Lifespan of Greater Rochester, Inc.

Prevention, Wellness, and Chronic Disease Management

Integrating Lifespan's community based services with health care systems

May 13, 2019

Lifespan serves over 40,000 people in the Greater Rochester and Finger Lakes Region annually, including older adults, people with disabilities and caregivers.

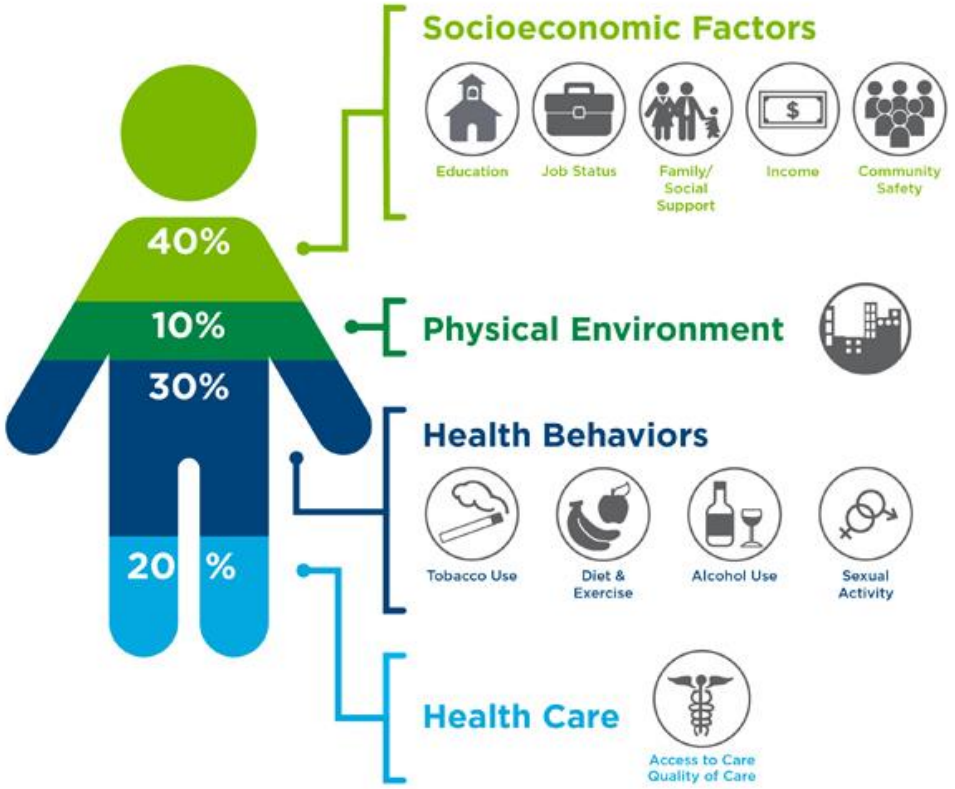
Community Care Connections

With support from the New York State Department of Health, Lifespan created **Community Care Connections (CCC)** because of an acute need for an integrated care approach for older adults.

From August 1, 2015 through the first quarter of 2018, Community Care Connections assisted 1,667 older adults who were referred by medical systems of care.

The program continues with an extension from NYS DOH and other bridge funding while we work to obtain value-based payment contracts.

Community Care Connections



Building an Integrated Delivery System: Address both Health and Social Determinants of Well-Being

Strategic Vision

Prove that integrating traditional community-based aging services with medical systems of care positively affects the triple aim of cost, quality and patient satisfaction.

We sought to change the paradigm by breaking down the siloes between community-based aging services and medical systems of care to help an increasing population of older adults access the right care, at the right time, at the right place.

Goals:

- Provide a proven model for replicability of integrated care for older adults in NYS.
- Reduce inappropriate hospitalizations and ED use.
- Determine which community-based aging services make a difference in health outcomes.
- Evaluate physician response to integration of Lifespan intervention.
- Reduce family caregiver stress.

Social Work Care Navigation

A Team Approach

Ongoing home visits
Geriatric Wellness Assessment
Care plan development

Connects clients to:
Housing
Financial benefits
Transportation
Respite
Socialization
Mental health intervention
Caregiver supports
Chronic disease management workshops
Geriatric addictions intervention
Caregiver supports
Home safety modification
Elder abuse intervention
+ other social supports

Healthcare Coordination:

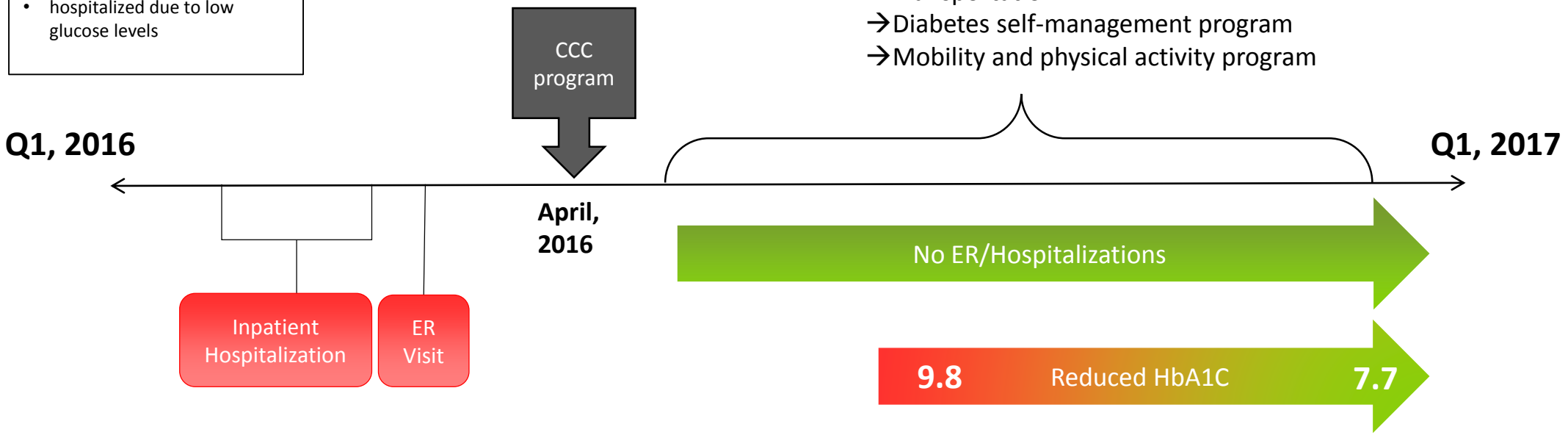
LPN's and Community Health workers supervised by an RN

CASE STUDY

2016-2017 Timeline: Client A

Client A:
- 67 year old male
- Diabetes diagnosis
- Insulin dependent
- No local support system
- hospitalized due to low glucose levels

→Care coordination
→Transportation
→Diabetes self-management program
→Mobility and physical activity program



Average costs* for patients age 65 or older
Hospitalization: $13,907
ER Visit: $918

Among patients with diabetes, those with controlled HbA1c have health care costs that are **2-8x lower** than those with uncontrolled HbA1c**

*NYAM calculations based on 2014 data from the Medical Expenditure Panel Survey, adjusted to December 2016 using the Consumer Price Index for medical care (U.S. city average, all urban consumers). The sample included for the average cost calculations included adults 65 years of age and older with Medicare or Medicaid health insurance coverage which had a hospitalization stay or an emergency department visit.

**American Diabetes Association. (2013). Economic costs of diabetes in the US in 2012. *Diabetes care*, *36*(4), 1033-1046.

PRE/POST: HEALTH CARE UTILIZATION ANALYSIS

Rochester Regional Health Information Organization (RRHIO) provided emergency room and hospitalization encounter data for pre- and post-intervention comparisons.
New York Academy of Medicine evaluated the effectiveness and return on investment of the interventions.

Average number of hospitalizations and emergency department visits per client decreases after 90 days of CCC program participation.

	# of CCC Clients (N)	Pre CCC	Post CCC	% Change
Hospitalizations	894	0.11	.07	-36%*
ED Visits	894	0.45	0.28	-38%*

** p<.05*

In this analysis, every dollar spent on the CCC program is associated with **$4.05 in savings** resulting from fewer hospitalizations and emergency department visits

THE NEW YORK ACADEMY OF MEDICINE

The Power of Lifespan's interventions

A measurement of the pre- and post-effect of the Community Care Connections intervention analyzed by service connection shows the following top six impactful services:

Decreased Hospitalizations

Services	% Change
Managed Long-Term Care	78%
Living Healthy with Diabetes Classes	77%
Bill Paying	71%
Home Meal & Grocery Delivery	60%
Matter of Balance Classes	57%
Transportation (non-Medicaid clients)	44%

Decreased Emergency Room Visits

Services	% Change
Home Meal & Grocery Delivery	61%
Matter of Balance Classes	50%
Minor Home Modification	47%
Financial Benefits Counseling	44%
Managed Long-Term Care	38%
Transportation (non-Medicaid clients)	37 %

Lifespan
take it on!

Successes

The most successful access point integration was with physician practices and certified home care agencies.

- 100% of medical professionals surveyed were satisfied with the CCC program and acknowledged the positive impact on patients' health of Lifespan's work to address social needs.
- 87% of caregivers reported a decrease in stress as compared to baseline.
- 94% of clients enrolled accessed at least one community-based service. 3,741 community- based services were accessed with an average of 3.78 services per client.
- The service linkages, as noted above, made a significant impact on decreases in emergency room use and hospitalizations and subsequent return on investment.

Lessons Learned

- Outreach efforts were critical to the successful establishment of relationships with referral sources.
- A tiered approach to Healthcare Coordination based on defined level of need was successfully employed to increase patient ability to self-manage their health with a transfer from LPN to Community Health Worker to “graduation” from the service.
- Consistent, structured communication among partners is critical to troubleshoot potential problems and issues, understand the full effects of the program, and identify areas of improvement.
- Cost analyses broken down by population of interest is essential in making the case for sustainability.

Questions?

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