NEW YORK STATE DEPARTMENT OF HEALTH

Office of Quality and Patient Safety

Plan – Technical Report
For
ElderServe

Reporting Years 2013 and 2014

February 2017

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Section One: About This Report

New York State (NYS) is dedicated to providing and maintaining the highest quality of care for enrollees in managed long term care (MLTC) plans. MLTC enrollees are generally chronically ill, often elderly enrollees and are among the most vulnerable New Yorkers. The New York State Department of Health's (NYSDOH) Office of Quality and Patient Safety (OQPS) employs an ongoing strategy to improve the quality of care provided to plan enrollees, to ensure the accountability of these plans and to maintain the continuity of care to the public.

The MLTC Plan-Technical Reports are individualized reports on the MLTC plans certified to provide Medicaid coverage in NYS. The reports are organized into the following domains: Plan Profile, Enrollment, Member Satisfaction, SAAM and UAS Clinical Assessment Data, and Performance Improvement Projects (PIPs). When available and appropriate, the plans' data in these domains are compared to statewide benchmarks.

The final section of the report provides an assessment of the MLTC plan's strengths and opportunities for improvement in the areas of service quality, accessibility, and timeliness. For areas in which the plan has opportunities for improvement, recommendations for improving the quality of the MLTC plan's services are provided.

During the review period of this report (2013-14), there were three (3) MLTC plan types:

a) Partially Capitated
b) Program of All-inclusive Care for the Elderly (PACE)
c) Medicaid Advantage Plus (MAP)

A description of each of the plan types follows:

Partially Capitated - A Medicaid capitation payment is provided to the plan to cover the costs of long term care and selected ancillary services. The member's ambulatory care and inpatient services are paid by Medicare if they are dually eligible for both Medicare and Medicaid, or by Medicaid if they are not Medicare eligible. For the most part, those who are only eligible for Medicaid receive non-MLTC services through Medicaid fee for service, as members in partially capitated MLTC plans are ineligible to join a traditional Medicaid managed care plan. The minimum age requirement is 18 years.

PACE - A PACE plan provides a comprehensive system of health care services for members 55 and older, who are otherwise eligible for nursing home admission. Both Medicaid and Medicare pay for PACE services on a capitated basis. Members are required to use PACE physicians. An interdisciplinary team develops a care plan and provides ongoing care management. The PACE plan is responsible for directly providing or arranging all primary, inpatient hospital and long term care services required by a PACE member. The PACE is approved by the Centers for Medicare and Medicaid Services (CMS).

Medicaid Advantage Plus (MAP) - MAP plans must be certified by the NYSDOH as MLTC plans and by CMS as a Medicare Advantage plan. As with the PACE model, the plan receives a capitation payment from both Medicaid and Medicare. The Medicaid benefit package includes the long term care services and the Medicare benefit package includes the ambulatory care and inpatient services.

An MLTC plan can service more than one of the above products and, where applicable, the report will present data for each product.

In an effort to provide the most consistent presentation of this varied information, the report is prepared based upon data for the most current calendar year available. Where trending is desirable, data for prior calendar years may also be included. This report includes data for reporting years 2013 and 2014.

Section Two: Plan Profile

ElderServe Health is a partially capitated Managed Long-Term Care (MLTC) plan, and is an affiliate of the Hebrew Home for the Aged in the Bronx, NY. The following report presents plan-specific information.

- Plan ID: 03234044
- Managed Long-Term Care Start Date: 2010
- Product Line(s): Partially Capitated
- MLTC Age Requirement: 18 and older
- Contact Information: 5901 Palisade Ave
Riverdale, NY 10471
(800) 370-3600

Participating Counties and Programs			
Nassau	Partial Cap	Suffolk	Partial Cap
New York	Partial Cap	Westchester	Partial Cap

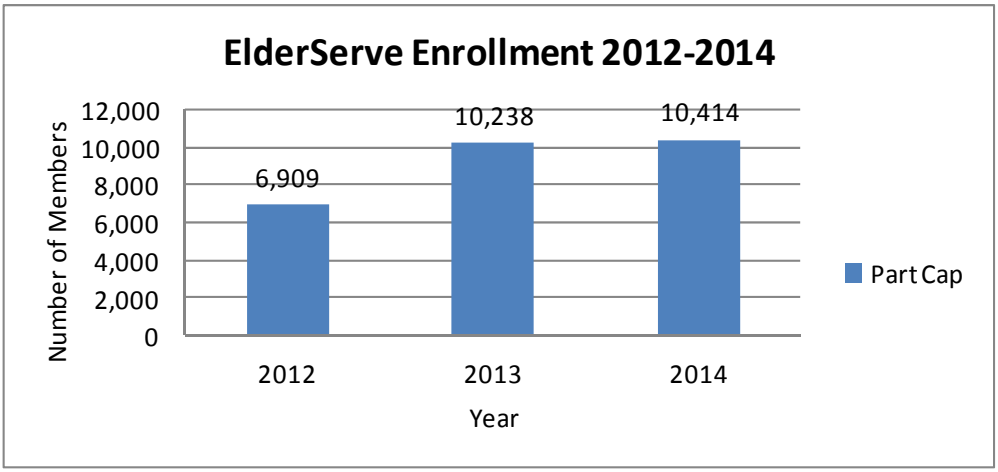
Section Three: Enrollment

Figure 1 depicts membership for ElderServe's partially capitated product line for calendar years 2012 to 2014, as well as the percent change from the previous year (the data reported are from December of each of these years). Membership grew over this period, increasing by 48.2% from 2012 to 2013 and by 1.7% from 2013 to 2014. Figure 1a trends the enrollment for the partially capitated product line.

Figure 1: Membership: Partially Capitated 2012-2014

	2012	2013	2014
Partially Capitated			
Number of Members	6,909	10,238	10,414
% Change From Previous Year	108.2%	48.2%	1.7%

Figure 1a: Enrollment Trends 2012-2014



Section Four: Member Satisfaction

IPRO, in conjunction with the NYSDOH, conducted a member satisfaction survey mailed between December 2014 and May 2015. The NYSDOH provided the member sample frame for the survey, which included the primary language for the majority of members. From this file, a sample of 600 members from each plan was selected, or the entire membership if the plan's enrollment was less than 600. Of the 18,909 surveys that were mailed, 1,109 were returned as undeliverable due to either mailing address issues or the member being deceased. This yielded an adjusted population of 17,800. A total of 4,592 surveys were completed, yielding an overall response rate of 25.8%.

The response rate for ElderServe's partially capitated product line was 21.6% (123 respondents out of 570 members in the sample).

IPRO had previously conducted a similar satisfaction survey that was mailed between December 2012 and May 2013. Figure 2 represents the results of these two satisfaction surveys from ElderServe's partially capitated product line, compared with all other partially capitated plans throughout the state, as well as all MLTC plans statewide, in the areas of plan rating, quality ratings for key services, timeliness of critical services, access to critical services, and advance directives.

Figure 2: Satisfaction Survey Results ElderServe Compared with all Partially Capitated Plans, and all Plans Statewide	ElderServe 2012-2013 (N=116)[a]		Overall Part Cap 2012-2013 (N=1,662)[a]		Statewide 2012-2013 (N=2,522)[a]		ElderServe 2014-2015 (N=123)[a]		Overall Part Cap 2014-2015 (N=3,306)[a]		Statewide 2014-2015 (N=4,592)[a]	
Description	**n[b]**	**%**	**n[b]**	**%**	**n[b]**	**%**	**n[b]**	**%**	**n[b]**	**%**	**n[b]**	**%**
Plan requested list of Rx/OTC meds **	102	85%	1,439	87%	2,197	88%	88	94%	2,677	94%	3,702	94%
Plan explained the Consumer Directed Personal Assistance option ++	-	-	-	-	-	-	68	90%▲	1,831	77%	2,495	75%
Plan rated as good or excellent	113	83%	1,625	84%	2,458	84%	95	90%	2,688	87%	3,739	87%
Quality of Care Rated as Good or Excellent												
Dentist	61	61%	1,009	71%	1,530	70%	63	81%	1,669	73%	2,382	73%
Eye Care-Optometry	84	83%	1,279	82%	1,951	81%	80	86%	2,167	81%	3,079	82%
Foot Care	58	78%	1,087	82%	1,640	80%	80	88%	1,903	83%	2,637	83%
Home Health Aide	79	98%▲	1,358	88%	2,056	87%	88	94%	2,437	87%	3,351	87%
Care Manager	82	84%	1,389	84%	2,108	84%	85	87%	2,479	83%	3,445	83%
Regular Visiting Nurse	97	88%	1,420	84%	2,132	84%	94	89%	2,412	83%	3,355	83%
Medical Supplies	65	88%	1,185	85%	1,844	86%	80	85%	2,066	82%	2,937	82%
Transportation Services	83	78%	1,242	77%	1,916	78%	84	87%	2,000	77%	2,853	77%
Timeliness- Always or Usually On Time												
Home Health Aide, Personal Care Aide	67	88%	1,258	79%	1,897	78%	90	93%	2,471	92%	3,385	93%
Care Manager	57	74%	1,225	70%	1,876	69%	79	84%	2,270	83%	3,144	83%
Regular Visiting Nurse	91	77%	1,351	70%	2,027	69%	91	91%▲	2,297	81%	3,177	81%
Transportation TO the Doctor	71	76%	1,147	68%	1,766	69%	76	87%	1,763	81%	2,515	81%
Transportation FROM the Doctor	70	76%	1,124	67%	1,742	67%	76	87%	1,753	78%	2,505	78%
Access to Routine Care (<1 Month)												
Dentist	56	46%	832	47%	1,234	46%	58	78%	1,323	75%	1,873	73%
Eye Care/Optometry	75	53%	1,093	43%	1,647	43%	71	80%	1,767	80%	2,486	79%
Foot Care/Podiatry	48	50%	932	45%	1,390	45%	72	83%	1,608	82%	2,220	80%
Access to Urgent Care (Same Day)												
Dentist	39	36%	612	28%	920	26%	44	48%	1,062	31%	1,526	29%
Eye Care/Optometry	48	35%	788	25%	1,195	22%	60	47%	1,497	34%	2,165	33%
Foot Care/Podiatry	35	43%	692	27%	1,039	26%	63	44%	1,368	35%	1,912	34%

Advance Directives												
Plan has discussed appointing someone to make decisions	85	45%▼	1,346	64%	2,087	68%	89	52%	2,660	64%	3,757	67%
Member has legal document appointing someone to make decisions	100	31%▼	1,387	55%	2,145	61%	97	23%▼	2,645	53%	3,722	58%
Health plan has a copy of this document ◊	21	24%[c]	533	74%	956	77%	14	57%[c]	913	75%	1,506	79%

LEGEND	
Symbol	**Description**
[a]	N reflects the total number of members who completed the survey
[b]	n reflects the total number of members who responded to each survey item
**	Represents question that has been added to the 2013-2014 technical report
++	Represents new question in 2014-2015 survey
▲	Represents a significantly higher rate versus the Partially Capitated/statewide rate ($p < .001$)
▼	Represents a significantly lower rate versus the Partially Capitated/statewide rate ($p < .001$)
◊	Item based on a skip pattern
[c]	Significance testing could not be performed due to small sample size ($n<30$)

ElderServe Satisfaction Survey Results Summary

An improvement in member satisfaction was observed across the majority of categories of care from 2012/2013 to 2014/2015. This difference was especially notable in the percentage of ElderServe members who rated their dentist as good or excellent (61% vs. 81%), had access to routine care and reported that their plan had a copy of their advance directive documentation (24% vs. 57%). In contrast, there was a decline in the percent of members who appointed a healthcare proxy (31% vs. 23%). It should be noted that the figures associated with advance directive documentation should be interpreted with caution, as the number of members responding to this question was small for both surveys (21 and 14, for 2012/2013 and 2014/2015 respectively).

In the most recent satisfaction survey administered to ElderServe's membership, there was a statistically significant difference between the percent of ElderServe members who reported their regular visiting nurse was usually or always on time (91%) compared to other partially capitated members (81%) and members statewide (81%). Additionally, a significantly lower percentage of ElderServe members had appointed a healthcare proxy, compared with other partially capitated plan members and all members statewide (23% vs. 53% and 58%, respectively).

Section Five: SAAM and UAS

The Semi Annual Assessment of Members (SAAM) was the assessment tool utilized by the MLTC plans to conduct clinical assessments of members, at start of enrollment and at six month intervals thereafter, through 2013. There are fifteen (15) care categories, or domains, in SAAM, as follows:

Diagnosis/Prognosis/Surgeries
Living arrangements
Supportive assistance
Sensory status
Integumentary status
Respiratory status
Elimination status
Nursing Home Admissions
Falls
Neuro/Emotional Behavioral Status
ADL/IADLs
Medications
Equipment Management
Emergent Care
Hospitalizations

SAAM data were submitted to the NYSDOH twice annually, in January and July, through July 2013. The January submission consisted of assessments conducted between July and December of the prior year; the July submission consisted of assessments conducted between January and June of the same year. Twice annually, following submissions, the NYSDOH issued plan-specific reports containing plan mean results and comparison to statewide averages.

In 2007, the SAAM was expanded beyond its role as a clinical assessment tool, to determine MLTC plan eligibility. An eligibility scoring index was created; the scoring index consisted of 13 items/questions, as follows:

Urinary Incontinence
Bowel incontinence frequency
Cognitive functioning
Confusion
Anxiety
Depression
Ability to dress upper body
Ability to dress lower body
Bathing
Toileting
Transferring
Ambulation/Locomotion
Feeding/Eating

Each item had a point value; a combined total score of 5 or greater constituted MLTC eligibility.

Effective October 2013, the SAAM tool was replaced by the Uniform Assessment System for NY (UAS-NY). The UAS-NY is a web based clinical assessment tool based on a uniform data set, which standardizes and automates needs assessments for home and community based programs in New York[1]. Data are immediately available to users during and upon completion of the assessment.

Figure 3a contains ElderServe's July 2013 SAAM results, and Figure 3b contains ElderServe's January-June and July-December 2014 UAS results.

[1] NYS Department of Health, *2014 Managed Long Term Care Report*. http://health.ny.gov

Figure 3a: ElderServe Partially Capitated and Statewide SAAM Data 2013

SAAM Items	July 2013	
	Plan SAAM N=9,464	Statewide SAAM N=102,248
Activities of Daily Living (ADL)		
Ambulation/Locomotion – % of members who could perform task independently, with setup help/device, or with supervision	95%	92%
Bathing – % of members who could perform task independently, with setup help/device, or with supervision	92%	89%
Upper Body Dressing – % of members able to perform task independently, with setup help, or with supervision	89%	87%
Lower Body Dressing – % of members able to perform task independently, with setup help, or with supervision	80%	79%
Toileting – % of members able to perform task independently, with setup help, or with supervision	93%	91%
Transferring– % of members able to transfer independently, with use of an assistive device, or with supervision/minimal assistance	91%	87%
Feeding/Eating – % of members able to eat/drink independently, with setup help, or with supervision	99%	99%
Continence		
Urinary Continence – % who are continent, have control with catheter/ostomy, or were infrequently incontinent	20%	27%
Bowel Continence – % who are continent, have control with ostomy, or were infrequently incontinent	79%	79%
Cognition		
Cognitive Impairment – % members with no cognitive impairment	15%	43%
When Confused – % with no confusion	19%	36%
Mood and Behavior		
Anxiety – % with no feelings of anxiety	23%	39%
Depressed – % with no feelings of depression	66%	75%

SAAM Items	July 2013	
	Plan SAAM N=9,464	Statewide SAAM N=102,248
Health Conditions		
Frequency of Pain – % experiencing no pain, or pain less than daily	35%	45%
Falls Resulting in Medical Intervention – % of members experiencing no falls requiring medical intervention	49%	55%
Prevention		
Influenza Vaccine – % who had influenza vaccine in last year	65%	73%

SAAM July 2013

ElderServe members had higher rates for transferring when compared with members statewide. A lower percentage of ElderServe members had intact cognitive functioning, no feelings of anxiety or depression, and no pain compared to members statewide. It should be noted that the SAAM questions pertaining to mood and behavior are prone to a high level of subjectivity on the part of the assessor and may also be scored based upon behavior/attitude exhibited solely at the time of the assessment visit.

Figure 3b: ElderServe Partially Capitated and Statewide UAS Data 2014

UAS Items	Jan-June 2014		July-Dec 2014	
	Plan UAS N=10,489	Statewide UAS N=125,702	Plan UAS N=10,565	Statewide UAS N=132,429
Activities of Daily Living (ADL)				
Ambulation/Locomotion – % of members who could perform task independently, with setup help/device, or with supervision	53%	56%	53%	53%
Bathing – % of members who could perform task independently, with setup help/device, or with supervision	19%	20%	20%	16%
Upper Body Dressing – % of members able to perform task independently, with setup help, or with supervision	28%	34%	27%	30%
Lower Body Dressing – % of members able to perform task independently, with setup help, or with supervision	18%	18%	18%	16%
Toileting – % of members able to perform task independently, with setup help, or with supervision	60%	64%	58%	57%
Feeding/Eating – % of members able to eat/drink independently, with setup help, or supervision	87%	87%	88%	85%
Continence				
Urinary Continence – % who are continent, have control with catheter/ostomy, or were infrequently incontinent	24%	37%	25%	37%
Bowel Continence – % who are continent, have control with ostomy, or were infrequently incontinent	84%	82%	86%	83%
Cognition				
Cognitive functioning – % with intact functioning	27%	40%	25%	34%
Mood and Behavior				
Anxiety – % with no feelings of anxiety	78%	76%	76%	75%
Depressed – % with no feelings of depression	77%	71%	74%	68%
Health Conditions				
Frequency of Pain –	23%	26%	21%	22%

UAS Items	Jan-June 2014		July-Dec 2014	
	Plan UAS N=10,489	Statewide UAS N=125,702	Plan UAS N=10,565	Statewide UAS N=132,429
% experiencing no severe daily pain				
Falls Resulting in Medical Intervention – % of members experiencing no falls requiring medical intervention	96%	87%	96%	90%
Prevention				
Dental Exam – % who had dental exam in last year	68%	47%	69%	48%
Eye Exam – % who had eye exam in last year	81%	70%	83%	72%
Hearing Exam – % who had hearing exam in last 2 years	54%	31%	54%	32%
Influenza Vaccine – % who had influenza vaccine in last year	75%	75%	75%	76%

UAS January-June 2014
There were a lower percentage of ElderServe members who demonstrated urinary continence compared with members statewide (24% vs. 37%, respectively). Similarly, a lower percentage of ElderServe members demonstrated intact cognitive functioning when compared to members statewide (27% vs. 40%, respectively). In contrast, a higher percentage of members had no falls requiring medical intervention, and had completed a timely dental, eye and/or hearing exam.

UAS July-December 2014
Similar to the January-June 2014 time period, a lower percentage of ElderServe members demonstrated urinary continence and intact cognitive functioning, however a higher percentage had no falls requiring medical intervention.

Section Six: Performance Improvement Projects

MLTC plans conduct performance improvement projects (PIPs) on an annual basis. Proposed project topics are presented to IPRO and to the NYSDOH prior to the PIP period, for approval. Periodic conference calls are conducted during the PIP period to monitor progress.

The following represents a summary of ElderServe's PIP for 2013:

ElderServe sought to more readily identify elder abuse by employing a screening tool during admission. The Plan suspected that elder abuse may have been under-recognized and under-reported in their member population. According to the National Center for Elder Abuse, between 2% and 10% of people over 60 years old are victims, and as few as one in 14 cases are reported to authorities. In the one year prior to this study, only seven cases of elder abuse were suspected in 6,000 members (0.1%) with only four referrals to Adult Protective Services (APS). No cases were recognized at enrollment.

A safety screen questionnaire was developed in an effort to improve the recognition of elder abuse and situations which may lead to elder abuse. The tool rephrased or asked additional questions about family members, sexual exploitation, hospitalizations and referrals to APS. The primary objective of this project was to determine whether this screening tool would be more sensitive for identifying abuse in the elderly as determined by the number of referrals to APS. All 1,400 community-dwelling members enrolled in ElderServe between January and March of 2013 were eligible to participate in this project. Screens were tabulated when performed, and positive screens were referred by the Director of Social Work for confirmation by nursing or social work. Referrals to Adult Protective Services were reviewed to determine whether they had been screened with this Safety Screen. The screen was administered between January and March, and the evaluation of a positive screen result and any subsequent referrals to Adult Protective Services started in January and continued through the end of October.

There were 1,400 screens performed between January and March 2013. Thirty-six members had positive screens of which four were confirmed and referred to APS. APS did not consider that abuse was occurring in any of these cases. All screened members continued to be followed through the end of the study period (October 31, 2013), as were the rest of ElderServe members. No further cases of abuse had been identified in the screened group during the follow-up period. ElderServe staff identified an additional two cases of abuse in members who had not been screened.

Results are detailed on the following page:

Table 1: Count and Percent of New Enrollees with Positive Findings on the Elder Abuse Safety Screen

Type of Abuse	*Count*	*Percent*
Emotional	3	0.214%
Financial	26	1.857%
Neglect	3	0.214%
Sexual	1	0.071%
Physical	1	0.071%
At risk for abuse, unspecified	3	0.214%
Total	37	2.643%

Table 2: Confirmation of Abuse in the 1,400 Newly Enrolled Members Evaluated by the Elder Abuse Safety Screen

Type of Abuse	*Count*	*Percent*
New enrollees identified by screen as possible abuse	36	2.6%
Members in whom abuse was confirmed after review by nurse or social worker	4	0.3%
Proportion of "confirmed" positive screens	4/36	11.1%
Members with "confirmed" screens accepted by APS	0	0%

Only 0.2% of the 6,000 members of ElderServe's Managed Long Term Care program were considered to have been victims of abuse severe enough to require referral to Adult Protective Services. This low number may reflect early intervention in situations with the potential for abuse, differences in populations, and an overestimate of the prevalence of abuse in various published studies, or other factors. ElderServe thought that the use of an enhanced abuse screening tool in newly enrolled members might increase their identification of members in abusive situations. Indeed, some individuals (2.6% of those screened) were identified who required further evaluation. A smaller number, representing 0.3% of the screened population, was referred to Adult Protective Services, but none of them were accepted. Thus, the screen did not prove to be a sensitive or specific tool for identifying people suffering from abuse rising to the level of severity needed for intervention from Adult Protective Service. Furthermore, during the study period only 2 more cases requiring referral to APS were identified in members who were not given the Safety Screen. It may be that abuse is simply less common in populations who participate in Managed Long Term Care programs such as ElderServe's because of the abundance of support services and the potential for early intervention before outright abuse develops or because of population characteristics. Abuse is also more likely to be revealed only after a long term and trusting relationship is established with members and care givers.

The following represents a summary of ElderServe's PIP for 2014:

Among older adults, falls are the leading cause of both fatal and non-fatal injuries. Many people who have experienced a fall develop a fear of falling again and begin to limit their physical activity which may lead to reduced mobility, loss of physical stamina and, ultimately, increase their risk of subsequent falls. The implementation of the Uniform Assessment System (UAS) in October of 2013 provided an additional way to identify members at risk for falls. The UAS report for October and November of 2013 showed that 109 of the 1,502 members who completed assessments triggered a Clinical Assessment Protocol for falls. ElderServe's goals were to establish baseline data for falls in its population educate staff about falls and fall prevention and to increase the proportion of members referred for Rehabilitation Therapy evaluations by at least 20%.

Indicators measured included:
1) Referrals to Rehabilitation Therapy for falls.
2) Fall risk per enrollee – members at risk for falls based on the UAS.
3) Falls per enrollee – members with one or more falls per all members.
4) Members with falls requiring medical intervention per enrollee.
5) Falls requiring medical intervention per total falls.
6) Fall stratification – number of falls per person/members who fell.

Interventions included the following:
- Education of Nurses and Nurse Care Managers on the following:
  - Completion of the UAS.
  - Post-fall assessment protocols.
  - Significance of falls in the elderly population.
  - Plan policies related to reporting member incidents.

Results are summarized as follows:

Table 1. Falls Recorded in the UAS which Generated a Clinical Assessment Protocol (CAP) for Falls

Period	Assessments Completed	Assessments Triggering a CAP	Rate of Falls Triggering a CAP
1/1/14-3/31/14	3,390	133	3.9% (Baseline)
9/1/14-10-31-14	2,215	132	6.0% (Baseline)
1/1/14-8/31/14	6,759	393	5.8%
1/1/14-10/31/14	8,974	525	5.9%

Table 2. Falls and All Incidents From the Member Incident Log

Period	Incidents	Falls	Rate
1/1/14-3/31/14	116	99	85.3%
9/1/14-10-31-14	64	55	85.9%
1/1/14-8/31/14	300	252	84.0%
1/1/14-10/31/14	364	307	84.3%

Table 3. Falls Stratification from Incident Reports

Number of Falls	Members	Total Falls
1	224	224
2	27	54
3	3	9
4	5	20
Total	259	307

Table 4. Falls Per Thousand Members Per Month from Incident Reports

Period	Falls	Falls/1000 Member Months
1/1/14-3/31/14	101	5.2
9/1/14-10-31-14	55	4.3
1/1/14-8/31/14	252	4.9
1/1/14-10/31/14	307	4.8

Table 5. Comparison of Fall Rates in Members from the UAS and Incident Reports of Falls

Fall Rate	10 Months	12 Months (Projected)
Fall Rates Per Enrollee from UAS Data	8.1%	9.8%
Fall Rates Per Enrollee from Incident Report Data	4.8%	5.7%
Fallers (one or more falls) Per Enrollee from Incident Data	4.0%	4.8%
Falls Requiring Medical Intervention Per Enrollee Incident Data	0.9%	1.1%
Falls Requiring Medical Intervention Per Total Falls	18.9%	22.7%

Table 6.

Period	Falls	Referrals	Rate
1/1/14-3/31/14	99	11	11.1%
9/1/14-10-31-14	55	11	20.0%
1/1/14-8/31/14	300	21	7.0%
1/1/14-10/31/14	364	32	8.8%

Results are summarized as follows:
A total of 8,974 UAS assessments and 364 member incidents were reviewed for all 6,450 ElderServe Health members from Brooklyn and Staten Island. Overall, 5.9% of UAS assessments reviewed had evidence of a fall; 4.0% of incident logs reviewed had evidence of a fall. Referrals for rehabilitation therapy assessments increased by nearly 100% from a baseline of 11.1% to a remeasurement of 20.0%.

Conclusions:
Baseline data for falls and injury from falls were established. Education of nurses and care managers resulted in an increase of referrals for rehabilitation therapy assessments. Future studies will show whether formal rehabilitation therapy referrals impact the incidence of falls and injury from falls.

Section Seven: Summary/Overall Strengths and Opportunities

Strengths

Consumer Directed Personal Assistance Option
Compared to other partially capitated plans and plans statewide, there were a higher percentage of ElderServe members who reported that their Plan explained the Consumer Directed Personal Assistance option in the most recent satisfaction survey. The rate for ElderServe was 90%, while rates for the other partially capitated plans and plans statewide were 77% and 75%, respectively. This difference was statistically significant.

Timeliness
A higher percentage of ElderServe members indicated that their transportation service to/from the doctor were usually or always on time compared with members enrolled in other partially capitated plans, and all plans statewide. Additionally, a higher percentage of ElderServe members (91%) reported that their regular visiting nurse was usually or always on time, compared with members enrolled in other partially capitated plans (81%) and members statewide (81%). This difference was statistically significant.

Mood and Behavior
Throughout both UAS reporting periods in 2014, a higher percentage of ElderServe members had no feelings of depression compared to members statewide (77% vs. 71% in the first half of the year, and 74% vs. 68% in the second half). These figures should be interpreted with caution, as UAS questions pertaining to mood and behavior are prone to subjectivity on the part of the assessor and may also be scored based upon behavior/attitude exhibited solely at the time of the assessment visit.

Falls Mitigation
A higher percentage of ElderServe members experienced no falls requiring medical intervention compared to members statewide, in both the January-June and July-December UAS reporting periods in 2014.

Prevention
ElderServe members performed very well with all the prevention indicators (dental exam, eye exam and hearing exam) throughout 2014. Rates were similar for ElderServe members and members statewide for the influenza vaccine.

Performance Improvement Project (2014)
ElderServe was able to increase the percentage of members referred for rehabilitative therapy from 11.1% in the beginning of the 2014 project year, to 20.0% by year end. Education of nurses and case managers appeared to have been very beneficial in improving the rate of referrals. Going forward, the Plan anticipates measuring the impact of these referrals on the incidence of falls, as well as fall-related injuries.

Opportunities

Advance Directives
A lower percentage of ElderServe members indicated that the Plan had discussed appointing someone as a healthcare proxy with them, that they had legal documentation appointing someone to make these decisions, and that the Plan had a copy of this document, when compared to similar plans and all other plans throughout the state. The difference in the percent of ElderServe members who indicated they had a healthcare proxy and those enrolled in other plans was significantly significant.

ElderServe may consider conducting a PIP, or focused study in order to determine barriers associated with advance directive completion, and ensure that providers and ElderServe staff are discussing this topic with their members.

Cognition
A lower percentage of ElderServe members appeared to have intact cognitive functioning compared with members statewide. This trend was noted in both the January-June and July-December reporting periods. It is therefore recommended that ElderServe conduct an inter-rater reliability project for clinical assessments, to aid in determining whether these members do in fact have higher levels of impairment than on a statewide basis, or if there are scoring issues. Two assessors could independently conduct the same assessments on a sample of members, to test the validity of responses.