ADVISER
The magazine of LeadingAge New York | Summer 2015

Change Happens

Because You Are
True To Mission

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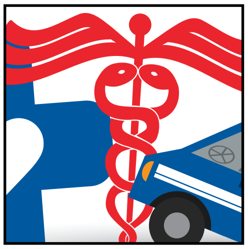

Features

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LeadingAge New York

Mission Statement

To create the future of aging and continuing care services in New York State.

Our national partner, LeadingAge, is an association of 6,000 not-for-profit organizations dedicated to expanding the world of possibilities for aging. Together, we advance policies, promote practices and conduct research that supports, enables and empowers people to live fully as they age.

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Founded in 1961, LeadingAge New York represents more than 500 not-for-profit, public and mission-driven senior care providers, including nursing homes, senior housing, adult care facilities, continuing care retirement communities, assisted living, home care and community services providers which serve approximately 500,000 people across New York each year.

Greetings

Change is Inevitable

According to Greek philosopher Heraclitus, "The only thing that is constant is change." In the aging field, this means that as times change, we must reinvent ourselves to remain relevant. Mission-driven organizations may have the advantage over their profit-driven competitors because historically they've had to be flexible and willing to experiment to stay true to mission and remain relevant as conditions like societal norms or funding change. Having the right tools and having tested new ideas in a smaller arena are keys to being able to change quickly as conditions warrant.

The Balancing Incentive Program (BIP) Innovation grants have been a time-limited means to test some new ideas. New York State has been awarded enhanced federal Medicaid matching funds to implement the BIP. As part of the award, the State has made available $47 million in BIP Innovation Fund grants to providers of community-based long term care services and supports. In this issue, LeadingAge New York public relations consultants, Steve Greenberg and Bob Bellafiore, checked in with seven LeadingAge New York members or affiliates who have implemented a demonstration project under BIP to see what type of ideas are being tested, what has worked well, what they have learned and what they'd tell the State if asked.

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As always ***Adviser*** is packed with information from Endorsed Vendors and Business Partners that offer new ideas, cost saving strategies and support in transitioning to new ways of doing business. Parker Jewish Institute for Healthcare and Rehabilitation and Custom Computer Specialists offer tips on *Monitoring Data Electronically for Better Patient Care;* Bonadio Receivable Solutions, LLC asks, *"Which Road are You Traveling to ICD-10?";* Cool Insuring Agency offers thoughts on *Safety Programs and Return on Investment;* Gordon Boyd, of EnergyNext tells of opportunities for *Competitive Energy Proposals for LeadingAge New York Members;* and Billy McKee of National MedTrans Network and Evolve Emod ponders *The Role of Creative Destruction in Long Term Care.*

Don't miss this issue's Spotlighted member, and new board member, Mary Costigan, administrator of Michaud Residential Services. Also, the Palate feature has been revived after a year in retirement with a new idea for an experiential restaurant in *The Melting Pot: A Taste of America with Benefits.*

I hope you find valuable information, tools and ideas through the stories in this issue of LeadingAge New York ***Adviser***. If you have ideas to share, or are looking for resources, be sure to contact the Adviser editor Kristen Myers at **kmyers@leadingageny.org.**

Sincerely,

James W. Clyne Jr.
President and CEO

Welcome Mary Costigan!

Meet Mary Costigan, administrator of Michaud Residential Services and newly elected member of the LeadingAge New York Board of Directors.

What do you think is the most significant threat to mission-driven long term care services and supports?

Having access to a qualified workforce and cuts to funding for providers in rural settings are serious issues. Also, as the level of change in healthcare in general accelerates, provider organizations are at risk if they are not able to adapt to change without losing their mission in their respective communities.

Conversely, what opportunities are presented?

Initiatives like DSRIP, under Medicaid redesign, and the emergence of Independent Provider Associations (IPA's) will provide an opportunity for collaboration among community providers in ways that have not been considered previously. These collaborations among community providers, who in some cases are also competitors, may help providers identify new programs or service delivery models that will help ensure continued viability in a changing regulatory and reimbursement environment.

How did you end up in the field of long term care?

I happened to take a gerontology course at SUNY Cortland in my undergraduate studies; it was from the *Introduction to Gerontology* course that I decided the path for my career, working with the older population. From there, I participated in the first ever Upstate NY Student Symposium for LTC and received my Bachelor of Arts with a concentration in Gerontology. I then decided advocacy was my mission and went to Syracuse University for my Masters in Social Work where I again received a certificate of concentration in Gerontology.

How did your earlier work experience, education and training lend itself to this career path?

Before preparing for my Master's studies, I worked in a nursing home in Albany in the recreation department. I then was accepted to Syracuse University for the MSW program. As soon as I graduated I applied for a Social Work Director position in a small Nursing Home in the suburbs of Charlotte, NC. While working there, the owner of the company felt I was Nursing Home Administrator material. I performed my AIT at that facility and was licensed as a NHA when I was in my mid-20s. After my first daughter was born, I decided to step out of Skilled Nursing Home and worked in a small Hospice in a suburb of South Carolina. When I moved back to New York, I knew my passion was working in a nursing home and being a voice for one of the most vulnerable populations.

What prompted you to apply to the LeadingAge New York Board of Directors?

I truly want to make a difference and be a voice for long term care providers. St. Luke CEO Terry Gorman has been active in Leading Age NY for many years and under his direction, I have come to better understand and appreciate the challenges and opportunities we all face today. As the saying goes," I want to be part of the solution, not the problem," and I think younger professionals such as myself have a perspective worth considering.

(See *Welcome Mary Costigan* on page 6)

Welcome Mary Costigan (continued from page 5)

What do you think you can add to the board?

Enthusiasm. More importantly, I have the experience of working for an organization that has affiliates providing various services along the continuum of senior care. Many decisions within my organization are made from the perspective of, "how do we deliver the best quality care, and how does a particular service add to other care options to enhance the overall level of service we provide." I think this perspective will prove useful to the Board.

What do you hope to learn from your board experience?

Personally, I am excited for the opportunity to work with so many talented individuals at LeadingAge NY. Professionally I hope to learn more about programs or service delivery models across the state that are working and why. Further, I am hoping to learn more about the other public continuing care providers.

What are your thoughts and practices to address healthy work-life balance?

...I knew my passion was working in a nursing home and being a voice for one of the most vulnerable populations.

It is imperative to have a work-life balance. I need to be able to recharge my energy so I am more effective as a leader. I have trained and participated in four sprint triathlons and am currently training for two more this summer, as well as a half marathon this fall. These personal fitness goals help me take the stressors of work and use that energy in a positive manner. I also practice kick boxing and yoga. During my LeadingAge NY Leadership Academy, we had a wonderful discussion on work-life balance and a co-facilitator led us all in a meditation session. I believe in this so much that I have passed on mindfulness techniques to my daughters to help them with their school-life balance. I also find solace in my strong faith and being able to spend time with my family.

Did you have a significant mentor in your life, either personally or professionally or both?

Two personal mentors in my life that are significant are Dr. William Lane, professor of gerontology at SUNY Cortland and Dr. Eric Kingson, Professor in School of Social Work at SU; both taught me so much on the psychosocial aspects and legislative aspects of aging. My professional mentor is Terry Gorman, CEO St. Luke Residential Health Service. His knowledge, skills, demeanor are all traits that are admirable. He allows me the opportunities to ask questions, give me honest answers and put me "in check" in a constructive way when needed.

What is your favorite book and movie?

Any John Grisham novel because his characters are advocates for the down and out. Movie: Erin Brokovich – again because of her fierce advocacy for the rights of people.

If able, what famous person would you like to have a conversation with, dead or alive, and why?

Sir Ernest Shackleton – During our Leadership Academy we watched a video on how he led his crew on an expedition through the South Pole. The tale of his leadership was inspiring and I would want to have a conversation about his leadership style and skills. I would like to ask him how did he not give up with all the barriers and obstacles that stood in his way? I would like to discuss how did he obtain these skills as a leader, who was his mentor? I would want to discuss how he was able to stay calm in some of the harshest conditions of his journey. I would like to ask if he ever would have thought his journey would have such a profound effect on leadership discussions as it does.

One Voice

Updating Tactics for Lobbying and Legislator Engagement

by Ami Schnauber, vice president, advocacy and public policy

For a long time, health care public policy and policy reforms have been discussed and implemented both through legislative action and by health care influencers outside the legislative process, such as the Department of Health (DOH), the Governor's office, Centers for Medicare and Medicaid Services (CMS), and large health system and health plan executives. More and more, however, policy decisions seem to be coming from policy makers outside of the State Legislature.

This has not gone unnoticed with the Legislature. In fact, the Legislature has begun looking closely at the power that has been vested in the DOH. This presents an opportunity for us to seek greater input into the health care transformation underway, but it comes with challenges and requires modifying our public policy and advocacy strategies.

It is important to understand the motives that drive these policy makers. For the Governor and DOH it is the "Triple Aim" of better health, better care and lower cost.

This evolving model of governing and regulating presents providers and lobbyists with new challenges for influencing policy makers and policy decisions. We need to rethink our past strategies and develop new tactics to ensure that we continue to have input into those decisions. This means developing ways to get lawmakers more engaged in policy making decisions and developing tactics to engage these non-legislative policy makers (DOH, Governor's staff, CMS, health systems and plans).

Energy policy has long been established off-budget and outside of the legislative process. We can learn from the tactics energy interest groups have utilized to help move their agendas, including engaging committee chairs and legislators through targeted budget questions, sign on letters to agencies, and introduction of legislation to encourage agency action.

Engaging Legislators

The good news is that the most important tactic remains the same – educating lawmakers – but we need to start changing our messaging and our requests for assistance when we engage with legislative representatives. As always, lawmakers need to be educated about the services organizations provide and the value that they bring to their community, both socially and economically. But lawmakers traditionally see their role as that of passing budgets and bills. While legislative committee chairs will be accustomed to engaging with the Governor's office and agencies, rank and file legislators will likely need to be educated and encouraged to play this role.

- When meeting with legislators, it will be important to educate them about the public policy decisions that are being made, without their input, and the impact that reality is having on providers, caregivers and consumers in their community.

(See *Updating Tactics* on page 8)

Updating Tactics... (continued from page 7)

They will need to know how their input is critical and be encouraged to engage directly with the Governor and agency heads to express concerns and recommendations related policy changes, regulatory reforms, departmental policies etc.

- Introduction of legislation to encourage agency action can be effective. Even when it is within an agency's authority to make a proposed change, the circulation and movement of legislation that would mandate changes can often encourage the agency to finally move ahead on its own. Such legislation can also offer a rallying point for interest groups and lawmakers and unify grassroots advocacy efforts.
- Lawmakers can be engaged to assist members on the local level to develop relationships between consumers, providers, plans and large health systems (and Delivery System Reform Incentive Payment [DSRIP] leads).
- Lawmakers can be asked to participate in meetings that their constituents (providers) have with agencies and the Governor's office.
- District office meetings with legislators are more valuable than ever in this new paradigm.

Engaging the non-legislative policy makers

It is important to understand the motives that drive these policy makers. For the Governor and DOH it is the "Triple Aim" of better health, better care and lower cost. Priorities for all of these non-legislative policy makers (DOH, the Governor's office, CMS and large health

(See *Updating Tactics* on page 9)

Updating Tactics... (continued from page 8)

This evolving model of governing and regulating presents providers and lobbyists with new challenges for influencing policy makers and policy decisions.

system and health plan executives) include promoting accountability for outcome and costs, preventing and managing disease, reducing avoidable utilization of services and delivering care at the lowest cost possible. Reducing inpatient hospital utilization is a top priority as is minimizing inappropriate, long-term nursing home placements.

- Any successful engagement with these other policy makers needs to be mindful of these priorities. Advocacy messaging has to include details and examples that show how a problematic policy runs counter to these goals. Any proposed solution needs to explain how it will advance the goals.
- Collaboration along the continuum and information sharing is essential. Develop and leverage relationships with local hospitals, physicians, home care, nursing homes, community services and consumers to deliver a consistent message and "ask," ie, what we want the legislator to do.
- Providers message should include a value proposition that makes the

(See *Updating Tactics* on page 10)

Updating Tactics... (continued from page 9)

case that they have the capacity to provide high quality care that will improve outcomes at a cost that will allow the state (or their partners) to achieve their financial goals (e.g., reductions in the overall cost of care and/or in readmission penalties, etc.)

- When bringing concerns to DOH or the Governor, provide concrete examples of problems being faced and how they impact the Triple Aim.

Long term care providers have an opportunity to thrive under new models of care that focus on decreased hospitalization and the management of post-acute care. This is the sweet spot for long term care providers who have decades of experience in managing post-acute care. Take a fresh look at your value proposition. Begin re-educating your legislators. Either begin or increase your networking with the non-legislative policy makers to ensure your organization can succeed in the changing health care landscape.

Keep informed and learn more at http://www.leadingageny.org/advocacy/

Monitoring Data Electronically for Better Patient Care

Part 2 of 3: Parker Jewish Institute Shares How It Began to Collect Data

By: MaryAnn Benzola, marketing manager, Custom Computer Specialists, Inc.

When Parker Jewish Institute for Health Care and Rehabilitation in New Hyde Park decided to take the data collection plunge, leaders first had to decide what data to collect. This was not an easy task given that in addition to being a 527-bed non-profit leader in sub-acute care, short-term rehabilitation, long-term care, medical model adult day health care, social model Alzheimer's adult day care, home health care and hospice care, Parker also maintains a renal dialysis facility, an on premise pharmacy, physician services, a managed long term care plan and a Medicare Advantage Plan. With all of these components, Parker Jewish Institute leaders realized they had many potential areas to monitor via data collection.

Parker Jewish Institute has become a leader in monitoring its clinical outcomes and even received a 2013 "Excellence in Technology" Gold Award from McKnight's, the largest long term care industry magazine in the U.S. However, the data-tracking journey began seven years ago.

"We all know about the healthcare changes going on now. In the future, having an electronic medical record, dashboards, and intelligent software will be critical."

– Michael N. Rosenblut, president and CEO
Parker Jewish Institute

"Leaders realized that changing reimbursement methods would eventually connect payments to proven clinical outcomes," says Michael N. Rosenblut, president and CEO of Parker Jewish Institute. "Additionally, Parker Jewish Institute leaders wanted to look at certain metrics in real time. To get things started, leaders selected both clinical and financial related data points."

"On the financial side that included FTEs, cost per resident per day and medical transportation use. On the clinical side, some of the initial areas monitored included falls, pressure ulcers and the use of nine or more medications by a resident," says Susan Costella, director of sub-acute care services at Parker Jewish Institute.

Although Parker Jewish Institute did not add any additional staff for its data collection efforts, organization leaders made the decision to partner with Custom Computer Specialists ("Custom"), a technology solutions provider that specializes in supporting long-term care facilities. Custom was able to provide the depth and breadth of IT skills that Parker needed to support their efforts to implement a data collection strategy.

"The team from Custom helped us to identify the data sources," says Vincent Villany, director of information systems at Parker Jewish Institute and a Custom employee. "Once we were

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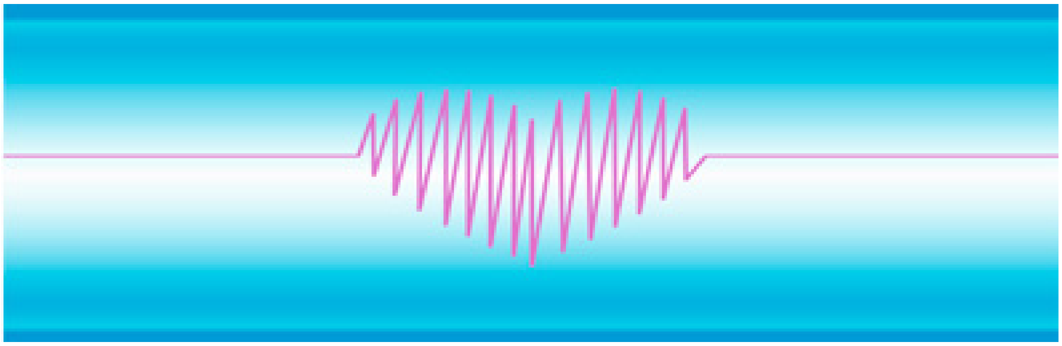

Monitoring Data... (continued from page 11)

able to identify the data that we wanted, we worked with Custom to determine where that data was residing and identified tools to bring it to a central location to read it."

Currently, Parker Jewish Institute has 11 FTEs in its information systems department, two thirds of whom are from Custom and one third from Parker Jewish Institute.

Any data the organization might need to review is still within its system, and leaders can now focus on the most critical data points they need on a daily basis.

"One initial challenge of electronic data collection was realizing that leaders actually tracked too much information," Rosenblut says. However, leaders did not realize this until after they began collecting data. "We had to set up cubes, or data lines, to look at on our computers. Parker doesn't utilize or purchase custom software, so we built our dash boarding capabilities using an existing Microsoft product. Then we realized we developed way too many dashboards. When we took a step back later, we had to reevaluate and size it down to something more manageable for leaders to look at every day," he says.

Any data the organization might need to review is still within its system, and leaders can now focus on the most critical data points they need on a daily basis.

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Monitoring Data...

(continued from page 12)

As with anything new, staff training was an initial concern. “You have to have buy-in so the staff understands what everything means,” Costella says. “We’ve been very fortunate. We can show staff what goes on week to week or month to month, and that’s important for them to see at the unit level.”

“Investment in electronic data collection and monitoring can be sizable, although this effort did not have the expenses associated with additional staff,” Rosenblut notes. “This is a financial investment but at the leadership level, we decided technology is a priority for us. We all know about the healthcare changes going on now. In the future, having an electronic medical record, dashboards, and intelligent software will be critical.”

Advice for Others

For other organizations just beginning data collection and monitoring, Rosenblut recommends first deciding what indicators are most important to study as an organization. Then, after you begin the collection and monitoring process, see if you need to scale back. “Once the dashboards are set up, reevaluate if you need all of that information,” he said.

“Presentation on the screen is also important,” Villany said. “For example, most systems can present data as an algorithm or as something more visual, like a chart. Find ways to show data that staff members will easily understand.”

Finally, Rosenblut says that tracking data doesn’t mean an organization has improved care. However, it does allow an organization to monitor care and then make decisions on how to improve it if necessary.

In part 3 of this article, Parker Jewish Institute will talk about how tracking clinical data helped the organization grow and improve its operations for the residents and community served every day.

The Melting Pot: A Taste of America with Benefits

Interview with T'Shana Tedder, food service director Dominican Village, Sodexo general manager

What if dining at the place you call home means grooving to a steamy jazz ensemble while enjoying a Mardis Gras-style dining experience that brings you the taste and feel of "N'awlins" on a five-star level? You are served traditional dishes like gumbo, fried okra and jambalaya and not only will you experience the fabulous food, you also learn more about the traditions associated with Mardis Gras such as the king cake. At Dominican Village, a not-for-profit, non-sectarian, independent, assisted living and respite care retirement community located in Amityville and sponsored by the Sisters of St. Dominic, this type of dining is a reality for residents through a unique dining option called the Melting Pot.

King cake: Extra-large oval doughnut pastry dusted with colored candied sugar. A plastic baby doll is hidden inside the cake – the lucky person who gets the piece of cake with the doll inside (and doesn't break a tooth or swallow it in the process!) buys the king cake for the next party of the Mardi Gras season.

The concept of the Melting Pot was developed specifically to improve communication among residents in the independent living and the assisted living and to add a touch of class to resident's lives.

"In the main dining areas residents would sit in the same seats with the same people for every meal. The folks in independent living rarely sat with the folks in assisted living unless they had come to the assisted living from the independent housing. This routine made it very hard for new residents to make friends and be integrated into the community," said T'Shana Tedder, Food Service Director at Dominican Village.

"Like a true melting pot where different substances are blended together to form a new version, this dining experience, by its structure, forces new interaction among residents," she said.

Since meals are what residents most look forward to, staff took an existing summer surf and turf special dining activity up a notch to entice participation among residents and add a little pizazz. Offering it to a smaller group allows the ability to be much more creative and upscale with the food offerings and atmosphere. The experience is so distinct that residents have even begun to dress up for their "night out."

This dining model, introduced in October 2014, is offered as a separate and exclusive "restaurant" but at no additional cost to residents. It is located

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The Melting Pot... (continued from page 15)

behind a screened off part of the main dining area and is complete with a maître d' and reservation book.

The overall theme is *A Taste of America* and brings diners the dishes and customs of regions, states and cities within the United States. Each sub-theme lasts from about 4-6 weeks, offering the same dining experience 2-3 times within that period for up to 30 people at each session. Prospective diners must sign up in advance to secure their reservation.

As seating is limited, if a residents has already attended and wants to sign up for the next session that month they are put on a wait list. Staff ensures that the goal of mixing up the contact among residents is achieved by looking at the mix of reservations and working to fill space with a new mix of people. Sometimes special groups will book together, for example the knitting group, but all must reserve ahead so that extra slots can be used to "mix it up." No walk-in dining is allowed at this venue.

Some of the sub-themes since inception include: *A New England Pub, A Taste of New York, The Midwest, California* and *Mardis Gras.* This dinner program is so popular, says T'Shana, "When the Melting Pot first began, we did send reminders but now the residents remind us!"

The Melting Pot will take a break from the Taste of America theme for the summer months to offer three months of different surf and turf combinations – a favorite of residents.

Much of the planning for ideas and menus comes from the established Food Committee meetings, held each month within the independent living and assisted living venues. Any resident is welcomed to participate in committee meetings with a steady core group of about 15 routinely participating. Ideas are vetted and progress toward implementing ideas is shared. For example, an idea that came from committee meetings was that residents wanted to incorporate a tour of the kitchen as part of the Melting Pot experience so now tours of the kitchen are offered at 3 p.m. before each Melting Pot dinner. Feedback is offered on general dining, Melting Pot pairing of dishes, themes, etc., and most importantly any problems are solved. Committee participants are very dedicated and prepared, arriving with notebooks full of ideas and suggestions they have collected from others.

The Melting Pot is a creative venue for residents to dress up, sample special foods and drinks, experience new culture, meet new friends and get a little special attention from the chef and staff-sometimes even a special cooking demonstration. It is five-star dining at its best designed to eliminate isolation, give residents something to look forward to encourage socialization.

Quotes from residents:

"This is like being at a five-star restaurant"

"We loved it! Where are we going next? Sign me up"

"The food was exceptional!"

Talking to another resident ***"It was nice to meet you, see you next time"***

"Wow all of this for us"

Safety Programs and Return on Investment

Occupational Safety and Health Administration (OSHA) statistics clearly illustrate that health care facilities that establish safety and health management systems can dramatically reduce injury and illness costs. In some cases, you could reduce costs by up to 40 percent. If you could save your company money, improve productivity and increase employee morale by implementing these systems, why wouldn't you?

In today's business environment especially in a healthcare-related field, these safety-related costs can impact the actual viability of your organization. Use these tips to understand how safety programs will directly affect your facility's bottom line.

Proving ROI

OSHA studies indicate that for every $1 invested in effective safety programs, you can save $4 to $6 on occupational illnesses and injuries. With a good safety program in place, your costs will naturally decrease. It is important to determine what costs to measure to establish benchmarks, which can then be used to demonstrate the value of safety over time.

But keep in mind that your total cost of safety is just one part of managing your total cost of risk. When safety is managed and monitored, it can help drive down your overall cost of risk.

Proving the Value of Safety

Demonstrating the value of safety to management is often a challenge because the return on investment (ROI) can be cumbersome to measure. Your goal in measuring safety is to balance your investment vs. the return expected. Where do you begin?

There are many different approaches to measuring the cost of safety, and the way you do so depends on your goal. Defining your goal helps you to determine what costs to track and how complex your tracking will be.

You may want to track your company's total cost of safety to show the correlation with reduced fixed expenses (in the form of workers compensation premiums), which would include more specific data collection like safety-related wages and benefits, operational costs and insurance costs.

Health care facilities that establish safety and health management systems can dramatically reduce injury and illness costs in the long run.

Since measuring can be time consuming, general cost formulas are available. A Stanford study conducted by Levitt and Samuelson places safety costs at 2.5 percent of overall costs, and a study published by the Economist Intelligence Unit (EIU) estimates general safety costs at about 8 percent of payroll.

If it is important for your organization to measure safety as it relates to your costs of operation, more accurate tracking should be done. For measuring data, safety costs can be divided into two categories: direct (hard) costs, which include wages, operational costs, insurance premiums, attorney fees, accident costs and fines or penalties, and indirect (soft) costs. Indirect costs go beyond those recorded on paper and include factors like:

- Accident investigation
- Overtime expenses

(See *Safety Programs* on page 18)

Safety Programs... (continued from page 17)

- Administrative expenses
- Worker stress in the aftermath of an accident resulting in lost productivity, low employee morale and increased absenteeism
- Training and compensating replacement workers
- Reduced quality of care due to inexperienced workers
- Poor reputation, which translates to difficulty attracting skilled workers and lost business share.

When calculating soft costs, minor accidents costs are about four times greater than direct costs, and serious accidents about 10 to 15 times greater, especially if the accident generates OSHA fines or litigation costs.

According to the International Risk Management Institute, just the act of measuring costs will drive improvement. In theory, those providing the data become more aware of the costs and begin managing them. This supports the common business belief that what gets measured gets managed. And, as costs go down, what gets rewarded gets repeated.

Safety as a Core Business Strategy

Industry studies report that companies who focus on safety as a core business strategy come out ahead. Consider the following as reported by the Occupational Safety and Health Administration:

- A West Virginia nursing home had an OSHA injury and illness rate that was 6 times the national average for skilled nursing facilities. A concerted effort was begun in conjunction with Labor Department consultants to bring occupational safety up to the same levels as resident safety.
- After initiating a comprehensive safety program, forming a safety committee, and instituting a safe resident handling program (which included both mechanical lift devices, assist devices and workplace modification), a 62 percent drop in recordable injuries was realized in the first two years. Over a 12 year period, the injury rate dropped from 31 injuries annually per 100 full-time workers to 2.1 injuries per 100 full-time workers.
- Workers compensation costs also dropped, from $330,000 when the safety initiative began to a 10 year average of $210,000 annually. This amounted to a 10 year savings of nearly $2,000,000.
- Other safety and health program success stories can be found at: **www.osha.gov/dcsp/smallbusiness/index.html**

Considering the statistics, there is abundant evidence that there is direct correlation between safety and cost savings. We are committed to helping you establish a strong safety, health and environmental program that protects both your workers and your financial future. Contact us today at 800-233-0115 to learn more about our value-added services.

The *Creative Destruction* of Long Term Care

There are very few industries more in flux than long term care and it is now experiencing a phenomenon that economists call *creative destruction.* Simply, *creative destruction* is when a new creative model of delivering services destroys the old and, to be defined as *creative destruction,* there must be a positive net effect. In the long term care industry it could ultimately be defined as happier recipients of care, with better quality of life and whose care produces a smaller burden on taxpayers. *Creative destruction* by definition also creates new problems with the assumption that the new problems are less burdensome than the old.

National MedTrans Network (NMN) and partners are no strangers to the problems created by New York's Managed Long Term Care (MLTC) and Fully Integrated Dual Advantage (FIDA) programs. NMN currently manages the transportation benefits of approximately 30 percent of the MLTC beneficiaries in New York State. The logistics of managing transportation are complex and when providing high-quality, safe service to an aged and disabled population, the equation becomes infinitely more complex. For example, the transportation service is often to medical appointments that can result in life threatening consequences if missed.

The *creative destruction* of MLTC has new and very complicated associated problems so it is vital that all stakeholders work together in finding solutions to ensure the health and well-being of the people served. In delivering a service such as non-emergency medical transportation, NMN, is willing to experiment if it will improve the service delivered to customers. The improvement will be measured and evaluated so that ideas that don't yield measurable results are discontinued to ensure resources are being used effectively. Following a process that continuously delivers poor results is not acceptable. Even if 98 percent of ideas are not successful, there remain two percent of ideas that have produced real solutions to real problems. The path to total quality improvement will be fraught with complications, but the greatest failure is not trying.

E-Mods . . . are simply home modifications designed to increase safety and accessibility, particularly in preventing falls.

A great example of this from NMN is the logistically agonizing and costly problem of two-man transports. "Two-man" simply describes the fact that it takes at least two people to get the person out of their home for a non-emergency medical transport. The liability for transportation vendors performing this type of trip is substantial and the resources and coordination required for such transports creates significant challenges. In addition, the lack of accessibility and mobility increases the safety risks for staff and the person being transported.

After almost a year of sitting through a painful weekly meeting where two-man problems were discussed, a viable idea was finally generated. After careful analysis of the

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Creative Destruction... (continued from page 19)

data related to these transports, accessibility was determined to be the key factor determining the need for a two-man transport. In 90 percent of the transports requiring a two-man transport, steps and narrow doorways required picking up the person out of a wheelchair and getting them through the doorways and down the stairs. A small fraction of transports will always require two people, for example bariatric cases, but with some simple environmental modifications, the rest could be transported more comfortably, safely and cost effectively.

This innovation, like most, involved connecting the dots. A conversation during a site visit almost two years earlier became critical to the solution. A question had been posed to a client asking what, besides transportation, presented a similar level of complexity to deliver. The answer was a strange acronym, E-Mod's.

E-Mods, in non-cryptic healthcare acronym language, are simply home modifications designed to increase safety and accessibility, particularly in preventing falls. Falls are the number one cause of death for seniors nationally, costing the United States close to $30 billion per year and New York State $1.8 billion per year. Forty percent of seniors who enter long term care after a hospitalizing fall will never be fit to move home again. Therefore, preventing falls in the home is an integral piece of keeping seniors mobile and in the community. E-Mods are part of the MLTC and FIDA benefit package, so while the funding is available finding a reputable contractor skilled in universal design is much more difficult.

I personally watched my parents struggle to find someone to perform home modifications for my 92-year-old grandmother who wanted to age in place. The result was poor work that truly didn't solve some core safety problems. After one fall resulting in a broken shoulder, my grandmother has yet to return home and has become part of the statistic cited above.

So NMN's answer to the two-man transfer dilemma and the larger safety problem encountered by all of the stakeholders of aging in place was to look at home modifications.

Wheelchair ramps and widened doorways would immediately enhance the

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Creative Destruction... (continued from page 21)

safety and independence of 2,700 MLTC members NMN identified in the Metro New York area who struggle with both extreme isolation and major safety hazards on a daily basis. Additionally, by virtue of the demographic of New York's MLTC population and general lack of universal design in New York's housing inventory, it was concluded that the majority of managed care plan members could benefit from basic home modifications aimed at falls prevention.

After 18 months of network development, a partnership with the USC Gerontology Department's executive education program for home modification contractors, another partnership with the Home Depot, and some technology development, Evolve Emod was born. The goal was an organized delivery system for home modifications designed to allow for managed care plans and other stakeholders to easily obtain competitive bids, coordinate home modifications, measure quality and administer claims.

> *Wheelchair ramps and widened doorways would immediately enhance the safety and independence of 2,700 MLTC members NMN identified in the Metro New York area who struggle with both extreme isolation and major safety hazards on a daily basis.*

This is but one example of *creative destruction*. Some might simply call it innovation but NMN and Evolve Emod want to encourage and challenge all of you, as major stakeholders in the New York long term care market, to continue thinking outside the box, analyze data, connect the dots and be creative in identifying solutions to problems. You possess the coveted "tribal knowledge" necessary to identify the dynamic problems our market faces and simply need to continuously act on ideas to solve them. Your efforts could leave a lasting legacy.

For further information, please contact Billy McKee, principal & executive vice president, National MedTrans Network, Evolve Emod billy@evolve-emod.com

Competitive Energy Proposals for LeadingAge New York Members

A significant upgrade in energy procurement options is now available for LeadingAge New York members participating in the Energy Alliance program.

Member facilities are familiar with the fact that energy is among the highest cost items in the budget every year, often just below personnel. So getting control of them is always a priority.

Now, the Energy Alliance program is able to offer current and new participants competitive pricing from multiple energy suppliers. This way, members will know that the pricing you are offered is the best available.

Facility managers have often been frustrated when they receive only one offer from a given consultant or broker. Is it the lowest available, or just the one chosen by the consultant?

Competitive pricing for all members

In response, EnergyNext, Inc., LeadingAge New York's endorsed vendor energy consulting firm, has upgraded its services to provide an enhanced market platform for member facilities. The platform will allow multiple energy companies to bid on each LeadingAge New York member's requirements, and it will also produce graphic information showing how a customer's pricing and usage have compared to general market trends.

If a facility's annual usage is above about 200,000 kWh (most LeadingAge New York members are in this category), EnergyNext will issue a formal Request for Proposals (RFP) for each new or renewing customer.

The enhanced program is available for both electricity and natural gas in all utility territories in New York State.

Prompt turnaround

Turnaround for the RFP will be one to three days, sometimes same-day response, so customers will get pricing when they are ready to make a decision.

Suppliers who will be invited to respond will include the major blue-ribbon energy suppliers in the industry in New York State: Direct Energy, Hudson Energy, Constellation, ConEd Solutions, and Nordic Energy (starting in July).

(See Competitive Energy on page 24)

Competitive Energy... *(Continued from page 23)*

A comprehensive pricing analysis complete with trending information, supplier information and background will be prepared and sent to clients.

As well as competitive pricing for electricity and natural gas, the LeadingAge New York program now offers renewable energy options that can provide facilities with a long term hedge against future market volatility.

> *The platform will allow multiple energy companies to bid on each LeadingAge New York member's requirements, and it will also produce graphic information showing how a customer's pricing and usage have compared to general market trends.*

The renewable supply options include both solar and micro-hydroelectric generation. Under recently implemented rules of the New York State Public Service Commission, customers can implement these options even if the generating unit is located some distance away from the facility.

"Our partnership with LeadingAge New York Services, Inc. means that we must always strive to bring value to the members," said Gordon Boyd, of EnergyNext. "We are delighted to bring a competition-based pricing platform to LeadingAge New York's participants, and we know that they will benefit from the cost control and savings available, as well as the transparent market analysis and supplier options."

Members wishing to learn more about the energy supply or renewable energy options should contact LeadingAge New York Services, Inc. staff at 518-867-8383, or EnergyNext, Inc. at 518-580-9244.

Health What???

Karen Burhans Laing, CEO/founder, Health Literacy for All Inc.

Health Literacy is a set of skills and knowledge that people need to navigate the health care system, make healthy choices and respond appropriately in a public health crisis. If you have ever tried to decide between two different medical treatments, forgotten to take your medications, wished you understood what your doctor was saying, or tried to live a healthier life but were confused by the research out there, your health literacy skills need improvement. You are not alone. The federal government estimates only 12 percent of English-speaking Americans are fully health literate **(www.health.gov/communication/literacy/quickguide/factsbasic.htm.)** Factor in the 20 percent of Americans who do not speak English at home – and the fact that skills related to public health emergencies were not included in this estimate – and we are really talking about only 3-4 percent of Americans being fully health literate. This is a real crisis in our health care system!

If the federal government knows how bad it is, what's being done to improve American's health literacy skills? The answer, sadly, is that very little is really being done. Our medical system has known since the 1980s, when people suffering from AIDS and breast cancer began demanding more information about treatments and their care, that people aren't as health literate as they should be. The medical system has slowly responded to the lack of health literacy skills by providing information in easier to read formats, speaking slowly, encouraging patients to ask questions and using translators to ensure the patient understands what is going on. None of these things, however, teach the patients the health literacy skills they need to be successful. It's like saying, "Johnny can't read, so rather than teach him to read, we will dumb down the curriculum."

As a public health educator with a history of special education and designing training programs, it didn't take me long to identify the need to teach people these skills. So, after months of research on what the skills are that the medical field feels is lacking, I designed a comprehensive program called "Health Literacy and You" to teach patients how to be fully health literate, as well as to teach providers how to be better communicators. As word has spread through the Capital District, I am seeing increasing numbers of people who are anxious to learn these skills and, as a result, live a healthier life.

The best care possible should be every senior's goal for their health needs.

So who is at risk of low health literacy? Obvious choices are the functionally illiterate, the non-English speaking immigrant and those living in generational poverty. An additional surprising answer is the elderly: "Poor health literacy is not necessarily limited to lower income patients; one study of

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Health What

(Continued from page 25)

affluent professionals living in a geriatric retirement community found that 30 percent scored poorly on a test of functional literacy in healthcare situations. These patients may be the most difficult to identify, as they generally have developed a range of coping skills to hide their difficulties from family, business colleagues and their healthcare providers"

Learning to prevent illness, lowering emergency room trips and hospitalizations, using medication properly and learning to recognize the dying process are keys to controlling health care costs as well as helping people reach the end of their life by sliding into home plate and cheering loudly! Communication and prevention are the keys to excellent medical care in most of the world. The United State historically put little emphasis on prevention. In fact, for many years Americans carried hospitalization only policies driven by the fear of big hospital bills for medical emergencies. They didn't think about, nor take advantage of, the future savings that can be afforded through the preventative care that insurers will cover. In the long term, this is a costly mistake.

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Health What *(Continued from page 26)*

While prevention is best addressed at young ages and continued through the end of one's life, anyone at any age can benefit from good preventative care. One of the issues I hear over and over when I teach in senior housing facilities is the comment, "My doctor thinks I am pretty healthy for my age." This comment is often linked to chronic diseases that are not being managed as well as they should be, or would be if the patient were younger. This is not good preventative care at all. Seniors who learn more about their chronic illnesses and how to navigate the health care system often insist on better results. In one community, a health literacy class on diabetes was presented to 6 residents with the illness. Four months later, 5 out of the 6 had brought their blood sugar levels back down into normal ranges and 2 (both in their mid-80's) had begun using endocrinologists because they didn't want to be "in control enough for their age."

Speaking of endocrinologists, doctors that specialize in the hormones our bodies make and use, prevention and chronic illness care often mean seeing a specialist. There are 13,000 known conditions that can affect the human body and no doctor is proficient in all of them. Most are really great at treating about 2,000 of them. The other 11,000 diseases will require

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Health What *(Continued from page 27)*

a trip to a different doctor. Everyone should be able to have the doctor with the most experience looking at their symptoms and their bodies, especially as they age. Improved treatments and medications may be cheaper, easier to use or more effective than the older way of treating a disease. Specialists keep up on the very latest in their fields and can provide seniors with the best care possible.

The best care possible should be every senior's goal for their health needs. However, if they lack the skills necessary to manage their medications, communicate with their doctors and families or cannot make good health choices because they have chosen "independence" over health and safety, they will never be able to access that care. Two of the saddest facts we know is that seniors naturally lose their health literacy skills over time, and having two or more chronic illnesses can also lower health literacy skills. Continuing health literacy training helps seniors to keep the skills they had and learn new ones.

So then the big question is, in terms of the Supportive Housing Initiative under the Delivery System Reform Incentive Payment, "is there proof that training patients on health literacy skills really works?" Unfortunately, there has not been a lot of research on this question, but the research that we do have is impressive: 57-61 percent reduction in ER use, 39-56 percent fewer trips to the doctors, increase medication compliance rates by 25-62 percent, increased exercise (33 percent), healthier eating (33 percent), and 87 percent shared what they learned with friends and family (While all that research comes from California's health literacy initiative to Medicaid parents, there are other states teaching health literacy skills: Florida teaches it primarily as an ESL program and Minnesota which provides classes only for seniors. New York State has the only program in the nation that teaches to all ages and demographics through the organization I run. Besides the diabetes results, we have had one senior who, at 87, is a regular attendee of health literacy classes and has been able to come off his blood pressure medication because he learned the skills to eat healthier, make his exercise routine more effective and reduce his stress. Many other residents feel healthier, more educated and report initiating discussions with their families about the end of life decisions. Many of the senior housing providers use the health literacy classes not only to teach their residents, but for outreach, family support or staff development. Health Literacy skills are life-altering, life-extending and life-affirming. How are your skills?

Two of the saddest facts we know is that seniors naturally lose their health literacy skills over time, and having two or more chronic illnesses can also lower health literacy skills. Continuing health literacy training helps seniors to keep the skills they had and learn new ones.

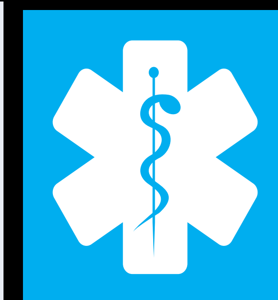
For more information contact: www.HealthLiteracyforAll.org

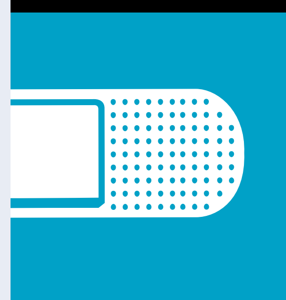
The Balancing Incentive Program and Mission

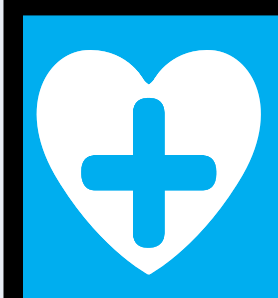
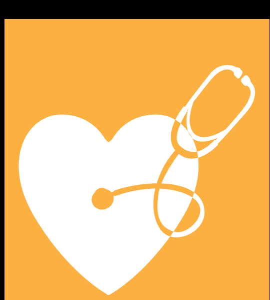
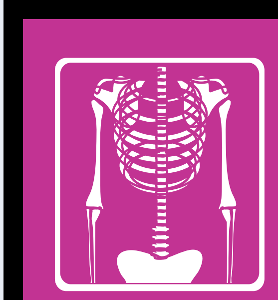
The Balancing Incentive Program Brings New Life to Community-Based Long Term Care Services and Supports









New York's implementation of the Balancing Incentive Program has created exciting opportunities for providers of home- and community-based services and the clients they serve. Established under the federal Affordable Care Act, the Balancing Incentive Program (BIP) provides a financial incentive for states to provide greater access to community-based, long term services and supports (LTSS). The BIP requires participating states to implement three major structural reforms: (i) a no wrong door/single point of entry process for eligibility determinations; (ii) a core standardized assessment for determining eligibility for non-institutional LTSS, and (iii) a Conflict-Free Case Management system (CFCM). By the end of the grant period, each participating state must achieve a specified Medicaid spending target for community-based LTSS.

New York State has been awarded nearly $600 million over three years[1] in enhanced federal Medicaid matching funds to implement the BIP. Under the grant, it is required to spend at least 50 percent of its Medicaid long term care dollars on community-based LTSS by the time the grant ends. Of the $600 million awarded, the State has made available $47 million in BIP Innovation Fund grants to providers of community-based LTSS to accomplish the following goals:

- Increase the number of individuals served in a non-institutional setting;
- Improve access to community-based LTSS;
- Ensure stakeholders are engaged in creating lasting solutions; and
- Create innovative approaches to assisting individuals to transition from institutional settings to the community or to remain in their communities.

Fifty-four organizations statewide, including 15 LeadingAge New York and Adult Day Health Care Council members, were awarded BIP Innovation Fund grants. The seven members featured in this article are engaged in a variety of activities all designed to either help individuals transition from an institutional setting or remain in the community in spite of requiring long term care or services

[1] The federal grant is scheduled to expire on September 30, 2015 and all federal funds are to be expended by that time. However, CMS recently announced a process by which states may request an extension of time to spend their awards and accomplish their deliverables.

Selfhelp Community Services, Inc.

Tova Klein, LMSW, assistant vice president, Senior Communities

Selfhelp was awarded three grant projects through the Balancing Incentive Program (BIP). They are Selfhelp Medicaid Care Transition Program (BIP CT), Selfhelp Medicaid Safety Net Program (BIP SN) and Selfhelp Enhanced SHASAM program (BIP SHASAM).

Selfhelp Medicaid Care Transition Program (BIP CT)

Q. Please provide a brief description of your BIP innovation grant project.

Tova: The Care Transitions program will provide transition coaching and short term case management to Medicaid eligible patients – from three hospitals in Queens – who are identified as being at risk of readmission. Coaching will take place in the hospital, at home and via telephone during the first 30-days post discharge. The goal is to transfer skills and knowledge to patients and caregivers to maximize understanding and compliance with discharge plans as well as enhancing access to health and social services as needed. The desired outcomes include improved transitions between hospital and home, establishing an effective exchange of information between the community and the hospital, increased access to and use of coordinated health and social care and a reduction in the rate of hospital readmissions. Performance measures will include number of patients served, readmission rates, patient satisfaction, tracking of physical visits within 14 days of discharge and number and types of community supports identified and obtained.

Q. What were the goals and objectives of the project?

Tova: To provide patients with coaching in order to prevent hospital readmission, to maintain a readmission rate of less than 15 percent and to provide community resources to clients.

Q. Overall, would you say that you met the goals and objectives? Please explain.

Tova: Overall the program has met the goals and objectives.

The program has maintained a readmission rate of less than 15 percent because we have connected patients to their primary care physicians in the first 14 days post discharge. Many of the patients were unaware that they need to follow up with their primary care physician and when the coaches visited the patients, the coaches made calls with the patients or directed them to make the call. This ensured that they clients received necessary follow up care.

The program provided patients with referrals to community resources at an average rate of 90 percent to date. Also, the program has been successful in meeting the goal of 50 percent of patients obtaining the services that were referred.

Q. Specifically, what worked? And what didn't work?

Tova: Through the program we have found that providing coaching to patients within the first weeks of discharge has helped to ensure that they follow up with their primary care physician. Additionally, helping patients identify red flag indicators of worsening condition and appropriate next steps helped the patients avoid hospital readmission.

The program has had some difficulty in receiving timely information on patient discharges and has not been able to meet the goal of visiting patients within 72 hours. However, even though we do not visit patients within 72 hours the program has had a significant impact on the patients that were seen.

Q. What are your plans for sustainability of the project?

Tova: The BIP programs will end September 30th 2015. There are no plans to sustain the project, though the lessons learned and the successful experiences attained will be used to

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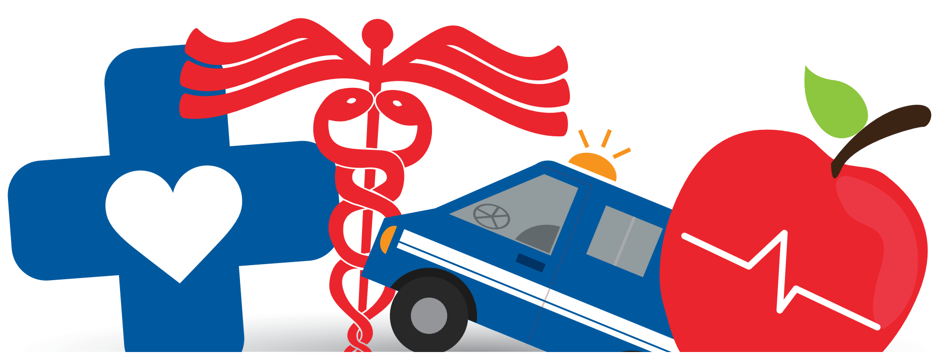


Selfhelp Community... *(Continued from page 32)*

participate in future DSRIP projects. We are also looking at various other funding streams to try and extend certain aspects of the projects.

Other projects have been built off the success of our BIP programs. For example, the NY Connects Program for Queens, which was recently awarded to Selfhelp, has a Care Transition component that was in part awarded to us due to our success in the BIP CT program.

Q. If you had it to do over, what would you have done differently?

Tova: The grant could have been written in a way that the targeted numbers and deliverables could have been lower initially and increased over time. Traditionally, programs take time to be fully functional. If the grant was written so that the program would increase gradually it would have more of an impact on the desired number of patients.

We would also build relationships with the hospitals prior to writing the grant so that they are fully committed to the process. The hospitals do not see the program as a partnership and it would be helpful to correct that perception. Perhaps if they were involved in the process initially they would be more committed to the process.

Q. If the State asked you what it should do next, what would you say?

Tova: The Care Transitions program is an effective way to avoid hospital readmission and the state should continue funding the program so that more patients can be provided coaching and support.

Q. What would you recommend to colleagues given your experience with this BIP grant?

Tova: I would recommend building strong relationships with hospitals and/or other partners to ensure their commitment to the program.

Selfhelp Medicaid Safety Net Program (BIP SN)

Q. Please provide a brief description of your BIP innovation grant project.

Tova: The Safety Net program was designed to provide comprehensive case management/social services to a subset of the population awaiting entry into Selfhelp's senior independent living sites. The population was noted to be at risk for functional decline due to social, financial and health issues.

Q. What were the goals and objectives of the project?

Tova: The program's goal is to maintain Medicaid eligible seniors, 60 years and over, in the community, living and functioning independently for as long as possible through the coordination and provision of a wide range of community based resources and services while they wait for Selfhelp housing to become available. The desired outcomes following client assessment, identification of needs and addressing these needs, is to enhance the ability of frail older adults to remain independent while reducing the risk of deterioration to the point of needing costly services such as ER, hospital or nursing home care.

New York State understands that vulnerable populations have complex needs and that these needs must be addressed prior to a health crisis. If these needs are not addressed, the financial burden will fall to healthcare providers and health care systems. This has pushed governments and policy makers into the direction of keeping people out of hospitals, nursing homes and ER rooms.

The Selfhelp Safety Net program was funded so that vulnerable clients could be identified by skilled community social workers, and once identified, they would be able to receive the intervention needed so as to prevent the use of costly health care dollars.

For example, Mrs. T., 90 years old, spent up to four hours each month sitting in a Medicaid clinic waiting to be seen by a doctor to treat her chronic asthma and high blood pressure. She was hospitalized once and seen in the ER twice in one year. Her Safety Net social worker linked Ms. T. to a home visiting doctor for ongoing monitoring. This simple intervention will have a real impact in reducing the amount of time she seeks medical attention in an ER (hence cost), but it also, more importantly addresses the quality of her care and consistent management of her chronic health conditions.

Q. Overall, would you say that you met the goals and objectives? Please explain.

Tova: Performance measures of the BIP Safety Net program consist of tracking the numbers of clients receiving assessments, the numbers of applications completed for benefits and entitlements, the numbers of referrals to other

(Continued on page 34)

Selfhelp Community... *(Continued from page 33)*

community based programs or services, the dollar value of entitlements received which help support independence, the volume of home visits and office visits, and the hours of case management services provided.

The BIP Safety Net program was fully staffed in November of 2014, and has been operating for seven months. To date, BIP social workers have assessed 222 clients and applied for 223 entitlements and benefits for these clients. The dollar amount of these entitlements and benefits that clients will receive is approximately $85,900 dollars annually. It is important to note that this money is returned to the communities that these clients live in, supporting the economy as a whole. There was also 179 referrals made on behalf of these clients that addressed health care and home care needs, transportation access, grants for needed house hold items, nutrition programs such as meals on wheels, legal and immigrations services, as well as programs to decrease isolation and increase socialization and mental health. The program has been hugely successful.

Q. Specifically, what worked? And what didn't work?

Tova: There were some challenges regarding office space as it was not anticipated that so many clients preferred to be seen in the office and not in their homes. Of the 222 clients, 83 were conducted in the office while 134 were conducted in the homes.

Clients were not being seen in one borough but in all 5 boroughs. There were times when the social workers would spend several hours trying to find a client's home, only to return to an office because they were lost or ended up in unfamiliar and isolated locations. Keeping workers in one borough, becoming the experts in resources and services in one community helps social workers to build strong community relationships and alliances as well as a very comprehensive resource data base. Many useful resources and services are not government funded but created by private foundations, religious institutions and volunteer organizations. Tapping into these resources when necessary helps to address the needs of some clients who are either ineligible for government programs or not appropriate.

Assessing clients, identifying needed services and applying for those services is only the first step in helping a client to remain functionally independent. An ongoing challenge has been the lack of specific resources and services available to meet a client's needs. We can identify that a frail older adult with heart failure who is frequently showing up in the ER is in need of subsidized housing because he is rooming in an illegal basement apartment with 10 other people and has no access to kitchen facilities. But what are we expected to do when we know that a client must wait years until a subsidized apartment will become available? The client who is wheelchair bound or memory impaired is in desperate need of home care services but must now wait months before the program he/she is enrolled in will actually begin services. Social workers can fill out forms, they can be strong advocates, but there are times when the actual coordination and implementation of community based services, despite client eligibility, just doesn't happen the way we expect or want it to.

Q. What are your plans for sustainability of the project?

Tova: The BIP programs will end September 30th 2015. There are no plans to sustain the project though the lessons learned and the successful experiences attained will be used to participate in future DSRIP projects.

Q. If you had it to do over, what would you have done differently?

Tova: We would have loved to start earlier in the year and be fully staffed with a data system in place. We also would have liked some training support from the State. The program had a delayed start and seemed rushed when it did start, but all in all everything worked out well.

We would have also written into the proposal from the get go and expansion of potential clients beyond the Selfhelp housing wait list to include Medicaid or Medicaid eligible clients in other housing unit wait lists as well as temporary housing sites/homeless shelters. The State's interest in serving undocumented seniors was also a late addition to the program and would have been valuable to begin with earlier.

Q. If the State asked you what it should do next, what would you say?

Tova: By reaching out to housing applicants as a result of provided housing waitlist information, the BIP Safety Net social workers were able to connect with frail older adults in need who would not have reached out for help on their own. We noted that many of our BIP clients needed to receive

(Continued on page 35)

Selfhelp Community... *(Continued from page 34)*

information in their own language and we were able to accommodate Chinese, Korean, Creole, French, Portuguese, and Spanish speaking clients. By linking frail older adults to community based services, the BIP program has helped many clients avoid hospitalizations and emergency room visits. The State should continue funding the program so that older adults can receive the support and services they need.

Two trends were noted from our work that the state needs to address. There is a lack of temporary home care hours available to clients waiting for long term home care to begin, and affordable housing for older adults with chronic health care needs remains limited. The State needs to be more aware of the necessity of stop-gap programs so that there are alternatives to costly medical care and nursing home placement.

Q. What would you recommend to colleagues given your experience with this BIP grant?

Tova: Identify in your own communities and programs what services are lacking. If you can tract trends and measure outcomes, you could seek funding to create programs and services to address these needs.

Selfhelp Enhanced SHASAM program (BIP SHASAM)

Q. Please provide a brief description of your BIP innovation grant project.

Tova: The Enhanced Selfhelp Active Services for Aging Model (SHASAM) program will enhance existing services at seven Selfhelp senior independent living sites by expanding the focus on health and wellness services onsite for a subset of Medicaid eligible residents.

Q. What were the goals and objectives of the project

Tova: The goal was to coordinate health/wellness services and tailor them to the individual's needs and to motivate clients to maximize their health/wellness. The desired outcome was to enhance their ability to remain independent, remain in the community and enhance functional levels and health outcomes. The model will include preventive care with an on-site health coordinator. Performance measures will include tracking the numbers of clients who receive assessments, referrals, by type of service, numbers who saw primary care provider, utilization of health screenings and other onsite wellness programs. Selfhelp will use several different tools to survey health/wellness outcomes in the areas of falls, memory, mental health, social isolation among others.

Q. Overall, would you say that you met the goals and objectives? Please explain.

Tova: Yes, we are on target with most of the goals and deliverables based on the project time line. We will be doing reassessments in August/September time frame to see the actual changes in certain deliverables such as Patient Activation Measure scores. This will demonstrate if one-on-one resident engagement practices have had an impact and if seniors see change in their motivation. We will also be comparing pre and post scores on individual interventions such as health and wellness programs to see if the interventions made any difference in, for example, stress levels, coping skills, healthy literacy, etc.

Q. Specifically, what worked? And what didn't work?

Tova: Due to the limited tenure of the project, we found hiring personnel to join as per-session recreational leaders was challenging. It was easier to hire them as consultants.

Q. What are your plans for sustainability of the project?

Tova: The BIP programs will end September 30th 2015. There are no plans to sustain the project though the lessons learned and the successful experiences attained will be used to participate in future DSRIP projects.

Q. If you had it to do over, what would you have done differently?

Tova: Put more money towards interventions, especially keeping in mind the diversity of the participants. For example, more money was needed to hire a mental health professional to serve Korean, Chinese, Russian and Spanish seniors.

Q. If the State asked you what it should do next, what would you say?

Tova: These health and wellness programs are so important for keeping seniors in the community and out of hospitals and nursing homes. There is no funding to provide such interventions in housing for seniors. We would advocate that such funding be continued and be a staple of any senior housing programs.

Q. What would you recommend to colleagues given your experience with this BIP grant?

Tova: We would recommend really knowing the seniors, getting their buy in by having a big resident engagement piece. Have all your stakeholders involved and on the same page.

Total Senior Care

Kelly A. Dickerson, communication, information and marketing director

Q. Please provide a brief description of your BIP innovation grant project.

Dickerson: Total Senior Care received a BIP grant to help with establishment of adult social day programs in Gowanda, Cattaraugus County, and Wellsville, Allegany County. Both are in rural areas, with limited services for the frail elderly.

Q. What were the goals and objectives of the project?

Dickerson: The goals and objectives were all aligned to successfully open adult day centers. This included buying equipment, finding and training staff and marketing the program.

Q. Overall, would you say that you met the goals and objectives? Please explain.

Dickerson: We have met our goals for the Gowanda site. It opened in May and we celebrated with a grand opening on June 12. Enrollment is still building, but we aren't concerned that we won't meet the target. Our Wellsville site will open last this summer, as was planned.

Q. Specifically, what worked? And what didn't work?

Dickerson: It was a little more difficult finding appropriate staffing than we had anticipated. Adult day center staff work closely with participants, so you want to make sure you have the right people. They need to be cheerful, helpful, empathetic and love working with the elderly. These locations are in very rural areas, so there is not a large applicant pool.

Q. What are your plans for sustainability of the project?

Dickerson: We absolutely believe the program is sustainable through use of the program by our Program of All-Inclusive Care for the Elderly, the Veterans Administration, private pay and other organizations who provide services to the frail elderly.

Q. If you had it to do over, what would you have done differently?

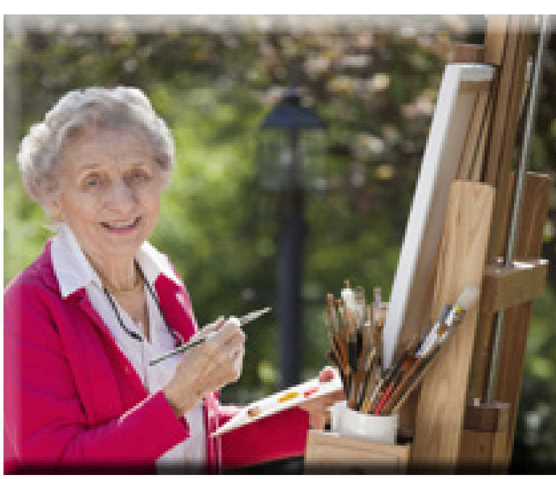
Dickerson: It took a long time to get the actual contract signed by all necessary state officials. That shortened our timeline to get everything done. The state changed its system of contract approvals and notifications, which we didn't know. Next time I would schedule a weekly reach out to the state comptroller's to have a better understanding of where the contract was in the approval process.

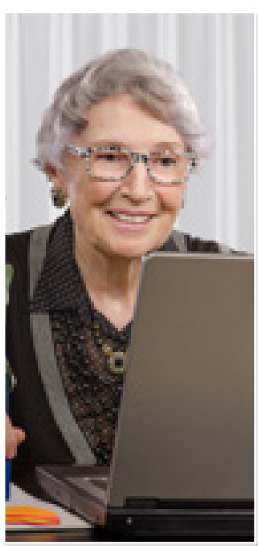
Q. If the State asked you what it should do next, what would you say?

Dickerson: We would love for the state to provide capital funding for expansion of the PACE program. The BIP grant didn't allow for any "bricks and mortar." Finding funding for construction costs is difficult.

Q. What would you recommend to colleagues given your experience with this BIP grant?

Dickerson: We were fortunate to have a wonderful grant officer at NYSDOH that handled our project. I would recommend that other organizations develop cordial relationships with their assigned person. They can help you solve problems and steer you in the right direction. I really felt our grant officer wanted us to succeed.





St. Mary's Heathcare System for Children

Jonah Cardillo, director of institutional gifts

Q. Please provide a brief description of your BIP innovation grant project.

Jonah: In the summer of 2014, St. Mary's was awarded a Balancing Incentive Program (BIP) innovation grant to launch a proof of concept telehealth project aimed at lowering avoidable hospital use among children with highly complex medical conditions enrolled in our certified home health agency. In October 2014, we launched the program – a nurse-driven telemonitoring initiative designed to enroll up to 500 medically complex children most at-risk for admission or readmission to hospitals, skilled nursing facilities or other more institutional settings. Those enrolled continued to receive skilled nursing and rehabilitation home care visits and case management as mandated by physician orders; as an adjunct service, parents or caregivers began to receive regular automated calls from an Interactive Voice Response (IVR) system administered by St. Mary's skilled nursing telehealth team.

Automated IVR calls request very basic information from a child's caregiver. Five automated templates are tailored to monitor patients with asthma, non-asthma respiratory conditions, and seizure disorders, as well as those who are at risk for dehydration, or who are otherwise at risk for hospitalization. Calls solicit yes or no responses from caregivers who are asked a series of questions on their child's medication adherence, occurrences of major medical events such as seizures or falls, and changes in condition. Responses to each automated call takes 2-3 minutes to gather, as opposed to other similar programs in which clerical staff spent nearly 30 minutes to make a similar call. Based on these calls, reports are generated automatically, flagging responses that indicate the need for follow-up. RN Telehealth Nurse Managers monitor alerts and make follow-up calls to further assess flagged responses. If an urgent need is identified, the Telehealth Nurse Manager will coordinate with the child's assigned home care nurse to make a follow-up visit, thus facilitating a preventative intervention days and maybe even weeks earlier than previously possible.

IVR enables our staff to track occurrences of lapses in medication adherence, seizures, emergency room visits and other major medical events more quickly and more accurately. Because skilled nursing visits may take place as infrequently as once every 60 days, these calls provide the opportunity to touch base several times between visits. Our telehealth nursing staff can therefore identify children who need care between visits, and quickly intervene before an issue develops into a major health concern. Prevention among this vulnerable population is key, and our IVR helps us keep New York City's sickest kids healthier.

Since launching in October, we have built an active census of about 450 enrollees:

- More than 11,000 IVR questions answered to date
- Some 1,100 alerts generated and responded to
- 88 percent of participants answered at least one template sent to them

Q. What were the goals and objectives of the project?

Jonah: The overarching objective is to increase the amount of communication that takes place between St. Mary's and its home care patients. If additional care, education or guidance is needed between visits, we now have a means of identifying that need and facilitating support. Our telehealth care managers are skilled nurses, and are therefore equipped to apply a great deal of clinical expertise and experience as they manage incoming alerts. As such, this project advances the following objectives:

- A reduction in avoidable hospital use among our patients
- An increase in medication adherence
- An increase in patient and family satisfaction

Q. Overall, would you say that you met the goals and objectives? Please explain.

Jonah: We are currently working with our telehealth vendor to track a vast amount of data generated by the automated IVR system, and with a consulting firm with expertise in data science to aggregate and analyze this data as we assess project outcomes. Initial data and anecdotal evidence suggests that we are on track to achieve a meaningful impact across all three of the above stated objectives. In the fall, we expect to release a white paper with a more robust analysis of program outcomes.

Q. Specifically, what worked? And what didn't work?

Jonah: Parents are very satisfied with the project – they feel that these additional touch points are helping to keep their children healthy and that makes them feel more secure. Needless to say, parents and children are very happy when we can help them avoid a

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St. Mary's Heathcare... *(Continued from page 37)*

trip to the ED or hospital by addressing a potentially serious health issue early on. It's too early to speak definitively on the impact on hospital utilization but we are amassing a significant number of success stories and program-wide data that indicates a drop in our non-elective hospitalization rate.

The one area we are working to improve is our compliance rate, which with more than an 88 percent participation rate and well over 60 percent of all calls receiving full responses, is quite strong. We are actively outreaching to and engaging families who do not answer IVR calls with the desired frequency.

Q. What are your plans for sustainability of the project?

Jonah: This summer, we will share initial outcomes with private funders and managed Medicaid plans to secure funding beyond the term of the BIP contract. As this program drives reductions in avoidable hospital utilization, it will also drive healthcare cost savings – an outcome that will entice managed care plans to support this intervention over the long-term.

Q. If you had it to do over, what would you have done differently?

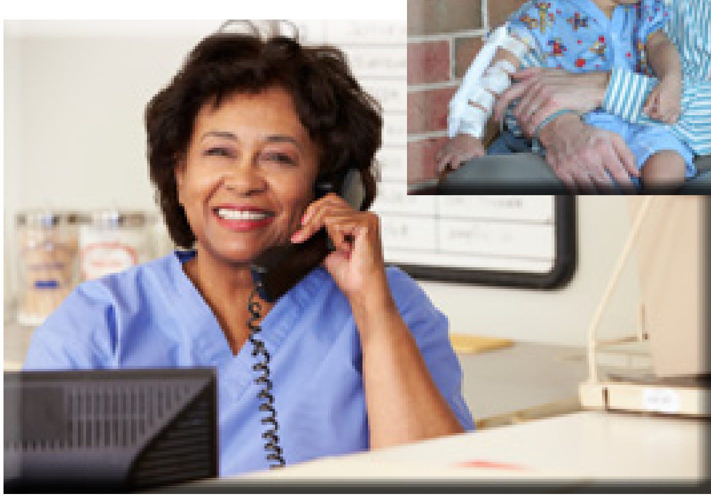
Jonah: We really had to create an entirely new program from scratch. There isn't another remote patient monitoring program out there that is as versatile as this one. Whereas IVR has monitored single, targeted patient groups with success, this intervention monitors children with a wide range of diagnoses and conditions via a single telehealth intervention. We are proud at how quickly we were able to mobilize and launch this project – and at its impressive initial results. Now that we have clearly defined policies and protocols in place, we can help others scale the program more quickly and effectively.

Q. If the State asked you what it should do next, what would you say?

Jonah: In the fall, when our final results are in, we will make the case to the State and other providers that this IVR intervention should be implemented more broadly to ensure more frequent, effective communication between home care agencies and their patients—and to ultimately drive improved care and fewer hospital visits. We are eager to play a role in making this happen.

Q. What would you recommend to colleagues given your experience with this BIP grant?

Jonah: We'd recommend that colleagues get in touch to learn more about the intervention. In November, we'll be hosting a conference to share a detailed analysis of program outcomes and ideas for how this project can be scaled by peer providers. We welcome our colleagues to visit **www.stmaryskids.org** to learn more and to register for the conference when its details are available later this summer.



LiveOn NY (Formerly Council of Senior Centers and Services of New York City)

Karol Tapias, director of training & innovation at LiveOn NY

Q. Please provide a brief description of your BIP innovation grant project.

Karol: It's called "A Community Focused Approach to Preventing Falls." This pilot will work with four Bronx-based senior centers as a vehicle to reduce falls among low-income (Medicaid eligible), at-risk, seniors in the Bronx through six programmatically integrated interventions and prevent unnecessary emergency room admissions; hospitalizations; rehabilitation services; institutionalizations to long term care; and other related medical costs.

Q. What were the goals and objectives of the project?

Karol: The overall goal of the program is to implement a community based falls prevention program that will help older adults prevent falls. We wanted to:

- Provide general education about falls prevention to all members of four senior centers in the Bronx which have high percentages of Medicaid eligible participants;
- Screen at least 60 individuals from those senior center members to identify those most at risk of falls;
- Provide intensive training at each of the four centers with 8-12 participants each, utilizing A Matter of Balance, an evidence based intervention;
- Link up to 150 seniors who are identified as a high risk for falls to an on-site Montefiore Hospital geriatrician;
- Make at least 150 at home-assessments of at-risk seniors' homes, including personalized recommendations to reduce falls;
- Provide up to $7,500 in minor home modifications, such as the installation of grab rail in the bathrooms, at those most at risk.

Q. Overall, would you say that you met the goals and objectives? Please explain.

Karol: Yes, we are on target to meet these outcomes. We've had three of the general education sessions and have screened approximately 100 seniors for their falls risk, while also connecting each of them to a physician screening. We have completed two of our Matter of Balance classes to date and both were wildly successful. We had engaged seniors that were unafraid of sharing their experiences with falls and their fears. They ended the class feeling validated and empowered and had a few new tools in their box for preventing falls. Our next class is starting in early June and we'll have the fourth one at the end of the summer. We have just begun performing in home safety assessments and will continue to offer them throughout the remaining months. We have not yet identified anyone in need of home modifications, but expect that will pick up as we do more home assessments.

Q. Specifically, what worked? And what didn't work?

Karol: Working within the senior centers works really well. The seniors are excited to learn more about this issue that affects so many of them. We have the educational session the week before the start of the class so that the participants get really excited about attending the class. We even demonstrate some of the exercises they will do in the class to demystify what happens in the sessions. We find this helps increase the attendance for the class. We have been struggling to get people as excited about the home safety assessments. We believe this is because it is more invasive and not everyone is comfortable with inviting a stranger, even a trusted stranger, in to their home. They are also probably a little nervous about what will happen if the assessment determines there is something unsafe. We have started strategizing around these concerns and will be presenting them in a different way in the coming months to hopefully ease the concerns of the seniors and get them more interested.

Q. What are your plans for sustainability of the project?

Karol: Through this program we have built the capacity of our partner agency that sponsors the senior centers we are working with so that they will be able to continue the classes after the funding is finished at a very low cost to the agency, making it a sustainable model. We are actively seeking funding to continue the project after the end of the BIP funding, especially to replicate this capacity building model for other agencies. Additionally, we are identifying new partners that we can work with as well as exploring other models of funding.

Q. If you had it to do over, what would you have done differently?

Karol: This is tricky, I'm not sure that I would do anything differently. We have had such a great experience on this program and have learned a great deal about implementing a program like this.

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Jewish Home Lifecare

Susan Holodak Robertshaw, MS, vice president for day care services

"We have two BIP programs: Jewish Home LifeCare – Westchester Sarah Neuman Night Care Program, and Enhanced Adult Day Care Rehabilitation Services in the Jewish Home Lifecare Manhattan Division.

"It's early in the life of the programs so some questions are difficult to answer definitively at this point. But here's what we know so far.

"I can only say that if we had it to do over again, we would have focused earlier on the contract addendums/amendments with the managed care companies for the Night Care program. Since it is a new program existing contractual agreements did not cover the provisions of the service. It is a very time consuming process to revise the contracts to reflect the new service and reimbursement rate.

"The state is offering an extension of the grant period due to the delay in the grant approval. This will definitely be a benefit to both programs that had projected census and service ramp up each month. So far we have achieved our goals for the first two months of the reporting period."

Jewish Home LifeCare – Westchester Sarah Neuman Night Care Program

Goals/Objectives

"The purpose of the Night Care program is to provide the traditional day care services to individuals with moderate to advanced cognitive impairments that pose specific behavioral and care needs during the evening and early morning hours. These services include socialization, supervision and monitoring, therapeutic activities, personal care, meals and assistance with care coordination.

"The program offers a safe, self-contained, secure environment for its registrants developed to minimize confusion and enhance socialization at a time when the behavior is most troublesome for the individual and problematic for the caregiver. By addressing these challenging behaviors consistent with sundowning syndrome, such as insomnia, agitation, wandering, anxiety, confusion and disorientation that contribute to caregiver 'burnout,' the program offers an avenue for respite.

"This program will improve the quality of life for the registrant and caregiver alike.

Outcomes will include;

- delaying or preventing institutionalization (nursing home placement) of the individuals with moderate to advanced dementias
- preventing or delaying the need for home care and personal care hours
- preventing or minimizing caregiver burden

Client profile

"The Night Care program began as a two-day per week program. Based on community needs and historical program operations, the program is estimated to enroll two clients per month. Census is ramped up and based on the average estimated days of attendance of 2.5 visits per week, it is estimated that a

(Continued on page 41)

LiveOn New York *(Continued from page 39)*

Q. If the State asked you what it should do next, what would you say?

Karol: I would say that we need to expand it to other centers because of the success of this model.

Q. What would you recommend to colleagues given your experience with this BIP grant?

Karol: It is great to try new programs and take a few risks in the process. This allowed us to try something that we had been discussing but had no path to try. Now not only have we tried working with evidence-based programs, we see the path forward to the next steps after this pilot program. For more information go to: www.cscs-ny.org

Jewish Home Lifecare *(Continued from page 40)*

third day will be added in month six. This ramp up will continue throughout the duration of the grant.

"By the end of the grant, the program is expected to be operational three nights per week and service 10 registrants per session or 130 registrants per month. The ramp up is conservative. As we project the census forward, the program is expected to be financially sustainable at month 18.

"We began by evaluating current clients for the Night Care program. We also informed our managed care partners, the Alzheimer's Association and other community agencies regarding program services. Since this program is not classified as a medical model, it can also serve as an adjunct to other medical model DC programs and service their enrollees afflicted with sundowner's syndrome that require supportive services at night. Ongoing marketing and outreach will build and increase the client census from month one through month 14. Those most at risk of nursing facility admission, and therefore candidates for this ADHC program, are the elderly with significant cognitive impairments that reside with family members.

"A significant number of referrals are expected to be generated by community agencies that provide services to families of individuals with Alzheimer's Disease and related dementias, elder care attorneys and managed care companies looking to control costs of service delivery including home care hours.

"Managed Long Term Care (MLTC) and Medicaid (primarily individuals who are Medicaid eligible with spend-down) will be the payer sources. The grant monies will offset the losses incurred as a result of start-up for the first 14 months.

Project

"The project tasks include:

- developing and providing Night Care services in collaboration with MLTC as an enhancement of traditional DC services to support registrant's ability to remain in the community
- Administering the Modified Caregiver Stress Index (MCSI) – a tool that assesses indicators for caregiver stress
- Purchase/Rental of Geri-beds, portable storage cabinets
- Assessing start-up staffing needs and enhancing staffing complement to cover program hours
- Enhanced training of staff on techniques for managing difficult behavior
- Outreach and marketing to community agencies, MLTC entities and stakeholders regarding the benefits of the program as a cost effective alternative to managing dementia care

Finance and Sustainability

"The service will reduce the number of nursing home placements due to caregiver burden. It also considers the Per Member Per Month (PMPM) offered for managed long-term care services by eliminating the need for 24 hour personal care services. MLTC agencies are expected to view each of these are attractive methods for cost containment.

"The proposed program addresses the need for qualitative and quantitative data collection and trending to support the program initiative, as well as, marketing resources to ensure that the benefits and successes of the program are communicated within the managed care arena."

THE NEW JEWISH HOME

Competitive advantage

"This Night Care program is appealing to referral sources as it is a cost effective alternative ($100 per 12 hour of service) as compared to long-term care placement ($343 per day) or home care ($240) for the same 12-hour period. Additionally MLTC plans are expected to view the program as a financially viable service that is able to manage care coordination and ensure quality outcomes.

"This Night Care program would be the only the second of its kind in New York State and the first offering extended DC services in accordance with NYSOFA standards.

Staffing

"The additional staffing required during the 14-month grant period will add FTEs to several part-time employees including CNAs, Nursing and Social Work making these positions full-time by the end of the grant period. The increased FTEs are covered by the grant funds through month 14 as a start-up program. By the end of 18 months, the program is expected to be budget neutral. Additionally, the effort to market this enhanced program will be done by CSD community outreach staff that was planned to be absorbed to the ADC budget even without these grant funds.

(Continued on page 42)

Jewish Home Lifecare *(Continued from page 41)*

Enhanced Adult Day Care Rehabilitation Services in the Jewish Home Lifecare Manhattan Division

Goals/Objectives

"The program goals address the need for an enhanced type of therapy (restorative vs. maintenance) and the methods and equipment by which rehabilitative therapy services (physical and occupational) are provided in a day care setting.

"Restorative treatment programs are designed to increase strength, restore range of motion and alleviate pain. Treatment methods are designed to improve clients' short- and long-term function in the community impacting a positive outcome in performing activities of daily living.

"Outcomes will include; delaying or preventing institutionalization of these individuals by reducing falls and serious injury resulting from falls of the elderly living in the community and to increase the self esteem of the population by increasing independence.

Client profile

"The success of this program is not dependent upon any census increase. The Enhanced Adult Day Care Rehabilitation Services began by evaluating current clients for these additional services to begin their enhanced therapy by month three. Ongoing outreach could build and increase the client census from month three through month 14. Those most at risk of nursing facility admission, and therefore candidates for ADHC program, are the elderly with significant disability.

"Keeping Residents in the JHL system would be an additional outcome and continued source of income. A significant number of referrals will be post-acute patients who are discharged home but require medically supervised day care in addition to rehab services in order to remain in the community. Similarly, individuals discharged from JHL and other nursing facilities will continue to have access to this service as needed, thereby ensuring continuity.

Project

"The project included construction of the space for rehab therapies at the Manhattan Day Center. The current Day Care Physical Therapy/Occupational Therapy gym consists of a large open room with four work stations, one storage closet and numerous pieces of equipment. The space is approximately 430 square feet of floor space. The current space needs to be reorganized and enhanced.

"Exercise equipment was purchased through these grant funds and is adapted for senior use with added padding to reduce impact and friction to joints. The equipment is designed to allow for the display of objective data and for recording progress and outcomes. The on screen data helps communicate progress to clients and physicians. All the equipment is wheelchair accessible and has lumbar support for the entire spinal column.

Finance and Sustainability:

"The development of the Enhanced Rehab Program will also provide an avenue for the Day Care programs to be reimbursed for Medicare services, i.e. Restorative therapies either through a Medicare D-SNP or FIDA plan.

"The service is expected to reduce the number of hospitalizations and subsequent nursing home placements in keeping with the triple aim goals of the Federal and State Governments.

"The program addresses the need for qualitative and quantitative data collection and trending to support the enhanced program initiative, as well as marketing resources to ensure that the benefits and successes of the program are communicated within the managed care arena. The daily rate of the medical model adult day program will not be increased as a result of the enhanced rehab program. Day care becomes an attractive financial alternative to managed care entities that are looking for restorative rehab for their members.

Competitive advantage

"This enhanced rehab program is appealing to referral sources since many outpatient offices lack the expertise and adapted equipment to offer safe and accessible physical therapy and occupational therapy, specifically for elders.

"We are providing full-service rehabilitation to our day care clients, and those who have additional rehabilitation needs on discharge from our Certified Home Health Agency (CHHA). Currently, we refer many CHHA patients on discharge to various outpatient physical therapy offices. We advise patients to seek an office near their home or provide a list of New York City outpatient therapy offices. These referrals do not allow for tracking the outcome or disposition of the discharged patients. Day Care offers the ideal environment due to its wide array of skilled clinical and ancillary services to maximize clinical outcomes.

Parker Jewish Institute for Healthcare and Rehabilitation

Lina Scacco, Director of Corporate Outreach and Development, Parker Jewish Institute for Health Care and Rehabiliation

Please provide a brief description of your BIP innovation grant project.

Parker Jewish Institute saw a tremendous need in the communities we serve to provide these services at home. Many of our patients are home bound or are unable to see a doctor due to lack of family support or transportation issues. Many have lost their primary care physician or no longer see them due to these barriers of care.

To address this issue, we created a physician house calls program called Parker At Your Door, which provides in-home primary medical care and case management to elderly Medicaid recipients. But it's much more than that. Yes, we have physicians who serve patients in their homes, but we also provide nursing services, care coordination, and help patients with both clinical and non-clinical needs. Our social workers connect our patients with in-home and community-based services that promote independence and improve their quality of life.

What were the goals and objectives of the project?

The goals of the program were to reach an underserved constituency and help them get the services they need so they can age in place. The program also sought to enhance the continuum of non-institutional care and insure the provision of essential services in the least restrictive setting.

The objectives of the program were to improve access to care, and to provide better quality of care and coordination of care for the population served. Other objectives include, reducing avoidable hospitalizations and hospital readmissions and delaying nursing home placements.

One of Parker's goals was to figure out ways to provide better care for patients and the more we can do that in a non-institutional setting, the better. We've created hundreds of partnerships with individuals and organizations in the community – many of whom we have worked with in the past, but many new ones as well – and that broadens our outreach.

This project was also an opportunity to tap into the knowledge and creativity of our staff. After the RFP was issued, we asked program directors what they wanted to see. After vetting several options, our team worked together on assembling our proposal.

Overall, would you say that you met the goals and objectives? Please explain.

Yes, we have and we will be looking to expand and extend the program. With this population, it's not always clinical issues that are the most difficult to address. Their health care is often effected by their living conditions, ability to obtain nutritious food and their mental health status. Through our work with partners in the community, we've successfully improved the level of care and the quality of life for many Queens residents.

We knew that we needed to be focused in developing and implementing the program and we have been. We've targeted communities with high numbers of elderly Medicaid recipients and those with a large number older adults, many of whom are severely medically underserved. While we take patients from anywhere in Queens, we have focused our efforts in the communities of Jamaica, Corona, East Elmhurst and Jackson Heights.

As a result of our successful outreach and marketing efforts, nearly 100 patients are now receiving regular primary care and case management services, which is keeping them healthier and improving their quality of life.

Specifically, what worked? And what didn't work?

Everything is harder and more complicated than you think and takes longer than you would like. That said, we were up and running within a few months of receiving state approval for the BIP grant. We hired staff, developed partnerships and did all the work necessary to begin implementing the program.

That's when we actively started seeking patients. Although we knew the need was there, patients did not kick down the door demanding services. Getting patients is hard and takes a lot of work – by our staff and by our partners. The marketing and outreach were tough initially but we learned as we went along and definitely improved along the way. Surprisingly, one of our most effective marketing campaigns was placing ads on public busses.

We also learned that marketing and outreach are more expensive than we planned but we were able to effectively move some money from other areas to that bucket. Thankfully, Parker Jewish Institute was committed to this program and helped us with other resources that proved crucial. The added resources clearly made a difference in the marketing and the improved marketing clearly made a difference in obtaining patients.

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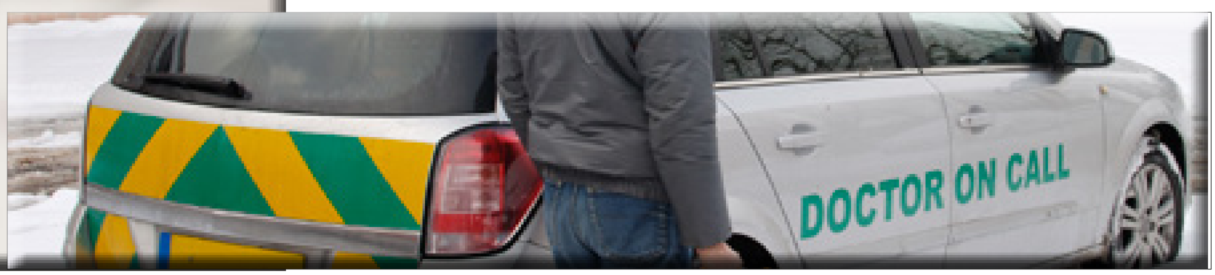

Parker Jewish Institute… *(Continued from page 43)*

What are your plans for sustainability of the project?

Currently, neither Medicaid nor any insurance companies are being billed because our services are subsidized by the grant. When the grant is over, we hope that we will be able to bill enough to be able to continue the program as we seek to expand the payer mix.

We absolutely believe the program is sustainable through the use of the program by our Program of All-Inclusive Care for the Elderly, the Veterans Administration, private pay and other organizations which provide services to the frail elderly. Good outcomes and satisfied patients, we believe, will also be key to the sustainability of the program.

If you had it to do over, what would you have done differently?

We would have built in more planning time and asked the state for more money.

If the State asked you what it should do next, what would you say?

Help those programs that succeed. Provide more money and resources to the programs that are accomplishing their stated objectives – such as Parker At Your Door – and help them expand their services. Also the state should do more to educate providers about the kinds of programs that are out there, particularly those that are successfully meeting community needs.

What would you recommend to colleagues given your experience with this BIP grant?

Look at community needs and develop programs to meet those needs. Talk to experts in your institutions, the folks on the front lines. Plan early and recognize that it is likely to be much more work than your anticipated.

RiverSpring Health

Deborah Messina, vice president strategic planning & business development at RiverSpring Health in Riverdale

Q. Please provide a brief description of your BIP innovation grant project.

Deborah: The Hebrew Home at Riverdale in collaboration with SAGE (Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders) has utilized BIP funding to establish the first Medicaid eligible, culturally competent, LGBT centered, social model adult day care program in New York State.

The Hebrew Home at Riverdale, by RiverSpring Health has continually strived to expand our continuum of services to meet the needs of seniors, especially the underserved, whether it is in our skilled nursing facility or within the community. We have had a relationship with SAGE for several years, working together to better learn and serve LGBT seniors throughout our own continuum of services.

We discovered through our connection with SAGE that the aging LGBT population is growing, isolated and has very unique social and medical needs. The Hebrew Home wanted to help fill in the gap in service in the most holistic manner possible through direct care service, as in SAGEDay and with cultural sensitivity training to all levels of staff.

SAGE's expertise and service to the LGBT population and the Hebrew Home's expertise in caring for seniors is a partnership that will further both our missions for years to come.

Q. What were the goals and objectives of the project?

Deborah: We had three primary goals and objectives. One, to identify and provide medically eligible LGBT seniors with services that can meet their social, mental and medical needs. Two, utilize the State's Universal Assessment Tool (UAS) and cultural competency training to identify LGBT seniors who are Medicaid eligible and underserved. Three, to provide information on the provision of MLTC and community services to underserved Medicaid eligible LGBT seniors in order to increase their access to care and services.

In 2014 New York State put into effect the Universal Assessment Tool (UAS). The UAS, used as a comprehensive assessment module for Medicaid eligible adults, included questions to give people the option to self-identify as LGBT. Both The Hebrew Home and SAGE saw two very significant areas that we wanted to address. First will the healthcare professionals administering the UAS know how to properly and sensitively ask these questions, and recognize their importance to the delivery of care for that individual? Second, we wanted to provide an option to be able to assist in better caring and meeting the needs of those who self-identified.

The population is continually growing as more education and outreach is performed daily. The uniqueness of the program is a challenge at times for caregivers and health professionals in reaching the audience, but our marketing through various media channels and grassroots approach has helped us to touch hundreds of organizations and seniors.

SAGE, like the Hebrew Home, has a plethora of programs and services that serve seniors in the New York Metro area, including other social and medical model day cares. This was a way to serve an additional cohort in a more comprehensive manner.

3. Overall, would you say that you met the goals and objectives? Please explain.

Deborah: It truly is a continuous process in meeting the goals of our BIP Grant funding. With the creation of SAGEDay and the LGBT training campaign, we have built a solid foundation for the first social day care for LGBT seniors in New York. We are reaching seniors, professionals and promoting awareness every day within communities and continue to do so to promote our goals and mission.

Currently we are serving approximately 20 individuals that attend the program one to five days per week.

SAGE and SAGE National Resource Center on LGBT Aging, are the experts that we used; not just to get advice from, but to partner with; both on

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RiverSpring Health *(Continued from page 45)*

the educational piece as well as on the day care model. This grant, from the application process to its execution, is truly a collaborative effort

4. Specifically, what worked and what didn't work?

Deborah: The creation and implementation of our training program worked very well. The commitment of executive leadership has been the cornerstone of success to the training initiative. The leadership team was the first group to participate in training, which enabled them to champion its importance to all members of our organization.

We have reinforced this training not only in a classroom setting but also in the folds of the organization including all of our residents. One example of this is having the SAGEDay art exhibition. Events such as these demonstrate to our residents, families and staff that we are educating our staff members, but more so that we are living the message.

Everyone involved learned so much from this initiative.

The most common feedback about education that I received and personally learned surrounds self-identification. I never thought that it was OK to ask someone if they were gay or transgender. I now know that not only is it OK to ask, but that I now have the tools to ask the question appropriately, especially to seniors who may still be questioning which group they identify with, resulting from past fear of discrimination or family alienation.

Mother Nature proved to be a challenge for us as it made it difficult to properly roll out our marketing plan and grass roots approach to reaching home bound LGBT seniors. We did our best throughout this stormy winter to reach as many seniors as possible, and spreading the word about SAGEDay.

5. What are your plans for sustainability of the project?

Deborah: Sustainability has always been our number one goal with the SAGEDay social day program. We are proud to offer an all-inclusive safe space for LGBT seniors to break the isolation barrier of aging and social stigma and

(Continued on page 47)

RiverSpring Health

(Continued from page 46)

to have much needed access to creative programming, proper nutritional service, health and wellness education, as well as acting as a bridge to other vital health and social services.

To keep this sustainable, we can use more funds for outreach and marketing so we can continually expand our reach. Allotment for transportation is also critical in the respects of SAGEDay being the first and only LGBT social model, we want to be able to better expand our catchment area and transportation is key to breaking the isolation barrier to seniors.

Most importantly, we need funds for education. We often are asked why we have an inclusive program for LGBT population. SAGEDay is a safe space for those who identify as or with the LGBT population. We hope that with continued education and training that the delivery of services or care to this population is mainstreamed throughout all settings and at all ages. We feel that an inclusive delivery of services is for now, not forever.

6. If you had it to do over, what would you have done differently?

Deborah: We had a very short window from planning to execution. We would have better utilized the time between submission to the awarding determination to brainstorm, plan, and imagine, so that we were better prepared to begin on day one.

Recruitment of staff is the most critical. It was very important to both organizations to recruit high quality and effective employees. It takes time not only to find these people, but for them to be trained and find their rhythm as a team.

We had less than a week from the grant being awarded to the start of the implementation process. It would have been beneficial to have a planning phase for recruitment, marketing creation and outreach.

7. If the State asked you what it should do next, what would you say?

Deborah: We would respond that we should expand and extend services to aging LGBT seniors. LGBT seniors are a growing population that has been typically underserved, isolated and facing unique medical and social issues. It is imperative that we are educating and training the healthcare industry on how to appropriately meet the needs of the LGBT population with dignity, compassion and sensitivity. We would like to see meaningful services like ours to take place in all areas of senior care outside of an inclusive setting.

8. What would you recommend to colleagues given your experience with this BIP grant?

Deborah: We recommend that colleagues collaborate with other organizations. The expertise that both entities brought to this project enabled us to meet the needs of a population in a very meaningful and comprehensive approach. The partnership between RiverSpring Health and SAGE has yielded a high level of learning for each organization. We have each expanded our continuum in caring and advocating for seniors. SAGE and RiverSpring Health's linkage and success have made us stronger both, collectively and independently.

For more information contact www.RiverSpringHealth.org

Consulting

ProCare[SM]
Accounting & Financial Management
Federal/State Policy & Advocacy
Human Resources
Capital Finance
Energy

Data Analytics

EQUIP
Quality Metrics
FASTracker
LeadingAge INsights
Custom Reports & Tools

Products & Services

Value First (GPO)
Insurance
Employee Benefits
Membership Directory
Therapy Management
Career Center

LeadingAge™
New York Services Inc.
SOLUTIONS

LeadingAge New York Services developed Solutions to help you remain competitive despite the challenging environment you operate in. We focused on your most pressing concerns and expanded the resources we have available to address them. The result is a suite of comprehensive, integrated, competitively-priced solutions that we can draw from, a bigger tool box to work with than ever before.

Contact Holly Smith, program administrator at 518.867.8383 or hsmith@leadingageny.org **TODAY!**

Which Road Are You Traveling to ICD-10?

The road your organization travels to ICD-10 implementation could be like traversing a smooth superhighway, or it could be akin to navigating an unpaved country byway. Here are seven expert-approved, pothole-avoidance techniques that can help provide a smooth ride to ICD-10 by October 1, 2015.

1. **Slow down.** The Centers for Medicare & Medicaid Services (CMS) recommends a 20-month implementation timeline. If you haven't allowed for that much time, don't worry, you can still avoid a rough road by staying organized and developing an implementation process that includes planning, communication, testing and training.

2. **Keep two hands on the steering wheel.** By developing an implementation plan, you will be able to maintain control. Your plan should include implementation strategies, identification of a team, the development of a timeline and budget and conducting a risk assessment. Your plan should outline what needs to be done, who is going to do it and how they will do it. Consider conducting interviews, surveys, walk-throughs and documentation reviews, and be sure to include how long each step will take.

   Your implementation team needs to span across your entire organization and include representatives from key departments, including nursing, medical staff, billing, therapy, medical records, finance and compliance. Involve long-time employees as well as new hires, because they are likely to have different perspectives on how things really work in your organization. The team will need a leader who can dedicate the time that's necessary for keeping the implementation moving forward. Executive-level support will be important if the group gets off track and needs help re-focusing their efforts.

   With planning and preparation, you can help to ensure that your organization travels over the Autobahn rather than a rough country road on your journey to ICD-10.

   CMS published several ICD-10 Implementation Timelines that can be used as a guide when developing your plan. Remember, once October 2015 arrives, you aren't done – you need to be prepared to address post-implementation problems. Not everything will work as planned, and some re-work and modification of processes may be needed. Post-implementation is the time to conduct audits to determine how complete your implementation plan was and whether you missed any critical issues.

   The tight margins in health care don't allow for extra expenses, so you need to be prepared for a financial impact. Be sure your budget includes technology modifications, staff education and costs related to productivity changes across the entire revenue cycle. It is estimated that there will be a 50 percent reduction in coding productivity in the first six months. Clinical and medical staff will be impacted by an estimated 15 percent more time spent on observing,

(See Which Road on page 50)

Which Road... *(Continued from page 49)*

asking questions, documenting and following up on requests for more information. Cash flow and accounts receivable are likely to be affected. You should prepare for delays in reimbursement in the form of rejections, denials and even in the claims-processing cycle. A three-to-six-month post implementation financial impact is possible.

To identify your overall exposure, consider conducting a patient-flow risk assessment. Follow a patient through admitting, entry into the EMR/billing system, clinical care services, claim creation and submission and payer adjudication. Identify each revenue cycle point where a diagnosis is used, and determine if any change in process is necessary. It is possible that changes to clinical and administrative systems will be needed, as well as in resident care processes and staff workflows. Prior authorizations and medical necessity may also be impacted.

3. **Map your route.** You need to develop a test plan that factors in both hardware and software, and includes a wide range of test data and test scenarios. Different service combinations, professional and institutional claims and ICD-10 codes of various lengths should be tested. You need to have a claims submission contingency plan that includes direct data entry of claims into payer-specific programs. If direct data entry of claims becomes necessary, you may need additional log-ons and staff training. Manual entry will be time consuming and costly from a productivity perspective, but may be preferable to reimbursement delays.

(See Which Road on page 51)

Which Road... *(Continued from page 50)*

4. **Stay focused.** You need to focus on role-specific staff training. It will be necessary to determine who needs what kind of training, how much training they need, and the type of training they need. Identify the best method of education for each role group. Look for ways to improve documentation and incorporate that into your training program. Dual coding is an excellent form of training and should begin as soon as possible.

5. **Beware of puddles.** Puddles can disguise a deep hole and prevent you from seeing what's lurking under water. ICD-10 puddles include the impact of the new coding system on other regulatory and revenue cycle requirements, such as MDS and OASIS completion. Another puddle is that the increased level of complexity and specificity will significantly increase the number of possible ICD-10 codes (from approximately 14,000 to 68,000). I recommend that you identify your top 25 diagnosis codes and compare them to ICD-10, and begin to address documentation and training needs. An additional puddle is determining a plan to enter the new codes in your EMR/billing system for patients as of October 2015, while maintaining ICD-9 codes for prior dates of service.

6. **Be cognizant of oncoming traffic.** While it is impossible to avoid ICD-10, you may need to consider how other projects, such as Managed Long Term Care, a new phase of an EMR implementation, or a capital project, will compete for capital and human resources, and how they may impact your ICD-10 readiness. Will one of your many projects have to be delayed in order to successfully implement ICD10?

7. **Look ahead.** By knowing what's coming, you should consider if there are ways you can offset ICD-10-related costs and issues. Are there ways for your revenue cycle to become more efficient across your organization? Could increased automation and technology improvements improve your revenue cycle performance?

With planning and preparation, you can help to ensure that your organization travels over the Autobahn rather than a rough country road on your journey to ICD-10.

Contact Andrea Hagen, director, Bonadio Receivable Solutions, LLC, to discover how BRS can help improve your revenue cycle operations at 585.662.2270 or **ahagen@bonadio.com.**

As part of an ongoing effort to include as many member stories and photos as possible, and to make access to member news easy, dates have been added to each member story headline. These dates refer to the release dates as posted on the LeadingAge New York website. All Noteworthy stories will link to the main "Member News" page where stories are listed by date, with the most recent postings first. Send us your news stories and be featured in the next issue of *Adviser*.

MEMBER NEWS NOTEWORTHY

St. Johnland Nursing Center Residents Participated in the 12th Annual Suffolk County Golden Games

Ten residents from St. Johnland Nursing Center in Kings Park participated in the 12th Annual Suffolk County Golden Games held at St. Joseph's College in Patchogue. 6/11/15

SELFHELP COMMUNITY SERVICES

Virtual Senior Center Enables Group Connections Based on Shared Interest 5/7/15

JEWISH HOME LIFECARE

Jewish Home Lifecare Celebrates "Older Americans Month" with Performance by "the Chanting Rabbi" Andrew Hahn 5/17/15

PRESWICK GLEN

Preswick Glen Presenting Dr. Roger Landry Talk On Successful Aging 5/6/15

FLUSHING HOUSE

Flushing House Director of Resident Services, Sandra Allen-Simms, to Receive Leading Age New York 2015 Professional of the Year Award 5/7/15

Elder Law Seminars Hosted By Flushing House 4/28/15

Flushing House Independent Living - Who We Are April 8 100th Birthday Celebration 4/8/15

(See Noteworthy on page 46)

Jazz in June: A Wartburg Celebration of Arts & Music

From left: Richard Rosen, Perkins Eastman, Terrie and Marie Williams, and Deaconess Raquel Rojas, Redeemer Evangelical Lutheran Church 6/24/15

WARTBURG

Join us for a Reading of Cheryl Wills' Die Free: A Heroic Family Tale 7/14/15

Wartburg Announces New Members of Board of Directors 5/11/15

Ceremony Marks First "Naming" of a Room in Wartburg's New Rehabilitation and Adult Day Services Building 6/19/15

FIELDHOME

Peligrina DeLuca Celebrates Her 105th Birthday With Her Friends at the Adult Day Care Center at Fieldhome 5/15/15

Occupational Therapy Assists Resident Following Traumatic Brain Injury to Transition Home
6/15/15

HEBREW HOME

The Hebrew Home's Medical Director, Dr. Zachary Palace, is Featured in the Annals of Long Term Care 6/12/15

Sweet Eats: Digging in at Hebrew Home 4/27/15

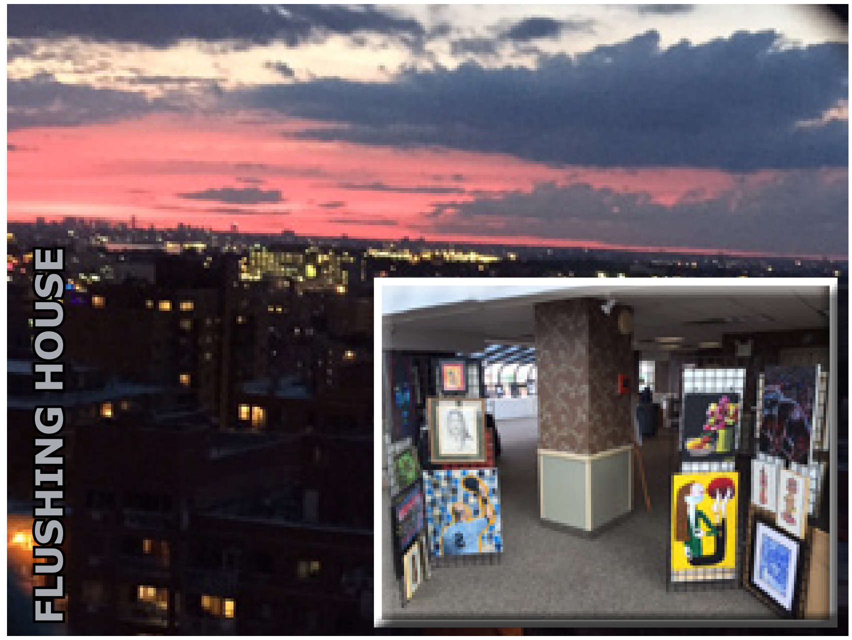
Alzheimer's and Sexual Consent Discussed on Recent HLN's Dr. Drew on Call television program 4/15/15

The Hebrew Home's "Good Morning Mom and Dad" Pilot Program is Featured on the Associated Press Wire Service 4/17/15

(See Noteworthy on page 54)

2015 Employee Recognition Ceremony at Fieldhome

From left: John R. Ahearn, CEO, with Field Horne, Catharine Field Home trustee 6/19/15



Flushing House Hosts "Jazz Up In The Sky" June 19! 5/6/15

BETHEL

Bethel's Marketplace Brings Community Together For Shopping and Sharing 5/15/15

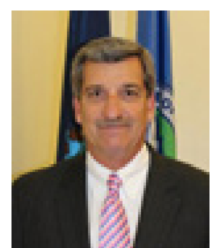
MEMBER NEWS

NOTEWORTHY

Wartburg Announces the Appointment of Two New Board Members 5/11/15

Wartburg


Clesont Mitchell


Kevin Ocker

THE WEINBERG CENTER

World Elder Abuse Awareness Day 6/15/15

The Weinberg Center for Elder Abuse Prevention Hosts Its Fourth Annual Awards of Distinction Breakfast 6/3/15

St. Johnland Nursing Home Welcomes Celebrity Chef Bal Arneson 6/17/15

HERITAGE MINISTRIES

Heritage Ministries Celebrates Employees at Annual Employee Recognition Dinner 6/29/15

(See Noteworthy on page 55)

ANDRUS ON THE HUDSON

Spring Fest at Andrus on Hudson 4/15/15

PRESBYTERIAN HOMES

Presbyterian Homes Foundation Sets New Goals With Corporate Sponsorship Program 5/7/15

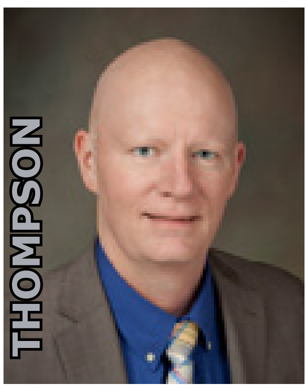
Community Fund Grant Supports Dance Therapy Program at Wartburg 6/10/15

MEMBER NEWS

NOTEWORTHY

VILLAGE CARE

A New Online Program to Improve Treatment Adherence through the Advanced Use of Technology in New York City 4/1/15



Klinetob Named VP of Long Term Care for Thompson 4/30/15

Backstage Theatre Company at Johnland Nursing Center

Members of the Backstage Theatre Company from Farmingdale State College brought their talent and enthusiasm to the residents of St. Johnland Nursing Center with a revue of songs from modern and classic Broadway plays. The showcase performance was a huge hit with the very appreciative audience for whom music is an important link to their past. 6/11/15

JEFFERSON'S FERRY

Jefferson's Ferry Celebrates Active Volunteerism with Thank You Luncheons 4/15/15

(See Noteworthy on page 56)

Parker Celebrates Exceptional Nursing Staff During National Nurses Week 5/26/15

RIVERSPRING HEALTH

RiverSpring Health Highlights 6/19/15

Philip Mehl Earns Eli Pick Award 5/20/15

Talent Show at the Pines

Pines residents (from left): Ms. Rose DiPierno, Ms. Sima Scherzinger, Ms. Debbie Smith (visiting friend), and Ms. Sue Guiseppi. 5/7/15

JUDSON MEADOWS

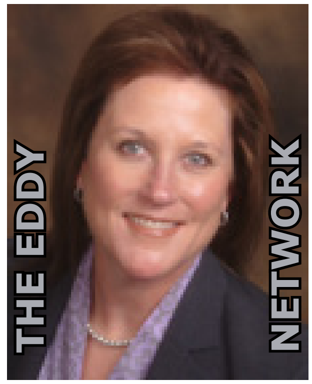
P.O.W. Medal Presentation Ceremony In Honor of Francis Miner 5/26/15

(See Noteworthy on page 57)

THE EDDY NETWORK

Eddy Visiting Nurse Association Recognized By HomeCare Elite As One Of Country's Top Agencies 4/15/15

The Eddy to Expand Elder Abuse Intervention Program into Saratoga County 6/23/15



St. Peter's Health Partners Names Kim Baker New CEO of The Eddy Network 4/14/15

ST. JOHNLAND

St. Johnland Nursing Center Volunteers Preparing for the 14th Annual Chinese Auction & Food Tasting Fundraiser 4/9/15

Volunteers Make a Difference at Jefferson's Ferry

Volunteers from inside and outside the Jefferson's Ferry community contribute to an integral part of life at the Lifecare Retirement Community. 5/19/15

Rich Yarusso (left) and Eddie Cepeda, local veterans who volunteer regularly in Jefferson's Ferry's Health Center help Jefferson's Ferry's Patty LeCausi serve the Health Center staff during National Nursing Home Week.

Independent Living resident Alice Rhodes conducts weekly "Short Stories with Alice" session in which she reads aloud to residents with visual impairment. Alice has a devoted following.

(See Noteworthy on page 58)

LeadingAge New York Selected for Second Year in a Row

The is the second consecutive year that LeadingAge New York has been selected as one of the ***Best Companies To Work For In New York***.

From left: **Deborah Shigley,** state director, New York State Society for Human Resource Management; **Ken Leissler,** principal, Ryan, LLC; **James W. Clyne Jr.** president and CEO of LeadingAge New York; **Richard Cohen,** managing partner, Goldberg Segalla; **Jeanne Donaghy,** learning & organizational development specialist, Medidata Solutions

LeadingAge New York IGNITE Leadership Academy Graduation Held at Annual Conference

Graduates were honored at the annual conference for completing this year-long leadership training course. Among the LeadingAge New York graduates were staff members Kathy Burke, education assistant/registrar; Earl Gifford, member specialist; and Kevin Webb, deputy director, technical services. Congratulations to all graduates of the class of 2015!

NOTEWORTHY

LEADINGAGE NEW YORK NEWS

LeadingAge New York Staff Graduate From ESSAE Leadership Academy

LeadingAge New York would like to congratulate two of their staff members: **Tim Thate,** associate director, technical services; and **Kristen Phillips,** communications manager and editor; on completion of their year of study on the principals of association leadership. Tim and Kristen were among the ESSAE Leadership Academy Class of 2015.

(See Noteworthy on page 59)

Being Mortal

In April, LeadingAge New York, the Community Hospice and the Hospice and Palliative Care Association of New York State, hosted a facilitated discussion featuring Laurie Mante, Executive Director and Dr. Paul Heasley, Chief Medical Officer of The Community Hospice and a showing of PBS premiere of Frontline's documentary on the #1 best seller, Being Mortal by Atul Gawande.

Welcome New Primary Members

Primary Members:
Samaritan Summit Village
Total Senior Care

Affiliate Member:
Leonard Hersh, Retiree

Associate Members:
Mark Hall, American Satellite LLC

Associate Plus Members:
Curt J. Hamlin, P&NP Computer Services, Inc.

Upcoming Conferences and Educational Events

Conferences

Sept. 1-3, 2015
Financial Managers Conference & Exposition
The Saratoga Hilton, Saratoga Springs

Nov. 16-18, 2015
Directors of Nursing Services/Directors of Social Work Annual Conference & Exposition
The Sagamore Resort, Bolton Landing

May 23-25, 2016
Annual Conference & Exposition
The Saratoga Hilton & Saratoga Springs City Center, Saratoga Springs

Educational Events

AANAC Resident Assessment Coordinator - Certified (RAC-CT) 3-Day Certification Workshops
Aug. 11-13, Mount Vernon

Oct. 13-15, Troy

AANAC Resident Assessment Coordinator - Certified (RAC-CT) 1-Day Recertification Workshop
Sept. 16, Latham

Behavior Management Through Non-Pharmacological Intervention: Techniques and Strategies You Can Implement Today
Oct. 8, Rochester

Oct. 20, Westchester

Oct. date TBD, Albany

Fall HR Summit
Oct. 15, Latham

Leading-U is offering many audio conferences and seminars. Check out our line-up by **clicking here.**

To feature your news items with LeadingAge New York send press releases to Kristen Myers at *kmyers@leadingageny.org*