Lifespan of Greater Rochester Inc.

Community Care Connections Final Report

New York State Department of Health Contract # C030146
Executive Summary

Our strategic vision for the three-year (2015 -2018) Community Connections pilot was to 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.

**Project Goal:** Evaluate and inform effective approaches to integrating community-based aging services with medical systems of care to provide a successful, replicable integration model.

**Projected Project Outcomes:**
- Reduce unnecessary hospital readmissions.
- Reduce unnecessary ED visits.
- Improve access to supportive services for unmet ADL/IADL needs.
- Reduce caregiver strain/burden.
- Medical providers report an increased understanding of how patients’ previously unknown social determinants affect health outcomes.
- Increased knowledge of which social services make the most difference for patients/caregivers.
- Provide tools for medical systems of care that improve quality of care.

**Evaluation**
The New York Academy of Medicine was the principle evaluator with data from Lifespan and the Rochester Regional Health Information Organization (RRHIO).

**Evaluation Results**
As evaluated by the NY Academy of Medicine, the Community Care Connections service resulted in:

- Decreased in hospitalizations.
- Decreased ED visits.
- Decreased health care costs.

**Community Care Connections Methodology**
Referrals from health care access points including:

- Five physician practices in Monroe, Ontario and Livingston counties with embedded social workers.
- Home care agencies (Lifetime Care & UR Medicine Home Care).
- Thirty other physician practices.
- Other anticipated care access points included Highland Hospital ED, Town of Brighton EMS, and Care Transition coaches. Barriers to these access points will be discussed.
Patient Inclusion Criteria

- 60 or older.
- Struggled with medical adherence.
- Co-morbidities – especially those with limited Activity of Daily Living (ADL) capabilities.
- Hospitalization and/or ED visit at least once in the previous year.
- Medicaid and/or Medicare eligible; all insurances.
- Current Health Home members who need time-limited extra support and assistance.
- Low health literacy.
- Low-income, communities of color experiencing high health disparities.
- Housing and financial instability.
- An aging or stressed caregiver.
- Without family and/or caregiver support.
- With substance abuse and mental health issues.

Intervention Components

1. In-home Social Workers
2. Healthcare Coordinators (Patient advocates and educators)

Number Served

1,667 patients through March 31, 2018. (Contract end date June 30, 2018.)
1,003 patients gave IRB consent.

Steering Committee Input

A Steering Committee formed at project launch. It included representatives from Rochester Regional Health, UR Medicine, Area Offices for the Aging, certified home health agencies, insurers, the Monroe County Medical Society, Common Ground Health, Finger Lakes Performing Provider System (DSRIP), geriatricians, Accountable Health Organizations, and the Rochester Regional Health Information Organization (RRHIO).

Evaluation Conclusion

Return on Investment (ROI): As evaluated by the NY Academy of Medicine, the return on investment is $4 per dollar spent on the service based on an analysis of 90 day pre- and post-data.

- Hospitalization decreased 36% post 90 days.
- ED visits decreased 38% post 90 days.

The most successful healthcare access point integration occurred with physician practices (embedded and non-embedded) and certified home healthcare agencies. 100% of medical professionals surveyed acknowledged the impact of Lifespan’s ability to address social determinants on their patients’ health. Common responses included a recognition of the value of (1) the care navigator and healthcare coordinator’s home visits (“my eyes in the home”), (2) our social workers’ knowledge of resources, and (3) the evident improvement in their patients’ health and well-being as a result of community service linkages made by Community Care Connections.
From 2015 to 2018, the Community Care Connections project in Rochester piloted integrating the services of a community-based aging service provider (Lifespan of Greater Rochester Inc.) as an authentic member of the evolving health care delivery system to help reduce hospital admissions/readmissions, ED visits and improve patient care.

With support from the New York State Department of Health, Lifespan created Community Care Connections because of an acute need for an integrated care approach for older adults. In this report, we conclude that the Community Care Connections pilot project successfully integrated with healthcare access points to breakdown the siloes between community-based aging services and medical systems of care. In doing so, Lifespan of Greater Rochester created a replicable model of integrated care for older adults for New York State. 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.

Lifespan of Greater Rochester has a 47-year history helping older adults take on the challenges of longer life by providing information, guidance and more than 30 services. In 2017, the agency assisted 39,000 residents in Monroe and surrounding Finger Lakes counties. As a provider of eldercare guidance, we receive calls like this, “Looking into info for help with in-laws. My mother-in-law is on peritoneal [sic] dialysis, took a fall at home, hospitalized for 4 days, UTI, concussion, severe anemia. Up and down several times during night and confusion- not sure if just from health issues but have noticed forgetfulness increasing. Family has been trying to stay 24/7 but now realize it is too much for us…. ” This caregiver did not call the discharging hospital for help. She did not call the primary care doctor. If she had, would she have found the information, guidance and linkages to services she needed? Given the siloes that exist between community-based services and medical care, it is unlikely. The best approach is for the medical and social service systems to work together to support the patient and the family before the next fall, before the next ED visit or before the next hospital admission.

Background
Community Care Connections Pilot

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

Project Goal: Evaluate and inform effective approaches to integrating community-based aging services with medical systems of care.
Project Outcomes:

- Provide a replicable, effective integration model for New York State.
- Increase medical providers’ understanding of how patients’ previously unknown social determinates affect health outcomes.
- Increase knowledge of which social services make the most difference for patients/caregivers.

Project Patient/Caregiver Outcomes:

- Improve access to supportive services for unmet ADL/IADL needs.
- Reduce unnecessary hospital readmissions.
- Reduce unnecessary ED visits.
- Reduce caregiver strain/burden.

Project Advisory Committee [Appendix 1]

To inform the pilot project, we formed a Steering Committee of stakeholders. It included representatives from Rochester Regional Health and UR Medicine, Area Offices for the Aging, certified home health agencies, local health insurance agencies, Monroe County Medical Society, Common Ground Health, Finger Lakes Performing Provider System (DSRIP), geriatricians, Accountable Health Organizations and the Rochester Regional Health Information Organization. The Steering Committee agreed to the following pillars of integrated health care:

Pillars of an integrated health care delivery system:

- Inclusion of the patient’s aging service provider as member of the patient’s health care team.
- Perceived improved patient outcomes by care team.
- Patient-centered planning and support.
- HIPAA-compliant communication between levels of care.
- Understood/shared culture and vocabulary.
- Shares best practices.
- Reduced use of inappropriate acute care.

Integration Value Propositions

- Aging service providers are more economically feasible.
- In-home community navigators are the “eyes and ears” in the home.
- Improves access to supportive services for the patient and caregivers.
- Improves care management across settings.
- Focus on prevention.
- Builds a common language and understanding.
- Reduces burden on physician practices/hospital staff.

Pilot Project Implementation Considerations

The implementation planning process explored the following development areas:

- Care Integration access points.
• Workforce.
• Electronic referral/communication.
• Risk screening.
• Training.
• Evaluation.

Projected Integrated Care Access Points
The planning committee believed the following would be natural access points between health care and community-based services for the pilot.

• Physician practices
• Transition coaches
• Home care agencies
• Hospital discharge planners and emergency department personnel
• EMS

Community Care Connections Methodology

Our health care access points included:

• Five physician practices in Monroe, Ontario and Livingston counties with Lifespan’s embedded social workers.
• Home care agencies (Lifetime Care & UR Medicine Home Care).
• Thirty other physician practices.

Anticipated care access points including Highland Hospital ED, Town of Brighton EMS and Care Transition coaches did not materialize. Barriers to these access points will be discussed.

Patient Inclusion Criteria
60 or older who:
Struggled with medical adherence.
Co-morbidities — especially those with limited Activity of Daily Living (ADL) capabilities.
Hospitalization and/or ED visit at least once in the previous year.
Medicaid and/or Medicare eligible; all insurances.
Current Health Home members who need time-limited extra support and assistance.
Low health literacy.
Low-income, communities of color experiencing high health disparities.
Housing and financial instability.
An aging or stressed caregiver.
Without family and/or caregiver support.
With substance abuse and mental health issues.
Intervention Components [Appendix 15]

1. Social Work Care Navigators
2. Healthcare Coordinators and Community Health Workers (Patient advocates and educators)
3. A combination of the above interventions

Community Care Connections uses a team approach that includes social workers as care navigators, LPN healthcare coordinators and community healthcare workers. Each patient referred is assessed via the Geriatric Wellness Screen (GWS) developed in partnership with the University of Rochester. The GWS is a tool for gathering information about patients’ health and social determinants of health. Each domain in the GWS results in an Older Americans Resources and Services (OARS) score which informs the development of a personal care plan to address health and social needs. Patients can access evidence-based chronic disease and fall prevention classes, post-hospitalization home meal delivery and light housekeeping, minor home modifications and transportation.

**Social Work Care Navigators** provide ongoing home visits, geriatric wellness assessment, care plan development and linkages to services such as:
- Housing.
- Financial benefits.
- Nutrition.
- Transportation.
- Respite.
- Socialization.
- Mental health intervention.
- Caregiver supports.
- Home safety modification.
- Chronic disease management workshops.
- Geriatric addictions intervention.
- Elder abuse intervention.

Our embedded care navigators became part of the physicians’ offices care teams, integrated in day-to-day operations. We established Memos of Understanding with the physician practices that defined the role, and we gained approval from UR Medicine and Rochester Regional Health for access to and documentation rights in the Electronic Medical Record. Our care navigators participate in the practices’ team meetings. Both physicians and their nursing staff can immediately link a patient with the social work care navigator. We found that patients were often more accepting of the assistance from a social worker when endorsed by the physician’s office.

[Appendix 2 for Physician Practice Partnerships in the Finger Lakes region.]

**Healthcare Coordinators and Community Health Workers** serve a subset of complex, high need patients. The Healthcare Coordinator role at Lifespan is staffed by LPNs and community health workers who are supervised by an RN. Patients are assisted in accessing preventive care and management including screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, and prevent disease progression and complications. Health literacy training is provided.
This service is unlike other efforts because our nurses and community health workers work across ALL health care settings as well as in patients’ homes and provide the following services:

- Schedule primary care/specialist appointments and tests.
- Coordinate transportation for doctors’ appointments and medical treatments.
- Meet patients at medical appointments.
- Ensure the right questions are asked at appointments.
- Advocate for patients.
- Scribe at appointments.
- Communicate results of medical appointments with appropriate family members and other professional providers.
- Help with filling prescriptions.
- Complete prescription reconciliations in the home and at provider appointments.
- Ensure linkages are made with other supportive community-based services (home care, chore services, adult day care, minor home modifications to prevent falls, in-home financial management assistance for billing paying/budgeting, meals, durable medical equipment, chronic disease self-care management workshops, etc.).
- Employ health education/teach back methods that activate patients to take more active roles in their own health care.

Healthcare Coordinator Role
Healthcare Coordination's Tiered Approach to Intervention

Continuous process improvement led us to develop a tiered service structure for Healthcare Coordination midway through the project. Community health workers were added to provide one-on-one support for patients who stabilized and no longer need an intensive level of support from an LPN healthcare coordinator. Through health literacy training and telephonic support, the community health workers assist the patients to increase their ability to self-manage health needs and become more independent.

Service Levels

LPN nurses work with patients for the high need period.
Concurrent intervention with social work to address social needs.
Transfer to a community health care worker for a maintenance period.

Patient progress is evaluated and reviewed every six weeks to update level of need and subsequent intervention.
Please see the Appendix for the Complexity Measures definitions. The navigation services provide bridge support until the patient has obtained access to preventive healthcare screens, achieved personal health and social goals and developed the confidence to manage his/her health.

[Appendices 3 & 3a for Complexity Measures definitions and worksheets.]
[Appendix 4 for CCC Patient Services in CCC]
[Appendix 5 for Actual Patient Path/Outcomes]
[Appendix 6 for Patient Timeline]

Evaluation and Results

We contracted with the New York Academy of Medicine (http://www.nyam.org/) to evaluate the effectiveness and return on investment of the interventions.

We contracted with the Rochester Regional Health Information Organization (RRHIO) (https://rochesterrhio.org/) to provide emergency room and hospitalization encounter data for pre- and post-intervention comparisons.

Data flow and analysis

Accurate data collection was critical to the ongoing analysis of the project. Significant work was required with Peer Place, our cloud data management platform, to incorporate the data points of interest to the Advisory Committee and to the New York State Department of Health.

The Rochester Regional Health Information Organization (RRHIO), Lifespan and evaluator, New York Academy of Medicine (NYAM) worked as a team to facilitate data analysis. Quarterly Peer Place data extracts were sent to the RRHIO. They isolated the patients with IRB consent and added dates of ED visits and hospitalizations occurring one year prior to and one year after enrollment in Community Care Connections. The RRHIO de-identified the data and sent the file to NYAM for analysis.
New York Academy of Medicine (NYAM) Analysis

PRE/POST ANALYSIS: HEALTH CARE UTILIZATION

[Appendix 12]

The following analyses are based on data provided from the Rochester Regional Health Information Organization (RRHIO) and Lifespan and presents information on changes in hospitalizations and emergency department visits among Community Care Connections (CCC) clients.

From 2015 to March 30, 2018, Community Care Connections served 1,667 patients. 1,003 signed Independent Review Board (IRB) consent for data analysis.

Patient Demographics [Appendices 7a, b & 8]
Female (62%)
White (79%)
Low-income (less than $1000/mo.) (40%)
Lives alone (41%)
Lives with a spouse or others (49%)
Two or more chronic health conditions (68%)
Medicare only beneficiary (80%)

Patients participated in CCC an average of 148 days and were connected to an average of four services (3.78). [Appendices 9 and 10 for Length of Service & Service Connections. Appendix 11 for Case Closure Reasons]

At the time of this report, complete data (90 days pre/post) was available for 894 clients who enrolled in prior to December 1, 2017.

The 90-day pre-and post-analysis provided the largest sample number and aligns with the average four-month length of service in the project.

NOTE: Return on investment (ROI) calculations assume that the program serves 1,000 clients at a cost of $610,000 annually.
Average number of hospitalizations and emergency department visits per client decreases after 90 days of CCC program participation.

<table>
<thead>
<tr>
<th></th>
<th># OF CCC Clients [N]</th>
<th>Pre-CCC</th>
<th>Post-CCC</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalizations</td>
<td>894</td>
<td>0.11</td>
<td>0.07</td>
<td>-36%*</td>
</tr>
<tr>
<td>ED Visits</td>
<td>894</td>
<td>0.45</td>
<td>0.28</td>
<td>-38%*</td>
</tr>
</tbody>
</table>

* = significant p<.05

A measurement of the pre- and post-effect of the intervention analyzed by diagnoses shows the following top five impacted diagnoses:

### Decreased Hospitalizations

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary Artery Disease</td>
<td>80%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>59%</td>
</tr>
<tr>
<td>Stroke</td>
<td>67%</td>
</tr>
<tr>
<td>Cancer</td>
<td>47%</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>33%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>33%</td>
</tr>
</tbody>
</table>

### Decreased Emergency Room Visits

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>73%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>46%</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>43%</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>36%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>34%</td>
</tr>
</tbody>
</table>

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

### Decreased Hospitalizations

<table>
<thead>
<tr>
<th>Services</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Long-Term Care</td>
<td>78%</td>
</tr>
<tr>
<td>Living Healthy with Diabetes Classes</td>
<td>77%</td>
</tr>
<tr>
<td>Bill Paying</td>
<td>71%</td>
</tr>
<tr>
<td>Home Meal &amp; Grocery Delivery</td>
<td>60%</td>
</tr>
<tr>
<td>Matter of Balance Classes</td>
<td>57%</td>
</tr>
<tr>
<td>Transportation (non-Medicaid clients)</td>
<td>44%</td>
</tr>
</tbody>
</table>

### Decreased Emergency Room Visits

<table>
<thead>
<tr>
<th>Services</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Meal &amp; Grocery Delivery</td>
<td>61%</td>
</tr>
<tr>
<td>Matter of Balance Classes</td>
<td>50%</td>
</tr>
<tr>
<td>Minor Home Modification</td>
<td>47%</td>
</tr>
<tr>
<td>Financial Benefits Counseling</td>
<td>44%</td>
</tr>
<tr>
<td>Managed Long-Term Care</td>
<td>38%</td>
</tr>
<tr>
<td>Transportation (non-Medicaid clients)</td>
<td>37%</td>
</tr>
</tbody>
</table>

A measurement of the pre- and post-effect of the intervention analyzed by number of comorbidities shows the most significant impact on:

- Patients with 5+ conditions had a 33% decrease in ED visits.
- Patients with 2 conditions had a 52% decrease in ED visits.
- Patients with 1 condition had a 39% decrease in ED visits.
Patients who received both social work care navigation and healthcare coordination had a 66% increase in hospitalizations. An assumption could be made that individuals who needed both services are the most vulnerable and ill, therefore most likely to have necessary hospitalizations.

RETURN ON INVESTMENT (ROI) CALCULATIONS
Every dollar spent on Community Care Connections generated $4.05 in savings resulting from reduced hospitalizations and emergency department visits based on an analysis of 90 day pre- and post-data.

<table>
<thead>
<tr>
<th></th>
<th>Pre-CCC</th>
<th>Post-CCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>894</td>
<td></td>
</tr>
<tr>
<td>Average number per client</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>.109</td>
<td>.073</td>
</tr>
<tr>
<td>ED visits</td>
<td>.450</td>
<td>.277</td>
</tr>
<tr>
<td>Cost per patient ($)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>13,510</td>
<td></td>
</tr>
<tr>
<td>ED visits</td>
<td>775</td>
<td></td>
</tr>
<tr>
<td>Total costs ($)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>1,310,456</td>
<td>878,066</td>
</tr>
<tr>
<td>ED visits</td>
<td>311,575</td>
<td>192,197</td>
</tr>
<tr>
<td>Total CCC program costs ($)</td>
<td>136,335</td>
<td></td>
</tr>
<tr>
<td>Total Savings ($)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>432,390</td>
<td></td>
</tr>
<tr>
<td>ED visits</td>
<td>119,378</td>
<td></td>
</tr>
<tr>
<td>ROI ($)</td>
<td>4.05</td>
<td></td>
</tr>
</tbody>
</table>

Notes: (i) Estimates based on The New York Academy of Medicine’s analysis of data provided from the Rochester Regional Health Information Organization (RHIO) and Lifespan. (ii) Data is for 894 clients enrolled in CCC program between June 1, 2016 and December 1, 2017. (iii) Admission cost per patient calculations are based on 2016 data from the Medical Expenditure Panel Survey. The sample included for the average cost calculations included adults 65 years of age and older with Medicare or Medicaid health insurance coverage who had a hospitalization stay or an emergency department visit. (iv) Program costs calculated on a per client basis assuming annual program cost of $610,000 for 1,000 clients enrolled. (610,000/4*(894/1000) = 136,335.
Community Care Connections Pilot Objectives

Objective: Increase medical professionals’ understanding of how patients’ previously unknown social determinants impact their health outcomes by the end of year three.

Result: In process. Through 6/30/2018, 100% of medical professionals surveyed were satisfied with the CCC program and have acknowledged the positive impact on patients’ health of Lifespan’s work to address social needs.

Objective: At case closure, 60% of caregivers will report a decrease in stress as compared to a baseline measure.

Result: Through 6/30/2018, an assessment of Modified Caregiver Strain Index results shows that 87% of caregivers reported a decrease in stress as compared to baseline.

Objective: 60% of patients/caregivers will access at least one new community-based support service.

Result: 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.

Objective: 85% of patients will advance at least one grade in at least one domain of the Older Americans Resources and Services Scale (OARS).

Result: 92% of patients served in this project have advanced at least one grade in at least one domain of the OARS.

Objective: Increase patient/caregiver satisfaction that they are getting the assistance, information and services they need by the close of service.

Result: Patient and caregivers are satisfied 100% of the time that they are getting the assistance/information, services they need by the close of service.
Quantitative Objectives

<table>
<thead>
<tr>
<th>Description</th>
<th>Workplan Target</th>
<th>Total Since 1/1/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total clients enrolled for co-located care navigators access point and for “non-contracted” physician practices</td>
<td>1000</td>
<td>1045</td>
</tr>
<tr>
<td>Total physician practices willing to co-locate care navigator</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total physician practices without co-located social workers</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>Total home health care agencies</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total client enrollment for home health care agencies</td>
<td>500</td>
<td>410</td>
</tr>
<tr>
<td>Total medical professionals surveyed re: increased awareness due to embedding care navigators</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>Total medical professionals surveyed re: satisfaction level with CCC</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>Total clients enrolled in Healthcare Coordination</td>
<td>250</td>
<td>212</td>
</tr>
<tr>
<td>Total client enrolled in Matter of Balance and Chronic Disease Management</td>
<td>50</td>
<td>54</td>
</tr>
<tr>
<td>Total enrolled in Home Safe Home</td>
<td>100</td>
<td>179</td>
</tr>
<tr>
<td>Total Modified Caregiver Strain Index Screens conducted (1st)</td>
<td>-</td>
<td>148</td>
</tr>
<tr>
<td>Total Modified Caregiver Strain Index Screens conducted (2nd)</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Total clients who received MOW</td>
<td>-</td>
<td>16</td>
</tr>
<tr>
<td>Total clients who received Emergency Food Delivery</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Total clients who received services through Touching Hearts at Home</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Total clients who received urgent transportation</td>
<td>-</td>
<td>93</td>
</tr>
<tr>
<td>Total Pre-Quality of Life Surveys conducted</td>
<td>-</td>
<td>922</td>
</tr>
<tr>
<td>Total Post-Quality of Life Surveys conducted</td>
<td>-</td>
<td>135</td>
</tr>
<tr>
<td>Total initial OARS (Older Americans Resources &amp; Services scale) administered</td>
<td>-</td>
<td>1002</td>
</tr>
<tr>
<td>Total post OARS (Older Americans Resources &amp; Services scale) administered</td>
<td>-</td>
<td>715</td>
</tr>
</tbody>
</table>
Significant Community-Based Service Linkages and their Impact

Discovering which community-based services most impacted patient health and well-being was central to the pilot. The following top service connections showed a significant reduction in hospitalization and emergency room visits. (See CHART #16 in the Appendix.)

**Matter of Balance** - an eight-session workshop designed to increase activity levels and decrease the fear of falling. Those who attended Matter of Balance classes had a 57% decrease in hospitalizations and a 50% decrease in emergency room visits.

**Living Healthy with Diabetes** - This is a 6-session, peer-led health education for people 60+ living with diabetes. The purpose of the workshop is to enhance skills the ability to manage health and maintain an active and fulfilling lifestyle. Those who attended Living Healthy with Diabetes classes had a 77% decrease in hospitalizations.

**Living Healthy with Chronic Disease** - This is a six-week, peer-led health education for people 60+ living with chronic illness(es). The purpose of the workshop is to enhance skills and your ability to manage your health and maintain an active and fulfilling lifestyle. Those who attended Living Healthy with Chronic Disease had a 40% decrease in hospitalizations.

**Minor Home Modifications**

**Home-Safe-Home** - This is a Lifespan service that provides minor home modifications to prevent falls. Those who received this service had a 47% decrease in emergency room visits.

**Transportation**

Community Care Connections funded transportation through Medical Motors for those without Medicaid and who had no other option to attend an urgent medical appointment. Those who received funded transportation had a 44% decrease in hospitalizations and a 37% decrease in emergency room visits post enrollment.

**Home Delivered Meals and Groceries**

**Meals on Wheels** and emergency grocery delivery were funded by Community Care Connections to support participants post hospitalization who would otherwise not be able to afford to pay for this service and would be at risk for hospital readmission. There is a long wait list for donation-based Meals on Wheels. Those who accessed home delivered meals and groceries had a 60% decrease in hospitalization and a 61% decrease in emergency room visits post enrollment.

**Caregiver Supports**

Caregivers were connected to respite services and Powerful tools for Caregivers classes. Patients with caregivers who received supports had a 38% decrease in hospitalization and a 26% decrease in emergency room visits post enrollment.
Meeting social needs
Our social work care navigators did not just work to meet the basic needs of patients, such as housing, food and finances; they listened carefully to their personal goals. Examples of unique connections include an Honor Flight trip, a writers group, and one gentleman began giving piano concerts. He reports having given a dozen concerts and will be doing a concert in San Francisco. Health and quality of life improve with access to personal goals.

Service Connections: A Case Study [Appendix 6 for Visual Demonstration]
The following is a demonstration of the positive impact of the Community Care Connections team approach. A patient was referred by his physician following a hospitalization due to a hypoglycemic event. He was found driving down the wrong way on the highway. Both a social worker and a healthcare coordinator worked with him. In the year following enrollment, he had no ED visits or hospitalizations and his A1c decreased from 9.8 to 7.7. His out of town daughter felt relieved that she did not have to travel to Rochester for her father’s medical appointments with assurance that she would be kept up to date on his progress by the Lifespan team.

Provider Comments [Appendix 13 for Provider & Patient/Family Comments]
“Karleen (Embedded Lifespan Care Navigator) helped connect several of my patients with HEAP, SNAP and EPIC which helped them to have more money and less stress. It has been a huge asset to my older patient population. She was able to help with many difficult patients who, for years had been with the practice without help; now we are finally making progress.”
Steve Betit, M.D. Panorama Internal Medicine

“Paul has been able to think outside of the box and help my patients significantly. Additionally, he has uncovered details about my patients’ health with his home visits that have been very helpful to me in treating them. He can identify and solve social stressors that are contributing to our patients’ health.”
Dr. Kellin King, Partners in Internal Medicine.

“I have had one of my patients under your program. It has turned her medical care around completely for the better. She was reclusive and difficult to engage in her own chronic medical problem and health care maintenance needs. Your LPN worker has been amazing. She connects with her incredibly well, keeps track of and makes sure she gets to her appointments, monitors her medications for her, and is overall maximizing her quality of life and medical care.”
Brett Robbins, MD, Culver Medical Group, Rochester, NY

Barriers & Lessons Learned

Projected Care Integration Points
Care Transition Coaches: At project inception, care transition coaches were included as a care access point. However coaching dissolved when CMS ended the Medicare Community Care Transitions Program.

Emergency Medical Services: The initial workplan included our intent to partner with Brighton Emergency Medical Services (EMS) based on an agreement from the supervisor. By the time the project launched, he was no longer employed with Brighton EMS. Despite many contacts and meetings with the new supervisor at Brighton EMS, he was not willing to engage with our project through to implementation.
Considering Brighton EMS’ lack of engagement with us, an alternate partnership was pursued with another EMS provider, American Medical Response (AMR), previously Rural Metro EMS. LaShay Harris of AMR, although enthusiastic about forming a partnership, expressed concern about HIPAA compliance. We discussed the use of a business associates agreement and sent Ms. Harris a summary e-mail with Business Associates Agreement (BAA) attached so she could forward the information to her corporate office for review. Ms. Harris called on 11/30/16 to inform us that her corporate office was unwilling to enter into a referral partnership with us due to HIPAA concerns.

Brighton EMS and AMR both ultimately stated the inability to make direct referrals to Lifespan due to HIPAA concerns and because they are simply not allowed to refer out to any other services.

**Highland Hospital Emergency Department:** With agreement from Highland’s director of social work, the initial workplan development included a pilot to serve 50 patients referred by the ED. Despite several contacts and meetings, no referrals received.

In the second quarter of 2017, the Advisory Committee recommended that the EMS and ED access points be withdrawn from the project in favor of further pursuing and expanding the more successful access points. Advisory Committee member, Vicky Hines, Chief Operating Officer University of Rochester Medical Faculty Group describes the rationale for the recommendation:

“We have several initiatives (DSRIP is just one example) that are ongoing in the ED, and there was concern that we wouldn’t be able to isolate the impact of the CCC program. More notably, the ED is a tough place to coordinate care for a specific population. i.e., because CCC was focused on older adults with complex medical conditions, there needs to be some internal triage approach to identifying the right candidates for the program. I remember this discussion well at the inception — the ED is 24/7, with diverse staff and provider support, requiring excellent communication and coordination across multiple people and shifts to identify patients for the program. We felt that — especially at the start of a pilot program — those factors would make it difficult to implement and to measure impact. Additionally, we have a program in the ED to connect patients BACK to their primary care docs in support of the Patient Centered Medical Home model here in Rochester. So, focusing the Community Care Connections at the Primary Care level makes sense to assure coordination happens at the right “place.”

**Using Medication Technology**

Two types of medication adherence technology were tested:

1. Remote Care tablets (formerly Touch Stream), Point Click Care
   (https://pointclickcare.com/wp-content/uploads/2018/06/PointClickCare-RemoteCare.pdf) This can be programmed to provide reminders to take medications and attend appointments; cloud-based data entry from WIFI connected scales, blood pressure cuffs and glucometers; sends alert messages for missed medications.

   MedaCube is a bulk-loaded machine. It can store up to 16 different medications, with a base of 90-day supply of each. MedaCube prompts the patient to touch the screen. A drawer on the right pops out with the medication dose. The patient tips the drawer to take the pills, then pushes in the drawer to close it. With permission from the patient, this information can be shared with physicians and pharmacists and caregivers via cloud-based reporting.
Despite repeated training and instruction from healthcare coordination staff, those who tried both technologies were not able to use them properly without adequate in-home support. Many of the patients who need medication adherence support live alone. Even with support from home health aides and family members, patients struggled to use the technology properly. For example, patients would not touch the “done” button on the Remote Care tablets, making it impossible to evaluate the effectiveness. Patients also complained about getting repeated reminders when they failed to touch the “done” button and would unplug the tablet and/or fail to charge the battery.

In addition to difficulties with managing the technology, cost was a barrier. Many do not have internet and cannot afford monthly fees for both internet and the reminder technology.

We are currently testing a simple and affordable technology: Reminder Rosie, a programable voice recorded reminder unit which can be purchased outright from a pharmacy for $10. Pre-filled blister packs have been the most often used and are effective for the most part. Healthcare coordinators work with each patient and his/her physician to problem solve medication issues.

Data Analysis
A challenge throughout the project related to the timing of data flow. All aspects took longer than anticipated starting with the Peer Place data platform build which was not live until June 2016. Staff captured data on paper until that point and then had to enter it when the platform became available. Secure pathways had to be created for transfer of PHI. Much coordination and communication were necessary to finalize the procedure for data flow. The Rochester RRHIO was not always able to deliver the matched files in a timely fashion due to the labor-intensive work that included some manual checking of encounter data. However, once the pathway was established and some automation was developed, data delivery became timelier. Frequent phone meetings with Lifespan, NYAM and the RRHIO were of great benefit to the process. [Appendix 14 for Data Flow]

Our original intent was to collect self-reported pre-and post-health data and stress reduction data from caregivers. Three factors negatively impacted our ability to do so: (1) There were far fewer involved caregivers than anticipated and (2) Caregivers were hesitant to provide information about their own health including frequency of ED visits and hospitalizations and (3) Caregivers often would not return phone calls 30 days after closure to answer the survey questions.

The number of completed post-closure quality of life surveys did not match the number of patients closed. Patients often would not return phone calls 30 days after closure to answer the survey questions.

Future projects should employ alternative strategies to collect data post closure. Shorter surveys may elicit a higher response rate and perhaps consider obtaining data just prior to close. Anecdotally, staff report that patients often perceive a loss of social support upon CCC service closure.

It should be noted that the data analysis contained in this report would be strengthened by results from a control group. The work completed so far made it possible for New York Academy of Medicine to obtain a grant from the Robert Wood Johnson Foundation specifically to create a control group in partnership with the RRHIO and technical assistance from Lifespan. It is anticipated that this additional step will strengthen the results presented in this report. The project title is Aligning Health Care and Social Services to Build a Culture of Health and the grant period is December 2017 through December 2019.
Conclusions

Wagner’s Chronic Care Model states,

“By looking outside of itself, the health care system can enhance care for its patients and avoid duplicating effort. Community programs can support or expand a health system’s care for chronically ill patients, but systems often don’t make the most of such resources.”

The Community Care Connections pilot project successfully integrated with healthcare access points to break-down the siloes between community-based aging services and medical systems of care. In doing so, Lifespan created a replicable model of integrated care for older adults for New York State.

The most successful access point integration was with physician practices and certified home care agencies. Multiple and ongoing outreach efforts with certified home healthcare agencies and more than 30 non-contracted physician practices were critical to the successful establishment of relationships with those referral sources. Print materials describing the intervention were geared towards both professionals and patients. In-person presentations were effectively employed.

Perhaps the most powerful support for the growing and sustained partnership with physicians’ practices and certified home healthcare agencies was the evident improvement of their patients’ health and well-being because of enrollment in the Community Care Connections intervention.

THE RETURN ON INVESTMENT OF COMMUNITY CARE CONNECTIONS IS SIGNIFICANT.

Return on Investment (ROI): As evaluated by the NY Academy of Medicine, the return on investment is $4 per dollar spent on the service based on an analysis of 90 day pre- and post-data.

- Hospitalization decreased 36% post 90 days
- ED visits decreased 38% post 90 days

100% of medical professionals surveyed acknowledged the impact of Lifespan’s ability to address social determinants on their patients’ health. Common responses included a recognition of the value of (1) the care navigator and healthcare coordinator’s home visits (“my eyes in the home”), (2) the Lifespan staff’s knowledge of resources they did not previously know existed for their patients and (3) the evident improvement in their patients health and well-being as a result of community service linkages made by Lifespan staff.

Recommendations

Anticipate the time needed to create a data platform as well as the time necessary to obtain a sample large enough for complete data analysis. Hold partners accountable to defined timeframes.

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.

Creating visualizations of actual and hypothesized program impacts can be vital in conversations around long-term effects of the program.

Cost analyses broken down by population of interest is essential in making the case for sustainability.
Appendix 1

3 Members of the Community Care Connections – Advisory Committee
NYS Department of Health Contract

Richard Gangemi, MD - Co-chair
Retired, Rochester Regional Health System

William Hall, MD - Co-chair
University of Rochester Medical Center

Trilby DeJung, CEO
Common Ground Health

Yeates Conwell, MD
Director, Aging Research and Health Ser.
University of Rochester Medical Center

C. Michael Henderson, MD
Rochester Regional Health System

Vicky Hines COO
Medical Faculty Group.
University of Rochester Medical Center

Michael Nazar, MD
Chief of Medical Groups, EVP
Rochester Regional Health System

Jane Shukitis, President/CEO
Visiting Nurse Service

Kathryn McGuire, Senior Vice President
Rochester Regional Health System

Katie Lashway, RN
Highland Family Medicine

Michelle Casey, Chief Program Officer
Common Ground Health

Daniel Mendelson, MD
Highland Hospital

Jeanne Chirico, VP
Lifetime Care

Christopher Bell, Executive Director
Monroe County Medical Society

Patrick Glavey, Executive VP
MVP Health Care

Robert Thompson, VP
Excellus BlueCross Blue Shield

Peter Bauman, Senior Project Manager
Finger Lakes Performing Provider System

Keri Hadcock, Director of Nursing
Population Health & Utilization
Rochester Regional Health System

Ann DiSarro, retired President/CEO
Senior Services of Albany

Carol Podgorski, Ph.D.
University of Rochester Medical Center

Mary Beer, Public Health Director
Ontario County

Jill Eisenstein, CEO
Rochester Regional Health Information Organization

Julie Allen-Aldrich, Director
Monroe County Office for the Aging

Denise Burgen, Faculty
UR School of Nursing
Appendix 2

Physician Practice Locations
## Appendix 3

### Complexity Measures – Health Care Coordination

| HIGH NEED  
(Lifespan LPN Care Coordination) | MODERATE NEED  
(Transition to Community Health Worker) | ABLE TO SELF-MANAGE  
(Discharge) |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute fall risk; injury from fall within &lt; 3 months.</td>
<td>Fall history but &gt; 3 months ago; attending Matter of Balance class or PT.</td>
<td>No current fall risk identified.</td>
</tr>
<tr>
<td>Number PCP visits REQUIRED is greater than once per quarter</td>
<td>Number PCP visits REQUIRED is no more than once per quarter</td>
<td>Number PCP visits REQUIRED is no more than once per quarter</td>
</tr>
<tr>
<td>Nutrition instability</td>
<td>Nutritional needs are being addressed.</td>
<td>Verbalizes or demonstrates nutritional knowledge.</td>
</tr>
<tr>
<td>One or more Emergency Room visits within the past 3 months for acute illness</td>
<td>1-3 emergency room visits for acute illness within the past 3-6 months.</td>
<td>No emergency room visits for acute illness in past 3-6 months.</td>
</tr>
<tr>
<td>Hospitalization within the past 3 months.</td>
<td>&gt;1 hospitalization for acute illness over the past 6 months.</td>
<td>0-1 hospitalizations over the past 12 months for acute illness.</td>
</tr>
<tr>
<td>4 or more specialist visits within the past 6 months.</td>
<td>&lt; 4 specialist visits within the past 6 months.</td>
<td>Routine or annual specialist visits only.</td>
</tr>
<tr>
<td>3 or more specialist visits scheduled in one month.</td>
<td>1-2 specialist visits in one month.</td>
<td>Routine visits to specialists 1-2 times per quarter.</td>
</tr>
<tr>
<td>Has history of missed medical appointments over past 3 months.</td>
<td>Needs reminders to attend appointments, but goes when they are scheduled.</td>
<td>Needs no reminders to attend medical appointments.</td>
</tr>
<tr>
<td>Lacks understanding of diagnoses and treatment goals; not following treatment Plan</td>
<td>Is aware of diagnoses; willing to participate with treatment plan/goal development; needs reminders to follow treatment plan.</td>
<td>Understands diagnoses and follows treatment plan.</td>
</tr>
</tbody>
</table>
| One or more of the following:  
- Cancer (in treatment)  
- Dementia  
- Uncontrolled diabetes  
- End Stage Kidney Disease and on dialysis less than 6 months  
- COPD diagnosis less than 6 months  
- On oxygen less than 3 months  
- Active substance abuse but accepts treatment |  
- Cancer treatment complete  
- Diabetes protocol being followed  
- On dialysis more than 6 months and stable  
- COPD diagnosis >19 than 6 months, and following treatment plan.  
- Oxygen use greater than 3 months and able to manage or has family member able to help manage. |  
Does not recognize “red flags” or warning signs indicating call to doctor in advanced of a health crisis. |  
Able to verbalize “red flags” or warning signs of SOME diagnoses, and when to call doctor in advance of a health crisis. |  
Can identify “red flags” to prevent ED use and hospital admission. Knows when to take action and call doctor in advance of a health crisis. |
| Lacking one or more up-to-date preventive health screens | Preventive health screens scheduled. | Up-to-date with routine health screens |
| Mental Health diagnosis or dementia with behaviors which significantly interfere with meeting goals, understanding directions, or adherence to medical treatment plan. | Mental Health diagnosis or dementia, but only mildly interferes with meeting goals, understanding directions, or adherence to medical treatment plan. | Either no mental health or dementia diagnosis, or present but strong family support and/or does not interfere with meeting goals, understanding directions, or adherence to medical treatment plan. |
Appendix 3a Complexity Measure Worksheets

Patient Name: ______________________________________________________

Coordinator: ________________________________________________________

Date of Review: __________________

**High Need 1.5**
*(Lifespan LPN Preferred or CHW with nursing oversight)*

Client need should be rated as “1.5” if:
1. Two (2) or more of the following are present; or,
2. There is no caregiver; or there is weak caregiver support along with at least one (1) of the following

<table>
<thead>
<tr>
<th>Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipated major Surgery for an acute illness</td>
</tr>
<tr>
<td>Within 6 weeks post major surgery</td>
</tr>
<tr>
<td>&gt;1 fall within prior 3 months</td>
</tr>
<tr>
<td>Number of PCP visits REQUIRED is greater than once per quarter</td>
</tr>
<tr>
<td>Nutrition instability (includes wasting, unexplained weight loss, diet exacerbating disease symptoms)</td>
</tr>
<tr>
<td>Emergency room visit within prior 3 months for acute illness</td>
</tr>
<tr>
<td>Hospitalization within prior 3 months</td>
</tr>
<tr>
<td>&gt;3 specialist visits in prior 6 months</td>
</tr>
<tr>
<td>&gt;2 specialist visits in prior one month</td>
</tr>
<tr>
<td>History of missed appointments within prior 3 months</td>
</tr>
<tr>
<td>Not following treatment plan; lacks understanding of diagnoses and/or treatment goals</td>
</tr>
<tr>
<td>Cancer treatment within the previous 3 months</td>
</tr>
<tr>
<td>Uncontrolled diabetes</td>
</tr>
<tr>
<td>ESRD and on dialysis less than 6 months</td>
</tr>
<tr>
<td>COPD diagnosis less than 6 months</td>
</tr>
<tr>
<td>Oxygen dependent less than 3 months</td>
</tr>
<tr>
<td>Active substance abuse (must show willingness to attempt treatment)</td>
</tr>
<tr>
<td>Does not recognize “red flags” or warning signs indicating call to doctor in advance of health crises</td>
</tr>
<tr>
<td>Lacking one or more up-to-date preventive health screens</td>
</tr>
<tr>
<td>Mental health diagnosis or dementia with behaviors which significantly interfere with meeting goals, understanding directions, adherence to medical treatment plan, or severe short-term memory deficits.</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
Moderate Need  1.0
(LPN or CHW)

Client: _____________________________________________________________

<table>
<thead>
<tr>
<th>Client need should be rated as “1.0” if:</th>
<th>Check all that apply:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Two (2) or more of the following are present; and, client does not meet “High Need Criteria”</td>
<td></td>
</tr>
<tr>
<td>2. There is no caregiver; or there is weak caregiver support along with at least one (1) of the following</td>
<td></td>
</tr>
</tbody>
</table>

- Anticipated elective or outpatient surgery
- < 4 weeks post elective or outpatient surgery with no complications
- Fall > 3 months ago; either received or in process of receiving PT or Matter of Balance class
- Number of PCP visits REQUIRED is no more than once per quarter
- Has nutritional needs but receiving support and showing improvement
- 1-3 emergency room visit within prior 3-6 months for acute illness
- >1 hospitalization within prior 6 months
- 3 or more specialist visits within prior 6 months
- 1-2 specialist visits within prior one month
- Needs reminders to attend appointments, but goes when they are scheduled
- Aware of diagnoses; willing to participate in treatment plan/goal development, but needs reminders to do so
- Cancer treatment within the previous 3 months but now complete
- Diabetes stabilized, but still needs reminders and teaching; may have occasional readings mildly outside of parameters.
- On dialysis more than 6 months and accepting of routine
- COPD diagnosis greater than 6 months and following treatment plan
- Oxygen dependent greater than 3 months and able to manage, or has caregiver able to help manage
- Prior substance abuse, but actively in recovery.
- Able to verbalize “red flags” or warning signs of SOME diagnoses, and when call to doctor in advance of health crises
- Preventive health screens scheduled
- Mental health diagnosis or dementia with behaviors which only mildly interfere with meeting goals, understanding directions, or adherence to medical treatment plan. Once reminder is provided, client is willing and able to follow through.

Total
**Low Need 0.5**

Community Health Worker Independently Managed, or Close

Client: _____________________________________________________________

<table>
<thead>
<tr>
<th>Client need should be rated as “0.5” if:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Client meets criteria below; and, client does not meet “High or Moderate Need Criteria”</td>
<td></td>
</tr>
<tr>
<td>2. Client meets no more than three (3) High or Moderate Need, but has active, capable caregiver.</td>
<td></td>
</tr>
<tr>
<td>No acute illness or surgery anticipated</td>
<td></td>
</tr>
<tr>
<td>No current fall risk identified; &gt; 6 months since falling and has completed PT or Matter of Balance</td>
<td></td>
</tr>
<tr>
<td>Number of PCP visits REQUIRED is quarterly or less.</td>
<td></td>
</tr>
<tr>
<td>Nutritionally sound</td>
<td></td>
</tr>
<tr>
<td>No emergency room visit for acute illness within prior 3 months or more</td>
<td></td>
</tr>
<tr>
<td>0-1 hospitalization over the past 12 months for acute illness</td>
<td></td>
</tr>
<tr>
<td>Annual specialist visits only</td>
<td></td>
</tr>
<tr>
<td>Routine specialist visits 1-2 times per quarter</td>
<td></td>
</tr>
<tr>
<td>Needs no reminders to attend medical appointments once they are scheduled</td>
<td></td>
</tr>
<tr>
<td>Understands diagnoses and able to follow treatment plan</td>
<td></td>
</tr>
<tr>
<td>No history of cancer; or, previous diagnosis of cancer but cleared or in remission</td>
<td></td>
</tr>
<tr>
<td>Diabetes management stable</td>
<td></td>
</tr>
<tr>
<td>No dialysis</td>
<td></td>
</tr>
<tr>
<td>COPD diagnosis &gt; 6 months and managed independently</td>
<td></td>
</tr>
<tr>
<td>Oxygen dependent greater than 3 months and managed independently</td>
<td></td>
</tr>
<tr>
<td>No substance abuse</td>
<td></td>
</tr>
<tr>
<td>Can identify “red flags” or warning signs to prevent ED use and hospital admission, and able to call for assistance.</td>
<td></td>
</tr>
<tr>
<td>Up-to-date with preventive health screens</td>
<td></td>
</tr>
<tr>
<td>Either no mental health or dementia diagnosis, or mild with strong family support and does not interfere with meeting goals, understanding directions, or adherence to medical treatment plan.</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4

Community Care Connections Patient Services

- Social Work: 64%
- Healthcare Coordination: 25%
- Both: 11%
PATIENT A:
- 67 year-old male
- Diabetes diagnosis
- Insulin dependent
- No local support system
- Recently hospitalized due to low glucose levels

**APPENDIX 5**

**CCC Service Connections**
- Doctor appointments
- Free transportation
- Diabetes self-management program
- Care coordination
- "Matter of Balance" program

**Improvements**
- Improved access to non-emergency care
- Improved ability to monitor glucose
- Improved eating habits
- Improved social support
- Increased physical activity

**Health Outcomes**
- Fewer diabetes complications
- Fewer ER/hospital visits
- Reduced need for meds
- Improved mental health
- Improved mobility, fewer falls

**Long-term Impacts**
- Lower health care costs
- Higher quality of life
- Reduced caregiver/family stress

**Health Outcomes**
- Fewer diabetes complications
- Fewer ER/hospital visits
- Reduced need for meds
- Improved mental health
- Improved mobility, fewer falls

**Long-term Impacts**
- Lower health care costs
- Higher quality of life
- Reduced caregiver/family stress
2016-2017 Timeline: Patient

Q1, 2016

April, 2016

Q1, 2017

CCC Intervention

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

Inpatient Hospitalization
ER Visit

Inpatient Hospitalization
ER Visit

No ER/Hospitalizations

9.8 Reduced HbA1C

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

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

*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.

## Appendix 7A

### Demographics

All Patients Enrolled as of 3/31/18

<table>
<thead>
<tr>
<th></th>
<th>Total (N)</th>
<th>Percent (%)</th>
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</thead>
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<tr>
<td><strong>Total</strong></td>
<td>1003</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
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<th>Age</th>
<th>Total (N)</th>
<th>Percent (%)</th>
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</thead>
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<tr>
<td>&lt;65</td>
<td>83</td>
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<tr>
<td>65-74</td>
<td>264</td>
<td>26%</td>
</tr>
<tr>
<td>75-84</td>
<td>388</td>
<td>37%</td>
</tr>
<tr>
<td>85+</td>
<td>257</td>
<td>26%</td>
</tr>
<tr>
<td>Not Available</td>
<td>11</td>
<td>1%</td>
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<table>
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<th>Gender</th>
<th>Total (N)</th>
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<tbody>
<tr>
<td>Female</td>
<td>617</td>
<td>62%</td>
</tr>
<tr>
<td>Male</td>
<td>373</td>
<td>37%</td>
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<tr>
<td>Not available</td>
<td>13</td>
<td>1%</td>
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</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Total (N)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>796</td>
<td>79%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>130</td>
<td>13%</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>1%</td>
</tr>
<tr>
<td>2 or more</td>
<td>2</td>
<td>0.2%</td>
</tr>
<tr>
<td>Not Available</td>
<td>62</td>
<td>6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Total (N)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic/Latino</td>
<td>26</td>
<td>3%</td>
</tr>
<tr>
<td>Not Hispanic/Latino</td>
<td>889</td>
<td>89%</td>
</tr>
<tr>
<td>Not Available</td>
<td>88</td>
<td>9%</td>
</tr>
</tbody>
</table>
### Demographics

All Patients Enrolled as of 3/31/18

<table>
<thead>
<tr>
<th>Monthly Income</th>
<th>Total (N)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$1000</td>
<td>406</td>
<td>40%</td>
</tr>
<tr>
<td>$1000-$1499</td>
<td>204</td>
<td>20%</td>
</tr>
<tr>
<td>$1500-$1999</td>
<td>151</td>
<td>15%</td>
</tr>
<tr>
<td>$2000-$2499</td>
<td>110</td>
<td>11%</td>
</tr>
<tr>
<td>&gt;$2500</td>
<td>132</td>
<td>13%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>County</th>
<th>Total (N)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monroe</td>
<td>762</td>
<td>76%</td>
</tr>
<tr>
<td>Other</td>
<td>213</td>
<td>21%</td>
</tr>
<tr>
<td>Not Available</td>
<td>28</td>
<td>3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insurance</th>
<th>Total (N)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare (no Medicaid)</td>
<td>806</td>
<td>80%</td>
</tr>
<tr>
<td>Medicaid (no Medicare)</td>
<td>24</td>
<td>2%</td>
</tr>
<tr>
<td>Dual Eligible</td>
<td>102</td>
<td>10%</td>
</tr>
<tr>
<td>Other</td>
<td>71</td>
<td>7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lives...</th>
<th>Total (N)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>...alone</td>
<td>408</td>
<td>41%</td>
</tr>
<tr>
<td>...with spouse</td>
<td>295</td>
<td>29%</td>
</tr>
<tr>
<td>...with others</td>
<td>204</td>
<td>20%</td>
</tr>
<tr>
<td>Not available</td>
<td>96</td>
<td>10%</td>
</tr>
</tbody>
</table>
Appendix 8

Diagnoses

<table>
<thead>
<tr>
<th>Condition</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>413</td>
<td>41%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>267</td>
<td>27%</td>
</tr>
<tr>
<td>Depression</td>
<td>207</td>
<td>21%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>201</td>
<td>20%</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>193</td>
<td>19%</td>
</tr>
<tr>
<td>Dementia</td>
<td>178</td>
<td>18%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>166</td>
<td>17%</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>105</td>
<td>10%</td>
</tr>
<tr>
<td>Cancer</td>
<td>102</td>
<td>10%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>81</td>
<td>8%</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>70</td>
<td>7%</td>
</tr>
<tr>
<td>Stroke</td>
<td>75</td>
<td>7%</td>
</tr>
</tbody>
</table>
Appendix 9

Length of Time in CCC

- Range: 0-693 days
- Mean: 148 days
- 25th percentile: 63 days
- 50th percentile: 120 days
- 75th percentile: 198 days
Appendix 10

Service Connections

- Total: 3,741 service connections made
- Mean: 3.78 services per client
- Range: 0-19 service connections per client

<table>
<thead>
<tr>
<th># of service connections</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>63</td>
<td>6%</td>
</tr>
<tr>
<td>1</td>
<td>139</td>
<td>14%</td>
</tr>
<tr>
<td>2</td>
<td>189</td>
<td>19%</td>
</tr>
<tr>
<td>3</td>
<td>182</td>
<td>18%</td>
</tr>
<tr>
<td>4</td>
<td>134</td>
<td>13%</td>
</tr>
<tr>
<td>5</td>
<td>94</td>
<td>9%</td>
</tr>
<tr>
<td>Greater than 5</td>
<td>202</td>
<td>20%</td>
</tr>
</tbody>
</table>
## Appendix 11

### Case Close Reasons

<table>
<thead>
<tr>
<th>Case Close Code</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful outcome of program</td>
<td>478</td>
<td>48%</td>
</tr>
<tr>
<td>Client chose not to continue</td>
<td>100</td>
<td>10%</td>
</tr>
<tr>
<td>Unable to contact greater than 2 months</td>
<td>58</td>
<td>6%</td>
</tr>
<tr>
<td>Death</td>
<td>41</td>
<td>4%</td>
</tr>
<tr>
<td>Moved to Skilled Nursing Facility</td>
<td>37</td>
<td>4%</td>
</tr>
<tr>
<td>Moved to an Adult Care Facility</td>
<td>29</td>
<td>3%</td>
</tr>
<tr>
<td>Client refused service or refused to participate</td>
<td>11</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>57</td>
<td>6%</td>
</tr>
<tr>
<td><em>None (Case remains open)</em></td>
<td>192</td>
<td>19%</td>
</tr>
</tbody>
</table>
Appendix 12

90-Day Analysis

**Q1 2018 Data Analyses (90 days)**

- The following slides present information on changes in hospitalizations and emergency department visits among CCC clients. We conduct analyses examining health care utilization at 90 days before and after program enrollment based on data provided from the Rochester Regional Health Information Organization (RHIO) and Lifespan.
- Complete data (90 days pre/post) was available for 894 clients who enrolled in CCC prior to 1/1/2018.
- ROI calculations assume that the CCC program serves 1,000 clients at a cost of $610,000 per year.
- No comparison group is available, which limits the conclusions that can be drawn from the data.

**Hypothetical example:**

![Diagram showing pre-intervention and post-intervention periods for hospitalization and ED visits.](attachment://diag.png)
Pre/Post: Health Care Utilization

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

<table>
<thead>
<tr>
<th></th>
<th>Pre-CCC</th>
<th>Post-CCC</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Visits</td>
<td>894</td>
<td>0.45</td>
<td>0.28</td>
</tr>
</tbody>
</table>

* = significant at $p \leq .05$

**Fewer clients have multiple hospitalizations and emergency department visits** after participating in the CCC program for 90 days.

<table>
<thead>
<tr>
<th></th>
<th>Pre-CCC</th>
<th>Post-CCC</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>63</td>
<td>42</td>
<td>-33%</td>
</tr>
<tr>
<td>ED Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>648</td>
<td>741</td>
<td>-36%</td>
</tr>
<tr>
<td>2</td>
<td>155</td>
<td>99</td>
<td>-36%</td>
</tr>
<tr>
<td>3</td>
<td>32</td>
<td>26</td>
<td>-19%</td>
</tr>
</tbody>
</table>
Pre/Post: Hospitalizations and ED Visits by Insurance

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>N</th>
<th>Pre Hosp</th>
<th>Post Hosp</th>
<th>% Change</th>
<th>Pre ED</th>
<th>Post ED</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare (no Medicaid)</td>
<td>721</td>
<td>.10</td>
<td>.07</td>
<td>-10%*</td>
<td>.44</td>
<td>.26</td>
<td>-41%*</td>
</tr>
<tr>
<td>Medicaid (no Medicare)</td>
<td>21</td>
<td>.14</td>
<td>.10</td>
<td>-29%</td>
<td>.14</td>
<td>.29</td>
<td>+107%</td>
</tr>
<tr>
<td>Dual Eligible</td>
<td>95</td>
<td>.14</td>
<td>.11</td>
<td>-21%</td>
<td>.60</td>
<td>.41</td>
<td>-32%</td>
</tr>
</tbody>
</table>

* = significant at $p \leq .05$

---

Pre/Post: Hospitalizations and ED Visits by Diagnosis

<table>
<thead>
<tr>
<th>Condition</th>
<th>N</th>
<th>Pre (Hosp)</th>
<th>Post Hosp</th>
<th>% Change</th>
<th>Pre ED</th>
<th>Post ED</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>376</td>
<td>.07</td>
<td>.06</td>
<td>-8%</td>
<td>.43</td>
<td>.23</td>
<td>-46%*</td>
</tr>
<tr>
<td>Diabetes</td>
<td>236</td>
<td>.12</td>
<td>.08</td>
<td>-33%</td>
<td>.50</td>
<td>.33</td>
<td>-34%*</td>
</tr>
<tr>
<td>Depression</td>
<td>191</td>
<td>.08</td>
<td>.07</td>
<td>-13%</td>
<td>.45</td>
<td>.32</td>
<td>-29%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>187</td>
<td>.07</td>
<td>.06</td>
<td>-14%</td>
<td>.42</td>
<td>.35</td>
<td>-16%</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>175</td>
<td>.09</td>
<td>.06</td>
<td>-33%</td>
<td>.36</td>
<td>.23</td>
<td>-36%*</td>
</tr>
<tr>
<td>Dementia</td>
<td>167</td>
<td>.04</td>
<td>.04</td>
<td>0%</td>
<td>.23</td>
<td>.16</td>
<td>-30%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disorder</td>
<td>149</td>
<td>.14</td>
<td>.11</td>
<td>-21%</td>
<td>.69</td>
<td>.50</td>
<td>-28%</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>94</td>
<td>.15</td>
<td>.03</td>
<td>-80%*</td>
<td>.49</td>
<td>.43</td>
<td>-12%</td>
</tr>
<tr>
<td>Cancer</td>
<td>91</td>
<td>.19</td>
<td>.10</td>
<td>-47%</td>
<td>.64</td>
<td>.44</td>
<td>-31%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>76</td>
<td>.17</td>
<td>.07</td>
<td>-59%</td>
<td>.74</td>
<td>.20</td>
<td>-73%*</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>62</td>
<td>.06</td>
<td>.06</td>
<td>0%</td>
<td>.65</td>
<td>.37</td>
<td>-43%</td>
</tr>
<tr>
<td>Stroke</td>
<td>65</td>
<td>.09</td>
<td>.03</td>
<td>-67%*</td>
<td>.55</td>
<td>.32</td>
<td>-42%</td>
</tr>
</tbody>
</table>

* = significant at $p \leq .05$
Pre/Post: Hospitalizations and ED Visits by Comorbidities

<table>
<thead>
<tr>
<th># of conditions</th>
<th>N</th>
<th>Pre Hosp</th>
<th>Post Hosp</th>
<th>% Change</th>
<th>Pre ED</th>
<th>Post ED</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>101</td>
<td>.19</td>
<td>.11</td>
<td>-42%</td>
<td>.28</td>
<td>.18</td>
<td>-36%</td>
</tr>
<tr>
<td>1</td>
<td>185</td>
<td>.09</td>
<td>.08</td>
<td>-11%</td>
<td>.56</td>
<td>.34</td>
<td>-39%*</td>
</tr>
<tr>
<td>2</td>
<td>191</td>
<td>.10</td>
<td>.08</td>
<td>-20%</td>
<td>.50</td>
<td>.24</td>
<td>-52%*</td>
</tr>
<tr>
<td>3</td>
<td>156</td>
<td>.05</td>
<td>.03</td>
<td>-40%</td>
<td>.37</td>
<td>.24</td>
<td>-35%*</td>
</tr>
<tr>
<td>4</td>
<td>110</td>
<td>.09</td>
<td>.03</td>
<td>-66%</td>
<td>.50</td>
<td>.40</td>
<td>-20%</td>
</tr>
<tr>
<td>5+</td>
<td>151</td>
<td>.15</td>
<td>.11</td>
<td>-27%</td>
<td>.42</td>
<td>.28</td>
<td>-33%*</td>
</tr>
</tbody>
</table>

* = significant at \( p \leq .05 \)

Pre/Post: Hospitalizations and ED Visits by Referral Source

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>N</th>
<th>Pre Hosp</th>
<th>Post Hosp</th>
<th>% Change</th>
<th>Pre ED</th>
<th>Post ED</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracted physician office</td>
<td>493</td>
<td>.10</td>
<td>.06</td>
<td>-40%</td>
<td>.29</td>
<td>.19</td>
<td>-34%*</td>
</tr>
<tr>
<td>Non-contracted physician office</td>
<td>120</td>
<td>.10</td>
<td>.06</td>
<td>-40%</td>
<td>.59</td>
<td>.41</td>
<td>-31%*</td>
</tr>
<tr>
<td>Home care agency</td>
<td>211</td>
<td>.15</td>
<td>.10</td>
<td>-33%</td>
<td>.78</td>
<td>.43</td>
<td>-45%*</td>
</tr>
</tbody>
</table>

* = significant at \( p \leq .05 \)

Pre/Post: Hospitalizations and ED Visits by Key Services

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>N</th>
<th>Pre Hosp</th>
<th>Post Hosp</th>
<th>% Change</th>
<th>Pre ED</th>
<th>Post ED</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case management only</td>
<td>699</td>
<td>.12</td>
<td>.07</td>
<td>-42%*</td>
<td>.45</td>
<td>.26</td>
<td>-42%*</td>
</tr>
<tr>
<td>Health care coordination only</td>
<td>48</td>
<td>.10</td>
<td>.06</td>
<td>-40%</td>
<td>.38</td>
<td>.33</td>
<td>-13%</td>
</tr>
<tr>
<td>Case management and health care coordination</td>
<td>84</td>
<td>.06</td>
<td>.10</td>
<td>+66%</td>
<td>.61</td>
<td>.44</td>
<td>-27%</td>
</tr>
</tbody>
</table>

* = significant at \( p \leq .05 \)
Pre/Post: Hospitalizations and ED Visits by Services Received

<table>
<thead>
<tr>
<th>Service</th>
<th>N</th>
<th>Pre Hosp</th>
<th>Post Hosp</th>
<th>Change</th>
<th>Pre ED</th>
<th>Post ED</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver support</td>
<td>265</td>
<td>.13</td>
<td>.08</td>
<td>-38%</td>
<td>.27</td>
<td>.20</td>
<td>-26%</td>
</tr>
<tr>
<td>Financial benefits counseling</td>
<td>250</td>
<td>.14</td>
<td>.10</td>
<td>-29%</td>
<td>.36</td>
<td>.20</td>
<td>-44%*</td>
</tr>
<tr>
<td>Transportation (all)</td>
<td>168</td>
<td>.08</td>
<td>.05</td>
<td>-38%</td>
<td>.47</td>
<td>.31</td>
<td>-34%*</td>
</tr>
<tr>
<td>Health insurance counseling</td>
<td>142</td>
<td>.15</td>
<td>.11</td>
<td>-26%</td>
<td>.34</td>
<td>.27</td>
<td>-21%</td>
</tr>
<tr>
<td>Transportation (non-Medicaid)</td>
<td>131</td>
<td>.09</td>
<td>.05</td>
<td>-44%</td>
<td>.54</td>
<td>.34</td>
<td>-37%*</td>
</tr>
<tr>
<td>Home modification</td>
<td>125</td>
<td>.10</td>
<td>.11</td>
<td>+10%</td>
<td>.51</td>
<td>.27</td>
<td>-47%*</td>
</tr>
<tr>
<td>Bill paying</td>
<td>71</td>
<td>.14</td>
<td>.04</td>
<td>-71%</td>
<td>.46</td>
<td>.37</td>
<td>-20%</td>
</tr>
<tr>
<td>Chronic disease classes</td>
<td>62</td>
<td>.10</td>
<td>.06</td>
<td>-40%</td>
<td>.24</td>
<td>.19</td>
<td>-21%</td>
</tr>
<tr>
<td>Home meal delivery</td>
<td>56</td>
<td>.125</td>
<td>.05</td>
<td>-60%</td>
<td>.41</td>
<td>.16</td>
<td>-61%*</td>
</tr>
<tr>
<td>Managed long-term care</td>
<td>47</td>
<td>.09</td>
<td>.02</td>
<td>-78%</td>
<td>.21</td>
<td>.13</td>
<td>-38%</td>
</tr>
<tr>
<td>Diabetes classes</td>
<td>40</td>
<td>.13</td>
<td>.03</td>
<td>-77%</td>
<td>.25</td>
<td>.20</td>
<td>-20%</td>
</tr>
<tr>
<td>Matter of Balance</td>
<td>29</td>
<td>.07</td>
<td>.03</td>
<td>-57%</td>
<td>.28</td>
<td>.14</td>
<td>-50%</td>
</tr>
</tbody>
</table>

* = significant at $p \leq .05$

Sub-Analysis: ED Visits Among Medicaid Clients

- Twenty-one CCC clients have only Medicaid.
- The number of Medicaid clients with zero ED visits remained the same.
- The total number of ED visits increased from 3 before CCC to 6 after CCC (due to two clients who experienced multiple ED visits).

<table>
<thead>
<tr>
<th># of ED visits</th>
<th># of Medicaid-only CCC clients (PRE)</th>
<th># of Medicaid-only CCC clients (POST)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
## Return on Investment (ROI) Calculations

<table>
<thead>
<tr>
<th></th>
<th>Pre CCC</th>
<th>Post CCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>894</td>
<td></td>
</tr>
<tr>
<td>Average number per client</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td>.109</td>
</tr>
<tr>
<td>ED visits</td>
<td></td>
<td>.450</td>
</tr>
<tr>
<td>Cost per patient ($)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>13,510</td>
<td></td>
</tr>
<tr>
<td>ED visits</td>
<td>775</td>
<td></td>
</tr>
<tr>
<td>Total costs ($)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>1,310,456</td>
<td>878,066</td>
</tr>
<tr>
<td>ED visits</td>
<td>311,575</td>
<td>192,197</td>
</tr>
<tr>
<td>Total CCC program costs ($)</td>
<td>136,335</td>
<td></td>
</tr>
<tr>
<td>Total Savings ($)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>432,390</td>
<td></td>
</tr>
<tr>
<td>ED visits</td>
<td>119,378</td>
<td></td>
</tr>
<tr>
<td>ROI ($)</td>
<td></td>
<td>4.05</td>
</tr>
</tbody>
</table>

Notes: (i) Estimates based on The New York Academy of Medicine’s analysis of data provided from the Rochester Regional Health Information Organization (RHIO) and Lifespan. (ii) Data is for 894 clients enrolled in CCC program between June 1, 2016 and December 1, 2017. (iii) Admission cost per patient calculations are based on 2016 data from the Medical Expenditure Panel Survey. The sample included for the average cost calculations included adults 65 years of age and older with Medicare or Medicaid health insurance coverage who had a hospitalization stay or an emergency department visit. (iv) Program costs calculated on a per client basis assuming annual program cost of $610,000 for 1,000 clients enrolled. ($610,000/4)(894/1000) = 136,335
Summary: Total Savings

- Three months of post-enrollment health care utilization data was available for 894 CCC clients; the costs associated with serving those clients for a three month period was $136,335.
- These expenditures were associated with $586,501 in total savings as a result of fewer hospitalizations and emergency department visits.

![Graph showing total savings from reduced hospitalizations and emergency department visits.]

Summary: Return on Investment

- 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.

![Graph showing annual ROI from CCC program, Q1 2018.]
Appendix 13

Professional and Patient/Family Testimonials

**RE: Social Work Care Navigation:**

Nice to know there is a professional in the community that can do the things that we cannot.

*RN from Dr. Noronha’s office said (in regard to Care Navigator, Sandy)*

[Michele Rice’s] presence in the department has made referrals and follow-up very easy. She has been able to focus on a number of high risk patients and families, helping them with accessing community resources. Her ability to go into the patient’s home helps us learn more about what needs exist for our patients. [I] strongly support continuing the Lifespan Care Navigator program. It will allow us to provide a higher level of care than we have been able to in the past.

*Carl Sahler, MD, Canandaigua Medical Group*

Paul has been able to think outside of the box and help my patients significantly. Additionally, he has uncovered details about my patients’ health with his home visits that have been very helpful to me in treating them. He can identify and solve social stressors that are contributing to our patients’ health.

*Dr. Kellin King, Partners in Internal Medicine*

Karleen conferenced regularly with both myself and my Nurse care manager, and any issues I brought to her she would bring to my care manager or other team members. I felt she kept us all on the same page. Often during visits [patients] would bring up what the Lifespan care navigator was doing for them. She helped connect several of my patients with HEAP, SNAP and EPIC which helped them to have more money and less stress. It has been a huge asset to my older patient population. She was able to help with many difficult patients who, for years had been with the practice without help; now we are finally making progress.

*Dr. Steve Betit, Panorama Internal Medicine*

**Do you feel that the Lifespan Care navigator has successfully integrated with your office and the medical team?**

Absolutely. We talk regularly in person about multiple patients. [Alyssa] has great rapport with all of the staff. I see many elderly patients who are very complex and have a diverse need. She has helped us negotiate through the complexities of getting patients the extra help they need. Does Lifespan’s intervention help to better address the patients’ social determinants of health? Yes, we simply cannot do the work Alyssa does. Without her involvement my staff would be overwhelmed. What are a few of the best ways that that Care Navigator successfully helps to address the patients’ needs? Home visits; family meetings in the home. These are valuable tools that I no longer have time for but are very necessary.

*Dean Romanick, MD, Genese Valley Family Medicine*

“Michele provides us with greater insight into barriers to better health by assessing patients in their home environments to see what obstacles are preventing their compliance with visits, meds, etc. One change I would suggest is to have more Navigators. I have enjoyed working with the Care Navigator.”

*Kipling Goh, MD, Canandaigua Medical Group*
Does Lifespan’s intervention help to better address the patients’ social determinants of health?
Yes; services not normally offered now available to demographic in need.

Leslie Algase, MD, Partners in Internal Medicine

Do you feel that the Lifespan Care navigator has successfully integrated with your office and the medical team?
Yes, Sarah is a key member of our team. She is active in our clinic and the home visits. She participates in our team meetings and helps guide our strategic plan.

Do you feel the patients of your practice benefit from having a Lifespan Care Navigator dedicated to your office?
Yes, Sarah provides a key and critical liaison to the patient and caregiver in the home, connecting with community resources and addressing needs we never could without her.

Does Lifespan’s intervention help to better address the patients’ social determinants of health?
Yes, there are social aspects to their care we would never uncover without Sarah and these social aspects end up, playing a critical role in the health of our patients and caregivers.

What are a few of the best ways that that Care Navigator successfully helps to address the patients’ needs?
• Assessing psychological needs and supports.
• Bridging the gap between what we do in clinic and what occurs at home.
• Addressing psychosocial needs.

If you could change the role of the lifespan care Navigator, how would you modify it?
Well, it’s pretty good the way it is! I need Sarah to remain part of our clinic forever.

David Gill, MD, Rochester Regional Unity Rehab & Neurology Clinic

Do you feel that the Lifespan Care navigator has successfully integrated with your office and the medical team?
Absolutely. Karleen is a wonderful resource to us. She has been immensely helpful in problem solving for our elderly patients. Karleen work very well with all providers, nurses and staff.

Do you feel the patients of your practice benefit from having a Lifespan Care Navigator dedicated to your office?
Yes – Karleen’s expertise and problem-solving skills have proven invaluable. It is so wonderful to have her here. Recently, an elderly patient whom Karleen was involved with called 15 minutes prior to her appointment, panicking that she couldn’t find her purse. The patients sounded confused and anxious. Karlene was able to rearrange her afternoon schedule to stop by the patient’s house to check in on her and helped her to locate her purse so that she could attend her appointment. Wonderful resource.

Does Lifespan’s intervention help to better address the patients’ social determinants of health?
Yes, Karleen is able to identify and address social factors that contribute to over-all health. I believe her work has kept many patients safe, allowed them to stay in their homes and provide financial stability.
What are a few of the best ways that that Care Navigator successfully helps to address the patients’ needs?
I think that Karleen’s ability to talk to, sometimes multiple family members and go to patient’s homes provides significant insight into patient barriers. She is then able to work through those and report back which is very helpful.

If you could change the role of the Lifespan care Navigator, how would you modify it?
I think Karleen is doing a fantastic job. I would not change her role at all.

Laura Converse, PA, Panorama Medical

Sandy has great follow up and follow through. When I call her, I know that she will help me work through a problem and provide great insight. She makes my job easier.

Susan T Murray RN, Care Manager

Lifespan’s programs have helped my patients over and over again. I feel the help they have received from Lifespans programs have helped keep my patients safer at home, get to appt, address abuse issues, financial issues. The services are invaluable. In fact, there is information obtained at the time that Sandy meets with the patients that the providers may not know which is important for the care they receive. In fact, there is information obtained at the time that Sandy meets with the patients that the providers may not know which is important for the care they receive.

Deborah Wayne, Care Manager Rochester Internal Medicine Associates

Do you feel that the Lifespan Care Navigator has successfully integrated with your office and the medical team?
There is very good communication with the Lifespan Care Navigators that I make referrals to. They see or speak with my patients in a timely manner and always get back to me with an update. I feel very comfortable calling Sandy if I have a question about a situation to see if a referral is appropriate.

Having a large practice and not having the navigator on site, it is difficult to get the team “on board.” The follow up we get is excellent and it is nice to have someone out in the home for patient needs.

Having patients in 3 counties (Livingston, Monroe and Ontario), we have different navigators for each. They have all been wonderful and it would be great to have someone dedicated to our office.

Our Care Manager and the Lifespan care navigator work closely to help get services to our patients in a timely fashion.

Do you feel the patients of your practice benefit from having a Lifespan Care Navigator dedicated to your office? If yes, how?
Absolutely, the feedback has been positive. Having the ability to help patients with social concerns has made a great impact and has decreased emergency room utilization.

Yes, they have provided help for many of our patients with aide services, transportation and social work.

Does Lifespan’s intervention help to better address the patient’s social determinants of health?
Absolutely. Yes, some of our patients are unable to afford extra services and Lifespan helps by providing alternatives that we may not be aware of.
It is beneficial to know there is a constant contact for continuity of care. There is also always someone covering if Sandy is not available. I have never had a delay in having a navigator reach out to me, returning a phone message or one of my patients. My patients benefit by having either phone conversation or face to face meetings and having someone give them the resources they need or help in following up with resources. Sandy always has good follow up with the patients as well if they would like it.

**What are a few of the best ways that the Lifespan Care Navigator successfully helps to address the patient's needs?**

Help with transportation, making sure there is access to food, heat. Helping with Medicaid and insurance concerns. Having a united front when caring for patients and making sure they have the best life they can. They have a wealth of great information at their fingertips!

I have a stoic patient that is struggling with COPD, and lifespan has helped to get someone in to help with her home responsibilities that are overwhelming and exacerbates her breathing issues.

**If you could change the role of the Lifespan Care Navigator, how would you modify it?**

I would make sure that every medical office had at least 3!! Sandy does a great job.

**Do you have any other feedback or suggestions in regard to the Care Navigator role?**

Keep doing the great work that you are doing!

*Jennifer McKay, RN *Care Manager

She is able to connect patients with services in the community that I was not aware of.

*Mike Mitchko, MD, Canandaigua Medical Group*

CCC Navigator Karleen’s involvement with patient, S. started about 2 years ago. At that time S. was living with family in a financially, emotionally and verbally abusive situation. S. did not want to involve the authorities or the Elder Abuse Prevention Program at Lifespan out of fear; however, he occasionally talked about moving to a higher level of care to better meet his needs.

Karleen connected S. to EISEP for help with personal care. Over time, Karleen, his EISEP care managers and the Nurse care manager from Panorama Internal Medicine Group were able to increasingly gain S.’s trust. He spoke about moving but cancelled tours to assisted living sue to his fear of retaliation. Karleen made home visits and frequently called S. to provide support and encouragement. Karleen arranged another tour along with transportation for S. to an assisted living community. Karleen accompanied S. on the tour, gathered information about services and costs, and acted as the liaison between the building administrator and S. S. really liked the community and realized it was possible he could finally move.

A room became available that S. needed to take or lose this opportunity. Karleen was able to secure funding to hold the room. Karleen also arranged for herself and two of her colleagues to physically move S. into the facility which went beyond the usual CCC program services. After the move, Karleen made a return trip to help S. organize some of his things, provide moral support in this transition and find medication that the staff needed to inventory. S. was
nervous to move right before having cataract surgery but the move was beneficial because it ensured the correct medical follow-up care that he wouldn’t have received if he was still living with his family.

In S.’s case, having a CCC Navigator to provide personal and sometimes intensive support enabled him to move out of an abusive situation. He now has the opportunity to enjoy a healthier, higher quality of life.

Charles Wadsworth, MD, Panorama Internal Medicine Group

[The Lifespan Care Navigator is] the first to identify needs, follow-up to ensure needs have been met and draws in family support. Her role as helped us to move along to see patients. These appointments are time consuming; she has been very helpful.

Sue Zambo, NP, Canandaigua Medical Group

[The Lifespan Care Navigator] talks with the patient; helps find out what barriers they may have.

Rachel Reed, PA, Canandaigua Medical Group

RE: Healthcare Coordination:
This program through Lifespan has made such a difference in the care coordination of a mutual patient who receives his care at the VA. The supportive presence of Kathy at this Veteran’s appts and her ability to assist with coordination of care and resource linkage has been of tremendous value to a vulnerable Veteran with functional and cognitive decline. With no supportive family presence at his appts Kathy was able to provide advocacy and information that we would not otherwise have obtained. As a result of the collaboration of several agencies and supports, this Veteran is now moved into a more supportive environment. I would highly recommend this program to others and look forward to working with Kathy again.

Catie Peck, LMSW, Social Work – PACT, Department of Veteran’s Affairs

Kathy — Amazing, amazing work that you do for us!! You are an incredible support for one of our wound center patients. This program is a well needed program in our community. We have a large number of elderly diabetics and this service provides support, coordination with appointments, reminders, family communication and companionship. You have such an incredible relationship with Betty. She is just thriving because of you. Thank you again for all that you do. I only wish more patients could be enrolled in this program.

Yvonne Stone MSN, St. Ann’s Clinic

[The Lifespan Healthcare Coordinator is] my eyes in the home.

Stephen Judge, MD, URMC

[The Lifespan Healthcare Coordinator] keeps a log of appointments; is aware of patient’s needs; able to provide important feedback.

Diane Thangathurai, MD, Wilson Health Center

I am writing to you with deepest respect and admiration for the dedicated and compassionate care Kathy Preish has given to a resident at St. Jude apartments. She has diligently supported her and family members during very complex medical and mental health situations. All of Kathys professional interactions have proved to be the catalyst in
obtaining the resident the care and services she so desperately needed. I am so grateful to have had the opportunity
to experience being part of this residents’ care team with Kathy’s devoted professionalism. She is an employee that
deserves the highest of all awards and recognition.

Sharon Seitz, Resident Service Coordinator, St Jude Apartments

Community Care Connections Family and Client Testimonials

“Dear Karleen,
Thank you so much for your very helpful information. The road ahead is certainly less intimidating with the
privilege of having a knowledgeable advocate such as you providing the very information needed. I’m very, very
grateful!” Belva

I am writing this afternoon to celebrate your team at Lifespan — especially Mary Law — and thank you for supporting
families. I have enclosed my communication to Mary on Sunday evening as my family and I were encountering
challenges with Unity Hospital, following, my mother’s emergency room visit last Thursday morning.

This morning, Monday, Mary was a lifesaver in reading and understanding our situation and immediately calling me
and being on scene at the hospital as we tried to be patient advocates for my mother, June, as the hospital was ready
to discharge her home. I could not have managed everything from a distance had Mary not assessed several needs at
once (my mother’s, my sister’s, the hospital’s, and mine) and offered to step in with her calm and clear-sighted advice
and support.

I and my family are so very grateful to Mary. And grateful to you and Lifespan for matching us up. Thank you. Earlier
this morning, I expressed to Mary my heartfelt thanks, but I wanted to share this experience of her care and kindness
with you as well. Warmest regards to Mary and to you,

Dawn (daughter of June)

I would like to take time to formally and officially applaud Kathy for going far beyond her services to make sure I made
numerous appointments weekly. Kathy has met me at all of my appointments and is very thorough in getting the
proper information from my PCP and each specialist. This organization, Lifespan has been and continues to be exactly
what I needed to meet unexpected issues. I would like to share a recent incident wherein I was discharged from the
hospital and the cab company transported me to my previous address by mistake, only to return me to the hospital
again. I called Kathy and she immediately arranged for another cab to pick me up and she came back to the hospital
to make sure I got home safely. Everyone that needs assistance should have Kathy as their Healthcare Coordinator.

Carolyn

Michele Rice has been delightful to work with. She has offered many suggestions on services to keep my 93-year-old
mother-in-law in the home she has lived in since 1931.

Alice, family member

We were referred by my mother’s doctor's office. We were so surprised to hear that a social worker was there to help
us. We don’t know where we would be now if we had not been referred. Michele gave us her cell number and email
so we could always contact her. She even responded to our emails at night and on the weekend, which we never
Family member

Dear Kathy,

Just wanted to take a few moments to say thanks for the help that you and this program does for my parents. As you know they are 92 and 95 and living at home (amazing but true) yet they need help.

The most important help they need is help with coordinating their healthcare needs....not easy for the young and even more difficult for the elderly! I love this coordination of care program you offer and Kathy you are “perfect” for the job. Mom says she can tell that you love your job and I can tell that you really care about both of my parents....so thanks, really.

Additionally, the simple but effective coordinated care techniques that you have put in place for them (essentially housebound) have made a huge difference in them receiving more timely and effective care. For example — having the blood drawing come to them (instead of arranging transportation to get 90+ folks out in the snow and ice just to get bloodwork!); arranging for a nurse to do dressing changes when it was clear that the infection on my dad’s face was not clearing up, re-scheduling and/or scheduling appts!! — huge — they can’t do that anymore — my folks would put it off or take next available....having a healthcare advocate that can listen (yup Dad can’t hear very well at all) and intervene and keep family members updated makes good healthcare sense as well as financial sense.

Thanks also for arranging transportation, meeting my folks at appointments and reminding the providers of your role in this process. Kathy — thanks again and thanks for caring when you provide care.

Kind regards,
Sheila (daughter)

Thank you is just not enough to say — for the wonderful support Lifespan and Michele Rice have given to my parents. Michele has searched tirelessly for the help and programs that could benefit my parents. A little background: my father is disabled and over the last year has gotten to the point where he is permanently wheelchair bound. He can transfer to a lift chair where he can sleep but nothing more. Dad is a tall man and as such has a large wheelchair. Mom is of very petite stature with health issues of her own. Dad had become housebound. And Mom had to deal with all his care. At their ages, this has been difficult. Yet neither one needs a nursing home.

My parents were recommended to Michele to participate in the program and since then she has been a wonderful advocate! Up to that point, I had no idea where to turn for help.

The idea of a knowledgeable trained person to identify needs, programs to fill those needs and then to navigate all the twists and turns is pretty much life-saving. The average person has no knowledge of programs that might be available much less how all the agencies work together. And then there are all the forms.....my parents (and me, at times) were confused and anxious. Michele guided us through it all.
My parents are now living a better quality of life than they had been. I’m so grateful for that.

The services this program provides are so needed in our community. We couldn’t have accessed these services on our own. We had no clue!

Again, thank you for the support and guidance Michele has been able to give us — and she did it all with grace, humor, and patience!

Sincerely,
Lin (daughter)

We are pleased to relate our experience with Sandy. She was very professional and helpful and was instrumental in us getting our apartment at Eastman Gardens. She is caring, positive and goes that extra measure to help with insurance and medical papers. We feel most fortunate to be connected with her.

Care Navigation clients

“I never would have known what help existed for seniors. God Bless Karleen. She has helped me financially and I’m sure this program has helped others besides me so it would be a shame to let it go.”

Katja

The money you saved me by getting my basic health insurance paid for by the government will allow me to pursue getting my dental needs up to par, along with being able to afford monthly medical prescription medications. Paul, thank you for all of the help you’ve given me relative to medical expenses. I'll be seeing Hank on May 8th @ 1pm… maybe I’ll see you then. In the interim, don't work too hard, and keep being the MPH (major problem hero) that you’ve been to me.

Randy
Appendix 14

- **Peer Place Customized Platform**: Demographics, diagnoses, community services needs and referrals and standardized wellness assessments, conducted at intake and case closure.

- **Rochester RHIO Data**: Hospital inpatient and emergency encounters from health systems in Greater Rochester Region.
ACCESS POINTS
(3) Home Healthcare Agencies
(5) Physician Practices with embedded Care Navigator
(30) additional referring Physician practices

Referral made to Lifespan Care Navigator

Care Navigator receives referral

Caregiver Support
Housing
Social Connectedness
Physical / Medical
Financial Benefits
Transportation

Healthcare Coordination
Matter of Balance
Chronic Disease MGMT
Home Safe Home

Links to Community Based Services referrals

Links to Lifespan Resources

Assessment
Care Plan
Referrals
Ongoing Home Visits

Community Care Connections " Access Points Work Flow"
4 in 5 physicians say unmet social needs are directly leading to worse health (for patients).*

Let’s change this together.

COMMUNITY CARE CONNECTIONS
A new service for older adults from Lifespan

Under a new contract with the New York State Department of Health, Lifespan can now work collaboratively with you and your patients to address social needs and improve health outcomes.

Because what happens on the other side of the health care door impacts health outcomes.

To make a referral to Lifespan’s Community Care Connections service, please call us at 585-287-6370.

For more information about this new service from Lifespan, please call Annie Wells at 585-287-6433 or Christine Peck at 585-287-6355.

Lifespan’s Community Care Connections service will assign a social worker or an L.P.N. to work with your patients age 60 and older who have:

- A demonstrated difficulty navigating the health care system.
- A history of missing appointments.
- An aging or stressed caregiver.
- Two or more ED visits or hospitalizations with the past year.
- Low health literacy.
- A history of non-adherence with treatment plan.
- Co-morbidities, especially those that limit ADLs.
- Poly-pharmacy.
- Or who lives alone.

Lifespan’s Community Care Connections social workers provide:

- Ongoing home visits.
- Geriatric wellness assessment.
- Care plan development.

We can connect your patients to services such as:

- Housing.
- Financial benefits.
- Transportation.
- Respite.
- Socialization.
- Mental health intervention.
- Caregiver supports.
- Home safety modification.
- Chronic disease management workshops.
- Geriatric addictions intervention.
- Elder abuse intervention.
- Among other social supports.

Lifespan’s Community Care Connections L.P.N.s:

- Schedule and track medical appointments for patients.
- Accompany patients to appointments to advocate and ensure understanding of health information.
- Conduct in-home medication reconciliation.
- Provide health care education.

Our social workers and/or L.P.N.s will connect back with you during our work with your patients because we believe a team approach provides the best outcomes.

Patients must be residents of Monroe, Ontario, Wayne, Livingston or Yates counties.

Exclusion criteria includes:

- Enrolled in Health Home Care Management.
- Living in supportive housing.
- Receiving palliative care or hospice.
- Enrolled in managed long-term care (MLTC).

“I have made multiple referrals to Lifespan. It is a wonderful resource for me as a clinician and also for my patients. The unique array of social and clinical services provided by Lifespan has filled gaps in the generic health care system, improved patients’ clinical outcomes and quality of life.”

– C. Michael Henderson, M.D., Rochester General Hospital

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LIFESPAN’S COMMUNITY CARE CONNECTIONS SERVICE

Helping you take on health care challenges

Give us a call at
585-244-8400 ext. 270
or e-mail CCC@lifespanrochester.org

Funded by New York State Department of Health.

Lifespan can help.

Navigating medical care and managing things at home can be difficult.

www.lifespanrochester.org
Navigating medical care and managing things at home can be difficult.

- Do you have difficulty getting to your medical appointments and managing your medications and health conditions?
- Have you had emergency room visits and/or been in the hospital too often?
- Are you trying to manage the care of a parent or spouse?

Lifespan can help.

For more than 45 years, Lifespan has been helping older adults and their caregivers approach aging with greater information, supportive services and the guidance to make the most of the years ahead.

Lifespan’s Community Care Connections social workers, LPN nurses and community health workers can visit you at home to help you.

- We can make sure you find transportation to doctor’s appointments.
- We can provide information about housing options, financial benefits, transportation and home safety modifications, fall prevention and disease management classes, just to name a few.

Our help doesn’t end there.

- We can schedule and track medical appointments for you and meet you and/or your loved one at medical appointments as your advocate.
- We can make sure you’re taking the right medications at home.
- We can help you understand your health conditions.
- If you’re a full-time caregiver, we can connect you to respite, so you can take a break.

*We are unable to provide clinical nursing services. You do need to live in Livingston, Monroe, Ontario, Wayne, or Yates county to use our services. Some other exclusions also apply.

Give us a call at 585-244-8400 ext. 270 or e-mail CCC@lifespanrochester.org
LIFESPAN’S COMMUNITY CARE CONNECTIONS SERVICE

Helping you take on health care challenges

Navigating medical care and managing things at home can be difficult.

Do you have difficulty getting to your medical appointments and managing your medications and health conditions?

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- And we can help you understand your health conditions.
- And if you're a full-time caregiver, we can connect you to respite, so you can take a break.

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