Comprehensive, client-centered health care through social service intervention keeps seniors healthy, happy, and independent--dramatically reducing hospitalizations

Coordinated Care Management

Improving lives: one meal, visit, or ride at a time

Elaine Clark, Executive Director

STRATEGIC PLAN 2013 - 2016

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Introduction

Who We Are

Meals on Wheels and Senior Outreach Services (MOWSOS) has served Contra Costa County seniors since 1968, providing health and wellness support services to help adults age 60 and older live lives that are healthy, happy, and safe.

Mission

Helping seniors live independently and with dignity.

Result/Impact

Seniors are Healthy, Happy, and Safe

Whom we serve

MOWSOS serves more than 5,000 seniors (age 60+) each year, of whom:

- 80% are low-income
- 40% are age 80 or older
- Two-thirds are women
- 40% live alone
- 5% are veterans

Sixty percent of MOWSOS clients are White, which is consistent with the overall population of Contra Costa County. Fourteen percent are Hispanic, 10% are Asian or Pacific Islander, and 9% are African American. More than 90% live in central or eastern Contra Costa County. MOWSOS defines its primary clients as seniors, but works closely with family members and/or other caregivers.

Where we work

Contra Costa County

Programs

MOWSOS operates six programs, each meeting an important need:

Meals on Wheels	•over 700 hot meals delivered to homebound seniors every weekday
C.C. Cafe's	•200 low-cost lunches provided in 6 locations in a social setting every weekday
Friendly Visitors	•companionship provided to 215 homebound seniors every week
Home Care Registry	•400 seniors and their families linked to trustworthy and low-cost in-home help every year, training and support provided to family care providers
Fall Prevention Program	•700 community members educated, 230 homes made safer, and 60 high-risk seniors enrolled in customized exercise programs annually
Care Management Program	•300 seniors annually linked to supportive health and wellness services

Our Competitive Advantage

Overall:

- Established volunteer network
- Positive reputation based on community trust earned as a local provider

Related to Care Management opportunity:

- Expertise and experience providing Care Management services: all the elements of the service program are in place and only need to be expanded

Funding

A majority of MOWSOS revenue (55%) comes from government grants and contracts. Like many nonprofits reliant on public support, MOWSOS has seen this funding diminish over time; it is expected to become less than 50% of the organization's total revenue by 2015. Nearly all the remaining revenue comes from contributed income – including donations from individuals, foundations, and corporations.

Emerging Needs

Over the next 20 years, demographic shifts will drive an unprecedented increase in demand for long-term health services and supports for seniors. The aging of the Baby Boomer generation will see vast numbers transition from being family caregivers to being recipients of care. Nationwide, the ratio of available family caregivers to recipients age 80 and older will drop dramatically, from 7.2 in 2010 to 6.1 in 2020 to just 4.1 in 2030.[1] In the meantime, the United States has experienced a trend away from institutional to home-based care for seniors, putting a greater burden on family. At the same time, the kinds of tasks expected of family caregivers have become increasingly complex. Support to live independently can help seniors stay out of expensive medical and convalescent facilities – and, importantly, transition successfully out of these facilities back to their homes.

Contra Costa County has more than 210,000 residents aged 60 or older, comprising almost 20% of the county population. The senior population in Contra Costa County is expected to double by 2030. The Area Agency on Aging reports that financial security, maintaining good health, and the cost of health care rank as the top three concerns of the county's Baby Boomers.[2] According to survey results, Boomers were as likely to report interest in Medicare and homecare counseling as in volunteering to help others, reflecting their transition from caregivers to receivers of care. Even so, aging in place was cited as a concern more frequently by senior service providers than by Boomers themselves, which could suggest a lack of readiness among aging adults to see themselves as needing – and making the necessary preparations for – related health and wellness supports. Another key takeaway of this report was that many seniors do not know about the range of services available or how to meet their needs.

At the same time, the Affordable Care Act is providing new incentives for health care providers and insurers nationwide to reduce treatment costs and improve patient outcomes. This includes a focus on reducing hospital readmissions, which can be accomplished in part by providing better transitional care services – especially for seniors. The health care field is entering a period of extensive change in treatment and funding outlays that provide an opportunity for non-traditional partners such as community-based support providers to secure new revenue streams for their services.

[1] Donald Redfoot, Lynn Feinberg, and Ari Houser. "The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers." AARP Public Policy Institute, 2013.

[2] "Contra Costa County Area Agency on Aging Four-Year Area Plan 2012-2016." Area Agency on Aging, 2012.

Coordinated Care Management – The Service Model

MOWSOS is reorganizing our service model and expanding the Care Management Program to a ***care transition service*** that provides comprehensive linkages for low-income seniors needing health and wellness support services. This change enables MOWSOS to respond more quickly and effectively to client needs, provide better overall customer service to seniors and their caregivers, and create a business model to sustain the organization financially through partnership with local health care institutions (such as community clinics, hospitals, insurers, etc.).

MOWSOS is making these programmatic changes over a three-year period beginning in January 2014. Two primary goals during year one are:

- Expand core capacity for intake, referrals, client assessment, and customer service
- Develop partnerships with local health care institutions programmatically and financially to further develop the Care Management Program.

The timing for this initiative is ideal. MOWSOS is ready to take advantage of the strengths we have already cultivated in care management at the same time that health care providers are looking for new solutions in response to Affordable Care Act incentives. Importantly, MOWSOS:

- Is the most comprehensive provider overall – and largest nonprofit provider – of care management services to seniors in eastern and central Contra Costa
- Serves as a community hub for seniors, enjoying a strong and positive brand for its operation of critical support programs
- Has cultivated strong partnerships with health providers such as John Muir, La Clinica, and Kaiser to support their transitional care needs
- Operates with a balanced budget and positive underlying financials
- Enjoys unified support around the need to move the organization forward

MOWSOS already receives regular requests for transitional assistance from John Muir and Kaiser hospitals, putting us in a strong position to expand and monetize our existing service; the County has also made overtures related to this type of service.

With support from the John Muir/Mt. Diablo Community Health Fund (CHF), MOWSOS has worked with La Piana Consulting to develop the expanded Care Management Program.

This program expansion affects MOWSOS' five other senior programs insofar as access to the range of services has become better integrated through enhanced care management. The result is a more client-focused approach to health care services.

Coordinated Care Management – Overview of Changes

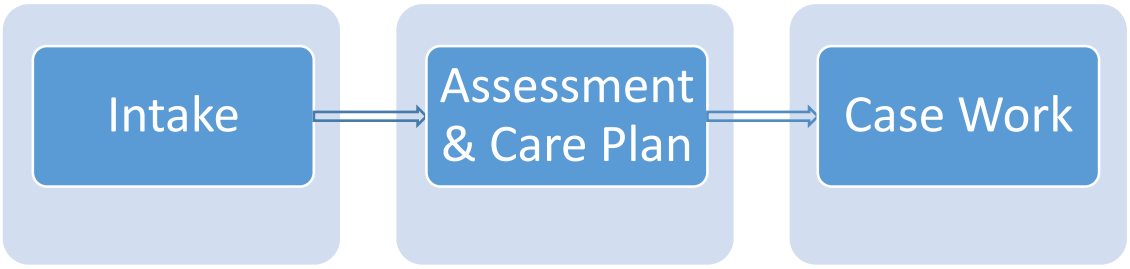
The Care Management Program is redesigned as a client-centered system for linking seniors to critical support services. The change at MOWSOS can be summarized in the following graphic.

Former		New	
Step 1	Client needs a service (e.g., meals) and finds out about MOWSOS	**Step 1**	Client needs a service (e.g., meals) and finds out about MOWSOS
Step 2 (24 hrs)	Client leaves a voice mail at MOWSOS asking for meal service	**Step 2**	Client speaks with trained receptionist who collects basic client information and full description of presenting need
Step 3 (8 days)	Meal staff returns call and arranges for first meal to be delivered in one week		
Step 4 (9 days)	During first meal delivery, volunteer observes client's limited mobility and relays information back to staff	**Step 3** (1-24 hrs)	Director of Care Planning speaks with client and determines that client needs extend beyond meals to fall prevention, in-home services, and mental health counseling
Step 5 (10 days)	Meal program staff asks Fall Prevention and Home Care programs to contact client about additional services		
Step 6 (12 days)	Home Care program follows up with client to link to in-home services Fall Prevention signs up client for a fall prevention course in one month	**Step 4** (1-2 days)	Case Manager contacts and/or visits client and signs her up for all identified needs, working off a care management plan provided by Director of Care Planning. Skilled volunteers and/or interns assist as appropriate. Services include MOWSOS-provided programs (in this example, Fall Prevention and In-Home Service Registry) as well as local mental health clinic
Step 7 (2 weeks)	Client has accessed needed services	**Step 5** (3 days)	Client has accessed needed services

Program improvements enable a significantly quicker response time more robust assessment and care planning, a wider variety of referral options for all clients (not just those who access the Care Management Program), and a better overall customer service experience.

Coordinated Care Management -- Functional Design

MOWSOS developed an integrated approach that considers three needs, or levels, of program structure – Intake, Assessment and Care Planning, and Case Management – and the appropriate roles for addressing them.



- **Intake**

The first contact with a new client is warm, professional, and efficient. Most importantly for MOWSOS purposes, the first contact results in the client connecting immediately (or soon thereafter) with the right person to respond to her or his need.

The Receptionist is responsible for receiving and routing incoming calls.[3] For all new clients, the Receptionist is responsible for client intake, including input of basic client information into the MOWSOS system – name, age, address, phone number, email address, presenting need, and source of referral. Once basic intake is complete, the Receptionist connects clients to the Director of Care Planning (see Assessment and Care Planning, below). The Receptionist also assists the Director of Care Planning and Case Manager(s) by scheduling appointments and assisting with client record-keeping.

[3] MOWSOS reorganized our system to direct returning clients to Case Managers or to specific programs.

- **Assessment and Care Planning**

Understanding a client's needs and developing a care plan is critical to providing high levels of service. Seniors often contact MOWSOS about a specific need, but through skilled assessment MOWOS staff discover that the client's actual needs are significantly broader or different.

The Director of Care Planning learns about the identified need of the client and seeks to understand client issues relating to overall wellness, health, and safety. Drawing from this assessment, the Director creates a care plan and assigns the client to a Case Manager (see below). The Director of Care Planning determines the client's insurance status and helps connect the client to appropriate enrollment and/or assistance programs.

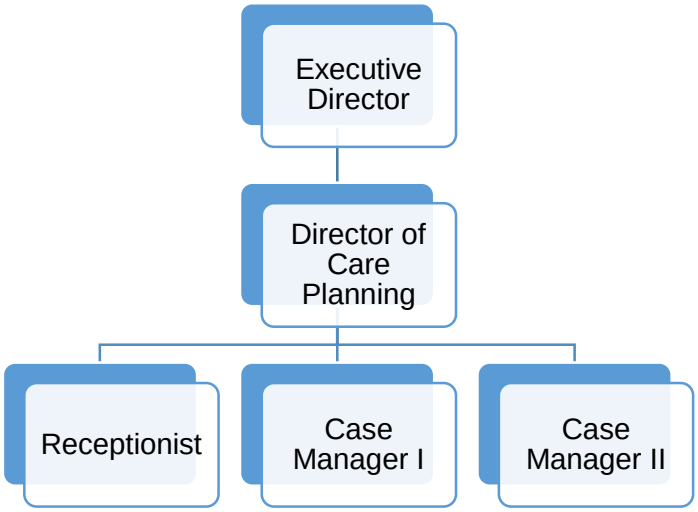
Although the Case Manager is responsible for carrying out the client care plan, the Director of Care Planning oversees the work and is responsible for problem solving, intervening in crisis situations, assuring quality of services and clinical integrity, and for assuring overall effectiveness of MOWSOS services.

- **Case Management**

Providing continuity of care with an advocate working on behalf of the client is essential. Operating through a case management system means that MOWSOS takes an active role in empowering our clients to access the services they need in order to promote their wellbeing.

Case Managers are primarily responsible for linking each client to needed services, as described in the care plan and regardless of whether the service is offered by MOWSOS or another organization. Case Managers work closely with clients and service providers (including MOWSOS programs) to make sure clients access services and follow up to gauge the client's success and state of overall wellness (conducting site visits as appropriate to best meet client needs). The Case Manager is supervised by the Director of Care Planning, including regular review of each individual client care plan and client progress.

Coordinated Care Management – Staffing*



*Staffing chart for Coordinated Care Management program only

Coordinated Care Management -- Capacity

The MOWSOS Care Management Program served about 300 new clients in 2013 with 1.3 FTE direct program staff. This equates to approximately 230 clients per FTE. The expanded program includes additional services including a more robust assessment process, more formal care plan development, and likely efforts to link clients to a greater array of services. For these reasons, the expanded program is expected to serve approximately 200 clients per direct service FTE per year.

At any given time a Case Manager should be able to provide services to approximately 40-45 clients with support from the Director of Care Planning, Receptionist, and volunteers and/or interns deployed by the Volunteer Coordinator. The typical client now receives services over a period of between three weeks and three months, which is not expected to change significantly under the expanded program.[4]

The assumption is that direct program staff in the program will rise to 2.8 FTE[5] with a target full year caseload of 500 clients (although the expected caseload in the first year is expected to be lower due to lack of efficiency during implementation). This number is an educated guess and must be confirmed during 2014, the first year of our expanded program.

[4] MOWSOS staff follow up with past clients at six months, or even up to a year or more, after the initial intervention, depending on the potential for continuing need.
[5] Excludes Receptionist

Cultural and Linguistic Competence

Not only is Contra Costa County's population of adults age 60 and older expected to double within the next fifteen years, but the senior population is growing increasingly diverse. In 2012, 46.8% of Contra Costa County's residents were White (down from 50.5% in 2008), followed by 24.8% Hispanic or Latino, 15.6% Asian, and 9.6% African American.[6] Roughly one-third of the county's residents speak a language other than English at home. The eastern part of the county, in particular, has large Spanish-speaking and immigrant populations, indicators which are also correlated to lower economic security. There is also growing recognition of the needs of LGBT seniors; it is estimated that 8.7% of the county's same-sex couples include at least one senior age 65 or older. Given these demographic trends, it is essential that MOWSOS program services be culturally and linguistically robust.

MOWSOS has responded to this reality by building cultural and linguistic diversity into our current services. Five current staff members are fluent in Spanish and English. MOWSOS has tapped into our strong community base to identify and train volunteers to provide services in Russian and Farsi. MOWSOS is also experienced with the needs of LGBT seniors, having worked closely with employees, volunteers, and the Rainbow Community Center of Contra Costa County.

Cultural and linguistic competence is critical to expansion of the Care Management Program, particularly in effectively extending services to low-income and socially isolated seniors. As part of our staff recruitment and volunteer outreach MOWSOS puts a high priority on expanding our capacity for reaching diverse communities.

Partnership and Financial Sustainability

This program expansion is a means to advance MOWSOS' core mission. The impetus for making this investment *at this time* is the potential to develop new sources of long-term funding. As MOWSOS enhances our internal capacity we are also pursuing an expanded relationship with current and new local health care partners. The ideal partners will:

- Be interested in working with MOWSOS as a learning partner to develop the MOWSOS program further and conduct an evaluation of the program's efficacy in enhancing senior wellness and reducing health system costs
- Be willing to explore funding options to pay for MOWSOS services, including providing some portion of health system savings to MOWSOS

This is also an important opportunity to:

- Strengthen MOWSOS' partnerships with foundations that currently fund our programs
- Leverage MOWSOS' healthy and long-standing donor base

[6] Contra Costa County QuickFacts, U.S. Census, 2012

Related Research

To inform MOWSOS' planning for the Pilot and continued implementation of the program expansion, La Piana Consulting conducted research into other models of community-based organizations that provide care management style services – specifically those partnering with health care. Four program models were explored, including three programs focusing on meal delivery to seniors transitioning from hospital care and one more robust transitional care management program.

Key learnings focused on the opportunities and challenges related to contracting with health care partners, included:

- *Expectations are high.* Health care institutions seek partners that can deliver immediate results, handle flexible case loads, and meet rigorous certification, data management, and reporting needs. There is a bias that this level of capacity can only be met by an organization that looks more like a "business" than a nonprofit.
- *Competition is strong.* Although nonprofits can be seen as a trusted community resource, an increasing number of for-profit providers are emerging to claim a piece of the growing long-term care management market.
- *Differentiation is critical.* Nonprofits desiring partnerships with health care will need to differentiate themselves in a positive way. Organizations bearing the Meals on Wheels name enjoy a strong overall reputation and brand recognition, but they are also typically best known for one thing – delivering meals.
- *Pricing is important.* Programs generally sought to recover actual costs while remaining price competitive – i.e., low enough so that health plans see a cost savings in contracting out rather than creating the capacity in-house and doing it themselves.
- *Partnerships are key.* The most successful of these efforts are defined by a specific contracting partner (or small set of partners), a specific population (e.g., health plan members or hospital patients), and/or other carefully considered parameters.
- *Funding is uncertain.* Transitional care is a timely concern, and hospitals are facing very real incentives to reduce readmissions. However, the landscape is still being defined, as demonstration projects and initiatives are just now getting underway and do not appear to define a clear role for either nutritional support or community-based care management services.

More detail on the research scope, findings, and key learnings can be found in *Appendix B*.

Evaluation and Learning

Developing an expanded program will be a multi-year process, built on a first-year Pilot beginning in January 2014 to develop new systems and to test key assumptions. Expansion for the second and third years of development will not be defined until after the first year Pilot is underway – and will be based on learning from the Pilot.

The learning agenda – critical items to evaluate during the Pilot that will inform further program development – include:

- Design and Effectiveness: Does the program redesign deliver on better customer service and improved client outcomes? Are the staffing-client ratios and staff case load assumptions accurate? Will the expanded program model result in health system savings (i.e. fewer readmissions)?
- Partnership: Can MOWSOS attract a health care partner organization (community clinic, hospital, insurer, or other) to participate in a shared learning process including further system design, program modification, and testing program outcomes?
- Funding: Will a partner be willing to explore financial support to MOWSOS to provide care management services?
- Pricing: Can MOWSOS offer services to a partner that are cost effective compared to the partner's other options?
- Competitive Advantage: Is MOWSOS' perceived competitive advantage both accurate and powerful enough to give it an advantage in seeking partnerships?
- Client Flow and IT: What are new needs for MOWSOS' intake and case management system generated by program expansion and servicing of partner needs? What solutions will meet those needs?
- Internal integration: Is MOWSOS able to operate smoothly under a more closely coordinated internal system?
- Enhanced staffing: Is MOWSOS able to incorporate interns and volunteers into the program to enhance cost effectiveness while maintaining program quality?
- Client Demographics: Will the expanded program result in greater cultural and linguistic capacity in the program? Will more culturally and linguistically diverse populations access MOWSOS services? Will MOWSOS' expanded client base remain at 80%+ low-income seniors?

MOWSOS will be working with **Harder + Company Community Research** to design and conduct an evaluation as part of the first year Pilot.

Appendix A: Planning Process

This program design effort has been coordinated throughout by a MOWSOS Project Team including Executive Director Elaine Clark and Board President Christine Scimia. They have met a half dozen times with the consultants to develop the thinking captured in this document, coordinated communications with the MOWSOS Board of Directors, and tested ideas with managers and staff.

Critical process steps led by the Project Team and Consultants included:

Board of Directors Meetings

The project formally launched with an extensive meeting of the board to explore the need for program change and to consider how changes in the care management program could produce powerful ripples that would transform the agency. As the project neared completion, the board met to review the draft report and provide input into the final shape of the program.

Managers

This program design was heavily influenced by conversations with the Maria Vandevier, the current Program Manager. Initial program design was brought before all the program managers for review and input, resulting in critical program adjustments and also acknowledgement that the entire organization would be affected by changes in the care management program.

Research

As discussed in the report and described extensively in Appendix B, La Piana Consulting engaged in research to identify similar models and to understand critical lessons MOWSOS could apply from their experiences.

Appendix B: Research Report

To inform MOWSOS' program development effort, La Piana Consulting has conducted research into other models of community-based organizations that provide care management style services linking health care with support services.

Research questions include:

- What are the key characteristics of these programs? How do they fit within the scope of each organization's work? Within the broader landscape of community-based services?
- How is this work supported (financially and in terms of staffing and other operational infrastructure, partnerships, etc.)?
- What challenges have been experienced and how have these been addressed? What have been elements of success?

With input from MOWSOS leadership, La Piana consultants identified four programs to investigate, conducting Internet research and phone interviews with representatives (subject to availability). This summary report includes findings from our research on the following:

Meals on Wheels of Greater San Diego
MOW of Greater San Diego is being contracted by health plans to provide home-delivered meals to seniors as part of discharge planning.
Debbie Case, President/CEO, interviewed 8/1/2013 and 8/15/2013
Pamela Mokler, MIS Gerontologist with Care1st Health Plan, interviewed 8/16/2013

Johnson County (Kansas) Area Agency on Aging, Nutrition Services
Johnson County AAA is piloting a program to coordinate with discharge planners to provide home-delivered meals and other supportive services to seniors.
Nancy Tanquary, Nutrition Program Manager and Connie Stankewsky, Nutrition Program Coordinator, interviewed 8/13/2013

Meals on Wheels of San Francisco
MOW San Francisco has a Social Work Services program that coordinates referrals and short-term case management linking seniors to a range of community-based services.
Anne Quaintance, Chief Operations Officer, interviewed 8/14/2013

Peninsula Family Service
Peninsula Family Service partners with Palo Alto Medical Foundation Mills-Peninsula to provide transitional care management for older adults. It has a similar partnership with Sequoia Hospital.
Susan Houston, Director, Older Adult Services, interview requested
Yvonne Chan, Program Coordinator with Palo Alto Medical Foundation, interview requested

The first section of this report provides a high-level overview of key findings. The second section calls out questions for further consideration, such as areas where additional information may be needed.

Key Findings

Scope of Services
We sought examples of programs operated by community-based organizations like MOWSOS in the context of transitional care and discharge planning. We identified three MOW programs and one multi-services agency.

MOW of Greater San Diego and Johnson County MOW each focus on meal delivery augmented by limited assessments and referrals. MOW San Francisco operates a social work program that is not currently integrated with its transitional care meal deliveries. Peninsula Family Service appears to have assumed a more traditional care management role, though it has done so only within a specific set of partnerships. Some focus on dual-eligible patients only

All provide services to transitional care populations through vendor contracts or partnerships with either health care providers or intermediary brokers.

Infrastructure and Financing
Transitional care is a timely concern, and hospitals are facing very real incentives to reduce readmissions. However, the landscape is still being defined, as demonstration projects and initiatives are just now getting underway in specific regions and have not yet been rolled out more broadly.

Furthermore, the financing mechanisms to support transitional care improvements are still evolving, and current programs do not appear to define a clear role for nutritional support or community-based care management services. Thus, meals seem to be included only at the discretion of each health plan or initiative, and nonprofits are viewed primarily as vendors of specific services, rather than as brokers of a broader range of supports.

Competitive Environment
In speaking with a health plan representative from Care1st, it seems that while there is a desire for greater integration and interest in having a “one-stop-shop” for referrals for social supports, there is skepticism that a single nonprofit could fill this role.

The health plan interviewee stressed that they are seeking partners who can deliver immediate results, handle flexible case loads, and meet rigorous certification, data management, and reporting needs. There is a bias that this level of capacity can only be met by an organization that looks more like a “business” than a nonprofit, and in fact an increasing number of for-profit providers are emerging to claim a piece of the growing long-term care management market. This poses a competitive challenge to nonprofits seeking a role here.

Competitive Advantage

Each of the case profiles speaks in a different way to the importance of competitive advantage. San Diego and San Francisco interviewees were upfront about the need to differentiate oneself in the field, to focus on one's strengths, and to develop information and relationships needed to understand and participate in this new market context. Johnson County and San Mateo both revealed that low utilization can be a result of failing to establish these strong relationships with referring health care providers. Finally, the health plan informant cautioned that nonprofits will have to prove their business savvy and ability to deliver in order to win confidence or contracts.

Generally speaking, MOWs have a strong overall reputation and brand recognition. But they are also typically best known for one thing: delivering meals. To be seen as a care management provider of choice, MOWSOS will need to redefine that image in the minds of its stakeholders.

Perception and Partnerships

Interviewees agree that the level of unmet need outweighs any concerns about duplication or competing over "turf," but relationship-building and communication are still critical to success. MOW of Greater San Diego and MOW San Francisco are both fairly large and well-established anchor organizations in their communities, and while this positions them well to compete for contracts, both are also active in collaboratives and coalitions in their respective communities, ensuring that even when they act independently, they are not acting in isolation. Collaboration is even more integral to Peninsula Family Service's care management efforts, those programs having been built on the strength of broad-based community involvement and partnerships.

Despite her concerns about whether nonprofits are really ready to partner with health plans to deliver transitional care coordination, the health plan interviewee also indicates that being a nonprofit can also make a provider a more attractive partner than a county-based program, noting that government agencies (such as county-based Area Agencies on Aging) can be hard to work with. At the same time, she acknowledges that directly competing with the local AAA could put community-based organizations in a politically tense position.

Pricing Services

Because the MOW organizations are primarily providing meal delivery services, they have been able to price their contracts (or to budget) on a per-unit cost basis. Pricing care management services can be more complex, particularly if it is assumed that some clients will have more far-ranging needs than others. Care management providers that work directly with clients and caregivers often use a tiered approach or sliding scale to determine service fees, a solution that may not be tenable when seeking to contract with health care providers or health plans.

Projecting real costs, not only of the services to be provided but the infrastructure needed to support them, is critical. MOW of Greater San Diego and MOW San Francisco interviewees emphasize the importance of knowing what your costs are, how they may be impacted by scaling up, and what are the added costs and pressures with respect to organizational growth. At the same time, pricing must be competitive – e.g., low enough so that health plans see a cost savings in contracting out rather than creating the capacity in-house and doing it themselves.

Testing and Development

The most successful of these efforts are defined by a specific contracting partner (or small set of partners), a specific population (e.g., health plan members or hospital patients), and/or other carefully considered parameters. Johnson County MOW has struggled in part because it did not launch with a committed partner(s) or target client population identified, and it is now scrambling to create these relationships in part by offering to be all things to all people.

The most sophisticated case management program included in this scope of research was planned with broad stakeholder input, and continued success is built on active partnerships, both with the lead hospitals and the community-based service providers receiving referrals. Developing and approaching these efforts as a "pilot" with built-in parameters, partners, and conditions has helped facilitate learning, enable mid-course corrections, build needed capacity incrementally over time, and manage the risk involved in what is essentially developing a new line of business.

Considerations

Although this initial research includes the perspective of a health plan representative, it does not capture the current state of transitional care in Contra Costa County or the needs, desires, or concerns of MOWSOS' potential customers, competitors, partners, and/or other stakeholders.

Additional information gathering might reasonably include a limited survey of existing transitional care and care management programs operated by the County (Contra Costa Health Services/ Contra Costa Health Plan and the Area Agency on Aging), major hospitals (Kaiser, John Muir, Sutter-Delta), and/or independent nonprofit and for-profit agencies.

Interviews with hospital discharge planners may also contribute to a more practical understanding of needs, gaps, and appropriate solutions.

Finally, it will also be important to gain a better understanding of any initiatives or collaboratives focusing on transitional and/or long-term care in the region and any opportunities or limitations these may pose.

Appendix C: Partner Benefits

Partnering with a community based organization such as Meals on Wheels and Senior Outreach Services can reduce costs, hospital readmissions, and improve overall health outcomes. Interventions are especially critical immediately following hospital discharge.

- Meal Delivery – Ensuring proper nutrition for at-risk patients including recently discharged patients improves their chances of recovery.
- Home Visits – Daily or weekly home visits including wellness checks by case workers and Friendly Visitors ensures rapid interventions.
- Home Modifications – Installation of grab bars, transfer benches, and wheel chair ramps allows seniors to live independently while reducing their chances of falling.
- Daily/Weekly Phone Calls – Regular phone contact alerts case workers to potential health issues, triggering in-home case worker visits.
- Caregiver Assistance – Screening and placement of low-cost, non-medical care givers in homes to assist with food preparation, general house cleaning, and light chores during the first 30 days following hospital stays allows clients to return to independence quickly.