

SUMMARY

Integration of Multipurpose Senior Services Program and Older Americans Act funding to prevent hospital re-admission is a novel approach to ensure safety of vulnerable APS-adults.

Hospital Transition and Long-Term Care for Abused and Neglected Seniors – An APS and AAA Partnership

Challenge According to the California Department of Social Services (2016), the APS program investigates over 150,000 reports of elder and dependent adult abuse each year¹. The legal mandate for APS in California is to investigate and offer services to any elderly or disabled person who is experiencing abuse, neglect, or exploitation. Individuals that come to the attention of APS, and who would benefit from hospital discharge planning and in-home case management, are simply outside of the scope of current APS regulations. Studies show that among seniors 65 and older, hospital readmission within 30 days of discharge range from 12.5 to 16.7 percent. With self-neglect being the most commonly reported abuse, lack of medical follow-through and risks of emergency readmission continue to be an ongoing concern.

Solution Office on Aging's **Holistic Assessment, Resources, & Transitions for Seniors (HARTS)** integrates several key services into one seamless program that seeks to increase positive health outcomes for hospitalized seniors with a history of abuse or neglect. The goals are to engage immediately upon admission, and offer tailored community services that would: (1) increase compliance with hospital discharge treatment plans; (2) enhance in-home resources to reduce further risks; and (3) focus on caregiver education and support for long-term quality of care. **Refer to Attachment 1.**

Innovation HARTS' innovation is grounded on effectively weaving four core service approaches from varied funding sources into one viable coordinated safety net for seniors:

- **Hospital Transition – immediate referral of APS clients** to a social worker upon hospital admission, to ensure that the client is offered the needed material and personal supports required for safe discharge;
- **Professional Nursing Care Follow-Up – home visitation within 48 hours** of client's discharge to review medical follow-up instructions and create safety plans with the client and caregiver(s);
- **Caregiver Support – to establish new emergency homemaker services** (if needed) and to support spouses and current family members who face new challenges managing the complex responsibilities related with illness and hospitalization;
- **Medical Case Management (MCM) – immediate medical, nutritional, social, and financial assistance** through collaboration with client, family, hospital and varied county department staff. Core to MCM is "case conferencing," with the goal of ensuring the least possible disruption to the client through in-home care and partnership with the health plans, county social service workers, and department networks.

Results APS clients with hospital admissions were referred immediately to the HARTS social worker for engagement prior to discharge. This direct linkage resulted in the effective coordination of professional supports from varied disciplines ensuring: 1) follow-through of essential safety and protective measures; 2) completion of clinic/medical appointments; and 3) delivery of basic nutrition and long-term care needs at home. The following service strategies were found to be critical in cases with successful service delivery.

1 Immediate & Quality Engagement

- **Multiple repeated attempts** (both at the hospital and at home) are required to successfully engage and build rapport with APS clients.
- **Joint visits** with the APS social worker (or other service staff) who have established trust with the client are critical to (1) introducing new services and (2) transitioning into long-term case management.

¹ Report to the Legislature: Child Welfare Services & Adult Protective Services Realignment Report: Outcome and Expenditure Data Summary – April 2016 Annual Report. <http://www.cdss.ca.gov/cdssweb/entres/pdf/legislature/2016RealignmentReportOAB.pdf>

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- Client acceptance of offered services (hospital transition and case management) *increased* when presented at the hospital setting, during face-to-face engagement at bedside.
- Case conferencing is critical for establishing professional services. Brief weekly discussions regarding new or ongoing critical cases with key workers and supervisors reduced duplication of work and effectively facilitated joint visits and service coordination efforts.
- Resource education is necessary for both professionals and service consumers. It is not widely known that Office on Aging/HARTs is able to offer a variety of safety net supports through diverse funding sources: meals, transportation, material aid, dental, financial and utility assistance, caregiver respite, one-time purchase of medical equipment, etc.

2 Coordinated Quality of Care

- Coordinated care among key partners provides *easier (and timely) access to necessary services, resulting in improved client outcomes*. Availability of in-depth information regarding client care history allows for program staff to offer services that are more likely to reduce the challenges that increase the risk of re-hospitalization.
- Investment in short, but timely team conferencing helped to facilitate solutions (e.g., securing needed follow-up appointments; purchase of respite care, meals, or home materials), reducing the need for APS or emergency intervention.
- Follow-up appointments are easier to secure when partners are involved in care coordination and/or phone conferencing.

3 Impact A total of 126 clients were referred during the first 18 months of HARTs implementation, about half (total 57, 45%) of whom accepted six months or more of medical case management (MCM) services. Of the 57 who received case management, **only one (2%)** had a subsequent APS referral within 90 days from service completion.

- **Post MCM Impact:** *By receiving resources and case management support, 98% of HARTs clients were able to successfully manage their health care goals independently 3 months after program completion. HARTs mitigated APS risk and safety concerns for the majority (98%) of senior participants 3 months after program participation.*
- **Ongoing MCM Impact:** Self-reported hospital re-admission affected only 5% (3 of 57) of program participants during the *first 90 days of enrollment* in case management. *95% of HARTs clients received support to successfully manage their health care goals within three months after hospital discharge. 89.5% were able to manage their treatment plans for at least 6 months after discharge, significantly reducing costly hospital re-admissions.*

Replicability HARTs changes the traditional approach to the lifespan of an APS case in Riverside County. Standard APS practice focuses on investigation of very specific allegations over a period of 30 to 60 days, with only short-term emergency interventions prior to case closure. Despite best intentions, lack of funding and increasing need make long-term case follow-up a rarity. HARTs' immediate service coordination, joint community-based delivery of services from APS social workers, and access to hospital, behavioral health clinics, and health plan partners offer a depth of service that is not typical of a county protective system.

Integration of long-term care waiver programs such as Multipurpose Senior Services Program (MSSP) and the **targeted and coordinated use of Older Americans Act (OAA) title funding to prevent hospital re-admission is a novel approach to ensure safety and well-being of abused vulnerable adults**. HARTs is replicable to the extent that jurisdictions are willing to share resources and client information for the purpose of emergency service intervention. Essential to the success of the design is relinquishment of professional "turf" practices and sharing in the responsibility for clients who are difficult to serve and are high utilizers of complex emergency and medical service systems. Critical elements include: investment in cross-training, co-location, blended-funding, outcomes data collection, and cross-systems access to common client information for the purpose of service delivery.

ATTACHMENT 1

Riverside County Office on Aging

Holistic **A**ssessment, **R**esources, & **T**ransitions for **S**eniors

Referral Criteria

APS Report of Adult Abuse + Hospital Admission



Service Engagement

Medical Case Management + Hospital Care Transition



Client Outcomes

Safe at home	Discharge plan compliance
Reduced medical risk	Completed appointments
Caregiver support	Improved health

68-year-old female
Living with caregiver
Multiple medical conditions

Ms. G.

HARTS Program Services

- Medi-Cal & CalFresh applications
- Social Security & Veteran benefits
- IHSS paramedical hours for wound care
- Home assistive devices and incontinence products
- Medication management & pharmacy refills
- Treatment education
- Nutrition monitoring

Client Outcomes

- *No subsequent APS report; no hospital re-entry*
- Weight gain, increased strength, improved health
- Able to walk without a walker inside the home
- Successful strategies for medication compliance
- Regular medical appointments & clinic visits
- Participating family assists with money management
- Caregiver support through IHSS & Public Authority