care. Under the same MOU with Health Care Services Agency, Public Health Nurses are imbedded in the APS program. Unlike IHSS in which PHN's carry a case load, PHN's in APS are currently used strictly for consultation, medical case planning, and coordination of services for both the APS and Public Guardian (PG) programs. Social Services Agency and Health Care Services Agency staff are actively exploring ways to expand the use of PHNs.

Solano County Approach

According to the 2010 – 2014 American Community Survey (ACS), there are 421,624 residents in Solano County. Area Agency on Aging (AAOA) for Solano County reports the number of the county residents age 60 and older accounts for nearly 17% of the county's total population. The number of adults age 65 and older is projected to grow to approximately 74,500 by 2020 and 105,200 by 2030, according to the California Department of Finance.[8] Solano County Health and Social Services is comprised of six Divisions: Public Health (including Older & Disabled Adult Services Bureau), Employment and Eligibility Services, Behavioral Health, Child Welfare Services, Public Authority, and Administration.

In order to coordinate services and leverage resources for improved health outcomes for older and disabled adults, Solano County sought board approval in 2016 to integrate Older Adult and Disabled Services Division (ODAS) under the Public Health Division. The integration allows for ODAS and Public Health to combine efforts aimed at addressing a distinct gap of prevention focused programs for vulnerable adults. The Public Health Division is implementing a pilot program called Strive2BHealthy: Adult Health Promotion and Wellness with the goal of slowing down the trajectory of Solano County older adults from entering IHSS, APS and Public Guardian programs. They are developing a hybrid home-visiting and broad strategy program comprised of three main components: nursing and mental health case management, health education, and broader environmental strategies to promote independent living and the management of chronic disease. The focus on prevention will reduce the need for crisis intervention programs and reduce overall health and nursing care costs. The Strive2BHealthy (Strive) pilot will use an integrated model with an interdisciplinary team comprised of a Public Health Nurse, Mental Health Clinician and Health Education Specialist with a focus on health promotion and prevention. As part of the development process, Solano County is conducting a needs assessment to identify risk factors that affect older adults' transition from living independently to requiring assistance. Their plan involves visiting senior centers and senior housing communities in each of the seven cities in the county, administering surveys, giving educational presentations and having in-depth discussions about the survey topics. The assessment will include a literature review of prevalent issues impacting older adults' health and autonomy, and data collection from ODAS staff, AAA and partners such as Meals on Wheels, churches, hospitals and senior housing agencies. Data collection will continue through June 2018 but initial implementation of the pilot is expected to launch in May of 2018. The findings will be used to adjust and develop the program.

Once implementation begins, the Strive team will use the following criteria to identify qualified persons:

- Over age 50 and a resident of Solano County
- Medi-Cal recipient or income below Federal Poverty Lines
- Diagnosed with two or more chronic diseases

7. "Memorandum of Understanding Between Alameda County Social Services Agency Department of Adult and Aging Services, Department of Children and Family Services and Alameda County Health Care Services Agency Public Health Department," July 1, 2015–June 30, 2018

8. "Four-Year Plan Area Plan on Aging, Area Agency on Aging Serving Napa and Solano, FY 2016-2020, http://www.aaans.org/wp-content/uploads/Area-Plan-Update-FY-2017-18-PSA-28-EDITS-FOR-CDA-2017.09.29a-2.pdf, Web

- Interested in improving ability to manage own chronic disease
- Does not receive other comprehensive case management services
- Medically fragile

Referrals can come from APS and community partners that work with low-income adults such as county clinics, senior centers, Area Agency on Aging, etc. Once criteria has been met, there will be an initial home visit and comprehensive assessment by the team, which includes an environmental, fall, and depression assessment, medication reconciliation, health and wellness education, and linkage to needed services. On-going case management will be provided with the aim of promoting self-care, wellness, and independence. The following metrics will be used to measure outcomes:

- Use of healthcare and non-healthcare resources
- Occurrence of serious injuries (e.g. falls)
- Client self-efficacy (perception of ability to manage own chronic conditions)
- Improvements in medication management
- BP and hemoglobin A1c levels
- Measures of social isolation or connections

Although in the early stages of the pilot, the Solano County Strive Team and ODAS expects to see a reduction in APS cases for self-neglect, and fewer older adults requiring the need for IHSS. Feedback from older adults who have attended the community presentations indicate they struggle to manage chronic conditions, have difficulty communicating with health care providers, have limited access to healthy food, and would be open to participating in prevention workshops. The Team hopes that by targeting low-income seniors with preventative interventions, there will be a measureable improvement in health outcomes. One of the challenges the program faces is the small capacity of staff on the team. With that in mind, it will take time to build a case load in order to measure outcomes and report out to Public Health leadership. The pilot is being paid for by one-time funding (Intergovernmental transfer) with the plan to leverage state and federal funding through County Expense Claim (time study). Although not directed to report the outcomes to the Board of Supervisors by a specific timeline, staff hopes the success of the program will be shared at a future board meeting.

Recommendations

The coordination of services is the most efficient way to address the resource challenges facing counties as they strive to meet the needs of growing older adult populations. Solano County has recognized this, and as a result has reorganized and placed multiple safety net programs into the Public Health Division of Health and Human Services Agency. While Alameda County is currently organized as two separate agencies, Social Services and Health Care Services, they have also recognized the value of collaboration as demonstrated by the programs described above. Recommendations to continue this effort include:

1. Continue to enhance partnerships for current programs.
    a. Explore collaborating with Public Health for a similar hybrid home-visiting program
2. Have both agencies do a "data bump" to identify the most vulnerable adults and conduct a needs assessment to inform strategies on how to reach these folks
    a. Look at Emergency Medical Services (EMS), IHSS, and APS data for overlap and commonalities
    b. Review AAA Area Plan and needs assessment
3. Develop and implement a multidisciplinary team (consisting of a social worker, PHN, mental health clinician and health educator) to pilot a program aimed at health education for the prevention and maintenance of chronic health (physical and mental) problems.
    a. Expand on existing MOUs, or create a new MOU, between SSA and HCSA to allow for this pilot
    b. To fund the program HCSA and SSA would split the costs of the program 50/50

through the County Expense Claim process (CEC) for the remainder of the costs of the program not covered through time study reimbursement: 75% Skilled Professional Medical Personnel (SPMP) reimbursement rate for health-related services and 50% for targeted case management services (TCM). For more on the expected costs of this program, see *Figure 2*.

FIGURE 2
Projected Costs of Hybrid Home Visiting Program

Job Title	FTE	S&EB&WC
Social Worker III	1	$132,568
Health Educator I	1	$111,423
Registered Nurse III / Public Health Nurse III	1	$218,093
Mental Health Specialist III / Mental Health Clinician	1	$116,061
Total Staffing Cost	**4**	**$578,145**

Direct & Indirect Costs

Direct Costs (training, mileage, etc.)	$23,126
Indirect Costs (overhead, space, utilities, HR, County Counsel, etc.)	$127,192
Total Other Cost	**$150,318**
Program Total Cost	**$728,463**

Revenue

Federal	$563,439
State	$0
Revenue Total	**$563,439**
SSA Cost	$82,512
HCSA-PHD Cost	$82,512
Net County Cost (NCC)	**$165,024**

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