C-1a. LONG TERM SERVICES & SUPPORT

AGING AND DISABILITY RESOURCE CENTER (ADRC)

Aging and Disability Resource Center (ADRC) provides individuals eighteen and over with a disability, older adults, and family caregivers the ability to contact one resource in the community when trying to access needed information, services, and supports. The role of the ADRC staff is providing individuals the support they need to make informed decisions about long term supports and services (LTSS) to prevent or delay unnecessary institutionalization. This may include a personal interview, assisting with the identification of choices available (including personal, public, and private resources), facilitating a decision-support process (weighing pros/cons of various options), assisting as requested and directed by the individual in the development of an action plan, connecting to services (when services are requested and assistance in connecting is requested or needed), and follow up.

It is an interesting time in Washington State as we continue to face funding issues as the population served grows. Sustainability and our ability to continue to cobble together funding sources to support the ADRC is paramount to enabling these important services to continue. The ADRC is primarily funded by the Older American's Act (OAA) and the Washington State Senior Citizen's Services Act (SCSA). ALTC has also participated in various grant opportunities which have allowed us to continue to build our ADRC program.

These opportunities have afforded us the ability to reach different populations and to train staff to provide unique services to these populations. However, the true opportunity in sustainability continues to be the building of a strong service network within each of our communities where each agency comes together to ensure that we all work together. Understanding the services provided by individual agencies and organizations, their referral processes and criteria, etc enables us to each ensure we are utilizing the best that each brings to the table to meet the needs in the community.

True collaboration allows for a purposeful approach to ensuring that individual needs are met successfully and that the approach is always the correct service at the correct time. Sustainability can then be addressed as a community vs. individual agency by agency, service by service.

CARE TRANSITIONS

Care transitions refer to the movement of patients between health care practitioners, settings, and home as their condition and care needs change. Much of the discussion nationwide has to do with the transitions that occur between medical settings. When community is discussed amongst medical providers they tend to refer solely to entities within the medical structure such as hospitals and primary care physician offices.

What is missing from this picture is a focus on social determinants of health data which states that only 10% of what makes a person healthy is attributable to medical care. The remaining 90 % is shared between genetics 30%, and then 60% behavioral choices, social circumstances and environmental conditions.

ALTC continues the efforts to emphasize

that Area Agencies on Aging throughout our State and in particular the work of our Senior Information and Assistance and ADRC offices have a significant role to play in care transitions work. Health professionals must recognize nonmedical needs that affect a patient's ability to achieve health. For example, a patient may not take insulin as prescribed because he or she has no transportation to get to a pharmacy, or no way to refrigerate it. Other patients may be unable to follow recommendations to eat more fruit and vegetables because they can't get to a supermarket or afford the food. Evidence suggests that when care is coordinated and is inclusive of both the medical and community aspects of a person's existence the outcome will be a healthier person and healthcare cost savings.

ALTC remains committed to continuing our efforts with the medical communities in each of our counties to spotlight the importance of broadening medical professional's definition of community and recognizing the impact of social determinants in order to be able to have impact and create more positive health outcomes. We have staff trained in two evidence based programs that focus on care transitions of clients back to their home. These models are Care Transitions Interventions and Bridges. We are able to provide one or both of these models in all eight counties within our service delivery area.

Medicare D assistance in Kittitas County

BENEFITS ASSISTANCE

In our service area we work with many individuals who experience financial issues especially related to health care costs. Our staff provides assistance to people likely to be eligible for the Low-Income Subsidy program (LIS), Medicare Savings Program (MSP), the Medicare Part D Prescription Drug Program (Med D) and in helping beneficiaries to apply for benefits.

ADRC display during Yakima office Open House

HOME CARE REFERRAL REGISTRY

ALTC has a Home Care Referral Registry that helps to match Washington State residents who receive publicly funded in-home care services with screened and pre-qualified home care workers. The Home

Care Referral Registry helps facilitate those needing in home workers to find someone that best meets their needs.

Challenges Related to Aging and Disability Resource Center

The following are some of the challenges and barriers related to the ADRC

- Growing number of older adults
- Funding – OAAIII-B and SCSA are the primary revenue streams for the ADRC program. When there have been increases, they have been marginal at best. OAA and SCSA funding has not kept pace with inflationary costs and more new programs compete for these limited funds as well.
- Workload challenges – with every opportunity to better serve our communities with new programs such as care transitions works, a focus on dementia care, and more in-depth service such as options counseling we experience an increased workload without the funding to support new positions. Lack of adequate numbers of ADRC staff to handle the increased work expectations has led to less involvement in many community events, networking and attendance at outreach evens such as Senior Fairs.
- Staff retention- our ADRC staff has experienced a significant amount of turnover in the last several years. With the exception of one county, the majority of our ADRC staff in each of our offices has been with us less than 3 years. This has impact both externally (our ability to serve the public well) and internally (our ability to work as a team utilizing expertise that develops over time).

GOAL:

Continue to develop an ADRC team that provides quality services to the public using a person centered approach as well as supporting each other to be successful. This team will develop office practices that will promote internal efficiencies to better support any workload fluctuations.

Objectives ***(January 2016 and ongoing):***

- All new ADRC staff will complete the Community Health Worker Training Program within the first year of employment.

- All new ADRC staff will become AIRS certified within their first two years of employment. Current ADRC staff will maintain their certification.

- All ADRC offices will hold a minimum of twice monthly ADRC staff meetings/trainings focused on ensuring that staff is well versed in interviewing techniques, resource development, and the skills necessary to provide quality service in their communities. These focused trainings will include routine review of standards and work within each office to develop processes that

focus on a teaming approach to a quality service delivery in each community.

- Provide necessary training and support to ensure that all ADRC staff is able to function effectively and efficiently in the Community Living Connections (CLC) statewide data base.

- ALTC will provide an all ADRC staff development day one time per year as budget allows for the purpose of staff development and team building.

- Elevate public awareness on the role of the ADRC in each community

- Continue to develop MOU's with community partners using this as an opportunity to clearly define, support, and promote the role everyone plays in serving the public well.

- Participate in media opportunities as funding allows. This includes print advertisement as well as radio.

- Participate in three health and wellness or population specific fairs annually with focus on reaching pre-Medicaid population and or underserved populations.

- Participate in community groups that evolve out of the Affordable Communities of Health, participate in work with hospitals regarding readmission rates, and other opportunities to collaborate within our service communities.