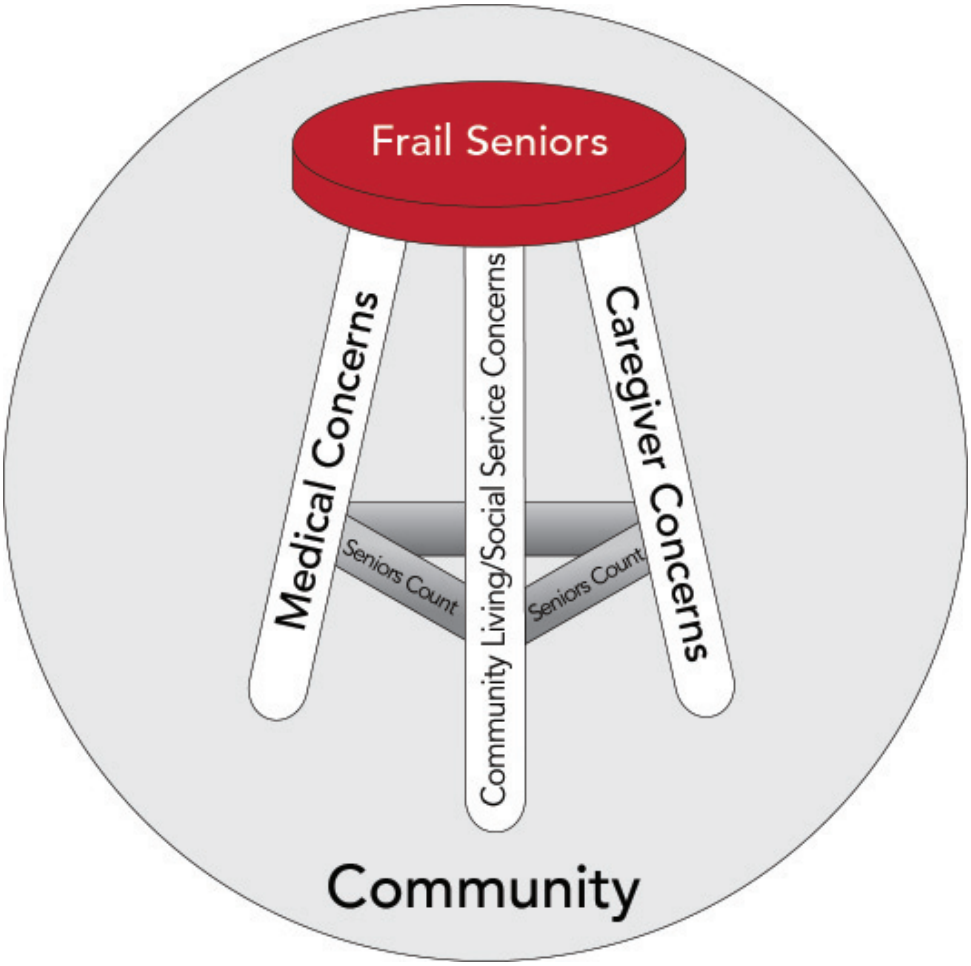

COMMUNITY INNOVATIONS FOR AGING IN PLACE GRANTEE CASE STUDY

SENIORS COUNT COMMUNITY CONNECTIONS (SCCC)

A PROJECT OF
EASTER SEALS NEW HAMPSHIRE

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BACKGROUND

The increasing population of older Americans necessitates an expansion in programs and services that are responsive to their priorities and needs.[1-3] Given the challenges of independent living for those with suboptimal health and/or functioning, programs that facilitate aging in place represent an important component of a responsive service system.[4] Such programs remain novel,[5] with much to be learned at both the local and national level—including identification of best practices for direct service delivery, as well as approaches that promote systemic solutions and community-wide changes. Community Innovations for Aging in Place (CIAIP) was funded from 2009 to 2012 by the United States Administration on Aging (AoA) in response to the need for systemic and integrated responses to shifting demographics. Through CIAIP, demonstration projects were funded in fourteen sites around the country. In addition, the Center for Home Care Policy and Research (CHCPR) of the Visiting Nurse Service of New York (VNSNY) was chosen as the Technical Assistance Grantee (TAG), which included VNSNY staff and consultants, to provide training and other supports focused around program design, program implementation, communication, and evaluation (see Table 1 for listing of sites).

Table 1: CIAIP Grantees

Atlanta Regional Commission, Atlanta, GA
Boston Medical Center, Boston, MA
Catholic Charities, Kansas City, MO
Catholic Charities, Stockton, CA
City of Montpelier, VT
The Coordinating Center, Millersville, MD
Easter Seals New Hampshire, Inc., Manchester, NH
Family Eldercare, Austin, TX
Jewish Family Service of New Mexico, Albuquerque, NM
L.A. Gay and Lesbian Center, Los Angeles, CA
Mt. Sanford Tribal Consortium, Gakona, AK
Neighborhood Centers, Inc. Bellaire, TX
New York City Department for the Aging, New York, NY
Supportive Women's Network, Philadelphia, PA
Center for Home Care Policy & Research, VNSNY (TAG)

This case study report is one in a series of six case studies developed by the TAG. The case studies describe program models, challenges, and lessons learned for organizations and funders seeking to develop aging in place programs, as well as others with interest in the topic. Data for this and other case studies was gathered primarily through site visits and in-person interviews and discussions with program staff and stakeholders.* Depending on the site, stakeholders included some combination of clients, partners, Advisory Board members, and community members with interest and expertise in issues related to aging in place. Additional information came from reviews of program documents including

*The data collection was approved by the Institutional Review Board of The New York Academy of Medicine, a member of the VNSNY TAG.

project proposals, reports, and outreach materials.

CIAIP grantees developed a range of program models and specific services. For the purpose of the case studies, they could have been grouped and categorized along a number of dimensions. The framework we utilized focused on a grantee's overall approach and delineated five overarching themes:

1. Broad based community development and planning
2. Service provision in places where older people live and congregate
3. Building bridges across program and organizational "silos"
4. Mobilizing human and social capital through volunteering and advocacy
5. Reaching out to and engaging specific groups of overlooked or disenfranchised older adults

Seniors Count Community Connections Initiative (SCCC), a project of Easter Seals New Hampshire, is a primary example of the third listed approach:Building bridges across program and organizational "silos." SCCC promotes aging in place for high risk frail older adults living in the Manchester, NH service area through enhanced, person-centered coordination of medical services, community and social services, and caregiver support. SCCC employs Community Liaisons to link these three areas and to act as a surrogate "eldest daughter," providing a range of case management and supportive services to high need individuals.

COMPREHENSIVE CARE COORDINATION

The medical needs of older adults are well recognized. Eighty percent of Americans over age 65 have at least one chronic condition; close to 50% have two or more.[1,2] This high burden of illness, not surprisingly, leads to high health care use and more frequent emergency department visits, hospitalizations, and nursing home placements as compared to younger populations.[6] For older adults with psychosocial issues, including isolation, mobility limitations, financial insecurity, and cognitive decline, problems with physical health are often exacerbated due to poor medication adherence, missed appointments, unhealthy diet, and other factors relevant to disease management. In fact, the linkages among psychosocial factors, health, and health care use are increasingly recognized and emphasized within new health reform models, including patient-centered medical homes and accountable care organizations. Care coordination and supportive services

are important components of these models, yet there is little detailed, descriptive information in the literature on service approaches and their impact.

This report, focused on the *Seniors Count Community Connections Program*, developed by Easter Seals New Hampshire, helps to address this gap in information by describing the implementation and outcomes of a comprehensive care coordination program targeting high risk older adults.

PROGRAM DESCRIPTION

Design

Seniors Count was first developed in 2001 as a coalition of public and private social service providers, as well as other key stakeholders, with Easter Seals New Hampshire as the fiscal agent. At its inception, the program sought to promote systemic change, while addressing the needs of frail older adults, who had been "invisible" compared to other high need local populations.

> *This is not just about helping individuals. It's about systems change. Most of the people I work with are all about helping individuals, which we are using in my mind as a laboratory or an example of what's really happening. But our real goal is not to help 120 people. Our real goal is to help change the system so that all 15,000—or whatever number—have a better system. (SCCC staff)*

In 2004, *Seniors Count* was one of 16 Robert Wood Johnson Foundation *Community Partnerships for Older Adults* grantees, which provided an opportunity for program self-assessment and for replication in other New Hampshire communities. *Seniors Count* focuses on facilitating increased independence for Manchester area frail older adults, with an emphasis on 1) medical care coordination, 2) social and community services, and 3) caregiver support. Utilizing a three-legged stool as an analogy—and recognizing the need for the legs of a stool to be connected to one another—*Seniors Count* designed the CIAIP-funded *Community Connections* initiative to link and support the areas delineated above through enhanced care coordination offered by Community Liaisons that were embedded within four partner organizations:

- Hillsborough County ServiceLink Aging and Disability Resource Center (ADRC)
- Catholic Medical Center
- Elliot Senior Health Center, and
- Dartmouth-Hitchcock Manchester, a multispecialty outpatient center that is part of the Dartmouth-Hitchcock academic medical system

SCCC was designed as a replicable, person-centered model focused on individualized needs. The Community Liaisons provide long-term, rather than episodic, care coordination, referrals, and other supportive services, which reflect client concerns and priorities—rather than the priorities of individual funding or entitlement programs. The program facilitates access to a range of medical and supportive services including home based medical and non-medical services, Meals on Wheels, food pantries, home maintenance and repair, and social and recreational activities. *Seniors Count* also has a Flexible Spending Fund, which is considered to be a "godsend." The Fund can be used to pay for necessary (but time limited) goods and services for clients that could not be afforded otherwise, including food, over the counter medicines, appliances, fuel and transport. One client, for example, came out of the hospital, discovered frozen pipes at home, and was able to access funds for a plumber. Other uses included a cellphone calling card, a grab-bar, and a smoke detector.

SCCC program outcomes focus on increased stability and quality of life, as well as sustained capacity to age in place, reduced hospitalization and emergency department use, and relieved caregiver burden. Beyond its focus on the individual, SCCC seeks to facilitate increased recognition within the health care system of the special issues of frail older adults and the systemic barriers to aging in place related to their basic needs, processes for health care delivery, and social supports. SCCC contracted with the University of New Hampshire Center on Aging and Community Living for a mixed method evaluation of its program, which included focus groups and client level pre-post (six months and one year) data related to demographics, health conditions and diagnoses, informal caregivers and other social support, and service need and use (frequency and type).*

Implementation

Seniors Count is very well known in the community; however, there was significant outreach to community providers to ensure that they understood

*This case study incorporates findings from the Center on Aging and Community Living evaluation report: Seniors Count Community Connections: Administration on Aging "Community Innovations for Aging in Place" Evaluation Report, October 2012.

the SCCC program and its target population, and made referrals for appropriate patients. In practice, referrals to SCCC were made by nurses, care coordinators, case managers, social workers, emergency department staff and medical providers. Eligibility for SCCC was restricted to older adults with high need. Thus, clients commonly had some combination of physical and mental health issues, scarce financial and nutritional resources, inadequate or precarious living conditions, minimal independent living skills, and inadequate social support systems. A relatively unique aspect of the SCCC program was use of a detailed matrix to assess eligibility and need, to develop care plans, and to measure individual level progress with respect to independence (see Appendix). Originally developed by a *Community Partnerships for Older Adults* grantee in Ann Arbor, Michigan, the matrix was piloted and adapted by *Seniors Count*. The matrix focuses on a number of psychosocial and health domains, including (but not limited to) finance, housing, food and nutrition, health care, mental health, mobility, social support, and life skills. For each domain, five levels of need (including no need) are delineated and described. Individuals must have had the highest level of need for at least two domains to be eligible. The expectation was that enrolled clients would move out of that highest need category within 45 days. As a screening and eligibility instrument, the matrix helped to systematically identify both high need and needs across multiple domains, which—in combination—suggested that care coordination and supportive services would be beneficial.

As noted above, the Community Liaisons were embedded in the partner hospitals, physician practice, and the ADRC—the rationale being that the Liaisons should be where the older adults are. In addition, SCCC felt that by having the Liaisons working within the hospitals, the program may be able to influence institutional leadership and staff, as well as the individual patients. Specifically, SCCC wanted the hospitals to better understand the relevance of psychosocial issues and basic needs to physical health and health care use; they wanted to demonstrate that by addressing these issues, high risk patients would be, for example, more likely to see the doctor, take their medicines, and avoid emergency department use and re-hospitalizations. As embedded positions, selected and supervised by their host institutions, the Liaison credentials and role differed somewhat by site, as did the expectations and regulations regarding appropriate and permissible activities. As described in more detail below, this was considered to be a challenge of the SCCC program. Briefly, the hospitals expected the Liaisons to have more clinical training and licensure and to focus largely on clinical issues, whereas the SCCC design gave equal weight to clinical and non-clinical (e.g. housing)

issues, and therefore felt that clinical credentials may be unnecessary as long as there was appropriate clinical expertise elsewhere on the care team, particularly as related to mental health.

In general, compared to these other staff, the Community Liaisons provided a greater range of services and supports. Liaisons provided enhanced care coordination services, made referrals, reconnected people to family members, drove them to appointments, and helped them to shop for food and other necessities. Transportation and home visits, though not permitted by the hospitals due to liability issues, were considered an important part of the SCCC model. Transportation was essential because there was little accessible transit available in the community, and home visits allowed for a more thorough assessment of the physical environment, quality of life, and social support; *"In the office, patients mask things."*

> *We discovered that one lady was living in squalor. No one knew she had no family; no one to advocate for her. With some assistance, we got the house cleaned. [We] took care of the dog, cooked and cleaned for her...she was able to stay home.* (SCCC Staff)

Consistent with program goals, the Liaisons engaged with the older adults that were most at risk and would benefit from a higher intensity of services. For example:

> Ted is a 74 year old man who worked as a teacher and social service administrator. He can no longer walk. Ted's wife, Jill, has Alzheimer's Disease and recently moved from the home they shared into a residential care facility. They have a daughter living nearby, but she is having trouble accepting her mother's illness so now maintains some distance from Ted. Other family members live in other parts of the country and visit rarely. The cost of Jill's care has been a significant burden to Ted. He is most appreciative of the assistance he has received from the SCCC Liaison to address his financial issues: *"That's where [the Community Liaison] has been helpful, trying to get me to get Medicaid coverage. I paid out over $50,000 in the past three months. It's over $9,000 per month at [residential facility]. I have to pay for her medications. That cost me over $1,000 so far...I'm in the donut hole. I had Medicare Part D. I'm*

getting pretty low on money. All we have coming in is just my Social Security and hers."

In working with Ted to access Medicaid (including a necessary spend-down), the SCCC Liaison was able to help Ted address other issues. In addition to assisting him with a spousal Medicaid application, she arranged for physical therapy, occupational therapy, homemaker services, and activities that would encourage him to leave his home more frequently. Ted went out just once a week to visit his wife at her residential care facility. His cognitive and social skills seemed undiminished, yet he became largely isolated from the wider community.

ACCOMPLISHMENTS

Seniors Count aimed to affect individuals as well as systems. As described below, it was likely most effective at the individual level, although the program made some progress toward change at the system level as well.

Individual Level Progress and Outcomes

Services were provided to 146 frail older adults, many of whom had had recent hospitalizations, emergency department use, falls, and depressive symptoms, as well as housing and food insecurity, inadequate social support, and inadequate financial resources. Eighty-four percent of participants reported income of less than $20,000 per year.

- For enrolled clients, Seniors Count Community Liaisons addressed the range of issues identified in the screening matrix, including finance, life skills, health care, home and safety, mental health, social support, and mobility.
- *Seniors Count* clients were linked to the ServiceLink ADRC, area food banks, transportation services, assistive technology, homemaker services, assistance with shopping, Meals on Wheels, volunteer home visitors, fix it services for minor home repair, and mental health care.
- Among 62 clients with six month follow-up assessments, there were noticeably decreased levels of need in five domains: financial resources, housing and home safety, food and nutrition, health care, and family relationships/social support.
- Through supplemental funding, *Seniors Count* was able to provide

needed dental services, including fillings, extractions, and dentures to frail older adults.

Systems Level Progress and Outcomes

Collaboration commonly presents multiple challenges, due to factors that might include unclear responsibilities and somewhat divergent interests among collaborators. *Seniors Count* employed a method of collaboration—embedding staff in other institutions—that may exacerbate these normal challenges, because the "collaboration" is enacted on a daily basis and absorbed within individual roles. However, embedded staff may also make the divergent expectations more evident and therefore "move the needle," which was the rationale behind the *Seniors Count* model. In fact, "the needle" did move a bit. The partner hospitals budgeted to support the Community Liaison position beyond the grant period, suggesting increased recognition, on the part of the hospitals, of the significance of psychosocial issues to health care use and health outcomes, particularly for the most vulnerable segments of the population. In addition, one hospital allowed the Liaison to drive clients, a seemingly limited victory with broad implications. The general perception was that the partner hospitals were increasingly embracing a role like "Community Liaison," either because of their experience with SCCC, or because of the Affordable Care Act and other directives focused on changing relations between hospitals and communities. The sense was that hospitals will define and fill this Liaison-type role internally.

> *What I've noticed and this is okay and this is a win: The hospitals are starting to do what we've been talking about. They're just going to do in on their own, because they're not...used to sharing or partnering. They're used to doing. If you go back ten years ago, the vision of Seniors Count was to change the system. People talking differently, thinking about frail seniors differently. I think that's happening and I think we've played a role in that. I think we will continue to. I'm not sure we're ever going to be a leader when it comes to the medical part. They're going to figure out how to do it their way with the money flow coming down their way. (SCCC Staff)*

Embedding a Liaison in the ADRC was an easier fit, and there was general agreement that going forward, the service works better in a community based organization. According to one SCCC partner, community

based Liaisons could *"think outside the box:"*

> *From the community, there was a lot more flexibility in terms of defining what the [client] problems were. Whereas coming from the medical, it was still that medical priority first. It was only going out into the community, getting the information and bringing it back to them that would make them understand the full picture of the individual.*

CHALLENGES

Like many other CIAIP programs, *Seniors Count* faced both practical challenges and conceptual challenges. To their great credit, the program was very open about the difficulties faced, providing opportunities to think about, discuss, and make changes in hopes of identifying the most appropriate ways to support vulnerable older adults and to address and coordinate their multiple service needs. Among the sustained program challenges:

- The Liaisons, employed by one organization and working in another, were operating under sometimes conflicting regulations and expectations. Particularly in the hospitals, there was some tension around shared supervision of the Liaisons, which was likely exacerbated by historically different approaches to care coordination services and the type of activities that might be subsumed within a care coordinator role. Hospitals viewed the position from a more clinical perspective than did *Seniors Count*. Finally, there was some sense that hospitals would "dump" difficult patients on SCCC, thereby abdicating their own responsibilities. Subsumed within these tensions was the recognition of unequal power, with the hospitals being larger, better resourced institutions, which discouraged them from coming together as a partner rather than acting as the lead.

- In addition to these issues around roles and responsibilities, placement of Liaisons in the hospitals creates logistical challenges. Separate electronic health record necessitated double entry of program data (into the hospital record system, as well as the SCCC record system). There were also concerns (although largely theoretical) related to continuity of care: if a patient changes hospitals, he or she would have to interact with a new Liaison, which would be problematic from the perspective of coordinated care.

- Payment for care coordination services is rarely consistent with the need; sustainability is therefore an ongoing challenge, particularly in an environment of fiscal constraints. It is possible that new requirements of the Affordable Care Act and new services models, such as Medical Homes, Accountable Care Organizations, and managed long term care insurance programs, may facilitate improved prospects for sustainability. *Seniors Count* has been wise in trying to demonstrate the impact of their services to hospitals and medical providers, as they will be the entities developing and implementing these new models. However, it is too early to tell how these systems will be implemented.

SUMMARY AND LESSONS LEARNED

SCCC had documented success in engaging and meeting the needs of vulnerable older adults living in the Manchester, New Hampshire area. As was intended, their Community Liaisons provided individualized services consistent with the idealized role of the eldest daughter, including help in meeting basic needs and help with accessing medical and social services. The program included a Flexible Spending Fund to cover necessary but time-limited expenses that clients could not afford otherwise, including food, medications, fuel, and transport. Clients derived notable benefits from SCCC services, particularly in the areas of finance, housing, food and nutrition, health care, and family relationships/social support. The program utilized an innovative assessment form for screening, care planning, documentation of progress over time, and evaluation. Its multi-functionality suggests utility for other enhanced care coordination programs.

Outside of the individualized services, *Seniors Count* had success—and challenges—in collaborating with area hospitals, providers, and the ADRC. Lessons learned include the following:

- Although not completely unexpected, the challenges in working through and attempting to influence hospital systems were daunting. By the end of the CIAIP funding, SCCC recognized physician practices as a possibly more effective conduit for linking medical services with social services and supports, since physicians are likely to have a closer relationship to patients and are therefore more likely to have recognized these important connections. Physician champions may more effectively advocate for hospital

changes than can those outside the medical system:

[Next time] I would work more with doctors' offices. I think one of the lessons learned is that in order to make this mean something, it has to solve a problem for an individual. And if we solve the problem of these difficult patients. And if the docs say to the hospital, "I want, "I need" [this service], I think we're in a better position. (SCCC Staff)

- The significance of the Flexible Spending Fund represents a second expected lesson learned. Inexpensive to administer, the Fund provided time limited financial assistance to clients for essential purchases (e.g. medications, home repair) that helped to prevent escalation of problems and promoted stability.

- Although most older adults do not require the intensity of services that SCCC provides, for those that are most vulnerable, comprehensive assistance can make a dramatic difference in stability and quality of life. A portion of this population has relatively longstanding psychosocial and/or health issues that have left them vulnerable. Others may face a dramatic change in fortunes as their own health declines and their support systems diminish due to the illness, death, competing responsibilities, and/or relocation of friends and family. For both groups, services like those provided are invaluable.

Seniors Count Community Connections was designed with dual aims: 1) to serve the frail older adults of Manchester, New Hampshire, and 2) to promote systems change so that the needs of this population are more consistently addressed by existing institutions, and separate programs like SCCC become unnecessary. Certainly, progress was made toward the first aim. The second aim remains a work in progress, as is the case in most other U.S. communities.

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Seniors Count Community Connections Pre-Screening Matrix

The Seniors Count Community Connections initiative is designed for frail seniors in the Manchester service area that need extra coordination of services ie; medical services, community living/social services, and caregivers support. To determine if your client is an appropriate referral to Seniors Count Community Connections they must have two or more domains at level one (1), two (2) or three (3).Circle appropriate acuity. If client meets criteria, refer to the Seniors Count Community Liaison within your organzation.

Domain	1	2	3	4	5
1. Financial Resources	No income. Insufficient or no retirement funds. Bills greatly exceed income in multiple areas. Unable to apply for or unaware of state programs.	Inadequate income or inappropriate spending. Bills for basic needs cannot be paid. Outstanding judgments or garnishments.	Meets basic needs with subsidy or assistance. Begins appropriate spending. Needs access to public assistance	Meets basic needs. Manages debt without assistance. Moderate budgeting skills	Income is sufficient
2. Housing and Home Safety	Homeless, in foreclosure, or facing imminent eviction. Home or residence is not safe. Possible APS involvement.	In transitional, temporary or substandard housing. Current rent/ mortgage payment unaffordable. Safety issues significant but not life threatening. Substantive oversight needed.	In safe, stable housing. Needs minimal support. Household is safe with support but future uncertain.	Adequate subsidized housing. Needs minimal support.Household is safe with support but future uncertain.	Household is safe, adequate, and affordable.
3. Food and Nutrition	No food or unable to prepare it. Relies to a significant degree on other sources of free or low-cost food.	Meals are missed at least one day per week.	Can meet basic food needs with home delivery, but requires assistance.	Can meet basic food needs without assistance	Can choose to purchase any food household desires
4. . Utilities	Utility shut off.	Unable to pay utility bill. Notice of eminent shut off. Utility repair urgent.	Sporadic payment of utility bills without oversight.	Needs minor assitance to budget and pay for utility bills	Bills are paid with regularity.
5. Health Care	Significant health concern unmet by health care provision. No medical coverage with immediate need.	Great difficulty accessing medical care when needed. Intermittent health care needs unmet. Inability to pay for or understand health care financing for specific need.	Occasional unmet needs. May delay, reduce or omit needed care. Does not follow routine healthcare.	Can obtain medical care when needed, but may not follow preventative care or may strain budget.	Covered by affordable, adequate health insurance including some preventative care
6. Legal	Current outstanding tickets, impending lawsuits or warrants of other unresolved legal issues.t	Current charges/trial pending. Noncompliance with legal issues impacting housing. Needs representation.	Compliant with plan to resolve other legal issues or has secured representation.	Has successfully completed requirements, no new charges filed or recently resolved other legal issues.	No active legal issues in more than 12 months
7. Mental Health, Psychosocial	Danger to self or others. Recurring suicidal ideation. Experiencing severe difficulty in day-to-day life due to psychological problems.	Recurrent mental health symptoms that may affect behavior, but not a danger to self/others. Persistent problems with functioning due to mental health symptoms or dementia.	Mild symptoms may be present but are transient. Only moderate difficulty in functioning due to mental health problems.	Minimal symptoms that are exceptable responses to life stressors. Only slight impairments in functioning.	Symptoms are absent or rare. Good functioning in wide range of activities. No more than every day problems or concers.

Senior Crisis Intervention Program (SCIP): A project of the Blueprint for Aging. Modified for Seniors Count 09/03/2010

Domain	1	2	3	4	5
8. Substance Abuse	Meets criteria for severe abuse/dependence. Resulting problems so severe that institutional living or hospitalization may be necessary.	Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.	Use within last 6 months; evidence of persistent or recurrent social, work, emotional or physical problems related to use (disruptive behavior or housing problems); problems have persisted for at least one month.	Client has used during 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.	No drug use/alcohol abuse in last 6 months.
9. Mobility	No access to transportation, public or private. May have care that is inoperable. Unable to obtain accompaniment for life threatening medical appointments.	Transportation is available, but unreliable, unpredictable, unaffordable. Has informal rides, but needs financial help to pay.	Transportation is available and reliable, but limited and/or inconvenient. Needs assistance finding transportation at times.	Transportation is generally accessible to meet basic travvel needs.	Transportation is readily available and affordable.
10. Family Relations and other Social Support	Lack of necessary support from family or friends. Abuse (DV, elder, financial) is present or there is neglect.	Family/friends may be supportive, but lack ability or resources to help. Family members do not relate well with one another. Potential for abuse or neglect.	Some support from family/friends. Family members acknowledge and seek to change negative behaviors; are learning to communicate and support.	Adequate support from family or friends. Household members support each other's efforts.	Has viable support network. Communication is consistently open
11. Life Skills	Unable to meet basic needs such as hygiene, food, and activities of daily living.	Can meet a few but not most needs of daily living without assistance.	Can me most but not all daily living needs without assistance.	Able to meet all basic needs of daily living with assistance.	Able to provide beyond basic needs of daily living for self and family.