Colorado's LTSS System

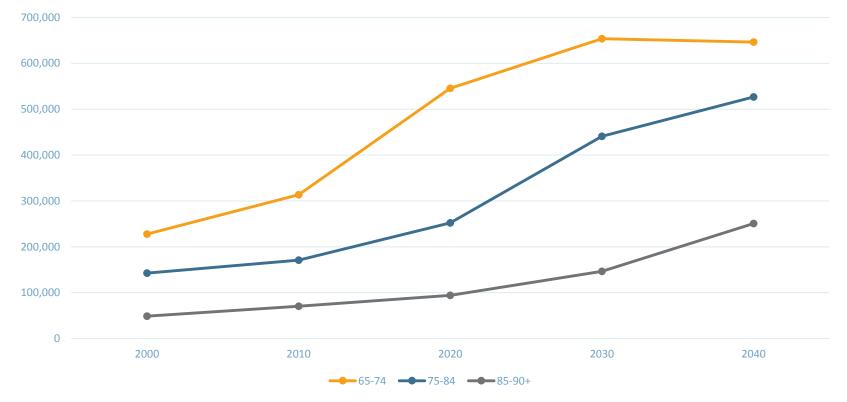
Piecing Together the Puzzle

September 26, 2013 COPIC – Mile High Room





Rapid Aging of Colorado

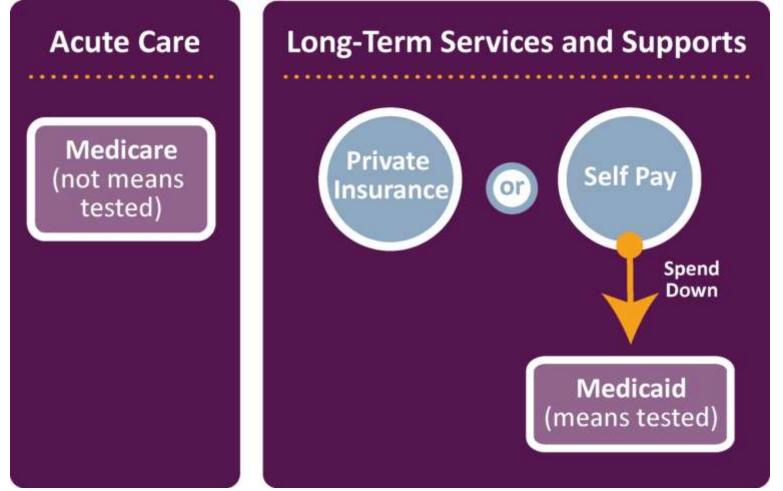


65+ Age Distribution in Colorado, 2000-2040



SOURCE: Colorado State Demography Office

Medicare, Medicaid and the "Spend-down"





LTSS Medicaid Enrollment

- 64,000 Coloradans received Medicaid LTSS in 2011-2012
- 78,100 Coloradans were low-income and reported a disability in 2011 and were not enrolled in Medicaid
 - Potential future Medicaid enrollees?



More Home- and Community-Based Services (HCBS)



Medicaid Enrollment, HCBS vs. Nursing Facility

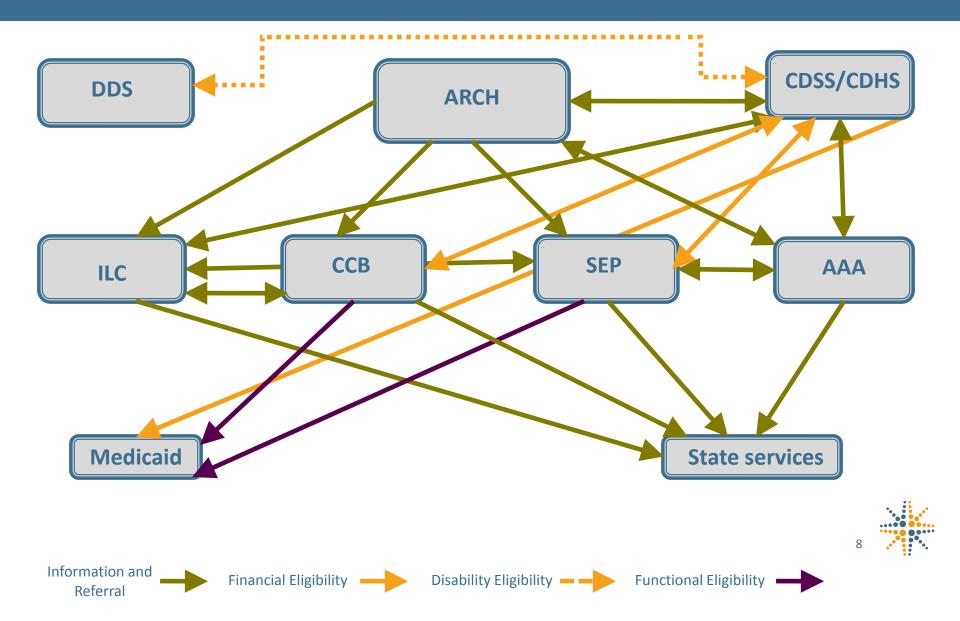
SOURCE: Colorado Department of Health Care Policy and Financing, FY2013-2014 Budget Request

How We Think About LTSS: An Analogy

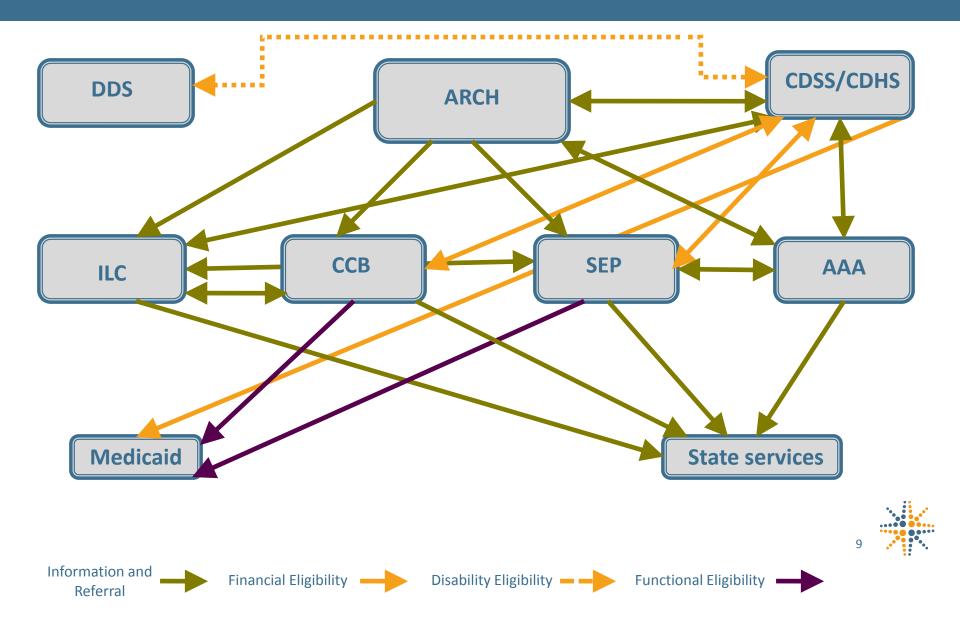




Colorado's LTSS Puzzle



Colorado's LTSS Puzzle



Sticking Points in the System

- Case management
 - Caseload size
 - Conflict of interest
- Assessment tool
 - Not tied to care plans
- Data systems
 - Multiple entry points using different systems
- Wait times



Recommendations from the Field

- Streamlined access
- Conflict-free case management
- Assessment tool
 - Person-centered care planning
- Integrated data system
- Presumptive eligibility?

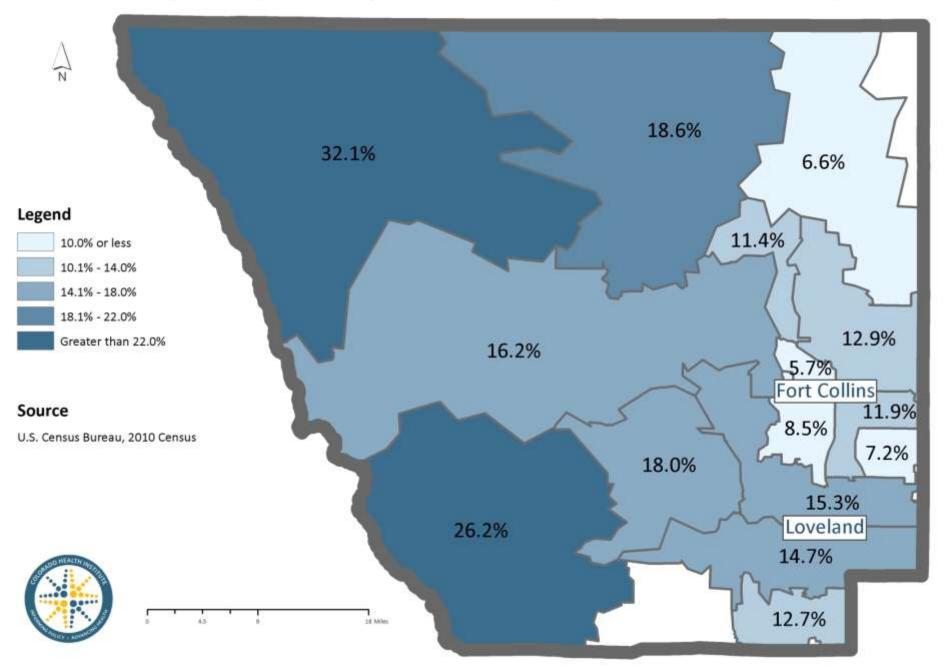


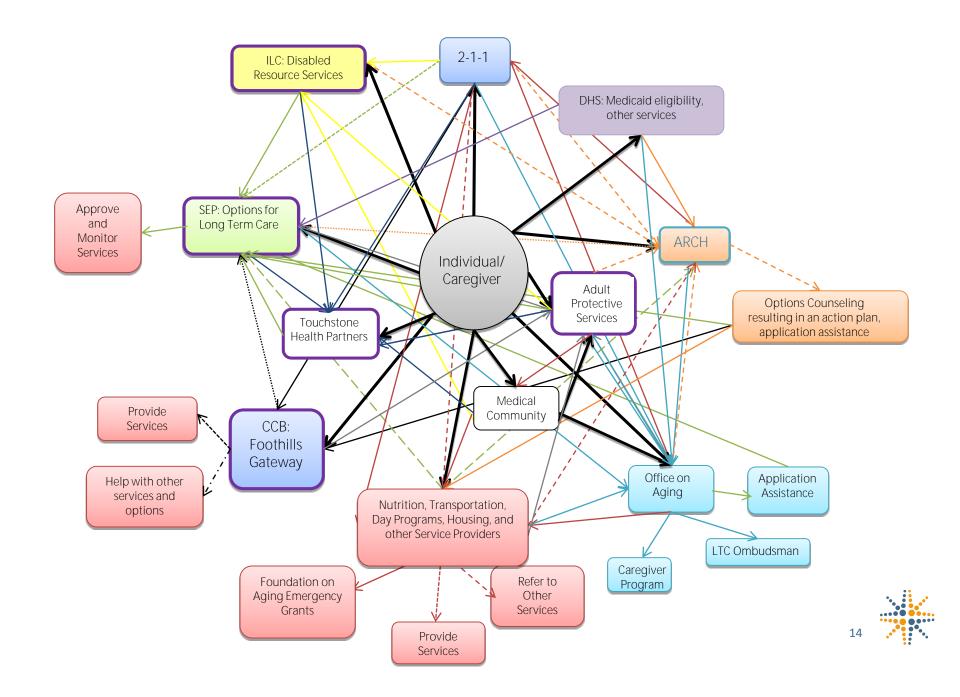


LTSS in Larimer County, Colorado: A Case Study

Elizabeth Bloemen MPH Student, Columbia University

Percentage of Population Age 65 and Over by ZIP Code, Larimer County, 2010





Barriers to Accessing Care

- Confusion and anxiety
- Social isolation
- Application process
- Geography



Weaknesses of the System

- Fragmentation
- Lack of access to isolated clients
- Disorganized service delivery
- Little understanding of available resources

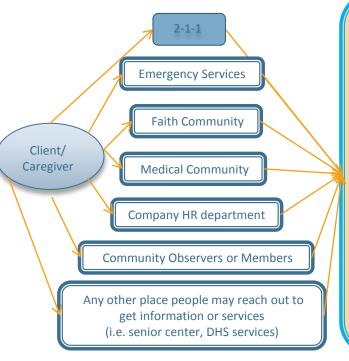


Strengths of the System

- Relationship building
- Regular communication
- Clients and caregivers at the center
- Willingness to innovate



Innovation in Larimer County



ARCH: 1. Initial

1. Initial contact, refer to immediate services

- 2. Determine Level of ongoing need
 - 1. Assign case manager
 - Provide a contact
 #, have brief follow
 up
 - 3. Set up Volunteer to visit regularly
 - 4. Set up appropriate visits by professional
 - services
 - 5. Assign a care coordinator
- 3. Establish care coordination procedures

Volunteers: would visit regularly to liaise with care coordinators, provide a friendly visitor, be a natural observer, and refer back to ARCH if needs are not being met, or change

Care Coordinator: Various organizations would provide this service to the most appropriate client, to provide coordination of services, and consultation with volunteer visitors on an ongoing basis (each client would only have one care coordinator, the organization will be determined by their needs) Service Providers: Meet routinely with clients and families, be in contact with the care coordinator and volunteer

Training: provided by one organization who will train all people who have direct contact with program clients The training would entail: knowledge of resources available and how to access them, informal assessment of needs, when and how to refer to ARCH, and coordination procedures from ARCH



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Community Awareness: Foundation On Aging creates a program for ongoing education, Summit 2014

Guiding Principles for the Future

- A person-centered system
- A flexible service determination system
- A truly no-wrong door entry point system



Today's Agenda

- On the Front Lines
- National Trends
- Colorado, Maryland and Other State
 Innovations
- Working together to solve the LTSS Puzzle







Tasia Sinn and Elizabeth Bloemen