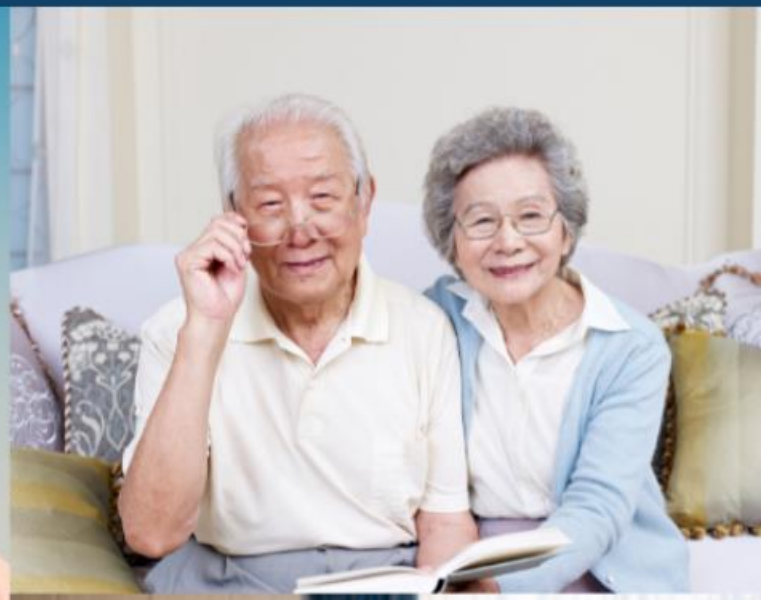
Leadership in Aging Webinar

CALIFORNIA DEPARTMENT OF AGING



Welcome!

***Webinar Logistics*: Join by smart phone, tablet, or computer**

- **To join audio by telephone:** 888-788-0099
- **Meeting ID:** 852 8016 2867
- **Live captioning streamed through webinar (Zoom)**
- **American Sign Language Interpretation via webinar (Zoom)**
- **Slides will be posted at CDA's Hubs & Spokes Network for Aging & Disability webpage.**

Questions & Comments

The final 15 minutes of the webinar is reserved for questions and comments:

- Attendees joining by **webinar (Zoom)**, use the Q&A function to ask a questions or *click* the raise hand button to join line. The moderator will announce your name or your last 4 digits of your phone number and will unmute your line.
- Attendees joining by **phone**, *press* *9 on your dial pad to "raise your hand". The moderator will announce the last 4 digits of your phone number and will unmute your line.
- For additional information or feedback email Engage@aging.ca.gov.

Leadership in Aging Webinar Series

Promising Practices, Performance Criteria & Excellence: **(October 6)**
With leadership from USAging (*formerly the National Association of Area Agencies on Aging*) and Association on Aging in New York

AAA Partnerships with Healthcare: Impact & Trends ***(September 22)***
With Professor Kate Wilber, PhD and Doctoral Candidate Haley Gallo of University of Southern California's Leonard Davis School of Gerontology

Measuring the Success of the Aging Network ***(September 15)***
With Professor Kate Wilber, PhD and Doctoral Candidate Haley Gallo of University of Southern California's Leonard Davis School of Gerontology

EQUITY IN AGING CALIFORNIA ALL AGES aging.ca.gov

CALIFORNIA DEPARTMENT OF AGING

Today's Speakers

Sandy Markwood
Chief Executive Officer, USAging

Becky Preve
Executive Director, Association on Aging in New York (AgingNY)

Conversation Facilitated by:

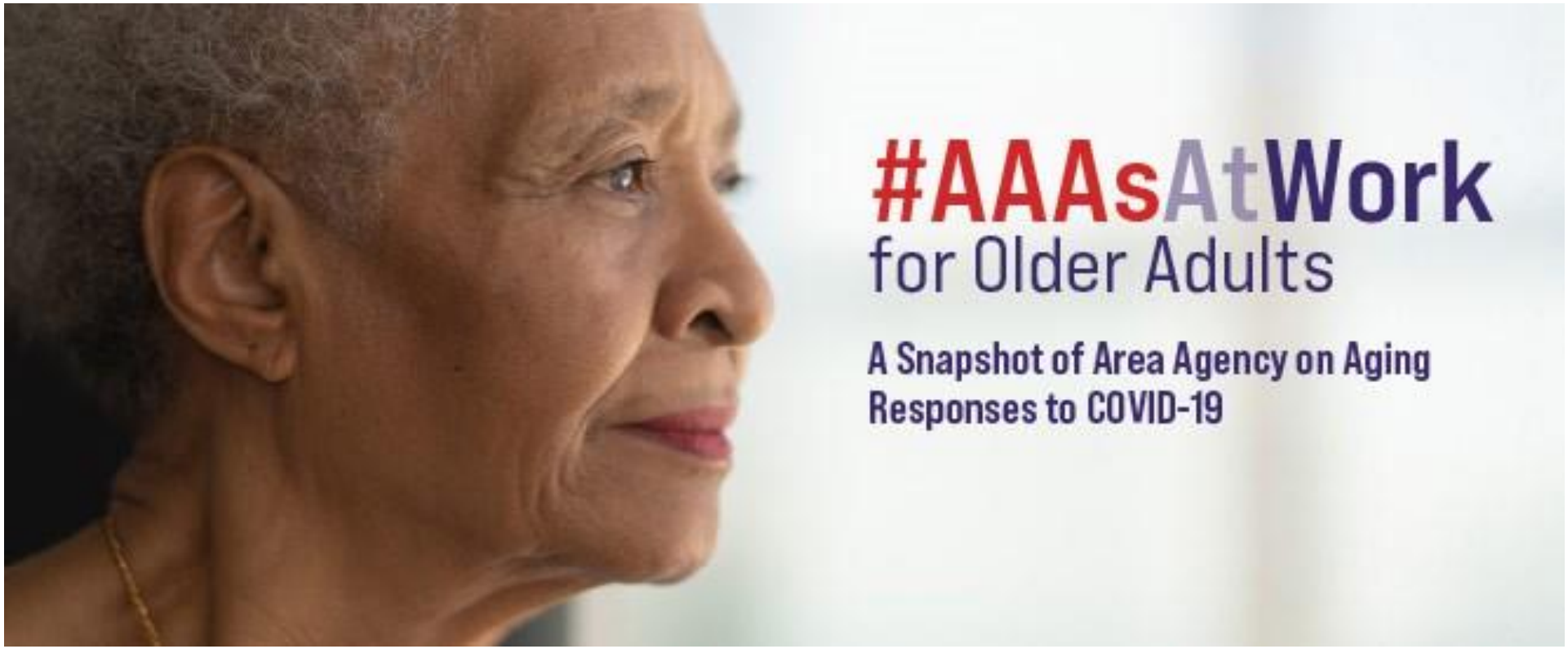
Michael Costa, MPP
Executive Director, California Association of Area Agencies on Aging

Leaders in Aging Well at Home

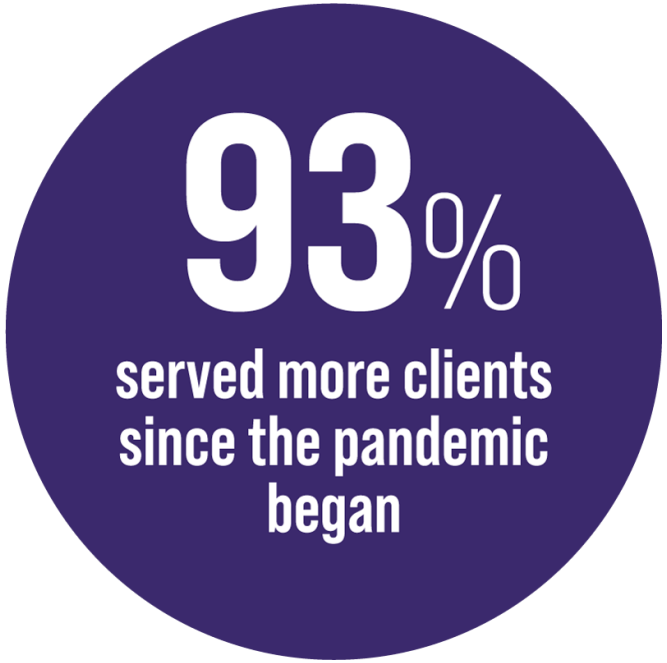
Sandy Markwood

Chief Executive Officer, USAging

How Did COVID Impact Aging Services

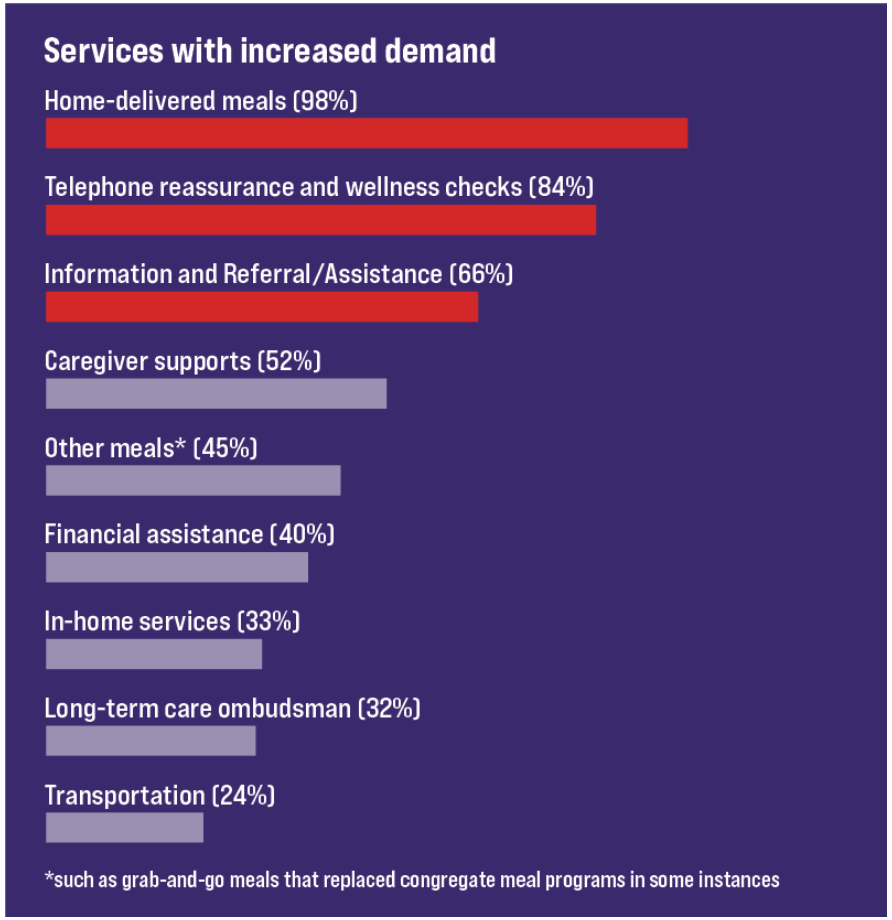


AAAs Saw Increased Demand for Services and Supports



USAging

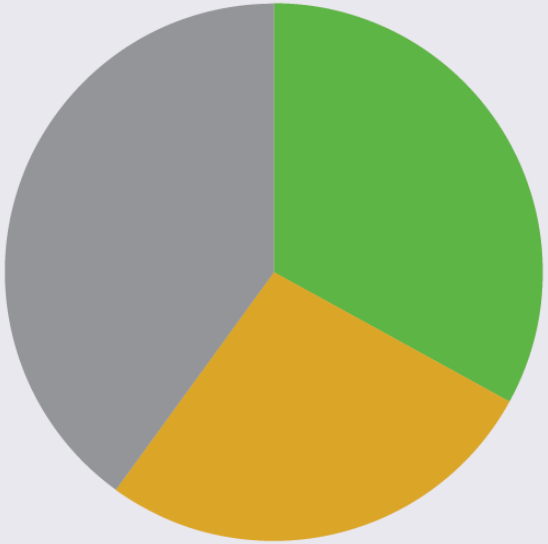
Most Common Aging Services With Increased Demand



Addressing Social Isolation

The negative health effects of social isolation

60 percent of responding AAAs said they were already seeing the negative health effects of social isolation, including:



- **33 percent** who said they were actively addressing this through new and updated programs and services *and*
- **27 percent** who said they were exploring how they can update programs and services to combat those negative effects

Addressing the Need of Special Populations

Additionally, 5.8 million Americans are living with Alzheimer's disease, the most common form of dementia.

80% of people with dementia live in the community; 30 percent of them are living alone.

USAging

Addressing Racial Equity and Disparities

According to the U.S. Administration on Aging, the number of minority older adults is expected to rise by 217 percent in the coming decades.

The increasing diversity of our aging population poises new opportunities and challenges for the Aging Network as we look to:

- Ensure that all staff and programs are culturally competent;
- Increase the number of leaders and staff who reflect the diversity of the clients we serve; and,
- Tackle the issue of health disparities.

COVID Changed the Way the Aging Network Operates: Which of Those Changes Will Remain?

Photos courtesy of the following AAAs: Vintage in CO; Jefferson Board on Aging in VA; AAA of Northwestern Ohio

USAging

Aging Network's Role with COVID Vaccine Access Solidified Our Role with Public Health

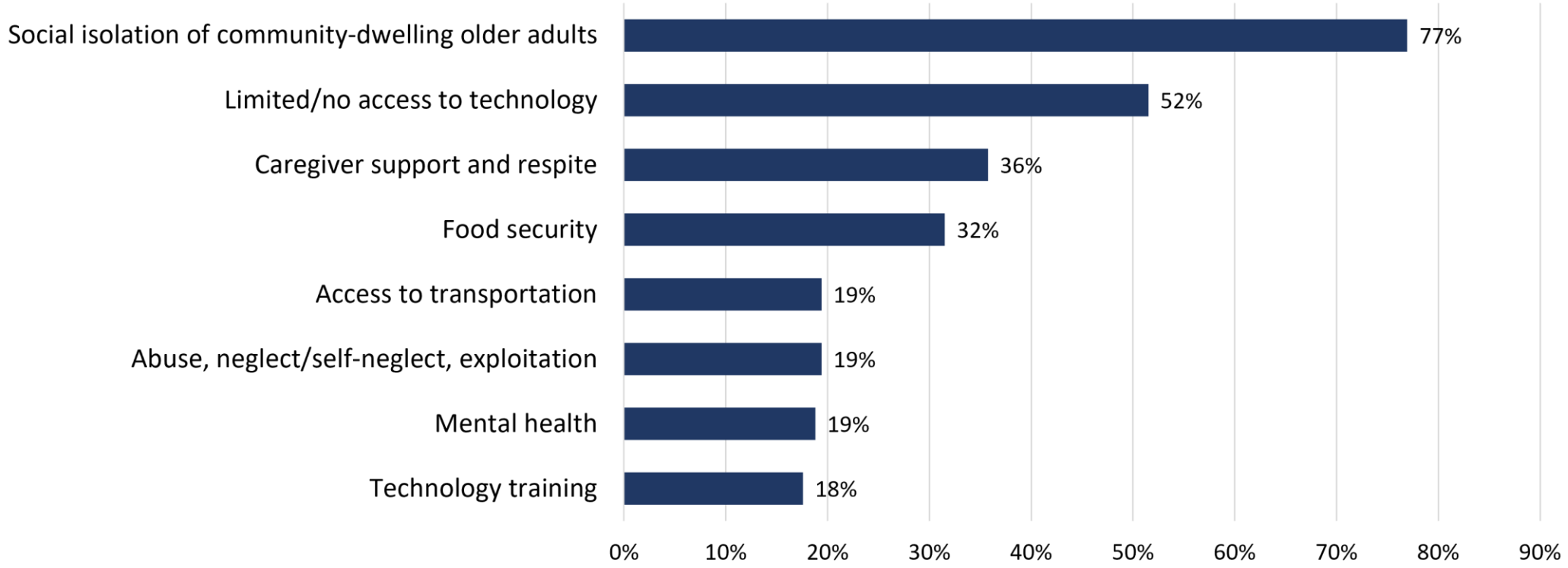
Courtesy of AgeOptions, the AAA in Oak Park, IL

USAging

Social Determinants of Health are Solidifying New Partnerships with Health Care

With All These Changes: What's Next for Aging Services?

Greatest challenges AAAs see for older adults and caregivers related to COVID-19*:



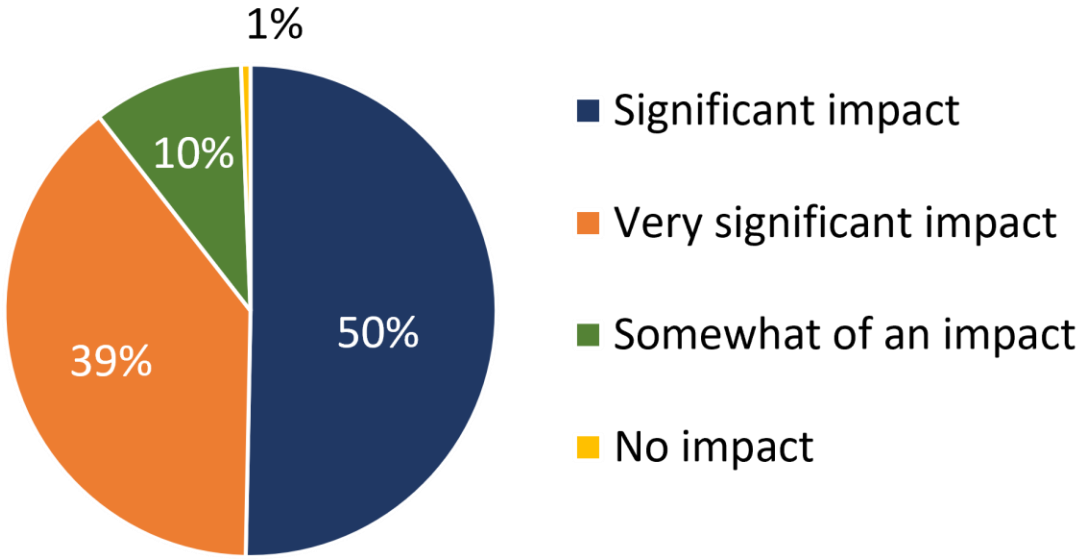
Respondents could select up to 3 challenges.

USAging

How much of a **continued impact** do you believe COVID-19 will have on your AAA's operations and services over the next 6-9 months, compared to now?

99% said COVID-19 would have **some impact**

50% said COVID-19 would have a **very significant impact**



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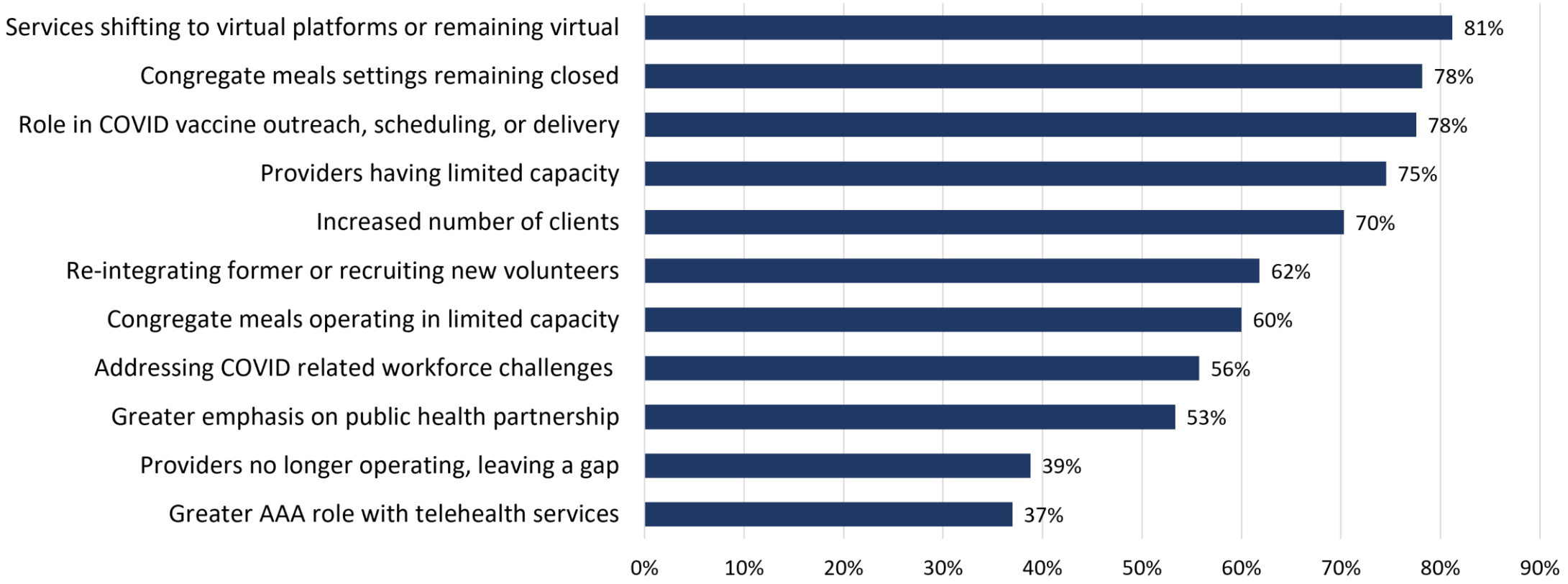
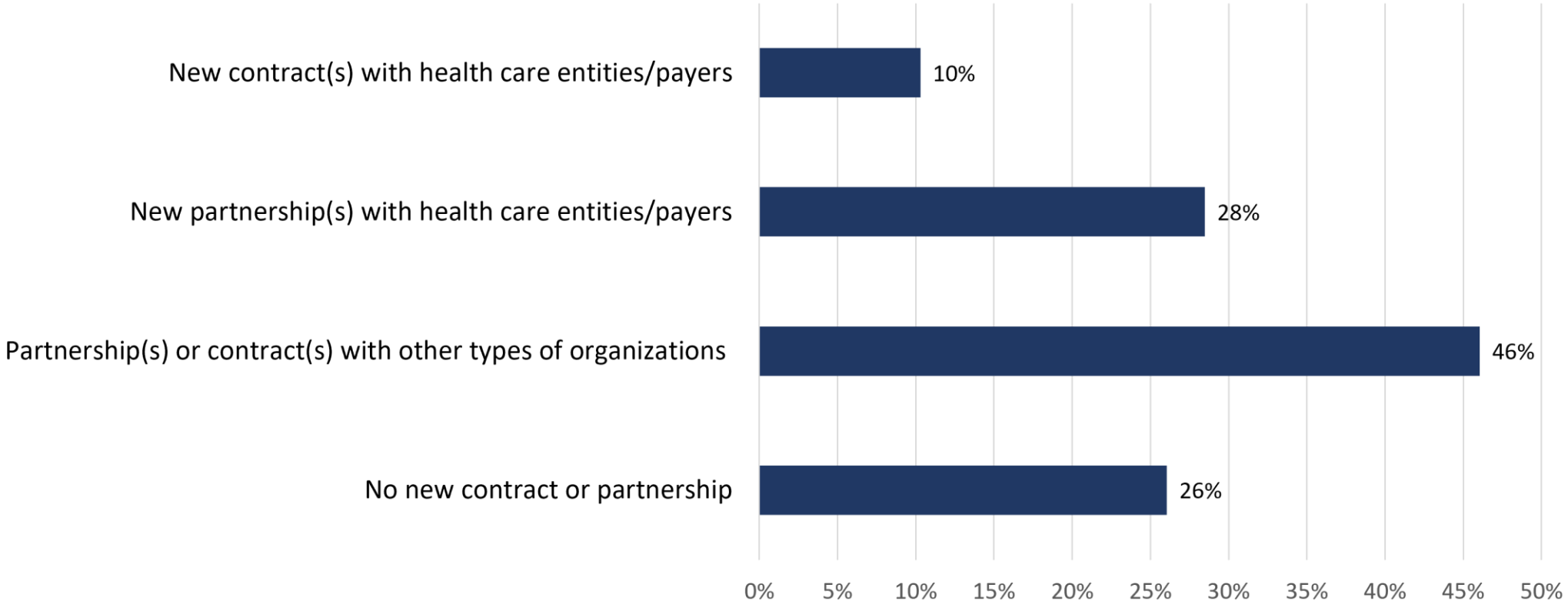
Changes related to COVID-19 AAAs Are Facing in 2021



USAging

74% of AAA developed new business, partnership or contracting relationships as a result of the pandemic



USAging

Aging Services 2.0






USAging

What Will Aging Services 2.0 Look Like?

- **New Ways of Delivering Services**: Hybrid Models of Services/Flexibility
- **Social Isolation/Engagement** as a Core Service
- Emphasis/Outreach on **Technology**
- Investment in **Home and Community-Based Services,** Caring Economy
- Emphasis on **Age/Dementia Friendly Communities,** Keeping People in the Community
- Greater Roles in **Transportation and Housing** with Services

USAging

What Will Aging Services 2.0 Look Like?

- Emphasis on **Supporting Caregivers,** Person-Centered/Caregiver Connected Care and Support
- Focus Capacity Building: **Investing in the Aging Workforce and Volunteers**
- Aging as a **Partner with Health Care** Accelerated, Social Determinants of Health Part of Health Solutions
- Aging as **Partner with Public Health**
- Amplifying Our Work on **Racial and Health Disparities**

You Are the Pioneers of Aging 2.0

And the Current and Future Generations Are Counting on You!

New York State

Becky Preve
Executive Director
Association on Aging in New York State

Opportunity to Better Connect Hospitals/Health Systems to Aging Services network

New York State Trends Demographics

FAMILY STRUCTURE in the United States	
Married couple families	↓
Married couple families with children	↓
Single parent households	↑
Single person households	↑
Non-traditional households	↑

New York State

62 Counties

Change in Population Aged 60 and Over

2020 to 2030

Proportion of County Population Aged 60 and Over	Number of Counties with Specified Percent of Older Adults	
	2020	2030
Less than 20%	3	2
20% to 24%	18	8
25% to 29%	32	17
30% and over	9	33

Source: Woods & Poole Economics, Inc., 2019 State Profile

NYSOFA Customers

- Focus on our customers - high risk, high-cost individuals = those with chronic conditions and functional needs
  - Of top 5% of Medicare spenders – 61% have chronic conditions and functional limitations (account for 53% of total spending - $almost 400 billion
  - Of top 20% of Medicare spenders – 46% have chronic conditions and functional limitations and 41% have 3 or more chronic conditions only
  - More likely to use ED and hospital inpatient

- CMS Identified top needs identified for this population:
  - HDM 19%
  - PC I and II 14%
  - Transportation 15%
  - CDSMP 14%

Health and Impairment of Older Adults

Chronic conditions are singled out as *the* major cause of illness, disability, and death in the United States.

It is estimated that the cost of chronic conditions will reach $864 billion by 2040, with chronic conditions among older adults being more costly, disabling, and difficult to treat – and also the most preventable.

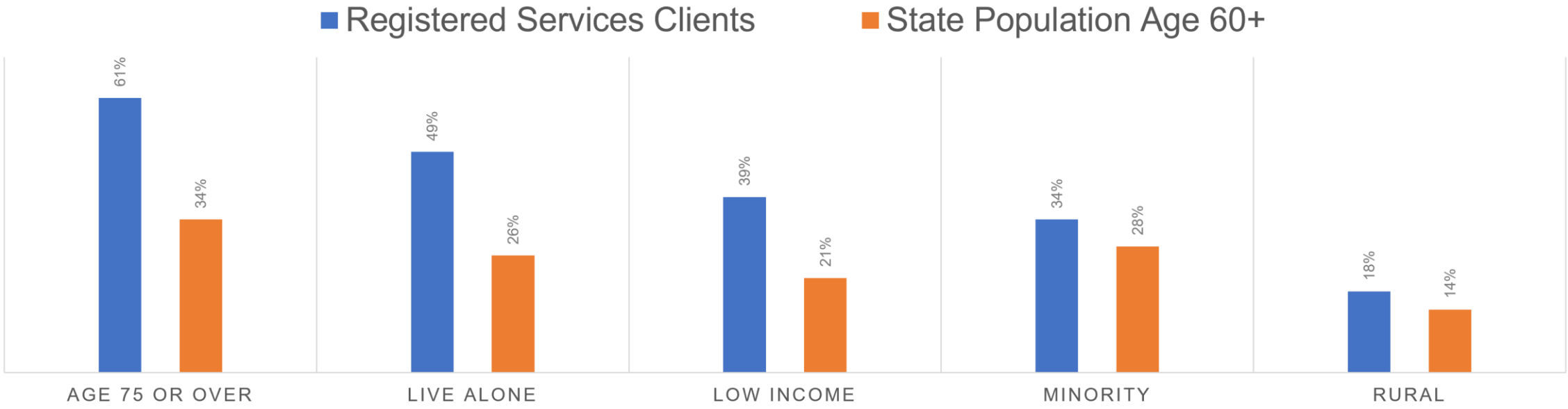
New York State Population: Disability	
Age Group	% of Group with All Types of Disabilities
5-20	4%
21-64	9%
65 and over	35%

Nursing Home Risk Indicators

Long established national risk factors for nursing home placement:

- ***Demographic characteristics:*** Older individuals and those who are non-Hispanic white.
- ***Socioeconomic status:*** Individuals with low incomes
- ***Health status and physical functioning:*** Those with certain health conditions (such as cognitive impairment, cancer, high blood pressure, diabetes, and a history of strokes and falls) and those who have difficulty performing activities of daily living (ADLs)
- ***Prior health care utilization:*** Individuals who have spent time in the hospital or in a nursing home. In 2009, about 7 percent of state residents 65 or older had one nursing home stay and 23 percent of state residents 85 or older had one nursing home stay. (Source: Nursing Home Compendium 2010 from CMS)
- ***Living arrangements and family structure:*** Those who live alone (including widowed and divorced individuals), do not own their home, and have fewer children than their peers not in nursing homes.
- ***Availability of support:*** Individuals who lack caregiver support

	Personal Care II	Personal Care I	Home Delivered Meals	Adult Day Services	Case Management	Cluster 1 Clients
Average Age	84	82	81	82	81	81
Age 75+	86%	79%	73%	82%	75%	75%
Age 85+	54%	44%	42%	45%	43%	43%
Female	82%	78%	65%	66%	69%	67%
Live Alone	65%	78%	61%	26%	61%	61%
Low Income	55%	56%	40%	31%	42%	41%
Rural						29%
Minority	26%	21%	24%	17%	27%	23%
ADL Count average	3.49	1.60	1.90	3.25	2.06	1.99
ADL 3+	64%	24%	29%	57%	32%	31%
IADL Count average	5.94	4.92	5.05	6.96	5.10	5.09
IADL 3+	95%	92%	86%	93%	86%	86%
High Nutrition Risk	39%	35%	42%	24%	39%	40%
Average BMI	27.18	27.79	26.51	25.61	26.64	26.60



ADL Type	Percent	IADL Type	Percent
Mobility	54.10%	Prepare Meal	89.40%
Bathing	49.70%	Shopping	86.80%
Personal Hygiene	24.50%	Housekeeping/Cleaning	83.50%
Dressing	24.30%	Transportation	81.20%
Transfer	20.60%	Laundry	73.90%
Toileting	14.90%	Handle Personal Business	48.10%
Eating	6.00%	Self-Admin of Medication	31.50%
		Use Telephone	12.20%

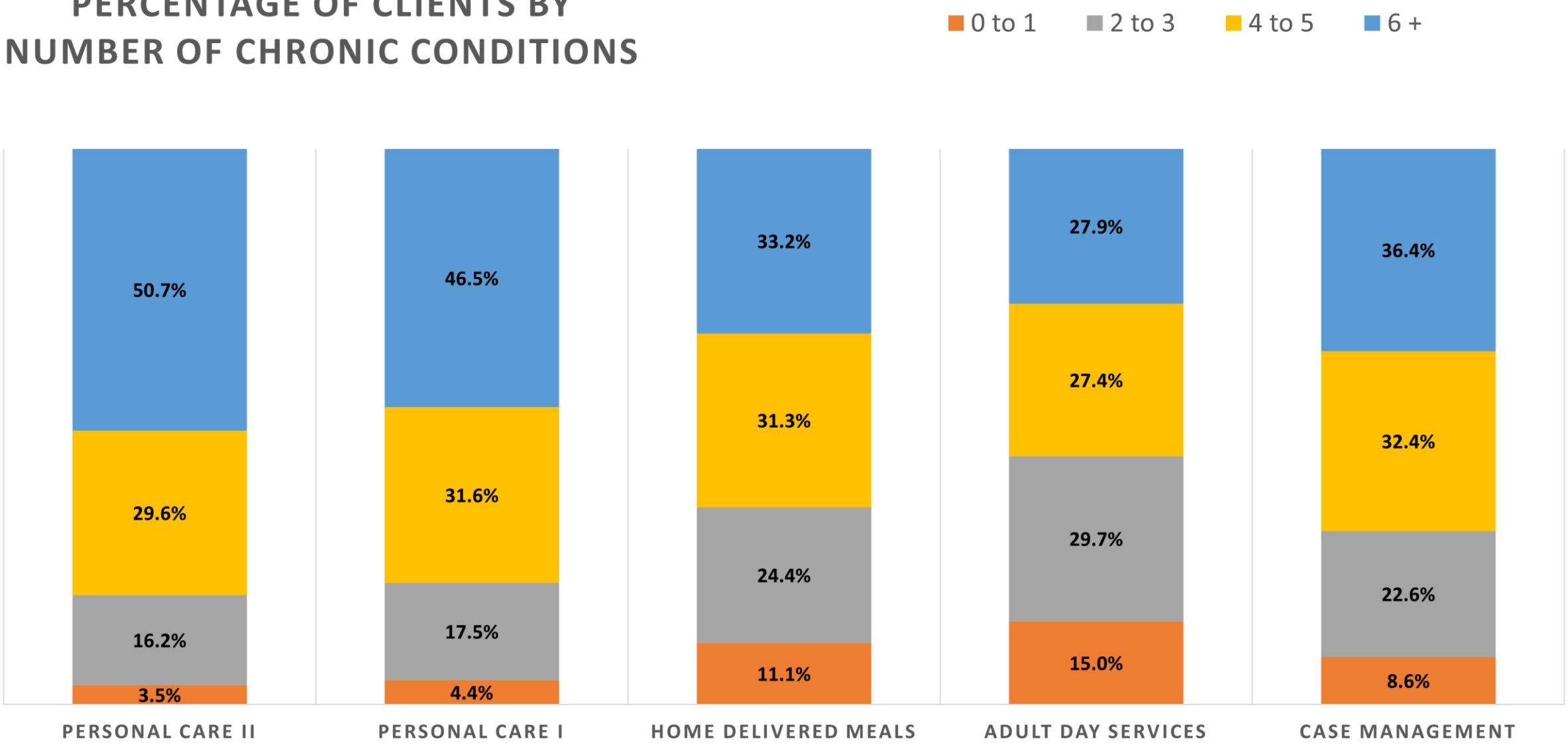
	Personal Care II	Personal Care I	Home Delivered Meals	Adult Day Services	Case Management
Average Age	84	82	81	82	81
Average ADL	3.49	1.60	1.90	3.25	2.06
Average IADL	5.94	4.92	5.05	6.96	5.10
Average BMI	27.18	27.79	26.51	25.61	26.64
Average Monthly Income	N/A	N/A	N/A	N/A	N/A

ADL Type	Personal Care II	Personal Care I	Home Delivered Meals	Adult Day Services	Case Management
Bathing	91.6%	42.0%	49.5%	75.8%	55.0%
Personal Hygiene	55.3%	18.4%	22.4%	63.7%	25.1%
Dressing	56.5%	16.7%	22.6%	57.8%	26.7%
Mobility	71.1%	51.1%	57.6%	40.6%	58.9%
Transfer	36.2%	16.2%	20.3%	30.6%	20.8%
Toileting	28.4%	12.0%	14.2%	37.7%	16.0%
Eating	11.4%	4.0%	5.1%	24.4%	5.6%

IADL Type	Personal Care II	Personal Care I	Home Delivered Meals	Adult Day Services	Case Management
Housekeeping/Cleaning	99.2%	98.5%	83.0%	92.3%	86.6%
Shopping	97.9%	90.9%	87.5%	96.9%	89.2%
Laundry	96.6%	90.0%	73.2%	91.3%	78.0%
Transportation	92.8%	79.5%	82.0%	96.1%	82.3%
Prepare Meal	89.0%	66.9%	95.5%	94.4%	89.6%
Handle Personal Business	60.4%	37.7%	48.2%	92.6%	49.6%
Use Telephone	19.1%	7.9%	10.8%	61.3%	12.2%
Self-Admin of Medication	42.2%	22.7%	29.9%	87.6%	29.6%

Number of Chronic Conditions	Personal Care II	Personal Care I	Home Delivered Meals	Adult Day Services	Case Management
0 to 1	3.5%	4.4%	11.1%	15.0%	8.6%
2 to 3	16.2%	17.5%	24.4%	29.7%	22.6%
4 to 5	29.6%	31.6%	31.3%	27.4%	32.4%
6 +	50.7%	46.5%	33.2%	27.9%	36.4%

PERCENTAGE OF CLIENTS BY NUMBER OF CHRONIC CONDITIONS



	Personal Care II	Personal Care I	Home Delivered Meals	Adult Day Services	Case Management
Arthritis	67.3%	67.1%	50.0%	37.0%	54.4%
Cancer	15.2%	16.8%	12.4%	11.7%	12.4%
Congestive Heart Failure	12.5%	11.5%	9.8%	6.5%	10.0%
Diabetes	30.2%	28.6%	28.1%	21.6%	28.4%
Heart Disease	40.0%	39.3%	33.0%	27.0%	33.7%
Incontinence	17.2%	11.1%	8.5%	13.1%	10.5%
Parkinson's	3.8%	2.0%	2.5%	4.4%	2.7%
Renal Disease	4.6%	3.9%	3.5%	3.5%	3.4%
Respiratory Problems	20.9%	21.0%	14.7%	7.6%	14.8%
Stroke	14.2%	10.7%	9.8%	12.8%	10.2%
High Blood Pressure	71.3%	69.8%	64.8%	52.2%	67.1%
Dementia/Alzheimer's	16.4%	7.0%	12.2%	64.3%	12.8%
Alcoholism	.7%	1.3%	1.0%	1.6%	.9%
Anemia	8.3%	6.7%	5.6%	4.6%	6.1%
Anorexia	.2%	.0%	.1%	.2%	.1%
Constipation	10.3%	8.3%	7.4%	5.2%	7.7%
Diarrhea	2.1%	2.1%	1.3%	1.2%	1.4%
Colitis	1.5%	2.2%	1.0%	.8%	1.1%
Colostomy	.8%	.6%	.7%	.2%	.6%
Diverticulitis	5.7%	6.4%	3.2%	4.6%	3.6%
Gall Bladder Disease	3.6%	4.0%	2.0%	2.8%	2.2%
Hearing Impairment	25.7%	22.9%	19.6%	19.7%	20.3%
Hiatal Hernia	5.2%	5.8%	3.0%	2.8%	3.1%
Hyperglycernia	1.1%	1.1%	.7%	1.3%	.7%
Hyporglycernia	.8%	.9%	.5%	.6%	.5%
Liver Problems	.7%	.9%	.8%	.4%	.8%
Low Blood Pressure	1.9%	1.9%	1.3%	1.5%	1.2%
Osteroporosis	22.4%	22.2%	13.7%	12.4%	15.4%
Smelling Impairment	1.5%	1.5%	.8%	1.6%	.7%
Ulcer	3.6%	3.5%	2.5%	1.5%	2.6%
Visual Impairment	46.5%	46.0%	35.8%	27.8%	38.2%
Taste Impairment	1.6%	1.6%	.9%	1.0%	.8%
High Cholesterol	26.5%	27.6%	26.2%	19.7%	27.6%

2019-20 Network Infrastructure

- 59 county-based Area Agencies on Aging (also called offices for the aging)
- 1,176 contractors
- 777 senior centers
- 819 congregate meal sites
- 315 central kitchens
- 2,057 HDM routes
- 41 Highest Level EBIs implemented through AAAs, serving 35,651 older New Yorkers
- 904 HIICAP and LTCOP volunteers
- 384 HIICAP counseling sites
- Require all Case Managers and HIICAP/SHIP Counselors to be state certified

with Local Network of Partners

Core Home and Community Based Services Provided by the Network of Aging Professionals

Coordinated with Local Network of Partners

- Home delivered meals (HDM)
- Congregate meals
- Nutrition counseling & education
- Senior center programming
- Health promotion and wellness
- Evidence Based Interventions – CDSMEs, fall prevention, etc.
- Volunteer opportunities
- Respite and caregiver supports
- Legal Services
- Home modifications, repairs
- Elder abuse prevention and mitigation
- NY Connects (ADRC) - LTSS I&A/R, options counseling, benefits and application assistance
- Health Insurance Information , Counseling and Assistance (HIICAP)
- Personal Care Level I and II (non-Medicaid)
- Case management
- Ancillary services such as PERS and assistive devices
- Social adult day services
- Transportation to needed medical appointments, community services and activities
- Long Term Care Ombudsman

COMPASS Comprehensive Assessment=Plan of Care

Info gathered during Assessment

- Personal Information
- Living Arrangement
- Elder Abuse/Neglect
- Frail/Disabled
- Caregiving Status
- Housing Status
- Home Safety Checklist
- Energy Checklist
- Social Interaction/Isolation
- Neighborhood Safety
- Pets
- Self Evacuation ability
- Medical Treatment Emergency Accommodation
- Health Status, Medical Insurance
- Chronic Illness and or Disability

Info gathered during Assessment

- Assistive Devices
- Health care visits – PCP, Dentist, Hospitalization, ER, Eye, Hearting
- PRI Score, UAS Assessment
- Legal Information – i.e. proxy, advance directives, MOLST
- Nutrition/NSI/BMI
- Psycho-Social Status – PHQ9, GAD7, CAGE-AID
- Loneliness/Isolation Scale
- Tech check
- Medication List
- Fall Risk Factors
- ADL/IADL History
- Services Receiving
- Informal Supports Status
- Income
- Veteran Status
- Benefits/Entitlements

Ready Set Home

BIP Innovations Project – Erie County

- NY Connects brought to hospital and skilled nursing facility to assist with care transition
- Compliments discharge efforts by providing extra resources and bridge funding to individual and family
- Bridge between facility based care team and in-home services
- Connects individual with community resources
- Assures services are in place and monitors for first month
- Warm hand off to MLTC, waiver, PACE

- Saved $3.41 for each $1 invested

Community Care Connections

BIP Innovations – Monroe County

- Integrates community-based aging services through physicians office
- Social work services, linkages to community services and nursing services
  - EBI's
  - Home safety and minor home modifications

- Decreased hospitalizations by 50% first 90 days and 65 % over 180 days

- Decreased ED visits by 62% first 90 days and 72% over 180 days

- ROI – saved $4.58 for each $1 invested - $2.8 million

Selfhelp Active Services for Aging Model - SHASAM

BIP Innovations – Queens

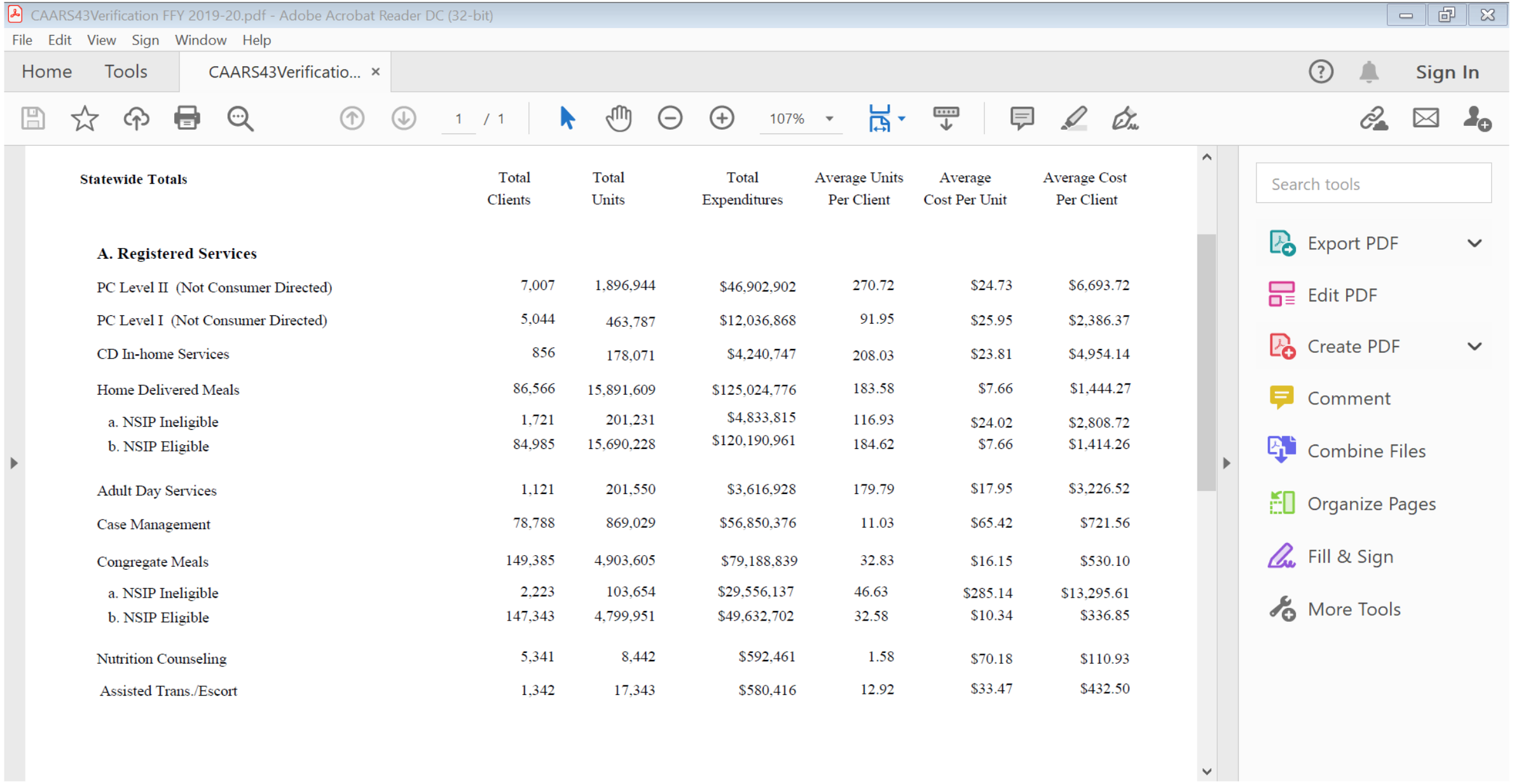
- Provides benefit and entitlement assistance, wellness programs, health screening, care transitions, referral to partner agencies, technology, socialization and volunteer opportunities.

- 68% reduction in hospitalizations
- 53% reduction in ED visits
- 76% reduction in ER for COPD, congestive heart failure and bacterial pneumonia

Hospital Costs – Selfhelp customers - $1,778

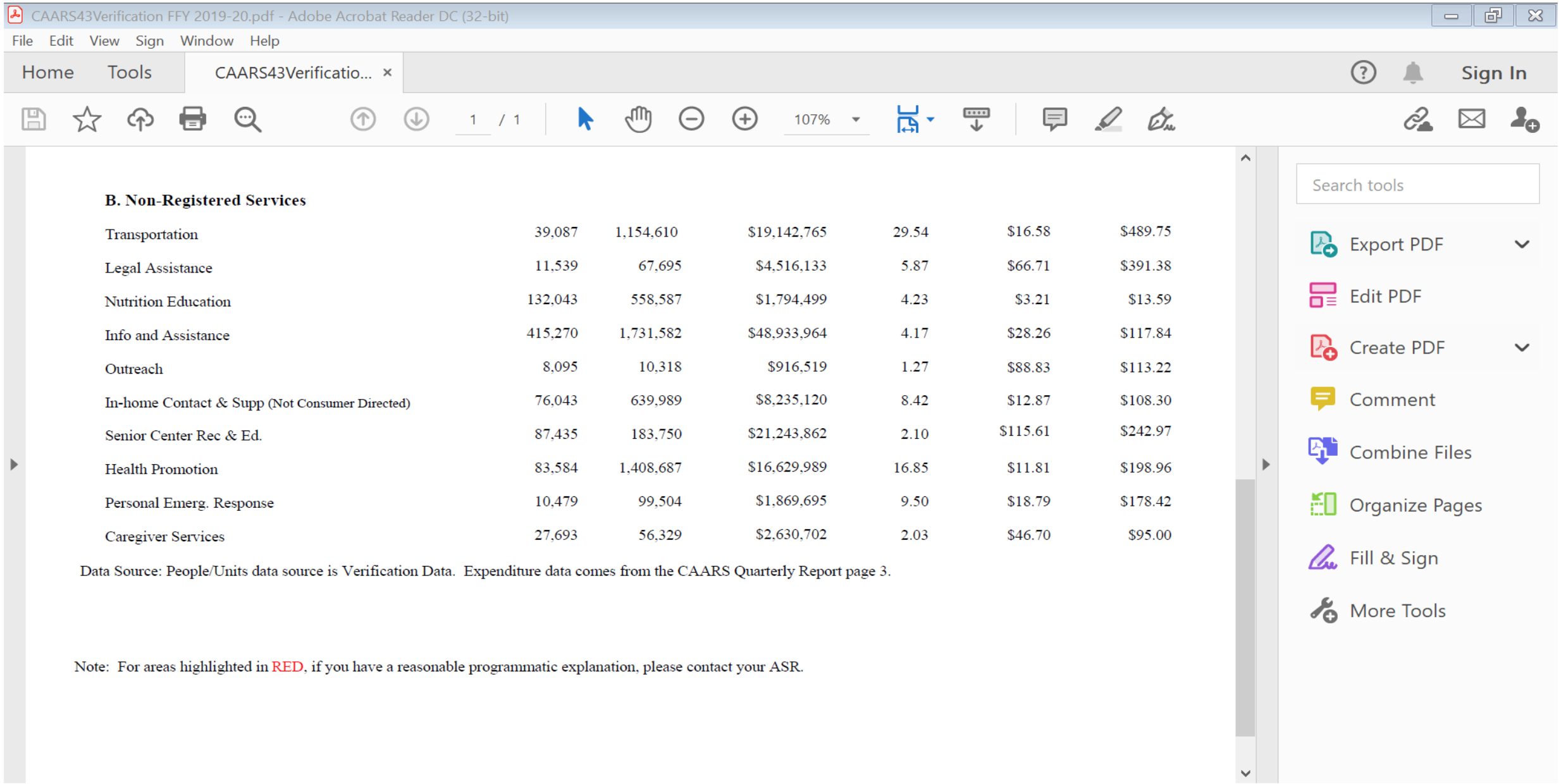
Medicaid customers- $5,715

Annual Cost of Services



Statewide Totals	Total Clients	Total Units	Total Expenditures	Average Units Per Client	Average Cost Per Unit	Average Cost Per Client
A. Registered Services						
PC Level II (Not Consumer Directed)	7,007	1,896,944	$46,902,902	270.72	$24.73	$6,693.72
PC Level I (Not Consumer Directed)	5,044	463,787	$12,036,868	91.95	$25.95	$2,386.37
CD In-home Services	856	178,071	$4,240,747	208.03	$23.81	$4,954.14
Home Delivered Meals	86,566	15,891,609	$125,024,776	183.58	$7.66	$1,444.27
a. NSIP Ineligible	1,721	201,231	$4,833,815	116.93	$24.02	$2,808.72
b. NSIP Eligible	84,985	15,690,228	$120,190,961	184.62	$7.66	$1,414.26
Adult Day Services	1,121	201,550	$3,616,928	179.79	$17.95	$3,226.52
Case Management	78,788	869,029	$56,850,376	11.03	$65.42	$721.56
Congregate Meals	149,385	4,903,605	$79,188,839	32.83	$16.15	$530.10
a. NSIP Ineligible	2,223	103,654	$29,556,137	46.63	$285.14	$13,295.61
b. NSIP Eligible	147,343	4,799,951	$49,632,702	32.58	$10.34	$336.85
Nutrition Counseling	5,341	8,442	$592,461	1.58	$70.18	$110.93
Assisted Trans./Escort	1,342	17,343	$580,416	12.92	$33.47	$432.50

Annual Cost of Services



B. Non-Registered Services

Transportation	39,087	1,154,610	$19,142,765	29.54	$16.58	$489.75
Legal Assistance	11,539	67,695	$4,516,133	5.87	$66.71	$391.38
Nutrition Education	132,043	558,587	$1,794,499	4.23	$3.21	$13.59
Info and Assistance	415,270	1,731,582	$48,933,964	4.17	$28.26	$117.84
Outreach	8,095	10,318	$916,519	1.27	$88.83	$113.22
In-home Contact & Supp (Not Consumer Directed)	76,043	639,989	$8,235,120	8.42	$12.87	$108.30
Senior Center Rec & Ed.	87,435	183,750	$21,243,862	2.10	$115.61	$242.97
Health Promotion	83,584	1,408,687	$16,629,989	16.85	$11.81	$198.96
Personal Emerg. Response	10,479	99,504	$1,869,695	9.50	$18.79	$178.42
Caregiver Services	27,693	56,329	$2,630,702	2.03	$46.70	$95.00

Data Source: People/Units data source is Verification Data. Expenditure data comes from the CAARS Quarterly Report page 3.

Note: For areas highlighted in RED, if you have a reasonable programmatic explanation, please contact your ASR.

Practical Examples

Successful discharge planning

Emergency room diversion

Reduction in social admissions

Patient satisfaction in partnership

Community interventions to address social determinates of health

Social Determinates Interventions

- Allows for support in the community
- Low cost/high yield services to assist aging in place
- Numerous interventions that improve health care outcomes
- Ongoing support to enhance medical interventions

Successful discharge planning

-reduce readmission through discharge planning process

-AAA's available to provide transportation, home delivered meals, PERS, and facilitate familial engagement

89 year old male – CHF and kidney disease – 5 admissions in 6 month period – no primary caregiver – in denial regarding disease progression and prognosis

Outcome – referral to AAA – Case manager developed rapport, implemented services, contacted out of state relatives, referred to volunteer friendship program, completed hospice referral and attended informational, client completed advanced directives and expired at his home

Emergency Department deferrals

-full training provided on social determinates/social services intervention to 911 dispatch staff

-all client case file information uploaded to EMS system

-real time triage referral to AAA

-Caller referred as appropriate with real time response

-caregiver breakdown

-out of fuel/food/confused

-low cost interventions

Reduction in Social Admissions

- Lack of understanding in the community of Medicare covered services
- We are the trusted source of information
- Provide community interventions
- Apply for Medicaid and higher level of care admissions
- Can be contacted from ED for interventions as appropriate
- Reinforcement of hospital criteria and process

Patient Satisfaction

- Paramount to hospitals
- AAA's are a partner to facilitate
- Secondary partners to ensure understanding of diagnosis, treatment, and follow up
- Act as patient advocates through the health care experience

Questions & Comments

- Attendees joining by **webinar (Zoom)**, use the Q&A function or *click* the raise hand button to join phone line. The moderator will announce your name or your last 4 digits of your phone number and will unmute your line.
- Attendees joining by **phone,** *press* *9 on your dial pad to join line. The moderator will announce the last 4 digits of your phone number and will unmute your line.
- For additional information or for feedback email Engage@aging.ca.gov.

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THANK YOU!

Send questions to Engage@aging.ca.gov