



**Enabling Aging in Place through
Telecare/Telehealth**

**NASUAD Conference
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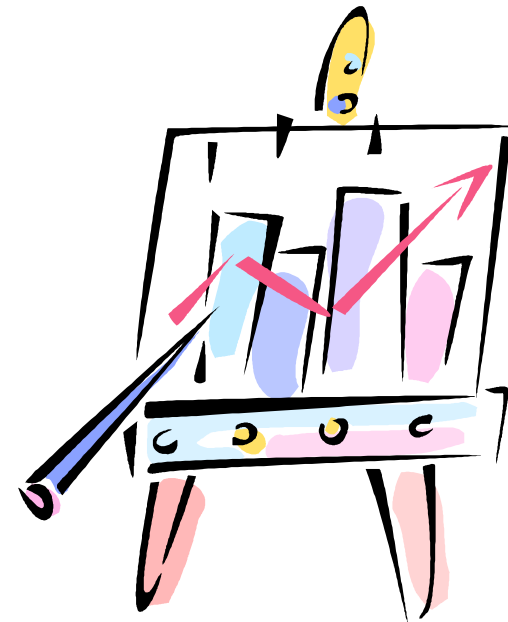
Agenda

- ✓ Background:
 - The Challenge: Unsustainable Long Term Care System
 - The Solution: Telecare/Telehealth Enabling Aging in Place
- ✓ Lassen County, California Pilot:
 - Pilot Demographics
 - Pilot Participants
 - Pilot Approach
 - Lessons Learned to Date



The Challenge: Unsustainable Long Term Care System

- Current system is unsustainable
- Growing senior demographic - The oldest old, most likely to need LTSS, are projected to almost triple, from 6.3 million in 2015 to 17.9 million in 2050, accounting for 4.5% of the total population
- Lengthened life-expectancy
- Limited financial resources
- Exploding health care costs
 - Management of chronic conditions
 - Recurring re-hospitalizations
 - Inadequate patient monitoring
- Shortage of healthcare professionals
- Social isolation of seniors/persons with disabilities in their homes

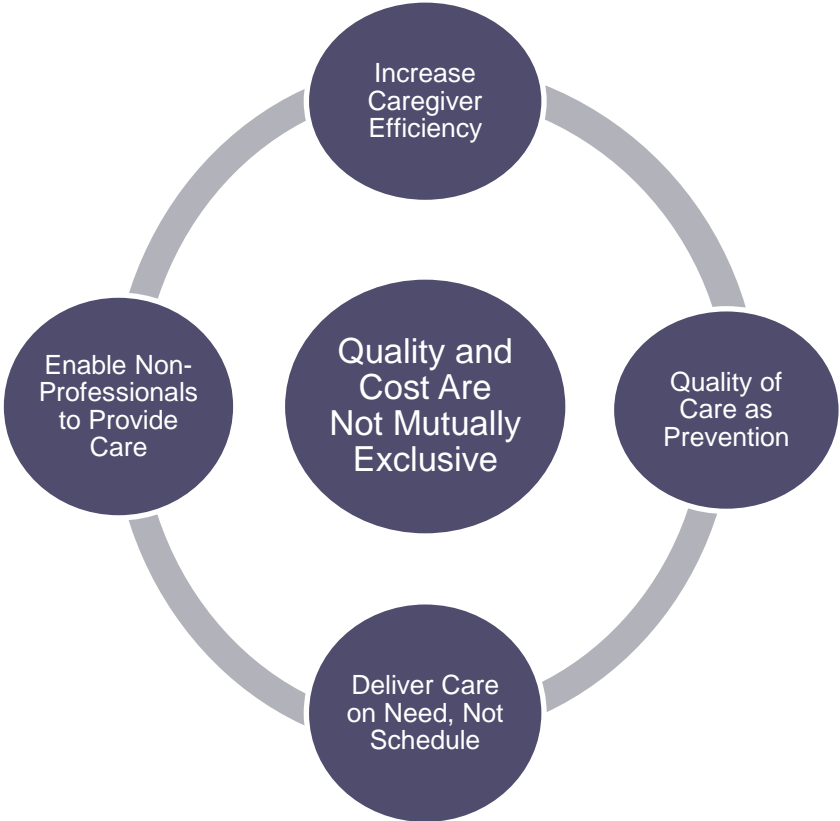


The Solution: Telecare/Telehealth Enabling Aging in Place

- Alternative approaches to monitoring that support 24/7 care
- Early interventions to reduce hospitalizations and re-admissions, and better manage chronic conditions
- Increasing access to wider network of caregivers
- Engaging and empowering family caregivers through enhanced communication, training, and support
- Reducing social isolation and increased involvement with community
- Greater personal investment in one's own health
- Decreasing costly nursing home admissions



Using Technology to Bend the Cost Curve and Maintain Quality



Technology can potentially bend the cost curve, while still maintaining quality.

Selecting the “Right” Location for a Pilot



- California is moving its “Medi-Medi” (dual eligibles) population to managed care
- Interest in telehealth growing across the State, but integrated telecare as a tool to support healthcare transformation is yet to be explored
- Like many other states, California is facing a “Silver Tsunami”
- Large parts of the State are rural and need telecare/telehealth to be able to deliver services in the frontier areas where there is a shortage of health care professionals
- Ongoing conversations about telehealth show widespread interest in innovative models
- California has a history of bringing people, process, and technology to improve the quality of life and maintain peoples’ independence
- Emergence of ACOs creating new partnerships with the goal of improving quality and lowering cost

Finding the “Right” Pilot Population

Northeastern Rural Clinics Service Area



Location:

- Lassen County, California
- Rural community on eastern slope of Sierra Mountains near Nevada border
- Most of Lassen County is considered “frontier,” with less than 9 people per square mile

Community Demographics:

- Largely a white, low- to-middle class area with a large Baby Boomer population
- Over the next 40 years, the percentage of Lassen County’s population that is elderly is expected to increase from 1/11th to 1/5th of all people
- Many transient low income individuals increase the challenge to provide continuity of care and follow up
- Large number of smokers
- High cancer rates
- Asthma and diabetes disparities and less effective rates of chronic disease management than in other areas of the State
- Mortality disparities with female breast cancer, drug induced deaths, firearm related deaths, and suicide.
- Limited availability of public transportation
- Underinsured and geographically isolated have challenges accessing specialty care

Target Population:

- 250 low income seniors with chronic conditions living alone
- Interventions for 125 and control group of 125

Finding the “Right” Pilot Partners



- **California Telehealth Network:**
Telehealth technical support and grant administration
- **Northeastern Rural Health Clinics:**
Medical care, telehealth consults, and protocol development
- **Lassen County Health and Social Services Agency:**
Recruitment of participants and linking of participants to services
- **GrandCare:**
Technical platform customization and maintenance
- **MAXIMUS:** Call center monitoring; recruitment, training, and management of Independence Coaches and Community Assistors
- **University of Southern California, Price School of Gerontology:**
Pilot Evaluation

Defining the “Right” Pilot Approach

Pilot goals:

- Extend aging in place, postponing or avoiding nursing facility admission
- Reduce adverse events -- hospital readmissions, ER usage, falls -- and improve chronic care outcomes
- Improve utilization and better target use of limited supply of health professionals and personal care assistants
- Encourage family care-giving by offering convenient, safe, and inexpensive respite for family caregivers



Pilot components:

- Telecare monitoring / Telehealth
 - Contact center monitoring of participants
 - Outbound reminder calls/alerts
 - Referrals to medical home case managers, direct care workers, family members, or other appropriate support
 - Use of telecare platform to support participant and caregivers – document and educate on transition protocols and chronic disease management
 - Telehealth appointments to allow in-home consults
- Work force services to develop alternative care workforce:
 - Development of training programs for family caregivers/Independence Coaches
 - Available worker database and referral for assistance with temporary needs
 - Create care support groups with social media channels and health education videos
- Literacy services to ensure appropriate pilot recruitment and health educational materials

Addressing Multiple Aspects of Aging in Place



Bringing Multiple Technologies Together



GrandCare platform offers multiple capabilities including remote sensors, vital sign monitoring, and video conferencing to support aging in place and chronic disease management

Source: GrandCare Systems

Helping Participants to Manage Their Chronic Conditions

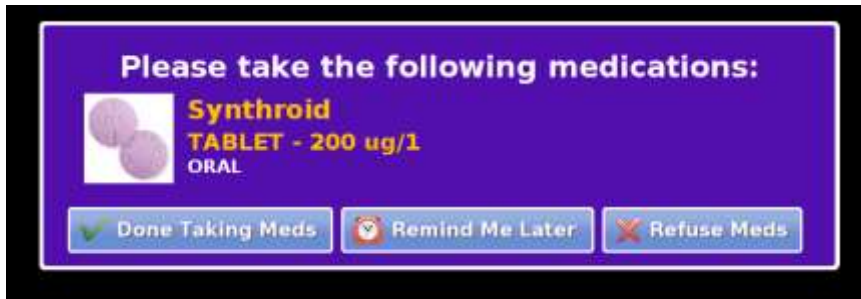


GrandCare enables participants to become more involved in their own health care, encouraging self-management of chronic conditions....

....while also enabling them to engage in meaningful social activities.



Assisting with Medication Management



GrandCare monitors participants' medication schedules, reminding them when medications are due...

...allowing patients to see when they need to take medications and visually recognize their different types of medications, alerting Telecare Navigators if a participant misses medications, and enabling the call center to follow-up with an outbound call to find out why medication was missed.

Medication Schedule

Name	Day	Timeframe	Purpose
Synthroid	Every Day	6:00am to 8:00am	Thyroid replacement
Plendil	Every Day	6:00am to 8:00am	Reduce chest pain
Lipitor	Every Day	4:00pm to 7:00pm	Reduces cholesterol
Lanoxin	Every Day	4:00pm to 7:00pm	Str

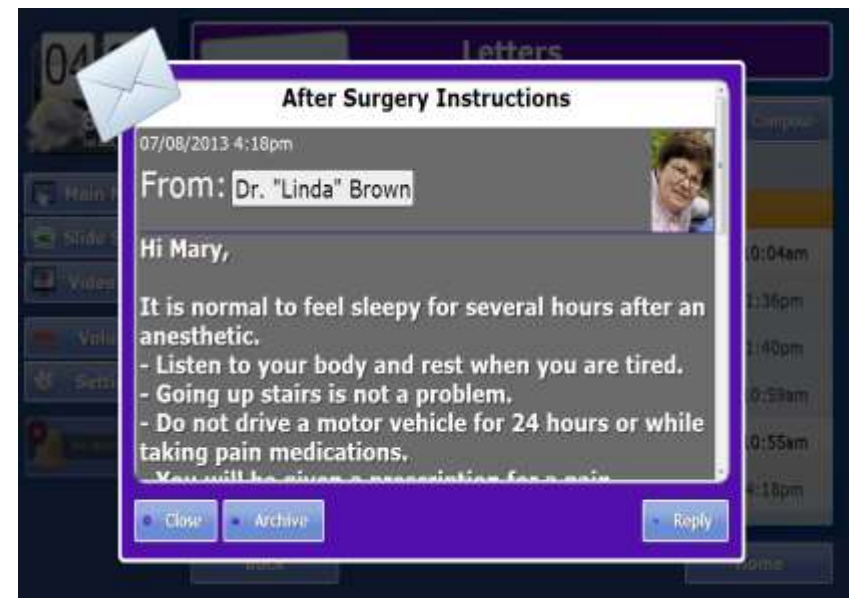
Medication Details

Generic Name
Lipitor
Specific Name
Atorvastatin
Simple Name
Cholesterol Pill
Doctor
Dr. Porter
RX Number
321-055sf

Dosage
pill - 10mg
Directions
By Mouth
Purpose
Reduces cholesterol

Close

Scheduling and Managing Care



GrandCare maintains individualized participant schedules, allowing scheduling of follow-up care, telehealth consults, social interactions, and needed services. It also delivers discharge information to provide additional assistance to participants and their caretakers.

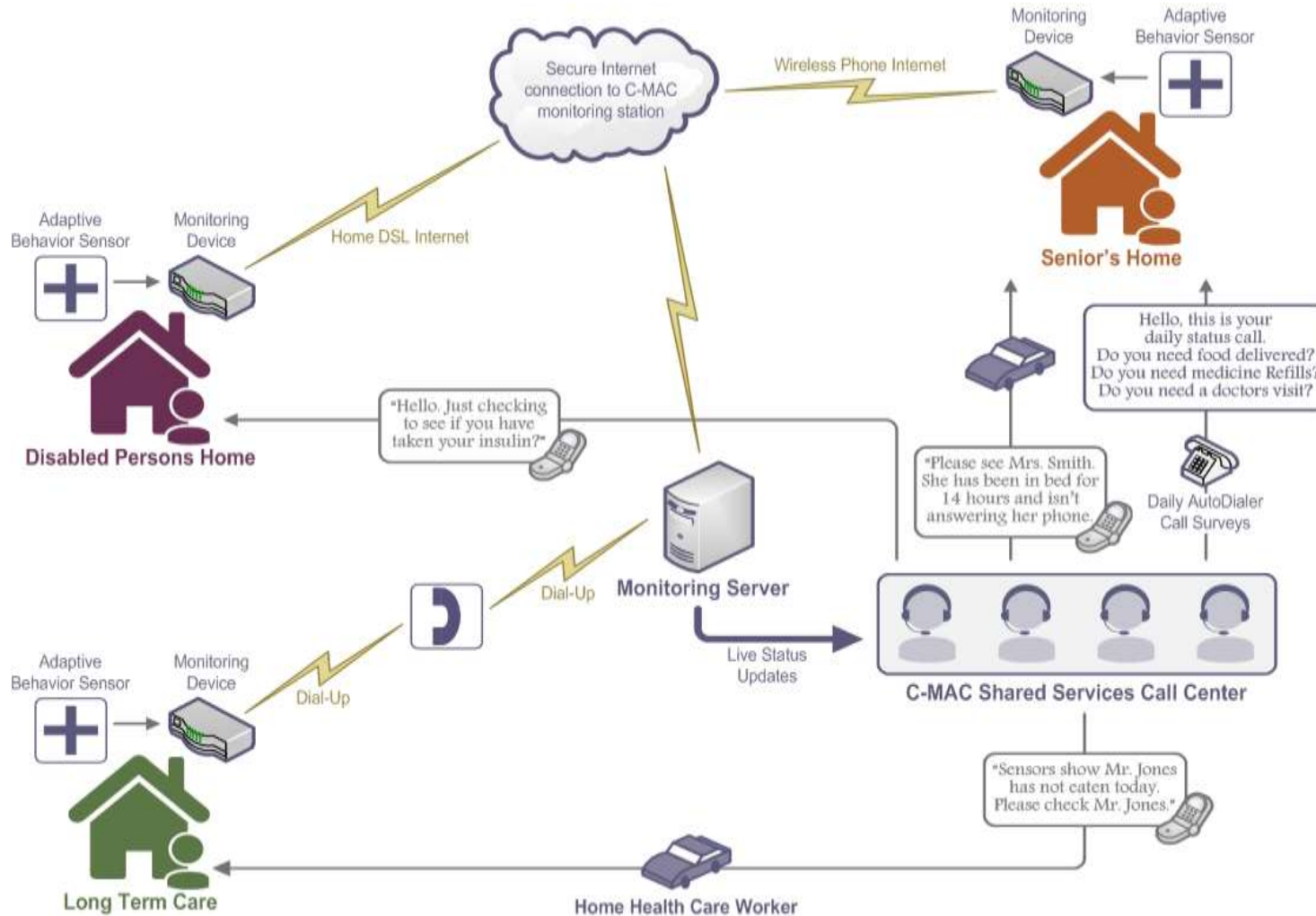
Implementing a Telecare Pilot



Once a person is determined eligible for services, there are four components of telecare:

1. Visit the approved individual's home, conduct an interview, and work with the Primary Care Provider to determine the appropriate monitoring support and technologies required, based on an in-home assessment
2. Acquire pilot-approved products from technology vendor, customizing the platform to meet individual participant needs
3. Conduct ongoing monitoring of the individual, based on their situation, needs, and approved services
4. Take appropriate actions based upon established protocols

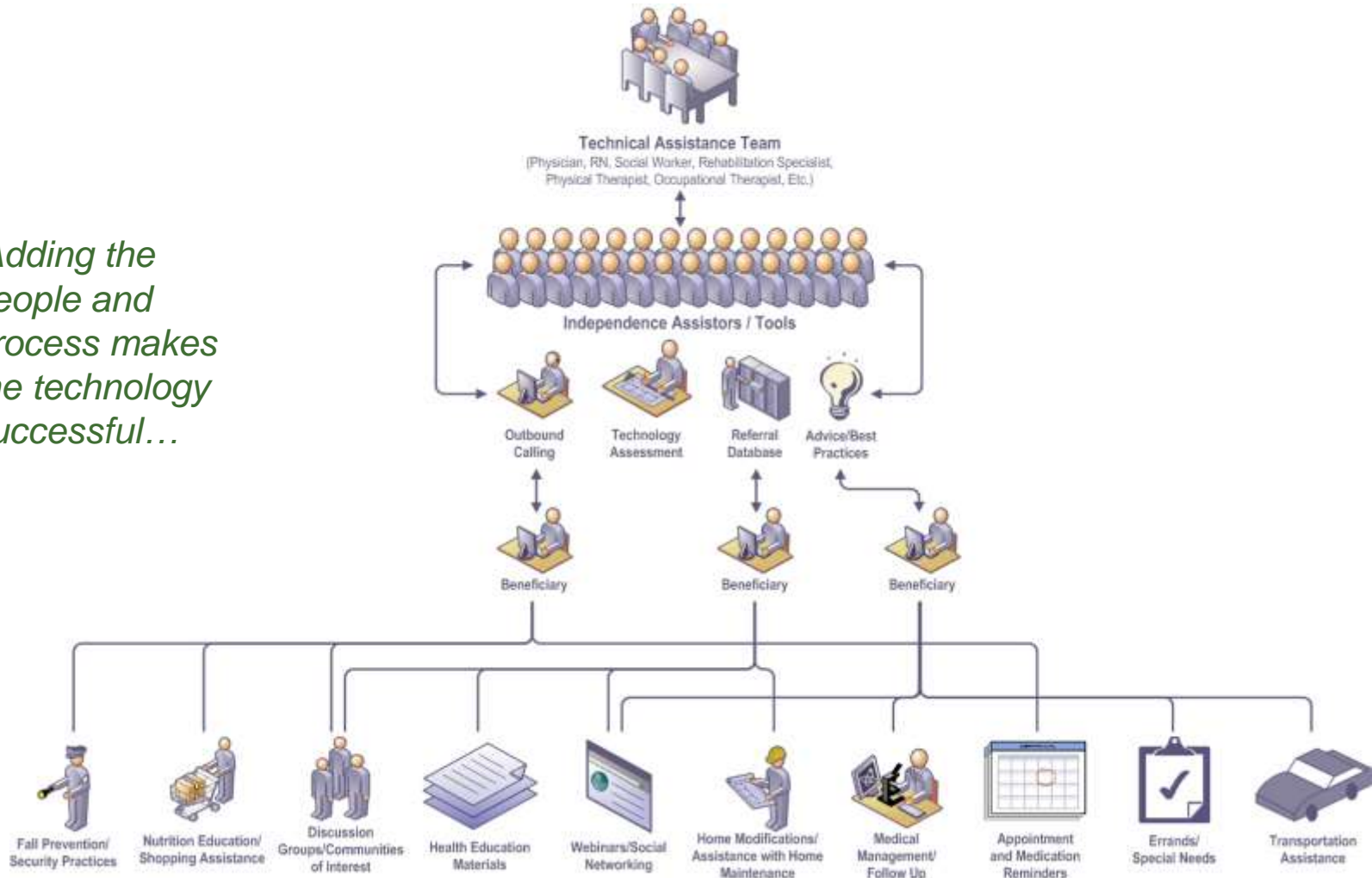
Operating a Telecare Model in HCBS Environments



... we offer a process to dispatch care when it is needed...

Combining the Medical and Social Models

Adding the people and process makes the technology successful...



Using Independence Coaches as the “Glue”

- A “problem-solver” that keeps at-home participants connected to their community and their families:
 - Technology assessment/technology trainer and coach
 - Arrange for persons to perform limited errands and address unscheduled needs
 - Perform regular communication via video teleconferencing and follow-up with case managers if remote readings are outside norm
 - Promote health education materials, workshops, webinars, and discussion groups
 - Encourage socialization through social media
 - Coordinate with caregivers and long distance family members about social issues
- Trained through formalized curriculum and augmented by part-time paid senior citizens or community volunteers
- Access to a database of part-time workers with flexible schedules available to provide “on demand” temporary services needed by persons at home



Providing “On Demand” Community Assistors

- Recruitment, training, and management of part-time workers and/or volunteers who can perform needed support tasks for home-bound participants – such as shopping, meal preparation, laundry, transportation, home modification, prescription pick up
- Create and maintain a database of Community Assistors
- Independence Coaches refer available Community Assistors for “on demand” tasks by matching skill set and availability with participant needs using referral database
- Provides part-time employment for local economy, allowing unemployed to get experience and references for further employment



Integrating Telehealth to Improve Care/Reduce Cost

- Allow hospitals to discharge their patients sooner, while providing increased access to medical follow-up and the frequency of provider interaction
- Allow patients to recover in more comfortable surroundings
- Allow medical professionals to more easily reach remote patients (especially those in rural areas), who typically can not access care
- Allow medical professionals to remotely triage their patients, thus preventing unnecessary hospitalizations
- Provide convenient access to specialists, saving costs associated with transporting patients from home or nursing and rehab facilities to the hospital or clinic
- Better educate patients and their caregivers to become more active participants in their recovery
- Provide mental health/substance use disorder patients a way to attend their sessions without leaving their home, reducing no shows and improving outcomes
- Provide remote access to language interpretation services, automatically routing requests to interpreters



Collecting Performance Metrics to Measure Success

Outcome	Measure	Method for Collecting Data
Delay or divert institutional care entry	Track the pilot group length of home stay against other LTSS program participants with similar demographic and health profiles, who are unable to access the key components of the proposed pilot	Request the Medicaid Department to collaborate on the identification of a control group of similar demographic composition and with similar health profiles.
Reduce preventable adverse events including hospitalization, re-hospitalization, emergency room visits, and falls	Post pilot enrollment incidence of adverse events as measured monthly versus pre-pilot entry history of adverse events	Review participant's history noting frequency and types of adverse events. Information collected from case files and interviews with participant
Enhance beneficiary independence, quality of life, and satisfaction	Increased MFP Quality of Life Survey scores; Utilization of GrandCare as a tool for social engagement (email, learning activities, video conferencing with peers, frequency and content of participant-initiated contact with caregiver	Administer MFP Quality of Life Survey monthly tracking score trends. Regular interviews where general ratio of negative to positive quality of life comments are monitored
Increase participation of available family caregivers in regular caring activities	For this pilot's purposes, "caring activities" are defined as those activities that require an investment of time and contribute to participant's capacity for independence, by improving quality of life, and reducing social isolation	Create, with Medicaid Department an inventory of "family caring behaviors" known to positively impact HCBS participant's ability to remain independent and without institutional care. Administer inventory monthly.
Reduce overall costs paid for by the Medicaid program for pilot participants	Measure average service delivery costs monthly for those participating in this proposed pilot against other pilots utilizing different strategies, as well as HCBS participants with a similar level of care determination but not participating in a pilot	The ability to obtain these figures will depend on the department's capacity to identify and track through customized reports average costs for pilot and other cohorts as identified.

Lessons Learned to Date

- Focus on reducing complexity – “Less is More”
- Technology is only part of the solution – people and process are critical
- Establish collaborative partnerships and obtain input from all key stakeholders to create a pilot “right” for rural California communities
- Ensure your business model, processes, and tools are optimized for the target audience and California’s unique environment



Allows the community to focus on quality, while reducing costs to the healthcare delivery system!

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