Presentation Goals:

• The ABC’s of the ADRC world.
• Learn how ADRC’s; AAoA’s and Care Transition programs support each other.
• Learn how to enhance the relationship between the Medical community and your ADRC.
• Opportunities for ADRC Sustainability.
The Aging & Disability Resource Center (ADRC) is a long term care systems change initiative aimed at improving and streamlining access to information, assistance and long term services and supports (LTSS) for older adults, people with disabilities, veterans and their families.

A program of the Lower Rio Grande Valley Development Council funded by the Texas Health and Human Services Commission serving Cameron, Hidalgo and Willacy Counties
The “No Wrong Door” Philosophy Is:

- It serves as a single point of entry into the LTSS system for older adults, people with disabilities, caregivers, veterans and families.

- The **Vision** is client-centered, accessible and coordinated services by using a holistic perspective and considering all the services a client may require.

- Working together, innovative thinking and new ways of sharing information to achieve the best possible client outcomes.

- ADRCs provide unbiased, reliable information and counseling to individuals with all levels of income and of age.
Core Functions

- Information Referral and Assistance
- Housing Navigator & Local Contact Agency-(MFP)
- Streamlined Eligibility Determination for Public Programs
- Data Management
- Quality Assurance and Continuous Improvement
ADRC programs are not necessarily located in a single physical place and their functions are not necessarily carried out by a single agency.

ADRC’s involve networks of state and local organizations working together in a coordinated manner to provide consumers with integrated access points to all long-term service and supports (LTSS).
Small Cities Resource Mapping Project

Partnership Players

- Area Agency on Aging
- Centers for Independent Living
- Other Aging and Disability Service Providers
- State Health Insurance Assistance program (SHIP)
- 2-1-1
- Adult Protective Services
- Medicaid
- Employment

- Social Services
- Advocacy Groups
- Social Security Administration
- Long Term Supports and Services Providers (e.g., home health agencies, nursing facilities)
- Critical Pathway Providers (e.g., hospital discharge planners, physicians)
- Transportation
- Housing
ADRC Partnerships focus on how all the pieces fit together as a whole system.

Coordinated Supports for your consumers
Any Organization, Any Agency, Any Business

ADRC partnerships serve people of all ages and types of disabilities, elderly, veterans and their families regardless of income level/source. We focus on the services that are used by people with long-term chronic conditions and/or disabilities; people who’s needs change frequently and who, without community LTSS supports, are seen frequently in emergency rooms, nursing homes and hospitals.
Texas RGV Hospital and ACO/MCO Partners
A relationship & commitment to facilitate ongoing changes and improvements to local consumer access to information and services

- Expediting Referrals (streamlining consumers & priorities)
- Sharing Expertise and in some cases staffing
- Identifying Gaps in Service (your clients multiple service needs)
- Cross Training Staff (services/operations)
- Extended ADRC Partner Network sharing (using ea. other’s strengths)
- Sharing of information (data)-MOU/MOA
- Potential financial relationships if/when there are funding opportunities
- ADRC partner organizations lead the effort to convene the local ADRC Advisory Committee
- Identify Key Stakeholders and Individuals for Participation as core extended partners
- Work groups and methods for stakeholder involvement & link to core partners
Network of Care

Seniors and People with Disabilities

Find Local Services by Topic or Keyword

RIO-Net ADRC Of The Lower Rio Grande Valley

Welcome to the Aging and Disability Resource Center. Our ADRC serves as a single point of entry into long-term services and support systems for older adults, people with disabilities, caregivers, veterans and families.

New-age care approach

Using the new-age care approach, the resource center assists consumers in accessing a variety of services and benefit programs by being a single point of contact. Services can range from Medicare application assistance to locating accessible housing resources in the resident’s community.

The ADRC inquires about a person’s needs and then refers the appropriate organization to the consumer instead of referring the consumer to the appropriate organizations. This approach streamlines the process for people seeking information. It also prevents the consumer from retelling their story multiple times to discover what benefits will meet their entire needs. Instead, every person, who receives the ADRC’s assistance, shares their story once with the center before the center connects the best benefit resources or service options to the consumer.
Community Partners Referral Form

Applicant Information
Has client's rights, responsibilities and release of information been clearly explained to client?
Name: [ ]
Date of Birth: [ ]
Current Address: [ ]
City: [ ]
State: [ ]
ZIP Code: [ ]
Country: [ ]
Primary Language: [ ]
Does client have Medicare?: [ ]
Does client have Medicaid?: [ ]
Does client have a Social Security Number?: [ ]
Does client have Legal Guardian?: [ ]
Has client been discharged from a hospital or nursing facility? If yes, state date [ ]
Is this client being referred due to answering YES through the MOS 3.8 SECTION D question?

Referring Agency
Agency: [ ]
Address: [ ]
Phone: [ ]
Fax: [ ]
Referral Date: [ ]

Emergency Contact
Name of a person not assisting you: [ ]
Address: [ ]
City: [ ]
State: [ ]
ZIP Code: [ ]
Phone: [ ]

Services
Current services client is receiving from your agency:

Client Consent
Has client consented to release information between community partners?: [ ]
Has client consented and signed HIPAA privacy information acknowledgment form?: [ ]
This section is to be completed by receiving agency and to be returned to Referring Agency within 24 hours of initial referral.
Agency: [ ]
Agent: [ ]
Phone: [ ]

Please Email Referral form to Bio-Net@RIVCRAND.org
Integrating Functions Across Core Programs

Building Capacity for Person-Centered Systems

AAA/ADRC

Packaging core functions for different programs within an organization

Operational Assessment

Care Transitions Program
(Intake, Assessment, Patient Activation, Care Plan, Service Connection)

VD-HCBS Program
(Intake, Assessment, FMS, Patient Activation, Care Plan, Service Connection)

Leveraging Existing Resources

Money Follows the Person
(Intake, Assessment, Patient Activation, Care Plan, Service Connection)
Texas Caregiving
2016 Behavioral Risk Factor Surveillance Data (CDC)
Acknowledgement of Sources:

• CMS; Centers for Medicare and Medicaid
• ACL; Administration on Community Living
• HHS; Health and Human Services
• CDC; Centers for Disease Control
Lower Rio Grande Valley Development Council (Community Based Organization)

• Area Agency on Aging
• Aging and Disability Resource Center
Community-based Care Transitions Program (CCTP): Awarded June 2012

- Community-based Organization (CBO)
- CTI Coaching Model: 230 patients/month
- PAC Collaboration Model: 450 patients/month
Why Readmission Reduction?

- CMS Hospital Readmissions Reduction Program - Begins October 2012
- Half of the RGV-Care Transition hospital partners were facing a total estimated $1 Million dollars or more in penalties a year for AMI, HF, PN.
- All of the RGV-Care Transition hospital partners had excessive readmissions in at least 1 of the 3 conditions; 22.7%
- 34% of readmissions from PAC providers
Taking our data on the road!

• 2016-CMS announces closing of all CCTP programs.
• LRGV-CCTP program ends: 2/29/16 (26,166 participants; 15.7 readm. Rate)
• Expansion talks with local RGV-ACO groups.
• Coordinated meetings with other MCO’s: Superior; Molina; United and Cigna.
• Solidifying relationships with partnering RGV hospitals for Bundle payment programs to come.
• FQHC’s become an interested player in CT game.
• CMS-CCTP Sustainability Groups are formed to help CT programs jump into the MCO world of healthcare.
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