Bridge to Home Partnership

Preventing Hospital Readmissions

ADVISER
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Bridge to Home Partnership

Preventing Hospital Readmissions

Features

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.

Departments

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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.

Be Part of the Solution

According to Wikipedia, problem solving "consists in using generic or ad hoc methods, in an orderly manner, for finding solutions to problems." Problems are either ill-defined or well-defined. The difference is whether there are clear goals and solutions paths.

New York's non-profit providers of care, service and housing have always been problem solvers. It is why we exist. Our strategy is simple – leverage available funding and work with anyone willing to help.

In this issue, see how some LeadingAge New York members are finding solutions to complex problems to increase efficiency within the system, save money and make the lives of New York's seniors happier and healthier.

Data from the Centers for Medicare & Medicaid Services (CMS) suggest that outcomes for patients with certain chronic clinical conditions can be improved, theoretically reducing the hospital readmission rates. The problem is defining the path to success. What steps are needed, who should be involved and how should it be measured? These are just a few of the many questions that need to be answered to solve this ill-defined problem. CMS is making money available to communities to define the goals and solution paths. In the feature story, explore the path Isabella Geriatric Care and partners will take to define this path using evidence-based practices and community supports to reduce hospital readmission rates in Northern Manhattan.

"New York's non-profit providers of care, service and housing have always been problem solvers. It is why we exist."

– Jim Clyne

Also in this issue:

- See how Long Beach Medical Center and community partners put experience to the test in a community setting to reduce pressure ulcers through a Gold Stamp grant;
- Learn how Jewish Home of Rochester created Marian's House to address the need for a safe, homelike place to bring loved ones with dementia during the day and for weekend and evening respite care;
- Explore how Jewish Home Lifecare's **Home Assistance Personnel, Inc.** (HAPI) students are learning by doing and are backed by a team to guide and support them before, during and after the training;
- Celebrate a Palliative Care program at Gurwin Jewish helping patients and their families by providing treatment during periods of serious or life-changing illness and providing support and education to help lessen the side effects of treatment; and,
- In the *Palate* section, learn about the role of the Homemaker as part of Beechwood Home's **Welcome Home** culture change project and see how a rehabilitative culinary kitchen at the Jewish Home of Rochester helps rehabilitation patients to relearn skills and foster reminiscing, manual dexterity, confidence and a sense of pride.

Finally, in *One Voice,* Director of Government Relations Ami Schnauber will talk about one of the most significant challenges we face in the State's grand experiment – the aging infrastructure and inadequate supply of safe and affordable senior housing.

As you read this, think about what you are doing to solve problems. Tell your story. It is part of the solution.

James W. Clyne Jr.
President and CEO

Care, Comfort and Dignity: The Palliative Care Center at Gurwin

The Gurwin Jewish Nursing & Rehabilitation Center will open a Palliative Care Center, including a dedicated area to accommodate patients receiving palliative care. The Palliative Care Center at Gurwin will offer residents with serious, life-changing or life-threatening illness a unique option to treat their illness and maximize their quality of life.

"We are delighted to be able to add palliative care to the services that we offer our residents," said Herbert H. Friedman, executive vice president. "Our mission has always been to care for the whole person and adding the Palliative Care Center at Gurwin is one more way that we can provide the care and support our residents need to enhance their quality of life."

David Siskind, MD, DABFP, CMD, director of medicine at Gurwin, is looking forward to the Center's opening in early summer.

"The Palliative Care Center at Gurwin will offer an experienced, inter-disciplinary team of professionals, including physicians, nurses, nursing assistants, social workers, chaplains, recreational therapists, physical and occupational therapists and respiratory therapists," Dr. Siskind said. "This team will have one goal – to help residents and their families cope with all aspects of a life-changing illness."

"Our focus will be on helping each patient achieve the best possible quality of life, both while they are here at Gurwin and wherever their journeys take them after discharge," said, adding that Gurwin's staff will work closely with the Palliative Care staff at local hospitals to identify patients who might benefit from the Center at Gurwin.

According to Siskind, palliative care is often confused with hospice care. But in actuality, it differs from hospice care in that patients who are not terminally ill can still benefit from its services.

"A patient can receive palliative care at any time during a life-changing or serious illness, while hospice care is available as an option only for end-of-life care," he said. Palliative care helps patients and their families by providing treatment during periods of serious or life-changing illness, not necessarily a terminal illness. In addition, the palliative care team will provide support and education, as well as well as lessen the side effects of treatment.

The initial unit will include three private rooms and a renovated family lounge to offer a homelike, relaxing atmosphere for patients and their families. "The rooms will incorporate a soothing décor and added amenities including sleeper chairs to accommodate family members who may wish to spend the night," Siskind said.

"The opening of the Palliative Care Center at Gurwin is an exciting addition to our already comprehensive continuum of care," Friedman said. "It will enhance our ability to treat our patients with the caring, comfort and dignity they deserve."

Within or Among Facilities – Communication, Coordination and Education are the Keys to Success

As told by Joan Hiland, RN and Sharon Player

Poor circulation, poor nutrition, skin moisture level, incontinence, muscle spasms, age and/or limited mobility can significantly increase the risk of developing difficult to heal wounds or pressure ulcers among the long term care population. But good communication among care settings can go a long way toward reducing this risk factor.

The collaborative recognized that the keys to success would be communication, standardization and coordination.

According to a 2007 article published in The Joint Commission Journal on Quality and Patient Safety, pressure ulcers cause considerable harm to patients, hindering functional recovery, frequently causing pain and often serving as vehicles for the development of serious infections. Pressure ulcers have also been associated with extended length of stay, sepsis and mortality. Nearly 60,000 hospital patients in the US are expected to die each year from complications due to hospital-acquired pressure ulcers. The estimated cost of managing a single, full thickness pressure ulcer is as high as $70,000 and the total cost for treatment of pressure ulcers in the United States is estimated at $11 billion per year.

Several years ago, the Long Beach Medical Center challenged nursing leadership at its hospital, skilled nursing facility and certified home healthcare agency to enhance wound management across care settings. Though the levels of care were within the same system, patients often moved between different physical locations, a factor that could contribute to a breakdown in communication among care givers. To ensure the highest quality of care, Long Beach Medical Center and its affiliates instituted a multi-disciplinary task force to review policies and protocols and make recommendations to implement best practices. A renewed focus on prevention plus continuing education to staff and family members led to a decrease in hospital-acquired pressure ulcers.

Another key to success is education. Staff and family members are provided with the education they need to succeed.

Prevention and quality care of pressure ulcers has been a priority at Long Beach Medical Center. The Medical Center was awarded the 2010 Patient Safety Initiative Award from Island Peer Review Organization (IPRO) and the 2011 Best Practices Award by Physicians' Reciprocal Insurers (PRI) in recognition of outstanding achievement in improving pressure ulcer care across the Medical Center's continuum. Already recognized for its innovative approach to wound care, Long Beach Medical Center and its affiliates were selected to participate, as part of a collaborative, in a

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Within or Among Facilities

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pressure ulcer reduction project funded by the New York State Health Foundation. That collaborative included: The Long Beach Medical Center Hospital, its skilled nursing facility - The Komanoff Center for Geriatric & Rehabilitative Medicine, Grandell Nursing Home, Park Avenue Extended Care and Long Beach Medical Center's Home Care Agency.

The New York State Health Foundation project is part of a larger New York State initiative called Gold STAMP a quality improvement program to reduce the incidence of facility-acquired pressure ulcers and ultimately improve care to patients and residents living with pressure ulcers, facilitated by the New York State Department of Health, a number of provider associations representing all settings of the continuum of care, New York's quality improvement organizations and others..

Begun June of 2012, the Gold STAMP program includes a physician representative. Dr. Bernadette Riley, a family practitioner in Long Beach and a teaching instructor at Long Beach Medical Center's Family Medicine Residency program, provides valuable input to the program while ensuring the next generation of physicians is skilled in pressure ulcer/wound prevention and care.

"The Gold STAMP program has fostered a team effort among community providers where communication and standardized care is positively addressing the management and prevention of pressure ulcers," Dr. Riley said. "Not only does this enhance each patient's quality of life at their respective facility, it raises the bar on patient safety and quality of care overall."

Mary Gracey-White, RN serves as the regulatory compliance/quality assurance coordinator at Greater New York Health Care Facilities Association (GNYHCFA). Her role is to facilitate the program, serve as a liaison between facilities and ensure the initiative moves forward.

Coordination within one organization has its own challenges but implementing it among different providers posed a significant challenge. The collaborative recognized that the keys to success would be communication, standardization and coordination.

The group meets in-person on a monthly basis to talk about issues, as regular communication among providers can forestall many potential problems. A single, standardized pressure ulcer communication tool was developed to use for patients who are

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being transitioned out of the hospital. This tool enhances communication among hospital, nursing homes and home care agency staff to ensure continuity of care. It standardizes information when a resident is transferred between facilities including risk factors, standardized pressure ulcer staging, treatments and equipment used to ensure the receiving facility maintains the current pressure ulcer treatment plan. All providers use the same form and it is continually revised and assessed as needed.

Another key to success is education. Staff and family members are provided with the education they need to succeed. A monthly handout has been created to educate patients and families. Each of the partnering organizations take turns crafting the text on topics of their choice. Some recent topics include pressure ulcer reduction steps and nutrition. This project encourages a focus on nutritional status, ensuring it is addressed in communication tools. Also, upon admission, a risk assessment is conducted and family members and staff are educated on pressure relief.

Encourage collaborative leadership of nurses, physicians, frontline staff and ancillary staff.

Staff also learn of new techniques and tips through webinars provided by the Gold STAMP Initiative. A list of contact information of key personnel at each institution was developed so that issues can be addressed directly with the appropriate point person. This type of coordination is vital when working among differing provider organizations. It's difficult to know who to talk to about a patient or issue within one organization but working on the community level is extremely challenging. Coordination is necessary to achieve success.

Educate staff to become skilled at strategies to enhance prevention and care of pressure ulcers.

Because of Hurricane Sandy, there are no official results to report. The project began in June of 2012 and the first full assessment would have been done in June of 2013; however, Hurricane Sandy and its devastating impact on the Long Beach community and the providers within the collaborative slowed progress.

All facilities, with the exception of Long Beach Medical Center's Home Care Agency, experienced closure of their facilities for a period of time. The Komanoff Center reopened three months after the storm, but the hospital remains closed. Long Beach Medical Center's 250 hospital and nursing home patients/residents were evacuated to nine different facilities. During this period, some staff continued to work directly with their residents in other facilities to maintain continuity or kept in touch with the other sites to maintain communication about the resident's special needs. In some cases, partners maintained their own units at other facilities. All tried to employ a strategic approach to maintaining contact and protocols with these at-risk residents during really intense and unusual circumstances.

Empower front line caregivers to utilize critical thinking to foster better outcomes

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Within or Among Facilities (continued from page 6)

With the reopening of The Komanoff Center, the collaborative met and reaffirmed their goals, which are to:

- Develop team-building tools and then identify and implement their appropriate use;
- Educate staff to become skilled at strategies to enhance prevention and care of pressure ulcers;
- Cultivate skills needed to conduct effective and meaningful communication;
- Provide staff with tools to develop effective communication;
- Empower front line caregivers to utilize critical thinking to foster better outcomes;
- Encourage collaborative leadership of nurses, physicians, frontline staff and ancillary staff;
- Enhance capabilities of physicians and nurses to give feedback; and
- Develop an interdisciplinary team.

This collaborative effort is a shining example of a community's commitment to the well-being of their patients and the delivery of quality care and services to a community.

Gold STAMP Program

Mission Statement:

The Gold STAMP (Success Through Assessment, Management and Prevention) Program to Reduce Pressure Ulcers in New York State is a coalition of organizations convened to provide evidence-based resources and education across the continuum of care in New York State in order to improve the assessment, management and prevention or pressure ulcers.

Goals

Provide information and education across the continuum of care about evidence-based practices for pressure ulcer assessment, management and prevention. Promote collaboration and communication within and throughout the continuum of care related to pressure ulcer assessment, management and prevention. Provide strategic direction and support for pressure ulcer performance measurement.

Objectives

Establish and distribute an electronic resource guide of evidence-based practices and tools for the assessment, management and prevention of pressure ulcers. Provide these materials for health care providers as well as patients, residents and their families related to pressure ulcers, specifically to address patients/residents who currently have pressure ulcers and patients/residents who are at risk of developing pressure ulcers. Provide tools which enable providers across the continuum of care to conduct assessments of their own organizational processes related to the assessment, management and prevention of pressure ulcers. Provide an overview on performance measures as it relates to pressure ulcers (i.e., incidence and prevalence). Promote and facilitate communication within and across the continuum of care. Distribute resources to existing local and regional collaborations focusing on pressure ulcer improvement.

Provide education which promotes the evidence-based practices for pressure ulcer improvement and communication within and between care settings. Provide support and strategic direction for utilizing the tools and resources made available by the New York State Gold STAMP coalition.

Happy Households: The Role of the Homemaker at Beechwood Homes

You're a night owl, so you prefer to wake up each day at around nine o'clock. Once out of bed, you like to have your coffee, still in your night clothes, while reading the daily paper. Afterward, you might eat a piece of toast for breakfast before you shower. Now you're ready to start your day!

Cummings House and Moran House staff interact with residents.

You decide to go to bingo and Wii bowling and then have a light lunch of soup. After a busy morning, a nap will hit the spot. You wake up, have a light snack and read for a bit. Then, it's off to exercise class, followed by dinner where you'll be joined by your daughter and grandchildren. You love your new household at Beechwood Continuing Care!

What elements constitute a happy home? Beechwood Continuing Care in Getzville recognizes that there is a different answer for every person. However, Beechwood also recognizes that a homemaker, a person who makes the house into a home, can be a major part of the answer for everyone they serve. Whether male or female, or even multiple people, a homemaker understands the individual's schedules, preferences, special needs and history.

About eight years ago, Beechwood began a culture change program called Welcome Home. Changing from a traditional institutional setting to home-like households was the main goal. The households would become the center of all activities and care for the folks residing within. Households would look like a real home with a common living space and a large open kitchen to encourage residents and their families to gather.

From inception, the planning team looked to form this homemaker position to focus on individual's needs in a more comprehensive way. They looked at several successful models and, in the end, chose a model that would work best with Beechwood's resources. They combined four primary roles: housekeeping, laundry, food/dining service and activities/recreation to form a new universal position, the homemaker.

The Job Summary reads: "Responsible to perform a variety of activities and services necessary to meet the needs and comforts of the residents including cleaning, meal services, personal laundry and resident supportive services."

Beechwood's homemakers are responsible to learn each resident's history, preferences, limitations, special needs, family members and friends. Administrator Kathy Nyquist said, "The resident is at the center of every decision. All staff must address the resident's needs first, then go back and finish whatever other tasks needs to be accomplished."

It was immediately recognized that this might be a struggle for people who are task-oriented, both staff and residents. It was essential that support was provided to residents, staff and families during the transition to household living.

Households hold between 11 and 20 residents and a formula has been developed to determine the number of homemakers per

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Happy Households (continued from page 9)

resident. Homemakers work side by side with the Certified Nursing Assistants (CNAs). They are allowed to answer call lights and assist residents with some tasks that don't require a CNA. If the task requires a CNA they will go get one to expedite assistance for the resident. Homemakers free up time for the CNAs to help more residents. Once each household has been constructed, that household's staff determines how tasks will be divided. Each household functions differently. Staff are even trained and some even certified in safe food handling practices to add expertise and increase safety for residents as some foods are prepared to order within the household.

Staff buy-in and understanding of the change was very important. Before any construction began, the organizational leaders were trained on how to coach for change and spent time shoring up their leadership skills to help staff manage the coming changes. Beechwood held a meeting with all staff and made the promise that no one would lose their job because of the Welcome Home initiative. Right from the start, they also put everyone on notice that they would have to work differently. Fear of the unknown had to be assuaged and it was.

The original planning team consisted of residents, staff and family members. They selected the wing that would hold the first household. They talked about the elements that make a household? What does a household look like, feel like and how should it be staffed? Prior to each phase of construction, staff, residents and families were prepared for the coming change. Resistance was most prominent in the early stages.

Once the first household was operational an open house was held to allow other residents, staff and families to experience the look and feel of the new living and working environment. Interested staff members were also able to sign up for some experiential learning where they could meet residents and experience working in household settings. Residents were really the greatest influencers. Staff and families could immediately see the positive affect of the change, even for residents with greater needs.

The setting is so totally different. There is no institutional feel. Residents, families and staff are happier and more engaged. In the beginning volunteers had to be recruited for the positions, now many people want them because they get to spend more time with residents in a homelike setting.

Training and coaching was, and is, vital to success. A training curriculum is provided to all Welcome Home staff. There are also mentors available from each of the four functional areas, dining, recreation, housekeeping and laundry, to help staff after their initial training. The household coordinator facilitates team development as well as tracking budgets for food and supplies. An educator works with each household team as needed on team development strategies. Everyone is a vital member of the team and has to be prepared and supported to achieve maximum success.

For Beechwood, the shift in job roles needed to be budget neutral.

(See Happy Households on page 11)

Homemaker Quote

"Part of my job as a homemaker is cleaning our resident's rooms. That is my favorite best time to interact with our residents. I ask them about the family pictures on the walls and I learn about what they did …if they were a mom or worked. I always ask them how they like their room arranged and what their preferences are in terms of laundry and how they like their clothes folded. Often we fold together and I put the clothes away when we are done."

"At Christmas, a daughter of one of our residents made angels for each one of us. She wrote a personal thank you on each angel mentioning something she noticed that we did special just for her mom. I have it on my refrigerator at home. Every time I look at it, I feel good."

"We feel more connected to the whole family! We have mementos in our households of our past residents … just like at home. We have Louis' mug…Winnie's picture when she was a little girl. Her family gave us a complete Victorian Christmas village collection. Every year we put it up, we think of Winnie and her family. It's sad that they are gone but it's nice to remember."

Tina McKerrow, Homemaker

Happy Households (continued from page 10)

Homemaker Quote

"As homemakers in the household, we have more time to get to really know our residents. It's the time that makes the difference. We chat in the kitchen, chat in the dining room during meals…just like you would at home! I know what they enjoyed when they were younger, talk about their children. I know exactly just how my residents like their food prepared…what their favorite ice cream is. I know that if Evelyn doesn't ask for her cheese omelet for breakfast….she will want it for lunch!"

"We get real close to families now, too. We become their family! Households make them feel more comfortable. We involve the families in household cookouts and parties. I think because of the households, more families become friends with each other!"

Kathy DiPasquale, Homemaker

Salaries were determined by taking an average of wages for the four consolidated positions to determine the average wage to be used for the homemaker position. The addition of this position has increased efficiencies in each household and has saved in ancillary costs, helping to keep the transition budget neutral. Each household has a household coordinator who is responsible for the budget for food and supplies.

There has been a modest decrease in the use of psychotropic drugs (modest because Beechwood's usage was already quite low), sleep aids and appetite stimulants as a result of the increase in resident happiness. There has also been a reduction in adverse behaviors, falls and the number of alarms.

Probably the most exciting element is the increase in family involvement. It is much easier for staff to focus on families. When family members come in they are greeted and may be asked if they want a cup of coffee. There is a play area for kids in the game room. Family members often come and share a meal and help the staff with dinner. The atmosphere is much more relaxed and stronger bonds among residents, family and staff have been created and staff is better able to focus on residents.

The goal of a happy household is working at Beechwood Continuing Care.

Homemaker Quote

"Homemaker's are like the mom of the house! They bake and cook, clean and take care of residents like my mom as if they were part of their family. I will come in in the morning and see Kathy writing a riddle on the bulletin board in the kitchen. Throughout her serving breakfast - she will give my mom and residents clues until somebody solves the riddle! She told me each night she goes on the internet and picks one out for the next morning! They know my mom doesn't like hot coffee, so they pour hot coffee in a small pot every morning to let it cool off so it will be just the right temperature! It's all the little thoughtful things that they do that makes homemakers so special!"

Family Quote – Cheryl Wasson
mom at Beechwood

Jewish Home of Rochester Opens State-of-the-Art Culinary Center

It looks like the set of a Food Network show: a chef's dream kitchen with all the bells and whistles. And just like any of the popular cooking shows, it features a preparatory area with seats on the other side. What's the catch? This kitchen's not on a prime time cooking show - it's in a nursing home! About a year ago, the Jewish Home of Rochester opened its ***Beyond Chicken Soup Culinary Center***, a state-of-the-art cooking center for residents of the Jewish Home and their families. The Jewish Home is the only long term care facility in the area to have a culinary kitchen for residents to use and enjoy.

The culinary kitchen is a constant buzz of activity. It reintroduces many of residents to the joys of cooking and provides opportunities for residents and their families to cook their favorite recipes together. It helps rehabilitation patients relearn skills they need to prepare meals when they return home and cooking can be very therapeutic in that it fosters reminiscing, manual dexterity, confidence and a sense of pride. The culinary kitchen is also a venue for cooking classes and demonstrations, where Jewish Home chefs and guest celebrity chefs exhibit their culinary skills for residents from all levels of care – independent living, assisted living and long term care.

Funds for the culinary center came from the sale of the *Beyond Chicken Soup Cookbook*, a collection of recipes from dedicated members of the Jewish Home Auxiliary and the greater Rochester community. Since first publication in 1995, proceeds from the sale of the cookbook have surpassed $150,000. The *Beyond Chicken Soup Cookbook* continues to be sold in Leo's Deli and the Gift Shop at the Jewish Home.

Spotlight

Meet Susan Bartholomew, RN, MPS

Policy Analyst/ProCare℠ Consultant

A registered nurse since before Omnibus Budget Reconciliation Act (OBRA), Susan returned to school after starting her family. She completed a BA and an MPS and has worked in a number of positions including Staff Development, Infection Control, Rehabilitation and Wound Care, but primarily as a director of nursing in several facilities.

What motivates you to do what you do in your field?

I like solving problems and fixing things. It might be a care plan or it might be my dishwasher, but if it isn't working I want to know why and then make it work and work well.

The consulting piece of my position fits into that perfectly because I can review systems and programs, then make recommendations that reduce workload and/or improve care. Of course, whether it's the care plan or the dishwasher, experience teaches you when to call an expert.

How did you develop an interest in this field?

It happened by default. After working for a number of years in acute care on the 3-11 shift, I needed a day job. The only open position where I lived was a staff development job in a nursing home. It turned out to be a good fit. I liked the job and I liked the fact that long term care (LTC) was evolving and I was excited to be part of it. The constant changes that were (and are still) occurring kept the environment stimulating and allowed for professional growth.

LTC is unique in its collaborative work environment which encourages ideas from all around the table to solve problems or develop plans. Learning about and appreciating the skills of the other members of the IDT interdisciplinary team (IDT) is an experience I wouldn't have had in other settings. However, with the increase in use of technology for medical records and care planning, there seems to be a shift away from this interdisciplinary effort and this needs some revival. I see the care area assessment (CAA) process as the motivator to restart the conversations among disciplines and lead to the development of useful plans of care and ultimately more personalized care.

I like solving problems and fixing things. It might be a care plan or it might be my dishwasher, but if it isn't working I want to know why and then make it work and work well.

What experiences in your life have affected your career?

I'm sure my experience with elderly parents has been much the same as others: Care that is lower quality than expected just makes one more determined to make sure the offending behavior never happens to residents in our care.

(See Susan Bartholomew on page 12)

Susan Bartholomew

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Did you have a mentor or a person who significantly affected the direction of your career or life?

My first administrator spent two years teaching me everything from how to write a business letter to how to prepare for a survey. I don't think he ever thought of himself as a "teacher" nor did I ever think I was being criticized or chastised. He just "brought me along" through conversation. There are still times when I am completing a task that I think about what he would have to say about my effort. That is what I believe defines mentoring.

In my own career, it has been extremely satisfying to have had a number of subordinates become very successful and move on to some impressive positions. I like to think I had a hand in their growth.

I find it somewhat discouraging that turnover in key positions in nursing homes has gotten so high and rapid. Even though it is expected that a person brings a specific skill set with them for a position, they certainly need direction (read: mentoring) to fully understand the expectations, culture, and subtleties of the position they have accepted. Constant turnover in these positions is incredibly disruptive to the agency and extremely costly. Planned mentoring, whether casual or a more formal program would reduce this trend.

What is your passion in life? What do you do outside of work to keep you balanced?

My outside life has always been about my family, four children and four stepsons, but the nest is now empty. My husband and I live in the Adirondacks and have refilled the nest with our two labrador retrievers, one border collie and two cats who have not come out of hiding since the labs moved in.

I want to be able to go to Washington next year and confidently speak with representatives about issues that impact services to the aging population.

I get revitalized by trips to New York City whenever I can manage it, and love the long weekends when our family comes "home" for a get-together.

Tell us a little about what makes you unique?

I am more common sense than cerebral.

I am told I tend to see things as they could or should be and try to change them to match my vision.

I see the "big picture" quickly.

What big goal are you striving toward in 2013?

I want to be able to go to Washington next year and confidently speak with representatives about issues that impact services to the aging population. "Policy" is an entirely new area for me and learning how what happens in Washington and Albany impacts our members has been a new experience.

Is there anything else you would like to share?

I am always pleasantly surprised that the commonalities among our membership are greater than the differences.

One Voice

The great Medicaid Demonstration: Policy Shift or Budget Cutting Scheme

Ami Schnauber, director of government relations, LeadingAge New York

Over the last few years, New York, like many states, has been trying to address rising Medicaid costs. The establishment of the Medicaid Redesign Team (MRT) began a multi-year effort, full of pilots, demonstrations and innovations, all designed to change how and where consumers receive health care services. The state is banking Medicaid savings as long term care consumers move into managed care. And now, the governor is proposing to use Social Impact Bonds to test more innovative, outcomes driven models, a potential opportunity for many LeadingAge New York members

You are well aware of the changing landscape as the foundation of care shifts from traditional institutions and segregated services to new nursing home models, independent housing with supports, residential care options such as assisted living and an array of home- and community-based services. The state, recognizing this change and the potential for Medicaid savings, has begun moving all Medicaid recipients requiring long term care into managed long term care (MLTC). Starting in October and rolling out over the coming years, individuals in nursing homes and the Assisted Living Program will move into MLTC plans as well. When that happens, the fee-for-service system for people needing continuing care will essentially be gone and MLTC plans will be coordinating care for virtually every long-term care Medicaid recipient at a capitated rate.

So is this just another budget cutting scheme or does this change reflect a sound policy shift? The answer is probably both. Our challenge is to ensure that legislators focus more on sound policy that can generate long-term savings rather than focus on short term cuts to providers.

"Our challenge is to ensure that legislators focus more on sound policy that can generate long-term savings rather than focus on short-term cuts to providers.

– Ami Schnauber

LeadingAge New York is perfectly positioned to advise state policymakers on how to effectively implement this historic change in Medicaid. Our members provide services across the continuum, from senior housing to home care to assisted living and nursing homes, as well as MLTC plans. We want to work with the state to reach a shared goal: assuring access to high quality care, at a reasonable cost, in the most appropriate setting for all New Yorkers.

Our members are not new to innovation. Indeed, it is our not-for-profit, mission driven providers who have been leading the way in innovative service delivery. In the report we issued last year, *IMPACT: Services for the Elderly and Disabled*, we highlight the groundbreaking work our members are doing including:

- incorporating advances in technology to help consumers age in place;
- transforming the institutional nature of nursing home care through "culture change" efforts focused on resident engagement and satisfaction, environmental modifications and changes to staff roles;
- implementing fully integrated, multi-program, clinical electronic record systems (EHR) that are completely interfaced with financial reporting and billing.

These advances are saving money, keeping people in the community longer and improving the quality of life and quality of care for the elderly.

(See Medicaid demonstration on page 16)

Medicaid Demonstration (continued from page 15)

One of the most significant challenges we face in this grand experiment is an aging infrastructure and inadequate supply of safe and affordable senior housing. The fact is that there will continue to be seniors and people with disabilities who will enter nursing homes and assisted living facilities, not because of their physical and health care impairments, but simply because they do not have access to affordable and safe alternative housing and services options. As seniors with more complex care needs transition into MLTC, providers will be searching for community living options. Independent senior housing provides the perfect base from which MLTC plans can provide community services to seniors.

That's why LeadingAge New York is seeking funding for a grant program, the Supportive Senior Housing Services Program, to provide funding for construction or renovation of senior housing as well as a supportive services component. The Department of Health supports our proposal and has recommended $3 million in initial funding.

Another innovative proposal we support is the Governor's proposed Pay for Success program, which would authorize $100 million in Social Impact Bonds (SIBs) for several issue areas, including health and aging. SIBs encourage private investment in cost-saving preventive services. Due to the way SIBs are structured, the best candidates are not-for-profits with strong track records of improving outcomes for a well-defined population. That's exactly what LeadingAge New York members do.

Our members have a strong track record of improving outcomes for the seniors, frail elderly and disabled for whom they provide care. No doubt you have a program – or would like to get one started – that could use funding. LeadingAge New York is participating in the MRT Affordable Housing Workgroup, which will soon be discussing how housing services providers can utilize SIBs. Other members with innovative ideas that could benefit from SIBs should contact us so we can make sure you're part of the discussion.

Here's the bottom line: like it or not, aging services are changing quickly and in remarkable ways. While providers have historically sustained year after year of budget cuts, the MRT process has, at the very least, provided some measure of predictability from which providers can plan their own budgets. More importantly, the state is now looking to help fund innovative service delivery models and LeadingAge New York's mission driven, not-for-profit members are uniquely prepared to capitalize on these opportunities.

Finally, there is a clear recognition that home- and community-based services and managed long term care are not a panacea. There will always be a need for quality nursing homes. There are still many frail elderly and disabled individuals who need the intensive care that a nursing home can offer. There are some individuals who remain isolated in the community and would thrive in a nursing home or assisted living facility. In the state's haste to get out of the fee-for-service business, reduce Medicaid expenditures and entice the business community to invest in health care, we will continue the fight to ensure that not-for-profit nursing home providers can continue to thrive and provide quality services for their patients.

New Training Program for Home Health Aides Improves Skills and Raises Care Standards

A new training program called Homecare Aide Workforce Initiative emphasizes communication, recognizes the value of life experiences and provides emotional and professional support. This innovative training, developed by Paraprofessional Health Institute, is being successfully employed at Jewish Home Lifecare, where students are getting first-hand experience, backed by a team to guide and support them before, during and after the training.

The first graduating class of 16 newly-minted Home Assistance Personnel, Inc. (HAPI) home health aides has completed more than 160 hours of interviews, training and seminars for the entry-level certification program. No salary is provided during training to ensure that only those who make the commitment to excel will stay.

HAPI RN instructor Maribel Espinell Quintero can already see the difference this new training program is having. "These graduating aides have more confidence in their skills, demonstrate better communication skills and take ownership in what they are doing. The rigorous selection process, intensive training and support make these students better caretakers. It also opens doors to greater job opportunities and growth."

Similar to how Jewish Home Lifecare clients and patients are surrounded by a care team, each new HAPI aide receives full support from a peer mentor, his/her case manager and a client services manager. There are also extensive discussion sessions taught by the case manager and training assistants.

The new HAPI program focuses on rigorous recruitment, intense training and ensuring the ultimate success of those graduating.

Jewish Home Lifecare was one of three agencies selected by the funders (UJA Federation of New York, the Harry and Jeannette Weinberg Foundation and the New York Community Trust) to receive a grant, based in significant part to its already well-regarded peer mentoring program.

Mentoring is an integral part of the new training. Once students have graduated, they are contacted by a home health aide peer mentor who has received extensive training to provide support. Initially, the mentors will check in with their assigned aides two to three times a week. Gradually this proactive support will taper off when the new aides no longer need as much guidance.

"We have this love and passion for taking care of people; it's more than a job for us," says Beverly Husband, training assistant and former Berman Peer Mentor and home health aide. "These new aides have the determination, motivation, abilities and passion to become amazing caregivers to every patient. The training is really pretty remarkable."

Making Home Safe for Seniors

Submitted by Jewish Guild Healthcare (formerly The Jewish Guild for the Blind)

On average, one-third of seniors take a serious fall each year. **Seniors with vision loss are more than twice as likely as seniors without vision loss to fall** and are also more likely to sustain injuries if they do fall. Not surprisingly, most falls result from poor lighting, walking into protruding objects, or tripping on unseen objects or uneven floor surfaces.

With age we all need more light to function, have increased sensitivity to sunlight and glare, take longer to adjust to changes in light levels and need more contrast in the environment. However, for seniors with vision loss due to eye disease or diabetes, these problems are often exacerbated and can make independence and safety in normal daily activities difficult or nearly impossible and pose significant risk for falls.

The good news is that there are some very basic, easy and inexpensive things you can do in your assisted living facility or senior housing site to make it safer and minimize the environmental risk of falls for older residents and those with vision loss.

Normal vision

Central vision loss (Macular degeneration)

Someone who has lost central vision may not be able to see a hazard in their walking path, such as a bucket left in the middle of a hallway.

Create adequate lighting in every room

Although seniors can require up to ten times more light than younger adults to complete the same tasks, in a study conducted in New York City, nearly ALL of the seniors had inadequate light levels in their homes! Some tips to ensure adequate lighting include:

- Higher wattage fluorescent or LED bulbs (avoid cool white fluorescent or clear bulbs that can cause glare);
- A variety of lighting types, including natural light, overhead lighting, floor lamps and adjustable table lamps;
- Uniform lighting levels from room to room – including hallways;
- Nightlights, especially from bedroom to bathroom (the same study showed that most seniors did not have nightlights); and,
- Reducing glare from lights and sunlight reflecting off shiny floors, tabletops or mirrors.

Normal vision

Blurred or hazy vision (Cataracts)

Someone with blurred or hazy vision might not see the handrail in the center of the stairs, or detect the slight step approaching the stairs (marked in yellow).

(See Making Home Safe on page 20)

Making Home Safe (continued from page 19)

Increase safety in bathrooms

The bathroom is the highest risk room for falls, yet it is usually the darkest room in a senior's home. Some tips to reduce fall risks include:

- Extra lighting, especially around the tub or shower area;
- Towels that contrast in color to the wall for easier location;
- Non-skid, contrasting bathmats (inside and outside of the tub);
- A toilet seat that contrasts in color to the commode – it is much easier to locate, especially at night; and,
- Grab bars in the shower and around the toilet – many people routinely grab onto towel bars that can be pulled from the wall.

Promote independent and safe mobility throughout the living space

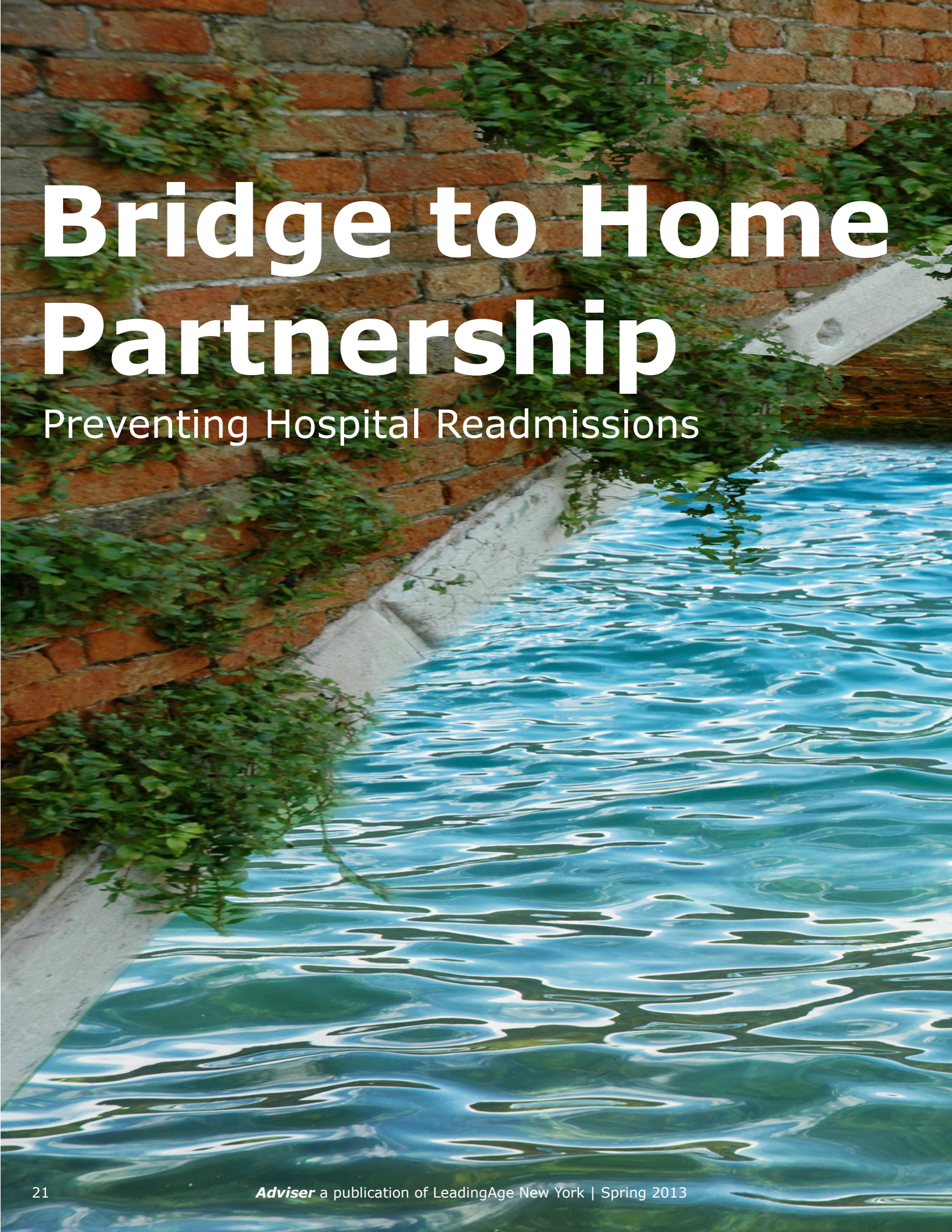
Some simple and inexpensive solutions include:

- Secure all rugs to the floor to avoid tripping (duct tape works great!);
- Use low pile and solid colored carpeting and flooring, as "busy" patterns can be disorienting;
- Minimize inconsistent floor surfaces (i.e. changes between linoleum/tile and carpet) and keep risers as flush to the floor as possible;
- Non-skid, matte finish wax on linoleum floors to avoid glare;
- Keep spaces free of clutter and have nothing protruding from walls that can be bumped into (e.g. water fountains, fire extinguishers, etc.);
- Eliminate furniture in main traffic areas and never rearrange furniture without warning;
- Keep doors all the way opened or all the way closed – a half opened door is a bumping hazard;
- Install non-slip stair treads that contrast in color to the steps; and,
- Paint doors, floor molding and handrails in distinct darker color than the walls.

This is certainly not an exhaustive list. However, if your patients include older adults with vision loss, these tips offer ways to mitigate falling hazards. Keep in mind that factors other than vision loss can contribute to falls among seniors, including balance and strength deficits, mental status, medications, etc. and additional solutions can address the risks associated with those factors.

Jewish Guild Healthcare offers programs to train health care providers in all settings to meet the unique needs of people with vision loss. Contact us at www.guildhealth.org or 800-539-4845.

Please visit us at an interactive breakfast briefing being offered at the Leading Age New York Annual Conference & Exposition in May.



Bridge to Home Partnership

Preventing Hospital Readmissions

Mrs. Gonzales is about to be discharged from the hospital after a stay to treat a serious infection related to diabetes. Upon discharge, Mrs. Gonzales, 90, is to follow up immediately with her primary care physician (PCP). She has assured the discharge planner that she will and that there is someone available to assist her at home. Her representation seems to be supported when someone does come to help her home so she is discharged with no additional supports.

(See Bridge to Home on page 21)

Bridge to Home (continued from page 22)

What Mrs. Gonzales hasn't told anyone is that she lives alone and has no family or other reliable care giver. She also hasn't mentioned that she has very few financial resources and no PCP. She is planning to go home and handle it herself because she is very private and too proud to ask for any assistance. Because English is not her first language, she isn't able to follow discharge instructions and she ends up back in the hospital after only five days in worse condition than at the time of her first admission.

This is a very real scenario. Without community supports to integrate care with non-medical needs, it is very difficult for seniors with limited resources to be successfully discharged back to the community after hospitalization.

Community-based Care Transitions

Recently, the Center for Medicare & Medicaid Services (CMS) awarded 102 community-based organizations (CBOs) for community-based care transition programs, including eight programs in New York, many involving LeadingAge New York members. The lead organization for one of those award-winning programs is Isabella Geriatric Center in Northern Manhattan.

According to CMS, "care transitions occur when a patient moves from one health care provider or setting to another. Nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—are readmitted within 30 days, at a cost of over $26 billion every year." (http://cms.gov/initiatives/CCTP) The project recognizes that community supports are essential for prevention of hospital readmissions and seeks to bring communities together employing best practices for purposes of preventing readmissions.

Bridget to Home Partnership

The partnership, consisting of Isabella Geriatric Center, New York-Presbyterian Health Care System (New York Presbyterian; Allen Hospital; Weil Cornell Medical Center) and St. Luke's-Roosevelt Hospital Center (part of Continuum Health Partners),was established to deliver transitional care services in northern Manhattan. Isabella is the lead and partners with both acute care partners and some of that areas' largest downstream community-based providers key to providing necessary post-discharge services to patients.

The target population of this initiative is Medicare fee-for-service patients who reside in the targeted area and have a primary or secondary diagnosis of congestive heart failure (CHF); heart attack (AMI); pneumonia (PNEU); chronic obstructive pulmonary disease (COPD); diabetes (DM); or end-stage kidney disease (ESRD).

New York-Presbyterian Hospital ranks higher than the national average in CHF readmissions and Continuum Partners, including St. Luke's-Roosevelt Hospital Center has high admission rates in the areas of CHF and AMI.

Data shows that for patients with chronic diseases, half of readmissions occur within 30 days and nearly two-thirds happen within the first seven days. There are many factors leading to readmission and often involve multiple providers within a continuum. Some of the factors are out of the control of the discharging organization, for example no care giver, no one to prepare food, no money to buy food and the patient's lack of follow up with the PCP.

Isabella is an experienced provider of care to the dually-eligible, chronically-ill population through its many home care services: Long Term Home Health Care Program (LTHHCP); recently approved Certified Home Health Care Agency (CHHA); Licensed Home Care Services Agency (LHCSA), Department for the Aging Case Management contract and Naturally Occurring Retirement Communities (NORC) Programs.

(See Bridge to Home on page 24)

Bridge to Home (continued from page 23)

The key to this project is that bridges are being built among different parts of the care continuum, including health care providers, care givers and patients, in order to meet as many of the patient's needs, medical and otherwise, to reduce hospital readmissions and to keep the patients healthy at home.

Using the Coleman Care Transitions Intervention, Isabella's CCTP Program ("Bridge to Home") will use social workers and nurses to make the initial contact with patients while they are still in the hospital. The Bridge to Home Coach will visit post-discharge with the patient in the community. The implementation strategy includes working directly with hospital discharge staff, meeting with the patient to plan and provide tools for success and visiting the patient within 48 hours of discharge to ensure physician follow up. In addition, the Bridge to Home coach will provide ongoing telephone support, coordinate with downstream providers, offer free "Meals on Wheels" and connect with other community services as needed.

Bridge to Home:

Preventing Hospital Readmissions

Interview with Isabella Geriatric Care Center staff Tracy Sokoloff, administrator for Home- and Community-Based Services and Betty Lehmann, director of marketing and communications, about the new bridge to home program.

Q Tell us a little bit about the origin of this project.

Looking at the data for Medicare/Medicaid fee for service clients, CMS believed that there were a lot of readmissions that could have been prevented. They benchmarked hospitals in terms of readmission rates and they looked at the readmission rates across diagnoses and saw specific conditions that could have likely been prevented. In the spirit of the Affordable Care Act, CMS decided to have hospitals "own" their readmissions within the identified diagnoses of pneumonia (PNEU) or congestive heart failure (CHF). If a patient came back within 30 days with the same primary diagnosis, hospitals would be penalized for those readmissions.

There was no clear understanding of what strategies would be most effective in preventing readmissions so CMS made some money available to communities for them to solve their respective readmission issues using an evidence-based model as part of a partnership. CMS clearly articulated the structure that was to be used. The lead had to be a community-based organization working with a hospital or hospitals.

Q Was the catchment area defined by CMS?

The applicants decided everything in terms of how to partner, whom to partner with and what areas would be served.

Q Did you have to prove that your project would save money?

The applicants had to demonstrate that there would be savings to the system with at least a 20 percent reduction in readmissions.

Q How did you determine which hospitals would be the partners?

New York Presbyterian reached out to us because they knew they were likely to be impacted by these new penalties and they clearly wanted to have the opportunity to effectively decrease their readmission rate. They looked for a community-based organization that knew their population and could effectively work with them to meet the goals of CCTP.

Essentially, New York Presbyterian supported working with Isabella. But we kept looking at data and thought that if we just did it with this one system it wouldn't hold water with CMS because they wanted to see multiple partnerships. We felt strongly that if we included multiple systems the grant would carry more weight in a very competitive process.

Incidentally, we applied in the first round and the proposal was rejected so this was actually our second application.

Q What did you change in your second proposal?

Feedback from round one was that the reviewers liked Isabella's Board of Directors and community participation but that the scope perhaps was too overwhelming because at the time it also included two additional hospitals. We listened to feedback from the first round and reduced the geographic reach.

(See Preventing Readmissions on page 25)

Preventing Readmissions (continued from page 24)

We also secured more physician participation. The hospitals assisted in getting more physician engagements with supportive Memoranda of Understanding (MOU's) from their various practices indicating their willingness to provide M.D. appointments within 5 days of hospital discharge. While we had included an MOU from the New York City Department for the Aging in both rounds, we bolstered it for round two by including more involvement by downstream providers, including physicians and certified home health agencies.

Q How did you decide who to serve?

We were required to conduct a root-cause analysis. We conducted focus groups with the doctors, utilized data from the hospitals, as well as chart reviews done by the participating hospitals. We met frequently with the various hospitals and collaboratively identified the types of patients that most often returned and the causes of these readmissions. We looked at the universe of these two acute care systems within the partnership. We did an analysis by zip code. IPRO assisted us in analyzing the hospital data and challenging us to meet the requirements of the application.

In the final analysis, we really had to drill deep to determine the essential intervention we could do within the costs constraints CMS gave us. We decided that for our model to work efficiently we had to focus on the zip codes where the majority of discharged patients live. In the end we created three teams.

CMS will be monitoring us closely to assure that we achieve the goal of decreasing hospital readmits. They are going to benchmark us against 2012 baseline data so we needed to be smart about how we structured our catchment area and targeted population to get the most effective outcomes with the least cost.

Q How do you get reimbursed?

We get a one-time per person fee to cover all costs. This fee was negotiated as part of the process. Our feet were really held to the fire, particularly in terms of administrative costs. For example, in our original budget we included modest costs for a software upgrade, smart phones and laptops for field staff. In the end, CMS would not pay for software, Electronic Medical Records (EMR's), laptops or phones. They told us reporting could be done through Excel. It was frustrating because technology goes a long way to increasing efficiencies. We understand, however that CMS has so many grantees nationally of differing sizes and sophistication that there needed to be a common denominator in terms of the reporting tool. Nevertheless, we decided that we needed to maximize the data for rapid cycle process improvement as well as patient/staff tracking – so Isabella decided to utilize the technology available and purchase what we need to make this program a success.

Q Is Isabella in this for mission or is there a financial gain?

The goal is for it to be at least budget-neutral. It is good for our organization to expand this cutting-edge training and delivery model which we already are integrating into all our Home-and-Community-Based services. Later, we can integrate the lessons learned into our own nursing home. So, no, for the moment, there is no financial gain, simply intellectual knowledge.

Q Give a brief overview of the program.

Our model is based on the Coleman Model of Intervention – its principals are based on empowering the patient/caregiver to "own" their own care. The focus is on coaching the patient / caregiver on the "four pillars" – 1) how to speak to their M.D. and making necessary medical appointments, 2) knowing their medications, 3) keeping a personal health record, and 4) understanding warning signs. We added a fifth pillar, working with the New York City Department for the Aging and other associated food providers, to offer the patient free "Meals on Wheels" post-discharge since food insecurity can play a role in hospital readmissions. We knew the value of Meals on Wheels from our Case Management Program. If a patient qualifies for Medicaid, we will help them enroll and help them get the benefits they are entitled to through that program. The ability to resolve the food issue is critical in many cases.

One of the pillars of the Bridge to Home Program is that the patient needs to see his or her PCP within five days of discharge. The doctor may be unaware that the patient has been in the hospital, however, the Bridge Program will work to ensure a successful transition. The Bridge Coach will fax the discharge information to the PCP. If they don't have one, we will hook them up with one and follow up in five days to be sure they have seen their PCP.

Another pillar is that patients learn how to "own" their own care through a Personal Health Record (PHR). Upon discharge, patients are provided with the PHR, designed by Coleman but tweaked a bit for our purposes. Key contacts for community support, follow up instructions, medications, etc. are all listed in the PHR and reviewed prior to discharge. Patients are encouraged to keep all pertinent information within this booklet.

We also try to standardize disease educational tools within diagnoses. This tool is a standardized form that describes "green zone" (healthy state), "yellow zone" (some warning signs are apparent), and "red zone" (call 911). It describes what conditions constitute each zone,

(See Preventing Readmissions on page 26)

Preventing Readmissions (continued from page 25)

what to do to avoid a "higher" zone and what to do when you enter a new zone. This tool was originally developed by IPRO and we easily adapted it to our targeted chronic conditions.

Q How do you integrate these forms outside of this collaboration?

A lot of people have begun using these tools on their own and are familiar with the model. We will standardize with downstream providers, so when patients go home with their Bridge to Home folder they will have their own personalized forms. This will be in their own language and will form the basis for conversations with the PCP.

Q In what languages are materials available to patients?

They will be translated into Chinese, Russian and Spanish.

Q Are there a lot of patients being discharged who have no caregiver support?

We don't have specific data but it appears to be rising. Through another recent grant on caregivers, we found that some people have an informal support system. We work with the client to think "out-of-the-box" on who can provide caregiver support. Sometimes it's a neighbor or even the building manager. Case managers are really good at finding necessary referrals, however, this will always be a creative process where trust is essential.

Q Talk about the MOU that you have with MJHS and Hospice and Palliative Care.

One of the things that the root cause analysis has shown us is that some of the "frequent flyers" have behavioral health issues or are experiencing end stage disease. Those are two categories that Coleman doesn't effectively address in his intervention model. So if we are evaluating someone who we believe is end stage, we are going to refer them to a palliative care or hospice program. The same issue is true for behavioral health patients. It is a reality that some behavioral problems develop late in life. We will be working with programs that do work with people who have behavioral issues. I do think one of the things we did in our second application is to strengthen our relationships with our downstream partners.

Q What happens to the patient at the end of the 30-day period?

We will make sure the connections have been made to provide the support and resources patients will need to remain healthy and in the community. We will try to provide the wrap-a-round services that are needed.

Q What types of resources do you get from CMS?

We recently had a three- day virtual orientation with the CMS Innovative Center. We will have monthly webinars, coaches from the CMS faculty and individual data analysis. CMS is spending a lot of money on the infrastructure. Their support is huge. We have the opportunity to benefit from lessons learned by others. Our partners are also encouraged to participate in this Innovative Learning Collaborative. The goal is to have the hospital liaison to the program from each hospital participate in these training sessions.

Q Talk about your assessment. How will you know if you have met your goal?

The truth is it's really simple. Are we bringing down readmission rates? It is not qualitative it is quantitative. There will also be a pre and post patient survey.

Q At what point and how often do you have to assess?

We will be looking at the data every thirty days. We are in our infancy. It would be fun to have you come back a year from today to find out what we learned and what improvements we have made. We are taking our first steps and hope to be operational by May 1.

Q Will CMS track anything beyond the thirty days?

Yes, they will track at least to 120 days but we won't be penalized for readmissions after day 30. We do believe that they will look at recidivism and compare it to the baseline. They will likely look at it over time to see if these interventions will have some longer term impact. That's why as we get benchmarked across the nation, one of the things that was so important was to be able to hand the baton to community supports at several points. We believe that the baton is critical to success.

Q How will this project be sustained over time?

This is a time limited issue. After two years, CMS will look at outcomes and if goals have been achieved they will renew for three more years. CMS also said if these demonstration projects are successful in providing a savings to the system, they would consider making it part of the Medicare benefit. It is important to note that this is not in lieu of anything else that a client is entitled to. It is an additional free service.

Q How do you think this two year grant will be effected by the quick migration to Managed Long Term Care?

Once Fully Integrated Dual Advantage (FIDA) Programs are implemented and these patients are enrolled, our program won't be able to accept them because they will be enrolled in another insurance product. We may find at the end of two years that their universe is smaller. There will still be "Medicare-onlys" and we will still be providing services to those at highest risk.

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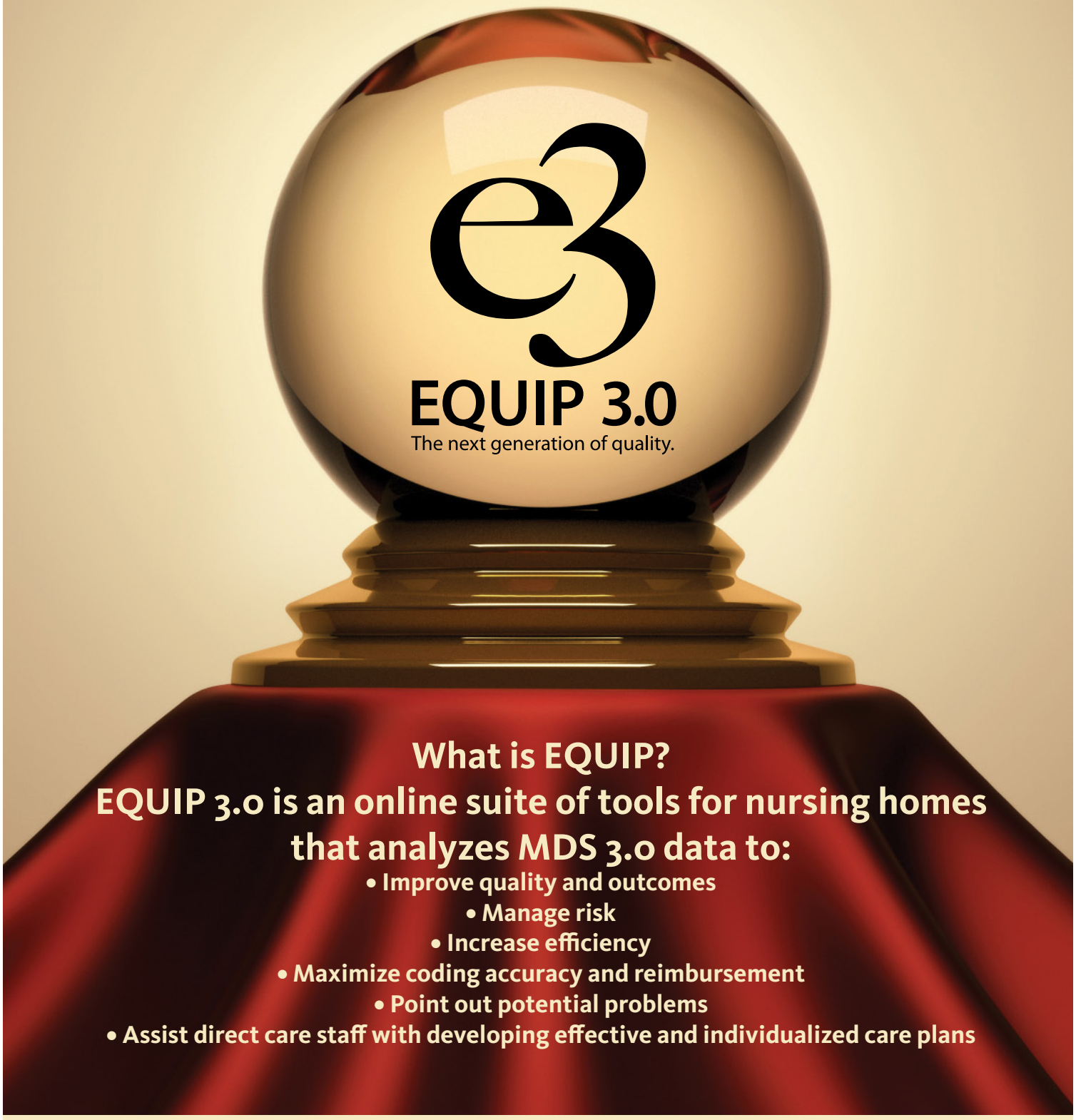

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Feature

The Evolution of Long Term Care Design – The Only Constant is Change

As a senior care architect with more than 30 years in the field, I have experienced the evolution of long term care (LTC) centers from the "other side of the drawing board." From my perspective, the wave of changes started with the elimination of the old health related facility model (HRF) which was followed by the development of home based and community based alternatives such as long term home health care (LTHHC) and adult day health care (ADHC).

These changes (and a number of other factors such as improved longevity) started to negatively impact the census of the average LTC center and changed the character of the average LTC resident; they were older, sicker and less ambulatory than in previous decades.

As many LTC centers moved to fill empty beds and deal with a heavier case mix, they did so with a different mindset; residents and families were customers who had a choice as to where they could receive LTC. Although the principals of the Eden alternative were already well known, this new "customer dynamic" seemed to really launch a wave of LTC culture change with a focus on resident centered care.

Here in New York, the move towards placing ALP beds within or abutting an LTC center was a move towards a continuum of care.

As our LTC design work was being focused on implementing the "neighborhood/household concept" the term "right-sizing" began to appear in the LTC lexicon. The first wave of right-sizing resulted in the phased closing of numerous LTC centers and hospitals across New York State. The second wave sought to incentivize LTC centers to surrender LTC beds in return for alternative services such as ventilator beds, ADHC slots, or assisted living program beds (ALP).

Almost in parallel, a broader view was taking hold; "age in place." In other regions of the country, continuing care retirement communities (CCRC) had been in place for some time. Here in New York, the move towards placing ALP beds within or abutting an LTC center was a move towards a continuum of care.

It is important not to forget that, at several points along this timeline of change, state and local governments were faced with unprecedented fiscal challenges which negatively impacted LTC reimbursement rates. LTC centers had to do more to compete, but with less funds.

We are now in the era of Medicare redesign. LTC has been moved towards an HMO model. Emphasis is being placed on the delivery of health care at the community level. LTHHC and ADHC are no longer financially sustainable for most LTC providers. However, the advent of managed long term care (MLTC) seems to be driving a new wave of social and medical model day care centers and community centers with an "adult care setting" (ACS).

(See The Evolution on page 30)

The Evolution (continued from page 29)

Interestingly enough, the recent evolution of subsidized assisted living into a more medical, age-in-place model has resulted in ALPs which resemble the old HRFs. We truly have come full circle.

So, that's where we have been. Where are we going? As an LTC architect, I can only go where you, my clients, take me. However, I have learned some valuable lessons over the last 30 years. The most important of these is to **design flexibly**, so that today's spaces can be adapted to tomorrow's uses.

As an interested observer, I have spoken to many LTC colleagues about what the near term future may hold. Several recurring themes came out of these discussions.

Short Term Rehabilitation

Rehab will continue to be the primary driving economic force in LTC centers. Today's short-term residents are technologically savvy, more independent and are used to a certain level of amenities. To meet their expectations, we are configuring rehab units with internet access and a variety of both active and passive amenity spaces ranging from quiet libraries to multi-media entertainment areas. The aesthetic most favored by short stay residents approaches that of a high-end hotel.

We are designing the rehabilitation areas themselves to resemble hi-tech health clubs with sleek lines and a sense of movement. Beneath all the aesthetic layers lies a cutting edge array of rehabilitative services; with a major area of focus being activities of daily living. Today our typical OT/PT suite includes an ADL kitchen, toilet, laundry area and a mock bedroom configured together to resemble a single apartment.

Dementia

Statistics show that more and more people are suffering from dementia and onset symptoms are occurring at a younger age. The nature of dementia is a varying degree of disorientation. In an "old school" institutional environment, disorientation breeds fear and agitation.

Our job as senior care architects is to translate the special needs of dementia residents into a built environment that is supportive and comforting. Harsh contrasts in light levels and finish colors can increase disorientation and agitation. Therefore, we customarily specify indirect light fixtures which produce diffused illumination and create less glare. When designing finish palates, we stay away from intense geometrical patterns and use soft contrasts between field and accent colors.

We also utilize color as a "way finding cue" to help confused residents better navigate through their environment. This is usually done in conjunction with three dimensional symbolism to reinforce the message. For example, the doors of a dining room would be painted a unique color. A shallow canopy and signage with restaurant symbolism are placed above and near the dining room door to help residents "make the connection."

The tendencies of dementia residents to wander and "rummage" (and to lose track of time) also dictates physical changes to a typical nursing unit. It is usually relatively easy to create a "rummage room" and/or a quiet room for "sun-downing" residents. Creating a wandering track is usually somewhat more difficult depending on the floor plan.

(See The Evolution on page 32)

We are designing the rehabilitation areas themselves to resemble hi-tech health clubs with sleek lines and a sense of movement.

The Evolution (continued from page 30)

Obesity

As a society, we are, and have been, overweight for some time. The link between obesity and diabetes, heart disease and renal disease is well documented. Some LTC centers have already implemented bariatric programs and on-site dialysis in response to this trend.

Dialysis Units

A LTC center's ability to implement on-site dialysis is driven by two factors; the health departments' need methodology and the availability of space (at least 3,500 square feet) to configure a treatment suite. Essentially, you are building an on-site Article 28 Diagnostic and Treatment Center with all the clinical bells and whistles.

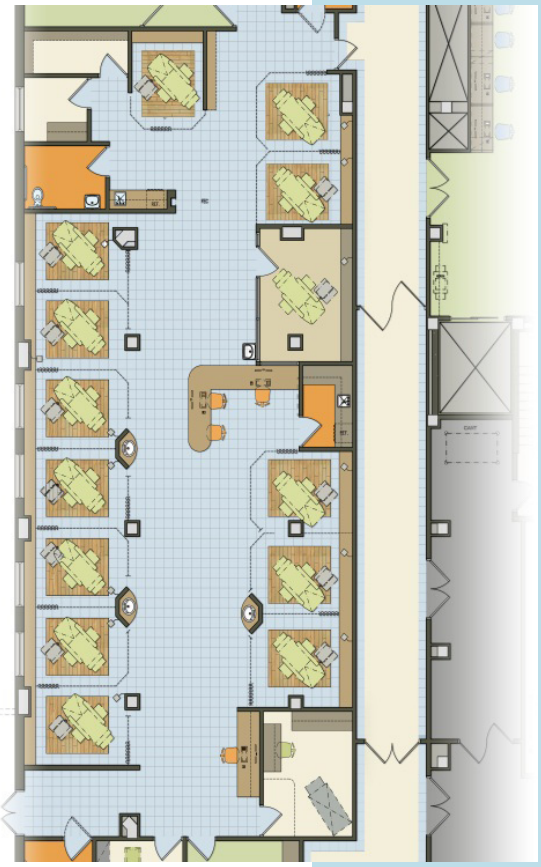
The most important ingredient in dialysis treatment is pure water. Treated water, in combination with acetate (acid) and bicarbonate form the dialysate solution delivered to each dialysis machine. In smaller operations, treatment can occur locally at each station through the use of a portable reverse osmosis (RO) machine. This approach results in the labor intensive hand mixing of acetate and bicarbonate at each treatment station and dictates a significant amount of storage space for these liquids.

The cleaner approach is to treat water centrally and pump the water and acetate (from a separate central tank) directly to each dialysis machine. There, only bicarbonate must be added. This approach allows for better quality control and is much less labor intensive. Most facilities utilize disposable dialyzers to avoid the need to clean and reprocess the units on site. This saves time and space and also reduces potential liability. The preparation of special dialysate solutions for specific patients is most often outsourced for the same reason.

Virtually the entire dialysis suite must be fed by emergency power, so a facility's existing emergency generator and distribution system must be evaluated to see if there is sufficient capacity. Additionally, treatment areas require a higher number of fresh air changes than staff, office or service spaces, dictating that a dedicated HVAC unit be installed for the dialysis unit.

Bariatric Units

In considering whether to create a discrete bariatric unit, a key decision for any facility is whether to place a weight limit on the bariatric residents they will care for. However, there is a basic, "minimum" amount of renovation required to establish a bariatric unit, regardless of a resident's weight.



Bariatric residents require wider wheelchairs (usually 54" wide) and wider beds (48" or 54"). Therefore, the most basic alteration that needs to be made is to widen doorways in all areas accessible to bariatric residents. The retrofit approach most often taken is to install a pair of doors with one leaf at 44" wide and the other 18" wide. This configuration avoids the use of a single, unwieldy door while still creating a wide overall opening usable by bariatric residents. Another "basic" bariatric alteration is a tub room retrofit. Pier tubs are not practical for bariatric residents and most shower stalls are not large enough for their use. It is usually necessary to replace an existing shower/tub configuration with two oversized shower stalls.

(See The Evolution on page 34)

The Evolution (continued from page 32

In older facilities, bariatric room toilets usually require fairly significant alterations (enlargement), especially if their "footprint" does not allow wheelchair access and a proper 5 foot turning radius. Wall hung toilets should be replaced with floor mounted units which can carry more weight and swinging toilet doors should be replaced with sliding "barn-type" doors to improve toilet access and ease of use.

If possible, bariatric rooms should be private rooms. In older facilities, this is the only option since only one oversized bed and oversized wheelchair will "fit" in the average room while still allowing a reasonable amount of maneuvering space. Where conditions permit, it may be possible to create some "oversized" rooms for the bariatric residents which in-turn may allow some existing 2-bedded rooms to be converted into "privates" for other bariatric residents. These new oversized rooms could be fitted-out with specialized equipment such as overhead lifts to allow staff to better assist the bariatric residents.

These are some of the continuing trends your colleagues see holding true for the foreseeable future. No matter what the future of LTC brings, there are some universal design themes that I feel are timeless; I shall always seek to design to promote resident independence and choice, to ensure resident privacy and dignity, to eliminate institutional barriers and to create a homelike environment.

For more information about the evolution of long term care design and what we can do for you, contact John W. Baumgarten of John W. Baumgarten Architect, P.C. at 516-939-2333.

For Those with Memory Loss: A Home Away from Home

Caring for a family member with memory loss is often like caring for very a young child. Constant care and supervision must be provided to ensure physical and emotional safety. All aspects of personal and environmental care generally fall on the care giver or care givers. Today, one in eight older Americans lives with some type of significant memory loss. According to data from the American Alzheimer's Association web site (alz.org) the number of American's living with Alzheimer's or other memory loss is expected to triple from 5.4 million in 2012 to more than 16 million by 2050. Today, someone develops the disease every minute and by 2050 it is expected to be two per minute.

According to a report on their website *Medical News Today* referenced a survey conducted by GFK Roper Public Affairs & Corporate Communications, there are currently "15 million unpaid caregivers, including family, friends, partners and neighbors. Caring for someone with Alzheimer's is often the equivalent to a full-time job. 80 percent of family caregivers provide at-home care for Alzheimer sufferers or for those with another dementia."

Support for caregivers is essential for their physical and emotional health. Unlike early childhood care, options are often very limited for families providing intensive supervision and care for an older adult. Availability and cost of respite and day care are the most common obstacles.

Jewish Home of Rochester saw a need for a safe, homelike place to bring loved ones during daytime hours while care givers went to work or enjoyed some much needed personal time. They also recognized that safe and affordable overnight respite care was missing in the community. So they created Marian's House.

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Memory Loss

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Funding was assembled for the project through gifts from the Farash Foundation (to name the retreat Marian's House, in honor and memory of Marian M. Farash), Larry & Jane Glazer, the William & Sheila Konar Foundation, Burton Gordon & Family, the John & Jayne Summers Foundation and the Alfred & Harriet Feinman Foundation to make Marian's House a reality.

Marian's House is primarily a day retreat for people with early to mid-stage Alzheimer's and other related dementias, offering meals, activities, supervision and specialized programming in a warm, residential setting.

The house is specially designed for both one-on-one interaction and group activities featuring a:

- Large, open kitchen and eating area, enabling guests to participate in meal preparation;
- Family room, providing ample space for activities, movies and relaxation;
- Quiet room, offering a soothing, calm environment;
- Screened porch, a bright, cheerful space in summer;
- Fenced-in yard with an abundance of plants, flowers and shrubs for safe outdoor walking; and,
- Two guest rooms that are available for occasional overnight respite stays, such as over a weekend or while care givers are on vacation.

A very unique feature is a live-in program manager, a licensed registered nurse, with expertise in the field of memory care, who supervises all activities and services. Guests can come for all or part of the day while their caregivers work or take much needed time to meet their own needs. Marian's House is a private pay model and is open daily except on holidays and caregivers must reserve their preferred slots.

Marian's house also serves as a resource for providing emotional support to care givers. Support groups and educational sessions for caregivers are held in evenings and on weekends.

"Improvement Standard" no Longer Valid Reason to Deny Coverage

By Barbara Kabaker, MS, CCC-SLP, VP Quality Assurance, HealthPRO Rehabilitation

Nursing home administrators, finance directors and rehabilitation program managers must, of course, stay current with regulatory updates that affect Medicare beneficiaries. They know it is critical to develop a strategic approach to optimize therapy outcomes and institutional reimbursement based on changing legislation, regulation and litigation. One key example is that skilled maintenance services are now covered by Medicare and this will affect the way LeadingAge New York members provide therapy services in 2013 and beyond.

...skilled maintenance services are now covered by Medicare and this will affect the way LeadingAge New York members provide therapy services in 2013 and beyond.

Traditionally, rehabilitation services have been reimbursed by Medicare only when patients can demonstrate improvement. This has been known as the "improvement standard." In 2011, the Center for Medicare Advocacy went to court to argue that service coverage guidelines should be clarified and include a broader range of care for those who demonstrate chronic conditions. Access to additional treatment, they argued, would optimize patients' quality of life and maintain current level of function. There has been a settlement in the case with significant implications.

- Settlement in the Medicare Improvement Standard case, Jimmo v. Sebelius, was approved on January 24, 2013 by a federal judge.
- The case involved a woman who was denied Medicare coverage for treatment of her chronic diabetes-related conditions.
- As a result of the settlement with the Department of Health and Human Services, individuals who need maintenance care for conditions that are not improving CAN NO LONGER BE DENIED MEDICARE COVERAGE UNDER AN IMPROVEMENT STANDARD.
- CMS will need to update the policy manual and undertake an educational campaign to increase awareness of the updated policy.

TREATMENT IMPLICATIONS

- Medicare coverage will be determined by whether the SKILLED SERVICES of a health care professional are needed, instead of whether the beneficiary demonstrates improvement.
- Skilled services are covered if they are required to maintain a patient's condition, or prevent further deterioration.
- Standards are effective immediately.
- Applies to both Medicare Part A and Medicare Part B services.
- Applies to Medicare Advantage as well as traditional Medicare programs.
- Settlement is not limited to particular conditions or diseases, but rather applies to patients who require skilled service to maintain or slow the deterioration regardless of underlying illness, disability or injury.
- Applies in Medicare home health, outpatient therapy and skilled nursing facility settings.

Access to additional treatment . . . would optimize patients' quality of life and maintain current level of function.

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Improvement Standard

(continued from page 37)

- Settlement does not increase the coverage benefit period of 100 days in a SNF.
- Settlement is retroactive to January 18, 2011.
- A re-review process will be established by CMS for beneficiaries who received a denial for skilled services. Support will be provided by our therapy teams for clients and patients who will need to participate in the process to be established by CMS and the MACs.

DOCUMENTATION

- Therapists should indicate in the Plan of Treatment that services being provided are skilled maintenance services.
- Therapists should indicate the diagnosis for which the skilled maintenance services are being provided and reason for current intervention.
- Be sure to justify skilled intervention in daily and weekly notes to support services.
- Be sure to tie the treatment provided in the maintenance program to functional activities that will maintain the patient's quality of life.

The impact of the settlement will depend on how CMS proceeds in updating payment and coverage guidelines and whether the proposed educational campaign that follows will be sufficient to discover and eliminate situations where the improvement standard continues to be applied by providers. It is important to note that by applying the broader coverage guideline an additional financial strain may be placed on the Medicare system.

Member News

Awards & Achievements

Schervier's Giuffrida Wins Award of Excellence

Jennifer Giuffrida, LCSW, ACHP-SW, director of social work at Schervier Nursing Care Center, Bronx has been awarded the 2013 Social Work Hospice & Palliative Care Network's Award of Excellence in Clinical Practices.

Jennifer has worked at Schervier for the past four years. She chairs the Palliative Care Committee and has been instrumental in developing the palliative care program. As a result of the program, the facility has experienced a significant decline in rehospitalization rates, an increase in established advanced directives and a strong decrease in the number of residents being tube fed. She has established strong collaborations with community hospitals and thanks to a grant from the Fan Fox and Leslie R. Samuels Foundation, Schervier has hired a Palliative Care Transitions Coach who liaises with these hospitals to facilitate transfers of palliative patients from acute care to the nursing home. Jennifer presented these program successes and best practices at Leading Age's annual conference in Denver this past October.

Sunnyview Rehabilitation Hospital Awarded Eleventh Consecutive Accreditation

Sunnyview Rehabilitation Hospital has been awarded a three-year accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) for six of its programs. The three-year accreditation from the international accrediting body marks the 11th consecutive three-year accreditation awarded to Sunnyview.

Founded in 1928, Sunnyview is a 115-bed rehabilitation hospital and one of the largest of its kind in the nation. It provides acute medical rehabilitation services as well as comprehensive outpatient services to patients in 40 counties from 10 states. Sunnyview Rehabilitation Hospital is an affiliate of St. Peters Health Partners, the largest healthcare system in the greater Capital Region.

"Achieving this highest level of CARF accreditation makes a strong statement about Sunnyview's expertise and commitment to providing the highest quality and safest care," states Chip Eisenman, chief executive officer of Sunnyview. "As the only area hospital specializing in physical medicine and rehabilitation, we are proud to combine our experienced team of professionals with the most advanced technology to achieve the fullest possible recovery for our patients."

To achieve the accreditation award, Sunnyview underwent a rigorous peer review process by a team of professional surveyors, and demonstrated during an on-site visit its commitment to offering programs and services that are measurable, accountable and of the highest quality.

Van Rensselaer Manor Celebrates Quality Care

Van Rensselaer Manor, a skilled nursing facility located in Troy and operated by Rensselaer County, is pleased to announce that it has achieved a "deficiency free" recertification survey. The survey team arrived on Monday, February 4 and left on February 7.

Van Rensselaer Manor Executive Director, Doug Cosey had heavy praise for his staff's dedication to residents and families every day of the year. "While we recognize that it can be unnerving to work while a surveyor is looking over your shoulder, we tried to reassure our staff that if they simply went about their business and performed as they do every other day of the year, we would be fine. We are incredibly fortunate to have such a committed and skilled team of care givers here at the Manor."

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Warburg's Palazzolo Promoted to Vice President of Residential Services

The Warburg in Mount Vernon announced the promotion of Janet Palazzolo to vice president of residential services.

A nine-year veteran of Wartburg, a licensed social worker and experienced administrator, Palazzola will oversee several residential facilities on the Wartburg's 34-acre campus, including: the highly regarded Meadowview Assisted Living Community; Lohman Village, an independent living community of townhouses; and the new Friedrich's Residence, a 61-unit independent living, affordable housing facility opening in March, 2013.

Ms. Palazzolo was most recently the administrator for Meadowview, one of the first facilities in the lower Westchester to receive three state licenses – Assisted Living Residence, Special Needs Assisted Living Residence and Enhanced Assisted Living Residence. She recently completed her Site Compliance Specialist Certification. In this capacity she has assisted in the opening of the Friedrich's residence. She also opened the 15-bed Memory Care Center at Wartburg in 2005, which has remained in full occupancy since its opening.

Ms. Palazzolo participates in the New York State Department of Health Architectural Review Group process and she serves on the Adult Care Facility/Assisted Living Cabinet and the Retirement Housing Cabinet of LeadingAge New York, a national advocacy and education professional organization for the aging. She serves as a statewide board member on the board for the Social Work Program at Concordia College, Bronxville as well as the Nazareth Nursery School for the Sisters of Saint Francis in NYC.

Daughters of Sarah Administrator, Joan Healey, ACHA 2013 Administrator of the Year

The New York Chapter of ACHCA (American College of Health Care Administrators) has named Joan Healey, administrator of Daughters of Sarah Nursing Home and COO of Daughters of Sarah Senior Community, Albany as the 2013 recipient of its Stanley Poskanzer Administrator of the Year award. Joan received her award at the chapter's annual conference on March 12.

Joan Healey has served Daughters of Sarah Nursing Center since 1998 as its Administrator and previously had been both its Assistant Administrator and Director of Nursing. Her leadership at Daughters of Sarah has included winning six New York State training contracts and designing and facilitating a New York State Dementia Conference.

Joan included in her comments upon accepting the award that it was especially meaningful to her because Stanley Poskanzer had been her mentor when he was the administrator at Daughters of Sarah Nursing Center and she served as the director of nursing from 1980 – 1986. She said that he remained her friend and mentor until his passing in 2007.

Beato New Chief Executive Officer of Bon Secours Health System

Bon Secours Health System (BSHSI) has announced the appointment of Carlos G. Beato as chief executive officer for Bon Secours New York Health System (BSNY) in Riverdale. Carlos will assume his new responsibilities on April 15, 2013.

In this CEO position, Carlos will report directly to Dr. Marlon Priest, the system's chief medical officer and executive vice president for senior services and work collaboratively with Brother Art Caliman, president of the board of directors for BSNY. He will be responsible for the effective and efficient management and growth of the BSNY ministry and will provide leadership, vision, inspiration and direction to ensure the success of its patient, resident, physician, employee, operational, financial, community and strategic initiatives. Key to his role is the ability to identify, develop and forge strategic relationships which will position BSNY as a valuable partner in the

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post-acute care continuum. Carlos will serve as an internal consultant to Dr. Priest and partner with Karen Reich, the chief executive for Bon Secours' St. Petersburg Health System and other system leaders regarding the development and execution of specific growth strategies to improve all service lines across the BSHSI's senior services operations.

A highly respected executive, Carlos has 25 years of senior level clinical, management and business development experience in for-profit, not-for-profit and faith-based organizations including assisted living, skilled nursing, home care and post-acute rehab. He comes to Bon Secours from United Methodist Homes of New Jersey, where he is currently corporate director of clinical services. His responsibilities include clinical management oversight of ten facilities, ranging from HUD housing, CCRC's, Assisted Living, Memory Support and skilled nursing services with over 1300 residents. Moreover, Carlos brings 15 years as CEO of his own consulting company. Clients included hospitals, nursing homes, homecare, hospices and assisted living – including several Bon Secours ministries. Key work focus included compliance/regulatory issues as well as developing strategic partnerships and alliances for profitability. Well-connected in the NYC market, Carlos brings strong relationships with area providers and community leaders at an important time in BSNY's growth.

Peconic Landing Promotes Laurelle Cassone to Sales Director

Peconic Landing has announced the promotion of Laurelle Cassone, currently sales manager, to the position of sales director of the not-for-profit continuing care retirement community in Greenport.

Previously employed by an Internet provider, Cassone served initially as night receptionist at Peconic Landing. She joined the marketing team as a retirement counselor in August 2003 and was promoted to sales manager in April 2010.

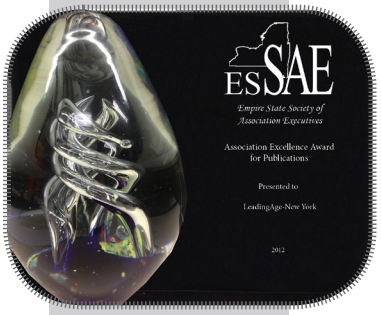
Happenings

Wartburg Opens New Housing

The Wartburg recently announced the opening of The Fredrichs Residence, located on the Mount Vernon campus and part of a $42 million expansion. It has 61 studio and one-bedroom apartments all at an affordable monthly rent. Listen to the reaction of one 81-year-old resident, Katherine Borak: http://goo.gl/y8MMw.

LeadingAge New York News

Adviser Publication Wins Statewide Award



LeadingAge New York was recognized by the Empire State Society of Association Executives (ESSAE) for Excellence in Publications for the re-make of its flagship publication, *Adviser*.

In the spring of 2012, LeadingAge New York launched a much anticipated revamp of the flagship publication, *Adviser*. A comprehensive communications audit identified a gap in communications so *Adviser* was re-purposed as an E-magazine to fill the need. The goal of the new format is to raise the profile of members and to illustrate the great work they do every day. The audience is other members, State leaders and the general public. Main stories fall within the buckets of innovations, best practices or efficiencies/cost savings/revenue generation and involve one or more members. Additionally, Kathie Kane, Leading Age New York's graphic designer, created a style guide and developed a format that is consistently applied, creating a sleek, professional look.

If you're interested in sharing your stories and raising the visibility of your organization, contact Kris Myers at kmyers@leadingageny.org. If you don't receive LeadingAge New York *Adviser* and want to do so, please contact Earl Gifford at egifford@leadingageny.org. And, if

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you are interested in sponsorship or advertising, contact Noreen Hiltsley-Mosher at nhiltsley@leadingageny.org.

LeadingAge New York Announces Winners of the 2013 Annual Art Competition and Exhibit

Best in Show

Moving Water – Ralph A. Westgate, Resident, New York State Veterans Home at Oxford

Merit Award

Girl Undisturbed – Joshua Lutz, Staff, Flushing House

Neighbors Farm on Elderberry Road – Sharon M. Frigon, Resident, Seneca Hill Manor, Inc.

Starlett – Betty C. Eksten, Resident, Lakeside Beikirch Care Center

Sunrise in Peru – Denise Hylton, Registrant, Sunrise Adult Day Health Care

Honorable Mention

Butterfly Scarf – Susan A. Howell, Resident, Jewish Home of Rochester

Natures Fireworks – Raymond J. Grela, Volunteer, Seneca Hill Manor, Inc.

Red Poppies – Rita Sulton, St. Johnland Nursing Center, Inc.

Suchers – Sarah Stephens, Volunteer, Jewish Home of Rochester

Winter in the Country – Anna Sapozhnikova, Registrant, Sea View Adult Day Helath Care Program

Another Conference, Another Success

This year's LeadingAge New York Housing Professionals Conference was a smashing success. A big thank you to the DoubleTree Hotel by Hilton Syracuse for their generous hospitality. We also want to thank our sponsors: National Church Residences, Value First, LeadingAge New York Services Inc. and our exhibitors: Matthews Buses, Inc., New York Relay Service, NYS EPIC Program, Senior TV and Smoke Free Housing.

Welcome New Members

DeMay Living Center

First Choice Health

Heritage Home for Women

Welcome New Associate Members

Timothy E. Folk, The Graham Company

John Freed, Unidine Corporation

Michael Hengehold, PointClickCare

Brian Hunt, Senior TV

Kenneth Kruger, Executive HealthSearch

Lori Richardson, C & S Companies

Toni Scierka, Triple A Supplies

Welcome New Affiliate Member

Council of Senior Centers of New York City, Inc.

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Upcoming Conferences and Educational Events

Annual Conference & Exposition

May 20-22, 2013:

Saratoga Hilton Hotel & Conference Center, Saratoga Springs

Managed Care Audio Series

As organizations are faced with the monumental task of transitioning to managed care, Leading-U is offering a three-part series to equip you with the tools you need to succeed. Register now for the series or one of the individual audio sessions.

1. Transitioning to a Managed Care Environment, April 25, 2013
2. Operating in a Managed Care Environment, June 13, 2013
3. Financial Reporting and Quality Measures in a Managed Care Environment, October 17, 2013

Click on this link to go to our educational trainings and programs page at leadingageny.org. There you can access all of our training programs and many other educational opportunities by clicking on "education."