NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Innovations Fund Grants Results Meeting

Balancing Incentive Program (BIP)
Empire State Plaza, Conference room 6
Albany, NY

September 22, 2016

BIP Innovations Fund Grant Awards created to:

- Engage and incentivize Stakeholders to:
  - Take a role in implementing BIP and have an impact on rebalancing MA in NYS
  - “Think outside the box” and develop capacity building projects
  - Develop creative solutions in removing barriers to community-based/least restrictive LTSS settings
  - Improve quality of life by enhancing assistance provided to MA eligible individuals and help them remain within the community or facilitate their transition out of institutional level of care

BIP Innovations Fund Grant Awards created to:

- Purpose
  - Improve health outcomes
  - Increase systemic efficiency and effectiveness

BIP Innovations Fund Grant Awards Goals:

- Implement LTC infrastructure changes that can be applied statewide
- Support increased utilization/capacity
- Mitigate barriers to community-based living
- Facilitate enhanced/improved community-based care and living options
- Reduce institutional LTC placement
- Utilize provider expertise/experience to “think differently” about community-based services and supports

Innovations Fund Grants

Initially, $45M was allocated for a fixed term 8/1/2014 – 9/30/2015

- 75 applications were received/reviewed and scored
- 54 selected/awarded and contracts managed by 8 BIP staff
- Largest $3M; Smallest $175K
- 70% were located in the metropolitan regions and 30% upstate
- 2 were designed to reach the entire state

Innovations Fund Grants

May 2015, CMS issued a *6 month No-Cost Extension* [10/1/2015 – 3/31/2016]

- $5M additional BIP funds were recast – increasing the Total Innovations Fund Award to $54M
- 5/54 grants identified/selected and given proportionate amounts of $5M and +12 months of demonstration time (varying end dates)
- 2 projects given additional demonstration time through 6/2017

Innovations Fund Grants

Common themes for proposed projects were to:

- Enhance proactive case management strategies
- Expand existing program service/increase supports and resources
- Increase outreach and marketing of existing services
- Increase staff skills and training to meet specialized needs
- Implement new technologies that will enhance/improve services

Objectives for convening today:

- Share project outcomes, findings, and best practices that best promote the BIP goals
- Showcase outstanding ideas and initiatives
- Celebrate awardees and provide opportunity to present their ideas and efforts to impact the LTC delivery system
- Foster networking and hear results of this significant investment

Innovations Fund Grants Results Meeting

- **4 Featured Presentations**
  - Advanced Care Alliance of NY
  - Lifespan of Greater Rochester
  - Children's Home of Jefferson County
  - St. Mary's Hospital for Children
- **5 Highlighted Presentations**
  - Parker Jewish Institute for Health Care and Rehabilitation
  - God's Love We Deliver
  - Catholic Managed Long Term Care
  - Erie County Department of Social Services
  - The Hebrew Home for the Aged at Riverdale
- **Video Vignettes**
- **Question and Discussion**

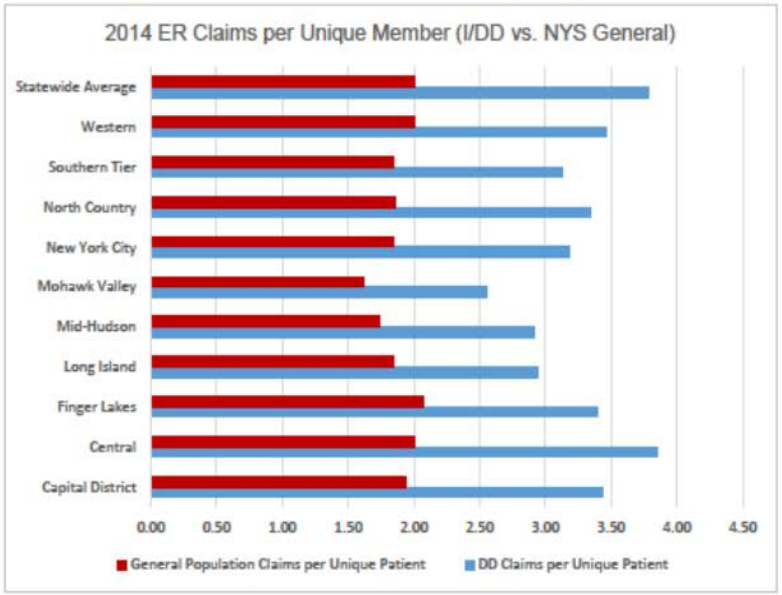
Urgent Care for People with I/DD
BIP Innovation Grant
“Centered Around You”

Steven Vernikoff
President, ACA

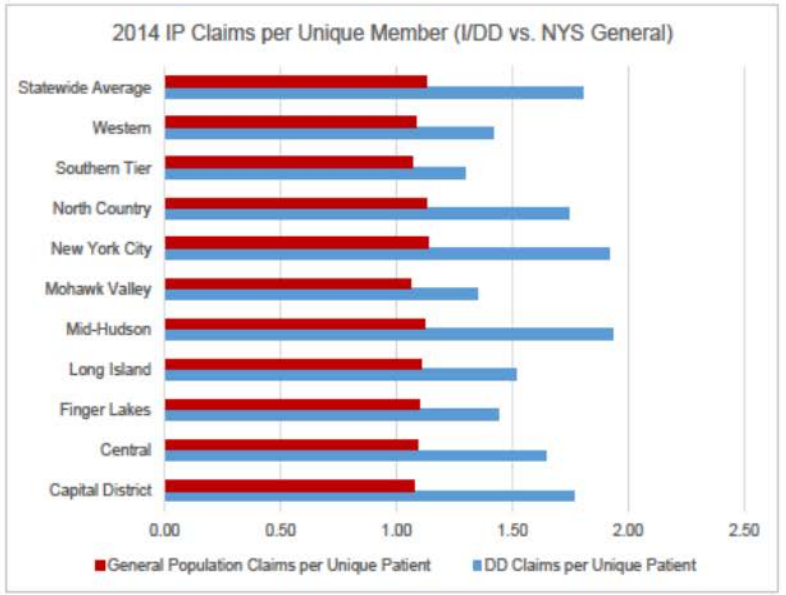
Terri Seppala
Director, Urgent Care Program Grant

Medical Utilization Higher for I/DD than General Population

Throughout NYS, per capita Medicaid ER and IP claims are higher in the I/DD population than the general population



ER Medicaid Claims



IP Medicaid Claims

** Statewide averages do not include regional duplications*

NEW YORK STATE OF OPPORTUNITY. Department of Health

Source: OPWDD, October 2015
Intellectual/Developmental Disabilities (I/DD) and DSRIP Opportunities for PPSs to engage providers and Medicaid members

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We Are Filling Gaps

1. Personal
   - Centered on individuals, in their residences
2. Less Expensive
   - Reducing unnecessary ER/ preventable hospitalizations
3. Efficient
   - Leveraging technology, right resources for right work
4. More Accessible
   - Care at home, 24/7 nurse line, free transportation to appts
5. Scalable

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Our Urgent Care Program For People With Intellectual and Developmental Disabilities

Bringing Clinical Expertise Into the Home

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Our Urgent Care Program For People With Intellectual and Developmental Disabilities

Bringing Clinical Expertise Into the Home

24/7 Call Center Nurse

Primary Care Physician

Caregiver or Parent

Residential Nurse

Medicaid Service Coordinator (MSC)

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Bringing Clinical Expertise Into the Home

24/7 Call Center Nurse

Primary Care Physician

Caregiver or Parent

Urgent Care Clinic

Residential Nurse

Medicaid Service Coordinator (MSC)

Transportation

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Cost Savings

Cost Savings for Non-Duals Enrolled Prior to August 19, 2015			
Population	# of Individuals	6-Month Medicaid Savings (Calculated*)	2-Year Medicaid Savings (Extrapolated**)
Midpoint Cohort^	230	$197,000	$780,000
BIP Cohort^^	800		$2.74 million

Key Outcomes:

22% Cost Reduction in 6 Months

* Calculated 6-month Medicaid savings using PSYCKES OMH data base. Methodology available upon request.

** The 2-year Medicaid savings were extrapolated based on the 6-month Medicaid savings calculation.

^ The Midpoint Cohort only includes Medicaid-only individuals (non-duals) enrolled prior to August 2015.

^^ The BIP Cohort includes Medicaid-only individuals (non-duals).

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Significant Projected Cost Savings

Extrapolated to DSRIPs, ACA, and NYS I/DD

Population	# of Individuals	6-Month Medicaid Savings (Extrapolated*)	2-Year Medicaid Savings (Extrapolated**)
DSRIP-NYC Boroughs & Long Island only^	5,600	$4.80 million	$19.20 million
ACA Members^	10,000	$8.57 million	$34.28 million
NYS I/DD^	50,000	$42.83 million	$171.32 million

* The 6-month Medicaid savings were extrapolated based on the 6-month Medicaid savings of the Midpoint Cohort.

** The 2-year Medicaid savings were extrapolated based on the 6-month Medicaid savings of the Midpoint Cohort.

^ The ACA, DSRIP,NYS I/DD Members only includes Medicaid-only individuals (non-duals) – 40% of Total Census.

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Utilization Reduction

Service Category	6 Months Prior				6 Months Post				Cost (Post Pre)	Days (Post Pre)
	# Recipients	# Services	Days of Utilization	Total Cost	# Recipients	# Services	Days of Utilization	Total Cost		
ER	79	172	244	$63,420	69	133	128	$61,000	**$2,420**	**-116**
Inpatient	21		146	$273,000	20		92	$160,000	**$113,000**	**-54**
Practitioner/ Outpatient Clinic	194	295	3520	$542,000	191	281	3327	$460,000	**$82,000**	**-193**
	230			$878,420	230			$681,000	**$197,420**	**-313**

Key Outcomes:

37% Reduction in Inpatient Days
47% Reduction in ER Visits

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Meaningful Clinical Results

Type of Data	n	10-day Baseline (avg)	10-day Baseline Std Dev	IQR	last 30 days (avg)	30-days Std Dev	30-days IQR	Difference Baseline - 30 days	%with any improvement in last 30 days	%w/in target range in last 30 days
Non-Diabetics: Systolic	31	128	19	138 - 111	123	20	134 - 106	5 mmHg	19/31 (62%)	97%
Non-Diabetics: Diastolic	31	81	16	86 - 68	76	13	82 - 66	5 mmHg	22/31 (71%)	94%
Most Severe Systolic	**8**	**146**	**18**	**148 - 130**	**132**	**14**	**137 - 122**	**14 mmHg**	**88%**	**100%**
Most Severe: Diastolic	**8**	**93**	**20**	**97 - 75**	**83**	**12**	**87 - 74**	**10 mmHg**	**100%**	**75%**

Key Outcomes:

For most severe hypertensive individuals:

34% Reduction of risk for Cardiac Events

36% Reduction of risk for Stroke

Source: Lewington S, Clarke R, Qizilbash N, Peto R, Collins R. Prospective Studies Collaboration. Age-specific relevance of usual blood pressure to vascular mortality: a meta-analysis of individual data for one million adults in 61 prospective studies. Lancet. 2002;360:1903-1913.
Heart Disease and Stroke Statistics – 2007 Update Dallas, TX: American Heart Association 2007.

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Mid Point Metrics

Compiled from BIP Grant Encounter Data 03/01/15 – 07/31/16

Program Actions	Quantity
Home Instructions Provided	243
Consultations with Supervising Physician or PCP	41
PCP or Urgent Clinic Referrals Made	95
Calls to 9-1-1	7
Mobile Crisis Units Dispatched	3
Urgent Care Nurses Dispatched	111
Total Calls Triaged	**>500**
Total UCT “Touches”: Initial visits, Urgent Care Visits, Follow Up Visits, Coaching Visits	>600
Behavioral IP* Avoided	11
ER** & Medical IP*** Visits Avoided	185

* Average $15,200/ IP Psych

** Average $340/ ER Visit

*** Average $9,000/ IP Medical

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More Analysis to Come

- Final Cost of Program Participation (PMPM)
- Pre-post comparison of access to outpatient primary/behavioral care
- Baseline vs follow up on health measures: Remote monitoring
- Baseline vs follow up of Patient Activation Measurement
- Pre-Post Analysis with Propensity Matched control: Medicaid claims utilization
- Identification of predictors of program impact
- Participant Satisfaction

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Our Recommendations

Actions to Advance Our Progress

We urge NY State to:

- Add reimbursement for Telemedicine visits from provider home and patient home at night and weekends
- Add reimbursement for Remote Patient Monitoring for preventing symptoms of chronic Illness

Grant will continue through March 2017 to evaluate:

- Telemedicine clinic– for cost savings and clinical value
- Telehealth monitoring for constipation – for practicality and results
- PAM Coaching for activation
- Directing resources to individuals based on their need

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Stratification Model

For Directing Resources Based on Need

	LOW ACUITY	MED ACUITY	HIGH ACUITY
PAM LEVEL			
4	C4 CFA, WEB	B4 CFA, WEB	A4 CFA, WEB
3	C3 CFA, WEB	B3 CFA, WEB, IVR	A3 – *73 enrollees* 1 X Week VC
2	C2 – *25 enrollees* IVR reminders, CFA	B2 – *54 enrollees* 1 X Week VC, RPM	A2 – *23 enrollees* 3 X Week VC, RPM, IVR, ADL, PERS
1	C1 – *32 enrollees* IVR reminders, CFA	B1– *125 enrollees* 1 X Week VC, RPM	A1 – *68 enrollees* 4 X Week VC, RPM, IVR, ADL, PERS

Greatest use of our services from highest Acuity enrollees

Further stratifying by type of residence increases relevance and value

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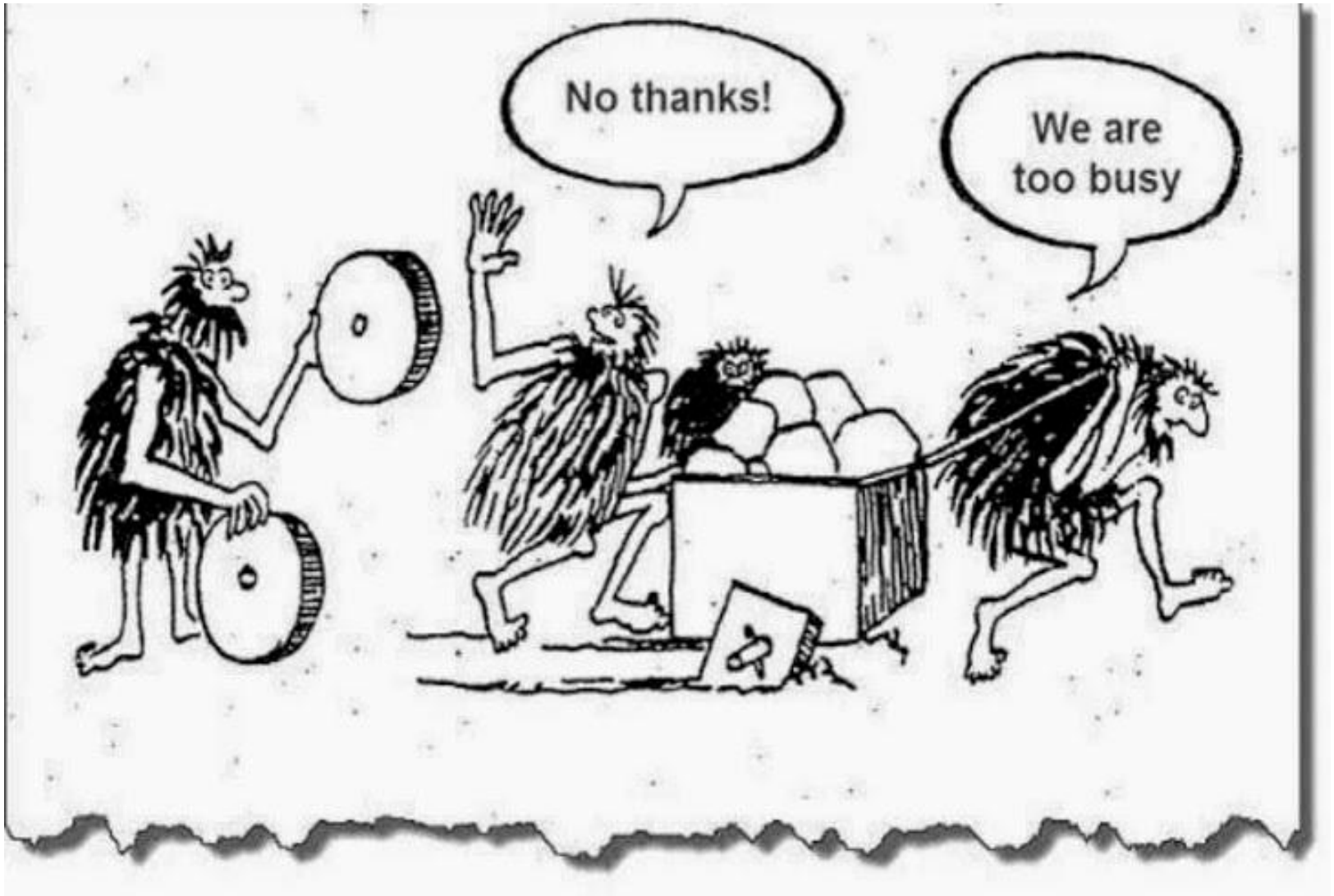

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The ACA-OPWDD-DOH Partnership

- A successful urgent care delivery system for the I/DD community
  Extendable to other populations, more providers, care management
- A connected health platform built for the future
  Scalable to EMRs, telemed and telehealth
- Lower utilization with better quality of life
  Cost savings, better clinical outcomes, increased access to care
- PMPM $ less than one ER visit/member/year

Quality Care At Right Place and Right Time to Improve Health Care at Lower Cost

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Let's Continue the Conversation

Terri Seppala
Director, ACA Urgent Care Grant
President, Telehealth Associates, Inc.
terri@telehealthassociates.com
612-396-5066

ACA website:
www.AdvanceCareAlliance.org/aca-urgent-care

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Using Medical House Calls to Reduce Hospitalizations and Readmissions Among Elderly Medicaid Recipients

The New York State Department of Health's BIP Innovations Fund Grants Results Meeting

Presented by:

Lorraine Breuer, Senior Vice President of Research and Grants

Thursday, September 22nd

Parker Jewish Institute for Health Care and Rehabilitation

271-11 76th Avenue

New Hyde Park, N.Y. 11040-1433

Phone: (718) 289-2100

www.parkerinstitute.org

Our Mission

On The Wings of Compassion, Excellence and Innovation

"Provide, with compassion and dedication, superior quality health care and rehabilitation for adults. Through continual improvement of Parker's programs and services, it will be a leader in health care delivery and education."

Parker Today

- A 527-bed skilled nursing facility located in New Hyde Park, NY.
- Offers a comprehensive system of post-acute care, including short-term rehabilitation, nursing and medical services.
- Also offers a diversified network of outpatient services including:
  - Social Adult Day Care
  - Home Health Care Program (Certified Home Health Care)
  - Hospice Program
  - Palliative Care Program
  - Research and Grants
  - Physician Services
  - Queens-Long Island Renal Institute, Inc.
  - Lakeville Transportation Ambulette, LLC
  - AgeWell New York, LLC
  - Medical House Calls

"Parker's nursing home without walls made it possible for me to receive the nursing care and therapy I needed, keep my independence, and stay where I most wanted to be -- at home."

Profile of Parker's Service Area

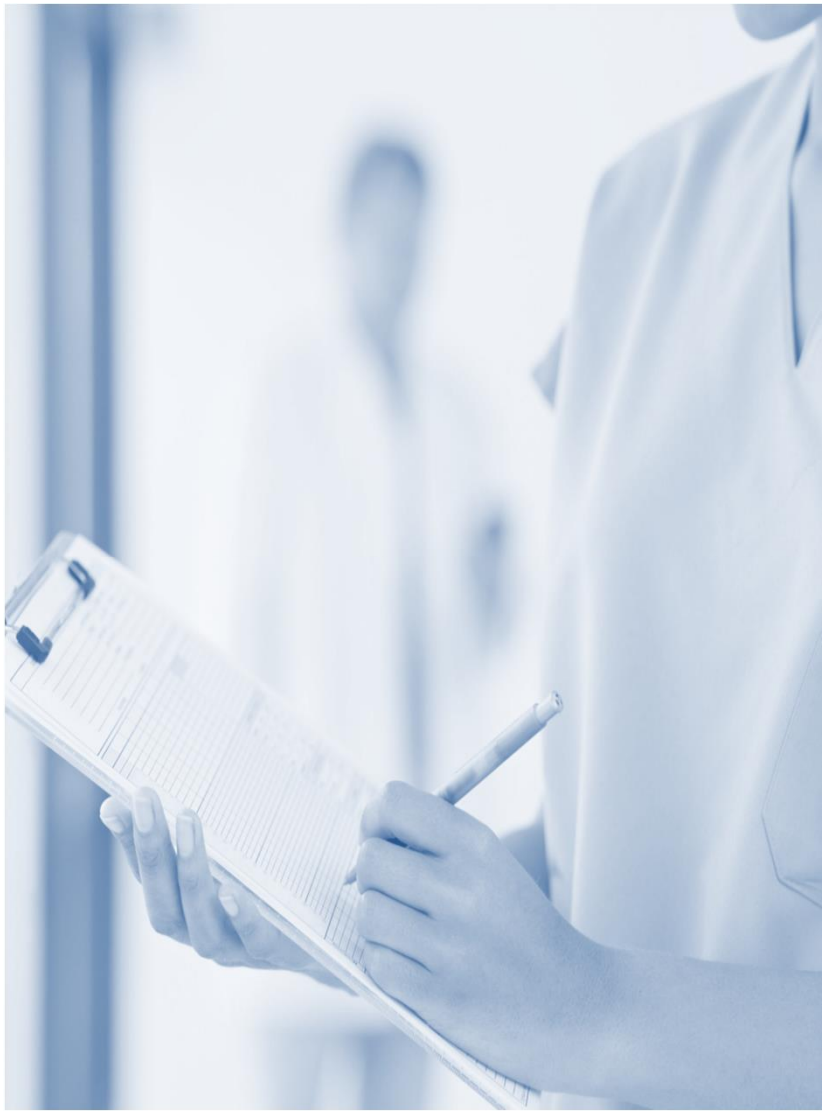
- A rapidly growing population of adults 65 and older.
- A large and diverse immigrant population.
- A growing population of older adults with special needs.
- Greater financial barriers.

Filling a Critical Gap in Care

- High prevalence of homebound, bedbound, disabled or frail, elderly individuals with functional limitations and multiple comorbidities.

- Tremendous need for home-based primary care in the communities we serve.

- Parker decided to address this **limited access to community-based primary care.**



Addressing the Problem

- Easier access to primary care is key.
- Many home-based primary care (HBPCs) programs have emerged to help address barriers to care.
- Parker utilized BIP funds to implement a unique geriatric care management and referral program that provided home-based primary care and case management services to older adults.

Parker's Medical House Calls Program

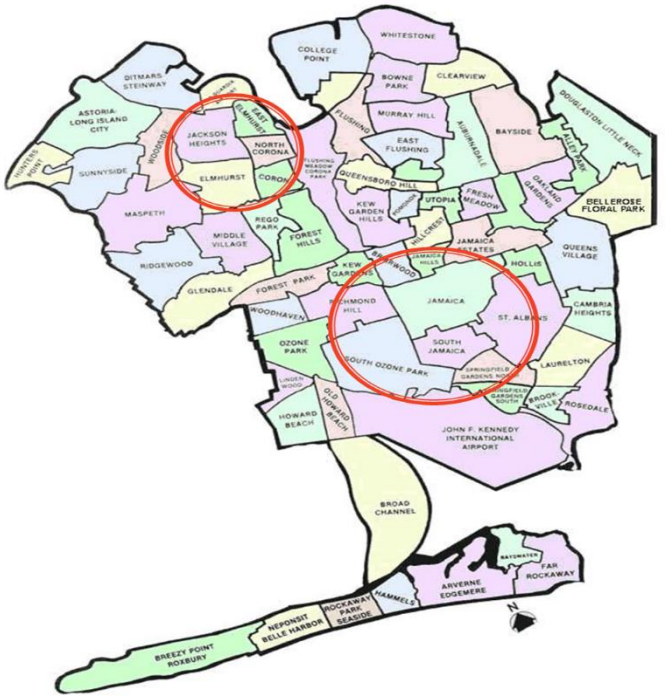
PARKER
AT YOUR DOOR
PARKER JEWISH INSTITUTE

The Target Population

Targeted elderly Medicaid recipients who were:

- Isolated and at risk of hospitalization and/or of becoming institutionalized.
- From diverse ethnic backgrounds and communities that are significantly underserved and most likely to use emergency rooms as their primary source of medical care.
- Are uninformed about home and community-based long term care services and supports.
- Persons without access to primary care.

Program Service Area



The initial three target geographic areas were:

- Corona/East Elmhurst
- Jackson Heights
- Southeast Queens

Allowable Services

Through the Program patients will be able to receive:

Primary Care

Case Management

Care Coordination

Psycho/Social Assessment

Program Objectives

1. Reduce preventable/avoidable hospitalizations.
2. Decrease emergency room utilization.
3. Reduce entry to higher levels of institutionalized care.
4. Achieve high rate of patient and caregiver satisfaction.

The Care Model

Access to Community Resources

Parker's consortium of several community-based organizations serve as a referral source for community services and include:

- Meals on Wheels
- Housekeeping

- Personal Care

- Social Activities

- Broad Range of Mental Health Services

- Legal Supports

- Transportation

- Financial Supports

- Food Stamps

- Support for Family Caregivers

Population Profile

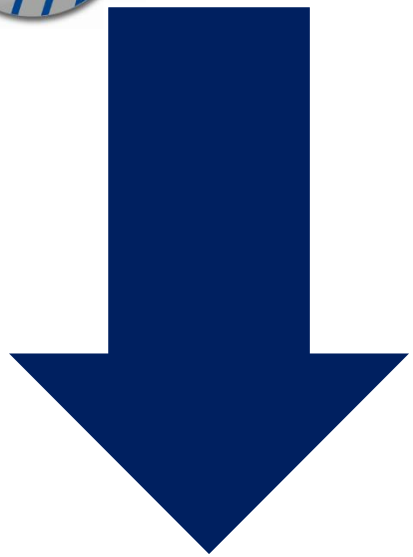
- All program enrollees were elderly Medicaid beneficiaries, living in Queens, New York.
- 80% of the program's patients were dual-eligible and 20% were only insured through Medicaid.
- Over 50% of patients were homebound.
- 34% of patients had at least one psychiatric diagnosis.
- 20% of patients had a diagnosis of Alzheimer's Disease or a related Dementia.

Results and Outcomes of PAYD

Data Collection Methods

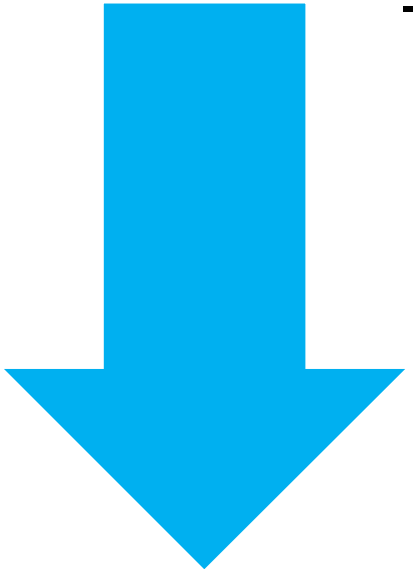
- Data was collected and assessed at baseline and every 6 months using the NYS-Uniform Assessment System (UAS).
- The UAS measures resource utilization such as:
  - Hospitalizations
  - Emergency Room Use
  - Medical Visits
  - Nursing Facility Admissions
  - Activities of Daily Living
  - Mental Health
  - Access To Health Care Services

Health Care Utilization



Hospitalizations

- 35% decrease in hospitalizations at the 6 month interval.



ER Visits

- 74% decrease in ER visits.

Nursing Facility Use

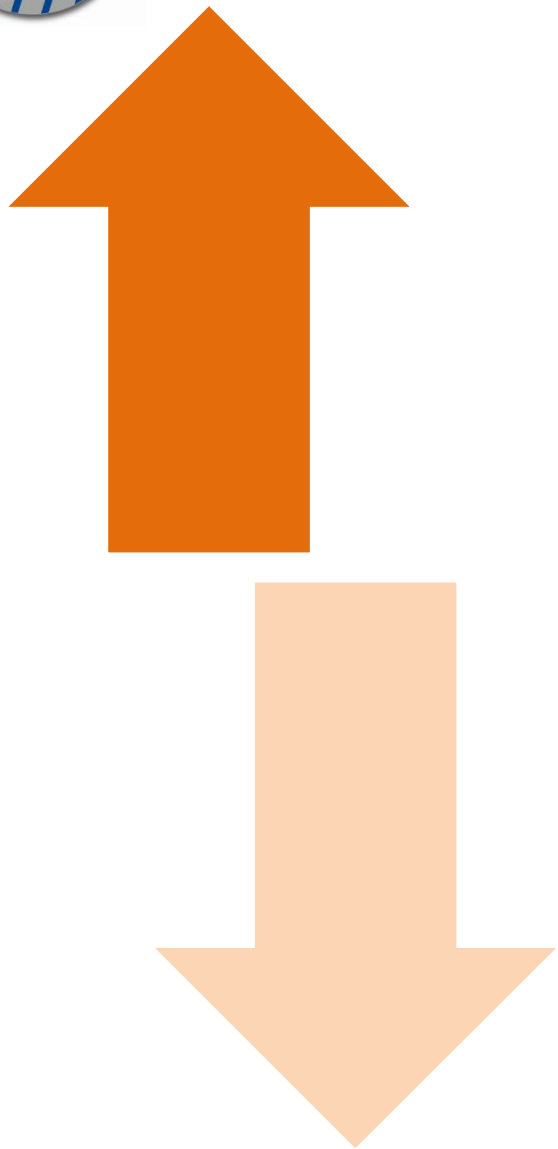
SNF Admissions

- 21% of our patients had an SNF stay 6 months prior to admission.
- Over the course of the program, only 5% of patients went to SNF.

Medication Compliance

- 20% of our patients were not compliant with medications upon admission.
- All were referred for pre-pour service and achieved compliance.

The HBPC Improved Access to Care



Physician Visits

- Approximately 1,000 visits. Due to patient acuity, most patients were seen monthly.

Difficulty Accessing Medical Care

- A 62% decrease from baseline in the number of individuals reporting difficulty in accessing medical treatments.

Successful Outcomes

- Prevented unnecessary utilization of care.
- Increased use of recommended specialty care.
- Increased medication compliance.
- Decreased caregiver burden.
- Increased awareness and utilization of community-based services and supports.

Barriers and Challenges

- Putting the right team in place.
- Recruiting patients.
- Care coordination.
- Maintaining relationships with patient's in-network physicians.
- Breaking the cycle of patient reliance on Emergency room for treatment.

Project Sustainability

- Parker has made a multi-year institutional investment in Parker At Your Door.
- Enroll in Managed Care Organizations (MCOs).
- Accept Medicare and private pay.
- Expand to other geographic areas.
- Seek funding for a mobile medical unit.


time for questions

Parker Jewish Institute for Health Care and Rehabilitation

Thank you.

Lifespan of Greater Rochester, Inc.

Balancing Incentive Program

Innovation Project

Health Care Coordination

Contract #: 029836

Results

September 22nd, 2016

From August 1, 2014 to March 31, 2016

Program Goals

- Provide healthcare-focused service coordination for at least 100 Medicaid beneficiaries 50 years and older.
- Help Medicaid beneficiaries remain in their homes by increasing access to community based medical, disability and aging service systems.
- Decrease Caregiver Stress.

Enrollment Criteria

- Age 50+ (required)
- Demonstrated difficulty navigating health care system
- History of missed medical appointments
- Aging/Stressed caregiver
- Lives alone
- 2 or more ED visits or hospitalizations in the past year
- Low health literacy
- History of non-adherence with treatment plan
- Co-morbitities, especially those that limit ADL's

Lifespan
take it on!

Participant Profile

Demographics	
Female	63%
Male	38%

Age	
<55	6%
55 – 64	39%
65 – 75	34%
> 75	21%

Race/Ethnicity	
African American	44%
Hispanic/Latino	8%
White	48%
Other	1%

Lifespan
take it on!

Participant Profile

- 86 % had no involved caregiver to assist
- 25% diagnosed with Dementia
- 50% diagnosed with Diabetes
- Participants' # of Chronic Health Conditions
  - 1 to 2: 26%
  - 3 to 5: 58%
  - 6 +: 16%

Program Description

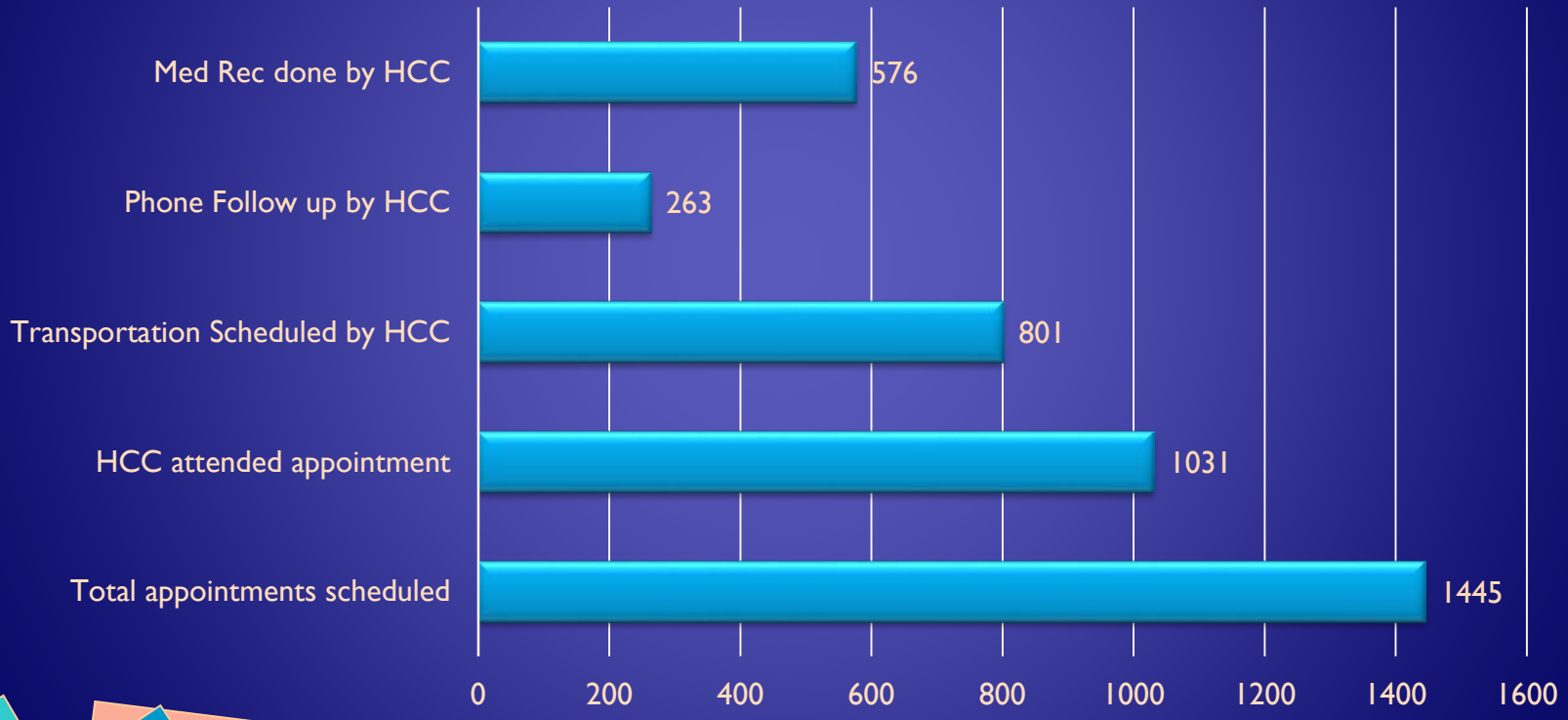
Healthcare Coordinators

- LPN's supervised by an RN.
- Schedule medical appointments and coordinate transportation.
- Accompany patients to medical appointments, scribe, advocate and ensure the right questions are asked and answered.

Program Description

- Communicate the results of medical appointments with family members and other professional providers.
- Complete a Medication Reconciliation at every encounter.
- Link to other supportive community based services.
- Increase patients knowledge of their own healthcare needs through education and training.

Healthcare Coordinator Services provided



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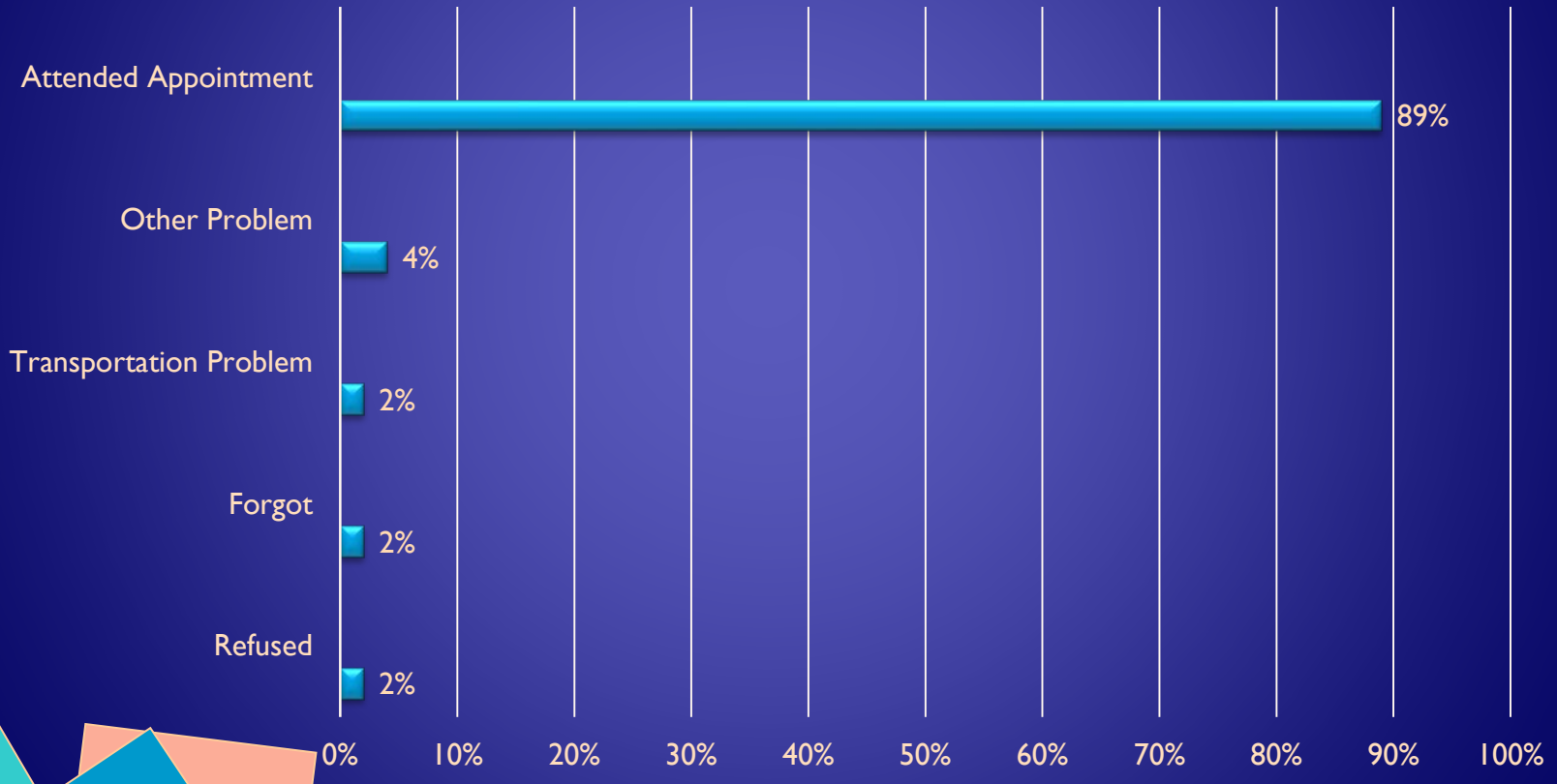
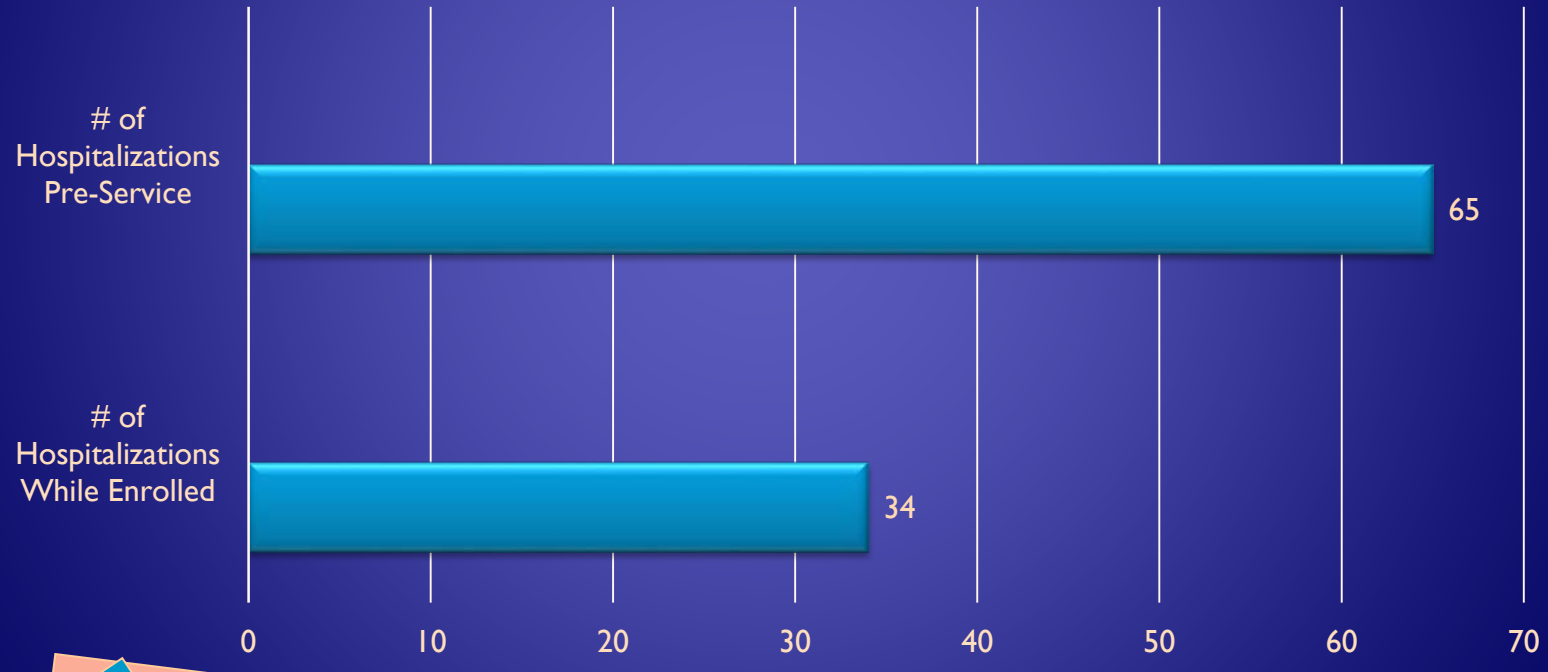
Program Outcome Goal: 75% of participants will attend 80% of Medical Appointments
Achieved 89%



Program Outcome: Reduced Hospitalizations 48%



Lifespan
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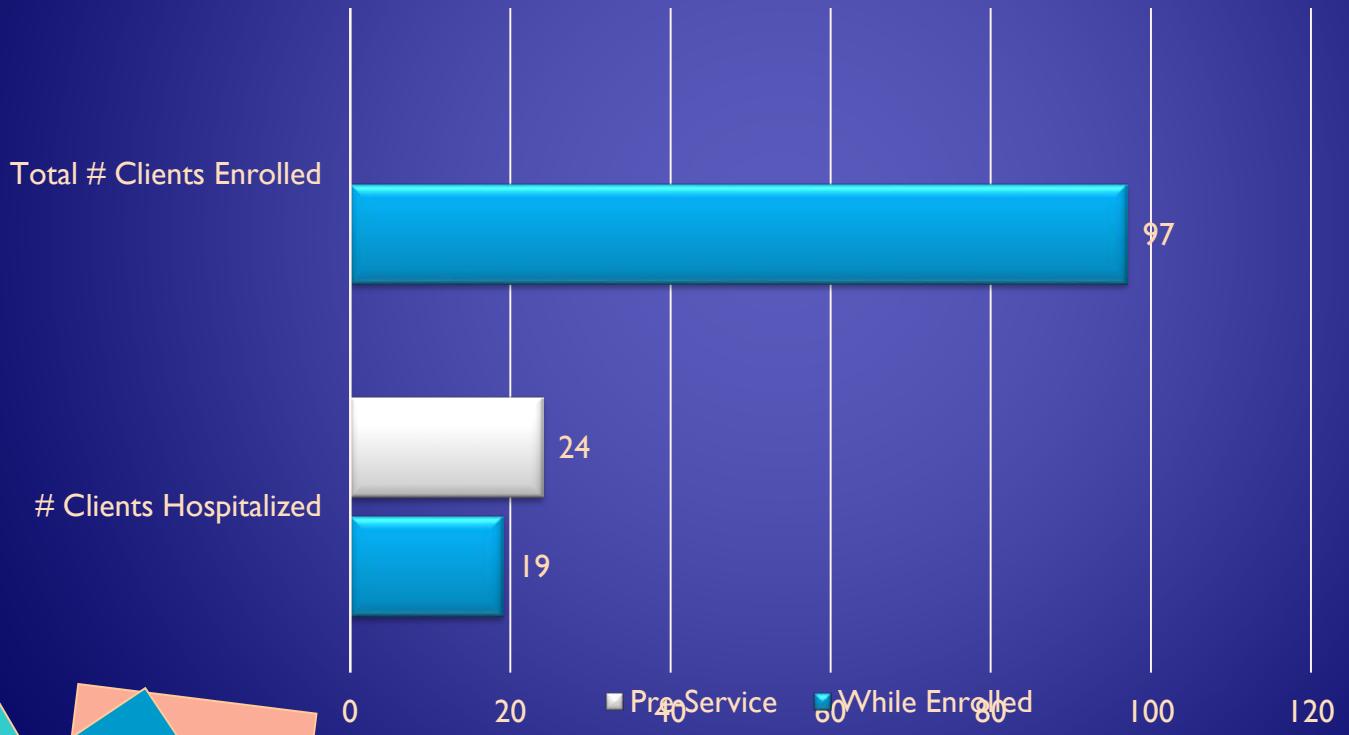
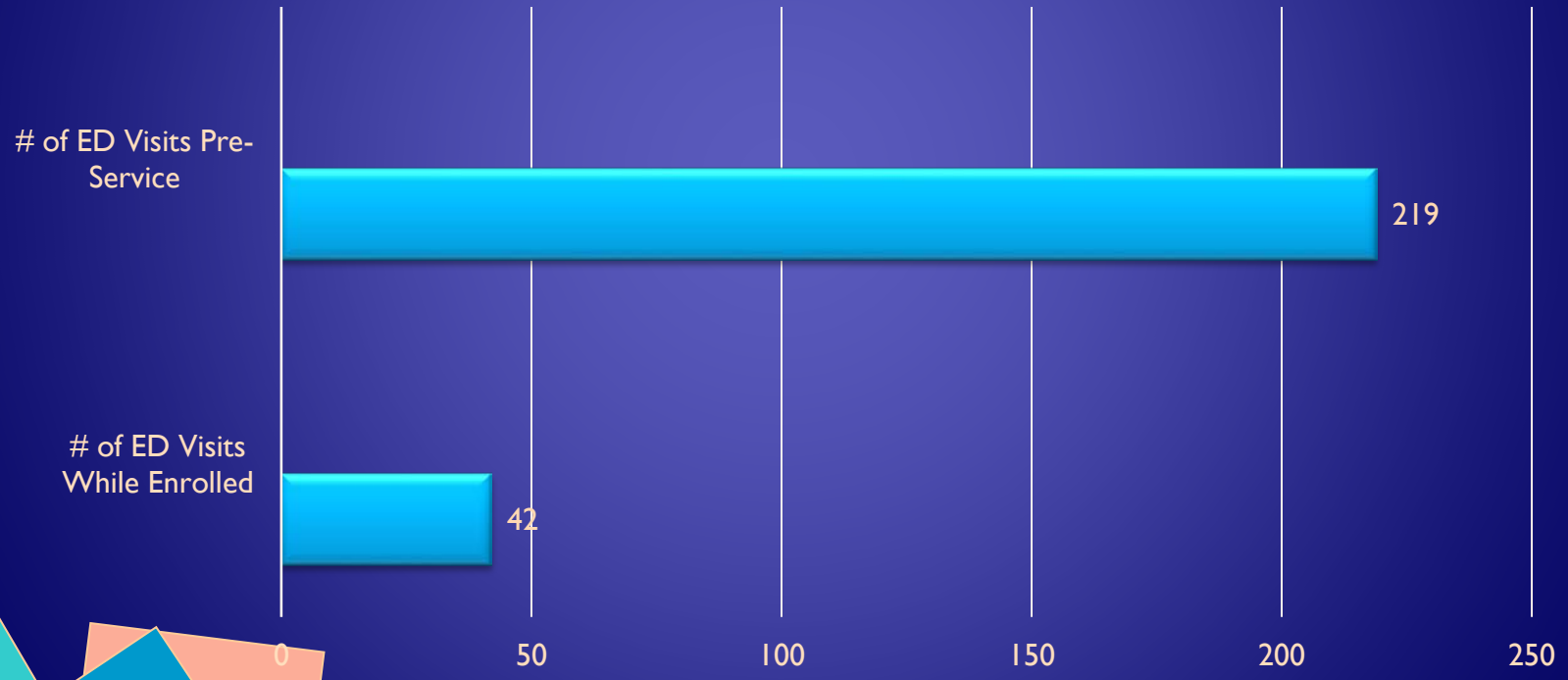
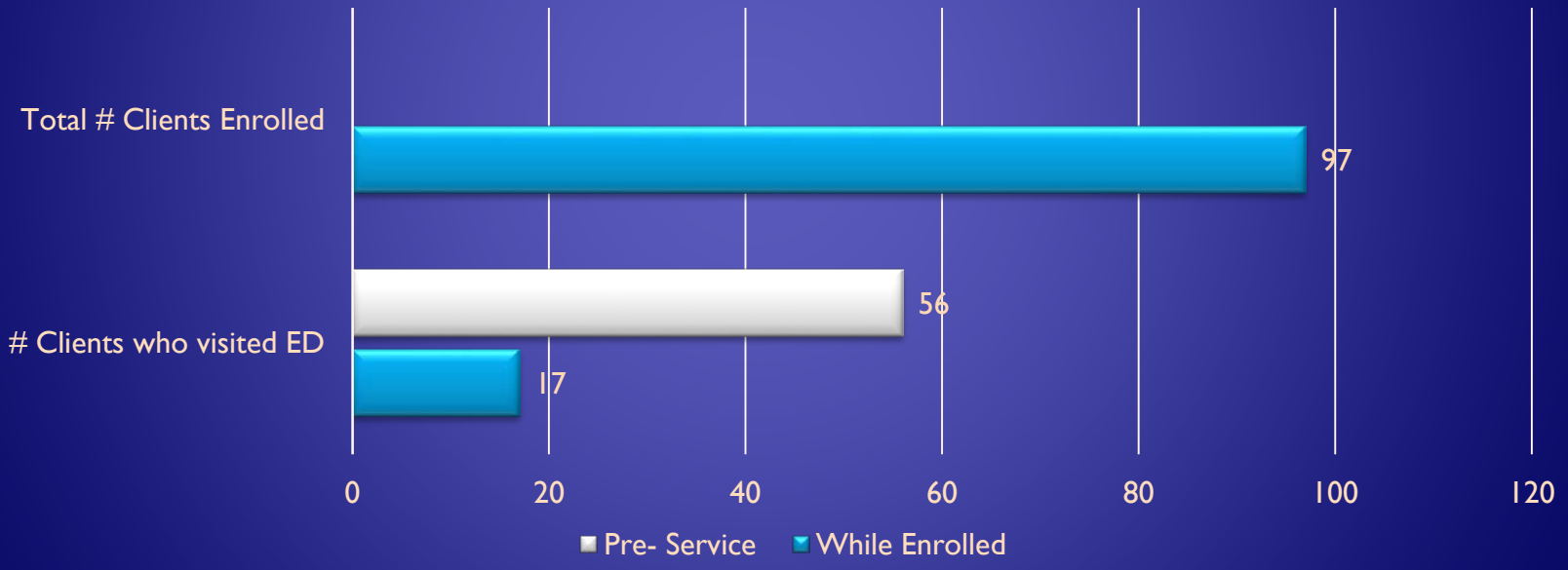
Hospitalizations Pre and Post Service



Program Outcome: Reduced Emergency Room Use 81%



ED Visits Pre and Post Service



Results of BIP Health Care Coordination Project – Total Estimated Cost Avoidance of $1,656,870

- Hospitalization was reduced 48% with an estimated cost avoidance of $349,680. [1]
- ED use was reduced 81% with an estimated cost avoidance of $218,241. [2]
- 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.

Lifespan
take it on!

Program Outcomes

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

- Achieved 67%

Program Outcomes

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 Outcomes

Goal: 60% of participants involved for 3 months will increase their patient activation score from baseline using the PAM-13.

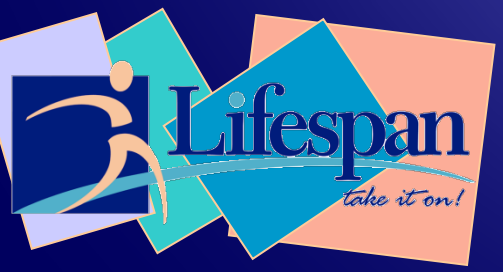
- At intake, clients completed the Patient Activation Measure (PAM 13) as part of their registration process to help determine their ability to care for themselves. Most (64%) scored at the lowest levels including 29 clients who scored at level one which is indicative of being overwhelmed with health management. Several clients were not even able to understand the questions and only three clients were identified as having sufficient confidence and skill to make appropriate decisions and actions.

* The Patient Activation Measure (PAM) assesses a consumer's knowledge, skills, and confidence for self-management.

Lifespan
take it on!

Strategies for Success

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



Strategies for Success

Outreach

- Physicians/Nurse Care Managers/Office Managers in Physician offices
- Rehabilitation facilities
- Hospital Social Work departments
- Senior Centers / Community Centers
- Health fairs
- Adult Protective Services

Strategies for Success

Communication

- LPN's maintained consistent communication across all client providers.
- LPN's communicated appointment results to family members/caregivers as appropriate.
- Teaching of medications/diagnoses/treatments with clients at their level of understanding.

Strategies for Success

Medication Reconciliation

- Completed at every medical appointment and in the clients' home.
- Assist client with systems to help them take their medications as ordered.

Strategies for Success

Transportation

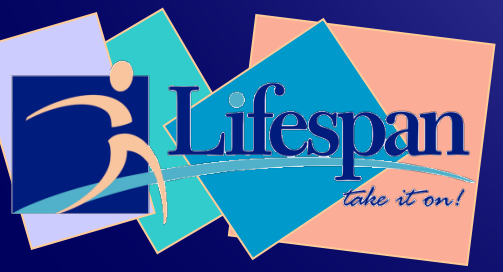
LPN's scheduled transportation for appointments with:

- Medicaid transportation
- STAR
- TRAC
- Give-a Lift

Strategies for Success

Motivational Approaches

- Client advocacy
- Emotional support
- Reminders
- Positive feedback
- Trust
- Education



Lessons Learned

- Patient Activation Measure (PAM-13) was not an effective pre and post measure of ability to self-manage health.
  - Better used as a tool to identify health literacy needs
  - Supports tailored care plans

Testimonials From Physicians

I have had one of my patients under your program. It has turned her medical care around completely for the better. She was reclusive and difficult to engage in her own chronic medical problem and health care maintenance needs. Your LPN worker has been amazing. She connects with her incredibly well, keeps track of and makes sure she gets to her appointments, monitors her medications for her, and is overall maximizing her quality of life and medical care.

~ Brett Robbins, MD, Culver Medical Group, Rochester, NY

Lifespan
take it on!

Testimonials From Physicians

I work as a primary care physician in an underserved, urban area. I have made multiple referrals to Health Care Coordination since the beginning of the program. It was been a wonderful resource for me as a clinician and also for my patients. The unique array of social and clinical services provided by HCC has filled gaps in the generic health care system, improving patients' clinical outcomes and quality of life. I hope that the program can continue to grow and enroll new patients.

~ C. Michael Henderson, MD,

Rochester General Hospital

Lifespan

take it on!

Testimonial from Care Manager

Lifespan's healthcare coordination service is a sigh of relief for care managers, such as myself. In the midst of chaotic and difficult coordination efforts, their expertise in navigating complex situations is readily apparent. They not only coordinate appointments, but heartily advocate for the patient's well being, reaching out to the appropriate persons for referrals. When there's a standstill of any sort, they'll be the first to inquire and help put a plan into action to see the patient's needs are being addressed and met. They are an integral part of the patient's team and genuinely concerned about their well being. I count it a privilege to have them as members of our team.

John Scruton, RN BSN

Accountable Health Partners Care Manager

Grace Family Medicine, Rochester, New York

Testimonials from Participants

"Now that I have you, I don't stress out because I have an appointment the next day. Now my sister has more time to deal with her own problems. I do not worry if I can't remember the doctor's instructions because if I forget I can easily call you." Howard

"I feel at ease knowing I have someone I can call with health care concerns or any other concern for that matter. I now leave my appointments confident that I understood everything discussed. The best is not having to carry all my medications with me to every appointment because you keep an updated list." Domingo

Lifespan
take it on!

Testimonial from Family

To whom it may concern:

I am writing this on behalf of Lifespan's Healthcare Coordination services. My mother is utilizing Lifespan's services and it is one of the main reasons why my mom was able to get out of the nursing home and move into an apartment.

My mom's biggest desire was to move back home and not reside in the nursing. Unfortunately, she requires assistance and someone to translate (Italian) for her when going to doctor's appointment and we are not able to take her to all the doctor's appointments. With Lifespan's assistance, we have a nurse that meets her at her doctor and is able to report back to me all that transpired at the doctor's appointment. Unfortunately, without this service, my mom would not be able to attend all her appointments.

Lifespan
take it on!

References

[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.

[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.

Lifespan
take it on!

Contacts

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GOD'S LOVE WE DELIVER®

BALANCING INCENTIVE PROGRAM
THE MEDICALLY TAILORED FOOD & NUTRITION EXPANSION PROJECT

Alissa Wassung
Director of Policy & Planning

Mission in Action

- Founded in 1985
- Deliveries in all 5 boroughs of New York City, Westchester and Nassau counties and in Hudson County, NJ
- 200+ diagnoses
- 6,200 meals prepared and delivered each week day
- 1.5+ million medically tailored meals delivered to 6,650 ppl. this FY

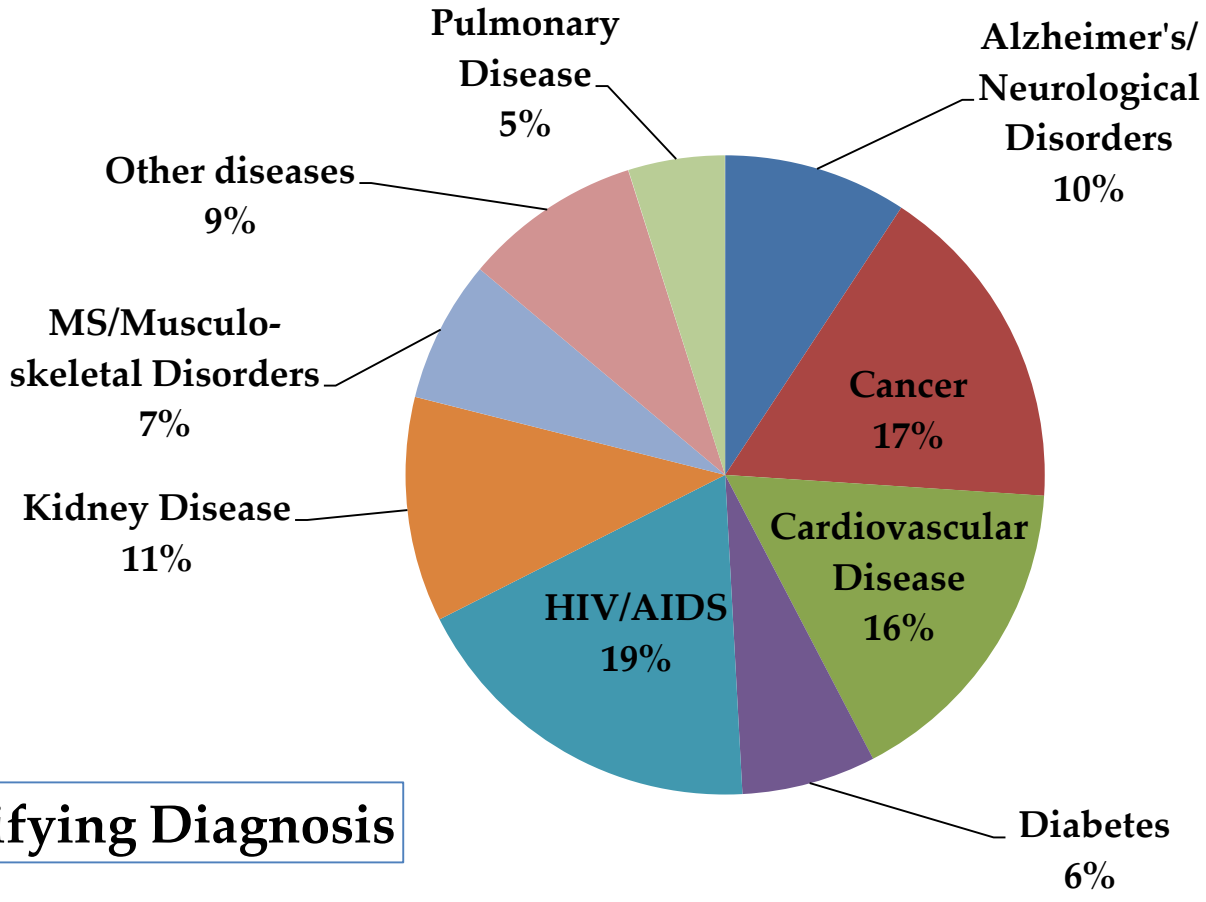
GOD'S LOVE WE DELIVER

Our Clients

90% living with more than one diagnosis

39.2% of clients suffer from Diabetes

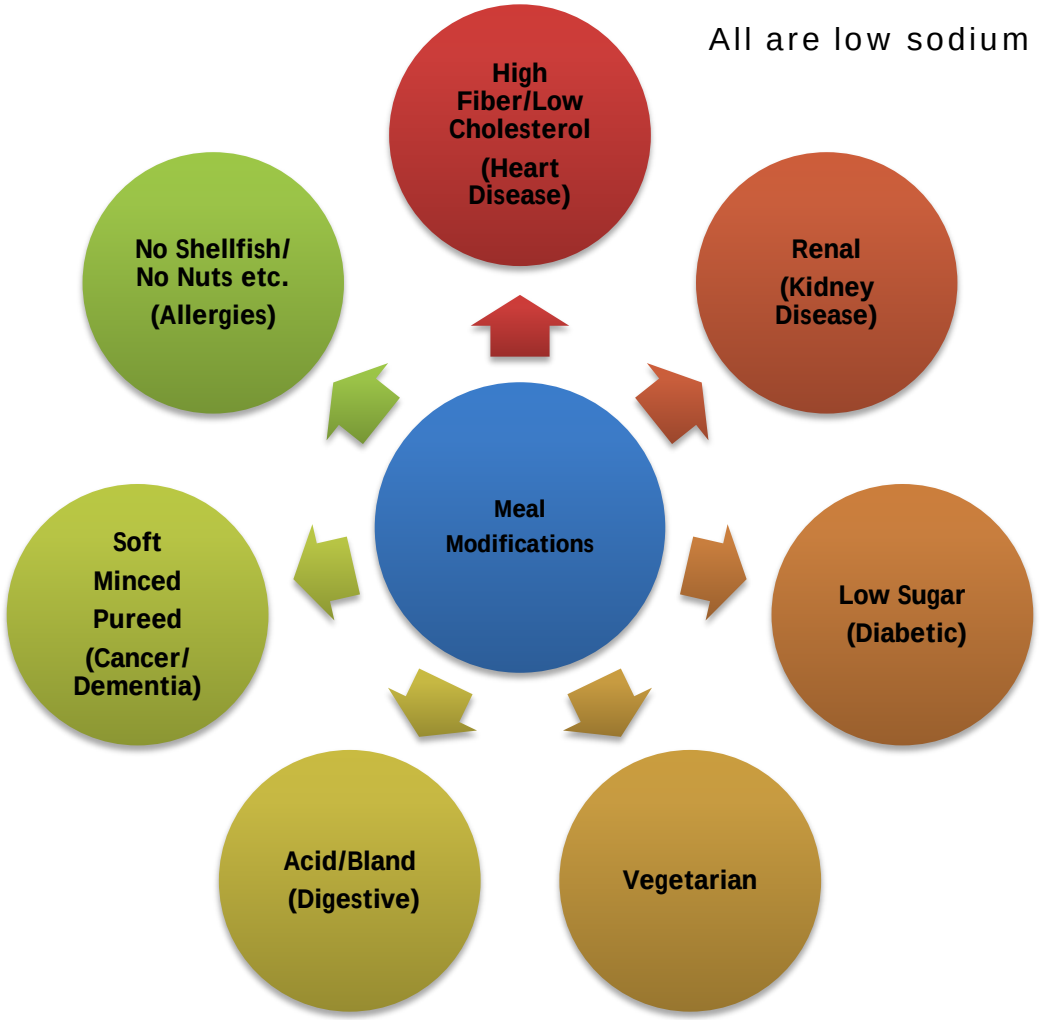
27.8% report Obesity in addition to their primary diagnosis



Clients by Qualifying Diagnosis

Medically Tailored Meals

- Referred by medical personnel
- Tailored by Registered Dietitians (RD/RDNs)
- Unique meal plans
- RDNs provide Medical Nutrition Therapy and education
- Follow client through trajectory of illness
- NO preservatives, additives, fillers



Food is Medicine

While adequate food and nutrition is important for all people, proper nutrition is **critical** for the management of chronic illness.

Food is Medicine

FOOD IS MEDICINE

Lowering Healthcare Costs with Medically Tailored Nutrition

Did you know?

1 in 3 hospitalized patients is malnourished on admission*

Nourished	Malnourished

# of Hospitalizations **

Hospital Length of Stay ****

93% to home

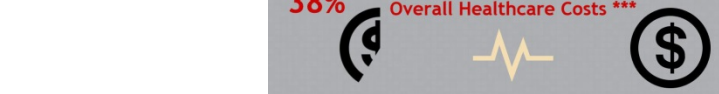
Post-Hospital Discharge ***

28% to home

Likelihood of Readmission in 15 Days **

38%

Overall Healthcare Costs ***



Nutrition is an Inexpensive Intervention

Feed someone for 1/2 a year
for the same cost as 1 day in the hospital

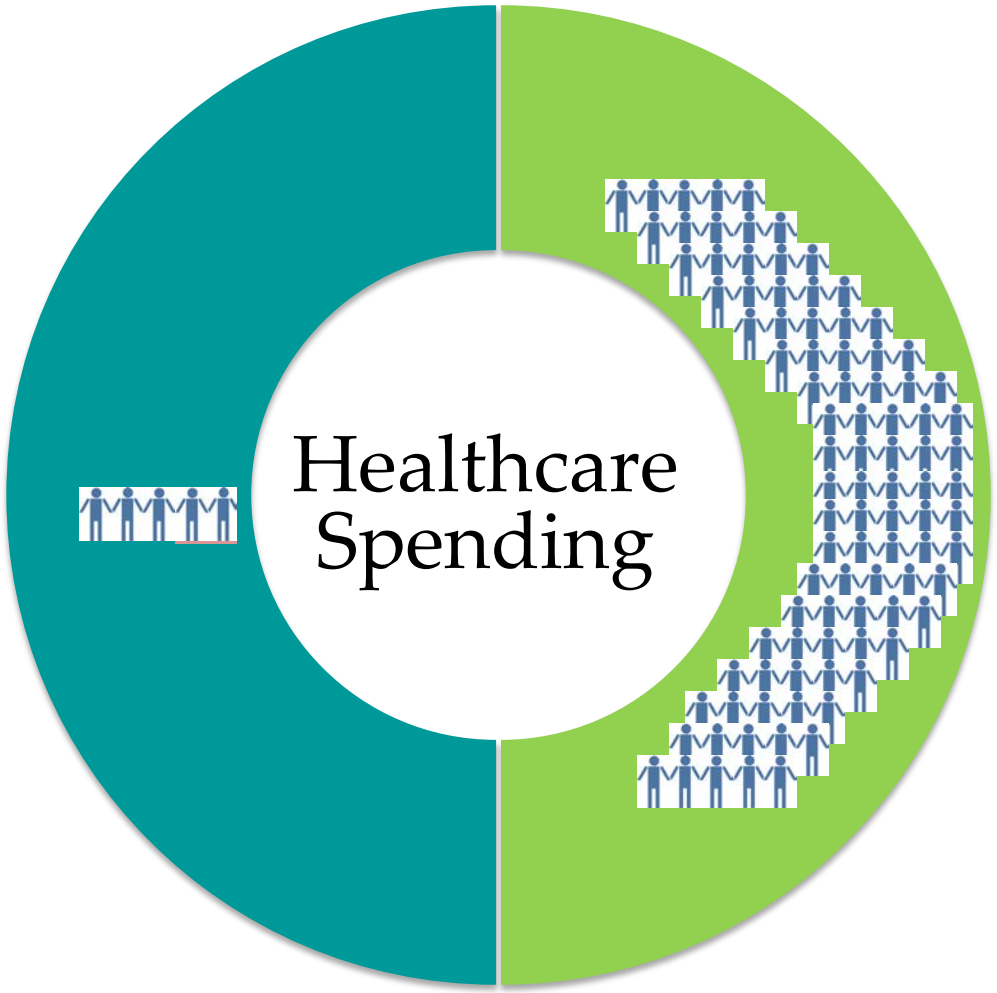
#foodismedicine

*Jensen GL, et al., Recognizing Malnutrition in Adults: Definitions and Characteristics, Screening, Assessment, and Team Approach. J. Parenteral and Enteral Nutrition (2010)
**Hai Lin Lim, Kate Chung Seaghan Ong, Yiang Huak Chan, Wai Chong Liau,Marie Ferguson, Lynne Daniels. Malnutrition and its impact on cost of hospitalization, length of stay, readmission and 3-year mortality. Clinical Nutrition 31 (2012) 345-350.
***Garvey et al., "Expanding Health Care Costs Among MANNA Clients and a Comparison Group," Journal of Primary Care & Community Health, 4(4) 311–317.
****Corkins MR et al., Malnutrition Diagnosis in Hospitalized Patients: United States 2010. J. Parenteral and Enteral Nutrition (2015)

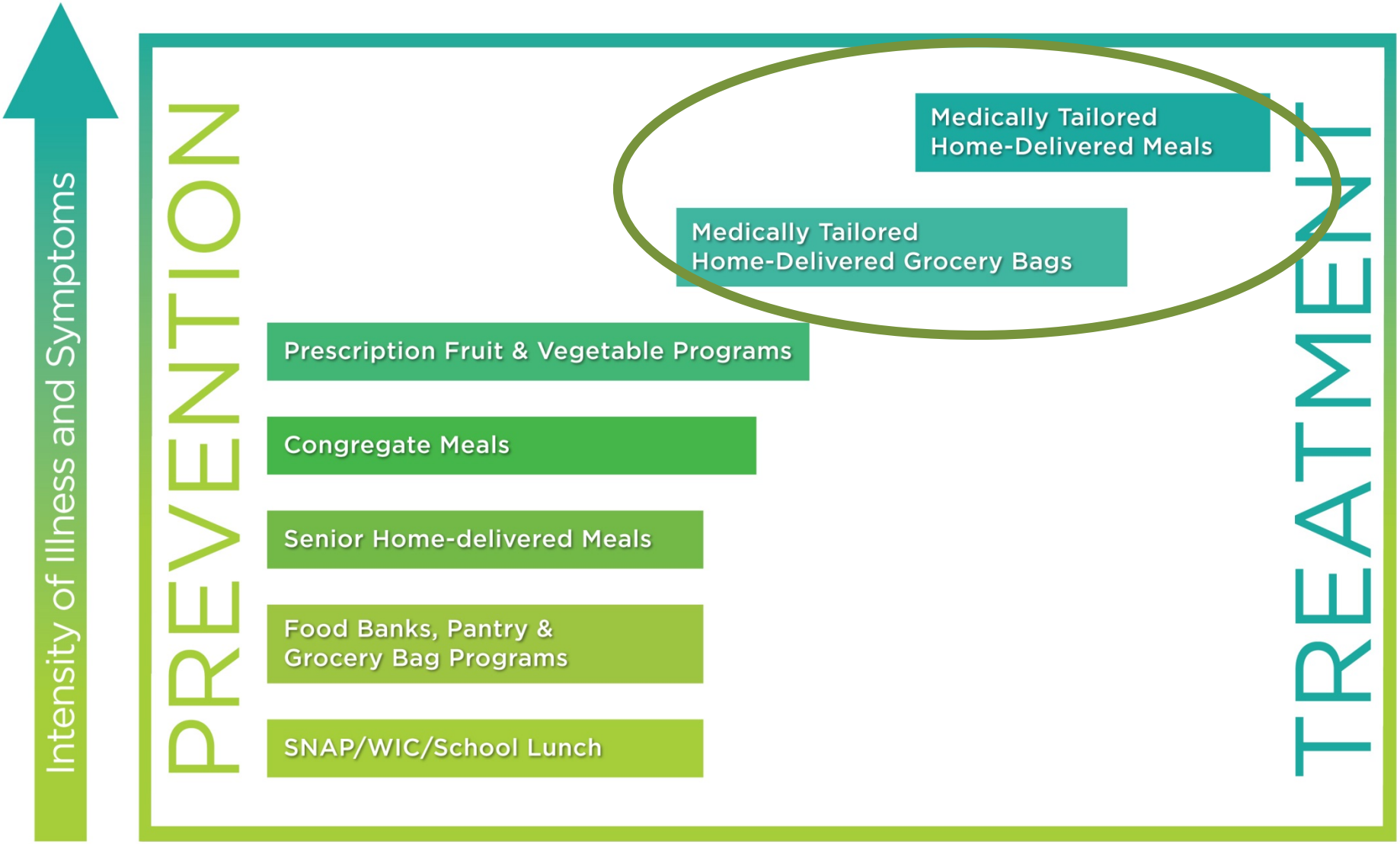
Nutrition is an Inexpensive Intervention

Feed someone for 1/2 a year
for the same cost as 1 day in the hospital

High Risk, High Need, High Cost



FNS CONTINUUM OF CARE



Coverage of Medically Tailored Meals in NYS

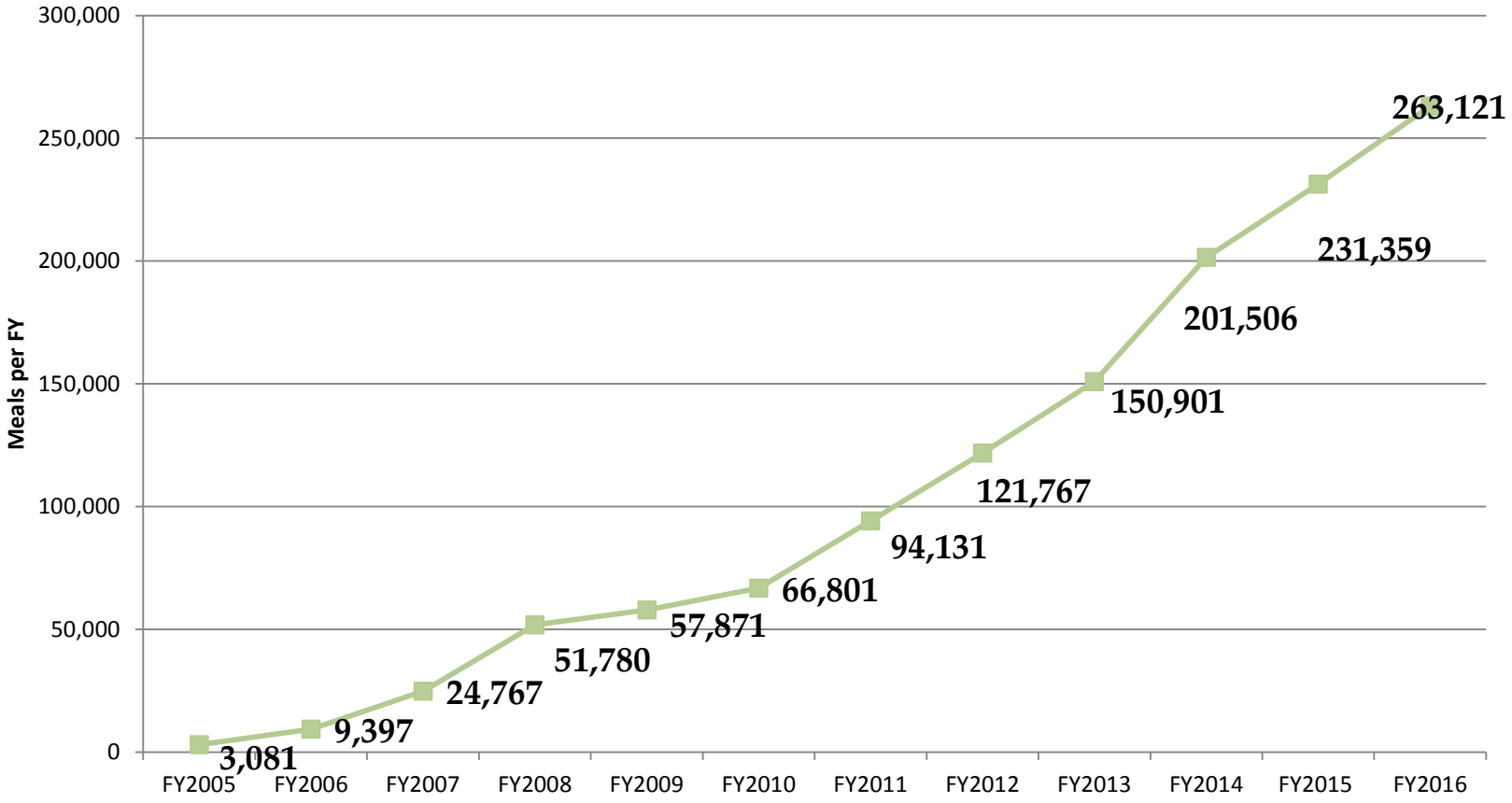
Fully Covered:

- Medicaid Managed Long Term Care (MLTC)
- Medicaid/Medicare – Fully Integrated Duals Advantage Plans (FIDA)

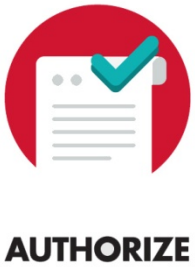
Can Be Billed to the Medical Line:

- Mainstream Medicaid Managed Care (MMC)

MLTC
Community Partners Growth



Balancing Incentives: The Issue



- No clear guidance on who is at risk for malnutrition/hospitalization in MLTC plans
- Lack of knowledge in MLTC plans about the benefits of FNS and services we provide
- Low numbers relative to need in NYC and no ability to serve Nassau and Westchester

The Response: Overview of the Project

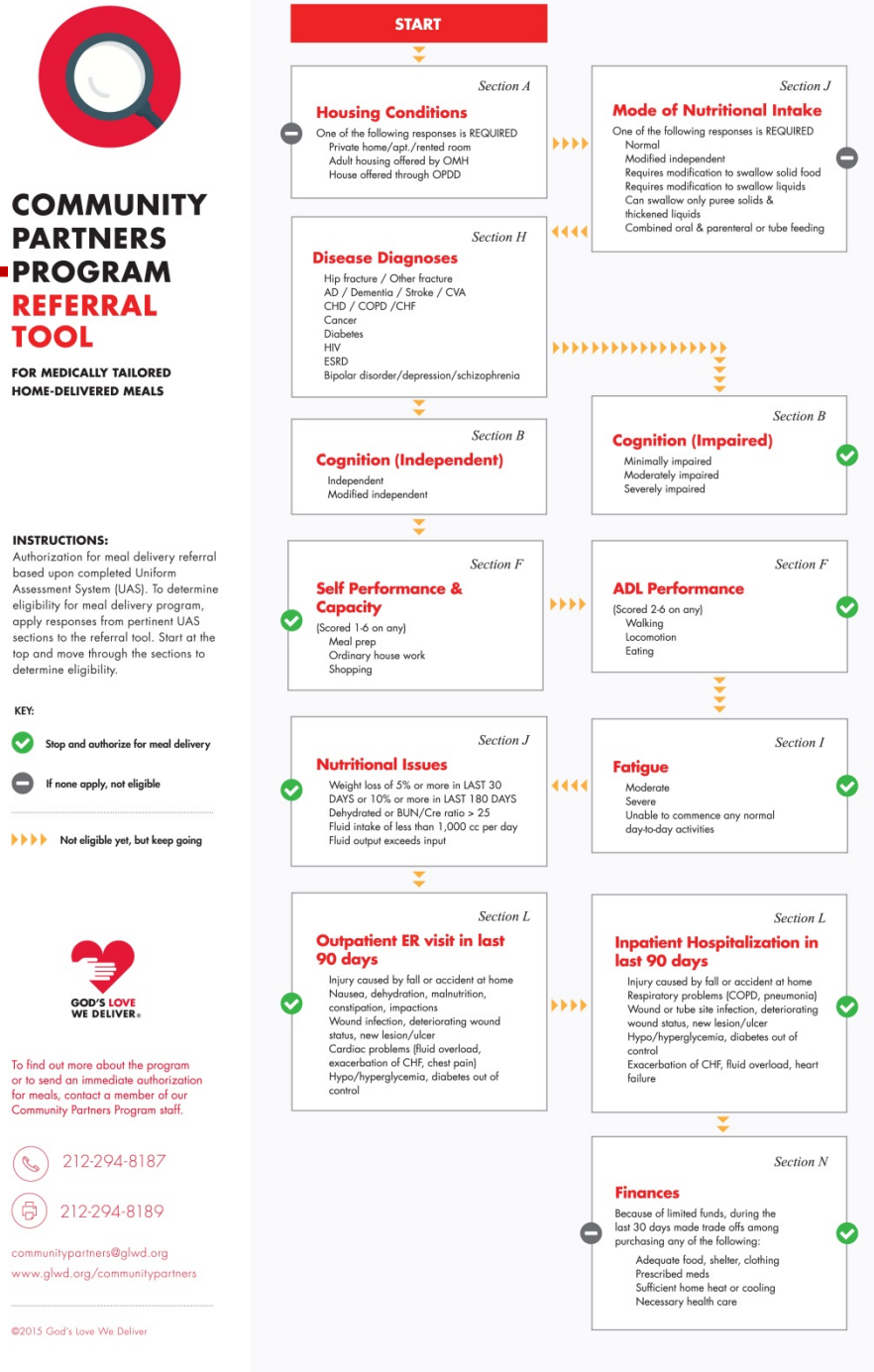
IDENTIFY

AUTHORIZE

NOURISH

Identify:
The FNS Referral Tool

- Gives a definitive answer about nutrition risk and referral necessity
- Does not create work: Uses the Uniform Assessment System required for Medicaid beneficiaries
- Helps guide case managers, care coordinators and transition planners



COMMUNITY PARTNERS PROGRAM REFERRAL TOOL

FOR MEDICALLY TAILORED HOME-DELIVERED MEALS

INSTRUCTIONS:
Authorization for meal delivery referral based upon completed Uniform Assessment System (UAS). To determine eligibility for meal delivery program, apply responses from pertinent UAS sections to the referral tool. Start at the top and move through the sections to determine eligibility.

KEY:

Stop and authorize for meal delivery

If none apply, not eligible

Not eligible yet, but keep going

GOD'S LOVE WE DELIVER

To find out more about the program or to send an immediate authorization for meals, contact a member of our Community Partners Program staff.

212-294-8187

212-294-8189

communitypartners@glwd.org

www.glwd.org/communitypartners

START

Section A
Housing Conditions
One of the following responses is REQUIRED
Private home/apt./rented room
Adult housing offered by OMH
House offered through OPDD

Section J
Mode of Nutritional Intake
One of the following responses is REQUIRED
Normal
Modified independent
Requires modification to swallow solid food
Requires modification to swallow liquids
Can swallow only puree solids & thickened liquids
Combined oral & parenteral or tube feeding

Section H
Disease Diagnoses
Hip fracture / Other fracture
AD / Dementia / Stroke / CVA
CHD / COPD /CHF
Cancer
Diabetes
HIV
ESRD
Bipolar disorder/depression/schizophrenia

Section B
Cognition (Independent)
Independent
Modified independent

Section B
Cognition (Impaired)
Minimally impaired
Moderately impaired
Severely impaired

Section F
Self Performance & Capacity
(Scored 1-6 on any)
Meal prep
Ordinary house work
Shopping

Section F
ADL Performance
(Scored 2-6 on any)
Walking
Locomotion
Eating

Section J
Nutritional Issues
Weight loss of 5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS
Dehydrated or BUN/Cre ratio > 25
Fluid intake of less than 1,000 cc per day
Fluid output exceeds input

Section I
Fatigue
Moderate
Severe
Unable to commence any normal day-to-day activities

Section L
Outpatient ER visit in last 90 days
Injury caused by fall or accident at home
Nausea, dehydration, malnutrition, constipation, impactions
Wound infection, deteriorating wound status, new lesion/ulcer
Cardiac problems (fluid overload, exacerbation of CHF, chest pain)
Hypo/hyperglycemia, diabetes out of control

Section L
Inpatient Hospitalization in last 90 days
Injury caused by fall or accident at home
Respiratory problems (COPD, pneumonia)
Wound or tube site infection, deteriorating wound status, new lesion/ulcer
Hypo/hyperglycemia, diabetes out of control
Exacerbation of CHF, fluid overload, heart failure

Section N
Finances
Because of limited funds, during the last 30 days made trade offs among purchasing any of the following:
Adequate food, shelter, clothing
Prescribed meds
Sufficient home heat or cooling
Necessary health care

Authorize

Spreading the word that we provide:

- Flexibility with delivery days and requested service adjustments
- Streamlined authorization process
- Responsive customer service care for all clients

We:

- Are fully HIPAA compliant
- Utilize HCVA billing forms (to bill per meal per service day) that are sent electronically to each provider

Authorize

Through BIP we:

- Hired an Outreach Coordinator
- Designed an Outreach Brochure
- Updated our Webpage
- Created an MLTC Training Module

MLTC Presentations

Community Presentations

Mount Vernon Neighborhood Health Center Network

FSW
Family Services of Westchester

Living Young Adult Daycare Center

CALLEN LORDE
COMMUNITY HEALTH CENTER

South Nassau
COMMUNITIES HOSPITAL
where quality matters

ST. JOHN'S
RIVERSIDE
HOSPITAL
Affiliated with The Mount Sinai Hospital

La Familia
ADULT DAY CENTER INC.

Monter Cancer Center at Northwell Health

Nourish

Able to add infrastructure to allow us to expand our service area to Nassau and Westchester and our deliveries in NYC:

- Community Partners Specialist
- Meal Program Packaging Supervisor
- Program Support staff funding
- A Driver
- A Van

Success!
Original Goals vs. Achievement

Goal for Balancing Incentive Program	Achievement for Balancing Incentive Program
680 Clients enrolled in NYC through Community Partners	**902** Clients enrolled through Community Partners
25 Clients enrolled in Nassau and Westchester through Community Partners	**34** Clients enrolled in Nassau and Westchester through Community Partners
100 Outreach Presentations	**111** Outreach Presentations

Healthcare Cost Savings

The NEW ENGLAND JOURNAL of MEDICINE

JPEN

AT THE INTERSECTION OF HEALTH, HEALTH CARE, AND POLICY

HealthAffairs

Healthcare Cost Savings – Hospitalizations Avoided

	Members Hospitalized (N=936)	Average Length of Stay (days) each year	Cost per Day	Total Cost per year
No MTFNS	374	5.46	$1,901.00	$3,881,918
MTFNS	187	3.44	$1,331.00	$856,206
Savings				$3,025,712

Healthcare Cost Savings – Nursing Home Avoidance

	Members Discharged to Nursing Home	Avg. Nursing Home Cost per Year	Total Cost
Nursing Home Discharge Costs Non-MTFNS (72% of 374)	269	$10,431	$2,805,939
Nursing Home Discharge Costs MTFNS (7% of187)	13	$10,431	$135,603
Savings			$2,670,336

Total Estimated Savings for BIP Project: $5.7 million

Lessons Learned

- There is more need for our services
- Because of MLTC plan staff turnover – constant outreach needed
- Plan staff work remotely – use of webinars and site visits to God's Love
- More automation of risk assessment and referral needed
- Community intervention works

Replication

- Objectives of the project continue
- God's Love now fully supports the staff hired through BIP
- Project has helped us leverage our core competency to participate in new models:
  - DSRIP, VBP, ACOs etc.
- Research will lend even more credence to cost effectiveness proposition

DSRIP

Citations

- Coats KG et al.. *J Am Diet Assoc* 1993; 93: 27-33. Giner M et al. *Nutrition* 1996; 12: 23-29. Thomas DR et al. *Am J Clin Nutr* 2002; 75: 308-313.
- Mark R. Corkins et al., *Malnutrition Diagnoses in Hospitalized Patients: United States, 2010*, 20 J. OF PARENTERAL AND ENTERAL NUTRITION 1, 3, 7 (2013).
- Su Lin Lim et al., *Malnutrition and Its Impact on Cost of Hospitalization, Length of Stay, Readmission, and 3-year Mortality*, 31 CLINICAL NUTRITION 345, 348-350 (2012).
- Jill Gurvey et al., *Examining Health Care Costs Among MANNA Clients and a Comparison Group*, 4 J. OF PRIMARY CARE & CMTY. HEALTH 311, 313-15 (2013).
- Bachrach, D. Pfister, H. Wallis, K., Lipson, M. Addressing Patient's Social Needs: The Emerging Business Case for Provider Investment. May 2014. Commonwealth Fund, Skoll Foundation, and Pershing Square Foundation.
- Thomas KS, Mor V, Providing *More Home-Delivered Meals is One Way to Keep Older Adults With Low Care Needs Out of Nursing Homes*, Health Aff., vol. 32, no. 10 (2013).
- Health Care Costs: A Primer. Kaiser Family Foundation. http://kff.org/health-costs/issue-brief/health-care-costs-a-primer/. (last visited Jan. 22, 2016).

Contact

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GOD'S LOVE WE DELIVER®




CHILDREN'S HOME
OF JEFFERSON COUNTY

A Legacy of Compassion Since 1859

THERAPEUTIC CRISIS RESPITE PROGRAM (TCRP)




Program Overview

- **Unique, short-term respite program**
- **Designed for youth aged 10 to 17**
- **Serves Jefferson, Lewis, and St. Lawrence Counties**
- **Services include:**
  - *Psychiatric evaluations*
  - *Medication management*
  - *Crisis intervention*
  - *Peer advocacy*
  - *Individual, family, and group therapy*
  - *Psychological testing*
  - *Supported family visitation*
  - *Intensive Aftercare*

Children's Home
of Jefferson County
A Legacy of Compassion Since 1859

Program Objectives

Through a family-centered, trauma-informed approach, TCRP:

- Stabilizes youth and families in crisis in the least restrictive manner
- Empowers youth and families to identify their strengths and use them to develop coping strategies
- Decreases recidivism of emergency room and preventable hospital utilization
- Decreases symptoms of behaviors, family stress, and functional impairment from the time of admission through discharge

Respite Phase

- CANS Assessment
- Referral to Mental Health Services
- School Partnership and Advocacy
- Family Support and Supported Visitation
- Psychiatric Assessment and Neurofeedback
- Psychological Evaluation
- Connection to Community Services

Aftercare Phase

90 Day Connection to Services
Phase Out - "Warm Hands Off" Method
Continuous Crisis Intervention

Ongoing Services

- Clinical Group
- Family Support Group
- Parenting Education
- Life Skills
- Crisis Intervention
- Therapeutic Recreation
- Academic Support
- Supported Visitation

TCRP staff and youth participating in the Project Adventure program.

New Improvements

- TCRP allows for integration of multi-systems
- Integrates OMH, DOH, and OCFS programs
- Breaks down barriers between programs
- Prevents disruption from other programs/services

In the words of a youth…

"TCRP helped me with my addiction to tobacco products. It helped me realize there is more to life than being a mess up. TCRP helped with my depression by doing recreation and activities. TCRP helped me with my social skills because I made multiple friends there and it helped my life at home with my parents. My parents and I get along much better now."

Benefits to Medicaid

Residential Treatment Facility Medicaid Dollars Spent Statewide (SFY – 2015):

Unduplicated Youth	Total Cost	Cost Per Youth
913	$94,531,278.00	$103,539.19

State Psychiatric Inpatient Medicaid Dollars Spent Statewide (SFY – 2015):

Unduplicated Youth	Total Cost	Cost Per Youth
2644	$308,126,579.00	$116,538.04

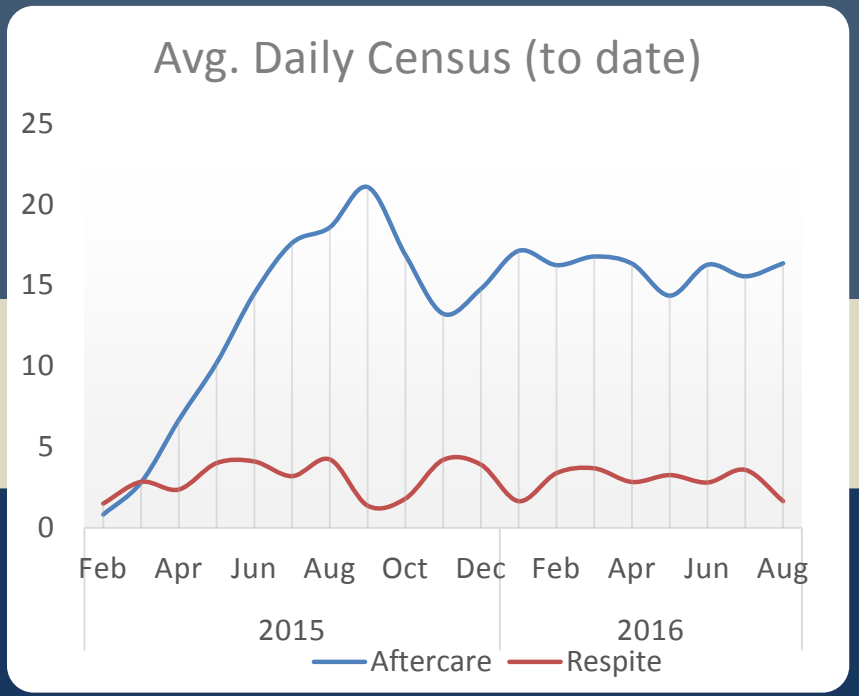
Two Year TCRP Cost Savings: (August 2014 – Present)

Unduplicated Youth	Total TCRP Expenditures (DOH)	Cost Per Youth
97	$2,380,219	$24,538.34

Evidence Based Approach

Program Start Date: February 2015
Capacity: Six youth placed in Respite Care;
Up to 25 in Aftercare

- Respite Average: 3.1 youth/month
- Aftercare Average: 13.5 youth/month
- Total Program Participation Average: 16.6/month
- Total Referrals: 213
- Total Admissions: 108



Children's Home of Jefferson County
A Legacy of Compassion Since 1859

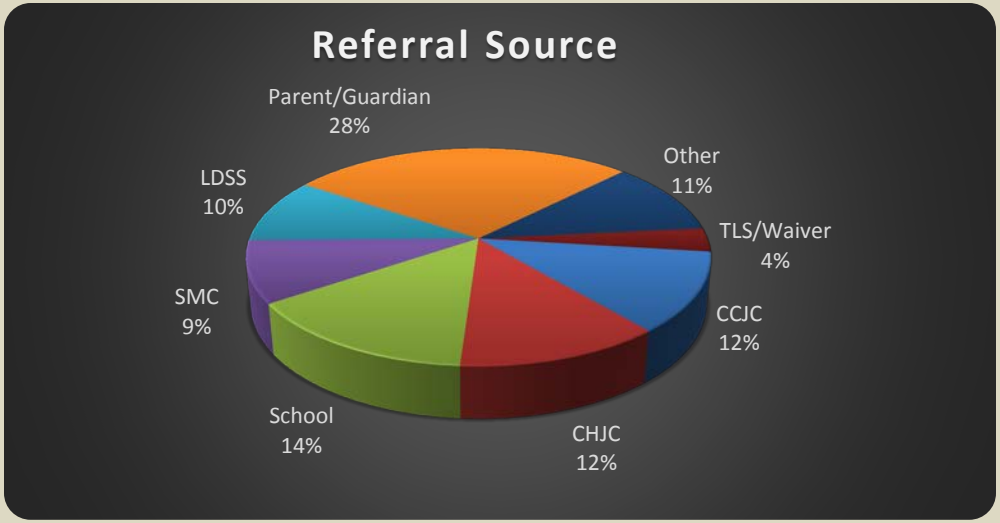
Evidence Based Approach

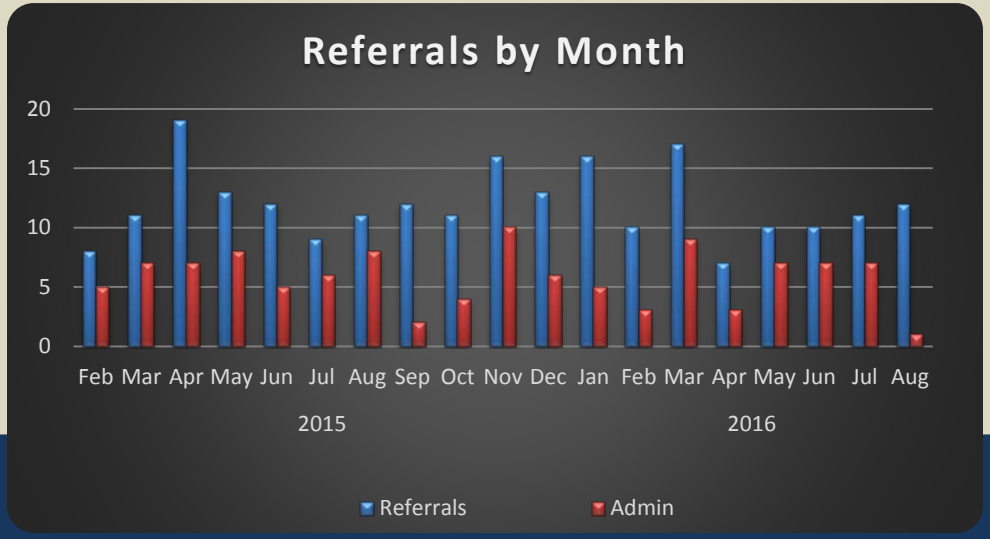
Post Respite (within 30 days of respite discharge): 10 youth seen at Emergency Department for mental health crisis

Post Final Discharge (within six months of discharge from Aftercare): No youth reported to have been taken to the Emergency Department or State Psychiatric Hospital for inpatient treatment.

Evidence Based Approach

Referral Source	Youth
CCJC	27
CHJC	28
School	33
SMC	21
LDSS	22
Parent/Guardian	64
Other	25
TLS/Waiver	8
Total	228





Children's Home of Jefferson County
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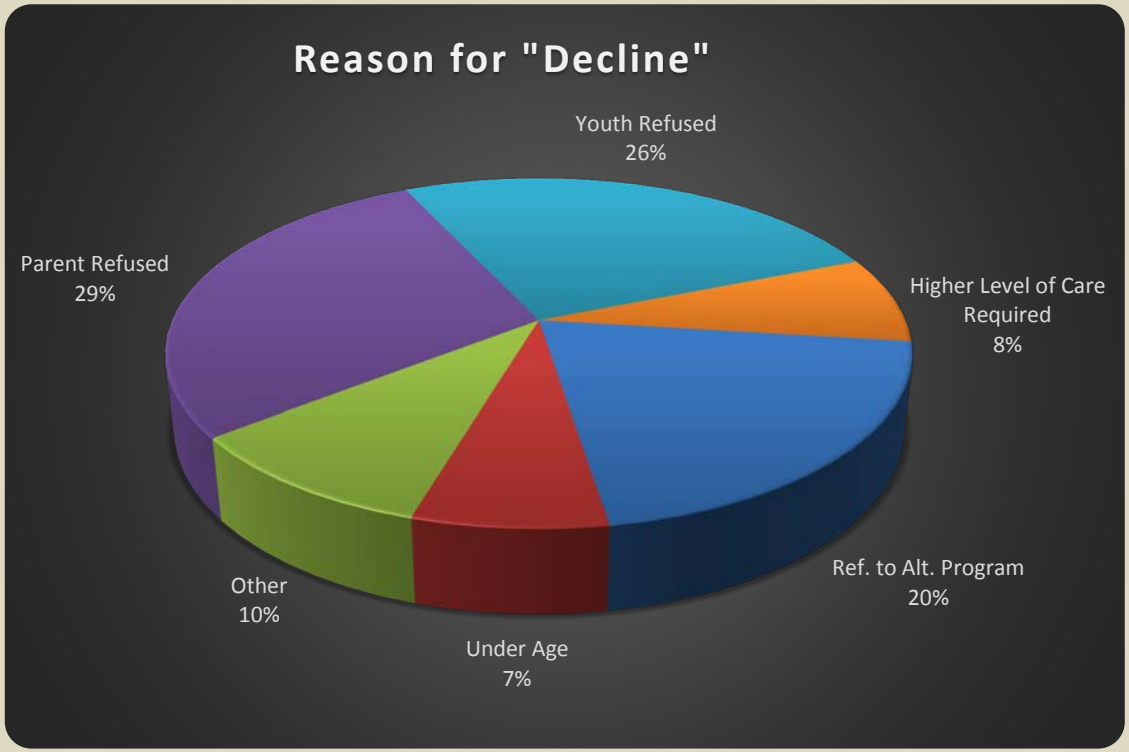
Evidence Based Approach

Referral Status	Youth
Pending	6
Accept	110
Decline	112
Total	228

Reason for Decline	Youth
Ref. to Alt. Program	23
Under Age	8
Other	11
Parent Refused	32
Youth Refused	29
Higher Level of Care Required	9
TOTAL	112



Evidence Based Approach

Goal 1: Assist families in identifying their strengths and needs through administration of the Child and Adolescent Needs and Strengths (CANS) assessment tool:

Performance Target	Compliance Rate	Corrective Action, If Needed
Within 30 days of their hire date, 100% of staff will have completed or participated in training necessary for the implementation and utilization of agreed upon clinical assessments. (Columbia Suicide Severity Rating Scale –C-SSRS)	100% - Target Met	N/A
Within 7 days of admission, 100% of youth will receive a clinical assessment.	98.3 % - Below Target	One youth was removed on day three by family prior to completion of Clinical Assessment in January.
Within 14 days of admission, 80% of families will complete the CANS-NY	93% - Target Met	N/A
100% of those families will be able to identify their strengths and needs as identified in the CANS-MH Assessment.	100% - Target Met	N/A
Of the families who completed the CANS-NY, 25% will complete a follow-up CANS-NY assessment at least one time post final discharge (6 or 12 months)	55% - Target Met	N/A

Evidence Based Approach

Goal 2: Decrease recidivism of emergency room and preventable hospital utilization:

Performance Target	Compliance Rate
Within 30 days, client specific historical data will be obtained for 70% of youth.	91% - Target Met
Of youth identified as "high risk" of having future crises, 100% of youth will be offered at least one intensive intervention within 7 days.	100% - Target Met
At least 75% will participate in at least one intensive intervention within 30 days of admission	100% – Target Met
Of youth identified as "high risk" of having future crises and are appropriate for community based services, 100% will be offered community based after care services within 14 days of admission.	100% - Target Met
50% of those youth will participate in community based after care services.	85% - Target Met
For at least 30 days post discharge, of the youth who received TCRP services, 75% will not have an encounter with the local Emergency Room Department as a result of a mental health crisis	13% - Target Met, therefore, post discharge 30 days, 87% of youth have not had a mental health emergency encounter with the ED.
For at least 6 months post final discharge, of the youth who received TCRP services, 50% of the youth who remain in contact with TCRP staff will not have an encounter with the local Emergency Room Department as a result of a mental health crisis.	9% - Target Met, therefore, post 6 months, 91% of youth have not had an encounter with the local ED.

Evidence Based Approach

Goal 3: Decrease symptoms and behaviors, family stress, and functional impairment from the time of admission through discharge as identified using pre- and post- survey instruments:

Performance Target	Compliance Rate
100% of families will be offered family engagement services, including but not limited to, psychoeducational counseling, parenting group, and family therapy.	100% - Target Met
Within 14 days of admission, 60% or families will participate in at least one family engagement service.	92% - Target Met
Prior to their discharge from CHJC services, 50% of youth/families receiving services will demonstrate improved behaviors, family stressors, and/or functional improvements	84% - Target Met

Lessons Learned

- Family engagement is key to success
- Connection to Article 31 Mental Health Clinic
- Integration with Residential amenities
- Incorporation of groups
- Initial Assessments
- Be flexible, but never lose sight of the program's vision

Replication

TCRP uses a unique service provision method ensuring all aspects of a youth's mental health crisis are addressed:

- Intensive family services
- 24 hour referral and admission
- 24 hour crisis response
- Supported family visitation
- In-home parenting classes
- In-home clinical services
- 90 day Aftercare program and community based service referrals
- Ongoing clinical services
- Ongoing Life Skills
- Parent Support Group/Network
- In-school support

A Simple Idea

"We brought our son to you, and you cared for him as we would and you may very well have saved his future…I could see my son heading towards a darker place. We were able to participate in the two week respite program. By allowing our family time to decompress, we were able to reset.
What a simple idea!"

Questions?

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Children's Home
of Jefferson County
A Legacy of Compassion Since 1859

archcare
Senior Life

A Program of All-inclusive Care for the Elderly (PACE) for Seniors with Intellectual and Developmental Disabilities*

September 22, 2016

*Supported by a NYS Balancing Incentive Program Grant

Mission

The Mission of ArchCare, the Continuing Care Community of the Archdiocese of New York is to foster and provide faith based holistic care to frail and vulnerable people unable to fully care for themselves. Through shared commitments, ArchCare seeks to improve the quality of the lives of those individuals and their families.

Overview

- Building on our existing **Program of All-inclusive Care for the Elderly (PACE)** in Manhattan, the Bronx and Staten Island, which provides comprehensive, integrated, managed health care and supportive services to adults, ages 55 year and older, who require long term care level of services, the BIP grant has enabled ArchCare to **integrate 50** PACE-eligible adults with intellectual and developmental disabilities (IDD) into our program through an appropriately adapted and enhanced PACE model of care.

- Our **Specialty PACE** aims to 1) support participants as they age in place in their homes and communities, 2) to reduce emergency room visits and hospital admissions, and 3) to forestall admissions into institutional settings.

- Participants receive primary and specialty medical care at our PACE clinics, transportation to our PACE day health centers daily for meals, socialization, activities and more, as well as home care services. PACE is also serving **7** aging parents/caregivers of adults with IDD in our program.

Highlight: Special Needs Alert

- The **purpose** of the Special Needs Alert (SNA) is to communicate pertinent medical information to networking providers to facilitate the highest quality of care for our participants with special needs.
- SNA information includes patient allergies, preferred modes of communication, sensory sensitivities, signs of pain, cognitive status, and behavioral management techniques.

Our SNA was inspired by and adapted from Staten Island University Hospital's "My Special Needs" form.

Policy & Procedure

- **Policy**: The Specialty PACE participant will be issued a SNA prior to a clinical visit.

- **Procedure**: The Home Care Registered Nurse assigned to the participant is responsible for creating the SNA after the participant's initial Inter-Disciplinary Team (IDT) meeting and ensuring updated information prior to a clinic visit.

Key Components

If you are a **healthcare professional** that will be helping me,

PLEASE READ THIS

Before you try to help me with my care or treatment

I am very sensitive to: (e.g. touch, specific lights, sounds, odors, textures/fabric)

_____
_____
_____
_____

You can talk to this person about my health:_____

Relationship:_____

Phone Number:_____

Date Completed:_____/_____/_____

If I am in pain I show it by:

_____
_____
_____
_____
_____

I communicate using: e.g. speech, preferred language, sign language, communications devices or aids, non-verbal sounds.

_____
_____
_____

Things that can help me pass the time and get more comfortable with you: (e.g. play cards, tell me a story)

_____
_____
_____

If I get upset, the best way you can help is by:

_____
_____
_____

If I get upset, the best way you can help is by:

_____
_____
_____

Other special needs are:

_____
_____
_____

SNA Pilot

Staten Island PACE
7 participants
I/DD Participants transferred to Respite Care

Goal: Improved Patient Care and Safety

- Ensure participants with IDD are seen by the health care provider
- Create an environment conducive for assessment and/or evaluation
- Prevent medical errors
- Prevent death

Findings

- The open ended questions in the SNA assessment can retrieve a copious amount of useful information. For example, “I am very sensitive to…” and “How I cope with medical procedures…” which can further guide care.
- Use of the SNA has broadened the scope of assessment for our Social Workers.
- The SNA can be used with the general PACE population too.

Next Steps

- Identify community providers that will benefit from the SNA
- Introduce the SNA to the community providers and strategizing implementation
- Orient community providers' employees to the SNA
- Continuously monitor use of the SNA

St. Mary's Telehealth Program for the Medically Complex Population

Elvira F. Roveto, FNP B-C
Home Care Administrator, DPS

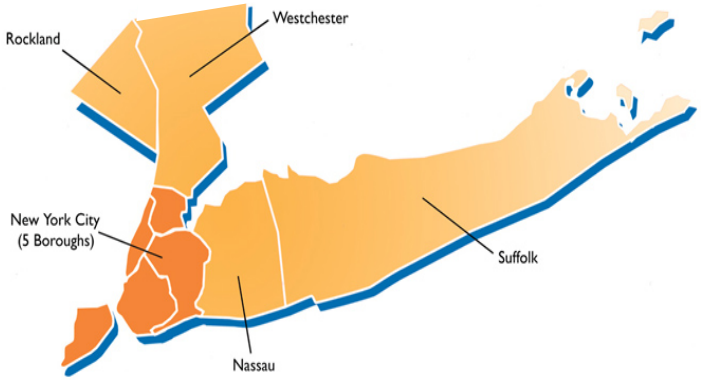
Donna Mapp-Reid, RN, CCM
Telehealth Supervisor

stmary's
Healthcare System for Children

Our Network of Care

St. Mary's cares for 2,000 children every day. We provide care wherever it's needed – at home, in the community, and at St. Mary's Hospital for Children.

- St. Mary's Hospital for Children
- St. Mary's Home Care, a special needs Certified Home Health Agency (CHHA)
- St. Mary's Community Care Professionals, a Licensed Home Care Services Agency
- St. Mary's Pediatric Day Healthcare Program
- St. Mary's Early Education Center
- St. Mary's Kids at Roslyn, a community-based therapy center



Background

- In July 2014, St. Mary's was awarded $928,668 from the NYS Balancing Incentive Program Innovation Fund (BIP)
- Grant was designed for St. Mary's to study the value of enhancing its home care services through the use of an Interactive Voice Response System (IVR)
- Original BIP contract period August 1, 2014 to September 30, 2015. DOH extension through 2017

St. Mary's Telehealth Program Goals

1. Decrease the risk of ER visits and re-hospitalizations

2. Increase medication adherence

3. Increase patient/family satisfaction

Telehealth Priorities

The program targets children with medical complexity, with diagnoses including but not limited to:

- Seizure Disorder
- Asthma
- Respiratory (non-asthma)
- Dehydration

How IVR works

- Patients / Caregivers sign consent to participate in the program
- Patients / Caregivers agree to accept calls and they specify day/time/frequency that is most convenient for them
- Automated calls are scheduled and monitored
- Alerts are triggered based upon responses
- Action is taken based on the type of alert

Alerts Trigger Action

Each patient that triggers an alert receives a call from a Registered Nurse with extensive pediatric experience to determine appropriate interventions.

- Common interventions:
  - Educating about the disease process, complications, and when to contact healthcare provider or seek emergency treatment
  - Providing education regarding medications and treatments
  - Identifying the need for an unscheduled home visit from patient's primary care nurse
  - Contacting the physician, pharmacy or vendor

General Interactive Call Demonstration

Interactive Voice Response (IVR) allows patients to have St. Mary's "eyes & ears" in the home in addition to regular scheduled in-person visits.

Sample Template (Asthma)

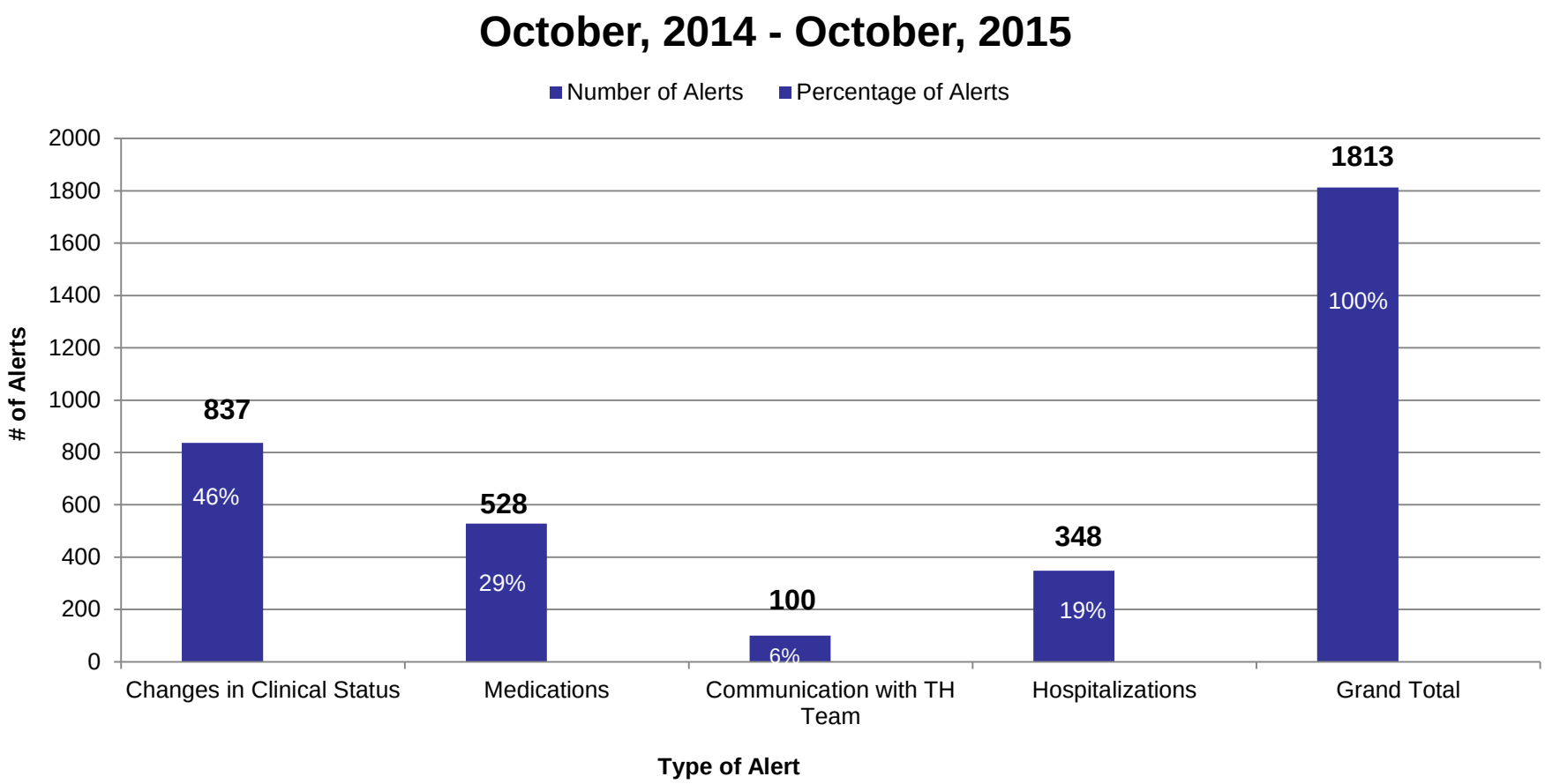
Asthma Program: Is the patient having any of the following:

- Coughing at night?
- Fast breathing?
- Noisy breathing or wheezing?
- Less physical activity?
- Using the rescue inhaler more than usual?
- Signs of a cold or flu?

If yes for any above, alert triggered:

- Yes: Alert Level: High
  - » We will let the nurse know
- No: Alert Level: None

Alerts Generated by Type



Reduction in Hospitalizations

Patient Type	Patients	Hospitalizations	Hospitalization Rate
Average Active Agency Census (1/1/13-12/31/13) Pre-Telehealth-Actual	844	297	35%
Expected Hospitalizations at Pre-Telehealth Implementation	567	198	35%
Actual Hospitalizations for IVR Patients Post Telehealth (10/1/14-9/30/15)	567	121	21%
Hospitalization Rate decreased			***14%***

Costs and ROI

Post Telehealth Reduction in Hospitalizations	77 (39%)
Average Cost per Hospitalization ($3,928 per hospital day x 7.2 days average stay)	$28,282
Total Estimated Savings ($28,282 x 77)	$2,177,714
Total Program Cost ($1,640 per patient for 12 months or $137 per month	$928,668
Net Savings	$1,249,046
Net Savings per patient (567 patients)	$2,200

Reduction in Readmissions

Pre/Post comparison of cohort enrolled on both Telehealth and non-Telehealth CHHA for equal time periods

Timeframe	# of Patients	30-Day Readmission Rate	90-Day Readmission Rate
Before Telehealth 1st 2 Qtrs, 2014	266	19.0%	35.7%
After Telehealth 1st 2 Qtrs, 2015	266	11.4%	22.7%

Medication Adherence: Outcomes

- Medication questions are incorporated in all IVR calls.
- First Year Alerts: 1813
  - 528 or 29% were medication related
  - More than 90% of these were for new or changed medications
  - Each followed up with a phone call to the home
  - 528 instances of communication with the home

Achievements

- Over 500 patients enrolled
- Decreased avoidable hospitalizations, readmissions and medication issues
- Increased patient and staff satisfaction
- Aligns with NYS DSRIP Goals

Testimonials

"The Telehealth program has helped so much, I am able to explain problems to the Nurse and the interventions on the phone help and prevent me from going to the ER. Having the Nurse come out to visit after the phone call is also very helpful. I love the fact that someone always calls back and I am not alone."

"The program helps me, once I took him to Urgicenter but he was still not better. The call came and it was helpful to speak to the Nurse on the phone and then have another nurse visit. This stopped me from having to take him back to the ER. My child is not normal so the additional expert advice benefits him."

" The program makes me feel safe."

"I have come to rely on the program, knowing I am not alone and have help even when life gets so busy."

Lessons Learned

Getting Started

- Determine Your Needs
- Obtain Leadership/Operational/Financial Support
- Engage Quality Team
- Develop Protocol and Policies
- Set timelines and benchmarks
- Build on Existing Telehealth Programs
- Share – Visit – Investigate - Research

Lessons Learned

Making it Work

- Communicate frequently
- Re-evaluate strategy
  - anecdotal info
  - statistical data
- Is the patient experience enhanced?
- Be early adopters of novel ideas
- Is there an adequate ROI, value and enhancement?

The Future

- Advocate for reimbursement
- Develop additional collaborative partnerships
- Continue to innovate and find cost effective ways to better serve our medically complex children
- Broaden our reach by testing and adding new devices and platforms for remote patient monitoring

St. Mary's Healthcare System for Children

we believe in POSSIBLE™

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BIP Transformation Grant utilizes "Federal funding" per section G, page 20 of 26 of the Master Contract for Grants.

Erie County Department of Senior Services
NY Connects

Ready, Set, Home

Karen Adamo- Aging and Disability Resource Center Representative
Erie County Department of Senior Services
716-858-7895

Daniel Szewc- Senior Coordinator of Neighborhood Services
Erie County Department of Senior Services
716-858-6070

Primary Objectives

- Reduce the number of Medicaid beneficiaries utilizing an inappropriate level of care
- Facilitate timely safe discharges of high risk patients in sub-acute care after a hospitalization

Who We Helped

- Currently in a Sub-Acute Rehab or SNF
- Medicaid Beneficiaries
- Appropriate for an MLTC plan or waiver program
- Informal caregiver support in the community

How We Helped

- Short term Case Management
- Services to Bridge the gap in MLTC coverage
  - Personal Care Services
  - Home Modifications
  - Personal Emergency Response System
  - Relocation and Home Setup
  - Home Delivered Meals

Recommendations

- Be prepared
  - Unexpected clients- largest age group 55-64
  - Unique home mods- creativity, understanding
- Get involved with clients early
- Partnership with facilities- not just a number to call

Lessons Learned - Surprises

- Our clients
  - Age
  - Sudden Health Change
- Housing needs
  - Unexpected needs

Lessons Learned- Successes

- Relationship with local hospitals
- Understanding client need at home
- Enhance and Expand our knowledge
  - Staff Training
  - NY Connects model

Lessons Learned- Limitations

- Timely and safe discharge
  - Home modification delays
  - Home relocation delays

Replication and Sustainability

- Extroverted ADRC- important and easy to replicate
- Model for NYConnects staff to build upon- offsite options counseling
- Sustainable as part of NYConnects workflow
  - RSH is part of the NYConnects team

Sustainability Challenges/Planning

- Identifying dedicated funds for service connections
- Working with LDSS to fund services prior to MLTC coverage.
- Currently using BIP-Caregiver funding to provide service
  - Not PERS, or relocation services

Health Care Savings

TOTAL TRANSITIONS	86	
	PARTICIPANTS	SAVINGS
FIRST 30 DAYS OUT ($9,000 30 day savings over LTC)	70	$630,000
90 DAYS OUT ($6,000 additional 60 day savings over LTC)	53	$318,000
180 DAYS OUT ($9,000 additional 90 days savings over LTC)	37	$333,000
TOTAL GROSS SAVINGS		$1,281,000
TOTAL GROSS SAVINGS		$1,281,000
TOTAL EXPENDITURES TO DATE		$575,158
NET SAVINGS TO THE SYSTEM		$705,842
RETURN ON INVESTMENT (SAVINGS REALIZED PER INVESTED DOLLAR)		$2.23
PROJECTED ADDITIONAL NET SAVINGS POST GRANT		$479,148
TOTAL Net Savings		$1,184,990
FINAL RETURN ON INVESTMENT per dollar		$2.50

Summary

- 235 clients served
- 202 clients received options counseling
- 143 clients received Short-term Case Management
- 129 clients referred to MLTC or waiver

RiverSpring Health™

Hebrew Home at Riverdale

BIP Innovation Grant
SAGEDay & LGBT Education Training

BIP Innovation Grant – SAGEDay

Inception of self identification questions on Universal Assessment Tool (UAS)

- Proper protocol for asking these questions
- What tailored services were in place for those individuals who chose to self identify as LGBT
- As a long standing partner with SAGE we learned that there was a gap in services for aging LGBT seniors who did not have a traditional family support system, which resulted in social isolation as well as proper access to privative and ongoing healthcare

BIP Innovation Grant – SAGEDay

- In order to bridge this gap in isolation together we formed SAGEDay. A social model day program. In which seniors would attend 1-5 days per week.
- This program broke the social isolation issue plaguing so many LGBT seniors of the New York City area.
- It provided structured activities for seniors who both physically frail and cognitively impaired.
- Enabled staff made up of social worker, recreational therapists, and certified nursing assistants to identify and link participants to additional services including community entitlements and healthcare related services.
- Provided a safe space for participants

BIP Innovation Grant – SAGEDay Training & Education

- In order to truly serve this population in the best way possible, The Hebrew Home at Riverdale embarked on a facility wide LGBT training program with SAGE.
- This program has trained over 1500 staff members of the organization from executive and clinical levels, to ancillary team members in housekeeping and dietary departments.
- This training took over one year to complete and is now embedded in the fabric of our culture.
- Programs and services geared towards LGBT residents and members are carried out both in admission and clinical competencies in a sensitive and respectful manner.

BIP Innovation Grant – SAGEDay

- Best Practices
- Replication Elements
- Lessons Leaned