Master Plan for Aging:

Recommendation *Template*

12-12-209

Instructions for submitting recommendation: *To submit your recommendation, please fill out as many of the fields as you can, but it is fine to leave some blank. Recommendations can be submitted at engage@aging.ca.gov. Initial recommendations are requested to be submitted by December 13, but continue to be welcome.*

Goal #1: We will live where we choose as we age and have the help we and our families need to do so.

Objective 1.1: Californians will have access to the help we need to live in the homes and communities we choose as we age.

Issue Statement:

Individuals, when they seek assistance for themselves or others, lack timely access to accurate information, assistance and supports needed to directly connect with Long-Term Services and Supports (LTSS):

LTSS encompass a variety of health, health-related, and social services that assist individuals with functional limitations due to physical, cognitive, or mental conditions or disabilities. LTSS includes Medi-Cal waiver programs, Older Americans/California Act, Rehabilitation Act programs, and any programs and services that assist with activities of daily living (ADLs, such as eating, bathing, and dressing) and instrumental activities of daily living (IADLs, such as housekeeping, supervision and managing money) over an extended period of time.

1) Older adults, people with disabilities and caregivers often "don't know what they don't know" – and, as such, are unaware of the services they or their loved ones need as well as the services that may be locally available to meet those needs.
2) Older adults, people with disabilities and caregivers lack access to a standardized state/local information platform that specifies available long-term services and supports (LTSS) options and assists them in accessing the necessary services and support in a seamless and timely manner.
3) A number of Information and Assistance or Referral (I&A/R) services operate across the state, often in conjunction with the local Area Agency on Aging or through Independent Living Centers, 2-1-1, Regional Centers, mental health systems, health care networks and numerous philanthropic and other call center networks – each with different program standards, stand-alone resource databases and call center practices. Many older adults, people with disabilities and caregivers who need critical supports are unaware of where to get comprehensive and accurate LTSS information with which to make life-changing decisions. Often, information is needed to access services that may be urgently needed to avoid costly institutional care and/or prevent health and safety emergencies.

4) I&A/R service providers often provide lists of programs and services without organizing and verifying the information according to individual needs and preferences and without regard to program eligibility standards. This often increases confusion and traps older adults, people with disabilities and caregivers in a maze of program referrals, with no assurance that s/he will find and actually access the necessary services and supports.
5) I&A/R service providers rarely provide "warm hand-offs" or follow-up, and many lack data to evaluate effectiveness in helping consumers actually start receiving the necessary services and supports; often requested in time of urgent need.

6) There is no consistent mechanism to track referrals and outcomes from I&A/R service providers or data to evaluate effectiveness.

7) Currently I&A/R service staffing is different with each network and oftentimes services lack training and expertise from peers (people with disabilities, older adults, caregivers, etc.) and individuals with lived experience who rely on assistance for daily living.

8) I&A/R service staff require core competencies and training to skillfully manage complex questions, sensitive subjects and urgent situations.

9) Older adults and people with disabilities are disproportionately impacted by disasters and emergencies that disrupt their safety and life-giving supports. These individuals have urgent and critical needs for assistance with emergency planning, response, and recovery. Without proper planning, response and recovery, disasters and emergencies result in increased risk to the health and safety of those who often have unique physical and mental health needs that require urgent attention.

10) I&A/R services are often driven by the staff or organization which may operate in siloes, have narrowly defined service menus and referral resource directories with protocols that are not always person-centered, i.e. responsive to the needs, preferences, and desires of the individual requesting services. Few have 24/7 response protocols.

Recommendation(s)

1) **ONLINE PORTAL:** Identify or develop a user-friendly, branded, standardized, accessible, web-based/online portal and digitalized statewide I&A/R system that provides public information about LTSS and streamlines the public's access to local LTSS service delivery systems. The online portal would be administered as a state-level function and a public-facing and trusted source of information for people seeking LTSS assistance near where they live.
2) **FAMILIAR LOCAL NETWORKS**: Leverage and enhance existing local-level coordinated I&A/R networks operated by Area Agencies on Aging and Independent Living Centers as core partners and other LTSS service providers though the Aging and Disability Resource

Connection (ADRC) No Wrong Door partnerships and specifically through the Enhanced I&A/R service and 211 systems in California. Local existing organizations have expertise with local issues, trends, and services to meet the diverse and unique needs of each community including cultural, multi-lingual, and Americans with Disabilities Act (ADA) competency and compliance. Utilize standards for information call centers and 211 practice such as the Alliance of Information and Referral Systems (AIRS) training competencies. Utilizing existing networks, LTSS information and services will be provided through collaborative and coordinated person-centered practices.

3) **COMPREHENSIVE, HIGH QUALITY and TRUSTED INFORMATION:** Develop statewide LTSS Information and Assistance practice and quality standards for locally coordinated person-centered Enhanced I&A/R and 211 programs to ensure consistency, accuracy and responsiveness. Adopt quality measures that monitor effectiveness, improve service delivery, and ensure positive customer outcomes from providing comprehensive and trusted LTSS information. Metrics will include a focus on follow-up; including what referrals the individuals received and what services they successfully used.
4) **PRE-SCREEN FOR URGENCY AND LTSS DATA**: Identify or develop and launch a new statewide pre-screen tool that does two things: 1. Screens for LTSS needs, presumptive eligibility for programs, and urgency and 2. Gathers data necessary for the State to inform future LTSS policy. Adopt an evidence-based, standardized pre-screening tool that is simple and can be self-administered through the online portal functionality, call center personnel or by local program professionals as is used in the State of Washington's Community Living Connections. *(See the examples named below.)* The new (for California) pre-screen tool can be implemented widely (with agreement with the State for data handling) by all LTSS public contact points quickly as an interim policy step toward a future universal LTSS assessment of need tool. It also informs I&A/R and local LTSS service providers' triage protocols for facilitating access to specific LTSS services. For example, a result that shows high risk for shelter and food insecurity will drive a high priority and timely response to connect the person to affordable housing and food/nutrition programs.
5) **24/7 RESPONSE:** Designate a 1-800 statewide phone number that is administered by the State (or State contractor), builds on local 2-1-1 service provider expertise or other existing local I&A/R and has the capability to respond whenever Californians seek LTSS information and assistance. A 24/7 LTSS responder would have the ability to connect the public seamlessly to local level services. The 24/7 call center response must have the capacity to provide multi-lingual access to services 24 hours day/7 days a week and in timely fashion, connect the caller with a warm hand-off to information and services.

Description:

- The online portal/website will provide California residents, caregivers and service professionals with a one-stop source for LTSS information, resources and services which include information about LTSS in general and specific local LTSS programs and services;

including, state-licensed health facilities, community-based support services such as adult day care, respite, transitions services, assistive technology, peer mentoring and options counseling, mental health, substance abuse programs, as well as other critical services such as transportation, housing, employment/employment support and local amenities. The web portal will include information, public education and pre-screening for LTSS needs functionally along with a single phone number that connects individuals to local I&A/R services, building upon the Area Agency on Aging and Independent Living Center Aging and Disability Resource Connection (ADRC) network. The call number will route to the local 24/7 call center service partner that will provide a warm hand-off to the ADRC and during non-program hours, will obtain and transmit safeguarded client information digitally for follow-up by the ADRC the next business day.

- 2-1-1 can be leveraged as the statewide network 24/7 consumer assistance call center that connects individuals with local LTSS programs and services and provides warm handoffs, after hour and weekend support, as a coordinating partner of the local ADRCs.
- The statewide and local I&A/R programs will be staffed by professionals with – whenever possible and as applicable to the role they serve, advanced training in older adult and disability services, trained and certified as a AIRS Community Resource Specialist/Aging and Disability, cross-trained in local resources and services, with salaries commensurate with their position training and experience.
- An ongoing LTSS public information/outreach campaign will educate Californians about LTSS topics and promote the statewide I&A/R call-in number, the statewide LTSS web portal, local ADRCs, and will include public educational efforts to promote advance planning, livable communities, and a broad range of issues related to aging and disability for all generations.
- The statewide branded, trusted and recognizable statewide ADRC No Wrong Door system will utilize a no-wrong-door approach and will seamlessly connect individuals into the system no matter where they enter.
- LTSS Pre-Screen: Adopt an LTSS Pre-Screening process as 1. A short-term step toward uniform LTSS assessment across programs and 2. An opportunity to gather LTSS user demographic and utilization data to drive future policy and financing innovation. The tool can be developed or adopted in coordination with the Master Plan on Aging Research Sub-Committee's work based on current research in order to advance data collection practices and drive system improvements. A pre-screening process can be implemented by all LTSS provider organizations, in coordination with or in place of existing LTSS and can benefit assessment tools while a longer-term solution (universal LTSS assessment of functional/social/medical need) is in development. Pre-Screening can be used by the online portal (self-administered) as well as by all 2-1-1 local and ADRC agencies in order to better document current risk (social determinants of health), volume and type of LTSS utilization and demographics of California's LTSS consumers. This data can be uploaded to the State,

aggregated, analyzed and used for future LTSS policy and system development.

- A long term goal is to adopt a standardized LTSS assessment and follow-up protocol to be utilized across agencies. Additionally, this assessment/protocol will be utilized to evaluate effectiveness in connecting consumers with the necessary services and supports.
- The local I&R/A providers will systematically plan for and provide emergency preparedness services for older adults, people with disabilities, and caregivers including disaster planning and coordinated access to resources during disasters or power outages. In this respect, it is encouraged to partner with 2-1-1 service providers who also serve a similar disaster information role for the general public in their communities.

- **<u>Program standards:</u>**
    - Each local ADRC will provide person-centered, culturally competent information and assistance to older adults, people with disabilities and caregivers across all income levels, with appropriate language services.
    - All I&A/R practices will be person-centered and based on individuals' needs and preferences.
    - No individual will be referred to a program/service for which s/he is ineligible or unavailable. Individuals will be referred to services they qualify for, with warm hand-offs and follow-up to ensure access to services.
    - Each local program will plan, collaborate and coordinate services with existing community-based organizations that provide LTSS information to older adults and people with disabilities in their communities. Information will be comprehensive, will be up-to-date and accurate.
    - Each local ADRC program will include information including but not limited to: Medi-Cal eligibility; Medi-Cal Home and Community-Based Services including IHSS, CBAS, MSSP, PACE; linkage to Adult Protective Services to address safety risks; direct screening and referral to waiver programs; mental health services; Older Americans Act programs including home-delivered meals and congregate nutrition; family caregiver support programs and the Caregiver Resource Centers; Independent Living Centers; transportation; personal care services; supportive housing; assisted living; group housing; skilled nursing and residential care facilities, home health agencies, hospice, and many others.
    - Each local ADRC will collaborate with Offices of Emergency Services, Public Health, and existing community-based service organizations including 2-1-1 that provide emergency preparedness and response support for older adults and people with disabilities in their communities.
    - Best practices at the local level will include the ability to not only provide information and assistance but perform pre-screening and presumptive eligibility

for key programs including Older American's Act/Older Californians Act program, including case management, as well as IHSS, APS and Medi-Cal.

Evidence that supports the recommendation: [Add links or summaries of research evidence that support the recommendation.]

1. **Leveraging Home-Delivered Meal Programs to Address Unmet Needs for At-Risk Older Adults: Preliminary Data.** Morris AM[1], Engelberg JK[1], Schmitthenner B[1], Dosa D[2,3], Gadbois E[3], Shield RR[3], Akobundu U[4], Thomas KS https://www.ncbi.nlm.nih.gov/pubmed/31188480
2. **Screening for Social Determinants of Health in Michigan Health Centers.** Byhoff E[1], Cohen AJ[2], Hamati MC[2], Tatko J[2], Davis MM[2], Tipirneni R
3. **Social Interventions Research and Evaluation Network (SIREN) Multiple Articles and Research Evidence** https://sirenetwork.ucsf.edu/tools/evidence-library

Target Population and Numbers: All California older adults, people with disabilities and families in need of, or anticipating the need for long-term services and supports.

Examples of local, state or national examples:

1. Local Example: San Francisco Department of Aging and Adult Services, Benefits and Resource Hub
   - Contact: *Shireen McSpadden, Executive Director, San Francisco Department of Aging and Adult Services*

2. State and Local Example: Aging and Disability Resource Connections (ADRC)
   - Contact: *Irene Walela, Deputy Director, California Department of Aging, Long-Term Care and Aging Services Division*

3. National Example: Alzheimer's Association Help and Support (please add more info)
   - *Susan DeMarois, Alzheimer's Association See this website: https://www.alz.org/help-support/resources/helpline*

4. Pre-Screen Tool: Oregon's Accountable Health Communities Study
   https://www.ohsu.edu/sites/default/files/2018-08/Accountable_Health_Communities.pdf

5. State and Local Example: Washington's Community Living Connections Website, portal, on-line self-screen and connection to local No Wrong Door organizations : *https://www.washingtoncommunitylivingconnections.org/consite/index.php*

6. Practical Example Evidence-Based Screening Tool: WestHealth Senior Social Screener-- https://www.westhealth.org/resource/addressing-the-social-needs-of-older-adults-a-practical-

guide-to-implementing-a-screening-and-referral-program-in-clinical-settings/

Implementation: [Insert here what actions state agencies, legislators, counties, local government, or philanthropy can take to move this recommendation into implementation. Some of the below entities may or may not be applicable to each recommendation]

- **State Agencies/Departments:** [action to be taken by governor or specific state agencies] California Department of Aging, Department of Health Care Services, Department of Rehabilitation, California Office of Emergency Services, Department of Social Services, Department of Developmental Services, Department of Public Health, CalVet, Department of Managed Health Care, CalTrans and others.
- **State Legislature:** [legislation needed to implement recommendation] Aging & Disability Resource Connections, Standards for Organizations and Responsibilities for Prescreen
- **Local Government:** County Health & Human Services, Department of Public Health, Offices of Emergency Services, housing authorities, etc.
- **Federal Government:** Department of Health and Human Services, Administration on Community Living, FEMA, Commerce, etc.
- **Private Sector**: Hospitals, Nursing Facilities, RCFE (Assisted Living), home health agencies, housing developments
- **Community Based Organizations:** Area Agencies on Aging, Independent Living Centers, regional centers, veterans' organizations, 211, meals programs, not-for-profit sector and many others.
- **Philanthropy:** Person Centered philosophy based on the individual's goals, strengths, and values. United Way, Foundations, etc.
- **Other:**

Person-Centered Metrics: Individual measures of inputs or outcomes that can be used to measure the impact on people due to the recommendation.

- Older adults who call the information line will report that they have fewer unmet needs for caregiving resources, personal care assistance, and other needs.
- Evidenced based metrics using social determinants of health
- Caregiver Research Study
- Coordinated with National Quality Forum Person Centered Practices Competencies http://www.qualityforum.org/ProjectDescription.aspx?projectID=89422

Evaluation (what is the measure of success?) – Outcomes measures will be coordinated with the Master Plan on Aging Research Committee.

- **Short term:** A statewide LTSS information and assistance system is developed (or adopted) by 2021. Californians will know where to go or call for comprehensive and trusted information when/if they or their loved one need(s) assistance with daily living activities due to chronic conditions, disability and/or health/safety emergencies. The State will also have a new source of data (from the Pre-Screen) about the volume and demographics of current LTSS customers; preferences,

locations, access issues, etc.

- **Mid-term:** By 2023, all Californian's who contact the online portal, the 800/211 and/or local ADRC systems will be connected in a timely manner to program and services that they are eligible for and will report coordinated follow-up assistance with their preferred services.
- **Long term:** By 2025, statewide LTSS I&A systems will report improved health outcomes, fewer unmet needs, caregivers will report support from State and local services and the public's utilization of emergency care and avoidable institutional health care costs will decline due to adequate access to community supports.

Data sources: [What existing data can be used to measure success or progress?]:

- Existing data sources: [specify datasets, variables, and data owner/location]
- Medi-Cal expenditures and analysis, nursing facility bed vacancy rates, health care utilization (emergency room usage, for example) pre and post implementing improved public access to local LTSS options.
- Minimum Data Set (MDS) data from Section Q regarding nursing facility residents stating preferences to return home.
- Suggestions for data collection to evaluate implementation of this goal when no data sources exist: Pre-screen tool implemented online and by all I&A/R organizations will provide an ongoing source of data. Broadly applied, statewide pre-screen data (risk, demographics, service need/use) self or other administered with all local Consumer Assistance organization. Utilize a pre/post measure with individuals that address Social Determinants of Health.
- Slower rate of Medi-Cal LTSS caseload for the population who spends down private resources to gain Medi-Cal eligibility and coverage of LTSS.

Potential Costs/Savings:

1. Consider integration of funding at the local level, across multiple networks to provide for integrated information, assistance and pre-screening (e.g., use of administrative dollars for Medi-Cal)
2. Leverage/combine with Older American's Act I&A, Independent Living Centers I&R funds, and 2-1-1 to create and fund staffing structure.
3. Utilization and leverage existing systems and experienced service provider networks by prioritizing coordination and collaboration to avoid redundancy, duplicative infrastructure costs and streamline access to services and programs.
4. Leverage state level public information/administrative budgets across multiple state agencies to include an LTSS component for people of all ages, disabilities, and incomes.
5. Re-invest savings in community – based organization infrastructure and information

technology.

6. Encourage active linkages to nonprofit and public sector programs to expand options and share costs among all public, government and private sector.

Stakeholder Issues: (stakeholders have reacted to but cannot be addressed at this early stage)

1. Define the roles of state and local responsibility for LTSS resource referral and information databases; online portal and local call centers. Lessons learned can be found in CalCare.net (consult California Community Choices federal grant project 2006-2011, California Health and Human Services Agency). Resource directory detail requires significant ongoing maintenance to avoid dead end or out of date referrals. Local directory details change frequently.

2. Service professionals, advocates and local citizens have taken great pride in building local brands and filling the gaps of a fragmented LTSS system with familiar points of LTSS service; e.g. food pantries, grief support groups, friendly visitor volunteer programs, etc. Some very small but important. Work to retain local familiarity, existing expertise and community culture when building State functions for a better statewide LTSS system.

3. Effective I&A system must be developed at the local level based on strong state standards for uniformity and quality. It would be extremely difficult for the State to maintain up-to-date information on all local programs for the 24/7 call center. A better system is where callers connect to the state and the state provides a direct connection to a local county-based ADRC, not directly to specific local programs or community-based organizations.

4. This I&A proposal leverages ADRC No Wrong Door systems as the coordinating entry into LTSS through their core service of Enhanced Information and Assistance. Stakeholders have noted that ADRCs not only serve as the entry pointed into a coordinated LTSS system but also provide additional person centered service coordination. ADRCs serve as a No Wrong Door system within local communities and are designed to serve as highly visible and trusted entities where people of all ages, incomes, and disabilities go to get information and one-on-one counseling on the full range of LTSS options. ADRC programs are:

    a. Creating a person-centered, community-based environment that promotes independence and dignity for individuals.
    b. Providing easy access to information and one-on-one counseling to assist consumers in exploring a full range of long-term support options.
    c. Providing resources and services that support the needs of family caregivers.

The core components of the ADRC designation criteria for local ADRC partnerships to qualify as a fully functioning ADRC in California include:

- Enhanced information, referral, and assistance
- Person Centered Options Counseling and assistance
- Streamlined eligibility determination for public programs
- Person-centered transition support from hospital to home and institution to community
- Involvement of partnerships, stakeholders, and consumer populations
- Quality assurance and continuous quality improvement

The ADRC No Wrong Door system and core services support the Scan Foundation Policy Recommendations submitted to the LTSS Subcommittee including:

- Enhanced information, referral, and assistance – Scan recommendation to ensure streamlined access to LTSS information and supports through a No Wrong Door system and to develop and implement a standardized assessment tool and protocol.
- Person Centered Options Counseling and assistance – Scan recommendations provide multiple reference to Person Centered service delivery.
- Streamlined eligibility determination for public programs – Scan recommendation to Ensure streamlined access to LTSS information and supports through a No Wrong Door system.
- Person-centered transition support from hospital to home and institution to community – Scan recommendation to Develop and implement a statewide strategy to ensure access to safe and timely transitions to the community through Establishment of the California Dignity Fund.

Name of person(s)/organization submitting recommendation: LTSS Subcommittee and ADRC Advisory Committee Mater Plan I&A Subcommittee

Date of recommendation submission: 12/13/2019

Prioritization: High. This issue impacts all older adults, people with disabilities and caregivers and can be implemented with short and long-term deliverables. It is a high priority due to the fact there are Californians who are at immediate risk and cannot access critically needed services in a streamlined, timely manner.