Visiting Nurse Association of Central NY
$308,000
Improving Outreach, Access, & Resources in CNY
Increased access to services and resources, promoted independence, and reduced hospitalizations by connecting individuals in rural communities to primary care and other healthcare providers. Provided transportation to health and community services and outreach coordinators to assess need and eligibility.

Visiting Nurse Service Association of Schenectady County (VNS of Northeastern NY)
$346,352
Care Choices & Healthcare Training Collaborative
Provided palliative home care to reduce institutionalization. Used training program to improve palliative competencies among front line healthcare providers and community engagement programs that focused on advanced directives and patient empowerment.

Yeshiva University & Montefiore Medical Center
$2,403,654
Enhancing the Developmental Disabilities Health Home with Behavioral Supports, Care Management, Crisis Stabilization, & Respite Services
Provided 24/7 on call crisis response and in-home behavioral supports to avoid unnecessary ER visits, hospitalizations, or long term placement. Integrated health home services with behavioral health supports and case management services and established crisis and respite services for individuals with I/DD.

For more information on any of these organizations or grant programs, please email:

BIP@health.ny.gov

Funding for these activities was provided by Grant CFDA 93.778 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. However, this information does not necessarily represent the policy of the U.S. Department of Health & Human Services, and you should not assume endorsement by the Federal Government.

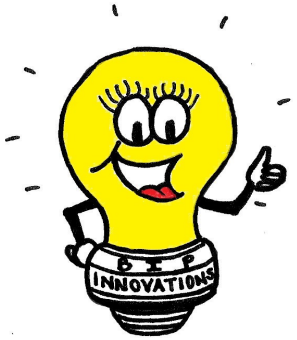
NEW YORK STATE | Department of Health | Office of Health Insurance Programs

BIP Innovation Fund Grant Awardees

NYS Balancing Incentive Program

Innovation Fund Grants Results Meeting

September 22, 2016



Advance Care Alliance of NY (ACA)
$5,056,108
Urgent Care for People with I/DD
Reduces avoidable ER visits and admissions and improves access and quality of primary/specialty outpatient medical and behavioral health care for people with I/DD. Provides telehealth medical triage with access to same/next day medical appointments and off-hours urgent care teams, and also tele-monitoring with Interactive Choice Response (IVR) and patient activation coaching.

Buffalo Federation of Neighborhood Centers
$2,312,510
MOOT Cares BIP Program
Provided community-based care, specialized assessments, and care management to Medicaid beneficiaries age 50 and above with disabilities and elderly who do not otherwise qualify for Health Home.

The Carter Burden Center for the Aging
$1,424,628
Metro East 99th Street Adult Day Services
Established hybrid adult day program integrated into low-income housing site to help transition chronically-ill individuals from hospitals, homeless shelters, and inappropriate housing back into community. Provided on-site services and activities, including tele-health, to reduce social isolation, food insecurity, and hospitalizations.

Catholic Charities of Broome County (Roman Catholic Diocese of Syracuse)
$587,558
OnTrack NY/ Southern Tier Connection Team (STCT)
Established "Coordinated Specialty Care Team" to provide case management for individuals, ages 15-35, after first psychosis. Established community supports to avoid hospitalization and ER/crisis visits and used early intervention to promote long term recovery.

Catholic Managed Long Term Care
$2,980,012
A PACE for Seniors with I/DD
Project to expand community-based long term support services for older individuals with I/DD, reducing need for admissions into institutional/ nursing home settings. I/DD population is integrated into existing PACE program, providing comprehensive, integrated, managed health care and supportive services by specifically trained staff.

Services for the Underserved
$1,942,164
Transition to Independence
Provided evidence-based behavioral support services to reduce need for institutional care and increase independence of individuals with co-occurring I/DD and severe behaviors. Provided care coordination, Applied Behavioral Analysis (ABA) therapy, medication management, and family liaison to support individuals transitioning out of institutional care or at high-risk of institutional setting placement.

St. Mary's Hospital for Children
$1,648,668
Remote Patient Monitoring for Children with Medical Complexity
Reduces need for more intensive medical care among children with multiple chronic conditions by using remote patient monitoring. Uses Interactive Voice Response (IVR) to check on medication adherence, falls, occurrences of major medical events, and other changes in condition. Follow-up then conducted by phone or in-person, depending on individual's response.

Tompkins County Office for the Aging
$223,365
Tompkins County Transitions Support Program
Used modified Coleman model transition program to improve health outcomes and reduce avoidable hospital readmissions and ER visits. Offered short term post discharge RN visits to provide medication management, education, tele-monitoring and referrals to community services. Engaged providers, advocates, and community leaders in provision of care to better meet complex health and psycho-social needs of individual.

Total Senior Care
$518,133
Daybreak Adult Day Services
Established two social day care programs for individuals residing in underserved rural counties at high-risk for institutionalization. Trained aides in care of frail elderly with chronic health programs, including early identification of possible health issues.

United Cerebral Palsy of NYC
$556,778
BIP Environmental Modifications
Assisted individuals either currently in, or at-risk of, institutionalized placement by making medically necessary environmental modifications. Helped individuals return to or remain home and avoid higher and more expensive levels of care.

Resource Center for Independent Living (RCIL)
$422,101
Targeted Outreach & Training to Increase Access & Utilization of Community Based Services
Increased access to community-based LTSS by educating potential consumers and caregivers of CDPAP, and increasing utilization of HCBS by limited English proficient (LEP) populations, including refugees and immigrants, through culturally competent trainings.

Rockland Independent Living Center (RILC)
$275,738
BIP-Bridges to Home Program
Served as bridge to wide range of programs and services for those in need of LTSS. Assisted consumers in finding connections in community to live as independently as possible and established a peer mentoring program.

Selfhelp Community Services
$821,976
Medicaid Care Transitions (MCT)
Expanded comprehensive case management program for seniors at high-risk for hospital readmission. Case management was provided in-home or by telephone within 30 days post-discharge to improve transitions between hospital and home, enhance communications between community and hospital, increase access to and use of community based LTSS, and reduce hospital re-admissions.

$751,463
Medicaid Safety Net (MSN)
Provided comprehensive case management services to individuals awaiting entry to one of Selfhelp's senior independent living sites. Enabled high-risk individuals to maintain independence in the community while avoiding costly hospitalization or nursing home care by providing a wide range of social services in the community.

$491,486
Enhanced Selfhelp Active Services for Aging Model (SHASAM)
Engaged participants and motivated them to participate in their care by taking advantage of the wellness options available, and other social services through case management programs. Educated participants on improving own wellbeing and health and enabled them to remain independent at home.

Center for Disability Services
$822,168
A multi-agency approach to support comprehensive care management for individuals with I/DD by eliminating duplicate administrative overhead
Partnering with Upstate Cerebral Palsy to create Care Management of Central New York (CMCNY) to identify opportunities to combine duplicative administrative resources, systems and applications to improve efficiency and reduce cost. Created in anticipation of applying to become managed care plan for individuals with I/DD in future. Created comprehensive care management model for individuals with I/DD.

Central Nassau Guidance & Counseling Services
$1,894,004
Stability at Home (SAH)
Provided in-home crisis de-escalation and prevention services for individuals with Serious Mental Illness (SMI) to reduce ER visits and hospitalizations and increase ability to self-monitor at home. Conducted community out-reach and in-reach within facilities to make safe transitions from institutional care back into community. Individuals were enrolled in more cost-effective LTSS resources including Health Homes, medication and case management, and 24/7 hotline.

Chautauqua County Chapter, NYSARC (The Resource Center)
$772,581
Enhance Community-Based Services to Increase Independence
Provides case management services, care coordination, and increased care navigation to address gaps in LTSS. Increasing opportunities for individuals with I/DD to remain in home or transition out of institutional settings by identifying barriers to community-based care and improving medication management and diabetes care.

Children's Home of Jefferson County
$2,680,195
Therapeutic Crisis Respite Program (TCRP)
Stabilizes and secures safe alternative to hospitalization for children aged 10-17 with social and emotional disturbances by providing short-term crisis respite with 24-hour supervision. Providing care coordination, as well as follow-up care, to strengthen and support individual and family during times of crisis.

Consumer Directed Personal Assistance Association of NYS
$295,500
Using Peer Mentoring to Increase the Availability & Effectiveness of CDPAP
Increased participation in Consumer Directed Personal Assistance (CDPA) and improved quality of care for CDPAP consumers. Created pilot peer mentoring service that provided current and potential CDPAP consumers with supports needed to successfully remain in community.

Coordinated Behavioral Care
$2,236,925
Transition Team for People with SMI
Pathway Home program facilitated transitions to community from institutional settings for individuals aged 18 and over who faced profound challenges due to Serious Mental Illness (SMI). Reduced re-hospitalizations by providing evidence-based treatment and support services.

Corning Council for Assistance & Information for the Disabled
$178,084
Crisis Relief Intervention Services & Immediate Supports (CRISIS)
Provided rapid-response crisis intervention to aged and individuals with disabilities who faced immediate risk of institutionalization. Provided short-term case management and skills training, and also follow up calls. Served as bridge to LTSS.

Council of Senior Centers & Services of NYC
$275,178
A Community Focused Approach to Preventing Falls
Provided evidence-based fall prevention services through "Matter of Balance" classes, informational health fairs, screenings, and self assessments. Conducted home assessments and funded home and safety modifications to reduce fall risks.

Elant at Goshen
$100,400
Adult Day Health Care Dementia Program
Increased availability of community-based dementia care services and prevented or prolonged move to institutional care. Helped individuals with Alzheimer's, dementia, or intellectual disabilities remain in community and provided support for primary caregivers.

Paraprofessional Healthcare Institute (PHI)
$1,958,592
Improving Care Transitions in Medicaid-Based HCBS with Senior Aide & Telehealth Interventions
Care Connections project improved quality, access, and efficiency of HCBS through development of advanced Home Care Aide position and use of mobile technology. Strengthened care transitions, reduced number of ER visits, and reduced caregiver burnout.

Parker Jewish Institute for Health Care and Rehabilitation
$928,942
ParkerCare Geriatric Mobile Care Management & Referral Program
Parker At Your Door (PAYD) program reduced unnecessary ER visits and hospitalizations by providing home-based primary care and case management services to high-needs seniors. Provided individuals in community and discharged from skilled nursing facilities with 24/7 assistance hotline to improve access to community-based LTSS.

Regional Center for Independent Living (RCIL)
$224,096
Transitional Coaching Program
Provided transition and diversion services for individuals with disabilities to re-establish or maintain independent living situations. Assisted in navigating and enrolling into MLTC or Medicaid waiver programs, educated social workers on LTSS through peer mentoring, and linked individuals to other agencies in community.

The Research Foundation for the SUNY, UAlbany
$348,105
Building Services & Supports to Reduce the Impact of Diabetes
Diabetes Self-Management Program (DSMP) and Lower Extremity Amputation Prevention Exam (LEAP) assisted individuals with diabetes through pre-intervention and self-management to prevent hospitalization and reduce ER visits.

$701,335
Reducing the Impact of Diabetes among Persons with Existing Disabilities
Reduced hospitalizations and institutionalizations and increased use of community-based services and supports by collaborating with Independent Living Centers (ILC) to provide Diabetes Self-Management programs (CDSMD) and care management to individuals with disabilities.

The New York Foundling Hospital
$1,484,667
BIP/FOCUS Program
Created Transition Development Team that connected developmentally disabled children and young adults in crisis to community supports and provided mechanisms to close funding gaps that delay start of treatment. Used evidence-based model to provide individual and family with skills necessary to remain in community.

New York Memory Center
$954,402
Increasing Access to Dementia Day Services in Brooklyn
Increased access to dementia day services for Afro-Caribbean and Latino individuals by opening second center and expanding hours, and offering educational sessions and memory screenings. Provided culturally competent care coaching and counseling for caregivers.

Niagara Falls Memorial Medical Center
$826,613
Building Bridges to Home & Community Care
Designed to identify caregivers, complete caregiver assessments, and provide training, education, and support to both caregiver and patient to ensure caregiver has knowledge and understanding of patient's care needs, along with follow up care for appointments and linkage to community support services.

NYSARC, Capital NYC Chapter (AHRC NYC)
$658,667
Using Technology to Support Independence & Autonomy for People with Developmental Disabilities
Provided technological devices (iPads and other devices) to individuals with I/DD through collaboration with GE Global Research. Devices increased independence and reduced need of direct care supervision. Created 'Technology Toolkit' with five goal areas to support future deployments.

Odyssey House
$444,763
Serving Older Adults Recovery System (SOARS)
Enhanced support services for older adults transitioning out of intensive in-patient treatment for substance use by utilizing both intensive care management and peer-based recovery coaching. Connected individuals with community-based LTSS, increased engagement in recovery process, and maintained individuals in own home.

Erie County Department of Senior Services
$738,276
The "Extroverted" ADRC
'Ready Set Home' program reduced utilization of inappropriate levels of care and failed discharges into the community. Targeted low acuity residents of skilled nursing facilities and individuals receiving sub-acute care following hospitalization, at risk of institutional placement, to provide assistance in overcoming obstacles and bridge services while waiting for MLTC coverage.

Family Residences & Essential Enterprises (FREE)
$599,041
Enhanced Mobile Crisis
Enhanced mobile crisis support to individuals with Serious Mental Illnesses (SMI) and Traumatic Brain Injuries (TBI). Educated individuals on medication management, stress/anger management, and community integration to decrease hospitalizations, 911 calls, and ER visits.

$530,069
Sustainable Employment
Created skill development program for individuals with disabilities to address barriers to LTSS. Improved functional performance and provided support to successfully maintain or secure employment.

God's Love We Deliver
$405,693
The Medically Tailored Food & Nutrition Expansion Project
Expanded home-based nutrition service into new counties, diverting more at-risk individuals from institutional care. Created 'Food and Nutrition Services Referral Tool' to identify need and standardize determination, and educated MLTC staff on tool and Food and Nutrition Services (FNS) benefit that is underutilized.

The Hebrew Home for the Aged at Riverdale
$1,045,108
LGBT Older Adult Initiative Expanding Community Awareness & Options in Care
SAGEDAY program addressed unique social and health care needs of aging LGBT community and developed LGBT competent training curriculum for adult day services program staff. Increased number of LGBT aging individuals served in non-institutional settings.

Hillside Children's Center
$1,177,541
Community Based Respite Program
Prevented ER visits and institutional placement by providing planned and emergency respite for high needs, emotionally disturbed children, ages 10-18. Continued home and community-based services and education during respite to minimize transition issues.

The Institutes of Applied Human Dynamics (IAHD)
$368,394
An Education & Training Program to Reduce Barriers to Community Care & to Assist Individuals with Developmental Disabilities to Remain Living in their Communities
Enabled families of older individuals with I/DD to continue providing supports at home instead of seeking institutional placement. Provided direct support, training, and communication to families that included prophylactic health and wellness issues, aging considerations, future planning, and social and emotional supports.

Jewish Association for Services for the Aged (JASA)
$367,259
Help Center Connector Project (HCCP)
Assisted seniors with securing Medicaid LTSS to remain safely at home. Provided in-depth assessment of each caller to identify eligibility and assist with application process and compiling needed documents.

Jewish Home Life Care, NYC Chapter
$221,712
Enhanced Adult Day Care Rehabilitation Services
Increased and enhanced number of skilled services offered in adult day care by providing restorative physical or occupational therapy to individuals following hospital stay. Enabled individuals to go directly home and avoid sub-acute placement or community rehabilitation services.

Jewish Home Life Care, Sarah Neuman Center
$282,995
Night Care Program
Established overnight adult day care to help cognitive and functionally impaired older individuals remain in community. Minimized caregiver burden and burnout and prevented institutional placement by providing comprehensive services and support for client and caregiver.

Kids Oneida
$1,131,548
Kids Mohawk Valley
Increased access to community-based care for severely emotionally disturbed youths and families. Avoided institutional placement by connecting individuals to vocational/educational programs and other community services, and increasing family involvement.

Lifespan of Greater Rochester
$374,236
BIP Healthcare Coordination
Community Care Connection program increased access to community-based medical, disability, and aging services for individuals with difficulty navigating LTSS due to barriers such as low health literacy, lack of support, transportation, and financial challenges. Decreased hospitalizations, ER visits, and caregiver stress through connections to community-based health care and support services and increasing individual healthcare knowledge.

Mental Health Association of NYC
$952,175
Community Older Adult Recovery Program (CORE)
Facilitated independence, recovery and re-integration into community through service coordination and planning tools. Diverted older adults with long-term psychiatric disabilities away from hospitalization by providing comprehensive services and supports and ensuring that proper providers and services meet needs of participants.

New Alternatives for Children (NAC)
$1,030,000
Healthy @ Home
Enabled medically complex children to remain home and out of institutional care by providing assistance to family and identifying foster/adoptive parents for children in need. Increased access to medical and mental health services through Mobile Medical Unit that functions as satellite medical clinic.

New Horizon Counseling Center
$664,933
Adult Support Program
Improved case management for individuals 55 and older by providing pre-screenings within 24 hours, full health assessments that identified high risk immediate need of care, and creation of new care plans that linked participants to community resources.