Using Peer Mentoring to Increase the Availability and Effectiveness of Consumer Directed Personal Assistance

Project Goals:

1. Increase participation in CDPA by those not currently enrolled by using peers to answer questions and address concerns;

2. Increase the success rate of consumers just entering CDPA and those in the program for less than 90 days when engaging a peer mentor for the first time, by addressing problems with the program and helping the consumer create strategies to effectively deal with them; and

3. Lower worker churn, improve continuity of care and quality of care in consumers using CDPA for over 90 days when they first engage a peer by working with the consumer to identify strategies to help them successfully manage workers and their program.

Consumer Directed Personal Assistance (CDPA) empowers the user to control his or her own workforce and service delivery. Consumers recruit, train, hire, fire and schedule their own personal assistants.

85%

of fiscal intermediaries surveyed believed that the availability of Peer Mentoring helped their consumers manage their CDPA programs more effectively.

73%

of respondents surveyed reported that using Peer Mentoring helped them better manage their CDPA program.

CDPA Peer Mentoring improves service delivery by strengthening the consumers' role as employer. This increases opportunities for access to community based LTSS and provides an additional service to the community.

CDPA Peer Mentors underwent rigorous training to build the skills necessary for them to help consumers and their families achieve sustainable solutions to their own problems and issues.

$1.9M

estimated savings to New York State's Medicaid program during CDPA Peer Mentoring project, resulting in a

700%

Return on Investment

CDPA Peer Mentoring can be replicated easily and adapted to suit needs of targeted populations and organizational stakeholders.

CDPA Peer Mentoring is beneficial for plan care managers and fiscal intermediary staff, who as a result of the availability of Peer Mentors can more efficiently allocate their limited resources.

CDPAANYS developed a referral system through which individuals could contact Peer Mentors by toll-free telephone or email. Real-time phone interpretation and email translation services were made available to all callers.

CDPAANYS recommends the inclusion of CDPA Peer Mentoring as a training resource in managed care and implementation of the Community First Choice Option (CFCO).

CDPAANYS is developing a certification in CDPA peer mentoring that will allow stakeholders to adopt peer mentoring in their organizations while maintaining consistency to the principles and practices developed in this project.

Stability At Home

and Improvements to Long-Term Support Services

Purpose

To provide short-term, mobile crisis intervention for Medicaid-eligible individuals with a Serious Mental Illness (SMI), living in suburban Nassau County and Western Suffolk County, New York. Stability At Home (SAH) aimed to connect individuals to stable supports in the community and thereby ***prevent or reduce the utilization of and costs*** associated with avoidable emergency and inpatient services. SAH ensured a "warm hand-off" to long-term support services for both mental and physical health through coordination in a Health Home.

Services Provided

- Person-centered Stability Plan
- In-home medication education, adherence support, & reconciliation
- Crisis de-escalation services
- Referral/connection to community based mental health, medical, & social support services
- Family/friend support & education
- Care management services
- Interim mental health services
- Peer support services

Outcomes

Improving Consumer Experience of Care:

- Satisfaction surveys & interviews show a high quality of consumer experience of care, new skills, & better connections to services.

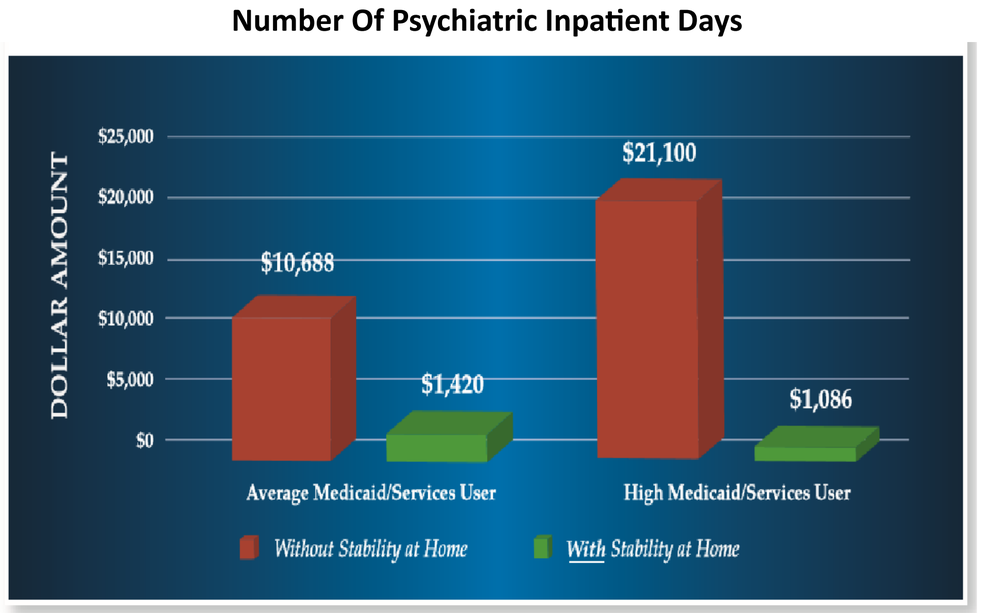
Improving the Health of Consumers Served:

- **510** referrals were made to community based supports representing dimensions of wellness.
- **77%** consumers were still engaged in mental health treatment as of the 30-day follow up.

Reducing Costs related to Avoidable Use of Inpatient Services:

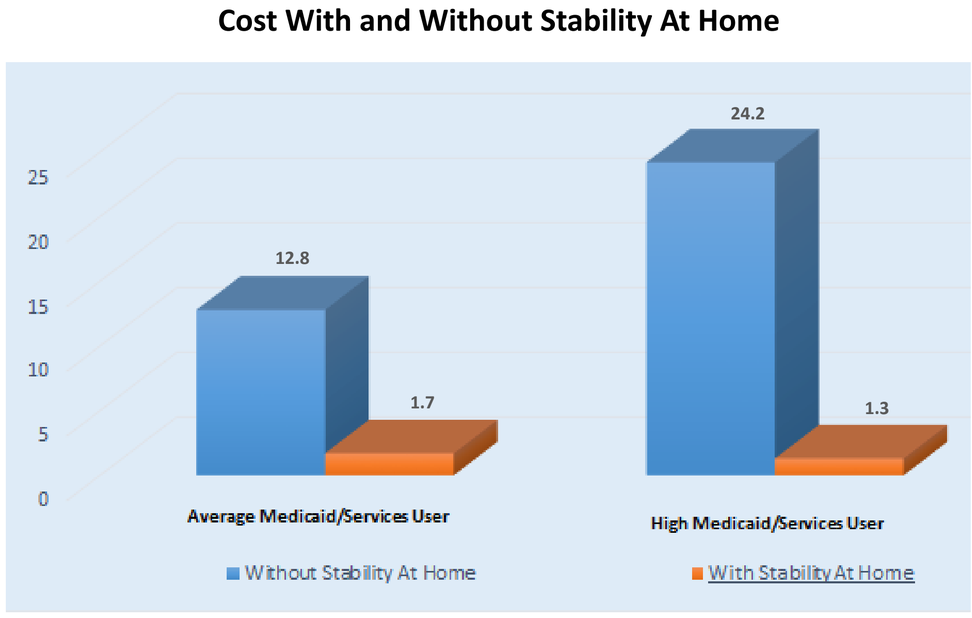
- An average **11.1 fewer** psychiatric inpatient days per consumer & an average of **22.9 fewer** days for high-resource-utilizers (more than 10 psychiatric inpatient days in the 3-month period) prior (baseline) to SAH program enrollment.
- Compared to baseline/status quo, the program yielded an average estimated/calculated 3-month savings per SAH consumer of **$9,247** and an average estimated/calculated 3-month savings per SAH high utilizer consumer of **$20,031.**

Number Of Psychiatric Inpatient Days

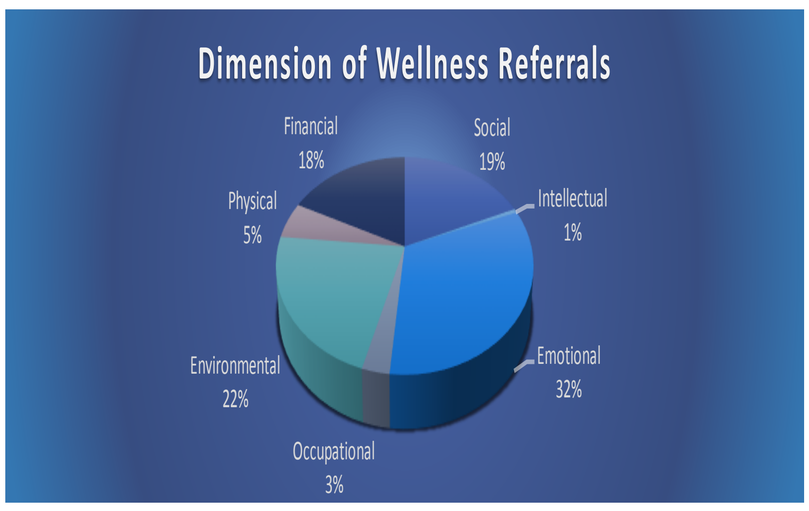


The Stability At Home program yielded an average 3-month savings per SAH consumer of $9,247 and an average 3-month savings per SAH *high-resource-utilizer* consumer of $20,031. These figures based on estimated savings of at least $835 per day of inpatient stay avoided during the post SAH 3-month period, compared to prior (baseline) period.

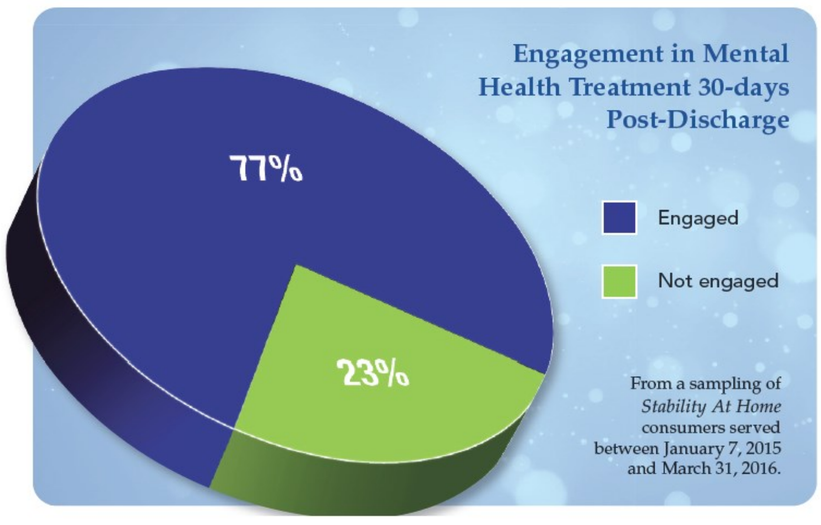
Cost With and Without Stability At Home



The Stability at Home program yielded an average of **11.1 fewer** psychiatric inpatient days per consumer in a 3-month period and **22.9 fewer** psychiatric inpatient days for high-resource-utilizer consumer.



Referrals relate to accessible programs/interventions or organizations that specialize in each respective category or aspect of wellness



Conclusions

- Cross-disciplinary team aids in the holistic approach to manage all dimensions of wellness.
- Cross-sharing of information increases awareness of the needs of consumers and eases ability of community-based services meeting those needs.
- Mobile services available to consumers help to manage crises, assist those unable to manage independently, and provide a greater sense of self-efficacy and connection to long-term support services (LTSS).
- Immediate response to referrals reduces the need for high-cost emergency rooms for crisis management.
- Inclusion of peer services brings a wealth of knowledge, consumer validation, and assistance with navigating community supports, which increases confidence in LTSS rather than utilizing high-cost services.

Acknowledgements

A special thanks to Adelphi University's School of Social Work for the evaluation of our program, and Options for Community Living & Long Island Crisis Center, who provided wonderful staff who contributed to the success of the program.

THE RESOURCE CENTER
Making a Difference in People's Lives

LUTHERAN
Life well lived. Every day.

Balancing Incentive Program Innovations Fund Grant

Enhance Community-Based Services to Increase Independence

<u>Goal & Objective -</u> To increase opportunities that make it possible for people to remain in their homes and communities. To successfully transition out of congregate settings by mitigating identified barriers through the expansion of care coordination services and supports targeted to improve medication management and diabetes care.

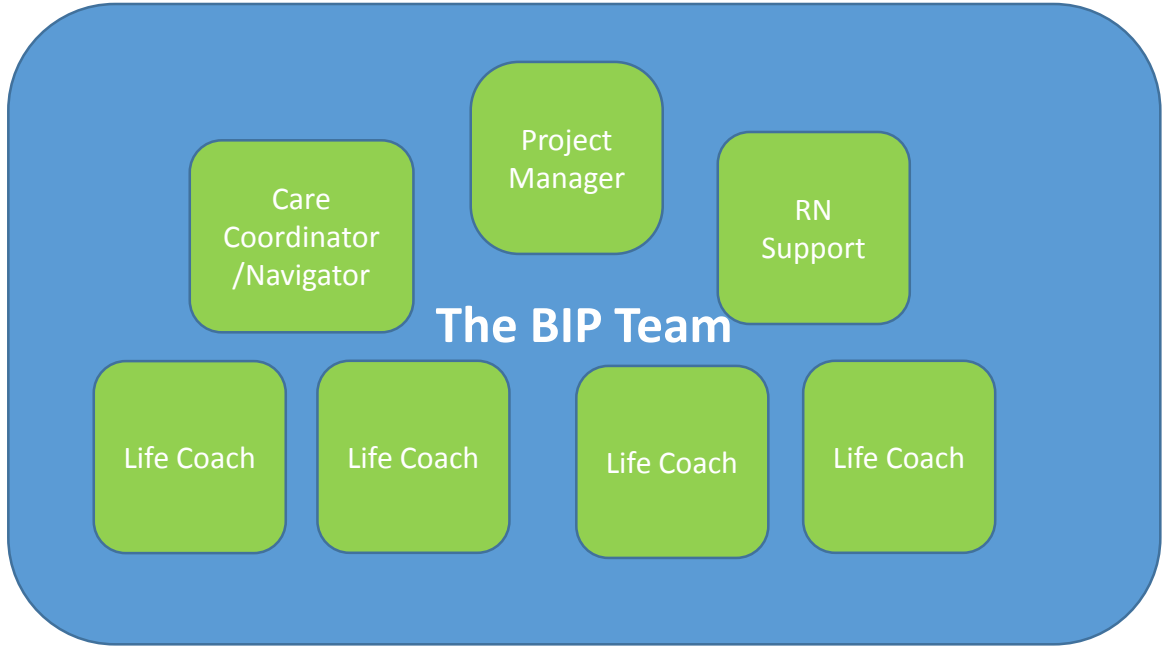
Implementation

THE RESOURCE CENTER
Making a Difference in People's Lives

LUTHERAN
Life well lived. Every day.

Steering Group
TRC and Lutheran Executive Leadership
BIP Project Director and Care Coordinator

Work Group
Lutheran Case Managers and BIP Team



How it is Done!!!!

Identify

Life Goals

Choose
a
Life Coach

Identify

Barrier(s)

Develop and Implement Strategies to mitigate the barrier(s)

Evaluate the effectiveness of the strategies and modify

Facilitate Sustainability Plan

Success!!

The BIP Team
Profile

Our Purpose

To assist you to do live a better life by partnering with you on a short term basis to:

- Mitigate barriers
- Develop a sustainability plan
- Be as independent as you want to
- Achieve your goals and dreams
- Enhance your quality of life
- Assist you to be a part of your community
- Manage your health; medication, diabetes, appointments
- Reduce the times you go to the ER
- Use Technology to be self-reliant
- Move from a congregate setting into the community
- Manage your supports

"Start by doing what's necessary; then do what's possible; and suddenly you are doing the impossible." Francis of Assisi

How We Support One Another

- Listening to each other
- Asking questions of one another
- Sharing resources and information
- Respecting one another
- Brainstorming and utilizing each other's strengths
- Everyone pitching in to get something done.
- Using each other to problem resolve
- Making time for one another
- Covering for each other
- Sharing each other's profiles

Collective Wisdom

- Knowledge
  - Medical, community resources, technology
- Problem Solving
- Inform people of their rights so they can make informed decisions
  - Experience, education, exploration
- Person Centered
  - Partnership, responsive
- Use of Resources
- Meets you where you are-individualized

How We Can Support You

We support people in a number of ways. We focus on what you want to do and what the barriers are. We work together to figure out a way to get over the barrier that works for you. Below are some examples.

- Figuring out a way to remember to take your medication
- Navigating how to get Medicaid or other insurance
- Assisting with researching and purchasing technology that can enhance your life and make things easier
- Fun meal planning
- Organizing appointments and learning how to schedule them
- Linking you to community resources-Food Pantries, Helping Hands, Health Homes, Aide Agencies, Eagles Nest, Warm Line, Cyber Safety, Advocacy groups, local health groups etc.
- Communicating effectively with your physician
- Navigating transportation
- Managing your health
- Helping you find an apartment
- Finding and understanding how to use technology to assist you
- Figuring out ways to remember to do things
- Helping you to be understood and listened to by others

"We talk a lot about hope, helping, and teamwork. Our whole message is that we are more powerful together." Victoria Osteen

Our Reputations

Tabatha
Trustworthy, doer, apartment guru, figures out an individualized path, knows what the office of aging offers, knows about community helping organizations and what they offer (i.e. Churches), likes a challenge, inventor.

Bob
Community knowledge, easy to talk to, safety, understands TRC systems, explains things well, quick, good provider of information, follows through, dedicated to his job, funny, outgoing, knows a lot of people

Daniel
Artsy, knows a lot about safety, breaks down tasks into steps, figures out an individualized path, patience, listens, strategist, thinker, intentional- focused

Jen
Fast, doer, has a good grip on medical topics, has peoples back- an advocate, trusting, good researcher, gets things done, problem solver, communicates, lots of energy.

Nikki
Helps map out a problem solving path, counseling, mental health knowledge, clarifies roles, helps prioritizes, good researcher, technology guru calm, role model

Beth
Knowledgeable, patience, understands self-direction, helps people look at other dynamics- what else could be true, looks at the big picture

Diabetic Management

Common Barriers	Intervention	Cost	Results	Cost Avoidance
Over eating	Portion Plates 	$15	Diet being followed Reduction in weight BGL is stabilized	Reduction in Physician visits Reduction in ER visits
Not eating per diabetic diet	Recipe books	$20		
Not understanding the diagnosis and doctors order	Assistance Communicating effectively with physician	$0		

Care Coordination

Common Topic	Issue	Common Causes	Intervention	Impact
Health Management	Not attending appointments	Transportation issues • Does not understand how to access Medicaid transportation • Does not have a phone/enough minutes to access transportation	Teach person how to navigate Medicaid Transportation. Write Scripts with words or pictures Assist finding alternate phone plans	Person attends appointments and gets medical symptoms treated as recommended. Continues with consistent treatment from the same physician.
		Communication • Does not understand what physician says	Attend appointments with person and facilitate communication. Develop an effective communication system	
		Frustration • Does not feel	Attend appointments with person and	

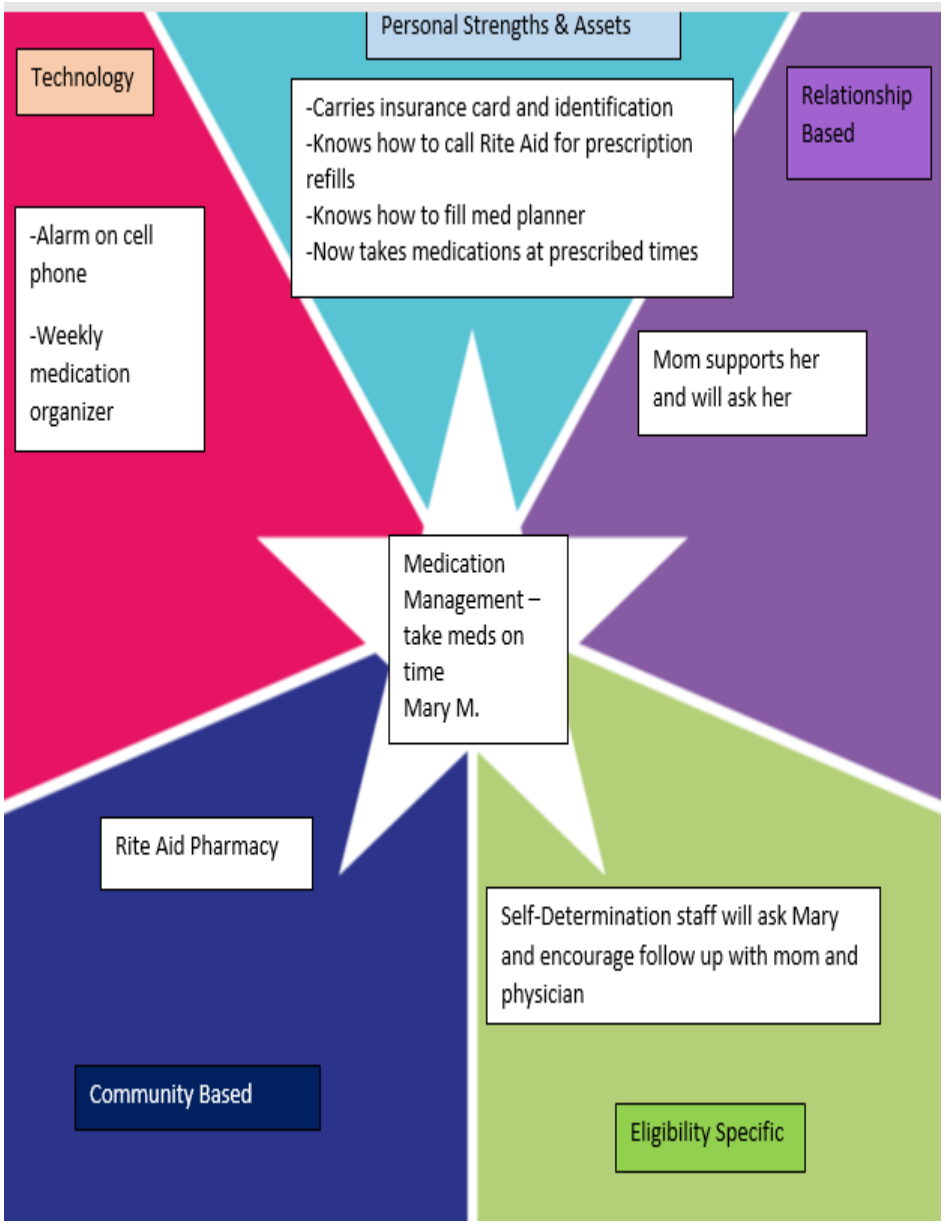
People Impacted (as of 8/1/16)

- 163 people referred
- 154 people eligible
- 139 Assessments completed
- **49 people reached their goal and have a successful sustainability plan**
- 34 people disenrolled
- 68 people still being supported
- 2 people moved out of Lutheran into the community
- 5 people moved out of OPWDD settings into the community

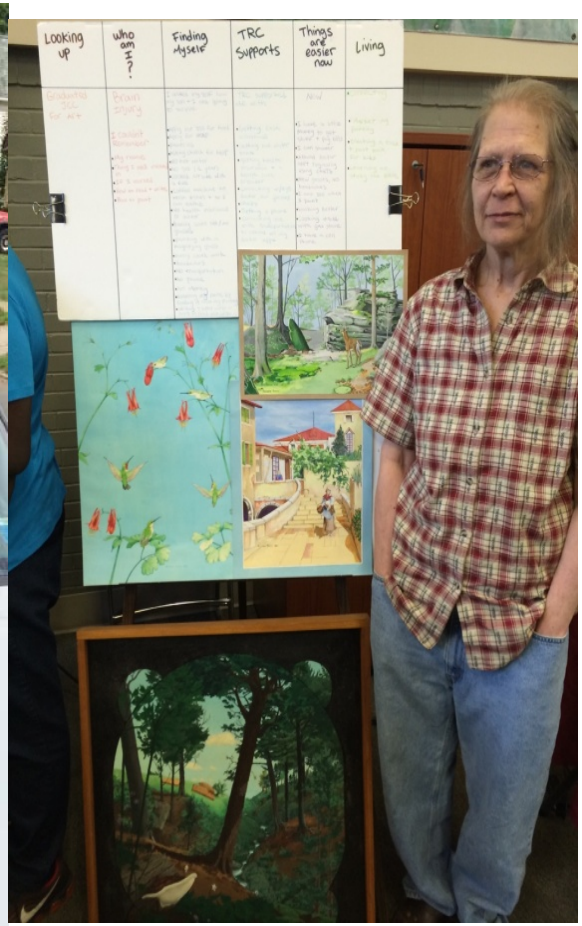
Why interventions are successful??

- Quick intervention- first meeting within 7 days of receiving the referral
- Focus on supporting the person- Selected Life Coach contacts the person within within 24 hours
- Supports occur at times and locations convenient for the person
- Able to intervene and get the technology needed within days of the decision on what is needed to mitigate the barrier
- Partnership and choice
- Link people- social and community networking
- Creativity

Sustainability Plan



Success Pictures



Success Pictures

An Education and Training Program to Reduce Barriers to Community Care:

Assisting Individuals with Developmental Disabilities to Remain at Home,

With Their Families, in Their Communities

iAHD
Embracing Families, Enriching Lives

Cara Levy
Director of Communication

Program Goals & Findings

Goal: Improving access to community based long term services and supports.

Finding: Individualized case management often yielded important, additional information. Case managers were critical in helping families access LTSS by including MSC, helping to find respite opportunities and health care sites with easier accessibility and understanding of the needs of the population.

Goal: Improving the health care system to promote community living.

Finding: Education and training of Individuals, families, staff has great potential to positively impact the health care delivery system. Preventative health and dental care, fall prevention, nutritional training and other topics offer strategies that can reduce future health care costs.

Modules

- Healthy Nutrition Practices
- Stress Reduction
- Preventative Care for Optimal Health
- Fall Prevention
- Benefits and Entitlements
- Life Planning
- Dental Care
- Medication Management
- Functional Behavior Analysis

Key Elements of Program

Case managers completed intakes and home visits.

Parents were invited to attend monthly information workshops. When they could not attend, case managers would present the information at home.

Home assessments were completed to link the information disseminated with the specific individual and family needs, concerns and home environment.

Community linkages of families to available resources were facilitated via tours of local health centers and health fairs.

Parallel module trainings were offered to DSPs so they can better assist individuals and families with whom they have daily and/or close contact.

Personal Outcome Measures were administered to ensure that individuals received supports aligned with their needs, dreams and wishes.

Program Goals & Findings

Goal: Mitigating barriers to accessing community based LTSS
Finding: Families listed difficulties in communication, transportation, information access, a need for respite and increased supports as barriers that are commonly faced. Case management was critical in identifying and addressing barriers faced by each family,
.

Goal: Increasing opportunities that enable individuals to remain in the community.
Finding: Many families requested personalized assistance on issues including accessing more resources, finding classes and trainings for family members and receiving assistance with legal, financial and futures planning.

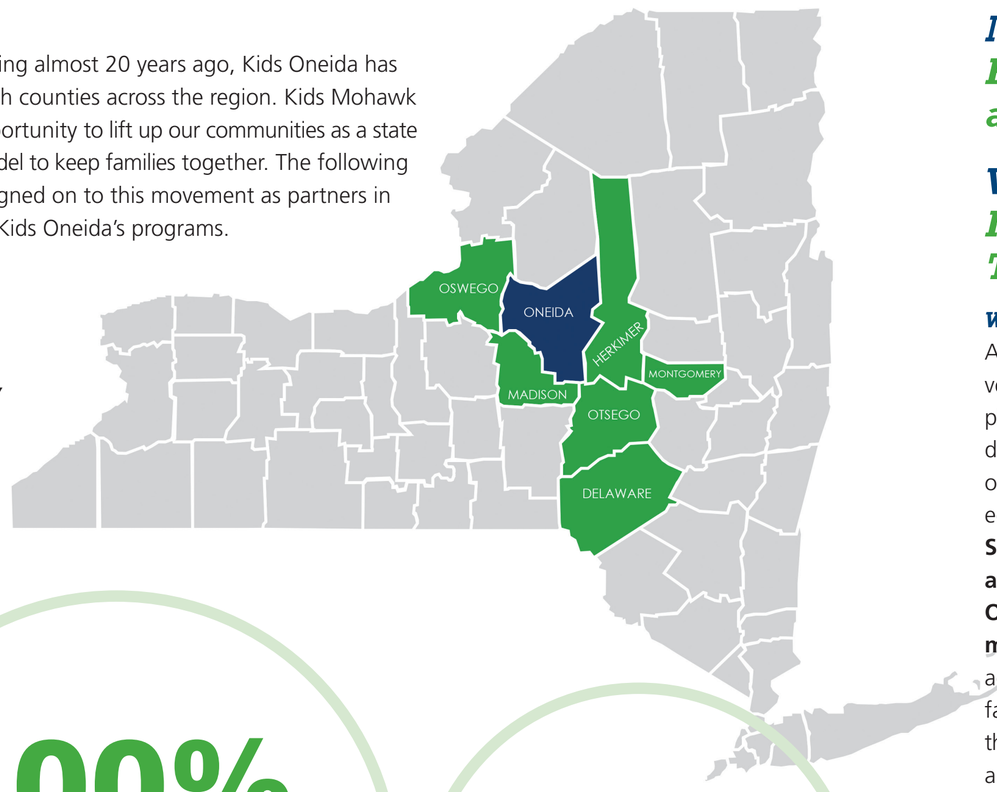
KIDS MOHAWK VALLEY

In 2014, Kids Oneida was awarded funding under the Balancing Incentive Program through the Department of Health in order to reduce long-term care and increase long-term services and supports. This funding allowed us to create an innovative regional program known as Kids Mohawk Valley. The program served youth and families throughout the Mohawk Valley Region in Madison, Herkimer, Montgomery, Otsego, Oswego and Delaware Counties. Kids Mohawk Valley served youth ages 5-21, who are Medicaid recipients and their families. Families were assigned a Care Coordinator and had access to a variety of community based in home services that met their needs while empowering them to meet their goals. Kids Mohawk Valley worked to maintain some of our regions most at risk youth in their homes and communities. Our goals were to keep youth home and out of unnecessary long-term placements while supporting them and their families in achieving goals they set for themselves. Kids Mohawk Valley has developed plans for sustainability through the New York State Children's Health Home Services.

OUR IMPACT

Since our founding almost 20 years ago, Kids Oneida has collaborated with counties across the region. Kids Mohawk Valley is the opportunity to lift up our communities as a state and national model to keep families together. The following counties have signed on to this movement as partners in one or more of Kids Oneida's programs.

- ***Delaware***
- ***Herkimer***
- ***Madison***
- ***Montgomery***
- ***Oneida***
- ***Otsego***
- ***Oswego***



100%
of families in our Kids Mohawk Valley Program had access to a network of mental health providers who work with the family to provide flexible and individualized services within the child's home, school, and community

100%
are enrolled in a school program

100%
of parents completed parent satisfaction surveys that measured increase in understanding of mental illness

ALL
enrolled families had an individualized crisis plan and access to 24/7 mobile crisis response.

0
Youth were placed outside the home

OUR APPROACH

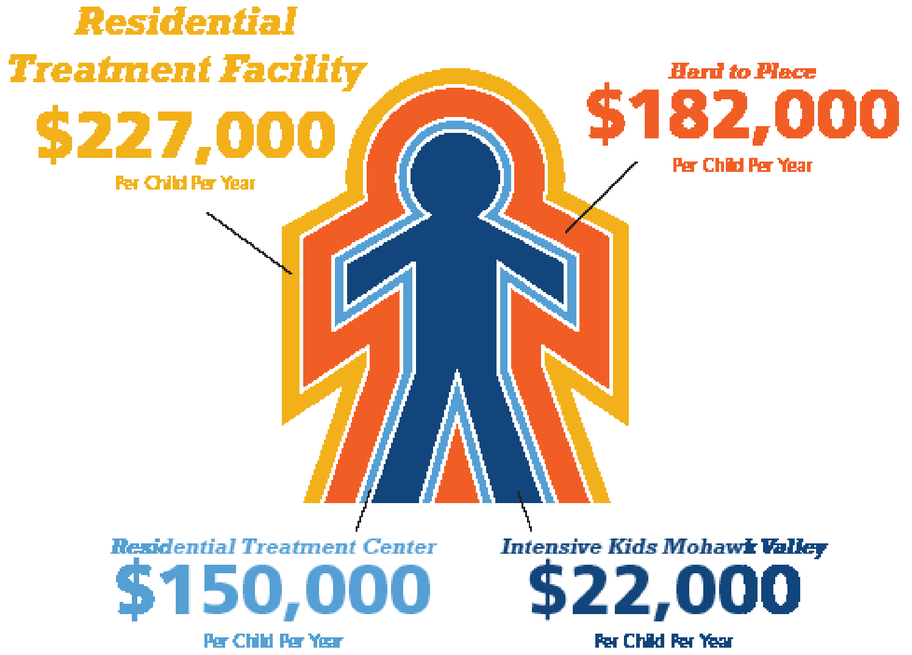
Mission:
Empowering Children and Families

Vision:
Keeping Families Together

Wraparound Approach

At Kids Oneida, every service, intervention and interaction is based on the philosophy of Wraparound. This foundational approach has been at the center of our organization since it was founded. **A best practice both in New York State and the nation for systems of care and working with youth and families, Kids Oneida has been recognized for its commitment to this philosophy.** We attribute much of our agency's success in developing sustainable solutions with families to our high fidelity wraparound approach. Emphasizing the strengths of families, building natural supports, and maintaining a commitment to community-based services ensures the long-term stability of families.

ANNUAL PER CHILD COMPARISON



Learning to Advocate: One Parent's Path

" Before Kids Oneida, Thadius was depressed, felt worthless, and didn't know where to go or who to talk to. And those were the same feelings I was having. My hands were tied like I was held prisoner to our situation."

– Charles, Thadius' father

Made possible by the NYS Department of Health through the Balancing Incentive Program (BIP)

Lifespan's Healthcare Coordination Service

for Medicaid beneficiaries 50 or older

SERVICES

- Lifespan's LPN Healthcare Coordinators:
- Schedule and track medical appointments,
- Arrange for transportation,
- Accompany patients to appointments to advocate and ensure understanding of health information,
- Conduct in-home medication reconciliation,
- Ensure access to appropriate specialists,
- Provide health care education and training,
- Ensure referrals are made for additional community-based services including the 30 other services provided by Lifespan.

PROGRAM GOALS

- Build patients' self-awareness, confidence and ability to self-manage health conditions,
- Provide education/training to increase patients' knowledge of their health care conditions and how)%-)) '-(" # $ -) '- %$) %$(-
- Decrease caregiver stress,
- Connect patients and caregivers with additional community-based services,
- Demonstrate the successful impact of this health care coordination service on the prevention of emergency room utilization and inpatient hospitalization.

ELIGIBILITY CRITERIA

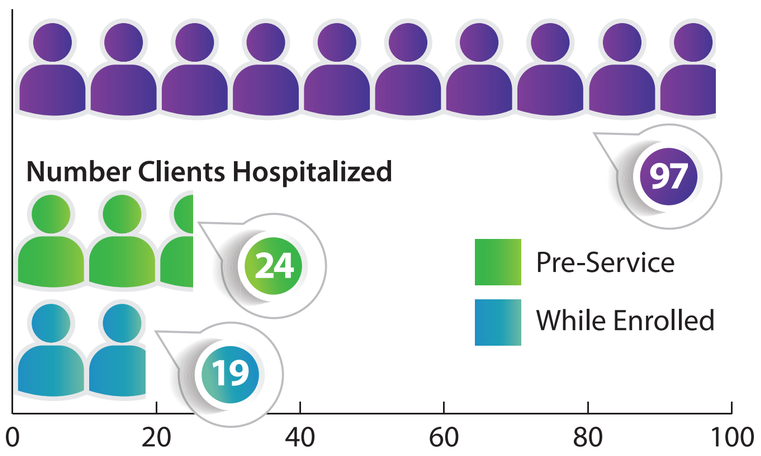
- Patients must have approved Medicaid and must be 50 or older.

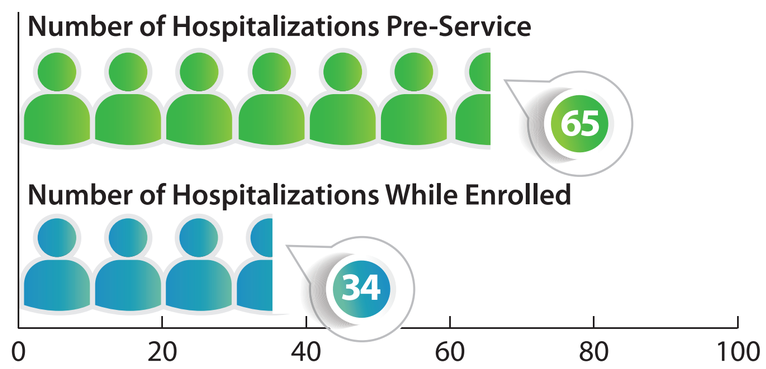
Additional Criteria May Include:

- Demonstrated difficulty navigating the health care system,
- History of missed medical appointments,
- Aging or stressed caregiver,
- Lives alone,
- Two or more ED visits or hospitalizations within the last year,
- Low health literacy,
- History of non-adherence with treatment plan,
- Co-morbidities, especially those that limit ADLs.

Balancing Incentive Program | Innovation Project Health Care Coordination | Results From August 1, 2014 to March 31, 2016

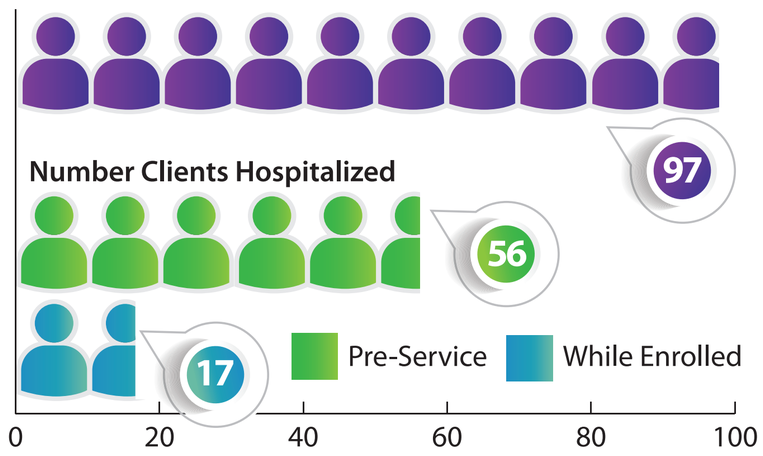
Hospitalization was reduced 48% with an estimated cost avoidance of $349,680.

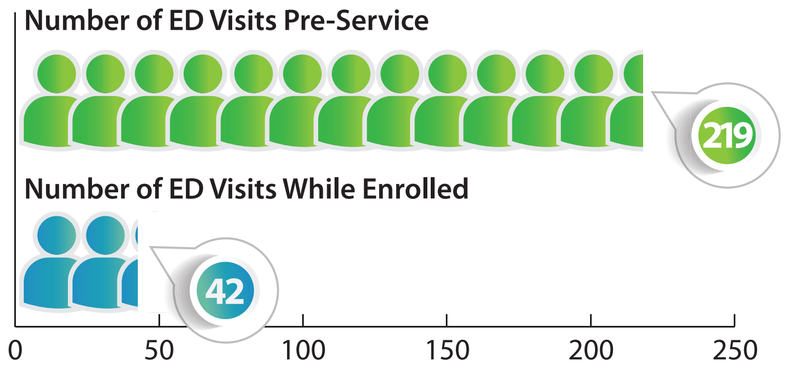




[1] The Henry J. Kaiser Foundation has determined the average cost of hospitalization in 2014 in New York State to be $2,350 per day with an average length of stay at 4.8 days (Centers for Disease Control and Prevention Report) for a total of $11,280.

ED use was reduced 81% with an estimated cost avoidance of $218,241.

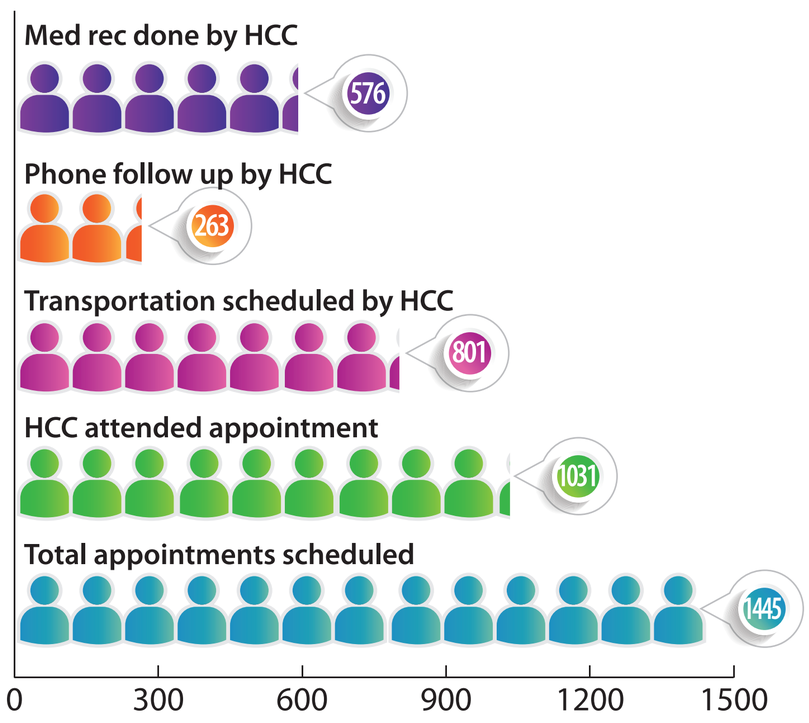




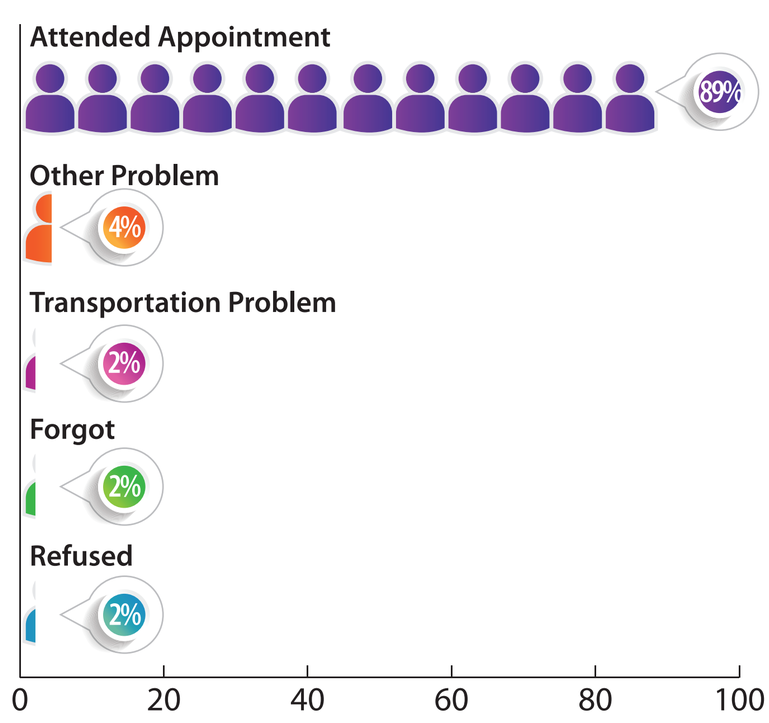
[2] National Institutes of Health study looked at medical expenditure bills that represented more than 8,303 emergency room visits; researchers found that the average charge for an emergency room trip for all these conditions came out to $1,233.

- 18 clients reduced hospital use with an estimated cost avoidance of $203,040.
- 64 clients had NO hospital stays during service with an estimated cost avoidance of $721,920.
- 39 clients had reduced emergency room visits with an estimated cost avoidance of $125,766.
- 31 clients had NO emergency room visits during service with an estimated cost avoidance of $38,223.

Healthcare Coordinator Services provided



Program Outcome Goal: 75% of participants will attend 80% of Medical Appointments Achieved 89%



Program Outcome Goal: 60% of caregivers will report a decrease in stress as compared to baseline

Achieved 100%

- 24% of the clients had a caregiver to assist them
- one-third were adult children of the client
- one-third were other family members including parents and siblings
- one-third were spouses, including one married couple, both served

Program Outcome Goal: 60% of participants or their caregivers will access at least one additional community based support service

Achieved 67%

Strategies for Success

- Outreach
- Communication
- Medication Reconciliation
- Transportation
- Motivational approach to patients

NEW ALTERNATIVES FOR CHILDREN

New Alternatives For Children's (NAC) Mobile Medical Clinic is fully equipped with two exam rooms, a nurse's station, a therapy room, and waiting area. The clinic

Using Technology to Support Independence and Autonomy for People with Intellectual & Developmental Disabilities

Philip Proctor,
Director, Individualized Technology Strategies AHRC New York City

AHRC new york city

Aim

Support people to achieve their goals, increase their independence and contribute to their well-being

Overview & Method

Digital technologies that provide connection to information and services on the internet have:

- become an essential part of everyday life.
- provide connection to information and services
- facilitate connection to the people and community around us.

The aim of this project was to identify ways of working with consumer technologies that would support people with ID/D in pursuing their documented goals with greater levels of independence, both in the service setting and in the community.

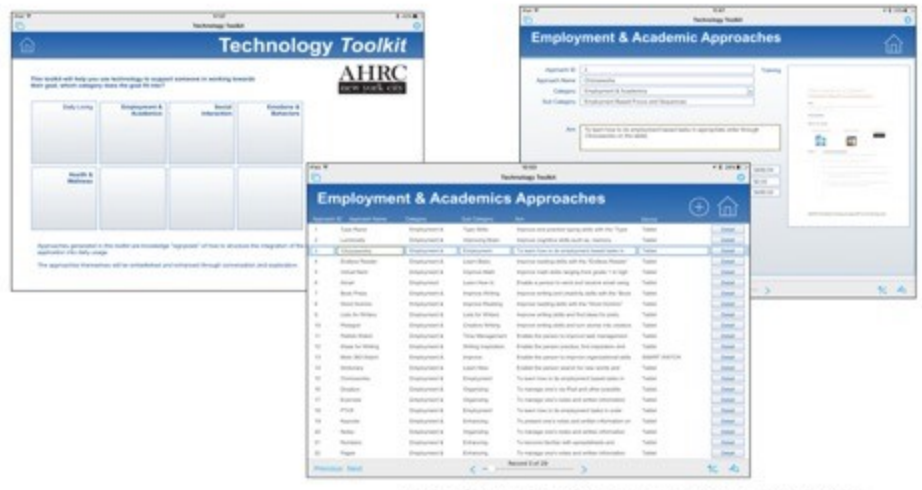
We used Individualized Service Plans and CQL interviews to identify participants, and the technologies that may provide useful. Then a technology support specialist mentored the individual and their direct support worker for at least 1.5 hours per week to support skills acquisition with the technology. This weekly support was given for 6 months and then gradually reduced. We collected data on the number of hours people spent in technology mediated independent goal pursuit both in the service setting and in the community.

Throughout the project we recorded all of the successful approaches and documented them in a **technology toolkit**. This toolkit was designed to be an essential part of the scaling of the project beyond the project period, supporting non-technology specialists in making decisions about the appropriateness of technology.

The project documented increases in the service setting of **7 hours per person** per week on average and increased independence in the community of **3 hours per person** per week on average.

Areas Supported & Toolkit Content

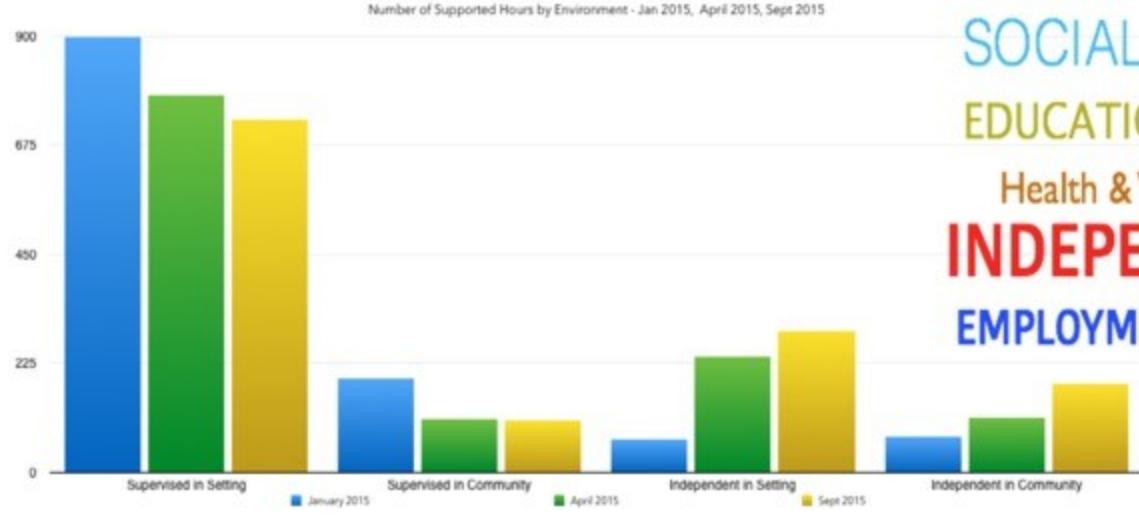
Throughout the project we supported the following goal areas; Health and Wellness, Daily Living, Social Interactions, Employment and Academics and Emotions and Behaviors. The supports that were created throughout the project led to **90 approaches** being documented in out technology toolkit.



Case Study

Jackson is a highly creative person who lives in Brooklyn, New York City. A little over a year ago Jackson was given his own iPad to work on his art. Jackson quickly mastered the device and the features of the app that would allow him to create new pieces of art. Not long after he received his iPad he asked the question "how can I put my art on t-shirts and sell them?" Not long after, Jackson purchased the Square micro transaction accessory for the iPad, and setup his own payment system. Jackson now produces his own t-shirts and sells them online.

Surprising staff and people around him even further, Jackson also uses his iPad top play in a band.



A Pathway Home for Individuals with Serious Mental Illness

Pathway Home is a Care Transition Program of Coordinated Behavioral Care Inc. (CBC) that offers mobile, time-limited services in Brooklyn, Manhattan, and the Bronx for adults with serious mental illness (SMI). The program includes a treatment team of **Peers, Nurses, Mental Health Clinicians, and Case Workers,** who provide support to enhance the system of care for those transitioning to the community from the hospital and mobilizes support for society's most vulnerable individuals during periods of transition. The Pathway Home intervention uses the **Critical Time Intervention Model,** a time-limited evidence-based practice that facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods.

Program Model

Participants are engaged while inpatient

Services Begin With High Intensity And Systematically Decrease Over Time

Team helps identify and facilitate housing

Medication management

Home visits and escort to appointments

Skill building

Case management and care coordination

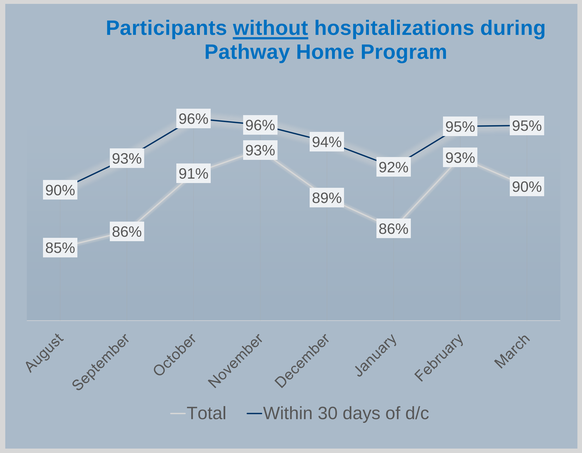
Crisis Intervention

Greater independence in the community

Critical Time Intervention Model of Care

- Time Limited Form of Case Management
- Focuses on helping people with SMI and Housing Issues
- "Critical Time" transitional period
- Response to "Revolving Door" homelessness/hospitalization
- Does not replace treatment models, rather compliments other approaches
- Sensitive to changing needs of individuals

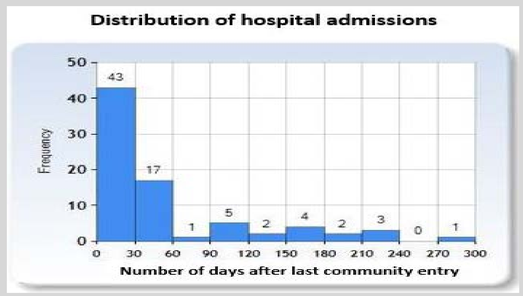
Wrap-around dollars provide for additional supports



94% of all Pathway Home participants stayed out of the hospital for their first 30 days back in the community

Compared with **87**% of 2013 NYC psychiatric hospitalization readmissions within 30 days to any NYC hospital (June 2016 DOHMH policy brief)

89% have not been hospitalized at all during the duration of the program



Mental Health and Physical Health

91% of client's living in the community had attended a **behavioral health appointment** within 30 days of being discharged from a hospital setting

74% of client's attended an appointment with their **primary care provider** within three months of moving to the community

Program Goals and Outcomes

Initial Program Goals

- Housing maintanence
- Decrease hospitalizations for 150 individuals
- Ensure continuity of care

91% of enrolled participants attended an **BH Outpatient appointment** within 30 days of returning to the community

74% of enrolled participants attended a **PCP appointment** within 30 days of returning to the community

6% 30-Day Readmission Rate

75% graduate with a health home or **ACT** services in place

Best Practices

FLEXIBILITY to allocate resources based on need

CREATIVITY to provide unique care to participants using wraparound funds

CONNECTION to care through phone calls, meetings, and case conferences with other providers, families, and collaterals

USING MOBILE TECHNOLOGY to communicate effectively and consistently to share information

RESOLVE barriers to successful transition to the community (lack of benefits, identification, medication, services, housing) while on the inpatient unit

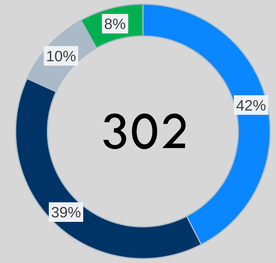
COLLABORATE with both inpatient and outpatient providers before discharge so as to connect multiple systems of care

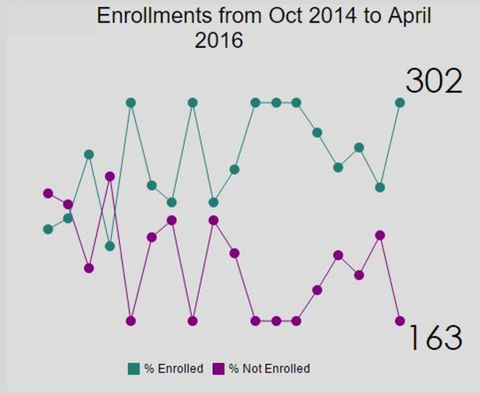
CULTURE promoting immediate crisis intervention by resolving issues in real time in the community

Referral and Enrollment

Referral Sources

- State Psychiatric Center
- Article 28 City Hospital
- State Operated Community Residences
- Community Housing Providers





Program Time Frames

Number of days spent engaging while inpatient is 8 business days

Rapidly link to services by enrolling within 2 business days

Average days in program is 166 days or 5.5 months

Next Steps and Contact

Pathway Home is now funded under an OMH grant and has recently opened up a third team in Queens.

Associate Executive Director Mark Graham, LCSW
mgraham@cbcare.org (646) 930-8842

Program Director Barry Granek, LMHC
bgranek@CBCare.org (917) 242-2090

Program Administrator Enmy Perez
eperez@ccbare.org (917) 757- 4672

Reaching Health Disparity Medicaid Beneficiaries with Type II Diabetes

McCallion, Philip & Ferretti, Lisa, A.

Centre for Excellence in Aging & Community Wellness, University of Albany

Background

United States

- Nearly 26 million people have diabetes
  - 8.3 % of U.S. adult population
- 25% do not know they have disease
- 79 million have pre-diabetes - 35% of U.S. adults
- 5-15% develop diabetes each year
- Higher rates of pre-diabetes and diabetes for ethnic minorities and for Medicaid beneficiaries

Risks for People with Disability as Compared to Peers without Identified Disability

- Higher levels of obesity
- More sedentary lifestyle
- Participate less in physical activity
- More likely to consume high fat diets

Heightened Risk In Health Disparity Communities

Compared to the wealthiest neighborhoods, New Yorkers in the poorest neighborhoods more likely to:

- Have diabetes (11% vs. 6%),
- Be obese (27% vs. 14%),
- Report no exercise in the past month (17% vs. 12%)

Additional Challenges in the Bronx

- Highest prevalence of diabetes in NYC
- Highest rates among Medicaid recipients

In addition:

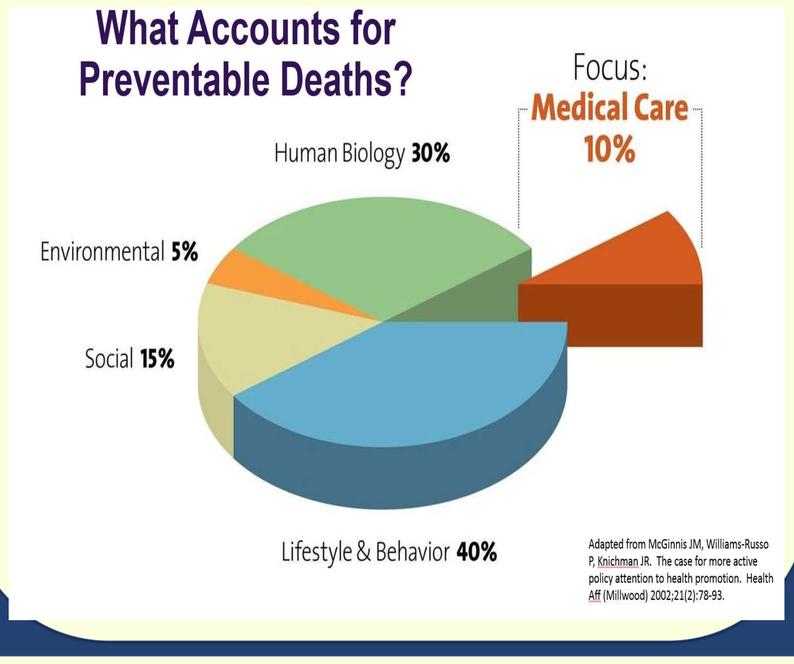
African Americans with Type 2 Diabetes

- 2.7 times more likely to suffer end-stage renal disease,
- 1.7 times more likely to be hospitalized,
- 2.2 times more likely to die from diabetes than non-Latino Whites.

Latinos

- higher rate of end-stage Renal Disease
- 50% more likely to die from diabetes than Whites.

Models Driving the Interventions



The Interventions

The Diabetes Self-management Program

- Developed by Stanford University's Patient Education Research Center,
- Six-week workshop once a week for 2½ hours facilitated by two trained Peer Leaders and/or Master Trainers.
- Helps people gain self-confidence in their ability to:
  - Control symptoms
  - Enhance medical treatment/management with techniques to handle fatigue, stress, pain and emotions
  - Increase physical activity, healthy eating, and self-monitoring,
  - Appropriately use medications/skin and foot care.

The Leap Program

Lower Extremity Amputation Prevention (LEAP) **a program to dramatically reduce lower extremity amputations in individuals with diabetes targeting:**

(1) Annual foot screening
(2) Patient education
(3) Daily self-inspection of the foot
(4) Appropriate footwear selection.
(5) Management of simple foot problems

Academic Detailing

A systematic outreach to physicians to support improved clinical decision-making by fostering one-on-one interaction between physicians and health professionals trained to communicate the latest evidence-based clinical data.

The Partners

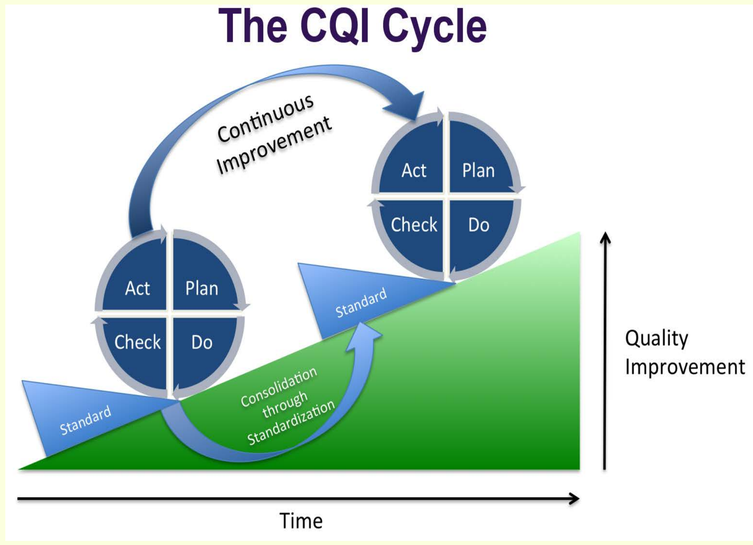
QTAC-NY, **promotes evidence based health promotion and self-management programs throughout New York State offering training, quality assurance and an online portal, Compass, that manages all aspects of programs and can respond to electronic referrals.**

Health People Inc**. - the Bronx's largest entirely peer educator-based health education and disease prevention community organization.**

The New York State Academy of Family Physicians (NYSAFP);

Capital District Center for Independence, Inc.
Resource Center for Independent Living
Suffolk Independent Living Organization
ARISE Inc.
AIM Independent Living Center
Brooklyn Center for Independence of the Disabled (BCID) Westchester ILC
Western New York Independent Living

An Active Approach to Problem-solving & Quality Management



Achievements - Bronx New York

1. Academic detailing visits were completed with more than 30 physician practices

2. Over 50 physicians participated in physician education programs

3. Capacity for the delivery of LEAP was created for the first time

4. A workforce of DSMP leaders was established at Health People, the community based agency

5. Participants were successfully recruited into both LEAP and DSMP

Willingness of podiatrists/physicians to have LEAP delivered in waiting rooms improves diabetes self- care and increases likelihood for self-management of symptoms of diabetes.

Building Physician Referrals and Feedback

Achievements – Work with Independent Living Centers

1. Increased referrals to DSMP of people with disabilities and diabetes

2. ILCs have a team of DSMP leaders in place

3. There has been a reduction in hospitalizations and no reported institutionalization of participants.

4. There has been an increase in use of community based services and supports

5. Capacity has been built among ILC peer counselors to offer conflict-free case management

6. Several cases identified of assistance to participants moving from institutional or hospital based care to community-based care

7. ILCs linked into other Department of Health and NYS Medicaid Reform Initiatives including Balancing Incentives Program and DSRIP

8. Several ILCs exploring Medicare reimbursement

9. Almost all participating ILCs also delivering the Chronic Disease Self-management Program and/or the National Diabetes Prevention Program

Implications

Bronx project demonstrated that Medicaid beneficiaries in health disparity communities will attend and benefit from DSMP classes and will seek community based long term services and supports when they are provided with this information.

ILC project demonstrated that persons with disabilities will attend and benefit from DSMP classes and will seek community based long term services and supports.

With the capacity available through CEACW's Quality and Technical Assistance Center (QTAC-NY) it is possible to upscale the availability of such services throughout New York State with similar results.

Programs like the DSMP expand LTSS with their emphasis on self-management and increase the likelihood of LTSS uptake

The authors wish to acknowledge all partners and participants and funding from the Balancing Incentives Program Innovation Fund

QTAC-NY: Ph: 877.496.2780 ¨ Fax: 518.591.8772 ¨ QTAC@albany.edu

http://qtacny.org

The Carter Burden
CENTER FOR THE AGING

The Carter Burden Center at Metro East 99th Street
Hybrid Social Model Adult Day Program

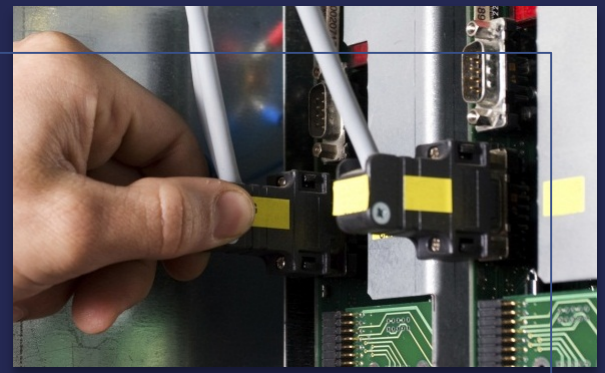
William Dionne, Executive Director
The Carter Burden Center for the Aging, Inc.

Dozene Guishard, Ed.D., Director
Metro East 99tth Street Demonstration Project

The goal of Metro East 99Th Street Project is to…

Conceive

Develop



Test

Implement

Analyze

The first of its kind hybrid Adult Day Program in an affordable housing development in New York State.

The Carter Burden Center for the Aging

The Carter Burden Center for the Aging (CBCA)’s mission is to promote the well-being of seniors 60 and older through a continuum of services, advocacy and volunteer programs oriented to individual, family and community needs. The agency was established in 1971 by Carter Burden when he was a NYC Council Member representing the Upper East Side to address the needs of his older constituents. Today the CBCA includes a host of programs and services provided throughout Manhattan to over 3,500 seniors annually. The agency employs over 60 staff members and it benefits from the services of more than 3,000 volunteers each year.

Collaborations

❑ The New York City Health and Hospitals Corporation (HHC)

The New York City Health and Hospitals Corporation (HHC) is an integrated healthcare system of hospitals, neighborhood health centers, long-term care, nursing homes and home care -- the public safetynet healthcare system of New York City. HHC is committed to the health and well-being of all New Yorkers and we offer a wide range of high quality and affordable healthcare services to keep our patients healthy and to address the needs of New York City's diverse populations.

❑ New York City Department for the Aging (DFTA)

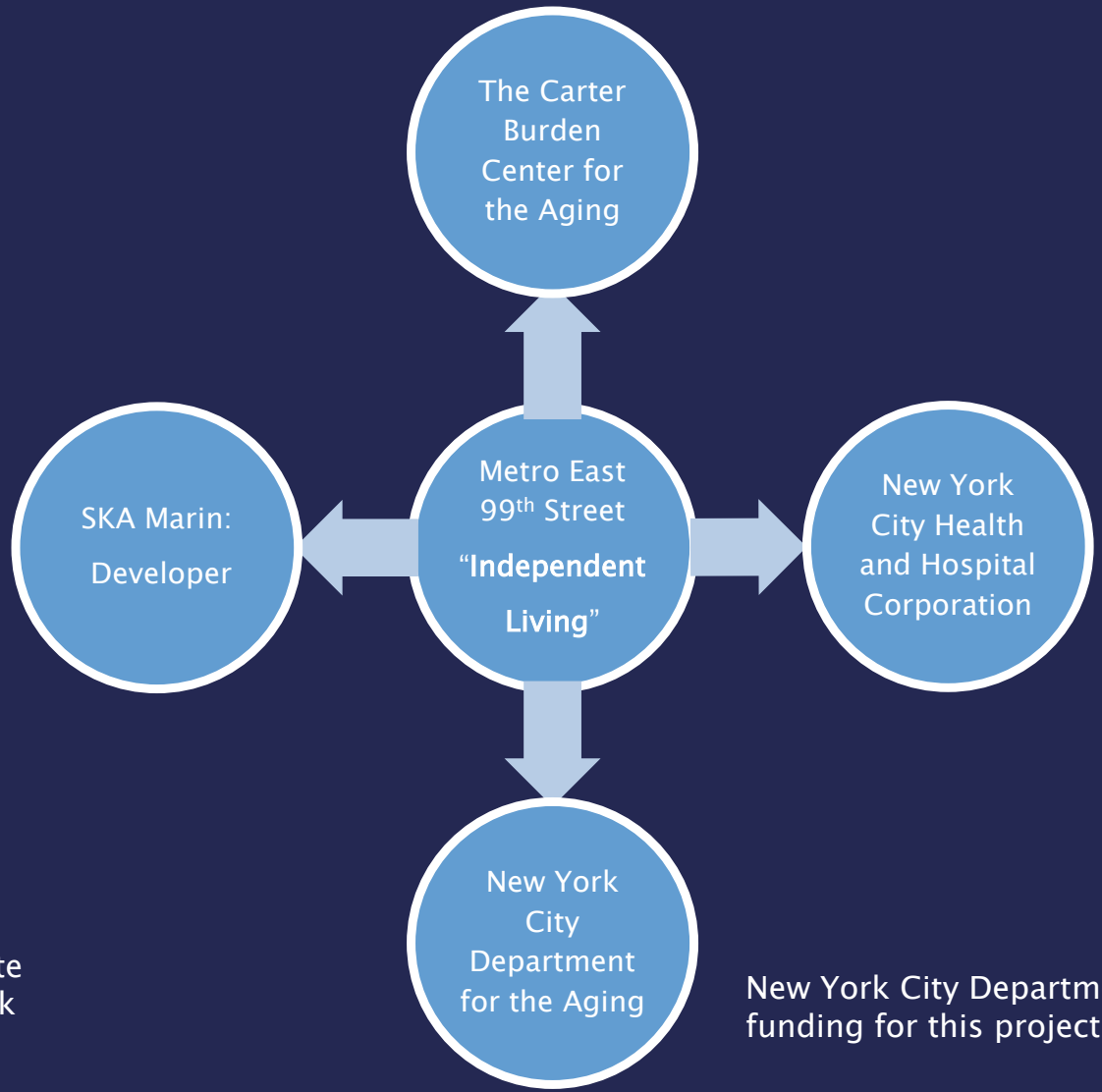
As an agency of City government and an Area Agency on Aging under the federal Administration on Aging, DFTA receives federal, state and city funds to provide essential services for seniors. It channels these monies to community-based organizations that contract with the Department to provide needed programs locally throughout the five boroughs. Hot meals and activities at senior centers, home-delivered meals, case management, home care, transportation and legal services are among the services these programs provide. DFTA manages the contracts with these programs and ensures service quality.

Collaborations Cont'd

SKA Marin

- SKA Marin is a real estate firm specializing in the development of affordable housing and community development projects. As developer, owner, and construction manager, SKA Marin has built thousands of affordable units in the Metropolitan New York area. The portfolio of properties owned by SKA Marin consists of primarily of senior housing projects, which is a niche specialty of the firms. SKA Marin is widely respected in the affordable housing industry for its innovative approaches to aging in place and ease in using creative finance.

Metro East 99th Street Hybrid Social Model Adult Day Program Partnerships



The project is supported by New York State Balancing Incentive Program and New York Community Trust.

New York City Department for the Aging provided the initial funding for this project.

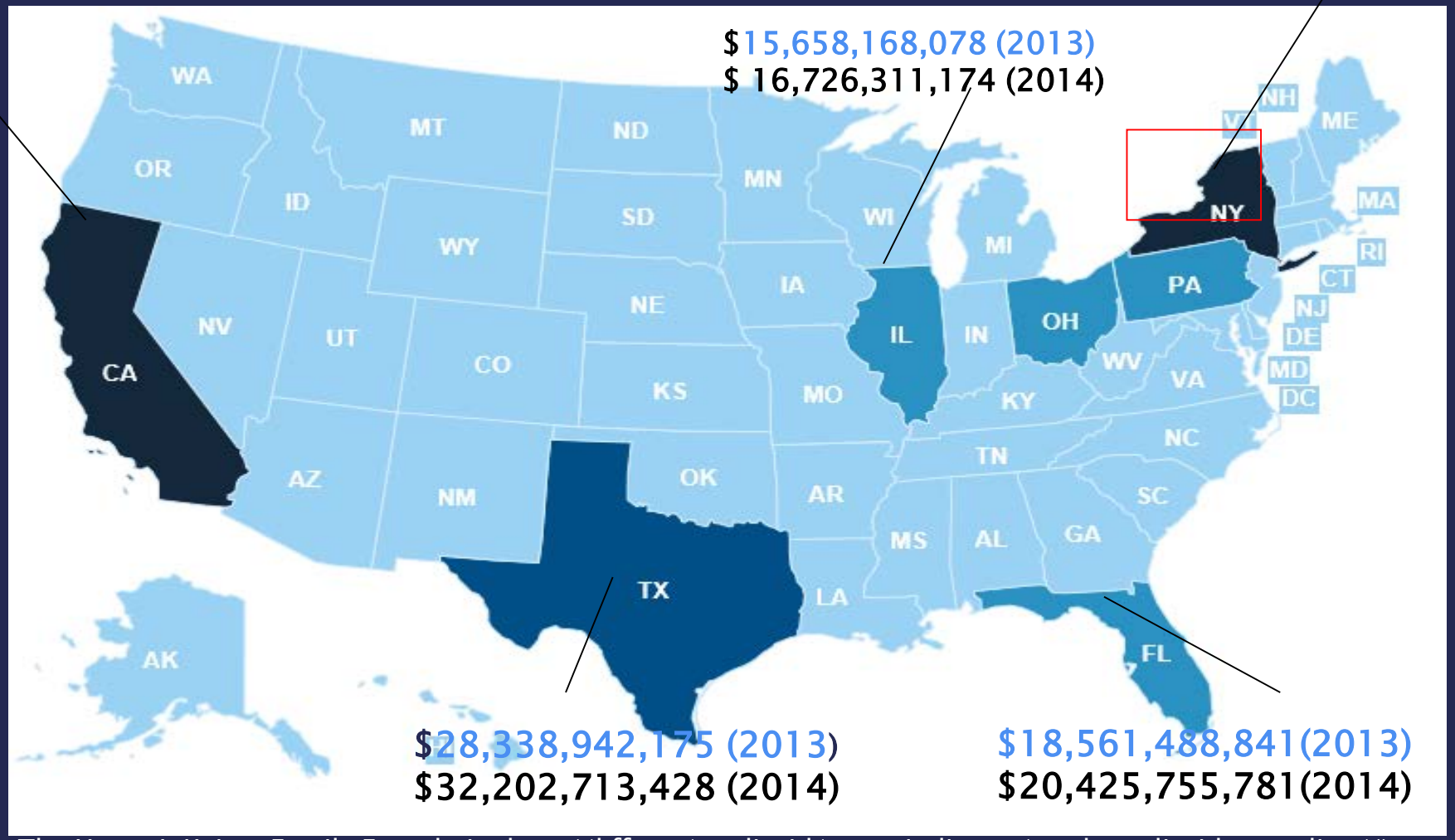
Background

- Approximately, 31.5 percent of Medicaid's $400 billion in shared federal and state spending goes to long-term care for the elderly and the disabled (*New York Times, 2009*) Most of the nation's costs for long-term care for the elderly and disabled are borne through the program.
- In 2014, New York State Medicaid spending totaled $**54,204,075,597**(*The Henry J. Kaiser Family Foundation)*
- To reduce the state's Medicaid expenditures with appropriate housing that promotes independent living with dignity. The transition from long-term care facilities and homeless shelters embodies the core principles of the New York State Department of Health Nursing Home Transition and Diversion Medicaid Waiver Program's strategic plan
- To increase access to community-based services that help individuals to live independently is a part of the community transition, which are predicated on the guiding principles of the 1999 Olmstead Decision

2014 U.S. Medicaid Spending

$61,903,522,460 (2013)
$63,941,985,764 (2014)

$54,420,497,814(2013)
54,204,075,597 (2014)



The Henry J. Kaiser Family Foundationhttp://kff.org/medicaid/state-indicator/total-medicaid-spending/#map

Metro East 99th Street Project Discovery

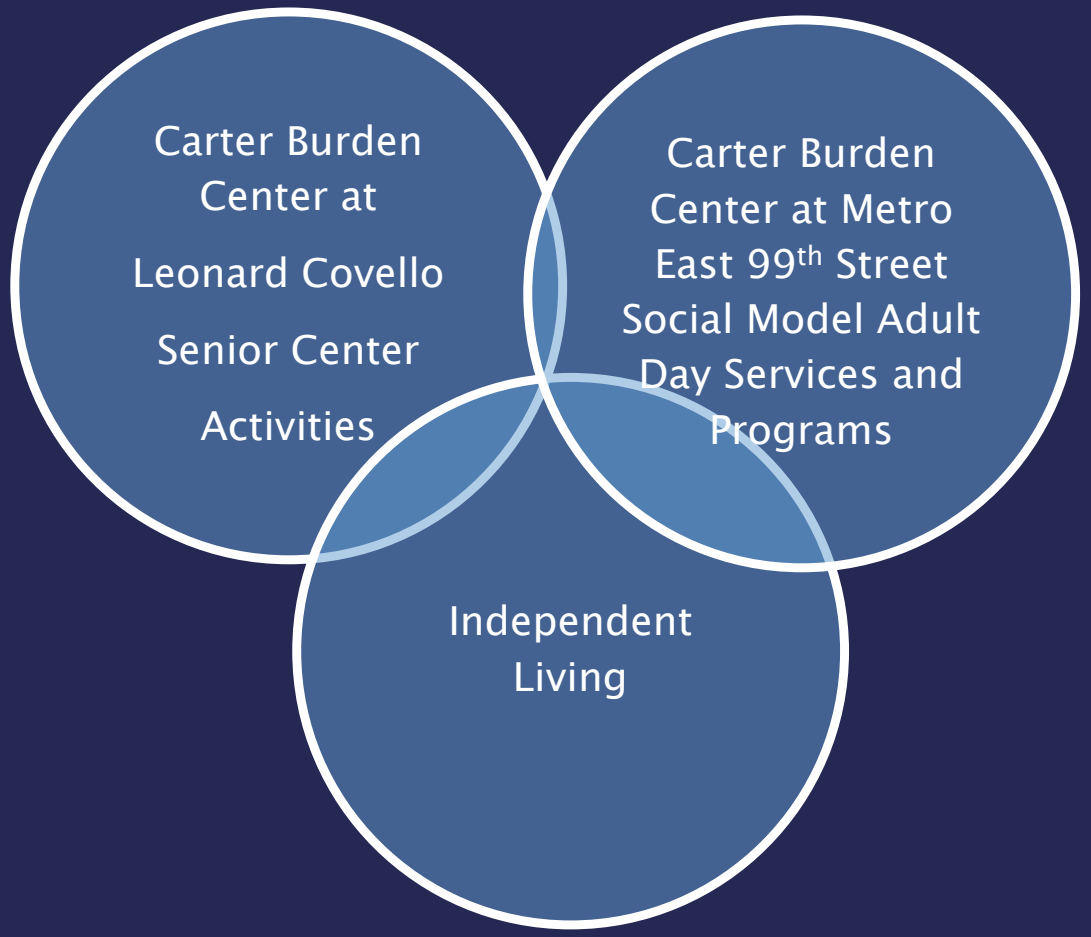
Metro East 99th Street Day Center located on **the first floor(2,912 sq. ft.) of the building.**

As a part of New York State Medicaid Redesign Team's efforts of deinstitutionalization of long-term care residents into community-based living.

The Project is designed to test and measure the impact of an innovative hybrid adult day program in an affordable housing development.

- Lessons learned from this project will impact decision-making regarding:
- Service Delivery model and programming
- Funding structures
- Transition programs
- Health outcomes after transition
- Healthcare cost containment

New Hybrid Model: Social Model Adult Day Services



Metro East 99th Street Proposed Adult Day Services

CBCA's Core Competencies

- Case Management Services
- Meal Service (e.g., home delivered meals and the senior centers)
- Cultural Activities(e.g., Cultural Connections)
- Leonard Covello-Lending library
- Technology Training Classes
- The Arts
- Crafts Activities
- Intergenerational Programs with college students, elementary school students and high school students

Metro East 99th Street Adult Day Menu of Programs, Services and Activities

- Individualized plan of care(e.g., areas of interests and goals)
- Meals services
- Intergenerational Technology Training
- Cultural activities on and off site
- Cooking and nutritional training sessions (e.g., grocery shopping, meal preparation)
- Current Issues discussion groups
- Technology Lending Library
- ✔ Book club
- Horticultural Programs (e.g., partner with a local elementary school)
- Media Art classes
- ✔ Transportation Services
- ✔ Telehealth Program
- Physical Fitness Programs(e.g., yoga, chair exercise)

The Carter Burden Center for Aging (CBCA) Inc. Capacity

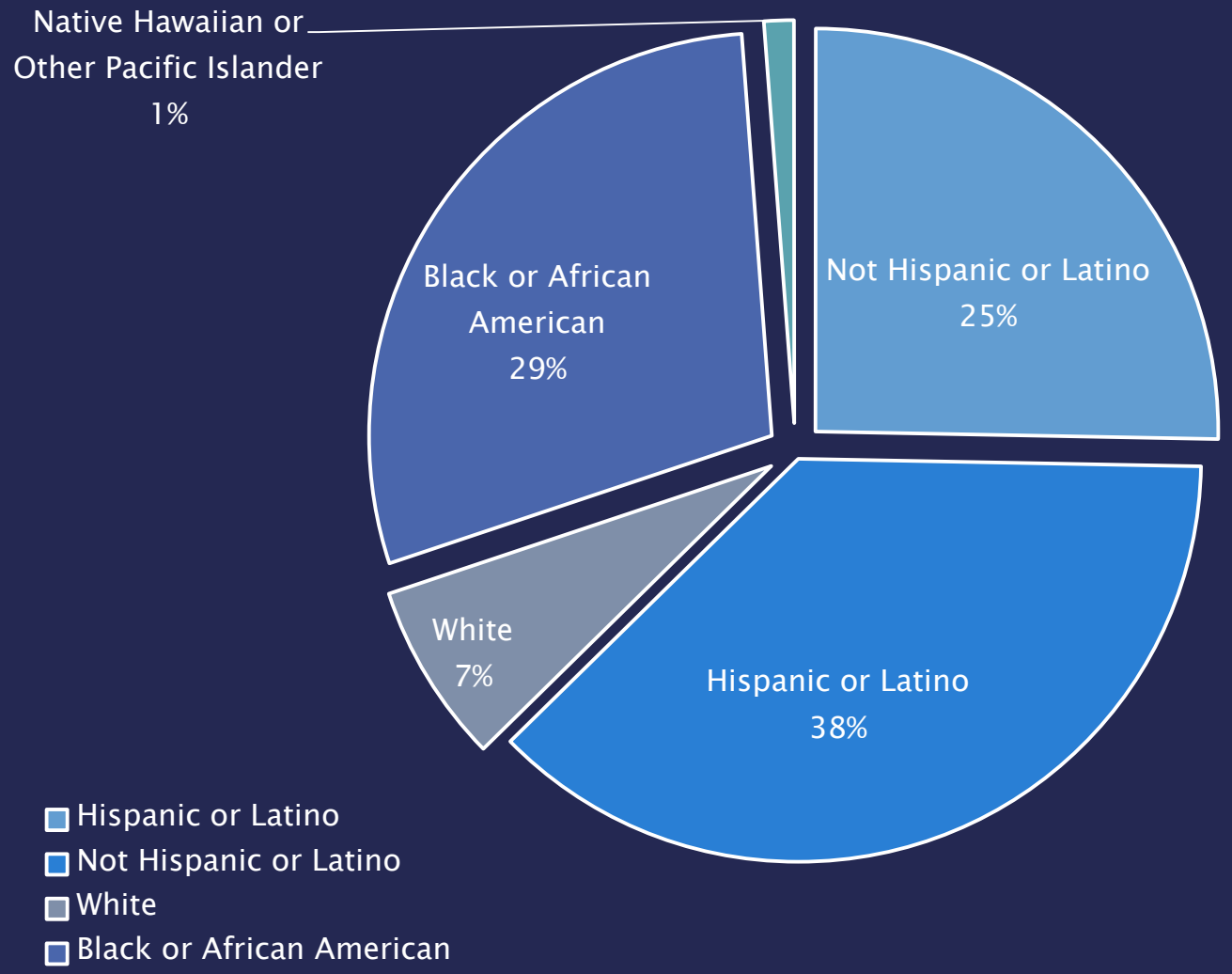
CBCA's Core Competencies

- Case Management Services
- Meal Service (e.g., home delivered meals and the senior centers)
- Cultural Activities(e.g., Cultural Connections)
- Leonard Covello-Lending library
- Technology Training Classes
- The Arts
- Crafts Activities
- Intergenerational Programs with college students, elementary school students and high school students

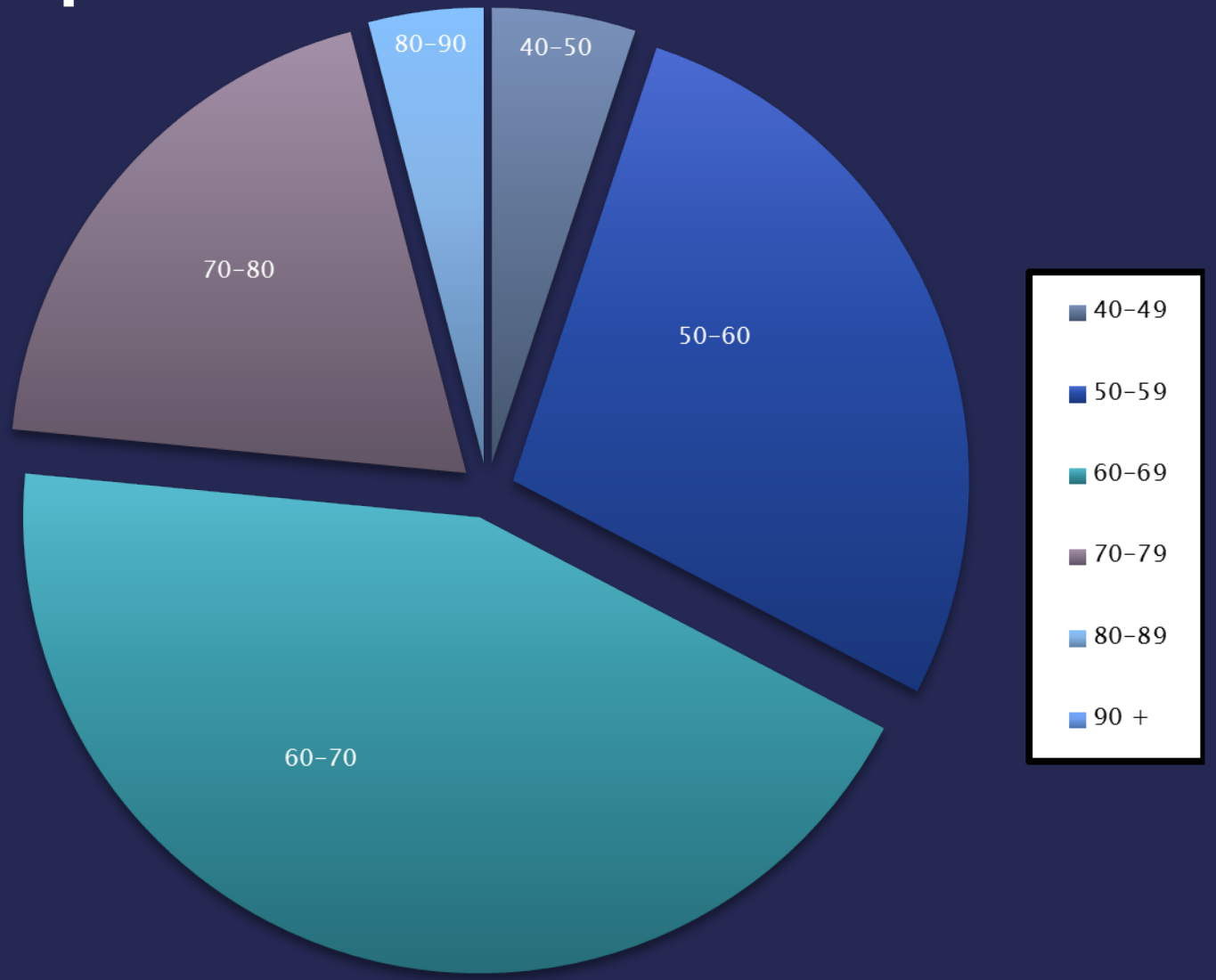
Services not provided by CBCA at Metro East 99th Street

- Home health attendance services provided by health plan
- Medical services
- Monitoring property management
- Providing building security
- Conducting grocery shopping and delivery
- Laundry services(laundry facilities on site)
- Scheduling of any medical appointments
- Coordinating transportation and transition services to medical appointments

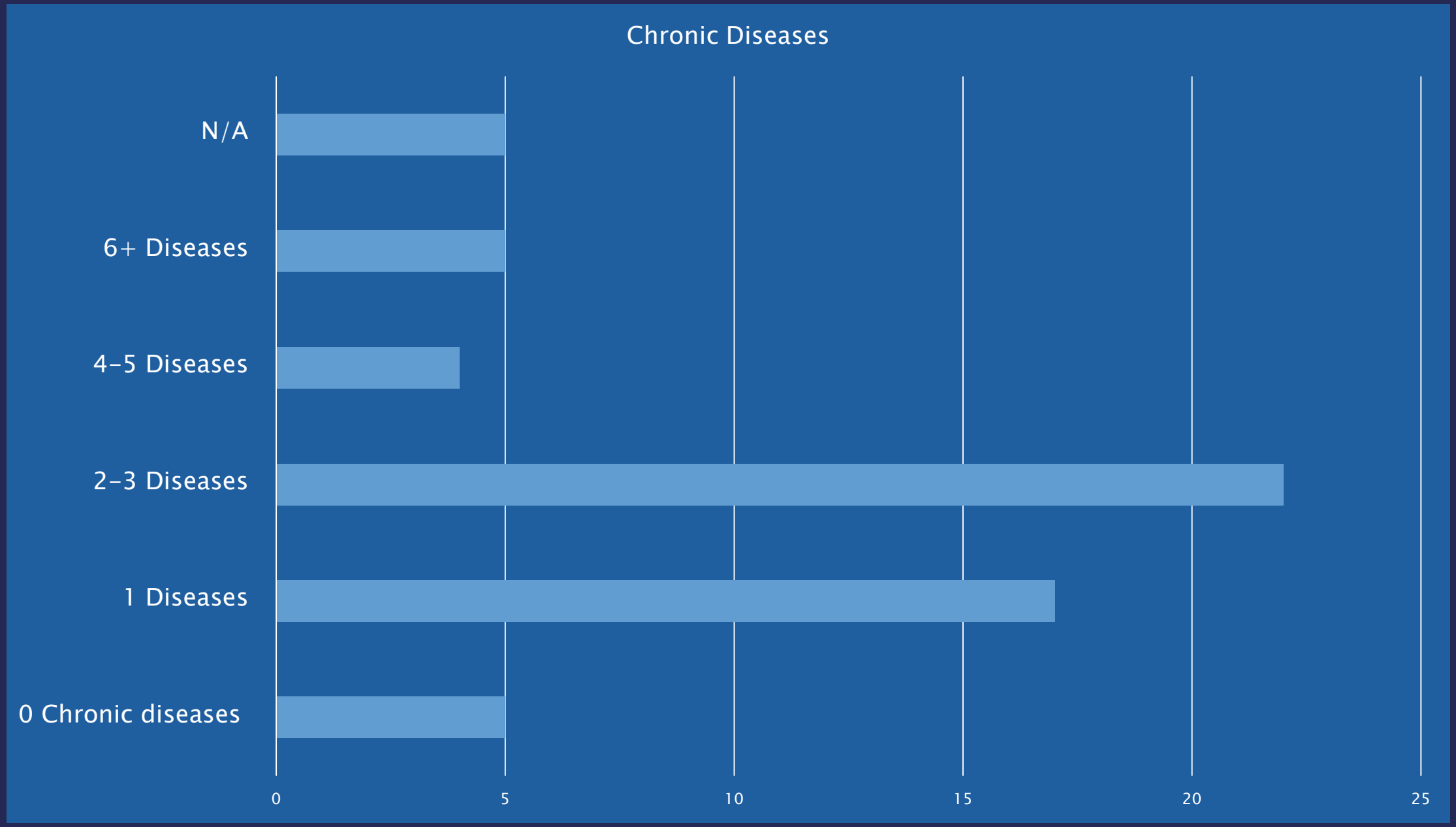
Metro East 99th Street Adult Social Day Program Demographics



Age Distribution of the Active Adult Day Participants



Enrolled 155 tenants

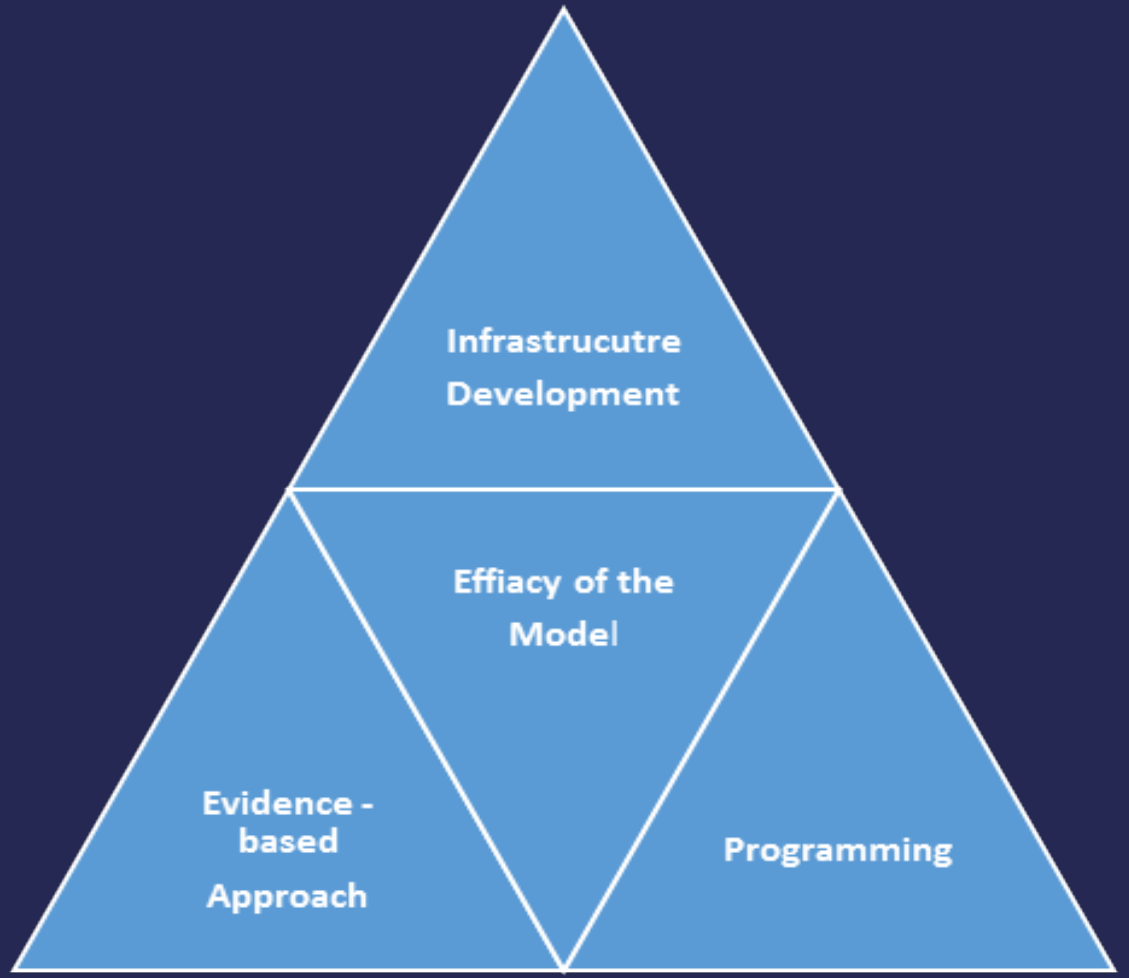

Chronic Diseases
N/A
6+ Diseases
4-5 Diseases
2-3 Diseases
1 Diseases
0 Chronic diseases
0
5
10
15
20
25

Impact of Metro East 99th Street Demonstration Project

"Less attention has been paid to how individuals fare once they have moved into home and community settings after an extended Nursing Home stay. Understanding this is critical for assessing how effectively Home Community-Based Services programs and policies are meeting the goals of caring for individuals with disabilities in the least-restrictive and most-cost-effective way possible."

Journal of the American Geriatrics Society Volume 62, Issue 1, pages 71-78, January 2014

Carter Burden Center at Metro East 99th Street Social Model Adult Day Program Development Framework



Evidence-based Strategies

Transitioning to Community Living….

Fordham University Graduate School of Social Service Transition Study is to examine:

- Investigate the challenges, opportunities and intervention in transitioning from congregant-long term care facilities into independent living for a chronically ill population

Health outcomes…

Vital Care Telehealth Program(Technology Enabled Community Health Program) remote monitoring will investigate:

- The effects of Telehealth on tenant health care adherence and management
- https://goo.gl/p7PYBB

Fordham University Graduate School of Social Service Transition in Care Study Design

The evaluation plan included a mixed methods, quasi experimental, longitudinal design -

(a) The quantitative component of the evaluation plan comprised individual interviews which would be held at baseline and again at 6 months. Respondents paid $20 at each interview.

(b) The qualitative component of the evaluation plan would comprise 4 focus groups with 8-10 participants each. These focus groups would be held with participants in the new model only. Respondents paid $20 for their participation.

Real Quality of Life Outcome…

- A 59 year old African American male wheelchair user living with MS was one of the first to join the Telehealth Program in April 2015 when it began. He self-reported that he was a Diabetic.

YouTube link

- Two-weeks ago he shared that on his last medical visit he was taken off Diabetic medication!!

- His smile was indescribable!

Permission to share this information was authorized by the participant .

Contact Information

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Transition to Independence

Services for the UnderServed

Project Participants

- The project specifically targeted: (a) individuals in need of transition from an Intermediate Care Facility (ICF DD); (b) individuals discharged from residential school settings out-of-state; (c) individuals living at home in the community and at significant risk for placement in an institutional setting.
  - 15 Participants living in an ICF
  - 5 Participants in out of state residential facilities
  - 5 Participants living at home

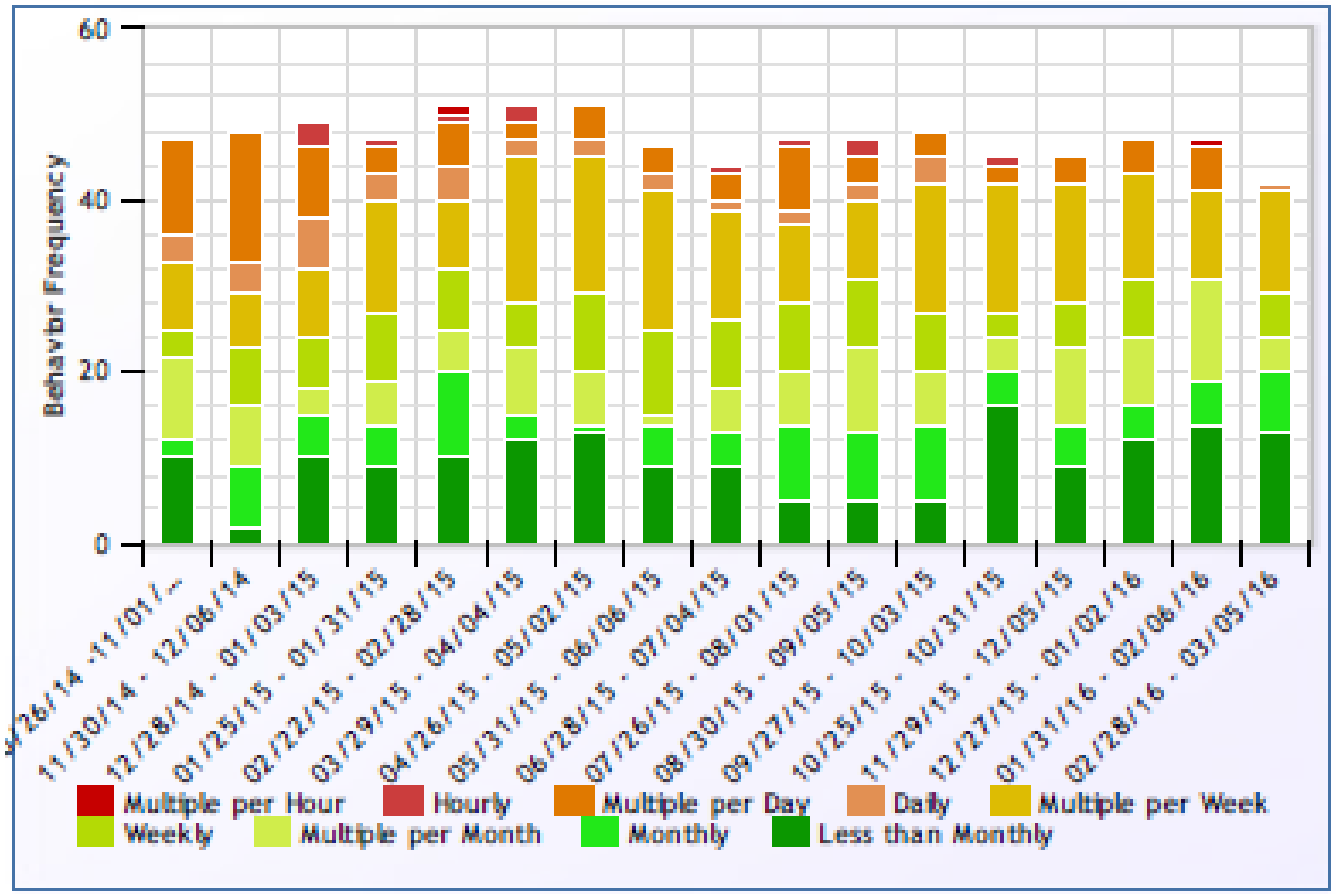
Objectives

- Through the support of ABA services and care coordination:
  - Transition individuals from more restrictive settings to community based residences
  - Reduce the frequency an intensity of challenging behaviors
  - Decrease poly-pharmacology and psychotropic medications
  - Decrease ER visits and hospitalizations
  - Increase functional communication and independence

Implementation

- The project's primary behavioral intervention included ABA-driven Functional Behavior Assessment and Behavior Plan development & implementation. Its Adaptive Communication and general skills building reduced target problem behaviors and promoted community inclusion and independence.
- The frequency and intensity of project interventions was driven by individualized data collection, and was monitored directly by the behavior team. It was not a manual based protocol with "one size fits all" services; rather, services were adjusted, terminated, or resumed on the basis of actual needs and interpretation of treatment data sets. The project operated seven days a week with 24 hour on-call coverage.

Results: Behavior



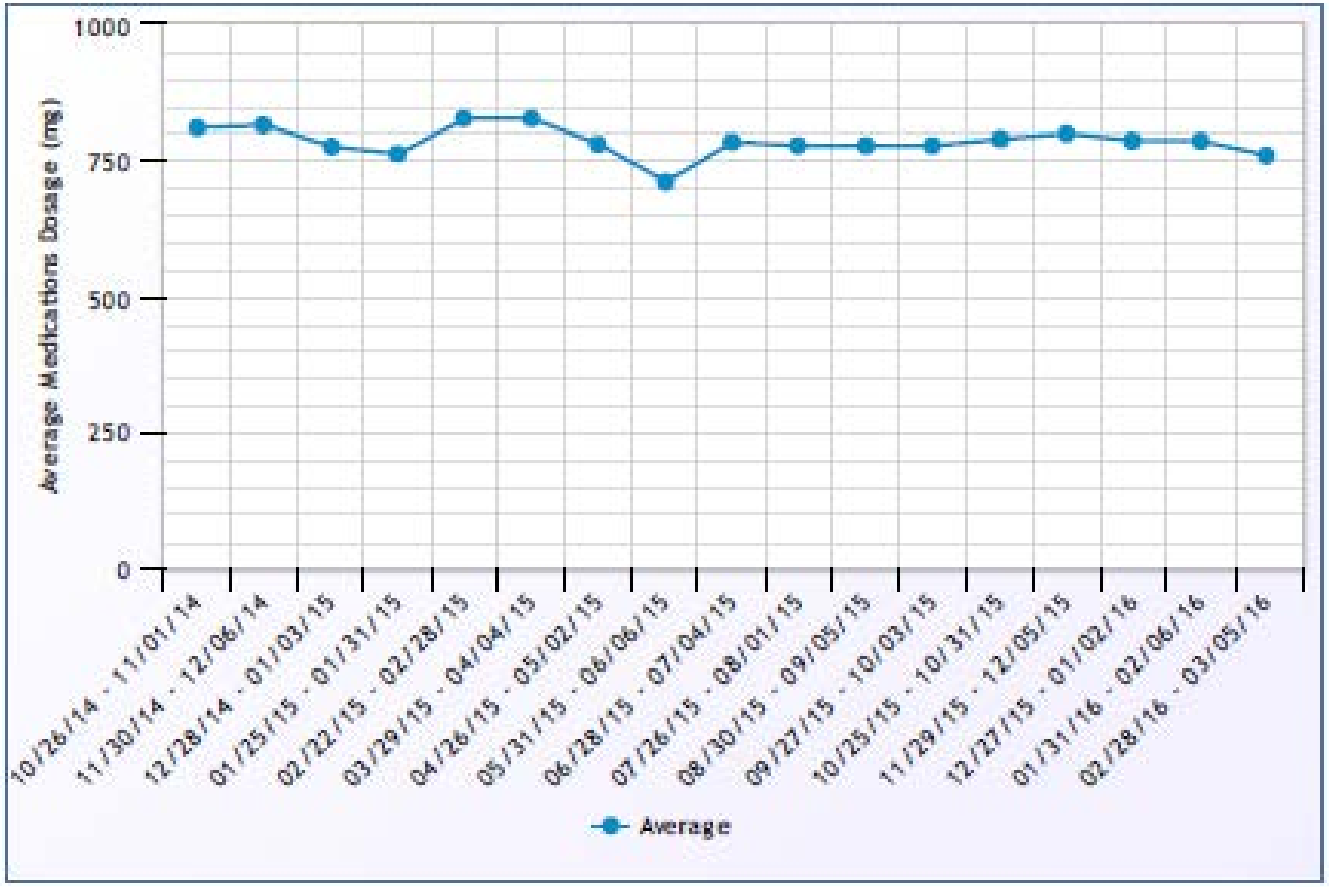
Challenging behaviors decreased significantly by moving from “Hourly/Daily” categories into the Weekly/Monthly categories. Overall number of challenging behaviors targeted decreased over time as behaviors were discontinued from behavior plans following 3+ months of zero rates.

Results: ER/Hospitalizations

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Hospitalizations	0	2	0	0	0	0	0	1	0	0
Overnights	0	4	0	0	0	0	0	0	0	0
Urgent Care Visits	1	4	3	3	1	0	2	5	3	0
Emergency Room Visits	3	1	1	2	3	7	1	4	5	1

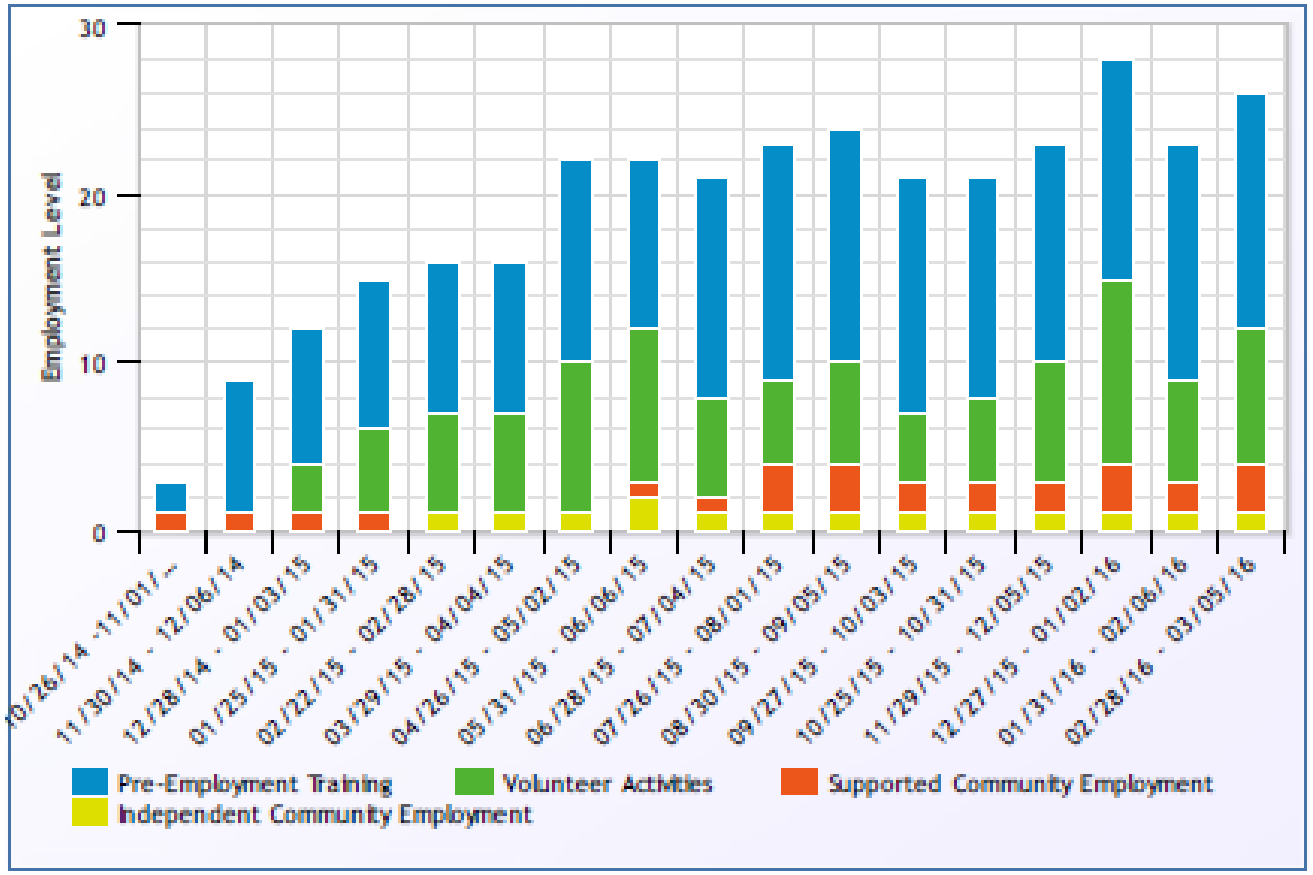
ER and Urgent Care were utilized during the grant period for both behavioral and medical reasons. Visits were later categorized into avoidable and unavoidable visits, informing us that as efforts to shift from ER to Urgent Care were made, Urgent Care visits were more often utilized for behavioral, avoidable and unavoidable needs; ER visits were more often utilized for medical needs. In November, January and February, an increase in ER visits is explained by an individual who broke her arm and experienced complications with recovery, thus requiring ongoing emergency consultation.

Results: Polypharmacy



Efforts were made to decrease medication dosage and numbers when possible. Average medication dosage was decreased by 10% while maintaining behavioral stability and increasing opportunities of independence.

Results: Employment/Volunteerism



At the beginning of the grant period, just 2 individuals experienced some level of community integration. Through behavioral support and coordination with the IDT, almost all individuals were receiving pre-employment training, participating in volunteer work and several were employed by outside entities.

Organizational Changes

- Registered behavior Technicians
- Virtual Health Data System

Strengths of Project

- Among all project participants, there was virtually no record (i.e. no official case history or anecdotal evidence) of participation in job training, volunteerism, or employment activities prior to the onset of project operations. All project participants previously resided in a state-operated facility without access to meaningful employment opportunities, and were not able to access employment related services and supports external to the residential facility.

- With the introduction of organized, structured job readiness and vocational activities as part of project interventions (typically embedded within day habilitation services), individuals experienced dramatic increases in instances of employment related activity and achievement, achieving a trend whereby a progressive increase in pre-employment training led to successive increases in volunteer activity and community employment.

- Despite the lasting effects of long-term institutional levels of care, a number of project participants transitioned to active engagements in supported employment. These results continue to inspire both staff and ICF residents, and we hope to realize further significant gains in levels of employment-related activity supportive of independence in the community.

Strengths of Project

- Varying directly with increases in employment activity among project participants, the Project produced similar gains over time in instances of community involvement levels across all individuals. Again, mindful of prolonged periods of institutional life and very limited regular opportunity to venture outside the walls of the residence prior to the onset of program operations, these increases in individuals' participation in community life were particularly significant, and proved contributory to eventual transitions from an ICF level of care to community-based residential settings.
- Project participants actively partook in supported community activities (e.g. shopping, recreational activities, volunteerism, library trips in the presence of support staff). Many participated in community activities independently (e.g. fully travel-trained individual shopping and using public transit without staff present).

Barriers of Project

- We faced a challenge involving access and control. We encountered two examples of that concern. One was that our five at-home individuals, who did not reside at SUS, could choose to go to the E.R. instead of an urgent care facility. And two was that, for these individuals, we could not change their medical providers, access their medical records, or coordinate our care with them.
- We faced another challenge involving time limits on eligibility. We encountered two examples of that concern. One was that individuals aged out of eligibility, and when we gave them a choice of other providers, we had no control over the speed of the transition and the ability of the replacement provider to coordinate with us. And two was that, when the BIP grant ended, except for a possible period of (relatively costly) pro bono service that was dedicated to training parents, we needed to address ethical concerns about letting consumers lapse into a lower level of care. This concern was particularly applicable to our at-home consumers.