VVCC Integrated Person – Centered Care Management

October 4, 2016

Over the past 25 years, Verde Valley Caregivers Coalition has successfully organized and provided a highly effective community-based program serving older adults in need. Through these years, VVCC has served over 10,000 adults experiencing challenges to their continued ability to live independently in their community of choice. VVCC continues to provide its basic services including transportation, in-home visitation, the Guardian Angel medical alert, minor home repair and maintenance, grocery shopping, pet care and business assistance to support aging in place. Almost all services are provided by volunteers with over 370 volunteers serving throughout the year. Over the past five years the number of people needing our help has grown from an annual average of 850 individuals to over 2,300 needing help. Additionally, the average age has increased from 84 to 90 and most have complex health conditions and socio-economic distress. With three years of experience, from 2012 through 2015, providing transitional care services to 670 patients referred from the local healthcare system, VVCC has the proven experience to integrate a person-centered care management program as a regular part of its services. Person-centered care management will give VVCC the tools to more effectively serve the many high-needs older adults now enrolling. The following logic model shows the outcomes we can accomplish for the growing and changing population of older adults in need, based on our prior experience with providing transitional care services.

Key Points

- 2,300 eligible older adults and adults with disabilities enrolled annually
- Approximately 500 new neighbors (our clients) enroll annually
- Eligibility is based on several factors including health conditions and/or socio-economic needs that may limit or threaten the individual's ability to continue living independently in their community of choice. Approximately 90% of the individuals we serve are unable to drive due to health conditions or disability.
- Referrals come from primary care providers, specialty health care providers, home care and hospice providers, acute care hospitals, independent social workers and care managers, family members, churches and others.
- RN Care Manager provides person-centered assessments and writes care plans with support from team of volunteer retired nurses. RN Care Manager provides training and case conferencing support to care management team.
- Person-centered care plans are implemented in conjunction with client input through follow-up visits and phone contact by the One-Call Center.
- One-Call Center is staffed by a team of volunteers and paid staff – Monday through Friday from 9:00 a.m. – 4:00 p.m.
- Community engagement activities take place throughout the year, resulting in 75+ new volunteers annually.
- Total volunteer team of 375 members, including 180 volunteer drivers.
- Feedback and quality measurement is gathered through surveys distributed by mail, by phone and routinely with client contact.

Resources

- Community volunteers from all parts of the Sedona and Verde Valley area.
- VVCC staff team with focused leadership.
- VVCC policies and procedures to guide program development and the work of staff and volunteers.
- Effective fund development with full participation by Board of Directors.
- Community-wide stakeholder partnerships with health care, social services providers, businesses, religious organizations and service clubs.
- Technology tools including operating system database for One-Call Center and Care Management activities.
- Private, corporate and community foundations willing to fund community-based nonprofit organizations supporting aging-in-place.

Activities

- Recruit and retain volunteers.
- Hire RN Care Manager
- Develop and implement fundraising, grant writing, and communications plan.
- Maintain a high-capacity One-Call Center – to respond to neighbors' calls and provide initial intake for referrals.
- Implement a community engagement and stakeholder plan to achieve volunteer recruitment goals and engage referral partnerships.
- Develop and implement a volunteer and staff training and in-service plan.
- Maintain updated CARE database and maintain functional capacity of current CARE database – the primary operating system for the One-Call Center and Care Management functions.
- Research and test improvements to current CARE database and research potential new database systems.
- Implement quality and needs survey process for neighbors, volunteers and stakeholders.

Outputs

- Provide services to 2,300 eligible individuals annually.
- Enroll 500+ new eligible neighbors annually.
- Respond to 500+ calls per week.
- Provide 10 or more eligibility screenings by phone weekly.
- Provide 450 person-centered in-home assessments per year by Care Manager and volunteer care managers.
- Care manager team completes 1,400 follow-up in-home visits annually.
- Deliver or arrange 22,000 one-way trips annually.
- Care manager team members and One-Call Center team works to link clients to 2,000 or more services provided directly by VVCC in addition to transportation.
- Link neighbors to 1,200 other services as requested through the person-centered assessment process.
- Recruit and retain 370 volunteers annually.
- Hold 6 volunteer training and support session annually.
- Care Management and One-Call Center teams complete 2,000 quality and needs surveys of new and enrolled neighbors.
- Care Manager provides 4 in-service support sessions for care management volunteers annually.
- Hold 20 care review sessions annually with Care Manager, care manager team members, Operations Manager and One-Call Center team members.

Outcomes

- 90% of individuals served are able to remain in their homes at least one year or longer subsequent to enrolling in VVCC services.
- During first year of service delivery acute care admissions are reduced by 50% compared to the 12 months prior to program enrollment.
- 93% of participants attend all scheduled primary care and therapy appointments.
- 95% indicate a greatly improved level of confidence in being able to continue to live in their own residence and community of choice.
- 75+ new volunteers are enrolled and serve.
- 80% of volunteers continue to serve 12 months or longer.
- Achieve full funding targets.
- 85% of staff and volunteers report they are very satisfied with their experience at VVCC.

Impact

- Individuals experiencing mobility challenges due to the impact of health conditions, advanced age, and socio-economic factors have the ability to continue living in their community of choice.
- As individuals age in their community of choice they are able to manage the various challenges brought on by health conditions and advanced age through support and partnership provided by VVCC.
- Older adults living with chronic health conditions and advanced age are able to utilize primary care services rather than rely on the Emergency Department or hospital admission to address ongoing health needs.
- Older adults with the greatest needs are able to obtain the social and environmental supports they need to support connected independence.
- Communities throughout the Verde Valley work together with VVCC dedicating volunteerism and financial contributions to transform aging from isolated independence to connected independence.