The Long Term Care Planning Project (LTCPP) is comprised of five meetings with the overall goal of creating a path for New York State to support its aging population. As such, key topics and notes will be published from each individual meeting; and then a final report of recommendations.

The second meeting of the LTCPP focused on showcasing evidence-based programs and innovative models that are being used by organizations across the State. Organizations were invited to submit a short proposal on their program. A total of 52 submissions were received from which 14 were selected to present. Each ten-minute presentation was given in the following categories: Prevention/Wellness/Chronic Disease, Care Transitions, Technology, and Other.

A brief description of each presentation and the significant dialogue after each category of presentations are below.

**Prevention/Wellness/Chronic Disease**

**Presentations**

- Catholic Health Services of Long Island – Diabetes Self-Management Program in a Primary Care Setting
  - Diabetes self-management education implemented in the ambulatory settings of Catholic Health Services to assist patients in managing their diabetes.

- Lifespan of Greater Rochester – Community Care Connections
  - A team approach, including community health workers, working with older adults referred by medical systems of care to avoid preventable readmissions.

- Lifespan of Greater Rochester – Geriatric Addictions Program
  - Community-based, in-home program that provides substance abuse intervention and support for older adults using a harm-reduction approach.

- Nurses Improving Care for Healthsystem Elders (NICHE)
  - Nursing education, consultation, and organizational development program designed to improve care of older adults through clinical education, evidence-based clinical guidelines, and other practice-improvement resources for nursing and interdisciplinary teams.

- Premier Home Health Care Services, Inc. – Real Time Data (RTD)
  - Program using RTD to promote and create an interdisciplinary team environment that improves health care outcomes through enhanced agency staff training, population management, and health plan quality incentive measures.
Q&A

To Premier: Is basic data from home care cases such as blood sugar, blood pressure, and weight being collected?
Answer: No but are looking into collecting additional information. Premier is currently reviewing its dashboard capabilities.

To Lifespan: How is the Community Care Connections program eliminating overlap between agencies?
Answer: Maintenance of an electronic medical record to ensure work is done in conjunction with organizations and making time for warm handoffs to other agencies as needed. Lifespan is part of NY Connects, which helps see what other services are being offered in the area.

To NICHE and Premier: Are trainings connected to a career step or wage increase?
NICHE Answer: Wage increases or other career incentives are determined by the participating facility.
Premier Answer: Trainings are not tied to a career ladder move.
Answer: 1199 noted via comment that they were in negotiations with Premier to increase wages for staff.

Statement to Premier: HIV should be included in training programs for your OAR IV.
Answer: That will be considered.

To Premier: Is there more information available on the level 2 and level 3 VBP contract arrangements?
Answer: Contract arrangements for level 2 have just begun. VBP level 3 will occur at a later date. Premier is willing to begin conversations.

To Lifespan: Is there more insight into improvements in data for the Community Care Connections program?
Answer: The goal of the data is to link it back to Medicaid Long Term Care.

Statement to Premier: The workforce shortage with homecare is in all parts of the State, this should be considered with any additional program developments.

Care Transitions

Presentations

- Cabrini of Westchester – ‘What Matters to You?’ Initiative
  - Program targeted at short-term rehab units where patients were asked by clinicians “What Matters to You” and had their responses incorporated into their plan of care to provide better quality care.
• Erie County Department of Social Services – Ready, Set, Home
  o Designed to increase the chances for a safe and successful discharge from a
    rehab or long term care setting to home through targeted short term case
    management.

• JASA – JASA’s Community–Based Care
  o Home-based care transitions program targeting older adults to address social
    determinates of health and reduce 10-day hospital readmissions. JASA staff visit
    clients in the hospital for a warm handoff and make home visits within 48 hours of
    discharge to complete a follow-up assessment.

Q&A

To Cabrini: Have staff turnover rates been considered since implementing the
program?
Answer: Initial data collection on staff turnover has been collected since
implementing the initiative. An in-depth review of the data is in the
beginning stages.

To Erie County: How does the program get an individual to a functional level in order for
them to go home?
Answer: All services are tailored to the individual’s needs; through the process
they are able to achieve the level needed for them to go home.

To Erie County: What if necessary care cannot be obtained for the individual to return
home? Once they are part of the program how many remained at home?
Answer: The program requires that services be in place prior to discharge. The
program has developed a strong working relationship with the providers
to ensure that necessary services are available. About 90 percent of
participants remained at home.

To JASA: Who are the contacts for congregate and home delivered meals?
Answer: JASA has case management services for home delivered meals and also
operates 22 congregate meal sites. JASA initially utilized its own services
but will recommend others if closer or easier for the individual to access.

To Cabrini: Does the ‘What Matters to Me’ care plan follow the patient when they are
discharged?
Answer: With the patient’s permission, it is shared.

To JASA: Is there training for peer/caregiver support?
Answer: Caregivers and peers can be trained in the home. Peer coaches are
trained by the agency and are deployed to individual homes and the
caregiver is included when possible.
Technology

Presentations

• Pace University – Improving Outcomes in Hospitalized Older Adults Using Tablet-Based Avatars and Robotic Pets Decrease Loneliness and Depression for Hospitalized Older Adults
  o Study to examine the effect of an avatar virtual service animal on cognition, loneliness, depression, delirium, and falls in hospitalized older adults.
  o Clinical trial measured the impact of inexpensive robotic animals on loneliness and depression among 100 adults over the age of 65 at an inner city community hospital.

• University of Rochester – Telepsychiatry and Project ECHO for Skilled Nursing Facilities
  o Project ECHO provides skilled nursing facility clinicians with skills and knowledge to treat complex patients in their own practices. The skilled nursing facility telepsychiatry program fills the gap of provider shortages in approximately 30 nursing homes across the Finger Lakes region.

Q&A

To University of Rochester: Has any work been done with the ECHO model in home care?
Answer: No, but the program has established partnerships with primary care for home services.

To University of Rochester: How will the end of DSRIP affect the program?
Answer: Funding was received separately from DSRIP, the future of DSRIP is unknown, but hopes to continue.

Other

Presentations

• Franklin County Office for the Aging – Office for the Aging and Emergency Services Collaboration
  o Training of first responder and dispatch staff on screening for social issues and services and supports available in the community. Additional information was built into the 911 dispatch system to allow dispatch staff to see additional pertinent information including possible cognitive or physical limitations with a 24/7 contact with Office for the Aging in cases that did not necessitate EMS or police intervention.

• The Harry and Jeanette Weinberg Center for Elder Justice at the Hebrew Home at Riverdale
  o Shelter for victims of elder abuse in the community who are unsafe in their homes. The shelter is housed in skilled nursing facility.
• OneCity Health – Achieving Best Practices in Advance Care Planning and Hospice Referral: A Novel Nurse or Social Worker-Mediated Collaborative Practice Approach for Ambulatory Practices and Inpatient Settings.
  o Introduces a palliative care-trained nurse or social worker to providers and clinical leaders and becomes part of the care team to educate patients about the benefits of palliative care, create goal-setting discussions with their provider team, and discuss advance care planning.

• ShareTheCaregiving, Inc. – Share The Care
  o Group of volunteers who know the care recipient and family that share in caregiving to promote overall wellness by preventing family caregiver burnout, assisting in care transition, and minimizing hospital readmission for the care recipient.

No questions were asked at the end of these presentations. The Presentations will be posted on the Department of Health website.
https://www.health.ny.gov/facilities/long_term_care/planning_project/